NURHI

Family Planning
On-the-Job Training Curriculum

Course 1: COUNSELLING TRAINING
FACILITATOR'S MANUAL

NOVEMBER 2012

Produced by Nigerian Urban Reproductive Health Initiative (NURHI), a Bill and Melinda Gates Foundation funded project in Nigeria.

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www.nurhi.org

List of Abbreviations/Acronyms and References

Abbreviations/Acronyms

ANC	Antenatal Care
ASK	Attitudes, Skills and Knowledge
COC	Combined Oral Contraceptive
CPR	Contraceptive Prevalence Rate
EC	Emergency Contraception
ECP	Emergency Contraceptive Pills
ELC	Experiential Learning Cycle
FAM	Fertility Awareness-based Methods
FMOH	Federal Ministry of Health
FP	Family Planning
GOPD	General Out Patient Department
HCT	HIV Counselling and Testing
HTSP	Healthy Timing and Spacing of Pregnancy
IEC	Information, Education and Communication
IMNCH	Integrated Maternal, Newborn and Child Health
IPPC	Interpersonal Communication Counselling Skills
IUCD	Intra Uterine Copper Device
IUD	Intra Uterine Device
LAM	Lactational Amenorrhea Method
LGA	Local Government Area
LMIS	Logistics Management Information Systems
MDG	Millennium Development Goal
MEC	Medical Eligibility Criteria
MNCH	Maternal, Newborn and Child Health
NSF	National Strategic Framework
NURHI	Nigeria Urban Reproductive Health Initiative
OJT	On-the-Job Training
PAC	Post Abortion Care
PMTCT	Preventing Mother-to-Child Transmission
PNC	Postnatal Care
SEM	Social Ecology Model
SRHR	Sexual and Reproductive Health Rights
STI	Sexually Transmitted Infection
USAID	United States Agency for International Development
WHO	World Health Organization

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The development of the On-the-Job Training curriculum has been recognised as another milestone in building the technical competence of the health workers in the provision of quality Family Planning service. This achievement has been through the concerted effort of the Ministry and its technical partners.

The Federal Ministry of Health would like to extend its gratitude to individuals and organizations who contributed to the development of the On-the-Job Training (OJT) curriculum for health workers in the provision of Family Planning services through **counselling skills.** The curriculum will continually strengthen the skills and capacity of health workers, most especially the Nurses/Midwives, who are key health providers at the grass root level.

I commend the support of our esteemed partners particularly Nigerian Urban Reproductive Health Initiative (NURHI) who provided technical support to Federal Ministry of Health in the development of the OJT Curriculum in line with the global concept of continuum of care.

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FOREWORD

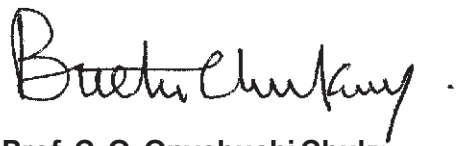
The Goal of achieving the health related Millennium Development Goals (MDGs 4, 5 & 6) may not be realized without family planning. Family planning plays a vital role in the health of the individual, family and also contributes significantly to the socio-economic development of a nation. In view of this, there is need to strengthen the health care system to ensure the provision of quality reproductive and family planning health care services across Nigeria. This is in tandem with the new global trends in family planning and reproductive health practice.

Providing quality family planning services to women, men and young people while ensuring that there are no barriers to assessing care is no doubt critical to reduction in maternal and child mortality, unplanned pregnancy, STDs and increasing awareness for child spacing. Thus, it is important that evidence-based information is given to family planning users to enable them make informed choices. Similarly, health providers need current information to facilitate provision of quality family planning services.

In response to this and in recognition of new global trends in family planning, the Federal Ministry of Health in collaboration with the Nigerian Urban Reproductive Health Initiative (NURHI), other development partners and NGOs developed On-the-Job training (OJT) curriculum for training the health workers on **counselling skills services.** The document is developed in line with the recently updated National Training Manual on Family Planning for Physicians and Nurses/Midwives, the service protocols, the Performance Standards for family Planning services in Nigerian Hospitals and 2008 WHO Medical Eligibility Criteria (MEC) and the performance standards for family planning services in Nigeria.

This approach provides learning through classroom teaching integrated with practical demonstrations of skills by trainees through group exercises and practical experience at the service delivery points. Throughout the duration of the training, participants will be trained to acquire the knowledge, skills and attitudes that are needed to provide quality FP services.

This curriculum will improve the technical competence and confidence of health workers, contribute to increase access to quality family planning service provision and which ultimately will lead to increase contraceptive prevalence rate (CPR) within the country so as to achieve the health related MDGs 4, 5 & 6 by year 2015.



Prof. C. O. Onyebuchi Chukwu
Honourable Minister of Health
November, 2012

AKNOWLEDGED LIST OF CONTRIBUTORS

This Family Planning On-the-Job Counselling Training Facilitators's Manual has relied heavily on international best practices and previous publications, especially the works of Engender Health and Johns Hopkins University Center for Communications, JHU/CCP.

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INTRODUCTION TO THIS CURRICULUM

1. PROJECT OUTLINE

The Nigeria Urban Reproductive Health Initiative (NURHI) is a five-year project (2009-2014) funded by the Bill and Melinda Gates Foundation to reduce barriers to family planning (FP)/child spacing use and increase the contraceptive prevalence rate (CPR) in selected urban areas of Nigeria. The program brings together private and public sector resources to strengthen the delivery of family health services. NURHI aims to ***eliminate the supply and demand barriers to contraceptive use in order to significantly increase the CPR over the five-year life of the project in six selected urban cities in Nigeria. NURHI*** envisions a Nigeria where **supply and demand barriers to contraceptive use are eliminated, particularly among the marginalized urban poor**.

NURHI has five objectives:

1. Develop cost-effective interventions for integrating quality FP with maternal and newborn health, HIV and AIDS, post-partum and post-abortion care programs.
2. Improve the quality of FP services for the urban poor with emphasis on high volume clinical settings.
3. Test novel public-private partnerships and innovative private-sector approaches to increase access to and use of FP by the urban poor.
4. Develop interventions for creating demand for and sustaining use of contraceptives among marginalized urban populations.
5. Increase funding and financial mechanisms and a supportive policy environment for ensuring access to FP supplies and services for the urban poor.

1.1 The situation of family planning in Nigeria

Data from the 2008 edition of the Nigeria Demographic Health Survey provides a context to situate the need for focusing on-the-job-training (OJT) as an important strategy to reduce barriers to access to and utilization of FP services. Nigeria has a population of over 150 million with over half of these being in the reproductive age group of 15 to 49. The total fertility rate is 5.7% with unwanted pregnancy at 4%, and mistimed pregnancies at 7%. Although there are high levels of knowledge about FP (90% among men and 72% among women), 29% of the population has ever used a method. Current use for FP is 15% for all methods and 10% for modern methods. Nigeria currently has an unmet need of 20%. The role of the private sector in providing FP services is significant: 61% of the population source FP from the private sector of which patent medicine vendors and pharmacies account for about half of this figure. Public sector participation accounts for 23% of FP service provision.

The reality behind these statistics is about the many missed opportunities to help clients access and utilize FP services. Often, providers' attitudes to clients' informed voluntary choices still act as barriers to FP, and gender-inequitable social and cultural norms create further obstacles. The strategic role that FP and maternal, newborn and child health (MNCH) services play towards the Millennium Development Goals (MDGs) is often still not fully understood by heath providers and the community at large, and this weakens efforts to address misconceptions and biases about FP.

OJT can play a very important role to address these issues and increase capacity of FP/MNCH services to minimize missed opportunities to access and use FP.

1.2 Addressing the national strategy and policy context

NURHI works in close collaboration with the Federal Ministry of Health (FMOH) and with State Health Ministries. Therefore this curriculum was designed to support and build on the strengths of existing service protocols and standards. In particular, the following documents were used to guide the design of the curriculum:

- The National Training Manual on Family Planning for Physicians and Nurses/Midwives.
- The National Family Planning/Reproductive Health Service Protocols.
- The Performance Standards for Family Planning Services in Nigerian Hospitals.
- The National Family Planning /Reproductive Health Policy Guidelines and Standards of Practice.
- The Streamlined Contraceptive Logistics Management System (CLMS, 2009) Participant's and Trainer's Guides.
- The USAID | DELIVER PROJECT, Task Order 1. 2009. *The Logistics Handbook: A Practical Guide for Supply Chain Managers in Family Planning and Health Programs.* Arlington, Va.: USAID | DELIVER PROJECT.)
- **The Integrated Maternal Newborn and Child Health (IMNCH) Strategy.**
- The **National Strategic Framework 2010-2015. Policy context and considerations for the development of the National Strategic Framework II (NSF II) 2010-2015.**
- The Global HIV/AIDS Initiative Nigeria Technical Strategies.

2. CONCEPTUAL AND METHODOLOGICAL DESIGN OF THE OJT CURRICULUM

2.1 Overall goals of the curriculum

These are to contribute to:

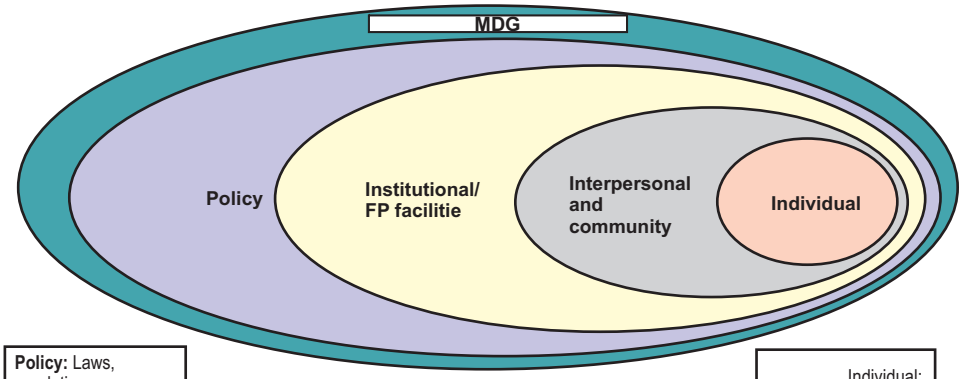
- Strengthening the strategic role of FP/MNCH service provision in achieving the MDG, and especially goals 3, 4, 5, 6, and 7.
- Strengthening quality of FP/MNCH service provision in Nigeria, and especially in high volume sites in urban areas.
- Advancing provision of client-centred integrated FP/MNCH services, and especially in high volume sites in urban areas.
- Removing barriers to access to and use of FP and child-birth spacing methods.
- Increasing the contraceptive prevalence rate in Nigeria.

2.2 The Social Ecology Model as a design framework

This curriculum was designed mirroring the conceptual approach of NURHI, namely the social ecology model (SEM):

- The SEM provides a framework to analyse *the big picture* in various disciplines, including health.
- The SEM looks at how structural and individual factors inter-relate across key spheres of influence to influence health issues. These spheres of influence are: **individual, interpersonal, institutional and policy.** In the case of FP/MNCH services and programs in urban areas of Nigeria, NURHI applied the SEM to analyse how the inter-relations of these spheres of influence affect the strategic role of FP/MNCH services and programs to achieve the MDGs.

Social Ecology of FP/MNCH in the context of achieving MDG in Nigeria



Policy: Laws, regulations, strategic plans, service standards, affirmative actions, etc addressing the root causes of health inequities e.g. gender inequity that hinder the role of FP/MNCH in achieving the MDG

Institutional/FP facilities: Role and capacity of FP/MNCH services in addressing barriers (e.g. providers' attitudes) to access to and use of quality services that ensure clients' voluntary informed decision making

Interpersonal/ community: Values and practices re gender and sexuality, reproduction, fertility, FP/MNCH, women's health, parenting, power in sexual relationships etc affecting voluntary informed decision making in FP/MNCH

Individual: Psychological & cognitive factors (e.g. believes, values, attitudes, knowledge) affecting agency and power to make voluntary informed decisions in FP/MNCH

- **Individual sphere of influence**: In order to be able to access and use FP/MNCH services and make voluntary and informed decisions, individuals and couples need to develop an understanding of the issues that affect their lives and an ability to take action on those issues. In other words, they need to have **agency**. But the development and use of agency requires self-reflection, self-esteem, self-assurance, and a sense of self-worth as human beings regardless of any other label. These psychological and cognitive factors shape our perceptions and our individual identities, and impact the power we have (or perceive we have) to make informed and voluntary decisions that we can carry out and sustain without fear of negative repercussions, e.g. deciding how many children to have and their spacing.

- **Interpersonal and community sphere of influence**: Individual agency is developed in and affected by the social context in which people live. The

interpersonal and community sphere is the primary social context that we get exposed to from very early on in our lives. Clearly, this sphere has a huge impact on how we develop self-reflection, self-esteem, self-assurance, and a sense of self-worth as human beings. This is the sphere of influence in which as individuals we have a first experience of what society expects of us as women and men, and the roles and opportunities that come with those expectations and norms. For example, beliefs that women should not have access to decision-making around their reproductive health or that "real men" should not be involved in caring for children may very negatively affect access to and use of FP/MNCH services for individual and couples and, in turn, undermine achieving the MDGs. The detrimental impact of such beliefs on the psychological and cognitive factors needed to develop agency for voluntary informed decision-making and health seeking is very significant and very pervasive because it precludes access to a wide range of opportunities for human and social development. Unless the institutional and policy spheres acts to redress this situation – for example through education and training of providers to support clients in making voluntary informed decisions and choices - inequities may become entrenched and turn into cultural features of a society. Thus any attempt to change such inequities may be easily labelled as an attack on "our culture" and inequities may be masked as moral righteousness. At the same time, those who face the brunt of inequity may find other ways to cope with their issues and needs, for example by turning to unqualified practitioners or to unsafe practices, or having to pay more (if they can afford it) to access services. Again and again, inequity breeds inequity and affects the most vulnerable.

- **Institutional/FP facilities sphere of influence**: This sphere of influence is connected to all the others by many interwoven threads. The family is perhaps the most obvious institution showing the impact of this sphere. Values, beliefs, attitudes, and social norms that affect the psychological and cognitive factors for voluntary informed decision-making and health seeking are first and foremost experienced in this context. From this perspective, the family really functions as the cornerstone of social ecology and plays a huge role in enhancing or hindering a supportive environment for equitable social development. Similarly, other institutions such as police, schools, media organizations, NGOs, religious groups, unions, political parties etc. all play an important role in shaping the social environment. The values and practices of these institutions greatly affect root causes of inequity, such as gender discrimination, denial of human rights, and stigma and discrimination, one way or the other. However, when change happens in one of these institutions, often there is a ripple effect over time especially if these institutions are elements of broader networks (such as in FP/MNCH) and if they can model change from within effectively, for example by championing and realizing equity. In health, this sphere of influence is paramount. Unless health institutions realize that they have a very significant effect on root causes of health problems simply by the values that they model (e.g. equity, respect of human rights and first and foremost the right to health, do no harm, ethical conduct, and accountability) they may continue to exclude many people from accessing life- saving information and services, and hindering the MDG.

- **Policy sphere of influence**: This sphere of influence is greatly affected by all the others and in turn affects the social ecology as a whole. In public health, we have come to realize the importance of informing policy development through

research and evidence. However, in order to affect the social ecology of health problems, health policy must also be the result of meaningful engagement of the communities and groups that it aims to benefit (e.g. women and families). Most important, health policy should aim to address root causes of problems, i.e. the social determinants (factors) that contribute to create specific health patterns or unfair and avoidable difference among socially defined population groups, such as women of reproductive age. Therefore, health policy development and its implementation cannot be divorced from an equity and rights-based perspective, because these are the fundamental issues that determine access to information, services, research, resources (including decision-making for health seeking behaviours). In the SEM, effective policy development and implementation (intended as a broad term encompassing normative and guiding principles and actions) is one of the most important strategies for equitable social development and for promoting social inclusion and cohesiveness because it focuses on addressing the social and system factors that undermine attaining the highest possible level of health and well-being, which is a human right as well as a social and individual outcome. At social level, this outcome requires the elimination of inequities in order to foster and maximize the development and sustainable use of agency and power for voluntary informed decisions for health seeking behaviours at individual level.

1. End poverty and hunger.
2. Achieve universal primary education.
3. **Promote gender equality and empower women.**
4. **Reduce child mortality.**
5. **Improve maternal health.**
6. **Combat HIV/AIDS, malaria and other diseases.**
7. **Ensure environmental sustainability.**
8. Develop a global partnership for development.

2.3 Contribution to strengthening the role of FP/MNCH in support of the MDGs

By developing the curriculum through an analysis of the social ecology in which FP/MNCH services operate, this curriculum aims to contribute to strengthen the role of such services toward structural change, and specifically in achieving MDGs 3, 4, 5, 6, and 7:

Many married women report having mistimed or unintended pregnancies or a desire to space or limit future pregnancies, but are not using modern contraceptive methods. Satisfying existing unmet FP need would help families achieve their desired family size, reduce total fertility, and, ultimately, slow population growth. In fact, to accelerate progress in achieving the MDGs, a new target was added under the maternal health goal (MDG 5) in 2007. The new target, 5b, calls for providing universal access to reproductive health services and includes the contraceptive prevalence rate and unmet need for family planning as key indicators for meeting this target.
Source: USAID | HEALTH POLICY INITIATIVE, Task Order 1, 2009: Family Planning and the MDGs: Saving Lives, Saving Resources

In order to contribute to strengthening the role of FP/MNCH in achieving the MDGs and broader social development aims, this curriculum focuses on strengthening providers' A-S-K to contribute to overcome health inequity and its causes, especially gender inequity and the inadequate empowerment of women.

2.4 Focus on competencies and performance improvement

This curriculum is structured in three courses, namely:

1. OJT for FP counselling service provision.
2. OJT for FP clinical service provision.
3. OJT for contraceptive logistics management for FP service provision.

In the approach used in this curriculum, a core competency is defined as:

> *Core competency: Units of attitudes-skills-and knowledge (ASK), which are essential to be achieved by a person (e.g. a FP/MNCH service provider) in order to provide quality services.*

The curriculum revolves around four cross-cutting core competencies, which are realized through clusters or units or A-S-K. These A-S-K clusters create synergy of the four competencies across the three courses:

CORE COMPETENCIES	SPECIFIC CLUSTERS OF A-S-K FOR EACH COURSE		
	ILLUSTRATIVE COUNSELING COURSE A-S-K	**ILLUSTRATIVE CLINICAL COURSE A-S-K**	**ILLUSTRATEIVE LOGISTICS COURSE A-S-K**
1. Effectively ensure client's voluntary informed **decisions**	Value and ensure clients' rights Effectively enable clients to assess their reproductive goals and needs Enable clients to choose most appropriate option for their circumstances Develop clients' skills to implement choices and decisions	Value and ensure clients' rights Effectively provide accurate and complete information in language that clients can understand Provide services with privacy, dignity, and safety for clients	Value and ensure clients' rights Value and ensure the six rights of CLMS Effectively implement the key principles of CLMS
2. Effectively enable access to and use of quality FP/MNCH services	Perform effective IPCC skills Value and promote gender equity Manage attitudes effectively Assess clients' additional reproductive and MNCH needs and refer appropriately	Demonstrate and effectively use technical knowledge Address misconceptions effectively Assess clients' additional reproductive and MNCH needs and refer appropriately Value and ensure reproductive rights	Collect and compile quality LMIS data Effectively maintain the inventory control system Ensure no stock-outs Ensure no over-supply

CORE COMPETENCIES	SPECIFIC CLUSTERS OF A-S-K FOR EACH COURSE		
	ILLUSTRATIVE COUNSELING COURSE A-S-K	**ILLUSTRATIVE CLINICAL COURSE A-S-K**	**ILLUSTRATEIVE LOGISTICS COURSE A-S-K**
3. Effectively provide quality reproductive care	Provide accurate and complete information in a language that clients can understand Provide effective client-centred FP/MNCH integrated counselling Address rumours and misconceptions effectively	Perform effectively and safely client assessment and screening Effectively implement medical eligibility criteria Effectively Address side effects Perform effective infection prevention	Effectively determine when to order supplies Effectively use different types of LMIS forms Effectively implement proper storage procedures Effectively conduct visual inspections for proper storage
4. Effectively provide referral and follow-up	Implement protocols effectively Enable clients to identify and plan follow-up Provide effective follow-up as necessary	Implement standards effectively Assess clients' additional reproductive and MNCH needs and refer appropriately	Implement standards effectively Effectively support contraceptive and non-contraceptive forecasting

In each course, the key A-S-K clusters are defined through the objectives of each session.

The core competencies and the A-S-K are aligned to the National Training Manual on Family Planning for Physicians and Nurses/Midwives, the National Family Planning/Reproductive Health Service Protocols, the Performance Standards for Family Planning Services in Nigerian Hospitals, and the Streamlined Contraceptive Logistics Management System (CLMS, 2009) Participant's and Trainer's Guides.

2.5 Focus on addressing gender inequity as a key barrier to ensuring the strategic role of FP/MNCH in achieving the MDGs

The four cross-cutting competencies that this curriculum focuses on are essential to strengthen the strategic role of FP/MNCH services in achieving the MDGs because each of the competencies and their synergy through the A-S-K clusters address key social ecology factors that impede access to and utilization of FP/MNCH.

The curriculum places particular emphasis on enabling health providers to explore in depth the role of gender inequity in undermining access to and utilization of FP/MNCH

services, and how they can use this enhanced understanding to facilitate clients' problem-solving for informed voluntary decision making. Through this approach, health providers can identify real life impacts of gender inequity on access to and utilization of FP/MNCH services and on quality of care. An important aspect of this learning process consists of enabling providers to explore how their own attitudes to gender and sexuality may reinforce barriers to FP/MNCH access and use, and how to re-orient their attitudes in support of clients' informed voluntary decision making.

The emphasis on addressing gender inequity runs across the three manuals of this curriculum:

- In the **counselling** training manual, it is realized through a focus on addressing the impact of gender inequity on quality of counselling as an essential pre-requisite to enable optimal access to and utilization of FP/MNCH services.
- In the **clinical** service provision training manual, it is realised through a focus on ensuring clients' reproductive goals, reproductive rights, and provision of client-centred quality care.
- In the **logistics** management training manual, it is addressed through a focus on skills for effective logistics management to ensure the strategic role of FP/MNCH services towards the MDGs.

In this way, the three manuals connect and reinforce learning opportunities to develop A-S-K clusters (i.e. the four cross-cutting competencies) in order to address gender inequity-related barriers to access to and utilization of FP/MNCH services.

2.6 Focus on FP/MNCH Integration

This curriculum emphasizes the development of A-S-K clusters that enable health providers to minimize missed opportunities thus helping clients access services and make voluntary informed decisions at any entry point of the FP/MNCH spectrum of services.

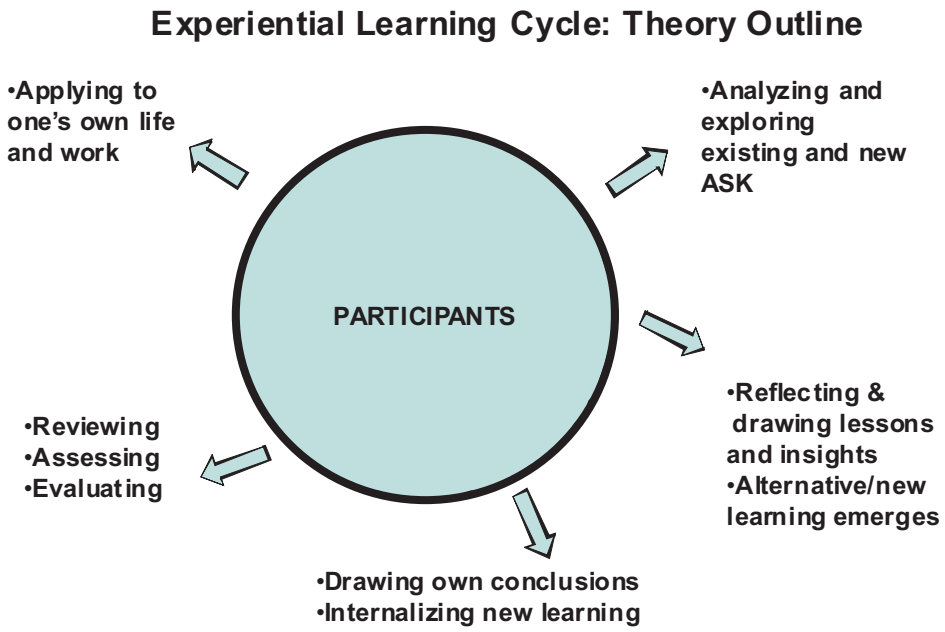
It is worth noting that the Master Trainers involved in the design of this curriculum developed a FP/MNCH Integration Framework through their knowledge and experience of the Nigerian clinical setting. This framework is used in the curriculum and applied to scenarios and case studies during the training to enhance skills for integrated service provisions and improved referrals. These analyses are in turn used to enable the participants to further reflect on the strategic role of FP/MNCH towards the MDGs.

2.7 Focus on effective clinical skills

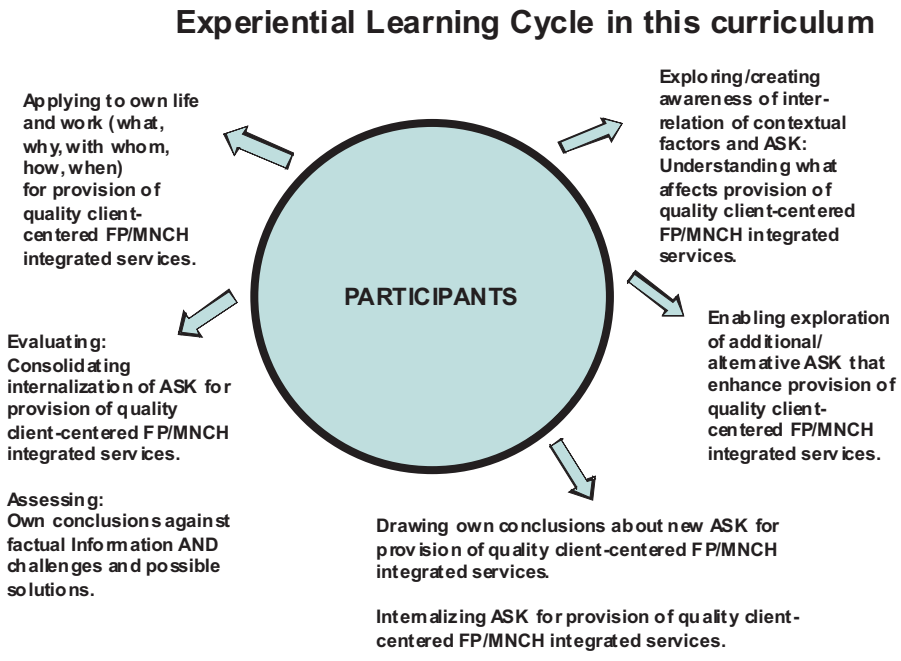
One of the important contributions to this curriculum to improve quality of care consists of its emphasis on developing effective skills to apply the Medical Eligibility Criteria (MEC) of the World Health Organisation. Both the counselling and the clinical service provision training manual contain sessions and materials to strengthen and apply knowledge and skills to use the MEC to facilitate clients' problem-solving and ensure their safe informed voluntary decisions.

2.8 Learner centred experiential focus

This curriculum adapts contemporary good practice models for learner-centred training, and namely the Experiential Learning Cycle (ELC). This model recognizes that participants and learners bring psychological and cognitive assets i.e. their existing attitudes-skills-knowledge (A-S-K) to the process. These assets, often informed by the participants' own experience of the issues being explored, are highly valued and contribute to the wealth of knowledge from which the activities in the curriculum will draw:



In this curriculum, the application of the ELC focuses on developing assets that support effective counselling for client-centred FP/MNCH integrated service provision:



The approach aims to foster the development of participants' insight, reflective thinking, problem-solving skills, and ownership of learning. In most activities, participants are encouraged to reflect on their own experiences and to draw from their real life issues either as a context for their reflection and problem-solving and/or to apply new insight and knowledge.

The curriculum creates connections and linkages across session topics by exploring key attitudes, skills, and knowledge (ASK) in different ways and perspectives by using a range of methodologies such as:

story telling	case studies	role plays
group work	buzz groups	structured discussions
brainstorms	presentations	values clarification

Teachable moments are created throughout the curriculum and are used to reinforce internalization of learning. Substantial time is allocated to skill-building through role plays.

The exploration of how individual and social factors interconnect in affecting both FP/MNCH and **provision of quality client-centred FP/MNCH integrated services** is a prominent theme in this curriculum and it is linked to developing ASK that support quality in service provision in order to contribute to address the structural factors of poor FP/MNCH.

The curriculum deliberately limits the use of power point presentations in order to focus on learner-centred experiential methodologies. Therefore a key aspect of this course is the active engagement of participants.

1. CURRICULUM DEVELOPMENT PROCESS

3.1 How the conceptual and methodological approach led to identifying, testing, and finalizing competencies and A-S-K of the curriculum

The development process of this curriculum drew from the facility assessments and performance improvement plans previously conducted by NURHI. The facility assessments confirmed that a major challenge for both the public and the private sectors was to manage a situation characterized by countless training programs offered by many development partners. As a consequence, health providers from health facilities were often absent from work for relatively substantial periods of time.

Therefore, NURHI set out to design a curriculum that would help to overcome this situation by providing materials that could be used flexibly and in a tailored way to address specific capacity gaps identified at local level.

Through a capacity strengthening process for curriculum design, NURHI engaged a group of Nigerian master trainers, national experts, and external expert technical assistance to use the SEM as a planning framework to identify core competencies for this course.

This process was realized through the following activities:

The participants conducted a social ecology analysis of FP/MNCH to identify issues that may function as barriers for access to, and use of, these services. This analysis was placed in the context of the role of FP/MNCH in contributing to achieve relevant MDGs, especially goals 3 to 7. This enabled the participants to connect to the broader population and development discourse, which is acknowledged in the existing policy

and service provision rationale, for example in the National Training Manual on Family Planning for Physicians and Nurses/Midwives. The participants were able to examine how the social ecology issues that they had identified can create inequities affecting access to and use of FP/MNCH, and the potential detrimental effect on achieving the MDGs. In particular, the workshop focused on examining gender issues and their inter-relations with other social ecology factors to identify the impact on people's decision making and their lives, particularly FP/MNCH clients.

Using these analyses, the workshop identified key Attitudes-Skills-Knowledge (A-S-K) that should act as the building blocks for competencies developed using OJT. Participants explored how the concepts of competency and skill work in synergy to inform a training approach that aims to contribute to system strengthening and the achievement of strategic goals, such as the MDGs. Participants made these connections by exploring the role of competency-based OJT in achieving client-centred service provision in an integrated FP/MNCH approach. Through this analysis, the participants produced a tentative framework for provision of integrated FP/MNCH services in Nigeria. This framework has been incorporated in the counselling training manual of this curriculum.

The next step in curriculum design consisted of connecting the analysis about competencies and A-S-K to the National Training Manual on Family Planning for Physicians and Nurses/Midwives, the National Family Planning/Reproductive Health Service Protocols, the Performance Standards for Family Planning Services in Nigerian Hospitals, and the National Handbook Contraceptive Logistics Management System. The last step consisted of linking the technical content to training approaches and methodologies best suited to ensure effective transferring and retaining of A-S-K and, ultimately, core competencies. For this purpose, the participants explored learner-centred experiential training, its conceptual overview, and its application to training. The workshop also reviewed good practice materials used in Nigeria and internationally to prevent re-inventing the wheel and to ensure harmonization with Nigerian national standards.

The result of the workshop was the production of outlines for three FP training manuals: 1) Counselling; 2) Clinical; and, 3) Logistics Management.

July 18-22, 2011: Curriculum review workshop and field test preparation with NURHI Master Trainers

NURHI master trainers were invited to review the three draft manuals to assess the extent to which the materials addressed the outlines produced during the May 2011 curriculum design workshop. The master trainers contributed to address gaps and made additional recommendations for improving the materials. The trainers worked in teams (counselling, clinical, and logistics) and each team was responsible for organizing and conducting the field test of one of the manuals.

Ilorin, July 23-31, 2011: Field test of the three manuals

The field test was structured as three concurrent training workshops conducted by the same three teams of trainers who had reviewed the draft manuals. Each course had about 20 participants. The three concurrent workshops took place in Ilorin and the participants included FP providers from Ibadan and Ilorin health facilities. After the completion of the field test, the trainers participated in a final debriefing and identified the changes to be made to the manuals as a result of the field test.

August-October 2011: Roll-out of draft curriculum
This period was used to continue to test the draft manuals in order to gather more input from trainers and providers for the final revisions.

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12 December 2011: Stakeholders' meeting
This was the final curriculum development activity in which key stakeholders provided their input and recommendations to finalize the materials.

2. MONITORING AND EVALUATION

This curriculum does not require any parallel monitoring and evaluation system outside of what already exists. The curriculum has been designed to build on the strengths of existing standards and protocols and all the A-S-K clusters, i.e. the four core cross-cutting competencies, were identified as contributing to achieve existing performance standards. However, it is recommended to train supervisors in this curriculum in order to enable them to effectively monitor and evaluate the impact of this training on service provision.

3. TAKING RESPONSIBILITY FOR ONE'S OWN LEARNING

This curriculum aims to achieve a balance of factual knowledge and knowledge for problem-solving in order to foster acquisition and retention of knowledge and skills. Therefore the activities focus on enabling participants to:

- Reflect critically on what they may already know e.g. How technically correct is their current knowledge? How well have they been applying it? How are their attitudes supporting or hindering them in ensuring optimal access to and use of FP/MNCH services?
- Analyse the important points of new knowledge being presented.
- Share reflections and insights to learn from each other and internalize (absorb) new or expanded knowledge and skills through the learning interactions.
- Apply their expanded or new knowledge to what they do, i.e. strengthening skills.
- Evaluate their learning through constructive peer-feedback.

Therefore the facilitators are not "knowledge banks" or the "know it all" experts. Facilitators, as the term suggests, have the fundamental role of enabling the participants' own learning, but the participants are expected to take full responsibility of their learning by actively contributing their thinking, reflections, analyses, practice and constructive feedback to each other.

4. ISSUES FOR FURTHER CONSIDERATION

We acknowledge that there are important issues that require additional attention in OJT and sensitivity to specific socio-cultural factors. For example: providing services to clients with mental health conditions; addressing the specific needs of under-age wives; addressing specific legal aspects of FP provisions; etc. At the time of developing this curriculum, efforts were being undertaken by other development partners to produce resources specifically focused on these issues. Therefore NURHI decided to prevent duplications by focusing this curriculum on key issues identified during the facility assessments.

1. CURRICULUM DEVELOPMENT PROCESS

3.1 How the conceptual and methodological approach led to identifying, testing, and finalizing competencies and A-S-K of the curriculum

The development process of this curriculum drew from the facility assessments and performance improvement plans previously conducted by NURHI. The facility assessments confirmed that a major challenge for both the public and the private sectors was to manage a situation characterized by countless training programs offered by many development partners. As a consequence, health providers from health facilities were often absent from work for relatively substantial periods of time.

Therefore, NURHI set out to design a curriculum that would help to overcome this situation by providing materials that could be used flexibly and in a tailored way to address specific capacity gaps identified at local level.

Through a capacity strengthening process for curriculum design, NURHI engaged a group of Nigerian master trainers, national experts, and external expert technical assistance to use the SEM as a planning framework to identify core competencies for this course.

This process was realized through the following activities:

The participants conducted a social ecology analysis of FP/MNCH to identify issues that may function as barriers for access to, and use of, these services. This analysis was placed in the context of the role of FP/MNCH in contributing to achieve relevant MDGs, especially goals 3 to 7. This enabled the participants to connect to the broader population and development discourse, which is acknowledged in the existing policy and service provision rationale, for example in the National Training Manual on Family Planning for Physicians and Nurses/Midwives. The participants were able to examine how the social ecology issues that they had identified can create inequities affecting access to and use of FP/MNCH, and the potential detrimental effect on achieving the MDGs. In particular, the workshop focused on examining gender issues and their inter-relations with other social ecology factors to identify the impact on people's decision making and their lives, particularly FP/MNCH clients.

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2.1 Selecting participants and using the curriculum with different types of providers

To ensure the effectiveness of the training methodology, a minimum of six to eight participants are required during each course. This is important to ensure the effectiveness of the methodology, which focuses on fostering the participants' reflective thinking and problem-solving skills. These skills are developed and internalized through activities that require learning interactions and practice of skills with others. Hence, it is recommended that facilitators and facility managers plan cooperatively within their Local Government Area (LGA) to ensure a minimum of six to eight participants for the learning interactions to be meaningful and effective.

This curriculum can be used flexibly with all the categories of providers identified in the National Family Planning /Reproductive Health Policy Guidelines and Standards of Practice. For example, it can be used to address gaps in capacity of Midwives/Family Planning Nurses CHOs who are newly qualified or who are experienced but require support around specific aspects of their capacity. Similarly, **the curriculum can be used with all types of service providers identified by the National Family Planning /Reproductive Health Policy Guidelines and Standards of Practice as long as facilitators and mangers identify which specific capacity gaps they want to address for which specific types of providers in relation to the functions of those providers.** Once they know which capacity gaps they aim to address vis-à-vis the functions of the different types of providers, facilitators and their counterparts can select the sessions that best help address these issues and create a suitable training agenda.

2.2 Deciding how to use these materials with public and private sector providers

These materials have been designed to help address the challenges that services and clients in both the public and private sectors face when health providers spend long periods of time to participate in training programs. The sessions in each of these manuals can be packaged flexibly in training agendas that can be delivered with minimal disruptions to the service schedules of public or private sector facilities. For example, the courses can be conducted either following the sample agendas provided in each manual or by focusing only on the specific sessions that address the capacity gaps identified. As previously explained, facilitators and managers need to work closely to identify which capacity gaps they want to address in order to select the most appropriate sessions and materials and develop their own training agenda.

2.4 A few essentials preparation tips

- Read the facilitator's manual and all reference materials carefully, including the participant's handouts and the knowledge pack of each course. Consider the flow of topics, the structure of each course, and the training methodology of each activity so that you will know how to conduct the sessions, what you need for each activity, the key messages to convey, etc.
- Make sure that the training venue is appropriate for learner-centred experiential training activities, i.e. most of the sessions require the participants to move around the room to interact. Space is an important consideration. Noise is also an important consideration. Therefore whenever possible ensure that the training will not be disrupted by excessive outside noises.

- Make sure that the sessions are adapted to the local context if necessary.
- Prepare all handouts, flipcharts, cards, and other materials and supplies in advance. Each session of each manual identifies the materials that facilitators should prepare in advance. Read the sessions carefully as part of your preparation and identify any additional materials you may want to prepare. **Please note: the methodology used in this curriculum requires facilitators to distribute handouts at the appropriate time during sessions in order to avoid pre-empting participants' learning. This in turn requires effective planning by facilitators to ensure that all printing and photocopying is completed in advance of starting the sessions.**
- If co-facilitation is involved, facilitators should determine how the course will be managed with their co-facilitators. Be sure to discuss potentially disruptive situations. For example:
    - How to intervene if a facilitator forgets an important point during an exercise, presentation, or discussion.
    - How to manage participants who dominate discussions.
    - How to respond to participants who upset others by making negative comments.
    - How to alert each other if the pace of training is too fast or too slow.
    - How to alert each other when a presentation or exercise is running longer than its scheduled time.

1. How to use the curriculum effectively: during the courses

3.1 Create a supportive learning environment

Many factors contribute to and affect the learning process. The facilitator's understanding of her/his role is a key factor. A learner-centred training requires facilitators to:

- Consider themselves equal to participants.
- Focus on enabling participants to use reflective thinking to develop insight, draw conclusions, and integrate new knowledge and skills into their lives.
- Understand that a facilitator's fundamental role is to ask useful questions at the right time and in the right way to foster creative thinking and problem-solving.

The manual provides sample questions for each activity that facilitators can use to achieve these purposes. Facilitators should also use participants' comments/observations/insights to formulate additional questions and expand reflection, analysis, and constructive feedback. Facilitators are encouraged to use their groups as a resource by inviting questions, enabling participants to answer each other's questions, and using participants' observations to link topics and issues.

Through behaviour and communication style, facilitators can create a positive, non-threatening, and inclusive environment. Facilitators are encouraged to apply learner-centred principles in adapting and implementing the curriculum materials to ensure a successful learning process.

In order to build trust and create a learner-centred environment, facilitators are encouraged to (see 3.2 to 3.17 below):

3.2 Create and maintain a non-threatening environment

- Treat the participants with **respect** and **as equals**, and make sure that the participants treat each other with respect and equality.
- Maintain **confidentiality** if the participants share private information with you or each other.
- Make sure that **the physical environment helps to create a positive learning environment** (e.g. thoughtful seating arrangements, comfortable temperature, ventilation and light in the room, scheduling of breaks, and other arrangements as feasible).

3.3 Pay careful attention to communication

The flow of **information** during this course is important. When people are informed, they feel valued and an integral part of the team. When there is secrecy, they feel excluded or threatened. Communication should be as complete as possible and should convey messages of trust and mutual respect. Other suggestions:

- Use icebreaker activities at the beginning of the course and warm-up exercises after breaks to increase comfort.
- Read body language of the participants and listen to all ideas, and help participants reflect on whether their suggestions are relevant to the learning objectives that are to be achieved.
- Acknowledge and praise participants' ideas, and help them reflect on their relevance to the learning objectives.
- Avoid judging participants and their comments, and enable constructive peer feedback.
- Acknowledge that it is normal to feel nervous, anxious, or uncomfortable in new and unfamiliar situations.
- Show the group that you enjoy working with them.
- If possible, spend time with the participants during breaks and meals so that you are able to communicate with them informally.
- Learn and use the participants' names.

3.4 Pay attention to the formulation of useful contracts

It is often standard practice to agree a set of "ground rules" with the participants at the beginning of the course to ensure useful and fair interactions. This curriculum suggests calling these agreements *contracts* in order to stress their importance in ensuring successful learning outcomes. Contracts play a very useful role if they are phrased in ways that help pre-empt or manage issues that may become potentially controversial or disruptive during the program.

Facilitators often feel that only the participants are entitled to suggest contracts. However, in a participatory learning process based on mutual respect, facilitators can also suggest contracts. For this course, facilitators may want to consider including the following:

- Mutual respect, including of diversity among participants e.g. ethnic, religious, geographic origin, marital status, seniority in the work place, etc.
- Taking responsibility for one's own learning, i.e. recognizing that a learner-centred experiential process requires the active contribution of each person.

- Recognizing that facilitators are not the source of all possible knowledge, i.e. accepting to be referred to other sources if the need arises.
- Committing to constructive feedback during interactions and throughout the course, and avoiding "blame games".

3.5 Model correct behaviour

By showing trust in others and being reliable yourself. Remember that your actions are as important as your words. Make sure that there is consistency between the two.

3.6 Avoid "I'm right/you're wrong" debates

Unless it is necessary to provide correct factual and technical information, facilitators should not engage in "right/wrong" discussions and should help participants to avoid such situations. In fact, "right/wrong" deadlocks will undermine the methodology and the learning aims of this curriculum, which is primarily focused on developing participants' reflective thinking in order to internalize and retain learning.

3.7 Use definitions flexibly to foster reflective and "out of the box" thinking

Some sessions provide definitions of concepts or approaches, and facilitators are encouraged to be flexible in how they use them. Use definitions to encourage reflections and insight. Don't waste time dissecting words, but do use words in definitions to help participants reflect on the key issues that the definitions focus on.

3.8 Involve participants in course management if possible

In order to foster participation and ownership of learning, consider introducing a "task roster." Invite participants to volunteer to manage some aspect of the course by rotating responsibilities for tasks such as time keeping, energizers, ice-breakers, and daily feedback.

3.9 Practice appropriate self-disclosure

When you share what you are thinking, people are more likely to trust you. However, revealing too much can be problematic, particularly in cultures in which it is not common to share feelings or inner thoughts. Keep the cultural context in mind when considering self-disclosure of opinions. Also always remember that you need to maintain a professional role and relationship with each participant. Excessive or inappropriate self-disclosure may jeopardize your professional role and relationship with the group and/or individual participants and may also create a conflict of interest.

3.10 Conduct daily debriefings of co-facilitators

If co-facilitation is involved, it is recommended to hold daily debriefings with your co-facilitators. Debriefings provide you and your colleagues with an opportunity to discuss aspects of the training that need improvement and to make adjustments to the training agenda or style.

Review the participants' daily evaluation (Appendix 3) to understand the opinions of participants. Below you will find sample questions for debrief discussions among facilitators (select only the most appropriate/useful for your team, or create your own):

- How well did we meet the objectives of our sessions today?
- What did we do today that promoted learning?
- What do we want to do differently tomorrow?
- How well did we handle problems that arose during the sessions today?
- How well are we working together? What do we need to improve?
- Which feedback issues from participants are the most important to address tomorrow?
- How thoroughly have we planned tomorrow's sessions? What are our roles in delivering the sessions? What needs clarification? Are all the supplies and logistics organized?

3.11 Address gender and sexual stereotyping

This curriculum focuses on strengthening performance improvement to ensure the strategic role of FP/MNCH services in achieving the MDG. In order to achieve this aim, reducing barriers to access to and use of such services is fundamental. Therefore helping to address gender inequity is of paramount importance because gender inequity is both a structural barrier to FP/MNCH optimal access and use as well as a social determinant of under-development.

This curriculum, and especially the counselling training course, addresses these issues as thoroughly as possible within the time limitations of OJT. The curriculum focuses specially on the inter-relations of gender, sexuality, power in relationships and FP/MNCH. Therefore, it is extremely important that facilitators are aware of their attitudes about these key content areas and ensure that their own personal values do not hinder participants' own reflective thinking.

Equally important, facilitators should be aware of participants' attitudes and beliefs and ensure that nobody attempts to impose their views on others.

Sometimes, agreeing to disagree is a strategy that facilitators may use if a discussion around these issues becomes too divisive. However, a more effective way is to help the participants reflect on how providers' attitudes to these issues may become barriers to access to and use of FP/MNCH services. Facilitators and participants are encouraged to put themselves in the shoes of clients who might experience judgmental or hostile attitudes because of gender or sexuality issues: how would they feel if they were those clients? What difficulty to access and use FP/MNCH services would they face as a result of providers' attitudes? How would such attitudes undermine achieving the MDGs? What can providers do to separate their own values from their professional and ethical duty to do no harm and to provide quality services to all clients? These questions may be more useful than agree to disagree in order to advance self-reflection and useful insights to improve performance. In addition, facilitators are encouraged to formulate and use contracts strategically, for example by having contracts that commit the participants to respect diversity in the group, including diversity of views and opinions.

Also, facilitators are encouraged to be sensitive to how gender and sexual stereotypes may be influenced by specific cultural beliefs and norms. It is never useful to blame "culture" as a whole for creating barriers to access to and use of FP/MNCH. This is why the curriculum places such an emphasis on the inter-connections of gender and sexuality issues, because these are specific aspects of social and cultural systems, and not the systems as wholes.

In some socio-cultural contexts, facilitators or participants may tell jokes as energizers. It is fundamental that facilitators assess whether such jokes and stories may perpetuate sexual, gender, or ethnic stereotypes that may offend or alienate some of the participants or potential clients of FP/MNCH services. For example, some jokes may generate or perpetuate stigmatizing and discriminatory attitudes about unmarried women who are sexually active, reinforce stigma and discrimination against commercial sex workers, or perpetuate perceptions of women as inferior to men. Particularly in the context of this curriculum, it is critical that facilitators pay attention to group dynamics that may reinforce inequitable power imbalances based on gender/sexual stereotypes and norms. This does not mean that facilitators bar or censure such jokes or stories. Rather, facilitators are encouraged to use them as materials to enable a reflection on the gender and sexual stereotypes that such jokes and stories communicate, and what attitudes they may contribute to perpetuate that hinder access to and use of FP/MNCH.

3.12 Conduct icebreakers and energizers

Facilitators are encouraged to use icebreakers and energizers that they are familiar with as well as to encourage the participants to volunteer what they have used in other workshops.

Icebreakers and energizers should aim not only to help participants maintain or revitalize their energy levels, but to build participants' confidence to interact openly. Facilitators are encouraged to use icebreakers and energizers that will make participants move around the room, use the space, and do things that require collaboration or team effort. Please be mindful of the recommendations about avoiding gender and sexual stereotyping discussed in the above sections.

3.13 Monitor participants progress during the training

It is important that the facilitators monitor the learning process and how/if participants learn and strengthen their skills. Facilitators are encouraged to:

- Conduct pre- and post- training assessments of participants in order to assess results at the end of the course. Use the pre-test and post-test questionnaires and answers provided in each manual.
- Evaluate participants' knowledge and skills during brainstorming, small group work, exercises, role-play, and discussions while the training is in progress. Correct misconception and provide correct factual information when necessary, and use the group as a resource to do this.
- Enable the participants to reflect on their learning. What questions you ask, how, and when, is the critical way of enabling participants to evaluate their learning. Also, reserve a few minutes before the end of each session to ask participants what they have learnt that is useful to improve their work.
- Conduct a formal evaluation at the end of each course to assess participants' perceptions of their learning through the training. This will help you identify changes to be made both to the training materials and your facilitation. The end-of-course evaluation allows participants to provide feedback about the usefulness of the training, the learning materials, the training methodologies used, the logistics of the training, and to assess facilitators' performance. Use the end-of-course evaluation guide provided for each course.

3.14 Use participants handouts

Participant's handouts are provided in most sessions of each of the manuals. **Please ensure that the distribution of these materials does not pre-empt participants' learning and reflective thinking.** Therefore it is important to acknowledge and discuss with the participants the following key points:

- Some participants may expect to receive all handouts at the beginning of the course, but if this happened the methodology of this curriculum would be undermined.
- The aim of the methodology is to foster participants' reflective thinking for problem-solving. Therefore this methodology is undermined by having access to knowledge for problem-solving before such problems are experienced during the training sessions.
- In this curriculum, handouts are resources to help participants consolidate their learning in their own time, and not to pre-empt it.
- When appropriate and useful, handouts will be distributed during training activities.
- Each session in each manual provides instructions as to when the distribution of each handout should happen. However, facilitators will use their own judgment to decide the most useful time to distribute these materials during training sessions.
- The title of each handout includes the session number and the activity in the session to which the handout refers to in order to help participants collate these materials in chronological order.

It is also important to emphasize the following messages:

- Most of the handouts in the three manuals can be used as job aids. Participants should take responsibility for collecting and collating the handouts they receive during the training in order to continue to use them as job aids or reference materials once they go back to their work places.
- Participants are also encouraged to use the handouts to share and explain to their peers and managers their learning from this curriculum.

Please also note that participants' handouts are useful materials for facilitators in preparing their sessions to review key points.

3.15 Use participant's Knowledge Packs

Each manual is accompanied by a participant's Knowledge Pack. The information contained in each Knowledge Pack is tailored to support the participants' learning during the courses, and not to pre-empt it, and this is why the Knowledge Packs are small and contain only essential information necessary prior to attending each course.

The purpose of the Knowledge Packs is not to duplicate what is contained in the handouts that participants receive during the training sessions. This is another reason why the knowledge packs are small.

The knowledge pack of each manual should be sent to the participants with the invitation letter to attend that specific course. Participants should be encouraged to read the Knowledge Pack before the course begins. It may be useful to explain in the invitation letter that the purpose of the knowledge pack is to provide essential additional

information about the topics addressed in the training. However, as the course uses a learner-centred experiential approach, most of the information will be provided during the sessions through handouts.

3.16 Enable participants to collate and keep knowledge packs and handouts

It is recommended to provide participants with a folder for each course to collect and collate the Knowledge Pack and the handouts. Ideally, the Knowledge Pack will also contain the introduction to the curriculum. A practical way to help participants collate and organize these materials is to provide a folder with plastic sleeves in which the participants can insert the handouts session by session.

3.17 Limit use of projectors and slides

This curriculum has been designed to minimize the need to use projectors and slides in order to avoid transforming the methodology into lecturing. However, facilitators are encouraged to use their judgment as to when additional visuals, such as power point presentations, may be useful. In any case, facilitators should avoid lecturing as much as possible because it will defy the skill transfer aim of the methodology used in this curriculum.

OJT FP/MNCH COUNSELING TRAINING COURSE

COURSE OBJECTIVES

By the end of the course, the participants will be able to:

- Demonstrate effective attitudes, knowledge, and skills in all four core competencies addressed in this course, namely:
    - Effectively ensure client's voluntary informed decisions
    - Effectively enable access to and use of quality FP/MNCH services
    - Effectively provide quality reproductive care
    - Effectively provide referral and follow-up
- Explain the strategic role of FP/MNCH services in achieving broader social development goals, and especially the Millennium Development Goals 3, 4, 5, 6, and 7.
- Demonstrate effective IPCC skills to provide quality integrated FP/MNCH client-centred counselling services.
- Demonstrate effective attitudes, knowledge, and skills to help remove barriers to access to and use of FP/MNCH services, and especially gender inequity.

SUGGESTED SAMPLE COURSE SCHEDULE

Please note: Although a sample training schedule organized by day is provided below, this course can be implemented flexibly either as a program covering the entire duration of the course, or by scheduling the course in modules over a few weeks, or by selecting the sessions that address specific capacity gaps and organizing a training schedule accordingly.

DAY 1

Time allocation	Session	Activity/Notes
15 minutes	Registration and official opening remarks	
1 hour and 45 minutes	SESSION 1: Climate setting and course overview	
30 minutes	**BREAK**	
1 hour and 45 minutes	SESSION 2: Defining quality of care in service provision, and especially in FP	
1 hour	**LUNCH**	
15 minutes	Energizer	
2 hours	SESSION 3: Defining the role of an integrated FP/MNCH client-centred approach to enhancing quality of care	
15 minutes	Participants' daily reflections	
	BREAK	

SUGGESTED SAMPLE COURSE SCHEDULE

DAY 2

Time allocation	Session	Activity/Notes
30 minutes	Day 1 Recap	
1 hour and 30 minutes	SESSION 4: Client-centred integrated FP/MNCH counselling. What it is, its key aims, and key service delivery issues for its realization	
30 minutes	**BREAK**	
2 hours	SESSION 5: Understanding how our own attitudes may affect access to and quality of client-centred integrated FP/MNCH services	
1 hour	**LUNCH**	
15 minutes	Energizer	
1 hour and 15 minutes	SESSION 6A: Why addressing gender, sexuality, and power in client-centred FP/MNCH integrated service provision?	
15 minutes	Participants' daily reflections	
	BREAK	

SUGGESTED SAMPLE COURSE SCHEDULE

DAY 3

Time allocation	Session	Activity/Notes
30 minutes	Day 2 Recap	
1 hour and 50 minutes	SESSION 6B: Why addressing power and agency in relationships in order to improve access to and quality of client-centred FP/MNCH integrated services?	
30 minutes	**BREAK**	
1 hour and 45 minutes	SESSION 7: Why addressing equity and sexual and reproductive health rights in client-centred FP/MNCH integrated service provision?	
1 hour	**LUNCH**	
15 minutes	Energizer	
1 hour and 15 minutes	SESSION 8: Interpersonal Communication Counselling Skills (IPCC). Part 1	
15 minutes	Participants' daily reflections	
	BREAK	

SUGGESTED SAMPLE COURSE SCHEDULE

DAY 4

Time	Session	Activity/Notes
30 minutes	Day 3 Recap	
1 hour and 45 minutes	SESSION 9: Effective client-centred FP/MNCH integrated counselling processes	
30 minutes	**BREAK**	
1 hour and 15 minutes	SESSION 10: Interpersonal Communication and Counselling Skills (IPCC). Part 2	
1 hour	**LUNCH**	
15 minutes	Energizer	
45 minutes	SESSION 11: Managing challenging situations in counselling	
1 hour and 15 minutes	SESSION 12: Addressing barriers to communication in counselling	
15 minutes	Participants' daily reflections	
	BREAK	

SUGGESTED SAMPLE COURSE SCHEDULE

DAY 5

Time	Session	Activity/Notes
30 minutes	Day 4 Recap	
1 hour and 30 minutes	SESSION 13: Exploring the sexual relationships of clients	
30 minutes	**BREAK**	
1 hour and 45 minutes	SESSION 14 Explaining medical terminology in language that clients understand, and using visual aids effectively in counselling	
1 hour	**LUNCH**	
15 minutes	Energizer	
1 hour and 30 minutes	SESSION 15: Addressing clients' misconceptions about FP methods	
15 minutes	Participants' daily reflections	
	BREAK	

SUGGESTED SAMPLE COURSE SCHEDULE

DAY 6

Time	Session	Activity/Notes
30 minutes	Day 5 Recap	
1 hour and 30 minutes	SESSION 16: Helping clients make or confirm their decisions	
30 minutes	**BREAK**	
3 hours	SESSION 17: Demonstrating skills for effective FP client-centred counselling: Counselling practice	
1 hour	**LUNCH**	
1 hour and 15 minutes	Session 18: Concluding the course	
	BREAK	

TABLE OF CONTENTS

SESSION 1: Climate Setting and Course Overview

Objectives
By the end of the session, the participants will be able to:

- Explain how the course is organized and the approach that it is based on.
- Explain the objectives of the course.
- Self-assess their pre-course knowledge.

Total Session Time
105 minutes (one hour and 45 minutes)

Materials

- Flipcharts, markers, tape, name tags
- Flipchart "Session objectives"
- Flipchart "Course objectives"
- Flipchart "Task roster"
- Pre-titled flipcharts for the structured brainstorm in Activity 4
- Copies of course schedule /training agenda
- Copies of pre course self-assessment questionnaire
- LCD projector if available/necessary

Facilitator's Resources

- Activity 4: Amina's case scenario.

Advanced Preparation
Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)
Introduce and review the session objectives (show them on flipchart or slide).
This session welcomes the participants and provides them with an overview of the course methodological approach, its objectives and content. Participants will be able to get to know each other and to self-assess their pre-course knowledge.

Activity 1: Welcome, opening remarks, and self-introductions (25 minutes)

1.1 After the initial brief welcome and opening remarks (five minutes maximum), explain that as in any workshop, introductions come first. This will be done in a game that will allow us to build a relaxed atmosphere and become more comfortable with the participatory and interactive approach of this course.

1.2 Ask the participants to organize their chairs in a circle. The facilitator stands in the middle and explains the rules of the game called "fruit salad". In this game, each participant will be a fruit. There should be at least two people who will have the same fruit name. For example, if there are six participants, the group may choose three fruits with two people named after each of the fruits.

1.3 The facilitator also chooses to be one of the fruits, e.g., banana, and starts walking inside the circle. As the facilitator walks, she/he says the following things about herself/himself:

- Name, and where from.

- Current job, and how long been doing it.
- Favourite food.

At this point, the facilitator says "*And I like*..." completing the statement by calling out one of the other fruits used in the game, e.g. *mango*.
All the people who picked the fruit name *mango* have to get up from their chairs and run around the circle to find a new seat. The facilitator at this point can step outside and remove her/his chair. The person who is left without a seat will introduce herself/himself and call a new fruit name as the facilitator did, and so on, until everyone has introduced herself/himself.

Explain that:

- Participants cannot simply shift to the next chair. If someone does this, s/he will automatically become the one standing in the middle.
- If someone who has already been introduced ends up standing again, she/he will choose a person with the same fruit name, and that person will stand in the middle and continue the game.

1.4 After the introduction, give each person a piece of card or a name tag, and ask her/him to put his/her name on it and either fold the card in half and place it on the table or floor in front of him/her or pin it on his/her chest.

Activity 2: Establish the contracts for the course, and create a task roster (10 minutes)

2.1 Explain that the group will agree on few ground rules – which we will call *contracts* in order to stress their binding role to guide the interactions during the whole course. We will use a brainstorm to generate an initial list of contracts. Encourage participants to suggest helpful rules.

2.2 Write participant responses on a flipchart.

Facilitator's Tip

In alternating colours, write down participants' suggestions. Consider rewriting in positive terms as needed. For example, if a participant suggests "Do not be late," consider rephrasing this as "Be on time."

Some examples of useful contracts :

- Participate actively
- Respect each other's opinions/ideas
- Speak one at a time
- No session within session
- Put cell phone on vibrator mode/turn off
- Limit to minimum the use of cell phones during sessions, even if on vibrator mode
- Be supportive, not judgmental

2.3 After all of the suggestions are written down on the flipchart, ask the participants to commit to those contracts.

2.4 Post the flipchart with the contracts on the wall so that all of the participants can see it during the course. **Please note:** In order to enhance the effectiveness of contracts, facilitators are encouraged to type and print out the list of agreed contracts and distribute to participants.

2.5 Explain that you would like the participants to be actively involved in running the workshop. For this purpose you would like the participants to rotate responsibility for the following tasks every day:

- Time keeping/Information: Ensure that everyone is on time at the beginning of each day and after breaks.
- Energizers/ Icebreakers /Social welfare: Help maintain energy, especially at the start of each day, after lunch breaks and/or whenever energy levels appear to decrease.
- Daily evaluation and daily recap: At the end of each day the participants will be asked to fill in a simple feedback form to assess how useful the sessions were (see Appendix 3). One person or a pair will use the daily evaluation to prepare a 30-minute participatory activity that they will conduct the next morning. This 30-minute activity will aim to identify the key learning from the previous day and present a summary of the participants' feedback/evaluation.

Post a flipchart on the wall with a roster for these four groups and ask the participants to write their names on one of the task for each day of the course:

COURSE DAY	TASK AND VOLUNTEERS		
	TIME KEEPING	ENERGIZERS & ICEBREAKERS	DAILY EVALUATIONS & DAILY RECAP
Day 1			
Day 2			
Day 3			
Day 4			
Day 5			
Day 6			Not required

If necessary, suggest simple icebreakers and energizers and offer to work at the end of the day with the person/pair who will prepare the recap activity for the next day.

Activity 3: Participant expectations and course objectives (10 minutes)

3.1 Ask participants to write their expectations on cards and to post them onto the expectation flipchart.

3.2 Gather and summarize participant responses on the flipchart.

3.3 Show the objectives of this course on flipchart and discuss how participants' expectations relate to the objectives. Help participants to identify which expectations are realistic and relevant to the objectives, and which ones may not be. Reach agreement on which expectations may have to be placed in brackets or erased because they are not directly relevant to the objectives of this course.

Activity 4: Approach and methodology of the course (25 minutes)

4.1 Ask the participants if they have read the sections in the introduction to their knowledge pack that explain the course approach, i.e. its focus on addressing the social ecology of FP/MNCH, and on developing core competencies through learner-centred methodologies and reflective thinking. Briefly discuss:

- What did you find new or useful about the social ecology model?
- What did you find new or useful about the focus on four core cross-cutting competencies?
- What did you find new or useful about the learner-centred experiential cycle?

Note for Facilitators

There is no need to write down responses on flipchart. These questions serve only an ice-breaking purpose to introduce the case study that you will use next. At this stage, spend only little time to elicit a few responses without delving into any in-depth discussion of these issues. However, make sure to review thoroughly the relevant sections in the participants' knowledge pack before the beginning of the course. Also please note that the same issues are addressed in the Introduction section in the Facilitator's manual.

4.2 Build on relevant participants' responses to explain that this course focuses on developing problem-solving skills to help clients make voluntary informed decisions about their reproductive needs and goals. Developing problem-solving skills requires that we put ourselves in clients' shoes to fully understand what factors can hinder their ability to overcome barriers for informed voluntary decision making. In this course, we do this by using learning methodologies that foster our reflective thinking, insight, and analyses that we then apply to our work. For example, we use case studies.

4.3 Distribute copies of the case study provided in the **Facilitator's Resources** section below. Review the case study with the group. Explain that we are going to explore this question (show on flipchart if necessary):

- What factors hindered Amina's access to and utilization of FP/MNCH services?

Explain that we are going to explore these factors at four different levels (post four flipcharts as follows):

Individual / Personal	Interpersonal & Community	Institutional	Policy

Rapidly brainstorm factors for each of these dimensions.

4.4 When you have several factors on each flipchart, help the participants draw connections across the four levels. Pick a factor from the Individual level and one from another level e.g. Institutional, and ask:

- How do these factors interconnect to affect Amina's access to and use of FP/MNCH services?

Repeat the same process a few times by selecting factors from different levels, e.g. one from Interpersonal & Community and another from Institutional or Policy, and discuss the same question.

Note for Facilitators

At the end of the discussion, please remember to highlight the following key messages:

- By identifying key factors and their connections across the four levels, the participants have conducted a rapid analysis of how the social environment affect a person's ability to access and utilize FP/MNCH services.
- The four levels that the participants analysed make up what we call the Social Ecology of FP service provision, i.e. the social environment in which FP services are situated.

(At this point you may want to refer the participants to the relevant section of the introduction to their knowledge pack in which the diagram of the Social Ecology Model is provided).

- Each of the levels is a sphere of influence, i.e. it both influences and is influenced by all the other spheres to create, maintain, or change such a social environment.
- This course is based on understanding the social ecology in which FP services are provided because the social ecology (the social environment) influences in many ways clients' ability to make voluntary informed decisions. As providers, we need to understand these factors in order to put ourselves in clients' shoes and help them develop solutions that meet their needs.

4.5 Ask the participants to work in pairs for five minutes. Give to each pair one of the following questions to discuss:

- How can the social ecology that you analysed in Amina's case study undermine the role of FP/MNCH service provision in contributing to the MDGs?
- How can an understanding of the social ecology factors help health providers reduce barriers to access to and utilization of FP/MNCH services for clients like Amina?

Invite the pairs to share and discuss.

4.6 Finally, help the participants reflect on the methodology that was used in this activity to foster their reflective thinking and insight. Discuss:

- In which ways did the methodology foster your own analysis and drawing conclusions?
- Now that you have begun to experience this methodology, what are the key differences with lecturing?

4.7 Conclude by emphasizing that this activity enabled the participants to define the Social Ecology Model that informs this course as well as identify key features of the learner-centred experiential methodology that will continue to be used in all the sessions.

Activity 5: Pre-course self-assessment (20 minutes)

5.1 Briefly explain that the purpose of the pre-course self-assessment is to help participants and facilitators assess the usefulness of the course and which areas or topics may require more attention during the training.

5.2 Distribute the pre-test self-assessment questionnaires to participants and allow 20 minutes for completion. Let them know when the time is remaining five minutes.

5.3 Inform the participants that they will be asked to complete a formal evaluation of the course at the end of the program.

Activity 6: Review of course schedule (15 minutes)

6.1 Distribute and clarify the training schedule/agenda. Invite questions for clarification.

6.2 Explain any logistics for the course.

6.3 Thank participants for their active participation in this session and transition to Session 2.

Facilitator's Resources

Activity 4: Amina's case scenario

Amina, a 34 year old housewife, married to 55 year old Zacharia, who is a petty trader. At the time when we want you to imagine this story is unfolding, they already had six children (five girls and a boy) and were living in a one-room apartment with their children. Amina's last baby was three months old but her husband kept pressuring her to have sex. Amina felt that it was too early to start having sex again, but she was also afraid of saying no to sex with her husband for fear of possible consequences she may suffer, for example denial of domestic allowance and violence.

Amina had heard of FP, but had no specific knowledge of any method. She had also heard people complain about FP saying that the methods had many side effects that could cause death. She was also afraid of how family panning providers might judge her if she told them about the problems with her husband.

Although Amina really didn't want any more pregnancies, she was afraid to talk about it with her husband for fear of his reaction. She was very worried that he might accuse her of infidelity just because she could not face another pregnancy. And so she felt that she had no choice and started having sex with her husband again.

Just four months after the delivery of her last baby, she became pregnant again. Amina could not consider abortion even though her family did not have enough food and there was no money for health care. Six months into her pregnancy, Amina started to bleed and her husband took her to see a traditionalist herbalist who gave her some herbs. The bleeding did not stop and by the time Amina was eight months pregnant it had become severe. Zacharia borrowed some money from his neighbours to take Amina to a nearby health post since a general hospital was too far and they could not afford the expenses. The health worker at the health post had no knowledge to provide emergency obstetric care, and Amina died while they were trying to sort out what to do.

SESSION 2: Defining Quality of Care in Service Provision, Especially in FP/MNCH

Objectives
By the end of the session, the participants will be able to:

- Define quality in health care, particularly in the context of FP/MNCH.
- Describe ways of defining quality in health care service provision.
- Identify perspectives of different stakeholders in defining quality.
- Identifying components of quality in health care and their inter-relations.

Total Session Time
105 minutes (one hour and 45 minutes)

Materials

- Flipcharts, markers, tape, blank A4 size paper sheets
- Flipchart "Session Objectives"
- Signs: "Client", "Provider", "Policy maker"
- LCD projector if available/necessary

Handouts

- Handout 1 – Quality of Care
- Handout 2 – Components of Quality
- Handout 3 – Family Planning Scenarios

Advanced Preparation
Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)
Introduce and review the session objectives (show them on flipchart or slide). Explain that there is a large body of evidence internationally showing that quality of counselling is very important in increasing access to FP services. However, we need to place an exploration of quality counselling in the broader context of defining and understanding quality in health care service. This is the starting point of our training program.

Activity 1: Exploring the Meaning of *Quality in Health Care Service*, Especially in the Context of FP/MNCH (35 minutes)

1.1 Depending on the total number of participants, ask them to work in pairs or small groups of three. For example, you can ask them to arrange small groups by counting 1-2-3 (all the 1's will form a group, the 2's another, and the 3's a final group). The important thing is that you have either 3 pairs or 3 small groups:
   - Give one A4 size paper sheet to each pair/group. They have seven minutes maximum to brainstorm a definition of quality in health care service, especially in relation to FP/MNCH. However, they will do this from different perspectives: #1's group from the perspective of clients; #2's group from the perspective of health service providers; and #3's group from the perspective of policy makers.
   - Groups will write their definitions in large block letters on their A4 papers.
   - Stop the exercise after seven minutes and ask the groups to post their A4 sheets on the wall under the corresponding signs (Client, Provider, and Policy Maker) that you will have pre-prepared.

1.2 Invite the participants to form a semi-circle around the wall and facilitate a brief discussion using questions such as:

- What similarities and differences can you identify across these definitions?
- Do most of the definitions describe quality in health care service as a process towards a goal? Do they focus on specific elements to define quality? Or do they focus on both process and goal? What could be the advantages and disadvantages of these different ways of defining quality?
- Which of these definitions take into consideration the influence of social and cultural factors in achieving quality? Why would it be important to consider such factors? Can you give examples of social and cultural factors that may influence quality, and how?
- If you were a client, which of the "Client" definitions would you want to see adopted, and why? As a health provider, which "Provider" definitions do you find more useful, and why? If you were a policy maker, which "Policy maker" definition/s would you select, and why?
- Which definition/s addresses most of the issues and needs of different types of stakeholders? How?
- Why is it important to ensure that a definition of quality in health care service addresses the perspectives and needs of different stakeholders?

Note for Facilitators

In facilitating the discussion, reassure the participants that the purpose is not to highlight right or wrong answers. We are at the beginning of our exploration into defining quality, and this discussion aims to trigger the participants' own reflections by drawing from their knowledge and experience, which are important assets they contribute to their own and the group's learning.

If participants do not articulate the following issues, make sure that you will discuss them:

- There is no single universally accepted definition of quality in health care service because of the reasons that the previous discussion highlighted. It depends on the perspectives of who is defining quality, whether and how different stakeholders are involved in the process of defining the concept, and what data is used and what components and issues of quality are considered.
- Striving for and achieving quality requires an appropriate policy environment addressing quality beyond a clinical or bio-medical perspective. Policies and strategies and modalities for service provision need to address key social issues that influence quality, such as gender inequity.
- Communities and clients/service users need to be engaged in defining what quality means to them and in influencing both policy development and how health services are provided to them if they are to become partners in improving their own health outcomes.
- Health-service providers should also be engaged as key stakeholders in defining the policy and strategies to achieve quality, which includes acknowledging and addressing their needs.

1.3 Stress how the discussion highlighted the complexities of defining quality. So how do we move forward toward developing a working concept of quality that can help respond to the issues and needs of different stakeholders and contribute to improved health outcomes? The next activity will explore this question. Invite the pairs to remove their A4 papers from the wall and bring them back to their seats because they will use the definitions in the next activity.

Activity 2: Defining Quality of Health Care Service, Especially in the Context of FP (20 minutes)

2.1 Connect to the previous activity, for example by stressing how the discussion showed the need to address different perspectives, issues and needs toward developing a useful concept or definition of quality in health care service. Over the years many organizations have contributed to this work and in this activity we will review definitions and frameworks that have proved to be useful.

2.2 Distribute Handout 1, which presents some of the definitions of quality in health care service most commonly used internationally:

Some Commonly Used Definitions of Quality
• Quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. • Meeting the needs, expectations, and requirements of clients and other customers with a minimum of effort, rework and waste. • Doing the right thing, right, right away. • Striving for and reaching agreed levels of care that are accessible, equitable, affordable, acceptable, client centred, effective, efficient , and safe.

2.3 Review the definitions and ensure that the participants understand them. Spend a few minutes discussing the similarities and differences that participants identify between their own definitions and those in the Handout. If you feel that it is useful, discuss these questions:

- Which of the definitions presented in the Handout are you familiar with?
- Which of the definitions take into consideration the influence of social and cultural factors in achieving quality?
- If you were a client, which of these definitions would you want to see adopted, and why? As a health provider, which do you find more useful, and why? If you were a policy maker, which definition/s would you select, and why?
- Which definition/s addresses most of the issues and needs of different types of stakeholders? How?

Activity 3: Scenario Analysis (35 minutes)

3.1 Transition into this activity by emphasizing that no matter which definition of quality of care we might choose to use, a definition per se may not be sufficient to identify and address key elements, factors or dimensions of quality. However, one point that we clarified in the previous activity was that a concept of quality should acknowledge and address the expectations and needs of different stakeholders at service user, community, health providers, and decision/policy maker levels. In this activity we will aim to explore what all this means in practice by discussing one or two scenarios.

3.2 Divide the participants in pairs. Distribute this diagram (Handout 2) to each participant and explain it using/adapting the talking points below:

Adapted from: USAID | EUROPE AND EURASIA REGIONAL FAMILY PLANNING ACTIVITY, 2008: Supportive Supervision: Training of Trainers and External Supervisors

Talking Points:

- The diagram shows how the concept of quality in health care has evolved over time.
- The evolution of the concept of quality of care has been a result of the changes in the definition of health.
- In the past, health was defined primarily from a bio-medical and clinical perspective, i.e. what now some people call "old public health". This understanding of health was reflected in a concept of quality of care that focused essentially on clinical standards and protocols (left oval).
- Over time, we have come to understand that health is as much a social issue as it is a bio-medical one, and in fact there is now global recognition that most health problems are social problems, e.g., many causes of maternal mortality are due to social issues such as gender inequity and not to bio-medical issues alone (bottom centred arrows). Therefore addressing the social causes of health problems is fundamental to resolve such problems.
- But in order to achieve this aim, we must ensure that both our understanding of health and of quality of care addresses the perspectives, issues and needs of different stakeholders (right oval). This means that policies, protocols, guidelines etc. must be developed in ways that help address the social causes of health problems as well as meet the expectations of different stakeholders for services that are accessible, equitable, affordable, acceptable, client centred, effective, efficient, and safe (middle centred arrow).

3.3 Distribute to each pair one of the scenarios from Handout 3. Explain the instructions:

- Pairs have 10 minutes to discuss the following questions about their scenarios using Handout 2 as the reference context:
  - Which aspects of quality of care from Handout 2 are realized in your scenarios? How?
  - Which aspects of quality of care from Handout 2 are not realized in your scenarios? How?

3.4 Invite only one pair per scenario to briefly share their analyses. Facilitate a brief discussion eliciting comments and observations from the larger group.

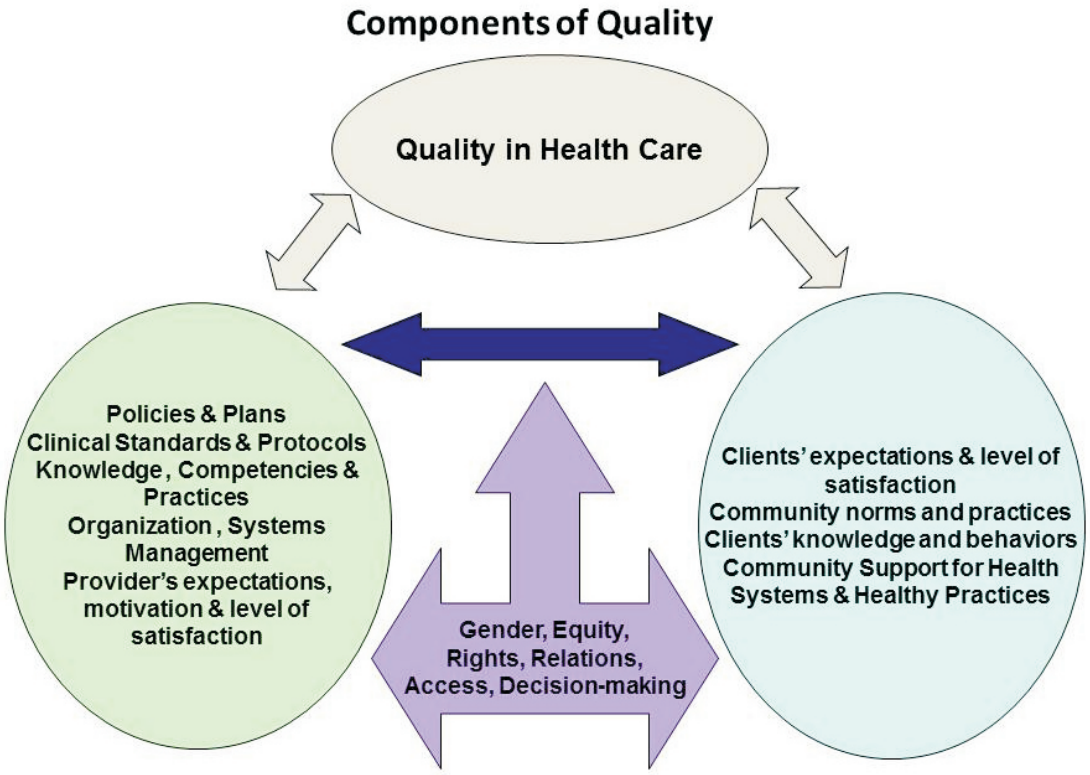
3.5 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Participant's Handouts

Session 2: Handout 1, Activity 2 – Quality of Care

Some Commonly Used Definitions of Quality
• Quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. • Meeting the needs, expectations, and requirements of clients and other customers with a minimum of effort, rework and waste. • Doing the right thing, right, right away. • Striving for and reaching agreed levels of care that are accessible, equitable, affordable, acceptable/patient centred, effective, efficient and safe.

Session 2: Handout 2, Activity 3 – Components of Quality



Adapted from: USAID | EUROPE AND EURASIA REGIONAL FAMILY PLANNING ACTIVITY, 2008: Supportive Supervision: Training of Trainers and External Supervisors

- The diagram shows how the concept of quality in health care has evolved over time.
  - The evolution of the concept of quality of care has been a result of the changes in the definition of health.
  - In the past, health was defined primarily from a bio-medical and clinical perspective, i.e. what now some people call "old public health". This understanding of health was reflected in a concept of quality of care that focused essentially on clinical standards and protocols (left oval).
  - Over time, we have come to understand that health is as much a social issue as it is a bio-medical one, and in fact there is now global recognition that most health problems are social problems, e.g. many causes of maternal mortality are due to social issues such as gender inequity and not to bio-medical issues alone (bottom centred arrows). Therefore addressing the social causes of health problems is fundamental to resolve such problems.
  - But in order to achieve this aim, we must ensure that both our understanding of health and of quality of care addresses the perspectives, issues, and needs of different stakeholders (right oval). This means that policies, protocols, guidelines etc. must be developed in ways that help both address the social causes of health problems as well as meet the expectations of different stakeholders for services that are **accessible, equitable, affordable, acceptable, client centred, effective, efficient, and safe** (middle centred arrow).

Session 2: Handout 3, Activity 3 – Family Planning Scenarios

Sample Scenarios for Activity 3

Please note: Facilitators are encouraged to adapt these scenarios to make them relevant to their local situations.

Scenario 1:
A young unmarried woman wants to use contraception with her boyfriend. She wants oral pills. The health provider gives her what she is asking for without exploring any other issue with her.

Scenario 2:
A married couple comes to the clinic. They already have five children. The health provider, a doctor, decides that the wife must have tubal ligation and tries to use his authority to convince them to accept this method.

Scenario 3:
A married woman comes to see the health provider asking for a FP method. She has two children and she doesn't want any more. She is afraid that her husband may find out about her intention, and ask the provider to give her a method that the husband will not be able to discover. The provider refuses to help her and instead tells her that she must come back with her husband to discuss the issue together.

SESSION 3: Defining the Role of an Integrated FP/MNCH Client-Centred Approach to of Enhancing Quality Care

Objectives
By the end of the session, the participants will be able to:

- Explain the role of an **integrated FP/MNCH client-centred approach** in enhancing quality in service provision.
- Identify the "Rights of Clients" and the "Needs of Service Providers" within FP programs.
- Explain why quality is important for FP/MNCH service delivery.

Total Session Time
120 minutes (two hours)

Materials

- Flipcharts, markers, tape, blank A4 size paper sheets
- Flipchart "Session objectives"
- AGREE and DISAGREE signs for Activity 1
- LCD projector if available/necessary

Facilitator's Resources

- Sample Questions for Activity 2

Handouts

- Handout 1 – An Integrated FP/MNCH Client-Centred Approach
- Handout 2 – An **Integrated and Client-Centred FP/MNCH Framework**
- Handout 3 – Clients' Rights and Providers' Needs
- **Handout 4 – Sample scenarios to analyse** an Integrated FP/MNCH Client-Centred Approach

Advanced Preparation
Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)
Introduce and review the session objectives (show them on flipchart or slide). This session expands the exploration on quality in health care service by focusing on exploring approaches and frameworks that have been developed and adapted internationally to realize quality in health care service.

Activity 1: The Role of an Integrated FP/MNCH and Client-Centred Approach in Enhancing Quality in Health Service Provision (45 minutes)

1.1 Create a link with the session on Quality of Care through a rapid discussion using probing questions such as:
   - What are key aspects of quality of care?
   - How is quality of care influenced by both medical and social issues?

1.2 Over the years, many organizations around the world have developed and adapted operational frameworks and approaches in order to address the interconnections of

medical and social issues affecting health. In the next exercise, we are going to explore two of these approaches: the client-centred approach and the integration approach, and we will discuss how they support each other in enhancing quality.
Instructions:

- Participants stand in the middle of the room. The facilitator will have pre-prepared two signs, namely "AGREE" and "DISAGREE", and posted them at opposite ends of the room.
- The facilitator reads out one statement at a time. If the participants agree, they will go standing under the "AGREE" sign or under the "DISAGREE" sign if they do not agree with the statement. If unsure, they will stand in between signs.
- Remind the participants that throughout the exercise each person participates as an individual. The purpose is to explore views and perceptions about the issues discussed and to learn from each other. Therefore during the exercise participants will not challenge or judge other people's opinions. The facilitator will ask questions to help clarify issues, and anyone can change their decision to agree or disagree at any time and move under a different sign.

Sample Statements about Client-Centred Approach:

- A client-centred approach is based on recognizing that clients and health providers are equal.
- In a client-centred approach, providers aim to find out accurate information about clients in order to fully understand their needs.
- In a client-centred approach, providers make decisions on behalf of clients.
- A client-centred approach means enabling clients to find solutions to their specific problems.
- A client-centred approach means that providers decide which solutions or choices are best for clients.
- In a client-centred approach, providers give accurate and tailored information to help clients make their own voluntary informed decisions.

Sample Statements about Integration of FP/MNCH:

- Providing integrated services means that health care providers use a client visit as an opportunity to engage the client in exploring and addressing her/his health and social needs that are broader than those prompting the encounter.
- When integration is applied to FP in MNCH, the goal is to use all available opportunities to reach clients with the FP services that can be provided at that specific entry point in the health system.
- Sometimes, when people hear the word integration, they may imagine a facility where a client could have all of her/his health needs met during one visit. This is not what integration necessarily means every time that a client visits a health facility.
- Integration of FP/MNCH can also mean that only specific FP services are provided during the client visit while the client is referred somewhere else for other FP or health needs.

Note for Facilitators

- Conduct the activity for about 15 minutes. It is not necessary to use all the statements.
- Avoid transforming the exercise in a "right/wrong" debate. Ask questions to help the participants clarify their reasons for agreeing/disagreeing/or being unsure, but without challenging their views. Instead, use the group as resource by asking other people to share their reasons for agreeing or disagreeing with a statement. During the discussion, it's useful to ask the participants whether they have heard anything from others that may convince them to change their opinion, and why.

1.3 Once the discussion is completed, distribute handout 1 and encourage the participants to review it in their own time.

1.4 Distribute copies of the **Integrated and client-centred FP/MNCH framework** (Handout 2). Explain that this framework was developed at a NURHI curriculum workshop by NURHI technical advisors, master trainers, and participants from ministries of health. This framework identifies possible **entry points** (vertical column on the left) in the health systems relevant to MNCH. The framework suggests **specific FP** services that can be provided at each entry point (across). Explain that you are going to conduct again the Agree/Disagree exercise using statements about the framework to reflect on both integration and client-centred approach.

Sample statements for the FP/MNCH integration framework (Allow 15 minutes. It is not necessary to use all the statements):

- It is not feasible to implement this framework in Nigeria.
- It is feasible to provide FP counselling for adolescents at immunization services.
- It is feasible to provide FP counselling to couples at Antenatal Care (ANC) services.
- It is feasible to provide FP education for men at Sexually Transmitted Infection (STI) services.
- It is feasible to provide condoms and dual protection counselling at delivery services.
- It is feasible to provide Intra Uterine Copper Devices (IUCDs) to clients who access immunization services.
- It is feasible to provide FP counselling for couples at General Out-Patient Department (GOPD).

1.5 Spend five minutes asking the participants to share what learning they take away from this exercise by discussing this question:

- What have you learnt about how the client-centred approach and the integration approach contribute to improving quality of care?

Transition into the next activity by explaining that it will focus on key elements of quality that relate to both providing FP/MNCH client-centred integrated services and addressing providers' needs.

Activity 2: Clients' Rights and Providers' Needs (75 minutes/one hour and 15 minutes)

2.1 Explain that in this activity we will review a tool that over the years has been used and adapted in many parts of the world and by various organizations to promote quality in health service. It is *IPPF's Clients' Rights, Providers' Needs* framework.

2.2 Acknowledge that probably most participants are familiar with the framework. Therefore you will summarize it briefly. Distribute Handout 3 and review it quickly.

2.3 The next exercise aims to help the participants deepen their reflections and insight on the role of clients' rights and providers' needs in achieving quality of care, using the **Facilitator's Resources** sheet "Sample Questions for Activity 2". Explain the instructions:

- Some participants will receive paper strips with questions about clients' rights, while others will receive paper strips with questions about providers' needs. There will be more than one person with the same question.
- Participants will sit forming two rows facing each other. At the start of the activity one row will be occupied by the participants who have received the clients' rights paper strips; the other row by the participants who have received the providers' need paper strips.
- When the facilitator gives the signal, the people facing each other in the two rows will begin discussing the questions on their respective paper strips.
- After a maximum of five minutes, the facilitator gives the next signal, and only the participants of the client's rights row will shift of one seat. As they shift seats, they also swap the paper strip with the person who will now move to their chair. Instead, the participants in the provider's need row do not shift seats, but each person swaps her/his paper strip with someone else in the same row. The discussion continues.
- The process will continue until the facilitators signal the end of the activity.
- As the activity unfolds, the participants are encouraged to use ideas and insight that they gain through their discussions to expand their own answers. Participants are not expected to write down anything, unless they want to make their own notes about ideas and insight that they find particularly useful.

Allow no more than 30 minutes in total for the above exercise.

2.4 The participants are still seated facing each other. Ask them to discuss this question in 5 minutes:

- Why a client-centred integrated FP/MNCH approach is important to enhance quality of care?

Record answers on a flipchart and enable the participants to discuss the issues from their brainstorm.

2.5 Ask the participants to go back to their seats and to work in pairs. Distribute Handout 4 (the scenarios) and assign one scenario per pair. They have 10 minutes to discuss the question provided in the handout for each scenario. Encourage them to refer to the other handouts previously distributed during this session.

Each pair presents and receives feedback and input from the other participants.

Note for Facilitators

As each pair shares the results of their discussion, make sure to ask questions such as:

- What additional health issues and needs of the client should be explored in this scenario to ensure an integrated FP/MNCH approach, and why?
- What client's rights are particularly important in this scenario, and why? Who else is affected, and how can providers do something to help them without undermining the rights of the client?
- What providers' needs may affect how services are provided in this scenario? What can be done to address those needs in ways that support integration of FP/MNCH and clients' rights?

2.6 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Facilitator's Resources

Sample Questions for Activity 2

Photocopy and cut the following questions. Facilitators are encouraged to adapt the questions to the needs of their groups.

Clients' Rights Questions:

Ensuring Clients' Awareness of FP Rights:

- From your experience, how aware are most clients about their rights? What influences their awareness?

Understanding Challenges to Implementing Clients' FP Rights:

- What are the most challenging clients' rights to implement in FP services, and why?

Understanding how Rights Make a Difference to FP Access:

- From your experience, how do clients' rights make a difference in increasing access to FP?

Providing Clear, Accurate, Complete Information on FP:

- How does this right contribute to access to and quality of FP?

Ensuring Clients Access to FP Services as an Integral Part of MNC:

- How does it contribute to access to and quality of FP?

Ensuring Informed Choice to Decide and Plan Family Size, Choose an FP Method that Best Meets a Client's Needs, and Receive FP/Healthy Timing and Spacing of Pregnancy (HTSP) Services as a Part of MNCH:

- How does it contribute to access to and quality of FP?

Ensuring Infection Prevention i.e., to Receive all Services Related to FP/MNCH without Risk of Contracting any Iatrogenic Infections:

- How does it contribute to access to and quality of FP?

Ensuring Privacy - both visual andute to access to audio - During FP Counselling and Service Delivery:

- How does it contriband quality of FP?

Confidentiality to be assured that any Personal Information will Not be Shared in Public:

- How does it contribute to access to and quality of FP?

Dignity i.e., Being Treated with Courtesy, Attentiveness, Respect, and in a Non-Judgmental Way:

- How does it contribute to access to and quality of FP?

Comfort i.e., Ensuring that Both the Physical and Emotional Space are Non-Threatening While Receiving FP/HTSP Services:

- How does it contribute to access to and quality of FP?

Continuity i.e., Receiving Ongoing, Appropriate Integrated FP/MNCH Services for as Long as it is Needed:

- How does it contribute to access to and quality of FP?

Providers' Needs Questions:

- From your experience, what are the most urgent providers' needs in relation to achieving quality FP services?
- In your experience, what role does facilitative supervision play in enhancing quality of FP services?
- In your experience, what are the main barriers to provide timely and effective facilitative supervision? What could be done to overcome these barriers?
- How do you see the role of training in addressing providers' needs in the context of a client-centred approach to FP provision?
- In your experience, what are the most important motivational factors for providers to strive for quality service provision?
- In your view, what are the most common misconceptions that health providers have about incentives that they should receive to strive for quality?
- In your view, what are the most common misconceptions that clients have about the role of providers in ensuring quality services?
- In your view, what are the most common assumptions that providers make about how clients perceive quality in FP services?

Participant's Handouts

Session 3: Handout 1, Activity 1 – An Integrated FP/MNCH Client-Centred Approach

Client-Centred

- A client-centred approach is based on recognizing that clients are equal partners with health services in improving their own health outcomes.
- In a client-centred approach, providers aim to find out accurate information about clients in order to fully understand their needs.
- A client-centred approach means enabling clients to find solutions to their specific problems.
- In a client-centred approach, providers give accurate and tailored information to help clients make their own informed and voluntary decisions.
- Evidence shows that clients are better served when the content of clinical interactions is guided by the client's needs rather than a standardized "one size fits all" model. Client-centred counselling enables the selection of a method that best fits the client's life circumstances and abilities, contributing to better outcomes for the client.

Integration:
"Any two services can be considered to be integrated when they are offered at the same facility during the same operating hours, and the provider of one service actively encourages clients to consider using the other service during that visit. According to this definition, integrated services may or may not be offered in the same physical location within the facility and may or may not be offered by the same service provider."

International Family Planning Perspectives (June 2002):

- Providing integrated services means that health care providers use a client visit as an opportunity to engage the client in exploring and addressing her/his broader health and social needs than those prompting the encounter.
- When integration is applied to FP in MNCH, the goal is to use all available opportunities to reach clients with the FP services that can be provided at that specific entry point in the health system.
- Sometimes, when people hear the word integration, they may imagine a facility where a client could have all of her/his health needs met during one visit. This is not what integration necessarily means every time that a client visits a health facility.
- Integration of FP/MNCH can also mean that only specific FP services are provided during the client visit while the client is referred somewhere else for other FP services.

Participant's Handouts

Session 3: Handout 2, Activity 1 – An Integrated and client-centred FP/MNCH framework

Providing Integrated and Client-Centred FP/MNCH Services

Entry Points	FP Services to be Provided													
	Referral *specify*	FP IEC	FP education for women	FP education for men	FP counselling for couples	FP counselling for men	FP counselling for women	FP counselling for adolescents and unmarried	Provide EC	Provide condoms and dual protection counselling	Provide pills, injectables and implants	Provide IUCDs	Provide tubal ligation	Provide vasectomy
FP Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Immunization	✓	✓	✓	-	✓	-	✓	✓	-	✓	✓	✓	-	-
Delivery	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓[1]	✓	✓	-
ANC	✓	✓	✓	-	✓	✓	✓	✓	-	✓	✓[2]	-	-	-
PNC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-
PAC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-
PMTCT	✓	✓	✓	-	✓	✓	✓	✓	-	✓	✓	-	-	-
GOPD	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-
STI Services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-	-
HCT	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-

[1]Progestin-only pills and injectables and implants. In settings where pregnancy morbidity and mortality risks are high and this method is one of few widely available contraceptives, it may be made accessible to breastfeeding women immediately postpartum. Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 20011: Family Planning. A Global Handbook for Providers

[2] Progestin-only pills are relevant if it is unlikely the woman will deliver in a clinic setting or seek Postnatal Care (PNC).

Participant's Handouts

Session 3: Handout 3, Activity 2 – Clients' Rights and Providers' Needs

(Adapted from: USAID | the ACQUIRE Project, 2008: Facilitative Supervision Curriculum, Trainer's Manual)

Clients' Rights

- **Information** – The right to accurate, appropriate, understandable, and unambiguous information about reproductive health and sexuality, as well as health overall.
- **Access to Services** – The right to services that are affordable, are available at convenient times and places, are fully accessible with no physical barriers, and have no inappropriate eligibility requirements or social barriers, including discrimination based on sex, age, marital status, fertility, nationality or ethnicity, social class, religion, or sexual orientation.
- **Informed Choice** – The right to make a voluntary, well-considered decision that is based on options, information and understanding. The informed choice process is a continuum that begins in the community, where people get information even before they come to a facility for services. It is the service provider's responsibility either to confirm that a client has made an informed choice or to help the client reach an informed choice.
- **Safe Services** – The right to safe services, which require skilled providers, attention to infection prevention, and appropriate and effective medical practices. Safe services also mean proper use of service-delivery guidelines, quality assurance mechanisms within the facility, counselling and instructions for clients, and recognition and management of complications related to medical and surgical procedures.
- **Privacy and Confidentiality** – The right to privacy and confidentiality during the delivery of services. This includes privacy and confidentiality during counselling, physical examinations, and clinical procedures, as well as in the staff's handling of clients' medical records and other personal information.
- **Dignity, Comfort, and Expression of Opinion** – The right to be treated with respect and consideration. Service providers need to ensure that clients are as comfortable as possible during procedures. Clients should be encouraged to express their views freely, even when their views differ from those of service providers.
- **Continuity of Care** – The right to continuity of services, supplies, referrals, and follow-up necessary to maintaining their health.

Providers' Needs

- **Facilitative Supervision and Management** – Health care staff function best in a supportive work environment in which supervisors and managers encourage quality improvement and value staff. Such supervision enables staff to perform their tasks well and thus better meet the needs of their clients. Staff need to know clear expectations, receive feedback, and feel motivated.
- **Information, Training, and Development** – Health care staff need knowledge, skills, and ongoing training and professional development opportunities to remain up-to-date in their field and to continuously improve the quality of services they deliver.

- **Supplies, equipment, and infrastructure** – Health care staff need reliable, sufficient inventories of supplies, instruments, and working equipment, as well as the infrastructure necessary to ensure the uninterrupted delivery of high-quality services.

Adapted from: Huezo, C., and Diaz, S. 1993. Quality of care in family planning: Clients' rights and providers' needs. *Advances in Contraception* 9(2):129–139; and International Planned Parenthood Federation. 1993. *The rights of the client.* Poster. London.

Participant's Handouts

Session 3: Handout 4, Activity 2: Sample scenarios to explore a FP/MNCH integrated and client-centred approach to service provision

Please note: facilitators are encouraged to change these scenarios and make them more appropriate for their local realities.

Scenario 1:
A married adolescent girl aged 17 years old comes to the clinic accompanied by her mother. The girl has been married for 12 months and has a three month old baby. The mother wants a contraceptive method for her daughter and thinks that her daughter should use implants.

Discuss:

- What would you do to ensure that a FP/MNCH integrated and client-centred approach is applied to this case?

Scenario 2:
An HIV positive woman comes to the clinic. She is divorced and has two children, who were born before she became positive. She has met a man and they are planning to get married and she wants a method, but she has not told him about being HIV positive.

Discuss:

- What would you do to ensure that a FP/MNCH integrated and client-centred approach is applied to this case?

Scenario 3:

A married man aged 55 comes to the clinic because he is interested in vasectomy. His wife is 35 year old and they have five children. He has a second wife who is 30 years old and with whom he has had two children. He tells you that he wants a vasectomy because he has all the children he wants and at his age he wants to enjoy himself without any more concerns.

Discuss:

- What would you do to ensure that a FP/MNCH integrated and client-centred approach is applied to this case?

SESSION 4: Client-Centred Integrated FP/MNCH Counselling. What it is, its Key Aims and Key Service Delivery Issues for its Realization

Objectives
By the end of the session, the participants will be able to:

- Explain what client-centred integrated FP/MNCH counselling is.
- Explain key aims of client-centred integrated FP/MNCH counselling.
- Identify important issues at service delivery level that should be addressed to realize client-centred integrated FP/MNCH counselling.

Total Session Time
90 minutes (one hour and 30 minutes)

Materials

- Flipcharts, markers, tape
- Flipchart "Session objectives"
- Flipchart "client-centred integrated FP/MNCH counselling" for Activity 1, step 1.12
- Sufficient blank A4 paper sheets for Activity 1, step 1.4
- Copies of the "service delivery issue card" for Activity 2, step 2.1
- LCD projector if available

Facilitator's Resources

- Service Delivery Issue Cards for Activity 2

Handouts

- Handout 1 – Client-Centred Integrated FP/MNCH Counselling
- Handout 2 – Informed Choice
- Handout 3 – Issues at service delivery level affecting provision of Client-Centred Integrated FP/MNCH Counselling

Advanced Preparation
Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)
Introduce and review the session objectives (show them on flipchart or slide). This session explores the concept of client-centred integrated FP/MNCH counselling and aims to enable the participants reflect on its central role in ensuring provision of quality FP services.

Activity 1: What is Client-Centred Integrated FP/MNCH Counselling? (40 minutes)

1.1 In the large group, brainstorm the following question:

- How would you describe what client-centred integrated FP/MNCH counselling is?

Write on flipchart key words that the group suggests, e.g., confidentiality, privacy,

and decision-making, etc.

1.2 Distribute Handout 1 and discuss the following definition:

Client-Centred Integrated FP/MNCH Counselling
A supportive, confidential and private type of interpersonal communication between a trained provider and a client **to enable the client**: • Explore the needs and concerns that prompted the interaction. • Access accurate and complete information about such needs and concerns. • Assess available options and possible decisions and choices that the client may want to make to meet her/his FP needs. • Explore and assess other potential concerns that the client may have (e.g. around STI and HIV, problems in the client's marriage or relationship) and that may influe nce the client's ability to make and carry out voluntary and informed decisions. • Assess potential consequences of decisions and choices, and how to manage such consequences in the client's context. • Make and confirm her/his voluntary and informed decisions and choices. Make follow-up and referral plans, as necessary.

Ask the participants to discuss in pairs for a few minutes:

- How does this definition relate to the results of their brainstorm?
- Are there any key issues from the brainstorm results that should be included in this definition, and why?
- How is this definition similar or different from what the participants have been doing in FP counselling?

1.3 After inviting a few pairs to share with the large group as time permits, stress that the important issue about client-centred integrated FP/MNCH counselling is its focus on:

- Supporting client's voluntary and informed decision-making and choices.
- Supporting a client to explore issues and concerns beyond the stated ones about a FP method, and especially those that may affect the client's ability to make voluntary and informed decisions and choices. Therefore the aim is problem-solving in order to support the implementation of informed choices and decisions.

Stress that by realizing these key aims, client-centred integrated FP/MNCH counselling plays an extremely important role toward quality in FP service provision. The next activity will explore these issues in more depth.

1.4 Remind the participants that in a previous session we discuss voluntary informed choice as one the rights of clients. However we neither defined what informed choice is nor what clients need to know to make one. We are going to discuss these issues in the next exercise.

1.5 Divide the participants in groups of three or in pairs and distribute a few blank A4 size paper sheets to each group. Organize pairs/groups by number 1-2. Instructions:

- #1 pair/group will develop a definition of **Informed Choice**.
- # 2 pair/group will answer this question: What do FP clients need to know to

make an informed choice?

They have five minutes to brainstorm and prepare their A4 papers.

1.6 Stop the discussion after five minutes and ask #1 pair/group to post their papers in a column on one side of the wall while #2 pair/group will post their sign in one column on the opposite side. Allow the participants a few minutes to read the cards. Facilitate a short discussion:

- Which definition/s of Informed Choice do you find most useful, and why?
- And about the answers to what clients need to know to make an informed choice, which ones do you find most useful and why?
- What key elements of Informed Choice are emerging from your definitions? How do they relate to the key purposes of client-centred counselling?

1.7 Distribute Handout 2 and discuss the main similarities and differences that participants can identify with their definitions and ideas.
Transition into the next activity by explaining the following point:

- In order to realize the focus of client-centred integrated counselling on enabling informed choice and voluntary decisions, at service delivery level there are some important considerations to take into account. These will be explored in the next activity.

Activity 2: Important Issues at Service Delivery Level that Should be Addressed to Realize Client-Centred Integrated FP/MNCH Counselling (45 minutes)

2.1 The aim of this activity is to enable the participants explore the role of a few critical issues at service delivery level that affect the implementation and the quality of client-centred integrated FP/MNCH counselling. Instructions:

- ➢ Participants will receive randomly one "service delivery issue card". There are five different types of these cards titled as follows:
- Ensuring availability of service options.
- Ensuring voluntary informed choices and decisions.
- Providing appropriate information.
- Ensuring good client-provider interaction.
- Ensuring that the social and rights context supports voluntary informed choice.
- ➢ Each participant will walk around the room looking for another person with a different issue card. They will discuss the issues and the questions on their cards. When the facilitator gives the signal, they will separate and look for other people with different cards, and so on till the facilitator signals the end of the exercise.

2.2 Stop the exercise after 20-25 minutes. Facilitate a group debriefing using the same questions provided on the issue cards. Finally distribute handout 3 as information the participants can continue to refer to.

2.3 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Facilitator's Resources

Service Delivery Issue Cards for Activity 2

Copy and print as many of the cards below as you need depending on the number of participants.

CARD 1: Ensuring Availability of Service Options

Service Delivery Issues to Consider:

- Where and when services are available.
- The method mix available at the site.
- How many trained providers are available to provide all the methods, or which methods are they trained in.
- Existence and effectiveness of referral system for methods, services and options not available at the site.
- Existence and effectiveness of a system to prevent shortages of methods and supplies.

Discuss:

- If these issues are not addressed, how can provision of client-centred integrated FP/MNCH counselling be affected?
- Which other issues concerning service options may affect provision of FP client-centred counselling, and why?

CARD 2: Ensuring Voluntary Informed Choices and Decisions

Service Delivery Issues To Consider:

- Providers' attitudes to clients' rights and ability to make their own decisions.
- Providers' awareness of the power imbalance between them and clients.
- Providers' attitudes to specific client groups, e.g. adolescents, post -abortion clients, men, etc.
- Providers' understanding of how social and cultural values may affect a client's decision making process
- Existence and implementation of consent guidelines.
- Existence and implementation of standards to ensure informed and voluntary decisions.
- Providers' skills in helping a client assess whether her/his decision meets her/his needs.

Discuss:

- If these issues are not addressed, how can provision of client -centred integrated FP/MNCH counselling be affected?
- Which other issues concerning voluntary informed choices and decisions may affect provision of FP client-centred counselling, and why?

CARD 3: Providing Appropriate Information

Service Delivery Issues To Consider:

- Providers' attitudes to discussing intimate issues, including sexuality, with all types of clients.
- Providers' skills in information giving about a range of FP/MNCH related topics.
- Time available to provide information and answer clients' questions.
- Use of staff other than doctors and nurses to provide information to clients, as appropriate.
- Availability of education materials for clients and job aids for providers.
- Providers' attitudes to the type of information given, i.e. wheth er it reflects the preference of providers or it is really tailored to clients' needs.
- Providers' attitudes and skills in checking whether clients understand the information they receive.

Discuss:

- If these issues are not addressed, how can provision of cli ent-centred integrated FP/MNCH counselling be affected?
- Which other issues concerning provision of appropriate information may affect FP client-centred counselling, and why?

CARD 4: Ensuring Good Client-Provider Interaction

Service Delivery Issues To Consider:

- The quality of providers' training in counselling.
- Providers' attitudes to delivering quality FP client-centred counselling.
- Providers' skills in assessing and addressing what clients want and need.
- Existence and effectiveness of supportive supervision.
- Privacy and confidentiality during counselling.
- Mechanisms for assessing client satisfaction.
- Adequate facilities to meet both client's and providers' needs for basic comfort and safety.

Discuss:

- If these issues are not addressed, how can provisi on of client -centred integrated FP/MNCH counselling be affected?
- Which other issues concerning client -provider interaction may affect FP client-centred counselling, and why?

CARD 5: Ensuring that the Social and Rights Context Supports Voluntary Informed Choice

Service Delivery Issues To Consider:

- Providers' training in sexual and reproductive rights and gender equity.
- Providers' support for clients' ability to exercise their sexual and reproductive rights and make voluntary decisions.
- Providers' support for client's decision to involve or exclude others from their decision-making process.
- Providers' ability to ensure that the power imbalance provider - client does not affect negatively a client's decision making process.
- Providers' attitudes towards specific client groups.

Discuss:

- If these issues are not addressed, how can provision of FP client -centred be affected?
- Which other issues concerning the social and right context may affect FP client-centred counselling, and why?

Participant's Handouts

Session 4: Handout 1, Activity 1 – Client-Centred Integrated FP/MNCH Counselling

Client-Centred Integrated FP/MNCH Counselling
A supportive, confidential, and private type of interpersonal communication between a trained provider and a client **to enable the client**: • Explore the needs and concerns that prompted the interaction. • Access accurate and complete information about such needs and concerns. • Assess available options and possible decisions and choices that the client may want to make to meet her/his FP needs. • Explore and assess other potential concerns that the client may have (e.g. around STI and HIV, problems in the client's marriage or relationship) and that may influence the client's ability to make and carry out voluntary and informed decisions. • Assess potential consequences of decisions and choices, and how to manage such consequences in the client's context. • Make and confirm her/his own voluntary informed decisions and choices. Make follow-up and referral plans, as necessary.

Key Aims of FP Client-Centred Counselling

- Supporting client's voluntary and informed decision-making and choices.
- Supporting a client to explore issues and concerns beyond the stated ones about a FP method, and especially those that may affect the client's ability to make voluntary and informed decisions and choices. Therefore the aim is problem-solving in order to support the implementation of informed choices and decisions.

Participant's Handouts

Session 4: Handout 2, Activity 2 – Informed Choice

A voluntary choice or decision based on knowledge of all information relevant to the choice or decision.
In order to make an informed choice, the client needs to know:

- All FP available methods
- Advantages and disadvantages of each method
- Possible side effects of each method
- Risks of not using any method, such as risks associated with pregnancy/childbirth versus risks associated with contraceptive use
- How to use the chosen method safely and effectively

Participant's Handouts

Session 4: Handout 3, Activity 2 – Key Issues at Service Delivery Level to Ensure Client-Centred Integrated FP/MNCH Counselling

Ensuring Availability of Service Options

Service Delivery Issues to Consider:

- Where and when services are available.
- The method mix available at the site.
- How many trained providers are available to provide all the methods, or which methods are they trained in.
- Existence and effectiveness of referral system for methods, services and options not available at the site.
- Existence and effectiveness of a system to prevent shortages of methods and supplies.

Ensuring Voluntary Informed Choices and Decisions

Service Delivery Issues To Consider:

- Providers' attitudes to clients' rights and ability to make their own decisions.
- Providers' awareness of the power imbalance between them and clients.
- Providers' attitudes to specific client groups, e.g. adolescents, post -abortion clients, men, etc.
- Providers' understanding of how social and cultural values may affect a client's decision making process
- Existence and implementation of consent guidelines.
- Existence and implementation of standards to ensure informed and voluntary decisions.
- Providers' skills in helping a client assess whether her/his decision meets her/his needs.

Providing Appropriate Information

Service Delivery Issues To Consider:

- Providers' attitudes to discussing intimate issues, including sexuality, with all types of clients.
- Providers' skills in information giving about a range of FP/MNCH related topics.
- Time available to provide information and answer clients' questions.
- Use of staff other than doctors and nurses to provide information to clients, as appropriate.
- Availability of education materials for clients and job aids for providers.
- Providers' attitudes to the type of information given, i.e. whe ther it reflects the preference of providers or it is really tailored to clients' needs.
- Providers' attitudes and skills in checking whether clients understand the information they receive.

Ensuring Good Client-Provider Interaction

Service Delivery Issues To Consider:

- The quality of providers' training in counselling.
- Providers' attitudes to delivering quality FP client-centred counselling.
- Providers' skills in assessing and addressing what clients want and need.
- Existence and effectiveness of supportive supervision.
- Privacy and confidentiality during counselling.
- Mechanisms for assessing client satisfaction.
- Adequate facilities to meet both client's and providers' needs for basic comfort and safety.

Ensuring that the Social and Rights Context Suppor ts Voluntary Informed Choice

Service Delivery Issues To Consider:

- Providers' training in sexual and reproductive rights and gender equity.
- Providers' support for clients' ability to exercise their sexual and reproductive rights and make voluntary decisions.
- Providers' support for client's decision to involve or exclude others from their decision-making process.
- Providers' ability to ensure that the power imbalance provider -client does not affect negatively a client's decision making process.
- Providers' attitudes towards specific client groups.

SESSION 5: Understanding How our Own Attitudes may Affect Access to and Quality of Client-Centred Integrated FP/MNCH Services

Objectives

By the end of the session, the participants will be able to:

- Identify providers' attitudes that facilitate or hinder access to and quality of FP services.
- Develop useful strategies to manage attitudes effectively.

Total Session Time

120 minutes (two hours)

Materials

- Flipcharts, markers, tape
- Flipchart "Session objectives"
- Flipchart "Attitudes" for Activity 1, step 1.1
- Smiling face and sad face signs for Activity 2
- Flipchart with sample attitudes, Activity 1, step 1.2
- Attitude cards for Activity 2
- Client statements written on paper strips for Activity 3, step 3.1
- LCD DESK/LAP TOP projector if available

Facilitator's Resources

- Sample List of Attitude Cards for Activity 2
- Activity 3: Sample Client Statements for Role-Plays

Handouts

- Handout 1 – What's in an Attitude?
- Handout 2 – Tips to Minimize Provider's Attitudes that Hinder Access to and Quality of FP Services

Advanced Preparation

Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)

Introduce and review the session objectives (show them on flipchart or slide). Attitudes play a very important role in many aspects of our lives. Sometimes we may not be aware of how attitudes influence how we see the world or how we interact with each other. As health service providers, developing an awareness of our attitudes and strategies to manage them effectively is very important to ensure that our work is effective.

Activity 1: What are 'Attitudes'? (15 minutes)

1.1 Introduce the session by asking participants to reflect on the following statement (show on slide/flipchart):

Attitudes
*Attitudes are **ways of responding** to situations, events, and people. Attitudes are learned and we may show them without being aware of their effect. Attitudes are shaped by experiences, how we grow up, the be liefs that we may have about certain issues, the assumptions that we may make about people, and what we feel is right and wrong.*

Invite participants to share their opinions about the definition and ask questions for clarification.

1.9 Ask:

- How can we explain this definition through examples?

If participants cannot provide any examples, show the following flipchart/slide:

1. *A person is asked if unmarried women should have access to contraception and immediately says "NO!"*
2. *A person finds out that his sister had an abortion and immediately accuses her of having done something "bad" or "immoral".*

Attitudes can also be expressed through body language. For example:

A client tells the provider that she is having an extra-marital relationship. The provider opens her yes very widely with a look of disapproval or disgust and withdraws from the client.

Facilitate a brief discussion using questions such as:

- What other attitudes have you observed in the community about these kinds of issues?
- Which of such attitudes hinder access to and utilization of FP/MNCH services?

1.3 It is also important to acknowledge that attitudes are not always negative and that they evolve over time. Briefly discuss with the participants:

- Have you observed attitudes to around FP and HTSP, sexual relationships, and women's empowerment that are not judgmental or negative? How common are these attitudes in the community?
- How are attitudes to these and other sexual and reproductive health issues changing in ways that support access to FP/MNCH? What is influencing these changes?

14 At the end of the discussion, distribute Handout 1

Activity 2: Identifying Providers' Attitudes that Enhance or Hinder Access to and Quality of FP Service Provision and Strategies to Manage Attitudes Effectively (55 minutes)

2.1 Before beginning the session, make sure that you have enough space to facilitate this activity. You will have already posted on the wall two signs, a smiling face and a sad face. The smiling face represents provider attitudes that enhance access to and quality of FP/MNCH services, while the sad face is obviously a sign for provider attitudes hindering access to and quality of FP/MNCH.

Ensure that there is enough space to list attitudes under each sign, as well as enough

space between the two columns. Instructions:

- Ask participants to join you in the middle of the room and to form a circle around you.
- Move around the circle holding an envelope in which you will have placed strips of paper. Each strip has a statement written on it. The statements express attitudes, and therefore we call these strips *the attitude cards* (Refer to the **Facilitator's Resources** below for a list of sample statements).
- Ask each participant to pick one or two cards from the envelope. The participant will decide without consulting with anyone else under which sign the card should be placed. If unsure, the card can be placed in the space between the two columns.

2.2 Once the participants have completed arranging the cards, invite them to stand in front of the two columns and reflect on the result of the game. Facilitate a discussion asking questions such as:

- Based on your own experience, which provider attitudes in the "smiling face" list are essential to enhance access to and quality of FP/MNCH services? How do these contribute to these aims? How do these attitudes reinforce each other?
- Which attitudes in the "sad face" list are the most damaging to access to and quality of FP/MNCH services? Why? How might these attitudes reinforce each other to undermine provision of quality FP/MNCH services?
- Which attitudes in the "unsure" space would you move to either the "Enhancing" or "Hindering" listing, and why?
- Are there any additional attitudes that we have not considered either as "enhancing" or "hindering"? What are they? (make sure you have a few blank cards to write any additional attitudes)
- Why is it important for us, as providers, to be aware of our own attitudes and beliefs about FP/MNCH issues?
- What can we do, as providers, when our beliefs about a particular FP method or MNCH issue make us uncomfortable talking about it with clients?

Note for Facilitators

It is important to help participants avoid a "right" and "wrong" deadlock. As this activity requires developing comfort to discuss issues that may touch participants very closely, it is important to maintain an objective and non-judgmental atmosphere. In order to facilitate reflections and insights, you may want to provide a hypothetical, real life context when discussing attitudes and how participants have listed them, e.g. "What would be a possible impact on access to and quality of FP/MNCH services if a FP provider demonstrated a judgmental attitude about the sexual life of the client?"

It is important that you remain neutral in the discussion. If you feel that it is useful to provide your opinion, it is advisable to do so by asking hypothetical questions, like the one provided above.

Sometimes participants may become focused on a specific interpretation of a card. This may derail the discussion and may cause the group to spend most of the time just on one issue, and/or lock the group or a few dominant individuals in a "right/wrong" discussion. For example, if the group becomes "stuck" on the meaning of *"Demonstrating openness to discuss certain issues only with certain types of clients,"* ask hypothetical questions:

- How can access to and quality of services be affected if a FP provider will only discuss certain issues with clients who always agree?
- How could such an attitude enable the provider to help clients who may want to ask lots of questions, or challenge the advice that they receive?
- How can such an attitude help the provider develop skills to manage different types of clients and interactions?

Often, participants focus on statements that concern sexual issues. For example, it is likely that participants may place a card such as *"anal sex is acceptable behaviour"* under the sad face sign. It is important to help the participants reflect on the fact that the activity is not about expressing a judgment on what people feel or believe, but on assessing the impact that such beliefs may have on helping clients to access quality FP/MNCH services. In this kind of situation, facilitators are encouraged to use questions such as:

- If a client told a provider that she is having anal sex with her husband because they like it, and the provider expressed a negative and judgmental attitude, what could be the implications for the counselling interaction and for the client to have her needs addressed?
- If a teenage client told a provider that for her anal sex is normal behaviour to protect her virginity, and the provider expressed a negative and judgmental attitude, what could be the implications for the counselling interaction and for the client to have her needs addressed?

The important message to emphasize is:

Each one of us has developed attitudes around certain issues that reflect our values and beliefs. We have the right to keep our values and beliefs, but we also have a responsibility to ensure that we do not impose them on clients through our attitudes. We have a responsibility to prevent that our attitudes become barriers for clients to access and use health and social services.

Spend no more than 20 minutes on the above steps.

2.3 Still in front of the attitudes wall, randomly divide the participants in small groups or in pairs. If you do not have enough participants for pairs or small groups, ask them to work individually. Instructions:

- Select a few attitudes from the "hindering" listing and assign the same attitude to discuss to at least two pairs/participants.
- Their task is to imagine that they have become aware that they hold that attitude. **What can they do to minimize its impact on the way they provide FP/MNCH services?**
- Each pair/participant discusses for five minutes a possible solution. They join the other pairs/participants that were assigned the same attitudes and spend five more minutes comparing and discussing ideas.

2.1 Make sure to stop the exercise after the total time allocated (10 minutes). Invite a few pairs/individuals to share their ideas and distribute Handout 2. Briefly discuss how some of the tips compare with the ideas from the participants. Conclude the activity by stressing the following message:

It is important to recognize that each one of us may hold "hindering" attitudes and not be aware of them. The important issue is to become aware of how attitudes may support or hinder what we aim to achieve. The process we just went through is a type of values clarification, i.e. it helps us become aware of how what we consider "right or wrong" (our values) influence how we respond to issues and situations (our attitudes). Whether or not we choose to abandon or change some or our attitudes, we have a responsibility to prevent that they create barriers for clients to access FP/MNCH and other services.

Activity 3: Counselling Practice (45 minutes)

3.1 Divide the participants in pairs and explain the instructions:

- The facilitator invites a pair at a time to role-play a rapid scenario in front of the group.
- One person will play the "client", and the other will play the "provider". The facilitator introduces the "client" to the group only by providing essential details, e.g. teenage female client.
- The pairs will **not** start the role-play from the beginning of a client-provider interaction, i.e. they will pretend that they already have gone through the initial phase of their interaction and now they are starting to talk about the client's needs and issues.
- The facilitator explains that the "client" has something to tell the "provider". The issue that the "client" wants to discuss will be written on a strip of paper that the facilitator will give to the "client" just before starting the role-play, and the "provider" must not know what it is (please see the **Facilitator's Resources** section below).
- The role-play therefore will start with the "client" saying something like *"There is just one thing I need to tell you…"*. The person playing the "client" will decide how to introduce the issue to the "provider" and the role-play will continue from that moment for maximum of 5 minutes.

3.2 After each role-play of no more than five minute duration, the facilitator begins the feedback. Firstly, **the facilitator reminds the "provider", the "client", and the group that feedback**

is not about defending their performance. Feedback is about taking a constructive critical look at what was done in order to improve it. Therefore feedback is not a debate.

The facilitator debriefs the "provider" by asking:

- What did you do well in responding to what the client said?
- What would you change, if anything, to manage your attitudes more effectively in a situation like that?

Next, the facilitator debriefs the "client":

- How effectively did the "provider" manage her/his attitudes to ensure that you would not feel judged, embarrassed, ashamed, humiliated, or any other negative feeling?
- What would you like the "provider" to do differently in a situation like that, and why?

Finally, the provider invites a few comments from the groups focusing on:

- What could the "provider" have done differently to manage her/his attitudes more effectively?

3.3 Continue the role-plays and feedback as time permits.

3.4 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Facilitator's Resources

Sample List of Attitude Cards for Activity 2

Facilitators are encouraged to adapt the cards and/or develop additional ones. However, please make sure that you do not write on any card statements like "provider should encourage/discourage this attitude". The aim of the activity is not for trainers to impose their views. The role of the trainers is to ask questions to help the participants reflect on how any of the attitudes selected for discussion may impact access to and quality of FP and especially client-centred FP/MNCH integrated counselling.
Please note: it is not necessary to use all the cards. Use your discretion to make a selection by picking the attitudes that would challenge participants to think and reflect on their own values and beliefs and how they bring such values and beliefs in their counselling through their attitudes.

- In a couple, it is the woman who should be responsible for using contraception.
- Unmarried adolescents should not engage in sexual activity.
- If a woman never experiences childbirth, she will feel less like a woman.
- FP methods should be available to unmarried adolescents.
- Illiterate women cannot use oral contraceptives effectively.
- Natural FP methods are ineffective, difficult, and time-consuming to teach.
- It is okay for a woman to have an intrauterine device (IUD) inserted without telling her husband.
- Some clients want to continue getting pregnant until they have children of both sexes.
- If a woman wishes to have a tubal ligation, she should have one, even if her spouse disagrees.
- If a man wishes to have a vasectomy, he should have one, even if his spouse disagrees.
- A 21-year-old woman with only one child should be refused a tubal ligation.
- Service providers have the right to know the HIV status of their clients.
- People with HIV should not have sex.
- It is a crime for people who are infected with HIV to have sexual relation without informing their partner.
- People who get HIV through sex deserve it because of the behaviours that they practice.
- AIDS is mostly a problem of prostitutes.
- Women with HIV should be sterilized so they can't have children and pass on the infection.
- It should be recommended that couples not marry until they have had sexual intercourse.
- Prostitutes provide a useful service.
- If people go too long without sex, it is bad for them.
- The purpose of having sex is to show love for someone.
- Any sexual behaviour between two consenting adults is acceptable.
- A person can lead a perfectly satisfying life while being celibate.
- Celibacy goes against human nature.
- Oral sex is wrong.
- Anal sex is normal behaviour.
- Condoms ruin the enjoyment of sex.

- Couples can have an enjoyable sex life while using condoms every time they have sex.
- Educating teenagers about condoms will only encourage them to have sex.
- If my teenage son asked me for condoms, I would give them to him.
- If my teenage daughter asked me for condoms, I would give them to her.
- Clients who have good, up-to-date information about HIV transmission will make good choices about keeping themselves safe.
- Clients with two children or more should be sterilized.
- Sterilization is indicated for women with medical reasons to prevent pregnancy.
- Our facility should make contraceptive methods available to adolescents.
- Fourteen is too young for a boy to have sex.
- Schools should provide sexuality education for children before puberty, starting at age 9 or 10.
- In most cases, it is not worth discussing condoms with young people because they will never use them.
- Children should be taught about HIV and other STIs in school.
- The parent of a teenage client who reports she is having sex has a right to know about it.
- Young, unmarried people should not have sex.

Source: USAID | the ACQUIRE Project, 2008: Counselling for Effective Use of FP, Trainer's Manual

Facilitator's Resources

Activity 3: Sample Client Statements for Role-Plays

Print/Copy and Cut the Following Statements, each one on a Paper Strip, and use one for each Role-Play.

Facilitators are encouraged to develop additional statements that will help elicit common providers' attitudes in the area where the training is carried out.

(teenage female client) I like to have sex with my boyfriend and I like to do it often.

(female married client) I don't have children and I don't want any.

(male unmarried client) I just like to have several girlfriends and to have sex with each one of them when I want.

(female married client) I just want pills and I don't want to waste any more time.

(female married client) I am seeing another man and I need a method that my husband will not realize I am using.

(teenage male client) I want to have anal sex with my girlfriend and I want to know if I have to use condoms.

Participant's Handouts

Session 5: Handout 1, Activity 1 – What's in an Attitude?

Attitudes
*Attitudes are **ways of resp onding** to situations, events, and people. Attitudes are learned and we may show them without being aware of their effect. Attitudes are shaped by experiences, how we grow up, the beliefs that we may have about certain issues, the assumptions that we may ma ke about people, and what we feel is right and wrong.*

Examples:

1. *A person is asked if unmarried women should have access to contraception and immediately says "NO!"*
2. *A person finds out that his sister had an abortion and immediately accuses her of having done something "bad" or "immoral".*

It is important to recognize that each one of us may hold "hindering" attitudes and not be aware of them. The important issue is to become aware of how attitudes may support or hinder our performance as FP/MNCH service providers and our role in enabling access to and effective use of these services. This is why it is necessary that we become aware of how what we consider "right or wrong" (i.e. our values) influence how we respond to issues and situations (i.e. our attitudes). Whether or not we choose to abandon or change some or our attitudes, we have a responsibility to prevent that they create barriers for clients to access and use effectively FP/MNCH and other health and social services.

Participant's Handouts

Session 5: Handout 2, Activity 2 – Tips to Minimize Provider's Attitudes that Hinder Access to and Quality of FP Services

If you realize that your attitudes may be a barrier for clients:

- Be honest about it. The first step to minimize an un-useful attitude is to admit that you hold it.
- Don't blame yourself, but do not blame the client either.
- You are not alone in dealing with it, and probably you are not the first or the last service provider to experience it.
- Try to understand how you may have developed it. From childhood? From schooling? From other influences? What values or assumptions about people and situation is it connected to? Attitudes are developed through life and are influenced by our upbringing and experiences.
- Try to become aware of what "triggers" it. If you can recognize the signs, maybe you can minimize how the attitude manifests in your interactions.
- Ask yourself: Do I really need to hold on to it? How useful is it to my life? How is it helping my self-development?
- As a provider, the most important question to ask may be: How is it affecting my work? How is it helping me to help others? What alternative attitude/s would be more beneficial for my work? Who can help me better understand these issues?
- Talk to other colleagues that you trust and that can support you. Maybe they have gone through similar experiences. There is no shame in seeking support about wanting to overcome a potential barrier to your performance.
- Remind yourself that each one of us has developed attitudes around certain issues that reflect our values and beliefs. We have the right to keep our values and beliefs, but we also have a responsibility to ensure that we do not impose them on clients through our attitudes. We have a responsibility to prevent that our attitudes become barriers for clients to access and use health and social services.
- If you show a negative/judgmental attitude with a client during service provision, you can correct the impact by rebuilding rapport and trust with her/him. For example, a simple *"Please let me explain again what I meant, maybe I didn't use the right words"*, when said with a smile can go a long way to salvage a counselling session…

SESSION 6A: Why Addressing Gender, Sexuality, and Power in Client-Centred FP/MNCH Integrated Service Provision?

Objectives
By the end of the session, the participants will be able to:

- Explain gender and sexuality.
- Explain how power in sexual relationships is a key element in the social construction of these concepts.

Total Session Time
75 minutes (one hour and 15 minutes)

Materials

- Flipcharts, markers, tape
- Flipchart "Session objectives"
- Gender and Sexuality flipchart
- GENDER and SEXUALITY signs
- Sufficient copies of Gender and Sexuality Discussion Cards, Activity 2, step 2.1
- LCD projector if available/necessary

Facilitator's Resources

- Activity 1: Reconstructing Gender and Sexuality Definitions
- Activity 2: Sample Gender and Sexuality Discussion Cards.

Handouts

- Handout 1 – Gender and Sexuality

Advanced Preparation
Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)
Introduce and review the session objectives (show them on flipchart or slide). Acknowledge that most participants may already have participated in training programs that have included discussing gender and sexuality. Through this and other sessions of this program, we aim to identify how gender and sexuality are inter-connected and why addressing these issues in FP/MNCH is important to provide client-centred FP/MNCH integrated counselling.

Activity 1: Unpacking the Meaning of Gender and Sexuality (30 minutes)
1.1 Start by asking the participants to quickly suggest words that they would use to describe what gender and sexuality are. Record their ideas on flipchart:

Gender	Sexuality

Do not spend more than a few minutes for this initial rapid brainstorm.

1.2 Divide the participants in two groups. Explain the instructions:

- In this exercise, one group will reconstruct a definition of gender and the other group a definition of sexuality.
- Each group receives one envelope containing strips of paper. Each strip of paper has a sentence written on. Each sentence is a part of a definition of gender and of a definition of sexuality. Each envelope contains all the strips that make up the two definitions (please refer to the **Facilitator's Resources** section below).
- The groups will have 10 minutes maximum to select only the strips that create the definition they have been given to reconstruct. The groups will reconstruct the definitions by posting the strips on a wall under the GENDER and SEXUALITY signs that you will have pre-prepared.
- Explain that in some of the paper strips the words *gender* and *sexuality* have been replaced with the word *it*.

1.3 Stop the exercise after 10 minutes whether or not the participants have completed reconstructing the definitions. Ask each group to comment on the work of the other by using these question:

- Which elements of the definition would you keep, and which would you remove, and why?

1.4 Distribute Handout 1. Review it with the participants and facilitate a brief discussion with questions such as:

- How different are these definitions from those that you are used to? What is new in these definitions that you had not considered before?
- How do these definitions relate to what we have been discussing so far in this course, for example about client's rights, and how?

Activity 2: A Matter of Power (40 minutes)

2.1 Invite questions for clarification, but do not spend too much time on the definitions now. Explain that the next exercise will enable the participants to explore the meaning of the definitions through the analyses of case scenarios. Explain the instructions:

- Divide participants in pairs or groups of three people depending on the total number in your group.
- Half or the pairs/threes will work on the definition of gender, and the others on the definition of sexuality.
- Gender pairs: Distribute a gender discussion card to each pair (discussion cards are provided in the **Facilitator's Resources** section below).
- Sexuality pairs: Distribute a sexuality discussion card to each pair.
- The task is to be completed in 10 minutes.
- Pairs will post their cards under the respective signs "Gender" and "Sexuality" that the facilitator will have already placed on a wall (place the signs one next to the other with a little space in between).
- Ask the participants to spend a few minutes reading the analyses on the cards and then to sit in a semi-circle around the wall.

2.2 Debrief the pairs by alternating gender and sexuality pairs, as follows:

- Invite one gender pair who used gender discussion card No. 1 to present their analysis. Ask the larger group to offer their comments and additional analyses.

- Invite one sexuality pair who used sexuality discussion card No. 1 to present their analysis. Ask the larger group to offer their comments and additional analyses.

2.3 Repeat the process with the gender and sexuality cards in the **Facilitator's Resources** section below.

2.4 Still sitting around the wall: Facilitate a discussion on the following issues:
- What important issues connect gender and sexuality in these analyses?
- In which ways power in relationships is affected by gender and sexuality norms and roles? For example, how do these norms and roles affect power of men and women to negotiate, or power to say no, or power to make decisions and choices?
- How do these gender and sexuality norms affect access to FP and HTSP in your community, and for whom?

Note for Facilitators

Important messages to convey include:

- Both gender and sexuality are socially constructed. They are the products of social processes about what people are expected to be like in order to fit in with dominant norms (or "rules') about "being a man" and "being a woman", and managing their choices accordingly.
- These social norms and expectations about being a man or a woman define the power –or lack of it– that people are supposed to have in personal and social interactions, including their sexual relationships.
- Therefore power is a very important issue that connects gender and sexuality.
- However, these social and cultural expectations about being a man or a woman change over time as societies continue to evolve and transform attitudes/beliefs/values about these issues. For example, there is now international consensus that many of these social and cultural expectations create and maintain inequities in health and are responsible for problems such as maternal mortality.

2.5 If time permits, ask the participants to refer to Handout 1 and discuss:
- As you read the definitions again, what did you learn from the previous exercise to explain what gender and sexuality are and how they are inter-connected?

2.6 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Facilitator's Resources

Activity 1: Reconstructing Gender and Sexuality Definitions

Copy and cut two sets of these paper strips. Put each set in an envelope for each group, i.e. each envelop must contain both the strips of the gender definition and the strips of the sexuality definition.

Gender:
It is not about biological differences between "male" and "female".
It is the widely shared social and cultural expectations and norms ("rules") that in a society define or influence opportunities for men and women, what choices they can make and how acceptable such choices are, what roles they can play and how acceptable such roles are (e.g., in the family.)
Therefore how a society constructs it will affect the power and the ability people may have in making decisions and choices about their lives.

Sexuality:
It is more than biological sex and sexual intercourse.

It is a central aspect of being human and is experienced and expressed in thoughts, fantasies, desires, feelings, behaviours, practices, roles, and relationships.

It is the result of a personal and social process of development. This process includes how a person internalizes attitudes/beliefs/values concerning how men and women are expected to express and use sexuality, what sexual roles they are expected to play, how acceptable these sexual roles are, and what power and ability women and men have or are expected to have in sexual matters.

Therefore it is influenced by many social factors, including gender norms.

Facilitator's Resources

Activity 2: Sample Gender and Sexuality Discussion Cards.

Print sufficient copies of the cards depending on the number of participants.

Facilitators are encouraged to develop their own scenarios, but please ensure that the discussion questions elicit reflections on the connections between gender/sexual norms and power in relationships.

Gender Discussion Card No. 1

Precious is 17 years old. She recently moved to the city to escape the pressure of her family to get married to an older wealthy man. She completed primary school only. In the city, Precious has found a job as shop assistant. The business is owned by a family who live at the back of the shop. Precious sleeps in the shop and she has to pay rent out of her wages for her accommodation. Recently, the man who owns the shop has started to put pressure on Precious to have sex with him. He is threatening her that unless she agrees to have sex, she will lose her job and he will tell his wife that he had to fire Precious because he found her having sex with a customer.

Discuss and write your analyses in the spaces provided under each question:

- What social norms about being a man and a woman are enabling the man to use power in the way that he does in this situation?

- What social norms about being a woman - and specifically a young girl – may have contributed to P recious' current situation? How are these norms taking away power from Precious to protect herself?

- If Precious was a mature woman and the owner of the shop and she tried to force a teenage boy to have sex with her, would she be able to do it as eas ily as the man in the scenario? Why yes/no?

Sexuality Discussion Card No. 1

Amina is 32 years old. She is married and has three children, a 12-year old boy and two girls, one aged 10 and the other six. Amina is married to a man who owns a small shop in a large city and they live at the back of the shop. Recently, Amina's husband hired a new shop assistant, a young 17 years old girl named Precious. Amina is very busy with the children, the shop, and the household chores, and feels very tired most of the time. Even before her husband hired Precious, Amina was under a lot of pressure to have sex more frequently with her husband and to try to have another boy. Amina likes her husband and enjoys sex with him, but she is also would like to say no to hi m when she feels too tired. Besides, she does not want to have another child at this point in her life. However, Amina has become more and more worried that her husband may take Precious as a second wife if she does not comply with his wishes.

Discuss and write your analyses in the spaces provided under each question:

- What social norms about how men and women are expected to feel about and express their sexuality are contributing to create this situation for Amina?

- What problems is Amina facing to negotiate their sexual lives in ways that are fair and satisfactorily for both of them? What social norms about how men and women can feel and express their sexuality are taking power away from Amina to have her needs and wishes met?

- If Amina was the husband, would she face the same problems to negotiate these issues? What social norms about how men and women can feel and express their sexuality give more power to men than women, and how?

Gender Discussion Card No. 2

Sam is 31 years old. He is married and has thr ee children, a 12-year old boy and two girls, one aged 10 and the other six. Sam owns a small shop in a large city and he lives at the back of the shop with his family. Recently, he hired a new shop assistant, a young 17 years old girl named Precious, who sleeps in the shop. He is happy in his marriage, but he really wants to have another boy. He is been putting pressure on Amina, his wife, for some time about this issue. Sam grew up in a large family and he was told since he was child that men must have mo re than one son to show that they are real men and also to keep their wives under control. He learnt from his father that women must obey their men in all matters, especially around decisions that concern managing the family. Sam is getting tired of talkin g with his wife about having another boy, and now that Precious around he is considering having a child with her.

Discuss and write your analyses in the spaces provided under each question:

- What social norms about being a man and a woman are enabling Sam t o use power in the way he does in this situation?

- What possible consequences can his wife and Precious face because of the social norms that allow Sam to use his power as a man in this situation the way he does?

- What social norms about being a woman and a teenage girl are taking power away from Sam's wife and Precious to deal with potential negative consequences that this situation can create for them?

Sexuality Discussion Card No. 2

Segun is 12 years old. He has two younger sisters aged 10 and six. He lives with his sisters, his father and his mother at the back of the shop that his father owns in the city. Just like his friends, Segun is becoming more and more interested in girls. His father has been telling him that one day he will have to marry and have children and that it's more important to have sons than daughters. Most of his friends believe that boys need to have more sex than girls, even if most of these boys do not know a lot about sex. Recently, Segun's father hired a new shop assistant, Pr ecious, who is 17 years old, and Segun is aware that his father finds Precious very attractive. He can see that his father is also talking in a low voice to Precious and trying to touch her, and that his father is very insistent with Precious. Segun is tal king about it with his friends, who tell him that this is normal behaviour for men while girls are expected to worry about possible consequences.

Discuss and write your analyses in the spaces provided under each question:

- What is Segun learning about how men and women are expected to express and use their sexuality?

- What is Segun learning about the power that social norms and roles about sexuality give to men and women, and how men and women can use power in relationships?

- What can be the possible impac t of the sexual norms and roles that Segun is learning on how he will develop and manage his sexual relationships in future?

Participant's Handouts

Session 6A: Handout 1, Activity 1 – Gender and Sexuality

Gender:

- Is not about biological differences between "male" and "female".
- It is the widely shared social and cultural expectations and norms ("rules") that in a society define or influence opportunities for men and women, what choices they can make and how acceptable such choices are, what roles they can play and how acceptable such roles are (e.g. in the family.)
- Therefore how a society constructs gender will affect the power and the ability people may have in making decisions and choices about their lives.

Sexuality:

- Is more than biological sex and sexual intercourse.
- It is a central aspect of being human and is experienced and expressed in thoughts, fantasies, desires, feelings, behaviours, practices, roles, and relationships.
- Like gender, sexuality is the result of a personal and social process of development. This process includes how a person internalizes attitudes/beliefs/values concerning how men and women are expected to express and use their sexuality, what sexual roles they are expected to play, how acceptable these sexual roles are , and what power and ability women and men have or are expected to have in sexual matters.
- Therefore sexuality is influenced by many social factors, including gender norms.

- Both gender and sexuality are socially constructed. They are the products of social processes about what people are expected to be like in order to fit in with dominant norms (or "rules') about "being a man" and "being a woman", and managing their choices accordingly.
- These social norms and expectations about being a man or a woman define the power –or lack of it– that people are supposed to have in personal and social interactions, including their sexual relationships.
- Therefore *power* is a very important issue that connects gender and sexuality.
- However, these social and cultural expectations about being a man or a woman change over time as societies continue to evolve and transform attitudes/beliefs/values about these issues. For example, there is now international consensus that many of these social and cultural expectations create and maintain inequities in health and greatly contribute to problems such as maternal mortality.

SESSION 6B: Why Addressing Power and Agency in Relationships in Order to Improve Access to and Quality of Client-Centred FP/MNCH Integrated Services?

Objectives

By the end of the session, the participants will be able to:

- Identify how gender and sexuality inter-connect.
- Explain the different types of power in relationships and how they affect agency for voluntary and informed decisions and choices in FP/MNCH.
- Explain why addressing gender, sexuality, power and agency is important to increase access to and quality of FP/MNCH services, including client-centred FP/MNCH integrated counselling.

Total Session Time

110 minutes (one hour and 50 minutes)

Materials

- Flipcharts, markers, tape
- Flipchart "Session objectives"
- Gender and Sexuality cards, Activity 1, step 1.2
- Two sets of Gender/Sexuality signs, Activity 1, step 1.2
- LCD projector if available/necessary

Facilitator's Resources

- Activity 1: Gender and Sexuality Cards
- Activity 2: The Story of Rashida and Malik

Handouts

- Handout 1 – Agency and Power in Intimate Relationships
- Handout 2 – Power in Intimate Relationships, Including Sexual Relationships

Advanced Preparation

Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)

Introduce and review the session objectives (show them on flipchart or slide). In this session we expand our reflections to identify how gender and sexuality are inter-connected, how they impact power and agency to make voluntary informed decisions and choices, the implications for client-centred FP/MNCH integrated counselling, and why it is necessary to address gender and sexuality issues from an equity and rights perspective to achieve broader structural goals for social and economic development, such as the Millennium Development Goals.

Activity 1: Gender and Sexuality. How do they interconnect? (45 minutes)

Note for Facilitators

This activity reinforces and expands the analysis of how gender and sexuality are interconnected, and how power is a key factor in their interconnection. This analysis began in the previous session though the activity with the gender and sexuality discussion cards. If facilitators feel that the participants do not need further help to understand how gender and sexuality interconnect, they can skip this activity and start the session with Activity 2 below.

1.1 Link this session to the previous one by brainstorming with the participants.

- Why is power a key factor in connecting gender and sexuality?

Record the responses on flipchart and explain that you will not discuss the results now, but the brainstorm list will be revisited at the end of the next exercise.

1.2 The next exercise will explore in more detail the inter-relations between gender and sexuality to highlight how they interconnect. Instructions:

- Participants will split in two teams.
- Facilitator will have prepared and posted on the wall two sets of Gender and Sexuality signs. Ensure some space between each Gender and Sexuality set, as well as between the two sets of signs, like this:

Gender	Sexuality		Gender	Sexuality

- Each team will gather under its set of "gender" and "sexuality" signs (If possible, place all the signs on the same wall, and make sure there is enough space between the groups to play the game without being too crowded).
- Each team receives two sets of cards; gender cards and sexuality cards (Please refer to the **Facilitator's Resources** section).
- The purpose of the game is to post the cards under the relevant sign. If the groups feel that a card does not fit either in Gender or Sexuality, they can post it to the side. If they feel that it is relevant to both gender and sexuality, they will post it in the space between the two signs.

Stress that the game should be conducted rapidly and completed in maximum 10 minutes.

1.3 Facilitate a discussion. Explain that due to time constraints each team may not be able to discuss the placement of all their cards. Help the teams to reflect by asking the following questions:

- What card/s were more difficult or more controversial to place under the signs, and why?
- Which cards clearly addressed strictly biological issues and therefore could not fit under the signs?
- What was the main reason for deciding that the issue on a card was more relevant to gender or to sexuality?
- *For cards placed to the side, discuss:* Why do you think that these cards are not relevant to either Gender or Sexuality?
- *For cards placed in between the two signs, discuss:* Why do you think that these cards are relevant to both Gender and Sexuality?

1.4 Now bring back the brainstorm conducted in 1.1 above and discuss again:

- Why is power a key factor in connecting gender and sexuality?
- What else would you add to this list after your analyses through the card activity?

Please note: *The two questions above in 1.4 constitute the most important part of the discussion. The note below provides ways to draw connections between gender and sexuality. Facilitators are encouraged to focus on the cards that groups have more doubts about or had more difficulty understanding any relation to gender or sexuality.*

Note for Facilitators

A key aim of this exercise is to help participants reflect on the power imbalances that some gender norms create between people just because they are men or women. In order to do this, you may want to focus on a few selected cards to expand the discussion. For example, facilitators may select a card like *"men are expected to make most decisions in relationships,"* and ask questions such as:

- How does a gender norm like this reinforce ideas about what men and women should be like, e.g. "act like man" or "act like a woman"?
- How does a social norm like this influence how men and women perceive their roles in relationships, including marriage? How might these perceptions affect their communication and negotiation?
- How might a social norm like this create different levels of power among men and women in relationships? How might such a power imbalance affect women and men in negotiation HTSP or using a FP method?

In order to continue to draw connections between gender and sexuality, the facilitator can pick one of the sexuality cards, for example *"pursuing a satisfying, safe, and pleasurable sexual life"* and connect it to gender issues by asking questions such as:

- How can this issue be affected by social norms about gender such as "men are expected to make most decisions in relationships"? How can men and women be affected by this gender norm in their efforts to achieve a satisfying, safe, and pleasurable sexual life?
- What social norms about "being a woman" may deny women the possibility of achieving a satisfying, safe, and pleasurable sexual life?"
- How might women be judged if they want to pursue a satisfying, safe, and pleasurable sexual life? For example, what gender norms about "being a woman" might discourage or prevent women from asking their husbands to use condoms in order to feel safer? And what gender norms about "being a man" may make it difficult for men to support the aspiration of their wives for HTSP or FP?
- What gender norms may create barriers for young unmarried women and men in their efforts to achieve a satisfying, safe, and pleasurable sexual life? How might such gender norms undermine achieving a satisfying, safe, and pleasurable sexual life for unmarried young women and men?

Please note: Some cards may be perceived as overlapping gender and sexuality, for example "forced marriage" or "consensual marriage". **In fact, ideally this will happen because in real life most of the issues written on the cards have to do with both gender and sexuality.**

1.5 Close the activity by explaining that in the next exercise participants will use what they have learned in this discussion to expand their reflections on the importance of addressing gender and sexuality to enhance quality in service provision, and especially in client-centred FP/MNCH integrated counselling.

Activity 2: Agency and Power in Intimate Relationships in Connection to Gender and Sexuality and Relevance to FP Client-Centred Counselling (60 minutes)

2.1 Create a link with the previous activity by reminding the group of how the previous exercise highlighted the issue of power as a key "connector" of gender and sexuality. The following exercise will explore the different types of power that people may experience in intimate relationships, including sexual relationships, and how these types of power can affect **the ability** of people to access FP/MNCH services as well the quality of such services, including counselling.

2.2 Distribute Handout 1, explain and discuss it.

2.3 After clarifying any questions from participants, ask them -without disclosing any personal information about themselves or clients- to discuss in pairs for 5 minutes:

- What type/s of power do most clients appear to experience in their relationships?
- What gender and sexual norms may determine the types of power that their clients appear to experience?

Please note: provide one or two examples if participants have difficulty starting their discussion, e.g. power to make decisions, or power to negotiate.

2.4 Process responses from pairs. Distribute Handout 2 and discuss it in light of the participants' responses to the two questions in 2.3 above.

Note: Make sure that you will have used no more than 20-25 minutes up to now.

2.4 Explain that in order to explore the connections of gender, sexuality, and agency and power to access to and quality of FP/MNCH services – including counselling – we are now going to use a methodology called mobile story telling. Instructions:

- The participants stand in a circle around the facilitator. The facilitator will tell a story concerning FP/ HTSP. They have to identify with Rashida, the main character in the story, i.e. they really have to put themselves in Rashida's shoes.
- The centre of the circle where the facilitator stands represents accessing quality FP/MNCH services, including FP/MNCH client-centred counselling.
- The story will be told in segments and the facilitator will stop after each segment. If the participants feel that the segment being told contains any issues relating to gender/sexuality/power in relationships that are hindering or undermining Rashida's or Malik's agency to access FP/MNCH services or the quality of such services, they will not move. If they feel that in the segment there are issues that support or facilitate access to and use of FP/MNCH services, they will take one step forward toward the centre of the circle. Each participant makes his/her decisions without consulting with others.

- After reading each segment, the facilitator should enable rapid reflections by using the questions provided in the note for facilitators below. If participants cannot make these analyses, facilitators can use the commentary provided after each segment of the story.
- By the end of the story, the exercise will show how close or far away people are from the centre of the circle and there will be a discussion on the main issues affecting access to and quality of FP/MNCH and especially FP/MNCH client-centred counselling.

Note for Facilitators

It is important to help the participants highlight the interconnections of gender and sexual norms, how they affect individuals and families in their agency and power to access and use FP/MNCH services as well as the quality of the services. After reading each segment of the story, use some of these questions:

- What types of power are being undermined in Rashida?
- What gender and sexual norms are creating such power imbalances?
- What are the repercussions for Rashida's agency to access and utilize FP/MNCH services?
- What could FP/MNCH services do to support Rashida and Malik? How could client-centred integrated counselling help Rashida? And how could counselling help Malik to share responsibility without disempowering Rashida?

Use the commentary provided after each segment of the story only if participants cannot analyse the story through the questions above.

2.5 Ensure that you reserve a few minutes before the evaluation of the session to discuss:

- How do the issues we explored in this exercise affect achieving MDG 3, 4, 5, and 6?
- And how do these issues affect achieving MDG 7?

2.6 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Facilitator's Resources

Activity 1: Gender and Sexuality Cards

Please note: It is not necessary to use all the cards. Usually, 6-8 gender cards and 6-8 sexuality cards per team are sufficient. Facilitators are encouraged to use their judgment.

Sample Gender Cards: Facilitators are encouraged to adapt these cards or develop their own in order to better reflect issues relevant to their audiences:

- Often, men are expected to make all the decisions in relationships
- Often, women are expected to be subservient to men
- Often, young men are expected to take risks in their lives and demonstrate that they are "real men"
- Often, men are expected to be dominant in relationships
- Often, women are expected to obey men
- Often, women are not supposed to challenge men, especially in the family
- Often, it is more acceptable for men than for women to be sexually active before marriage
- Often, it is more acceptable for men than women to know a lot about sex
- Often, men are not expected to take as much care of children as women
- Often, women who want to have an equal say in their relationships are judged as "difficult"
- Often, girls are still expected to marry young and have children
- Often, unmarried young women who are sexually active are judged harsher than unmarried young men who have sex before marriage
- Often, women and men who have extra-marital sexual affairs are not judged in the same way. For women, the judgment is harsher.
- Often, older men who have sexual relations with younger women are not judged as harshly as older women who have sex with younger men
- Often, men are expected to be the bread winners in their families
- Often, men and women are not expected to talk openly about sex and sexuality, even in marriage
- Often, young unmarried people are not expected to have access to information about sex and sexuality before marriage, including FP/ HTSP
- Often, women fear of being rejected if they are childless
- Often, both men and women feel pressure to fit in with norms about "being a man" or being a woman". **The following additional cards address biological differences between male and female. Some of these cards should be included in the set for each team to highlight the difference between gender and biological sex. (Participants should place these cards on the side)**
- Men have testicles, women don't
- Women can menstruate, men can't
- Men can't breastfeed babies, women can
- Women can get pregnant, men can't
- Both men and women can have orgasms
- Women have fallopian tubes, men don't
- Men have penises, women have vaginas

Sample Sexuality Cards: Facilitators are encouraged to adapt these cards or develop their own in order to better reflect issues relevant to their audiences.

- Pursuing a satisfying, safe, and pleasurable sexual life
- Freedom (or lack of) from coercion in sexual relationships
- Having the right to choose one's own sexual partner
- Sexual desire
- Sexual pleasure
- Consensual marriage
- Forced marriage
- Having the right to decide when to have sex, with whom, and under which circumstances
- Knowing how to protect oneself from unplanned pregnancies
- Having the right to say no to sex, even in marriage
- Freedom from discrimination because a person is heterosexual, homosexual, or bisexual
- Freedom from sexual exploitation
- Trust
- Self-esteem
- Respect
- Self-confidence
- Self-perceptions of risk for unplanned pregnancies and/or STI and HIV
- Internalized stigma, e.g. about being HIV positive
- Love and understanding
- Fear of violence in relationships
- Knowing how to manage one's own sexuality safely if living with HIV
- Peer pressure to have sex early
- Using sexuality for survival purposes

Facilitator's Resources

Activity 2: The Story of Rashida and Malik

Please note: the commentary after each segment presents suggested points that facilitator can use in the discussion after each segment is read out and participants decide whether to take a step forward or not. It is not meant to be read out to the participants. It is provided to help facilitators formulate answers to questions that participants may have, especially when different disagree on whether they should take a step forward or not.

Rashida and Maliki live in Ilorin. They have been married for 6 years and have 4 children. Rashida was 18 years old when she got married and Malik was 20. Neither of them knew very much about FP/ HTSP, and in fact they didn't know very much about sex and sexuality either. **[Stop. Participants should not move because of the gender and sexuality norms that have prevented R and M from accessing information about sex, sexuality, reproduction and FP/ HTSP. These gender and sexual norms have prevented them from developing power within, power to and power with around those issues.]**

Malik was sexually more experienced than Rashida, but still he really didn't understand what contraception was and he thought that it wasn't his business anyway. In his mind, Rashida would have to deal with it if necessary. **[Stop. Participants should not move because gender and sexuality norms clearly create a power imbalance between M and R, as M is already sexually more experienced than R. At the same time, gender and sexual norms create a belief in M that as a man he doesn't have to share responsibility for contraception and this in some ways is dis-empowering him as human being, while at the same time it increases the power imbalances between him and R because not only does R have to carry the burden, but this has been decided for her before she can even have a say in the matter.]**

Malik also thought that FP/ HTSP wasn't a big deal anyway because they were going to have children as soon as possible and if they were going to have several it was better to have them while they were young, and certainly before they hit their 30's. **[Stop. Nobody should move because once again gender and sexual norms are creating beliefs and attitudes that dis-empower both M and R to make informed choices while continuing to create a power imbalance between M and R as R is faced with more and more decisions already made by others.]**

Rashida knew that she was expected to have children, though she wasn't really sure how many she might want. She and Malik had talked a little about marriage and children before getting married, and she knew that he wanted at least two boys. Rashida's mother had used FP, but this was an issue that mother and daughter had never discussed. So Rashida didn't have any awareness of FP/ HTSP. **[Stop. Participants should not move because there is a web of gender and sexual norms that are affecting R's agency and power in many ways. Mostly, her agency to make informed voluntary decisions is continually being undermined.]**

Rashida got pregnant about two months after she got married. The child was a boy, and everybody was very happy. However, Rashida got pregnant again about 4 months after the birth of her first child. Malik felt that this was perfectly fine. After all, something

similar was happening to many people all around them. **[Stop. Participants should not move. R's agency and power is continually undermined. She has no power to speak of. Gender and sexual norms are also affecting M's ability to support R because these norms make him feel that what's happening is just what should be happening. The gender and sexual norms are preventing him from even considering the impact on R's health and wellbeing and the potential impact on the family as a whole.]**

The second pregnancy was more difficult for Rashida. She was feeling tired all the time, like she had never experienced the first time. She had to take care of her young family, and Malik didn't really seem to understand what she was going through. He accompanied Rashida to the Ante Natal Care clinic a couple of times, but the providers didn't engage him to help him understand what he could do to help Rashida have a safe pregnancy and delivery. **[Stop. Once again a web of gender and sexual norms is not only undermining R's agency and power to take care of her health, but these norms have also affected the provider's attitudes so that the provider is not even considering talking to M to support R. Quality of counselling is undermined and R cannot make an informed choice.]**

Rashida had a miscarriage. It was a terrible experience for her. She got worried that she might not have more children, even though they told her that everything was fine with her. She knew that one child wasn't enough to prove that she was a good wife. Besides, many people still considered big families as a symbol of prestige, wealth, and success. She knew that this was important to Malik. Rashida didn't want to disappoint anybody. **[Stop. Participants should not move. Ask them to identify all the types of power that R does not have here and which gender and sexual norms create this situation, and how this situation is undermining her agency and ultimately her health.]**

Rashida increasingly felt the pressure to have children, especially from Malik's family and particularly from Malik's mother. Malik too was worried that the miscarriage might be a sign of something wrong with Rashida's fertility. He took Rashida to a private health provider who confirmed that everything was fine with Rashida and she could continue to have children straight away. So Rashida got pregnant again. **[Stop. Participants should not move. Here it is important to highlight how gender and sexual norms prevent people to value women's health in itself. M is taking R to see a provider mostly because he is worried that she may not be able to have more children. Her health as a woman is mostly valued in terms of her ability to procreate. Obviously this is not because M is a bad man. It's because of the gender and sexual norms that influence his attitudes.]**

Rashida had a girl. After the delivery, Rashida really wanted a break before having another pregnancy. It was all too much for her. She realized that with two young children to look after and still recovering from her last delivery, she didn't have the physical and emotional strength to have more children for some time. But how was she going to discuss her intentions with Malik? She found the courage to discuss these issues with him and mentioned that she would like to see again the same health provider. Malik agreed to give her the money, but he would have to approve any decisions. Rashida went back to see the health provider and was advised on FP. **[Stop. Although finally R is able to use some power to and power with, clearly her power with and agency continue to be undermined because ultimately the gender and**

sexual norms dictate that M must make all the final decisions even if it is her health that is at stake.]

Meanwhile, Malik was also thinking about what to do. He had heard so many bad things about women using contraception that he was not sure if it was a good idea to let Rashida do it. Some of Malik's friends had told him that they did not allow their wives to use contraception because a woman freed from the fear of getting pregnant might be tempted to be unfaithful. They were telling him that husbands should make decisions about these issues, not wives. **[Stop. Participants should not move due to web of gender and sexual norms that are misdirecting M to assess the situation and his actions.]**

Rashida really didn't know what to do. She told Malik about the advice she had received from the health provider, but she could sense that Malik was unhappy about it. Rashida became increasingly worried that Malik might bring in a second wife if she started using contraception, and so over the next two years they had two more children. Rashida has seen a FP provider at the hospital where she delivered her last son, and she was advised to use an IUD. The provider also talked to Malik and explained the importance of the method for Rashida's health and for the family. However, Malik had concerns about how this method might affect their sexual life, but he was too embarrassed to ask questions. **[Stop. Although finally R access some services, her agency and power to make voluntary and informed decisions and choices continues to be undermined in many different ways.]**

Participant's Handouts

Session 6B: Handout 1, Activity 2 – Agency and Power in Intimate Relationships

Individual Agency *means having an understanding of what affects our ability to take action for the issues in our own lives and using that understanding to do something useful about those issues.*

Example: John wants to quit drinking alcohol because he knows that it is damaging is health, but he is facing peer pressure as all his friends drink, and this makes it hard for him to carry out his intention to quit. In order to be able to take the action to stop drinking, probably first John would need to ***understand*** how peer pressure undermines his ***ability*** to enact his decision. Or he may be well aware of the effect of peer pressure, but may lack self-esteem to deal with the social and cultural consequences of quitting e.g. a fear to lose friends or to be seen as different or strange. These social and cultural factors are undermining his ability to **take action** despite is knowledge on the risks of drinking.

Agency therefore is:

- ***having knowledge about the issue we face*** *(e.g. the health risks of drinking)*
- ***understanding how other factors can affect our ability to use our knowledge to take action*** *(e.g. peer pressure, social expectations that men will drink socially)*
- ***being able to do something useful about the issues we face*** *(e.g. developing strategies to overcome peer pressure and quit drinking)*

Knowledge per se often is not enough to do something useful about the issues we face in life because social and cultural factors heavily influence our chances of fully using our knowledge to realize our intentions and aspirations.

Participant's Handouts

Session 6B: Handout 2, Activity 2 – Power in Intimate Relationships, Including Sexual Relationships

In order to develop individual agency, a person needs information, knowledge, and skills. However, in order to use her/his agency, a person also needs power to manage the factors in the social ecology that may undermine her/his agency.

Power in intimate relationships

1. Power *within*, derived from a sense of self-worth and understanding of one's preferences and values, which enable a person to realize well-being and health.
2. Power *to* influence, consent, and/or decline.
3. Power *with* others to negotiate and decide.
4. Power *over* others to manipulate, control, or harm other people.

Power within: We have this type of power when we are confident, self-assured, and feel that we have worth as human beings regardless of our biological sex, gender, or any other aspect of who we are. Power within is fundamental for developing and using agency and making and carrying out one's own voluntary decisions.
Power to: We have this type of power when we can talk openly and without fear about the issues that really concerns us, when we feel that we can communicate our point of view or our needs without fear of being judged or oppressed. This type of power is very important to build openness and trust in relationships, and to feel valued and equal.
Power with: We have this type of power when we can negotiate with others without fear of being rejected, mistreated or abused. This type of power is obviously essential for our agency to negotiate with others.
Power over: This type of power is used to impose or force ideas, values, and choices on others. In order to use this power, a person would have to deny all the other three types of power to someone else and undermine the agency of the other person.

These types of power are obviously part of a whole. The first three types of power intersect and support each other. However it is not just about having them. It is also about being aware of how they are used. For example, sometimes people confuse *power over* with *power within*, but there is a very clear difference between the two: Power within is never used to crash someone else's agency. Those who really use power within are open and able to allow others to also use their power within, power to, and power with.

SESSION 7: Why Addressing Equity and Sexual and Reproductive Health Rights in Client-Centred FP/MNCH Integrated Service Provision?

Objectives

By the end of the session, the participants will be able to:

- Explain what health equity is.
- Explain what sexual and reproductive health rights are.
- Explain why addressing equity and rights is important in FP/MNCH service provision, and especially in FP client-centred counselling.

Total Session Time

105 minutes (one hour and 45 minutes)

Materials

- Flipcharts, markers, tape
- Flipchart "Session objectives"
- BARRIERS TO ACCESS and UNDERMINE QUALITY signs, Activity 1
- LCD projector if available/necessary

Handouts

- Handout 1 – Millennium Development Goals
- Handout 2 – Commonly Held Expectations about "Being a Man" or "Being a Woman" (Gender and Sexual Norms and Roles)
- Handout 3 – Health and Gender Inequities and Equities
- Handout 4 – Sexual Rights as Defined by WHO
- Handout 5 – Dimensions of Sexuality
- Handout 6 – Dimensions of Sexuality and Relations to Health Equity

Advanced Preparation

Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)

Introduce and review the session objectives (show them on flipchart or slide). In this session we aim to further expand our understanding of the importance of addressing gender and sexuality in health service provision in order to achieve good health outcomes. However this requires addressing gender and sexuality from a health equity and rights perspective. In this way, FP/MNCH services can really contribute to reduce or eliminate the social, cultural and economic root causes of health problems and play a very important role in the broader social and economic development of countries, such as the Millennium Development Goals.

Activity 1: Gender and Sexuality: A Matter of Power (45 minutes)

1.1 There is recognition at international level that provision of quality FP/MNCH services greatly contributes to social and economic development of countries. In recent years studies have shown that investing in quality FP/MNCH services is very important to achieve the Millennium Development Goals.

Ask the participants if they are familiar with the MDG. Ask if they can summarize them briefly. Distribute Handout 1 and review it quickly.

Stress that the current policy framework in Nigeria about FP/MNCH is also focused on achieving the MDG. Provision of quality FP/MNCH is particularly important to achieve goals 3, 4, 5, and 6. However, for FP/MNCH to play such an important strategic role two crucial issues must be addressed:

- Removing barriers to access
- Improving quality

1.2 Distribute Handout 2, which includes a list of gender and sexual norms and expectations about being a man and being a woman that may create barriers to access to and quality of FP/MNCH, including FP client-centred counselling. These are the same issues discussed in the Gender/Sexuality card activity in the previous session.

1.3 Divide the participants in pairs or small groups of three and distribute one or two blank A4 size paper sheets to each pair/group. Instructions:

- Some pairs will identify *which barriers to access* to FP/MNCH, including FP client-centred counselling, gender and sexual norms may create.
- The other pairs will identify *how gender and sexual norms may undermine quality of FP/MNCH*, including FP client-centred counselling.
- Pairs will have max 10 minutes to complete their discussion. The task is not to address one by one all the issues listed on Handout 2, but to take a holistic view of how those issues as a whole may create barriers and affect quality. Therefore pairs will develop a few answers that they consider really important and that capture the big picture.
- At the end of the allocated time, the pairs will post their papers under the corresponding sings on the wall, namely BARRIERS TO ACCESS and UNDERMINE QUALITY, which the facilitator will have posted side by side with some space in between:

BARRIERS TO ACCESS	UNDERMINE QUALITY

1.1 Ensure that the pairs complete their task within the allocated time. Once the papers are posted on the wall, allow a few minutes for the participants to read them. Facilitate a discussion:

- Which barriers contribute to one or more of the issues that undermine quality, and how?
- Which or the issues that undermine quality may also be a barrier or create barriers to access, and how?
- Which <u>unfair, unjust and avoidable differences</u> in the health and well-being of different groups of people can the issues in both categories create?

Note for Facilitators

The last question above is the most important to discuss. Possible answers may include:

- Higher level of poor health among poor people.
- Higher level of unsafe abortions among young unmarried people.
- Higher level of maternal mortality among young women.
- Higher level of STI and HIV among groups that are stigmatized and discriminated, e.g., men who have sex with men.
- Increasing level of STI and HIV among married people due to perceptions that marriage protects from these problems.

1.5 Explain that when we talk about unfair, unjust and avoidable differences in the health and well-being of different groups of people we are defining **health inequities**.

1.6 If you have enough participants, divide them in five pairs by using the number count 1 to 5. If not, divide them in as many pairs as the total number allows. Ask the pairs to organize their chairs in a semicircle around the BARRIERS TO ACCESS/UNDERMINE QUALITY wall. In the next activity they will continue to explore in more depth the inter-connections of health equity and inequity in relation to gender and sexuality social norms, and implications for access to and utilization of FP/MNCH services.

Activity 2: Equity and Rights as Tools for Removing Barriers to Access to FP/MNCH and Improving Quality of Services (55 minutes)

2.1 Once the pairs are seated in a semi-circle around the wall, distribute Handout 3 and review with the group. Acknowledge that the participants may be already familiar with some of the terms. Create a link with the previous activity by reminding the participants of the health inequities that they identified (use some of those example again). Discuss briefly:

- Which key similarities can you identify between all these definitions?

Note for Facilitators

Important issues to highlight

- Both health and gender inequity are created by social norms or social issues that are unfair, avoidable (i.e., preventable) and remediable (can be fixed). Therefore both types of inequities can be eliminated if political will and technical capacity exist.
- In many cases, the issues that create health and gender inequity are the same, as the participants highlighted in Activity 1.
- Therefore, if we aim to ensure that FP/MNCH services really contribute to achieve MDG 3, 4, 5, 6, and 7 service providers have a very important role in addressing gender inequity, i.e., in addressing any type of barriers to services and quality of services that are created by unfair and unjust gender and sexual norms, especially those that create stigma and discrimination or undermine power and agency for voluntary and informed decision making.

2.2 Fortunately, there are tools to help eliminate inequities. Some of the most important tools that we have are the Sexual and Reproductive Health Rights (SRHR). Distribute Handout 4 and review it with the group.

2.3 In order to understand the importance of SRHR as tools to address inequities, we need first to understand more about sexuality. Distribute Handout 5 and explain:

- Sexuality is complex, and the way we address it in service delivery has a major impact on how clients can develop their agency and power for health seeking behaviours, including voluntary and informed decisions and choices.
- Sexuality has a few key dimensions:
  - Sensuality has to do with how we get pleasure from our body. Therefore it has to do with touching, stimulating the body sexually – which includes also fantasies and thoughts.
  - Intimacy has to do with emotions and feelings, e.g. feeling respected as a human being.
  - Sexual orientation and gender identity are not the same things although they are parts of the same dimension. *Sexual orientation* is about who we are sexually attracted to (opposite sex, same sex, both sexes). There are many

misconceptions about these issues, for example that same sex sexual behaviour does not exist in the animal world. In fact, there are more than 500 scientific studies showing that it exists, for example among the African lion, the African elephant, and even among insects. *Gender identity* has to do with how a person deeply feels about being a man or a woman. For example, someone who was assigned a specific gender at birth, e.g. boy, may not feel like a boy when he grows up. We don't really know exactly what causes this, but it is not a disease and most of the problems that these people experience are in fact caused by the stigma and discrimination they face.

- SRHR – In addition to sexual and reproductive health, this dimension also includes sexual and reproductive rights. We just discussed them and we will use them in an exercise in a few minutes.
- Sexual practices: the handout provides a few examples.

2.4 Next, the participants will explore the role of sexual and reproductive rights in addressing inequities. Instructions:

- Each pair will discuss the case study and the questions at the bottom of Handout 5 (dimensions of sexuality).
- Pairs have 10 minutes to discuss the questions included in the case study.
- Pairs do not have to prepare a formal presentation. They will share the main points from their discussion.

2.5 Ensure that the pairs complete the task within the allocated time. When you start the discussion explain that due to time constraints you will ask each pair to present only on one question. As each pair presents, ask the others to contribute different issues and insights.

2.6 Finally, distribute Handout 6 and discuss it:

Note for Facilitators

Key message to conclude:

- If we do not address gender and sexuality in FP/MNCH service provision, and especially in FP/MNCH client-centred counselling, it will be very difficult to help address the social inequities that unfair gender and sexual norms create.
- If we do not address social inequities, like stigma and discrimination or lack or denial of voluntary and informed decision making and choices, some groups of people will continue to be especially vulnerable to health inequities, e.g. persisting high maternal mortality rates among women of reproductive age because their agency and power to choose and implement health seeking behaviours will be undermined.

2.7 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Participant's Handouts

Session 7: Handout 1, Activity 1 – Millennium Development Goals

Millennium Development

1. End Poverty and Hunger
2. Achieve Universal Primary Education
3. Promote Gender Equality and Empower Women
4. Reduce Child Mortality
5. Improve Maternal Health
6. Combat HIV/AIDS, Malaria, and other diseases
7. Ensure Environmental Sustainability
8. Develop a Global Partnership for Development

In 2000, members of the United Nations pledged their commitment to the Millennium Declaration. The declaration, adopted by more than 190 nations, calls for achieving the Millennium Development Goals (MDGs)—a set of eight vital, time-bound goals, ranging from reducing poverty by half to improving maternal health. The goals are delineated as 21 targets with 60 measureable indicators. With a target year of 2015, the MDGs are an important framework for monitoring countries' progress, ensuring accountability, and advocating for stepping up efforts to meet the health and development needs of the world's poorest populations.

Many married women report having mistimed or unintended pregnancies or a desire to space or limit future pregnancies, but are not using modern contraceptive methods. Satisfying existing unmet FP need would help families achieve their desired family size, reduce total fertility, and, ultimately, slow population growth. In fact, to accelerate progress in achieving the MDGs, a new target was added under the maternal health goal (MDG 5) in 2007. The new target, 5b, calls for providing universal access to reproductive health services and includes the contraceptive prevalence rate and unmet need for FP as key indicators for meeting this target.
Source: USAID | HEALTH POLICY INITIATIVE, Task Order 1, 2009: Family Planning and the MDGs: Saving Lives, Saving Resources

Participant's Handouts

Session 7: Handout 2, Activity 1 – Commonly Held Expectations about "Being a Man" or "Being a Woman" (Gender and Sexual Norms and Roles)

- Men are expected to make all the decisions in relationships
- Women are expected to be subservient to men
- Young men are expected to take risks in their lives and demonstrate that they are "real men"
- Men are expected to be dominant in relationships
- Women are expected to obey men
- Women are not supposed to challenge men, especially in the family
- It is more acceptable for men than for women to be sexually active before marriage
- It is more acceptable for men than women to know a lot about sex
- Men are not expected to take as much care of children as women
- Women who want to have an equal say in their relationships are judged as "difficult"
- Girls are still expected to marry young and have children
- Unmarried young women who are sexually active are judged harsher than unmarried young men who have sex before marriage
- Women and men who have extra-marital sexual affairs are not judged in the same way. For women, the judgment is harsher.
- Older men who have sexual relations with younger women are not judged as harshly as older women who have sex with younger men
- Men are expected to be the bread winners in their families
- Men and women are not expected to talk openly about sex and sexuality, even in marriage
- Young unmarried people are not expected to have access to information about sex and sexuality before marriage, including FP/ HTSP
- Women fear of being rejected if they are childless
- Both men and women feel pressure to fit in with norms about "being a man" or being a woman"
- All men and women should be heterosexual (attracted to the opposite sex)
- Women should not be concerned with sexual pleasure
- Women's sexuality is about having children
- Men have more sexual desires than women

Participant's Handouts

Session 7: Handout 3, Activity 2 – Health and Gender Inequities and Equities

Health Inequities

Health inequities are health differences which are: socially produced, systematic in their distribution across a population group, unfair, and avoidable or remediable.

Health Equity

It means the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically.

Gender Equality

All women and men equally enjoy socially valued goods and resources (e.g., education, health, decision-making, employment, income, time, and information).

Gender Equity

Eliminating unfair, unjust, and remediable social disparities between men and women that prevent equal opportunities to access and enjoy socially valued goods resources.

Participant's Handouts

Session 7: Handout 4, Activity 2 – Sexual Rights as Defined by WHO

Sexual Rights as Defined by WHO

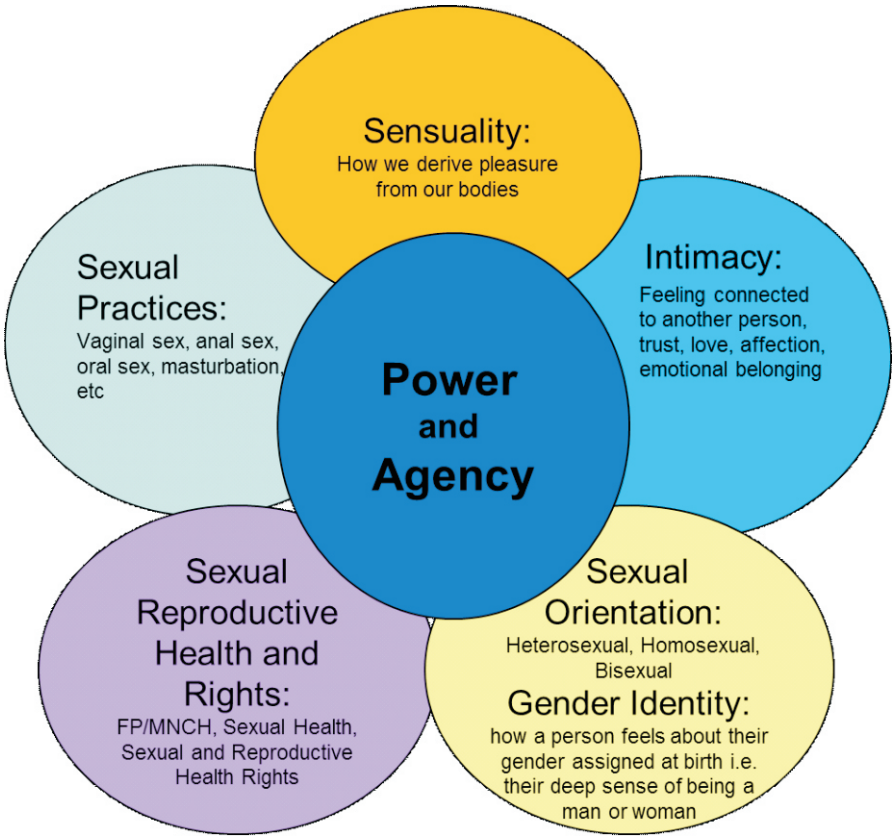
Include the right of all persons, free of coercion, discrimination, and violence, to:

- The highest attainable standard of sexual health, including access to sexual and reproductive health care services.
- Seek, receive and impart information related to sexuality.
- Sexuality education.
- Respect for bodily integrity.
- Choose their partner.
- Decide to be sexually active or not.
- Consensual sexual relations.
- Consensual marriage.
- Decide whether or not, and when, to have children.
- Pursue a satisfying, safe and pleasurable sexual life.

The responsible exercise of human rights requires that all persons respect the rights of others.

Participant's Handouts

Session 7: Handout 5, Activity 2 – Dimensions of Sexuality



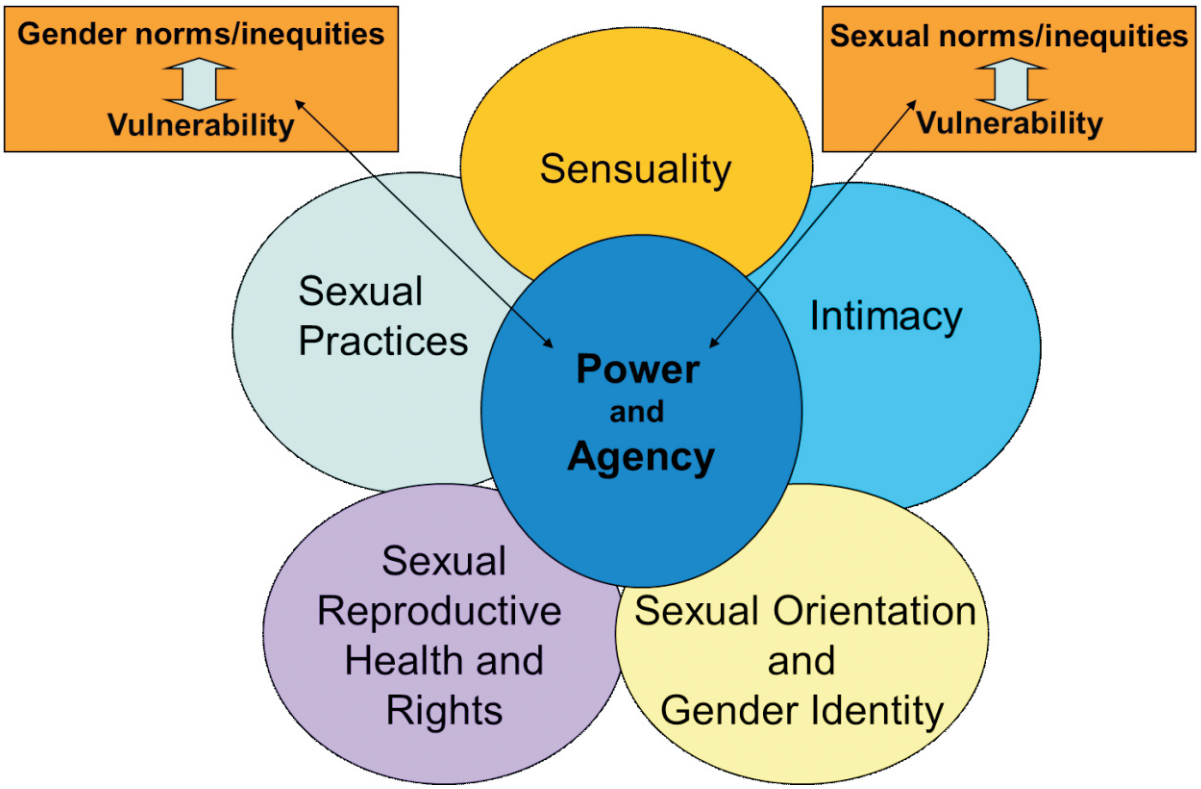
Case Study:

Your client is a married woman, 27 year old, has two children already. She has come to see you for a FP method, but you sense that there is something else that worries her. She seems quite upset and unhappy. Finally, she tells you that she has been unhappy in her marriage for a long time and she feels very guilty about it. Her husband is a good man and she respects him very much, but she doesn't love him. She was forced to marry him when she was very young, and she has never been sexually attracted to him. Now she is finding the sexual intimacy with him more and more difficult to face. She believes there is something terribly wrong with her and she doesn't know what to do.

- What are some of the gender and sexual norms and roles that may make this client feel so bad about her sexuality?
- How is her power and agency to make decision and choices being affected by how she is experiencing her sexuality?
- How could this situation affect her sexual and reproductive life?
- Which providers' attitudes are important in a situation like this to help the client cope, and why?
- Which sexual and reproductive rights could help this client if they were realized, and why?

Participant's Handouts

Session 7: Handout 6, Activity 2 – Dimensions of Sexuality and Relations to Health Equity



The previous case study highlights how these dimensions of sexuality in their interconnections with gender issues may affect a person's reproductive health, including her/his agency and power to access and use effectively FP/MNCH services:

- The client seems to have internalized gender and sexual norms about being a woman that make her believe that she should not question how she feels sexually about her husband. In turn, the feeling that she is not complying with these gender and sexual norms is creating guilt and conflicting emotions. She feels that she has no power within, power to, and power with, and her ability to think through her situation and do something useful about it is greatly undermined.
- Although she does not want to have sexual intimacy with her husband, she feels that as a woman she is wrong in feeling that way. The gender norms about being a woman make her feel that she does not even have the right to feel the way she does.
- This situation may result in depression and other psychological problems for this client, which in turn may affect not only her reproductive health but her overall wellbeing. Also, these problems may further negatively affect her marriage and her contribution to her family, and to society at large.

SESSION 8: Interpersonal Communication Counselling Skills (IPCC) Part 1

Objectives

By the end of the session, the participants will be able to:

- Identify five fundamental areas of IPCC.
- Perform effective IPCC skills for counselling.

Total Session Time

75 minutes

Materials

- Flipcharts, markers, tape
- Flipchart "Session objectives"
- "Clients" paper strips for Activity 1 step 1.3
- Flipchart with the definitions of Praise and Encouragement, Activity 1 step 1.4
- Flipchart "Three aspects of communication", Activity 1, step 1.6
- Flipchart "Close-ended and open-ended questions", Activity 1 step 1.9
- Sufficient blank paper strips
- LCD projector if available/necessary

Facilitator's Resources

- Activity 1, Step 1.3

Handouts

- Handout 1 – Interpersonal Communication Counselling Skills (IPCC)

Advanced Preparation

Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)

Introduce and review the session objectives (show them on flipchart or slide). IPCC skills are fundamental to provide quality FP/MNCH client-centred counselling. This session introduced essential IPCC and provides opportunities for the participants to improve their IPCC.

Activity 1: Five Fundamental Areas of IPCC (75 minutes)

1.1 Ask the participants to work in pairs for five minutes to brainstorm this question:

- If you were to identify five fundamental IPCC areas of skill, what would they be?

Record participants' responses on a flipchart and disclose the five key IPCC areas:

- Respect for clients.
- Praise and encouragement.
- Nonverbal communication.
- Eliciting information (with a focus on open-ended questions).
- Listening and paraphrasing.

Compare with the brainstorm list and discuss how it relates to the five issues above.

1.2 Brainstorm with the participants:

- How can providers show respect to clients?

In the discussion, highlight the following points:

- Smiling.
- Standing up to greet the person.
- Saying "hello" and/or "welcome" or an appropriate greeting according to social and cultural customs.
- Shaking hands.
- Inviting the person to sit down.
- Introducing oneself.
- Addressing the person by his or her name and title if appropriate (e.g., Mrs/Mr.).
- Maintaining eye contact.

1.3 Arrange the chairs in the room to make two concentric circles:

- "Providers" sit in the inner circle and "clients" in the outer circle.
- Each "client" will have a strip of paper describing a key characteristic that he/she has to demonstrate in the interaction (e.g., shy). The "providers" will have to practice how to demonstrate respect.
- At the facilitator's signal, only the "clients" shift seat so that the "providers" get a new client.
- After a few minutes ask the participants to swap roles and those who played "clients" will hand over their paper strips as well.
- Continue the exercise for a few more minutes.

Discuss with the group:

- What made the provider-client interactions effective? What could be improved, and how?

1.4 Participants work in pairs:

- Half of the pairs will discuss: What does praise mean to you?
- The other pairs will discuss: What does encouragement mean to you?

Invite a few of the pairs to share their responses. Show the flipcharts with the definitions of praise and encouragement:

Praise is the expression of recognition, approval, and admiration.

Encouragement is the provision of support, courage, confidence, and hope.

Explain that the purposes of praise and encouragement are to:

- Show that you are listening to the client and valuing what he or she says.
- Show your support.
- Motivate the client to continue the discussion (telling and asking).

1.5 Distribute blank strips of paper to each participant:

- Each participant writes a client statement, i.e. something that a client might say and that might be challenging to respond to with respect, praise, and encouragement.
- Each person pairs up with someone that they have not interacted closely in

the last few sessions and practice responding to each other's statements with respect, praise and encouragement.

After a few minutes stop the exercise and invite a few volunteers to demonstrate in front of the group. Discuss:

- What made the provider-client interactions effective? What could be improved, and how?

1.6 Explain that when we hear the word *communication*, we may think of words or of verbal communication. However research shoes that much of human communication is done without words. Show the flipchart:

THREE ASPECTS OF COMMUNICATION
Research shows how these three key components of communication impact on the person(s) with whom we interact:
Body Language 55%
Tone of Voice 38%
Actual Words 7%

1.7 Explain that nonverbal communication (e.g., how we move our body) can signal interest, attention, warmth, and understanding to clients. On a flipchart, write the word "positive" on the left side, and "negative" on the right side. Brainstorm with the participants examples of positive and negative **nonverbal communication**. Write each response in the appropriate column:

Positive	**Negative**

1.8 Explain that tone of voice is important for ensuring good interactions with clients because it can communicate different emotions and can also cause misunderstandings.

Write on a flipchart the following sentences:

- Please fill in this form (indifference).
- So, you are having an extramarital relationship (judgmental).
- The test shows that you have an STI (pitiful).

Ask volunteers to say the sentences with the tone of voice in brackets. Discuss:

- What effect could tone of voice in similar situations have on the counselling process?
- How could the client feel? What could the impact be on her/his feeling comfortable in the situation or feeling respected and treated with dignity?

Now ask the same volunteers to say those statements again with a tone of voice that would not compromise the interaction, and discuss with the group why.

1.9 Stress that one of the most important tools in counselling is the questions we ask and how we ask them. Brainstorm:

- What is the purpose of asking questions during counselling?

Emphasize the following points in discussing the purpose of questions:

- To establish a good relationship by showing concern and interest
- To determine what educational/language level will be most easily understood by the client
- To accurately assess needs any concerns of the client
- To elicit information about the client's circumstances (life and social) that may impact her/his ability to make voluntary decisions and carry them out
- To find out about the client's health status
- To prioritize key issues to target during the counselling session
- To learn what the client already knows and avoid repeating such information
- To identify areas of misinformation that need to be corrected

Ask:

➢ What are open-ended and close-ended questions?

Invite a few responses. Show on flipchart:

Close-ended questions usually can be answered "yes/no" or by one word or a number. Closed questions are useful for quickly getting basic information about the client's background, condition, and medical history.

Open-ended questions are useful for exploring the opinions and feelings of the client, and they usually call for longer responses. These questions are effective to find out what the client needs (in terms of information or concerns to be addressed) and what he or she already knows. Usually these questions start with "What", "How", "How come", "Why". However, "Why" questions can be replaced by questions such as "What are your reasons for . . .?", "What made you . . . ?", "Can you tell me your reasons for …?" in order to pre-empt any feeling of being judged.

1.10 Ask the participants to work in pairs. They have to first think of 3 close-ended questions and then change them into open-ended in no more than 5 minutes. Invite a few pairs to share, and discuss.

1.11 Stress that we have not covered all the five important areas of IPCC and we will continue this work in another session.

1.12 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

1.13 Close the session by distributing Handout 1.

Facilitator's Resources

Activity 1, Step 1.3

Print these strips in sufficient number to distribute to the participants playing the "provider" role:

You are a shy client

You are a client distracted by the room

You are an assertive client

You are a client dissatisfied with the FP method and complain a lot about it

You are an angry client because the receptionist was rude to you

Participant's Handout

Session 8: Handout 1, Activity 1 – Interpersonal Communication Counselling Skills (IPCC)

Adapted from: USAID | the ACQUIRE Project, 2008: Counselling for Effective Use of FP, Participant Handbook

Please note: Study this handout carefully in your own time. You will be expected to apply what you have learned in this session about the issues below during the counselling practice exercises in the following sessions.
IPCC Areas

Five Key IPCC Areas:

- Respect for clients.
- Praise and encouragement.
- Nonverbal communication.
- Eliciting information (with a focus on open-ended questions).
- Listening and paraphrasing.

Ways of Showing RESPECT to Clients:

- Smiling.
- Standing up to greet the person.
- Saying "hello" and/or "welcome" or an appropriate greeting according to social and cultural customs.
- Shaking hands.
- Inviting the person to sit down.
- Introducing oneself.
- Addressing the person by his or her name and title if appropriate (e.g. Mrs/Mr.).
- Maintaining eye contact.

PRAISE and ENCOURAGEMENT

Praise is the expression of recognition, approval, and admiration.

Encouragement is the provision of support, courage, confidence, and hope. The purposes of praise and encouragement are to:

- Show that you are listening to the client and valuing what he or she says.
- Show your support.
- Motivate the client to continue the discussion (telling and asking).

Non-Verbal Communication
U.S. research conducted in the 1970s showed that 55% of the impact of verbal communication was in one's body language, 38% was in one's tone of voice, and just 7% was in the actual words used. Nonverbal communication can signal interest, attention, warmth, and understanding to clients.

Non-Verbal Communication that Supports Interactions:

- Leaning towards the client.
- Smiling (in a way that is culturally appropriate); not showing tension.

- Avoiding nervous or inappropriate mannerisms.
- Presenting facial expressions that inspire trust.
- Maintaining eye contact with the client.
- Making encouraging gestures, such as nodding one's head.

Non-Verbal Communication that Hinders Interactions:

- Reading from a chart.
- Glancing at one's watch.
- Yawning or looking at papers or out of the window.
- Frowning.
- Fidgeting.
- Not maintaining eye contact.

Please note: Non-verbal communication (e.g., a smile) might have different meanings in different cultures and even within different population groups in the same culture. Use your experience and check your knowledge about nonverbal communication in the settings where you work.

Tone of Voice

It is important for ensuring good interactions with clients because it can communicate different emotions and can also cause misunderstandings.

Asking Questions During Counselling

The purpose of asking questions in counselling:

- To establish a good relationship by showing concern and interest.
- To determine what educational/language level will be most easily understood by the client.
- To accurately assess needs any concerns of the client.
- To elicit information about the client's circumstances (life and social) that may impact her/his ability to make voluntary decisions and carry them out.
- To find out about the client's health status.
- To prioritize key issues to target during the counselling session.
- To learn what the client already knows and avoid repeating such information.
- To identify areas of misinformation that need to be corrected.

Types of Questions:

- **Close-ended questions** usually can be answered "yes/no" or by one word or a number. Closed questions are useful for quickly getting basic information about the client's background, condition, and medical history. For example:
  - How old are you?
  - How many children do you have?
  - Do you have a method in mind?
  - Are you confident that you can remember to take a pill every day?
  - Is your house far from this clinic?
  - When was your last menstrual period?
  - Are you currently using an FP method?

- **Open-ended questions** are useful for exploring the opinions and feelings of the client, and they usually call for longer responses. These questions are effective

to find out what the client needs (in terms of information or concerns to be addressed) and what he or she already knows. Usually these questions start with "What", "How", "How come", "Why". "However, "Why" questions can be replaced by questions such as "What are your reasons for . . .?", "What made you . . . ?", "Can you tell me your reasons for …?" in order to pre-empt any feeling of being judged. For example:

- How can we help you today?
- What do you like about the method you want to use?
- What have you heard about the method?
- How would you feel if you experienced changes in your monthly bleeding?
- What do you think could have caused this problem?
- What did you do when you had this problem before?
- What have you heard about this FP method?
- What questions or concerns does your husband/partner have about using FP?
- What do you plan to do to protect yourself from getting a sexually transmitted infection again?
- What made you decide to use the same method as your sister?
- Why do you want to change methods? (Better: Can you tell me why you want to change methods?)
- Why did you stop using your last method? (Better: What made you stop using your last method?)
- How do you remember to take your pill every day?
- What do you do if you forget a pill? What if you forget to take more than one pill?

SESSION 9: Effective Client-Centred FP/MNCH Integrated Counselling Processes

Objectives

By the end of the session, the participants will be able to:

- Explain what an effective FP/MNCH client-centred counselling process is and how it is realized.
- Explain the role of providers/counsellors in ensuring an effective FP/MNCH client-centred counselling process.

Total Session Time

100 minutes (one hour and 40 minutes)

Materials

- Flipcharts, markers, tape
- Flipchart "Session objectives"
- LCD projector if available/necessary

Handouts

- Handout 1 – An Effective FP Client-Centred Counselling Process
- Handout 2 – Instructions for Mini Role-Plays in Pairs
- Handout 3 – Using Counselling Steps as a Process
- Handout 4 – The Role of Providers in Ensuring Quality and Effective Counselling

Advanced Preparation

Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)

Introduce and review the session objectives (show them on flipchart or slide). Usually when discussing counselling, often people describe it as a series of steps. Although this is a useful way to "break down" what may seem a complex exercise into manageable parts, the disadvantage is that the steps may be perceived as a mechanical sequence of procedures. When this happens, quality of counselling may suffer because providers may be more concerned about going through the mechanics than focusing on clients' needs and issues. For this reason the session explores counselling as a process in which steps or stages need to be always seen as serving the holistic aim of staying focused on the client's needs and issues.

Activity 1: Defining an Effective FP/MNCH Client-Centred Counselling Process. (25 minutes)

1.1 A very important reason to focus on counselling as a process first and a sequence of stages later is because no matter which counselling sequence or steps one may be familiar with, the client is more important than the framework.

1.2 Distribute and discuss Handout 1:

An Effective FP Client-Centred Counselling Process:
• Respects the priorities and concerns identified by a client. • Utilizes active listening techniques. • Acknowledges unique context of client's life and circumstances. • Is non-judgmental. • Offers options, not directives. • Takes into considerations societal and cultural influences on a client's ability for decision-making (e.g. gender inequity). • Enables a client to make own voluntary informed choices and decisions. • Helps a client in problem-solving to implement choices and decisions.

This table summarizes in a few key points what we have been discussing so far in this program about counselling.

1.3 Ask the participants to mingle and discuss the following question with a person with whom they have not interacted yet very much:
- If you were a FP client, would you prefer to interact with a provider who could manage those elements of counselling as a continuum process or would you prefer a provider who could manage them only as fixed steps? Why?

1.4 After a few minutes, stop the discussion and invite volunteers to share their reflections, and transition into Activity 2.

Activity 2: Mini Role-Plays (50 minutes)

2.1 Acknowledge that managing counselling processes is not an easy task, especially when time and resources are limited. This is why we use frameworks with steps and stages. However it is important to keep in mind that frameworks are a means to an end and should not become an end per se.

2.2 One way in which we can use counselling steps usefully without losing sight of the process is **by making sure that the steps we use help address both the immediate needs and concern of the client as well the broader circumstances in the client life that influence the client's agency and power to deal with those issues.** Let's try to do this in the next exercise: Divide the participants in pairs. Once they are in their pairs, distribute copies of the instructions for the mini role-plays to each person (provided in Handout 2).

2.3 Make sure that the pairs complete their preparation within the 10-minute limit. Invite each pair to perform their mini role-plays and facilitate feedback/comments.

2.4 Finally, ensure that you have at least 10 minutes to distribute and provide an overview of Handout 3. Discuss which similarities and differences they identify between their mini role-plays and the guidance in the handout.

Note for Facilitators

Stress that participants should study the handouts provided in this session in their own time to help them prepare for the counselling role-plays demonstrations, which they will perform at a later stage in the course.

Activity 3: Defining the Role of Providers in Ensuring an Effective FP/MNCH Client-Centred Counselling Process (20 minutes)

3.1 By now the participants should have explored counselling in sufficient depth to be able to define the role of providers in ensuring quality and effective counselling. Facilitate a brainstorm on the following issue:

- Based on your experience and what you have learnt in this course so far, how would you define the role of providers in ensuring effective and quality client-centred counselling interactions?

3.2 Record on flipchart participants' responses and discuss.

3.3 Distribute Handout 4 and discuss similarities and differences with the brainstorm results.

3.4 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Participant's Handouts

Session 9: Handout 1, Activity 1 – An Effective FP/MNCH Client-Centred Counselling Process

An Effective FP Client-Centred Counselling Process:
• Respects the priorities and concerns identified by a client. • Utilizes active listening techniques. • Acknowledges unique context of client's life and circumstances. • Is non-judgmental. • Offers options, not directives. • Takes into considerations societal and cultural influences on a client's ability for decision -making (e.g. gender inequity). • Enables a client to make own voluntary informed choices and decisions. • Helps a client in problem -solving to implement choices and decisions.

Participant's Handouts

Session 9: Handout 2, Activity 2 – Instructions for Mini Role-Plays in Pairs

- We are going to use the GATHER framework, which most participants will know:
  - G **Great** the client warmly
  - A **Ask** the client about herself or himself
  - T **Tell** the client about the services, options, and FP methods
  - H **Help** the client make a decision that is best for her/him
  - E **Explain** e.g. the method, or treatment, or any other relevant issue
  - R Schedule a **Return** visit and/or **refer** and **record**

- Participants will work in six pairs (if there are not enough participants to make up six pairs, the facilitator will assign more than one step to one or two pairs). Pairs will have 10 minutes to prepare a 5-minute maximum mini role-play to show how they would expand the basic GATHER steps in order to ensure that the client in the following scenario receives FP client-centred counselling:

You are the FP counsellor and you are about to meet Mary who is a 27 year old married woman. She came to the clinic this morning wanting a FP method. However, when she was examined the doctor found that she has an STI. Now she is coming to see you.
Please note: **G** and **R** pairs may feel that their task is relatively quick. In fact, they should think very carefully about it because both steps are crucial in counselling as a process, and they should identify how those steps can be used to enhance the process, like all the other pairs.

In order to help the pairs, here are some questions to help them focus their mini role-plays:

- How would you use **G** in order to build trust and comfort for the client? Which issues would you introduce, and why? How would you introduce such issues, and why in that way?
- How would you use **A** to ensure that you address the priorities and needs of the client? What would you ask to assess the client's life and circumstances to ascertain if there is any additional need that the client has but she is not expressing? What questions would you ask to explore the societal and cultural influences on the client's ability and power for decision-making?
- How would you use **T** to provide appropriate information? What would you ask to make sure that it is tailored to her priorities and concerns? What would you do to make sure that the information is helping the client?
- How would you use **H** to enable the client to make her own voluntary informed choices and decisions? How would you help the client in problem-solving to implement her choices and decisions?
- How would you use **E** to address key concerns and needs of the client? What would you ask or say to help the client overcome difficulties with any of the issues she is facing? How would you ensure that what you explain is understood correctly?
- How would you use **R** to support the client's choices and decisions, and why? What would you do to use R to consolidate the trust build with the client during the process? What would you do to help the client anticipate any challenge to make a return visit?

Participant's Handouts

Session 9: Handout 3, Activity 2 – Using Counselling Steps as a Process

Making sure that counselling steps create a cohesive process. Key things to do:

Greet:

- Welcome and register client.
- Prepare chart/record.
- Determine purpose of visit.
- Give the client full attention, showing that you care for his/her well-being.
- Assure the client that all information discussed will be confidential.
- Talk in a private place.
- Explain that during the interaction you may need to ask personal questions, and that this is in order to better understand the clients needs and issues in order to tailor your help.
- Reassure the client that she/he can decline to answer any questions that she/he is not comfortable answering.
- Encourage the client to stop you and ask for clarification at any time, and reassure the client that you are comfortable using simple everyday language.

Ask:

- Find out about the client wishes/preferences in relation to contraception.
- Find out about the client's important data e.g. age, marital status, number of previous pregnancies and births, number of living children, basic medical history, previous use of FP methods.
- Explore the client's needs, risks, sexual life, social context, and circumstances, including possible risks and additional health needs.
- Assess the possible profile of the client, e.g. an adolescent girl who has been raped is not in the same situation as a married woman who has two small children and does not want to have another child within the next two years.
- Assess what the client knows about optimal birth spacing and FP methods.
- Provide encouragement to the client by praising her for the information she already knows and for coming to the centre to seek out more information.
- Ask the client if there is a particular method s/he is interested in.
- Discuss any client concerns about risks vs. benefits of modern methods (dispel rumours and misconceptions).

Tell:

- Tell the client about optimal birth spacing and the available methods.
- Focus on methods that most interest the client, but briefly mention other available methods.
- Show/describe how each method works, the advantages and benefits and possible side effects and disadvantages. Use job/visual aid. Answer client concerns and questions.

Help:

- Help the client to choose a method.

- Repeat information if necessary.
- Explain any procedures or lab tests to be performed.
- Examine client.
- If there is any reason found on examination or while taking a more detailed history that there are precautions for the method, help the client choose another method.
- Help the client assess the benefits, disadvantages, and consequences of each option.
- Assist the client to make his or her own realistic decisions.

Explain:

- Demonstrate/explain how to use the method (how, when, where).
- Explain to the client how and when s/he can/should get re-supplies of the method, if necessary.
- Provide confidence and encouragement again by complimenting the client on her decision and ability to practice a FP method.

Return/Refer/Record:

- Make a concrete, specific plan for carrying out the decision.
- Identify skills that the client will need to carry out the decision.
- Practice skills, as needed, with the provider's help.
- At the follow-up or return visit ask the client if s/he is still using the method.
- If the answer is yes, ask her/him if s/he is experiencing any problems or side effects and answer her/his questions, solve any problems, if possible. If the answer is no, ask why s/he stopped using the method and counsel her/him to see if s/he would like to try another method or retry the same method again. Make sure s/he is using the method correctly (ask her/him how s/he is using it).

Adapted from: CATALYST Consortium / Pathfinder International: Optimal Birth Spacing and Family Planning Counseling Training Manual

Participant's Handouts

Session 9: Handout 4, Activity 3 – The Role of Providers in Ensuring Quality and Effective Counselling

- Create an atmosphere of privacy, respect, and trust
- Engage in two-way communication with the client
- Ensure confidentiality
- Remain non-judgmental toward values, behaviours, and decisions that differ from your own
- Show empathy for the client's needs
- Demonstrate comfort in addressing sexual and gender issues
- Remain patient during the interaction with the client and express interest
- Provide complete, reliable and factual information
- Support the client's rights, including sexual and reproductive rights
- Support the client in making her/his own informed choices and decisions
- Support the client to problem-solve to implement choices and decisions

SESSION 10: Interpersonal Communication and Counselling Skills (IPCC). Part 2

Objectives

By the end of the session, the participants will be able to:

- Perform effective IPCC skills for FP/MNCH client-centred counselling.

Total Session Time

75 minutes (one hour and 15 minutes)

Materials

- Flipcharts, markers, tape
- Flipchart "Session objectives"
- Flipchart "Paraphrasing", Activity 1 step 1.2
- LCD projector if available/necessary

Handouts

- Handouts 1 – Active Listening
- Handouts 2 – Paraphrasing and Reflecting
- Handouts 3 – Practicing Paraphrasing and Reflecting
- Handouts 4 – Practicing Paraphrasing and Reflecting: Mini role-plays keys

Advanced Preparation

Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)

Introduce and review the session objectives (show them on flipchart or slide). We continue to explore and practice fundamental IPCC skills.

Activity 1: Defining Listening, Paraphrasing, and Reflecting (45 minutes)

1.1 Most observations and evaluation of counselling show that usually providers do most of the talking and lack effective listening skills. Ask the participants to discuss in pairs:

- What could be some reasons for this?

Invite a few pairs to share their views.

Explain that in counselling providers should demonstrate *active listening*. Brainstorm with the group key elements of active listening. Distribute Handout 1 and compare it with their brainstorm results, and discuss briefly.

1.2 Discuss *paraphrasing*. Ask the participants:

- What is it? What are its purposes?

Invite a few responses and show the definition on flipchart, and discuss briefly comparing it to the ideas previously expressed by the group:

Paraphrasing means restating the client's message in simple different words. The purposes of paraphrasing are to:

- Make sure the provider correctly understands the client.
- Let the client know and feel that the provider is doing her/his best to understand what the client is saying.

- Summarize or clarify what the client is saying.

1.3 Discuss *reflecting.* Reflecting means understanding and interpreting the feelings and emotions behind what the client is saying, and using this information in the interaction. It is similar to paraphrasing, but it goes beyond it because reflecting also requires identifying and interpreting (decoding) what the client feels or thinks. Provide these examples:
Client: *"I heard that the IUD causes pain in the abdomen."*
Provider (*paraphrasing*): *"Someone told you that IUD causes pain in the abdomen?"*
Provider (*reflecting*): *"I wonder if you mean that you are worried that the IUD may have side effects?"*
C: "*My husband will get angry if he hears that I've come to the clinic."*
P (*paraphrasing*): *"Does he get angry when you come to the clinic?"*
P (*reflecting*): "*I wonder if you mean to say that you are afraid of how your husband my react if he finds out that you are here?"*
C: *"This method is not good for me."*
P (*paraphrasing*): *"This method is not working for you?"*
P (*reflecting*): *"I wonder if this method is creating any problems for you, or in your marriage?"*
Inform the participants that in the next activity we will practice these skills
Conclude the activity by distributing Handout 2.

Activity 2: Practicing Active Listening, Paraphrasing, and Reflecting. Mini role-plays (30 minutes)

2.1 Ask the participants to work in pairs. Instructions:
- Each participant receives a copy of Handout 3. First, the pairs will have five minutes to discuss Exercise 1. Facilitate a brief discussion to enable the pairs to share and discuss their views **(note for facilitators: the first statement is the reflected one, and second statement is the paraphrased one)**.
- Next, assign to each pair one of the statements in Exercise 2. Each pair will perform a mini-role play of two-to-three minutes maximum, and the other pairs will provide their feedback.
- Finally, distribute Handout 4 and discuss it with the large group. How similar or different are the possible responses suggested in the handout from those produced by the participants?

2.2 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective. *Participant's Handouts*

Session 10: Handout 1, Activity 1 – Active Listening

Active listening means to:

- Establish and maintain eye contact.
- Demonstrate interest by nodding, leaning toward the client, and smiling.

- Sit comfortably and avoid distracting movements.
- Pay attention to the client (e.g., do not engage in other tasks while you are meeting with the client, do not talk to other people, do not interrupt the client, and do not allow others to interrupt).
- Listen to the client carefully. Do not become distracted and think about other things or about what you are going to say next.
- Listen both to what your clients say and to how they say it, and make note of tone of voice, choice of words, facial expressions, and gestures.
- Imagine yourself in your client's situation as you listen.
- Allow for pauses of silence at times during your interaction so that the client has time to think, ask questions, and talk.
- Encourage the client to ask questions.
- Encourage the client to continue talking by using expressions like "yes," "hmm," and "and then what?"
- Repeat what the client has said. (Note, however, that exact repetition of what the client has said should be used sparingly. Instead, counsellors should use paraphrasing or reflecting, as discussed below.)

Source: USAID | the ACQUIRE Project, 2008: Counselling for Effective Use of FP, Trainer's Manual

Participant's Handouts

Session 10: Handout 2, Activity 1 – Paraphrasing and Reflecting

Paraphrasing

Paraphrasing means restating the client's message in simple, different words.
The purposes of paraphrasing are to:

- Make sure the provider correctly understands the client.
- Let the client know and feel that the provider is doing her/his best to understand what the client is saying.
- Summarize or clarify what the client is saying.

Reflecting
Reflecting means understanding and interpreting the feelings and emotions behind what the client is saying, and using this information in the interaction. It is similar to paraphrasing, but it goes beyond it because reflecting also requires identifying and interpreting (decoding) what the client feels or thinks.

The purposes of reflecting are to:

- Interpreting the hidden messages that a client may be trying to communicate in order to overcome the client's embarrassment, fear, or other concerns that are blocking the interaction.
- Making the client feel that it is fine to talk about those concerns and that there is no judgment.
- Building trust, comfort, and confidence.

Examples of Paraphrasing and Reflecting:
Client: *"I heard that the IUD causes pain in the abdomen."*
Provider (*paraphrasing*): *"Someone told you that IUD causes pain in the abdomen?"*
Provider (*reflecting*): *"I wonder if you mean that you are worried that the IUD may have side effects?"*
C: "*My husband will get angry if he hears that I've come to the clinic."*
P (*paraphrasing*): *"Does he get angry when you come to the clinic?"*
P (*reflecting*): "*I wonder if you mean to say that hat you are afraid of how your husband my react if he finds out that you are here?"*
C: *"This method is not good for me."*
P (*paraphrasing*): *"This method is not working for you?"*
P (*reflecting*): *"I wonder if this method is creating any problems for you or in your marriage?"*

Basic Tips:

- Do not paraphrase negative statements that people might have made about themselves. In such cases *reflecting* is more useful to try to interpret the feelings of the client about that issue.
- Do not interrupt. This is a basic recommendation for effective interactions. If you really have to, apologize first and explain why you need to do it.
- Do not overuse paraphrasing and reflecting. Use it when the client is hesitating in order to help her/him continue. Excessive use of these techniques can make you waste precious time.

Participant's Handouts

Session 10: Handout 3, Activity 2 – Practicing Paraphrasing and Reflecting

Exercise 1:

Whole Group Exercise on Paraphrasing & Reflecting Skills

Which of the statements below is a paraphrased statement, which is a reflecting statement? Give reasons for your choice.

- Client: I want to use FP but I am not sure if I am pregnant.
- Provider: 1st statement. Are you saying you would like FP, but you are concerned, if it's too late to use one?
- Provider: 2nd statement. Are you saying that perhaps you may be pregnant already?

Exercise 2:

In your group: paraphrase and reflect the client's statement that will be assigned to you, and role -play the interaction.

Client's statements:

1. (teenage client): Mummy, I am going out with my boyfriend tonight for a party. I want some information.
2. I'm not sure I can use this method.
3. People say if you use this method you can never again have children.
4. My husband complains that he can feel the IUD.

Participant's Handouts

Session 10: Handout 4, Activity 2 – Practicing Paraphrasing and Reflecting: Mini role-plays keys

Client 2: Possible responses
Client: I'm not sure I can use this method.
Provider (paraphrasing): Do you mean to say that this method will not work for you?
Provider (reflecting): I wonder if you are worried that you may have complications?
OR
I wonder if you are worried that this method may create problems with your husband?

Client 3: Possible responses
Client: People say if you use this method you can never again have children.
Provider (paraphrasing): Do you mean to say that this method causes problems?
Provider (reflecting): I wonder if you are worried about your chances of having children in future?
OR
I wonder if you are worried that you may not stop this method quickly if you decide to have children?

Client 4: Possible responses
Client: My husband complains that he can feel the IUD.
Provider (paraphrasing): Do you mean that the method is causing problems in your marriage?
Provider (reflecting): I wonder if you are worried that the method is effecting how your husband feels for you?
OR
I wonder if you are worried your husband may stop wanting to have sex with you?

SESSION 11: Managing Challenging Situations in Counselling

Objectives
By the end of the session, the participants will be able to:
- Manage effectively challenging situations in counselling.

Total Session Time
45 minutes

Materials
- Flipcharts, markers, tape
- Flipchart "Session objectives"
- Flipchart "Challenging situations in counselling", Activity 1 step 1.1
- LCD projector if available/necessary

Handouts
- Handout 1 – Possible Solutions to Challenging Situations in Counselling
- Handout 1 – Possible Solutions Matching Challenging Situations in Counselling

Advanced Preparation
Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)
Introduce and review the session objectives (show them on flipchart or slide). An important aspect of effective communication in counselling is managing challenging situations. In this session, participants will explore some of the most common "difficult moments" that may arise in counselling and practice skills to overcome such challenges.

Activity 1: Identifying Common Challenging Situations in Counselling and Possible Solutions (45 minutes)
1.1 Show on flipchart the following list of possible challenging situations in counselling:

Challenging Situations in Counselling:
- Client stops talking.
- Client breaks down crying.
- Client appears to refuse any help.
- Client feels unappreciated (by family, partner, etc.).
- Client shows discomfort with the provider's attitudes or questions.
- Client becomes hostile and confrontational.
- Provider feels that the case is too difficult to deal with.
- Provider makes mistake(s).
- Provider can't answer to the client's question.
- Provider is running out of time.

Explain that for the time being we will discuss these situations and later we may add more if the group wants to suggest any.

1.2 Ask the participants to work individually:
- Assign one or more challenging situation per person. Their task is to identify a possible solution to the challenge/s among those listed on Handout 1

(distribute it). They have 10 minutes to select possible solutions from the handout.

- The participants will find all the other people in the group who have worked on the same challenge/s and compare and discuss their ideas for no more than five minutes.
- Next, each person has to find someone in the group who worked on a different challenge/s and give feedback and suggestions to each other on their ideas about addressing their respective challenge/s - five minutes maximum.
- Stop the activity and distribute Handout 2. The participants compare it with the solutions they identified. Discus briefly similarities and differences – 10 minutes maximum.
- Finally, ask the participants if they have any additional challenging situations to add to the initial list. For each of the new situations, discuss with the group which solutions they would select from the handout, and why, or if they have additional solutions to suggest.

1.3 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Participant's Handouts

Session 11: Handout 1, Activity 1 – Possible Solutions to Challenging Situations in Counselling

Use questions effectively to find out essential information as quickly as possible:

- Prioritize the client's problems (if he or she has more than one problem to be addressed) and address the most urgent problem first; make an appointment to resolve the other problem.
- Refer the client to another service provider who is not busy.

Apologize and provide the correct answer (if you have contradicted yourself, acknowledge it and provide the correct information).
Ask a colleague to help you.

Ask colleagues or supervisors to help:

- Check reference materials.
- Refer the client.
- Reassure the client that you will help him or her resolve the issue.

Empathize with the client, telling him or her that you understand that he or she might feel shy, and that many clients feel the same way:

- Remind the client that everything discussed will remain confidential.
- Reassure the client that nobody will overhear your discussion.
- Stress the need to hear more about the client's needs and situation to be better able to help him or her.
- Find out if there is a language barrier.
- Check that the client is hearing properly.
- Review your own communication skills.

Find out the cause and address it accordingly:

- Tell client that he or she is free to decide what to do.
- Explain that you are making suggestions; you are not trying to impose your ideas.
- Reassure the client that you are there to help any time.

Express your caring in the way that is culturally most appropriate (e.g., holding the client's hand, touching him or her on the shoulder, or giving a tissue):

- Use *reflecting* the feelings of the client (e.g., "you must be very sad," or "this must be worrisome").
- Reassure the client that crying is a normal reaction when in distress.
- Say that the client is not the only one facing a similar situation and many clients like her/him have been able to overcome this problem.
- Divert/distract the client by introducing another topic; then continue with counselling.
- Find out if the client's complaints are justified.
- If yes, explore and address the issue with the responsible service provider.
- If no, find the cause of the complaint and manage it.
- Use empathy, reflecting, and reassure the client that everyone at the facility has her/his best interest at heart.

Remind the client that anything discussed will remain confidential:

- Use praise and encouragement in order to re-focus and rebuild the rapport.
- Explain that you see many male and female clients from different age groups, backgrounds, and so on.
- Ask if the client would be more comfortable with another service provider.
- Use Empathy and reflecting, and show interest in and understand of how the client feels.
- Stress that you and the client are equals and that you are not trying to judge the client or impose your ideas.

Tell the client that you care about him or her:

- Use praise.
- Use reflecting to try to understand why the client is feeling that way.
- Reassure the client that she or he is very important to his or her loved ones.

Participant's Handouts

Session 11: Handout 2, Activity 1 – Possible Solutions Matching Challenging Situations in Counselling

Client stops talking	• Empathize with the client, telling him or her that you understand that he or she might feel shy, and that many clients feel the same way • Remind the client that everything discussed will remain confidential • Reassure the client that nobody will overhear your discussion • Stress the need to hear more about the client's needs and situation to be better able to help him or her • Find out if there is a language barrier • Check that the client is hearing properly • Review your own communication skills
Client breaks down crying	• Express your caring in the way that is ***culturally most appropriate*** (e.g., holding the client's hand, touching him or her on the shoulder, or giving a tissue) • Use reflecting the feelings of the client (e.g., "you must be very sad," or "this must be worrisome") • Reassure the client that crying is a normal reaction when in distress • Say that the client is not the only one facing a similar situation and many clients like her/him have been able to overcome this problem • Divert/distract the client by introducing another topic; then continue with counselling
Client appears to refuse any help	• Find out the cause and address it accordingly • Tell client that he or she is free to decide what to do • Explain that you are making suggestions; you are not trying to impose your ideas • Reassure the client that you are there to help any time
Client feels unappreciated (by family, partner, etc.)	• Tell the client that you care about him or her • Use praise • Use reflecting to try to understand why the client is feeling that way • Reassure the client that she or he is very important to his or her loved ones
Client shows discomfort with the provider's attitudes or questions	• Remind the client that anything discussed will remain confidential • Use praise and encouragement in order to re-focus and rebuild the rapport • Explain that you see many male and female clients from different age groups, backgrounds, and so on • Ask if the client would be more comfortable with another service provider • Use Empathy and reflecting, and show interest in and understand of how the client feels • Stress that you and the client are equals and that you are not trying to judge the client or impose your ideas

Client becomes hostile and confrontational	• Find out if the client's complaints are justified • If yes, explore and address the issue with the responsible service provider • If no, find the cause of the complaint and manage it • Use empathy, reflecting, and reassure the client that everyone at the facility has her/his best interest at heart
Provider feels that the case is too difficult to deal with	• Explain to the client that you would like to consult with a colleague who has a lot of experience with similar issues in order to help the client in the best possible way. Ask the client for her/his permission to do so. • Consult with a colleague.
Provider makes mistake(s)	• Apologize and provide the correct answer (if you have contradicted yourself, acknowledge it and provide the correct information)
Provider can't answer the client's question	• Explain to the client that you would like to consult with a colleague who has a lot of experience with similar issues in order to help the client in the best possible way. Ask the client for her/his permission to do so. • Ask colleagues or supervisors to help • Check reference materials • Refer the client • Reassure the client that you will help him or her resolve the issue
Provider is running out of time	• Use questions effectively to find out essential information as quickly as possible • Prioritize the client's problems (if he or she has more than one problem to be addressed) and address the most urgent problem first; make an appointment to resolve the other problem • Refer the client to another service provider who is not busy

SESSION 12: Addressing Barriers to Communication in Counselling

Objectives
By the end of the session, the participants will be able to:

- Assess effectively a range of factors that influence clients' decisions and choices in order to prevent and overcome barriers to communication in counselling.

Total Session Time
75 minutes (one hour and 15 minutes)

Materials

- Flipcharts, markers, tape
- Flipchart "Session objectives"
- LCD projector if available/necessary

Handouts

- Handout 1 – Five Categories of Factors Influencing a Client's Decisions and Choices
- Handout 2 – Sample Questions that may be used in Counselling to Explore the Key Categories that Impact Clients' Decisions and Choices

Advanced Preparation
Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)
Introduce and review the session objectives (show them on flipchart or slide). FP client-centred counselling requires also skills to overcome many possible different barriers to communication. This session explore which barriers may exist and strategies to overcome them.

Activity 1: Identifying Barriers to Communication in Counselling (20 minutes)
1.1 Acknowledge that there may be several barriers to communication in counselling. Some barriers may be due to providers' hindering attitudes (e.g. being judgmental), or to providers' insufficient counselling skills (e.g. not showing empathy, compassion or interest in the client, or not being able to use questions effectively, or not being able to explore the client's life and social circumstances that make undermine her/his agency and power to make voluntary decisions and carry them out). Training and supportive supervision plays a very important role in overcoming these barriers, although there is also a need to act on other social ecology issues, which training alone may not be able to affect (e.g. inadequate policies on gender equity).

Other barriers may be due to the lack of adequate infrastructure, for example not having a private space to conduct counselling. This type of barriers may require other types of interventions.
However, there is a very important barrier to communication in counselling that often is overlooked: **Understanding factors that influence clients' decision and choices.**

If providers are unable to assess these factors, they may steer the counselling interaction in a direction that is not meaningful to the client and thus lose the client's interest, motivation, and engagement in the process.

1.2 Distribute Handout 1 and review it with the group. There are five broad categories of factors that may influence a client's decisions and choices and they are:

Five Categories of Factors Influencing a Client's Decisions and Choices

- Individual characteristics
- Community and social influences
- Method characteristics
- Service factors
- Other reproductive health conditions

Service factors include all the issues that were discussed above in 1.1. Therefore, we are going to focus on the other four categories.

1.3 Review the points about categories 1, 2, 3, and 5 from Handout 1 and ask the participants to briefly share from their experiences how these factors may create barriers to communication if not assessed effectively by providers.

Activity 2: Assessing Factors Influencing Clients' Decisions and Choices as a Tool to Prevent and Overcome Barriers to Communication in Counselling (50 minutes)

2.1 Participants work in four groups or four pairs (depending on the total number in the group). Instructions:

- Each group/pair will work on one of the four categories of factors that we are exploring (Individual characteristics; Community and social influences; Method characteristics; Other reproductive health conditions).
- Their task is to brainstorm possible questions that they would use in counselling to assess those factors.
- Pairs/groups have 20 minutes to brainstorm, discuss, and finalize their list of questions and prepare them on flipchart for presentation.

2.2 Ensure that the pairs/groups complete their task within the allocated time. Each pair/group presents and receives feedback from the **others on the usefulness of the questions and on how to improve them**. Finally distribute Handout 2 and discuss similarities and differences with the questions produced by the participants, i.e. **why** some questions are more useful than others.

2.3 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Participant's Handout

Session 12: Handout 1, Activity 1 – Five Categories of Factors Influencing a Client's Decisions and Choices

Individual characteristics include age, number, and gender of the client's children; the client's health status; the client's risk for STIs and HIV; the client's socioeconomic and education background; previous contraceptive use and experiences; nature of the client's relationship(s) with partner(s) (including existence of sexual coercion or abuse); the client's sexual life; and religious and personal beliefs.

Service factors include provider attitudes, knowledge, and skills; quality of counselling; availability of FP methods and information, education, and communication (IEC) materials; accessibility of service; and supervision to ensure that all of these elements are in place and working well.

Community and social influences can have a major impact on the clients' knowledge and choice of FP method. Word of mouth and gossip play an important role and sometimes reflect misinformation, cultural norms, religion, politics, societal pressures, legal issues/considerations, and gender roles.

Method characteristics include factors such as whether the method is provider controlled, partner controlled, or user controlled, whether it requires partner cooperation, whether it requires application/use with every instance of sexual relations, common side effects, and whether it offers dual protection from STIs (including HIV) and from pregnancy.

Other reproductive health conditions: Providers must be sensitive to the possibility that clients have needs beyond those they initially identify as the reason for their visit. Nothing that affects a client's reproductive health happens in isolation. For example, issues like HIV status and being immediately postpartum must be considered when choosing a FP method.

Some Useful Tips to Consider:
People use contraception because they are sexually active or plan to be. Providers should assess if clients' use of and satisfaction with contraceptive methods is influenced by real or perceived effect of contraceptives on their sexual practices and enjoyment.

Providers should help clients think about which FP methods will meet their needs and which ones might cause problems for them in order to prevent discontinuation or incorrect and/or irregular use of the method. For example:

- If clients are concerned about whether a method may complicate their sexual lives, probably they won't use it.
- Providers should assess if women who are considering hormonal methods or the IUD are worried about menstrual changes and repercussions with their partners.
- It is important to assess how frequently clients have sex. For example, individuals who have sex occasionally or infrequently might prefer a method that can be used as needed, such as condoms, rather than a method like the pill that requires doing something every day.

- On the other hand, with clients with multiple partners providers should assess the need for both FP and protection from HIV and other STIs.
- Some clients will have partners who do not cooperate with FP use, and for these clients methods like condoms and natural FP might not be ideal choices.
- There may be clients who feel they have to hide their sexual activities (e.g., unmarried adolescents) or their use of contraception (e.g., clients whose partners do not approve). These clients might want methods that do not require obtaining supplies or daily use.
- Clients who strongly associate fertility with their sexuality or self-esteem might not be comfortable with permanent methods.

Adapted from: USAID | the ACQUIRE Project, 2008: Counselling for Effective Use of FP, Trainer's Manual

Participant's Handout

Session 12: Handout 2, Activity 2 – Sample Questions that may be used in Counselling to Explore the Key Categories that Impact Clients' Decisions and Choices

Community and Social Influences:

- How do you feel about FP?
- What concerns do you have about FP?
- How do people in your community feel about FP? Are you concerned about what they think?
- How is your family supporting your decision to use FP?

Sometimes it is useful to use **hypothetical questions, i.e. questions that ask "What if…?"** These questions are especially useful if the client is shy or if the provider needs to discuss sensitive issues. Examples:

- What would happen if someone tried to discourage you from using FP because of their views about it? How could you cope with that pressure?
- What could you do if your family didn't support your decision?

Hypothetical questions are useful to help the client think of possible solutions, i.e. to problem-solve. Obviously it is very important how the provider asks these questions (tone of voice, non-verbal communication, and empathy are extremely important).

Method Characteristics:

- What concerns do you have about discussing your FP method with your husband?
- What information about the method would you like to have in order to clarify any concerns that may come up when you discuss the method with your husband?
- Do you have any concerns about explaining the method to your husband? How can I help you to feel more confident to talk about it with him?
- How comfortable do you feel about explaining to your husband how to use male condoms? What do you think his main concerns may be?

Hypothetical Questions:

- How would you explain the advantages of the method for your health and your family health if your husband challenged you about using it?
- What could be the best way for you to explain why you have decided to use this method if your husband challenged you about it?

Other Reproductive Health Conditions:

- How comfortable do you feel about discussing intimate personal issues with your husband?
- What would you like to know more about apart from your FP method to feel more comfortable to talk about intimate personal issues with your husband?
- Have you heard about some infections that can be transmitted through sexual activity? What would you like to know more about these issues?
- Have you been concerned about how these infections might affect your health or

your husband's health? What concerns you in particular?

Hypothetical Questions:

- What could you do if you were concerned about your husband having sex with other partners?
- How could you talk to your husband about your concerns? Would you feel safe to do it? What information would you like to have if you were to discuss these issues with him?
- How could you discuss practicing safer sex with your husband if you were worried about his sexual behaviour? What do you think that could motivate him

to listen to you?

SESSION 13: Exploring the Sexual Relationships of Clients

Objectives

By the end of the session, the participants will be able to:

- Identify useful strategies to introduce the topic of sexuality in the counselling interaction.
- Develop useful questions to use in counselling to help clients explore their sexual lives, including the social context of their sexual relationships.

Total Session Time

90 minutes (one hour and 30 minutes)

Materials

- Flipcharts, markers, tape
- Post-it stickers
- Flipchart "Session objectives"
- AGREE and DISAGREE signs, Activity 1 step 1.1
- Flipcharts "SEXUAL RELATIONSHIPS", "COMMUNICATING WITH PARTNER", and "PARTNER'S OTHER RELATIONSHIPS", Activity 2 step 2.1
- LCD projector if available/necessary

Handouts

- Handout 1 – Sample Questions to Help Clients Explore their Sexual Lives, Including the Social Context of their Sexual Relationships

Advanced Preparation

Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)

Introduce and review the session objectives (show them on flipchart or slide).
Providers have a responsibility to introduce the subject of sexuality in counselling and to help clients feel comfortable about responding to questions concerning their sexual practices. Providers should always be mindful to avoid stigmatizing different sexual behaviours or practices or judge whether they are right or wrong; instead, it is useful to recognize that these practices exist and that the responsibility of providers is to help client assess how they may be at risk of unplanned pregnancies and/or infections.

Activity 1: How Can Providers Introduce the Topic of Sexuality in the Interaction with Clients? (30 minutes)

1.1 Invite the participants to join you standing at the wall where you will have already posted an AGREE and a DISAGREE sign at opposite ends. Instructions:

- The facilitator reads out a statement at a time. The statements present possible strategies to introduce the topic of sexuality in the counselling interaction. By now the participants know how an AGREE/DISAGREE exercise is conduced, but remind them that we do not challenge or judge people's opinions.

After reading out each statement and allowing the participants to decide where to stand,

make sure that you ask questions to help them reflect on their reasons. For example:

- How would a client feel if you used this strategy?
- What possible reactions may such a strategy produce in the client?
- How useful is this strategy to avoid discomfort of defensiveness in the client?
- How culturally appropriate is this strategy in your setting? What could be a more culturally appropriate strategy?
- For what types of clients would this strategy be useful? And with what types of clients it may not be useful, and why?

Sample Statements:

- Sexuality should be the first topic that a provider addresses with a client.
- It is always best to start with general open-ended questions to establish rapport and get the conversation flow.
- It is important to explain to clients why providers need to ask personal and sensitive questions and explain the benefits for helping clients.
- It is very important that the provider demonstrate comfort and confidence in talking about sexual issues in order to make the client comfortable as well.
- It is useful to explain to clients that they are free to decline to answer any question that they are not comfortable with.
- It is useful to explain that it is a policy of the service to discuss sensitive issues with all clients, including their sexual lives, in order to help clients assess any potential risk for infections and the best FP methods that suit their sexual lives.
- It is useful to reassure clients that everything discussed in counselling is confidential.
- It is useful to reassure clients that the provider is not concerned with judging the client in any way and that the only reason to ask about the client's sexual life is to help the client make informed decisions and choices.

1.2 Reserve at least five minutes to discuss:

- Which additional strategies would you suggest to introduce the topic of sexuality?

Activity 2: Helping Clients Explore Their Sexual Lives, Including the Social Context of their Sexual Relationships (55 minutes)

2.1 Participants work in groups of three or in pairs, depending on the total number of people in the group. Instructions:

- The facilitator will have already posted on the wall the following three flipcharts:

1. SEXUAL RELATIONSHIPS	2. COMMUNICATING WITH PARTNER	3. PARTNER'S OTHER RELATIONSHIPS
Explore: sexual relationships the client is in; the nature of the relationship (e.g. stable, abusive, etc.); how the client feels about it.	Explore: how client communicates with spouse/partner about sexuality, FP, any concerns about STI/HIV, and any other MNCH concerns.	Explore: if the client has concerns about spouse/partner's sexual behaviour outside of the relationship; what the client knows about it.

- The facilitator divides the pairs/groups by number counting one-two-three.

The groups will work on the corresponding topics.

- Each pair/group receives six post-it stickers. They have 25 minutes to develop up to six questions that they would use in counselling to explore the issues listed on their flipchart. They will write one question per sticker and post on the corresponding flipchart.
- Before they start working, ask the participants if there are any additional key issues they feel should be explored for each flipchart. Add any issues on which there is majority consensus.

2.2 Once the stickers have been posted, allow a few minutes for the participants to read. Ask them to gather around the flipcharts and facilitate a discussion (10 minutes):

- Which questions do you find useful and why?
- Which questions appear to be less useful, and why?
- Have you used some of these questions in the past? How did they work in the counselling?

2.4 The participants remain gathered around the flipcharts. Distribute Handout 1 and facilitate a discussion about similarities and differences with the questions the participants developed:

- Which of the questions on the handout do you find useful and why?
- Which questions on the handout appear to be less useful, and why?
- Do you find any of these questions challenging for you to use with clients? Why?
- How could you overcome these challenges?

2.4 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Participant's Handout

Session 13: Handout 1, Activity 2 – Sample Questions to Help Clients Explore their Sexual Lives, Including the Social Context of their Sexual Relationships.

1. SEXUAL RELATIONSHIPS	2. COMMUNICATING WITH PARTNER	3. PARTNER'S OTHER RELATIONSHIPS
Explore: sexual relationships the client is in; the nature of the relationship (e.g. stable, abusive, etc.); how the client feels about it. • How would you describe your sexual relationship with your spouse/partner? • How satisfied are you in the relationship? • Does your relationship include anything that worries you? • How has your relationship changed over time? What are you happy about the changes? What changes you don't like? • Have you ever felt scared in your relationship? • What would you like to improve in your sexual relationship with your spouse/partner?	Explore: how client communicate with spouse/partner about their sexuality, FP, any concerns about STI/HIV, any other MNCH concerns. • How easy is it for you to talk about sexuality issues in your relationship with your spouse/partner? • What makes it difficult to talk about these issues? • What are the sexuality issues that you would really like to discuss with your spouse/partner? • What are the issues that you think your spouse/ partner would like to discuss? • How would your relationship improve if you could discuss these issues? • What would you need to know more about to feel more comfortable to discuss sexuality issues with your spouse/partner?	Explore: if the client has concerns about spouse/partner's sexual behaviour outside of the relationship; what the client knows about it. • How stable do you think your relationship is? • How concerned are you about your spouse/partner's sexual behaviour outside of your relationship? • What makes you feel that your spouse/partner may have other sexual partners? • How long have you had these concerns for? • Have you discussed your concerns with anyone? What advice have they given you? How do you feel about the advice they gave you? • What information would you like me to give you to help you assess your situation and possible consequences for your health?

SESSION 14: Explaining Medical Terminology in Language that Clients Understand, and Using Visual Aids Effectively in Counselling

Objectives

By the end of the session, the participants will be able to:

- Demonstrate comfort in using the words and expressions that clients use to talk about FP/MNCH, including sexuality issues.
- Demonstrate how visual aids should be used effectively during counselling.

Total Session Time

105 minutes (one hour and 45 minutes)

Materials

- Flipcharts, markers, tape
- Post-it stickers
- Flipchart "Session objectives"
- Flipcharts for Activity 1, step 1.1
- Sample visual aids to use in role-play practice, Activity 3
- LCD projector if available/necessary

Handouts

- Handout 1 – Using Visual Aids Effectively During Counselling

Advanced Preparation

Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)

Introduce and review the session objectives (show them on flipchart or slide).
Effective FP/MNCH client-centred counselling requires that providers have the comfort and ability to explain FP/MNCH issues in ways that clients understand. This entails knowing and using the language that clients use to talk about these issues and being able to use it without judgment and embarrassment. Effective use of simple language can highly enhance the use of visual aids in counselling.

Activity 1: Using with Comfort the Words and Expressions that Clients use to talk about FP/MNCH, Including Sexuality Issues (25 minutes)

1.1 Post the following flipcharts on the wall:

Reproductive organs (female)	Reproductive organs (male)	Sex and Se xual behaviours	Pregnancy, Delivery, STI, other FP/MNCH issues

Instructions:

- Divide the participants in four pairs if the total number allows, or ask them to work individually (each pair/individual is assigned one of the flipcharts. If you have a very small group, assign more than one flipchart per individual).
- The pairs will have five minutes to write on their assigned flipcharts all the colloquial words that they know about those issues. Encourage the

participants to overcome their potential resistance and ask them to imagine that they are clients who do not know medical or technical terminology.

- Once the pairs have completed their task, allow a few minutes for reading. Facilitate a discussion:
- Are there any additional words or expressions that you want to suggest?
- How did you feel about hearing and saying these words?
- If you were a client and heard a provider use words or terminology that you do not understand, how would you feel? How could it impact your ability to make informed decisions and choices?
- If you were a provider using medical terminology that the client cannot understand, what kinds of power would you be undermining in the client?
- How could you respond if a client uses a term that you consider inappropriate without making the client feel judged or inferior?

Activity 2: Using Visual Aids Effectively during Counselling (25 minutes)

2.1 Distribute Handout 1. Instructions:

- Participants work in pairs or small groups of three depending on the total number in the group. They review and discuss the handout, which offers suggestions for using visual aids effectively during counselling. They have 15 minutes to discuss these questions:
  - How do these tips compare with how you have been using visual aids?
  - What are the most useful suggestions in the handout, and why?
  - Which additional suggestions can you offer drawing from your experience?

2.2 Facilitate the discussion and explain that in the next activity participants will apply what they have learnt by doing role-play practice.

Activity 3: Role-play practice (50 minutes)

3.1 Prior to conducting the session, you will have gathered several visual aids that are used locally such as illustrations of anatomy, anatomical models, counselling flipcharts, client brochures, wall-charts, posters, and FP cue cards.

3.2 Divide participants in small groups of there. Instructions:

- Give one or two visual aids to each group. One person will be the "client", one person the "provider" and one person will be the observer who will give feedback at the end of the role-play. Encourage the groups to apply what they have learnt so far about using simple language and the suggestions contained in Handout 1.
- Let the groups role-play for 15 minutes, then stop them.
- Ask each group to perform their role-play in front of the large group. Facilitate feedback. Continue with the role plays with different visual aids.

3.3 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Participant's Handout

Session 14: Handout 1, Activity 2: Using Visual Aids Effectively During Counselling

Visual aids and job aids include illustrations of anatomy, anatomical models, counselling flipcharts, client brochures, wall-charts, posters, FP cue cards, sample contraceptives, wallet cards, booklets, audiotapes, videotapes, drawings, and diagrams. These help clients better understand and retain information provided during counselling.

Tips on Using Visual and Job Aids:

- Make sure clients can clearly see the visual materials as you explain them.
- Start by asking the client what the picture looks like to him or her. The next step is to identify parts of the picture that the client knows and then go on to those that he or she is not familiar with.
- Explain pictures and point to them as you talk.
- Look mostly at the client, not at the flipchart or poster.
- Change the wall charts and posters in the waiting room from time to time. This will draw attention to them so that clients can learn something new each time they come to the facility.
- Use sample contraceptives when explaining how to use them. Invite clients to touch them.
- Clients can practice putting a condom on a model penis, a stick, or a banana. Clients might want privacy when they practice.
- If possible, give clients pamphlets or instruction sheets to take home. They can be helpful reminders of correct method use. Be sure to go over the materials with the client.
- Suggest that the client show take-home materials to other people.
- Small flipcharts are not appropriate for use with large groups.
- Order more materials before they run out.
- Make your own materials if you cannot order them when they run out.

These Materials Help to:

1. Capture the clients' attention.
2. Prompt a discussion and help clients ask questions and make decisions.
3. Explain anatomy and contraceptives that might not be familiar to clients.
4. Make comparisons between different contraceptive methods.
5. Demonstrate what is involved in medical procedures (e.g., IUD insertion).
6. Demonstrate physiological processes (e.g., development of a fetus).
7. Demonstrate physiological or contraceptive features that one cannot see (e.g., the position of an IUD in the uterus) or point out parts of the body such as sexual organs.
8. Assist with explaining sensitive and/or complicated subjects like FP and risk related to STIs.

These Materials are Useful also because:

- Clients can take printed materials home.
- Clients can share printed materials with partners and friends.

- Giving brochures to clients helps them remember essential information and instructions about FP methods or procedures.
- Posters can be used to introduce a new service or a sensitive issue.
- Flipcharts (illustrated flipbooks) can be used to present step-by-step instructions.

Reflect on:

- How do these tips compare with how you have been using visual aids?
- What are the most useful suggestions in the handout, and why?
- Which additional suggestions can you offer drawing from your experience?

Adapted from: USAID | the ACQUIRE Project, 2008: Counselling for Effective Use of FP, Trainer's Manual

SESSION 15: Addressing Clients' Misconceptions about FP Methods

Objectives

By the end of the session, the participants will be able to:

- Identify the most commonly held misconceptions in the geographical areas where the services are provided.
- Demonstrate how to correct misconceptions during counselling.

Total Session Time

90 minutes (one hour and 30 minutes)

Materials

- Flipcharts, markers, tape
- Flipchart "Session objectives"
- LCD projector if available/necessary

Handouts

- Handout 1 – Tips for Correcting Misconceptions and Addressing Rumours

Advanced Preparation

Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)

Introduce and review the session objectives (show them on flipchart or slide).
Addressing clients' misconceptions about FP methods is extremely important because misconceptions and rumours can lead to discontinuation of FP methods. Thus, correcting misconceptions is an important step in ensuring continued use.

Activity 1: Identifying the Most Commonly Held Misconceptions in the Geographical Areas Where the Services are Provided (30 minutes)

1.1 Divide the participants in as many pairs as the total number allows. Instructions:

- Each pair will identify the most common misconceptions and rumours about FP methods in the geographical areas where the participants work.
- Each pair will focus on one FP methods selected among those in following list (assign more than one method per pair if you do not have enough pairs):
  - Male and female condoms.
  - Intrauterine Devices (IUDs).
  - Spermicides.
  - Diaphragm.
  - Lactational Amenorrhea Method (LAM).
  - Standard-Days Method.
  - Emergency Contraception (EC).
  - Pills (both combined and progestin-only).
  - Injectables.
  - Implants.
  - Female Sterilization.
  - Vasectomy.

Note for Facilitators

Check with the group if the above list is relevant or how it should be amended.

- Pairs have 10 minutes to brainstorm their list of misconceptions/rumours.

1.2 As the pairs present, make sure that any additional misconception or rumour is added to the lists. Collect all the flipcharts. Stress that the lists will be used to plan for the next role-play practice activity.

Activity 2: Correcting Misconceptions and Addressing Rumours During Counselling. Role-play Practice (60 minutes)

2.1 Instructions:

- Rearrange the participants in small groups of three.
- In each group one person will play "client", one person will be the "provider" and one person will be the observer giving feedback. Distribute Handout 1, which provides some tips for correcting misconceptions and rumours as well as the feedback guidelines for the role-plays.
- Give to each group one of the lists of misconceptions and rumours developed in Activity 1. The "client" will use one of the misconceptions or rumours and the "provider" will correct it. The observer will then provide feedback. Each role play should be no more than 10 minutes, including feedback.
- Every 10 minutes stop the groups and make them swap lists. In each group, the members will also swap roles to ensure that everyone gets to play all the roles.
- Stop the practice a few minutes before the end of the session to conduct the session evaluation.

2.2 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Participant's Handout

Session 15, Handout 1, Activity 2 – Tips for Correcting Misconceptions and Addressing Rumours

Correcting Misconceptions

- Find out what clients have heard about FP methods and their concerns about the methods.
- Show that you do not dismiss the client's concern or misconception.
- Ask where the client heard the misconception or rumour.
- Explain that the misconception or rumour is not true without offending or upsetting the client.
- Ask the client what she/he needs to know to have confidence in the FP method. Find out who the client will believe.
- Give the correct information. Be aware of traditional beliefs about health because they can help you both understand rumours and explain health matters in ways that clients can more easily understand and accept.
- Encourage clients to come back any time to ask for more clarification or to check with other health providers if they have any additional questions or doubt about the method.

Dealing with Rumours in the Community

- Identify someone who would be credible and respected in the community and ask her/him to explain the correct information about the method.
- Make sure that more than one credible source is telling the community the truth about the method.
- Find out how the rumour began. It is important to address the root of the rumour.
- If rumours appear in the media, your facility director might wish to act at the institutional level.
- Make clients aware of the damage that rumours can do and encourage them not to repeat them.
- Involve outreach workers, if they are available locally, in detecting and correcting rumours.

Role-play Feedback Guidelines

- The observer asks the "client":
  - What did the "provider" do well to address rumours and misconceptions?
  - What communication skills did the provider use effectively?
  - What could the "provider" improve in her/his interaction to better help you?

SESSION 16: Helping Clients Make or Confirm Their Decisions

Objectives
By the end of the session, the participants will be able to:

- Identify the types of decisions clients might need to make.
- Explain how to help and support clients in making their own decisions and planning for follow up.

Total Session Time
90 minutes (one hour and 30 minutes)

Materials

- Flipcharts, markers, tape
- Post-it stickers
- Flipchart "Session objectives"
- Copies of WHO Medical Eligibility Criteria
- Flipcharts "new clients/returning clients/permanent method clients", Activity 2 step 2.1
- LCD projector if available/necessary

Handouts

- Handout 1 – Supporting Clients in Making Their Own Voluntary and Informed Decisions

Advanced Preparation
Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)
Introduce and review the session objectives (show them on flipchart or slide).
A fundamental purpose of FP client-centred counselling is to ensure that clients can make their own voluntary and informed decisions and choices. Therefore this phase of the counselling is the completion of a very important process that aims to support the rights of individuals to make choices for their health and well-being.

Activity 1: The WHO Medical Eligibility Criteria (30 minutes)

1.1 Different types of clients may need to make different types of decisions. However, sometimes clients may want a specific method that may not be medically suitable for them. In such cases it is important to clearly explain to the client that:

- The provider is not trying to force her/him to choose what the provider likes.
- There are medical reasons for discouraging the client from choosing that method, and explain what these reasons are in language that the client can understand, and inviting the client to ask questions for clarification.

1.2 In these situations it is useful to refer to the WHO medical eligibility criteria, which provides a chart highlighting eligibility criteria for each method. This chart is included in the participant's knowledge pack for this course and participants should have studied it before participating in this session. However, make sure that you have spare copies of the chart to distribute during the session if the need arises.

Briefly orient the participants to the chart. Ask them to identify the categories for as many medical conditions as time permits in order to practice how to use it, and address

misconceptions. Stress that this is a tool that they can use in counselling especially when they need to explain to clients why the method they want is not medically suitable. Explain that the OJT for FP clinical service provision will explore the use of these eligibility criteria in depth.

Activity 2: Supporting Clients in Making Their Own Voluntary and Informed Decisions (55 minutes)

2.1 Depending on the type of clients, there may be several and different decisions that they may need to make or confirm. Instructions for the next exercise:

- Ask the participants to imagine that we are at the end of the counselling process and the client is nearing the decision-making moment after she/he explored options.
- Divide the participants in pairs. Arrange the pairs in clusters by number counting 1-2-3 (depending on how many pairs you will have).
- All #1's pairs will discuss *new clients.* They should keep in mind that at this stage of the process some new clients may have a method in mind, but others may still be undecided.
- All #2's pairs will discuss *returning clients*. They should keep in mind that some returning clients may be happy with the method they have been using, while others may have problems with it.
- All #3's pairs will discuss clients who want permanent methods.
- Give several post-it stickers to each pair and show them the following flipcharts on the wall:

1. New clients with no method in mind Issues/Questions to consider and explore to help them make a voluntary informed decision:	**1. New clients with a method in mind** Issues/Questions to consider and explore to help them make a voluntary informed decision:

2. Returning clients satisfied with their method Issues/Questions to consider and explore to help them make a voluntary informed decision:	**2. Returning clients dissatisfied with their method** Issues/Questions to consider and explore to help them make a voluntary informed decision:

3. Client who want a permanent method Issues/Questions to consider and explore to help them make a voluntary informed decision:

- The pairs have 20 minutes to brainstorm issues to consider and some questions to ask their clients to help them make voluntary informed decisions. The pairs will write their issues/questions one per sticker and post them accordingly.
- Stop the exercise after 20 minutes. Once the stickers are posted, allow a few minutes for reading.
- Ask the participants to gather around the flipcharts and distribute Handout 1. Discuss similarities and difference.

2.2 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session

Participant's Handout

Session 16, Handout 1, Activity 2 – Supporting Clients in Making Their Own Voluntary and Informed Decisions

1. New clients with no method in mind Issues/Questions to consider and explore to help them make a voluntary informed decision: • What would they want to discuss further to clarify their need for FP? • Do they need more information to clarify if they need FP as well protection from STI? • Which method/s that was discussed during the counselling do they feel that meets their needs best? Would they like to review the key information about them?	**1. New clients with a method in mind** Issues/Questions to consider and explore to help them make a voluntary informed decision: • Do they need more information to clarify if they need FP as well protection from STI? • What additional information do they want about the method they have in mind? • Are there any other methods that the client wants to know more about before making a decision (to make sure that client really wants to rule out other methods)?

2. Returning clients satisfied with their method Issues/Questions to consider and explore to help them make a voluntary informed decision: • What has changed in their lives since they first used the method (e.g. new health concerns? New partners?) • What else would they like to know/assess about the method before confirming their decision? • Do they need to check any information about using the method correctly? • How are they managing re -supply (if needed)?	**2. Returning clients dissatisfied with their method** Issues/Questions to consider and explore to help them make a voluntary informed decision: • Do they clearly understand what other options mean or require? Would they like to discuss these issues further? What specifically? • What would discontinuation mean? When would the client need protection again? What would be the family and social implications? • Does the client clearly understand what switching methods involve? What would the client want to clarify? How would the client cope with different requirements of the method? What would be the implications for the client's relationship?

Important Considerations for Permanent Methods Clients:

- Permanent methods (female sterilization and male vasectomy) are surgical methods and there are some risks associated with this (infection, bleeding, anaesthesia-related problems, and method failure). The client needs to understand these risks, even if they rarely occur.
- The client needs to understand that these methods are considered **permanent**. Reversal is not a realistic possibility for most clients (might not be available; Are

usually costly; Often fail; Require that the doctor have special skills; Might not be appropriate for some individuals due to medical factors).

- Because of the permanent nature of female sterilization and vasectomy, **informed and voluntary decision making** must be documented on an **informed consent** form signed by the client.

Informed Consent for Permanent Methods Must Address the Following Seven Elements:

1. **Temporary methods of contraception are available** to me and my partner.
2. **The procedure to be performed on me is a surgical procedure,** the details of which have been explained to me.
3. **This surgical procedure involves risks, in addition to benefits,** which have been explained to me, and I understand the information that has been given to me. Among the risks is the possibility that the procedure might fail.
4. If the procedure is successful, **I will be unable to have any more children.**
5. **The effect of the procedure should be considered permanent.**
6. **The procedure does not protect me or my partner against infection** with sexually transmitted infections, including HIV/AIDS.
7. **I can decide not to have the operation at any time before the procedure is performed, even on the operating table** (without losing the right to medical, health, or other services or benefits).

Additional Considerations:

8 Preventing Regret

Factors contributing to sound decision making	**Factors contributing to possible regret**
• Mature age • Desired family size achieved • Partner in agreement • Marital stability • Well-considered decision	• Young age • Few or no children • Partner's doubt • Pressure from partner, relatives, or service provider • Marital instability • Unrealistic expectations • Unresolved conflict or doubt • Excessive interest in reversal • Decision made under stress (during labour or immediately before or after an abortion)

Adapted from: USAID | the ACQUIRE Project, 2008: Counselling for Effective Use of FP, Trainer's Manual

SESSION 17: Demonstrating Skills for Effective FP Client-Centred Counselling: Counselling Practice

Objectives

By the end of the session, the participants will be able to:

- Demonstrate skills for effective FP client-centred counselling
- Use effectively checklist for peer-based assessment and provide constructive feedback.

Total Session Time

180 minutes (three hours)

Materials

- Flipcharts, markers, tape
- Flipchart "Session objectives"
- Sufficient copies of role-play scenarios
- Medical Eligibility Criteria chart/wheel
- LCD projector if available/necessary

Facilitator's Resources

- Role-Play Scenarios

Handouts

- Handout 1 – Counselling Skills Role-play Checklist

Advanced Preparation

Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)

Introduce and review the session objectives (show them on flipchart or slide). This session aims to provide the participants with opportunities to consolidate the learning through the program, demonstrate attitudes that support FP/MNCH client-centred counselling, use the knowledge their expanded knowledge and practice the skills acquired so far. Participants will also improve their skills to give and receive constructive feedback from peers and trainers by using a role-play observation checklist that mirror those used for competency based observations.

Activity 1: Role-Play Demonstrations by Trainers (40 minutes)

1.1 Distribute Handout 1, i.e. the Counselling Skills Role-play Checklist. Briefly review it with the participants. Explain that you and another trainer will demonstrate two short role-plays to show a "bad" and a "good" interaction. The participants should observe the role-plays using the checklist. However, explain the following overarching recommendations for providing feedback (show on flipchart):

- The feedback is given to the person playing the "provider" to highlight what was done well, what was missing, and what was wrong.
- Every time, feedback must be constructive. For this purpose, we always start from what was done well.
- When giving feedback on what needs improving, it is good practice to say *"I would do this or that in such and such a way because …."*. Highlighting only *what* needs improving is not very useful. Feedback should also suggest *how* it can be

done differently.

- The feedback session is not a debate. The person receiving feedback may accept it or not, but she/he will do so privately. Feedback is not about defending one's own performance. Being defensive does not help learning.

1.2 Demonstrate a role-play at a time and have the participants practice giving feedback using the checklist. It is useful at this stage to give feedback to the participants on how they use the checklist.

Activity 2: Participants' Role Plays / Return Demonstration (140 minutes)

2.1 Explain the process:

- Participants will work in small groups of three people (or in pairs, depending on the total number in the group) for about 60 minutes. Each group/pair will receive role-play scenarios (please refer to the **Facilitator's Resource** section below).
- They will use the first 10 minutes to rehearse. In performing their role-play, **they are expected to use the chart of the Medical Eligibility Criteria.**
- Each role play should not be longer than 8-10 minutes. Participants will take turns to play the "client" and the "provider" characters in the-role plays, as well in playing the role of observer to give feedback using the Counselling Skills Role-play Checklist.
- At the end of their group/pair practice, each group will perform in front of the larger audience and receive feedback, first by the audience and then by the trainers (they will use the Counselling Skills Role-play Checklist when giving feedback).

2.2 Stop the group/pair practice after 60 minutes. Conduct a rapid energizer and begin the second phase, i.e. the role-plays in front of the other groups/pairs and the trainers and feedback.

2.3 Reserve the last 10 minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Facilitator's Resources

Role-Play Scenarios

Print, cut and distribute for group practice. Select, adapt, or develop other scenarios that you feel are more representative of the real client profiles in the settings where your participants work.

1. A 24 year-old woman with three children comes to see her clinician. She wants to practice some method of FP. She is not sure about having any more children. She has heard that the IUD causes a lot of bleeding.

2. A 20 year-old lactating woman, with a three month-old baby wants to postpone her next pregnancy. Her sister uses the COC and likes that method very much. She says she wants to use the COC.

3. A 19 year old, unmarried woman comes to see the clinician. She explains that she and her fiancé are having sexual relations and she is worried about becoming pregnant before she is married.

4. A woman, age 25, has just had a son and does not want to have another child. She is interested in having an IUD, like her colleagues at work. Her husband is very caring for her and the baby, and he believes that they should not have another child so as to take better care of their son.

5. A male client, age 26, is using condoms with his girlfriend and with other girls he meets occasionally. Last night the condom slipped during intercourse, and he is concerned his girlfriend might get pregnant.

6. A female client, age 27, comes to the FP station saying that she forgot to take her last two pills (yesterday and the day before) while she was lying in bed sick with the flu. She has been married for one year, and she and her husband believe that they are not ready to have a child yet.

7. A female client, age 29, HIV positive, divorced with two children (they are HIV negative), wants to have a method to use with her new partner with whom she plans to get married. He has been using male condoms with her, and she has not told him yet about her HIV status.

8. A male client, age 34, married. His wife is 27 years old. They have four children. He is interested in vasectomy because he feels he has completed his family and he wants to enjoy himself without any worries about getting more children. However, during the medical examination you find out he has an STI.

Adapted from: 1) CATALYST Consortium / Pathfinder International: Optimal Birth Spacing and Family Planning Counseling Training Manual, and 2) USAID | the ACQUIRE Project, 2008: Counselling for Effective Use of FP, Trainer's Manual

Participant's Handouts

Session 17, Handout 1, Activity 1 – Counselling Skills Role-play Checklist

Instructions: Use the checklist to record your observations of the role play. Observe the counselling process as well as content. For example: Does the counsellor address the problem adequately? Does s/he address the "client's" concerns? Is the information given correct and complete? Does the "counsellor" explore the "client's" life circumstances? Does the "counsellor" explore societal influences on the "client's" ability to make decisions? Does the "counsellor" support the client in making her/his own choices and decisions? Does the "counsellor" support the "client" in problem-solving to implement plans and decisions?

TASK	Performed	
	Yes	No
Counsellor's Nonverbal Communication:		
Friendly/welcoming/smiling?		
Non-judgmental?		
Listens attentively/nods head to encourage and acknowledge client's responses?		
Appears rushed/impatient?		
Counsellor's Verbal Communication:		
Phrases questions clearly and appropriately? Uses non-technical terms?		
Listens to client's responses closely?		
Answers client's questions?		
Uses language the client can understand?		
Counselling Process and Content:		
Greets the client in a friendly and respectful manner? - Greets the client politely, according to local custom? - Offers the client a seat? - Explains that provider may ask personal questions of all clients to better help them select and use FP and stresses that everything is **confidential** (i.e., that no one outside the counselling room will learn what is discussed)? - Asks open-ended questions to encourage the client to speak?		
Asks client about self? - client's needs and concerns? - reproductive goals?		
Provides client information on optimal birth spacing and FP methods? informs about optimal birth spacing and all methods available? asks which method interests client? asks what client knows about method? corrects myths/rumours/incorrect information? describes how method works and its effectiveness? uses A/V aids during counselling? describes benefits and risks? describes potential side effects? answers client's questions clearly?		

Explores the clients' social and relationship issues? asks about the client's additional concerns? asks about spouse/partner's support? asks about the client's sexual relationship/s? asks about the client's issues in discussing/negotiating with spouse/partner? asks about any pressure the client is facing in relation to her/his FP decisions?		
Helps client to reach an informed decision? asks if anything not understood? asks "what method do you want?" encourages the client to ask any additional question?		
Provides more information on the selected method? explains clearly what client has to do to use method successfully? instructions to client are complete and clear? asks client to repeat back instructions? reminds client of potential minor side effects? reminds client of danger signs? explains to client what to do if problems?		
Plans a follow-up visit?		
Problem Solving:		
Does "counsellor" respond appropriately to the client's needs and problems?		
Is "counsellor" convincing on advice given?		
Is advice given/method provided appropriate?		
Does "counsellor" treat client/family with respect?		
Is the counselling: counsellor-controlled? client-controlled? balanced?		
Additional comments:		

Adapted from: Indian Medical Association/Development Associates, 1994: Family Planning Course, Module 2: Counselling for Family Planning Services

SESSION 18: Concluding the Course

Objectives
By the end of the session, the participants will be able to:

- Self-assess their course learning.
- Identify doable steps to integrate their learning into their work practice.
- Evaluate the course.

Total Session Time
75 minutes (one hour and 15 minutes)

Materials

- Flipcharts, markers, tape
- Flipchart "Session objectives"
- Sufficient copies of the participant's self-assessment questionnaire (Appendix 1)
- Sufficient copies of the end of course evaluation form (Appendix 4)
- Sufficient copies of the Individual Action Plan Form provided in Appendix 5 (this form should be distributed the day before conducting this session)

Advanced Preparation
Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

> ***Note for Facilitators***
>
> Facilitators should distribute the Individual Action Plan Form the day before conducting this session and ask the participants to complete it before the next day. Therefore, participants will be expected to come to this session with their individual action plans already developed.

Introduction to the Session (5 minutes)
Introduce and review the session objectives (show them on flipchart or slide).
This is the last session of the course. It provides an opportunity for the participants to self- assess what they have learnt through the course, to develop their individual action plans, and to evaluate the course to enable improvements and revisions for the future use of the program.

Activity 1: Post Course Self-Assessment (20 minutes)
1.1 Distribute blank copies of the same form that was used for the self-assessment at the beginning of the course. Remind the participants to use the same personal identification code that they used for the initial self-assessment. The facilitator/s will compile the pre and post self-assessment scores during Activities 2 and 3 in order to return both forms to each participant by the end of the session.

Activity 2: Individual Action Plans (25 minutes)
2.1 Ask the participants to mingle for 10 minutes to share their action plans with others in the group. Stop this informal sharing after 10 minutes and facilitate a discussion:

- Each participant shares at least two actions from her/his plan.
- The other participants offer their advice, comments, and suggestions to pre-empt or overcome challenges to implement those actions.

Activity 3: End of Course Evaluation (25 minutes)

3.1 Distribute the end of course evaluation form to each participant (see Appendix 4) and allow 15 minutes for completion.

3.2 Finally, invite the participants to sit in a circle and give them an opportunity to express their final thoughts about the course. Conclude by thanking the participants, and distribute the certificates of participation if they have been planned by the organizers.

APPENDIX 1: PRE AND POST COURSE PARTICIPANT'S SELF-ASSESSMENT QUESTIONNAIRE

Dear Participant,

This questionnaire aims to help you self-assess your learning in this course. You will be given the same form at the end of the course and you will be able to see how much you have learnt.

Nobody except you will know that these are your answers. Simply create your own PIC (personal identification code), just like a password or a bank pin. You can use letters, numbers, or a combination of letters and numbers, for example A1R. The most important thing is that you will find a way to remember your PIC because you will have to use it again when you fill in this questionnaire at the end of the course. Please make sure to write your PIC somewhere safe where you will be able to find it when you need it at the end of the course.

PIC: _____ Date: _____

QUESTIONS:

1. Which of the following is **not** a definition of quality in health care services?

    a. Providing services which meet essential clinical standards of care.
    b. Meeting the needs, expectations, and requirements of clients and other customers with a minimum of effort, rework and waste.
    c. Doing the right thing, right, right away.
    d. Striving for and reaching agreed levels of care that are accessible, equitable, affordable, acceptable/patient centred, effective, efficient and safe.

2. Which of the following is **not** an element of client-centred approach?

    a. A client-centred approach is based on recognizing that clients are equal partners with health services in improving their own health outcomes.
    b. In a client-centred approach, providers aim to find out accurate information about clients in order to fully understand their needs.
    c. In a client-centred approach, providers make decisions on behalf of clients
    d. A client-centred approach means enabling clients to find solutions to their specific problems.

3. Which of the following is **not** a correct principle of integration of health services?

    a. Providing integrated services means that health care providers use a client visit as an opportunity to engage the client in exploring and addressing her/his broader health and social needs than those prompting the encounter.
    b. When integration is applied to FP in MNCH, the goal is to use all available opportunities to reach clients with the FP services that can be provided at that specific entry point in the health system.
    c. The fundamental principle of integration is to have health facilities that can

provide clients with all services under one roof.

d. Integration of FP/MNCH also means that only specific FP services may be provided during the client visit while the client is referred somewhere else for other FP/MNCH services.

4. Which clients' rights are missing in the following list?

Information; Access to services; informed choice; confidentiality; dignity; comfort.

---

5. Which of the following is **not** required for a client to be able to make an informed choice?

e. Service provider's recommendation
f. Availability of appropriate information
g. Voluntary decision-making process
h. Availability of adequate service options

6. Which of the following issues **is** a key service delivery factor affecting voluntary and informed decision making?

a. Providers' attitudes to clients' rights and ability to make their own decisions.
b. Providers' awareness of the power imbalance between them and clients.
c. Providers' attitudes to specific client groups, e.g. adolescents, post-abortion clients, men, etc.
d. Providers' understanding of how social and cultural values may affect a client's decision making process.
e. All

7. Which of the following issues **is** a key service delivery factor affecting provision of appropriate information to clients?

a. Providers' attitudes to discussing intimate issues, including sexuality, with all types of clients.
b. Providers' skills in information giving about a range of FP/MNCH related topics.
c. Time available to provide information and answer clients' questions.
d. Use of staff other than doctors and nurses to provide information to clients, as appropriate.
e. All

8. Which of the following is **not** found in definitions of gender?

a. A social construct.
b. Biological sex.
c. Power imbalances due to the norms and roles associated with being a man or a woman.
d. Social and cultural expectations and norms that in a society define or influence opportunities for men and women.

9. Which of the following is **not** correct?

a. Sexuality is a central aspect of being human.
b. Sexuality means biological sex and sexual intercourse.
c. Sexuality includes thoughts, feelings, and fantasies.
d. Sexuality is the result of a personal and social process of development.

10. Which one of the following is **correct**?

a. The counsellor should not discuss sexuality with clients unless the client raises the issue.
b. The counsellor should inform the client that certain sexual practices are right or that some are wrong.
c. Sexuality is mostly about sexual intercourse.
d. The counsellor should help clients explore possible health risks in their sexual practices and relationships, implications for choosing a method, and any need for treatment/referral/follow up.

11. Which of the following is **not** a type of power in sexual relationships?

a. Power within.
b. Power to.
c. Power with.
d. Power over.
e. Power above.

12. Which of the following is **not** a fundamental IPCC area of skill?

a. Respect for clients
b. Praise and encouragement
c. Eliciting information
d. Summarizing information
e. Nonverbal communication

13. Which of the following is **not** a purpose of asking questions in counselling?

a. To establish a good relationship by showing concern and interest.
b. To determine what educational/language level will be most easily understood by the client.
c. To decide whether to allow the client to make her/his own decisions.
d. To learn what the client already knows and avoid repeating such information.

14. Which of the following is **incorrect** about giving information to clients?

a. Information should be tailored to clients' needs.
b. First the counsellor should explore what the client already knows.
c. The counsellor should start with the method used most frequently in the country.
d. The counsellor should check whether the client understands the information givenduring the counselling session.

15. Which of the following is **not** an element of an effective FP client-centred counselling process?

a. Respecting the priorities and concerns identified by a client.

b. Utilizing active listening techniques.
c. Offering directives, not options.
d. Acknowledging unique context of client's life and circumstances.

16. Which of the following is **not** a role of providers in ensuring quality counselling?

a. Engage in two-way communication with the client.
b. Ensure confidentiality.
c. Ensure that the client's family can make decisions for the client.
d. Support the client in making her/his own informed choices and decisions.

17. Which of the following is **not** a good technique to correct clients' misconceptions about FP methods?

a. Find out what clients have heard about FP methods and their concerns about the methods.
b. Show that you dismiss the client's misconception.
c. Ask where the client heard the misconception or rumour.
d. Explain that the misconception or rumour is not true without offending or upsetting the client.

18. Which one of the following **is not** among the information elements of informed consent for permanent methods?

a. Temporary methods of contraception are available to the client and his or her partner.
b. The procedure to be performed on the client is a surgical procedure.
c. The client can have the procedure reversed if he or she decides to have children again.
d. The procedure does not protect the client or the partner from infection with HIV or other STIs.

APPENDIX 2: KEYS FOR THE PRE AND POST COURSE PARTICIPANT'S SELF-ASSESSMENT QUESTIONNAIRE

The correct answers are highlighted in **bold**.

1. Which of the following is **not** a definition of quality in health care services?

   a. Providing services which meet essential clinical standards of care.
   b. Meeting the needs, expectations, and requirements of clients and other customers with a minimum of effort, rework and waste.
   c. Doing the right thing, right, right away.
   d. Striving for and reaching agreed levels of care that are accessible, equitable, affordable, acceptable/patient centred, effective, efficient and safe.

2. Which of the following is **not** an element of client-centred approach?

   a. A client-centred approach is based on recognizing that clients are equal partners with health services in improving their own health outcomes.
   b. In a client-centred approach, providers aim to find out accurate information about clients in order to fully understand their needs.
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   a. Providing integrated services means that health care providers use a client visit as an opportunity to engage the client in exploring and addressing her/his broader health and social needs than those prompting the encounter.
   b. When integration is applied to FP in MNCH, the goal is to use all available opportunities to reach clients with the FP services that can be provided at that specific entry point in the health system.
   c. The fundamental principle of integration is to have health facilities that can provide clients with all services under one roof.
   d. Integration of FP/MNCH also means that only specific FP services may be provided during the client visit while the client is referred somewhere else for other FP/MNCH services.

4. Which clients' rights are **missing** in the following list?

   Information; Access to services; informed choice; confidentiality; dignity; comfort.

   Safe services; privacy; comfort; expression of opinion; continuity of care

5. Which of the following is **not** required for a client to be able to make an informed choice?

a. Service provider's recommendation
b. Availability of appropriate information
c. Voluntary decision-making process
d. Availability of adequate service options

6. Which of the following issues **is** a key service delivery factor affecting voluntary and informed decision making?

a. Providers' attitudes to clients' rights and ability to make their own decisions.
b. Providers' awareness of the power imbalance between them and clients.
c. Providers' attitudes to specific client groups, e.g. adolescents, post-abortion clients, men, etc.
d. Providers' understanding of how social and cultural values may affect a client's decision making process.
e. All

7. Which of the following issues **is** a key service delivery factor affecting provision of appropriate information to clients?

a. Providers' attitudes to discussing intimate issues, including sexuality, with all types of clients.
b. Providers' skills in information giving about a range of FP/MNCH related topics.
c. Time available to provide information and answer clients' questions.
d. Use of staff other than doctors and nurses to provide information to clients, as appropriate.
e. All

8. Which of the following is **not** found in definitions of gender?

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e. during the counselling session.

15. Which of the following is **not** an element of an effective FP client-centred counselling process?

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c. The client can have the procedure reversed if he or she decides to have children again.
d. The procedure does not protect the client or the partner from infection with HIV or other STIs.

APPENDIX 3: PARTICIPANT'S DAILY EVALUATION AND REFLECTION FORM

Day of course: _____ Date: _____

1. How much did you benefit from today's sessions?

   Very much ____ Much ____ Not much ____

2. What are the most important things you learned from today's sessions? Why?

   _____

   _____

3. What action do you plan to take to apply to your work the ASK (attitudes-knowledge-skills) you learned today?

   _____

   _____

4. What should be improved for the next days? How?

   _____

   _____

   Other comments:

   _____

   _____

APPENDIX 4: PARTICIPANT'S COUNSELING TRAINING END OF COURSE EVALUATION FORM

Please do not write your name on this form.

Duration of your course (how many days):

Dates of your course: _____

Venue: _____

Section 1: Attitudes

1.1 How did the course help you to expand your understanding of how attitudes may support or hinder access to and quality of FP/MNCH services?

Very effectively☐ Effectively☐ Adequately☐ Non enough☐

1.2 How did the course help you to reflect on how your own attitudes may affect access to and quality of FP/MNCH services?

Very effectively☐ Effectively☐ Adequately☐ Non enough☐

1.3 How did the course help you to consider/develop alternative or more useful attitudes to enhance FP/MNCH service provision?

Very effectively☐ Effectively☐ Adequately☐ Non enough☐

1.4 How did the course help you better understand client's attitudes that may influence their access to and use of FP services?

Very effectively☐ Effectively☐ Adequately☐ Non enough☐

1.5 How did the course help you to develop a problem-solving attitude to enhance FP/MNCH service provision?

Very effectively☐ Effectively☐ Adequately☐ Non enough☐

Your comments:

_____

_____

_____

Section 2: Knowledge

2.1 How did the course help you draw from your knowledge and experience?

Very effectively☐ Effectively☐ Adequately☐ Non enough☐

2.2 How did the course help you expand existing knowledge and acquire new factual knowledge useful for your work?

Very effectively☐ Effectively☐ Adequately☐ Non enough☐

2.3 How did the course help you to apply existing and new knowledge to your work?

Very effectively☐ Effectively☐ Adequately☐ Non enough☐

2.4 How did the course help you reflect on what you were learning, and why it was useful for your work?

Very effectively☐ Effectively☐ Adequately☐ Non enough☐

2.5 How did the course help you learn elements of innovation in your work?

Very effectively☐ Effectively☐ Adequately☐ Non enough☐

Your comments:

_____

_____

_____

Section 3: Skills

3.1 How did the course enable you to share the skills that you already had?

Very effectively☐ Effectively☐ Adequately☐ Non enough☐

3.2 How did the course enable you to strengthen your existing skills?

Very effectively☐ Effectively☐ Adequately☐ Non enough☐

3.3 How did the course enable you to develop new skills?

Very effectively☐ Effectively☐ Adequately☐ Non enough☐

3.3 How did the course enable you to practice how to apply new skills?

Very effectively☐ Effectively☐ Adequately☐ Non enough☐

Your comments:

_____

_____

_____

Section 4: Course design

4.1 How do you find the order of the sessions?

Very useful☐ Useful☐ Not useful☐

Please explain why:

_____

_____

_____

4.2 How do you find the topics covered?

Very useful☐ Useful☐ Not useful☐

Please explain why:

_____

_____

_____

4.3 How do you find the materials provided (e.g. handouts)?

Very useful☐ Useful☐ Not useful☐

Please explain why:

_____

_____

_____

4.4 What additional topics, if any, should be covered to make the course more useful?

_____

Very useful☐ Useful☐ Not useful☐

Please explain why:

_____

_____

_____

Section 5: Facilitation

5.1 How effective was the facilitation to enable your active participation?

Very effective☐ Effective☐ Adequate☐ Inadequate☐

5.2 How effective was the facilitation to help you explore and analyse issues?

Very effective☐ Effective☐ Adequate☐ Inadequate☐

5.3 How effective was the facilitation to help you use existing and new knowledge?

Very effective☐ Effective☐ Adequate☐ Inadequate☐

5.4 How effective was the facilitation to help you use your existing skills and develop new ones?

Very effective☐ Effective☐ Adequate☐ Inadequate☐

Your comments:

_____

_____

_____

Section 6: Additional Comments

Please write any additional comments on any other issues relevant to this course you wish to offer

_____

_____

_____

_____

Thank you!

APPENDIX 5: INDIVIDUAL ACTION PLAN FORM

Dear Participant,

You are now almost at the end of your participation in this course. We would like to give you an opportunity to think of specific actions you will take to bring your learning from this course into your work. We also hope that you will use this form as an additional tool to help you assess your performance in the future.
Thank you!

#	Specific action to be taken	Reason for selecting this action	Time – by when this action will be implemented	Indicator
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

What opportunities and resources (people, materials, management support, extra skills, etc.) do you have that will help you implement your action plan?

_____

_____

_____

What barriers might impede implementation?

_____

_____

_____

How will you overcome these barriers?

_____

_____

_____

What resources (people, materials, management support, extra skills, etc.) will you need to complete the implementation of your action plan?

_____

_____

_____

Any other comments?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Family Planning

On-the-Job Training Curriculum

COURSE 1: COUNSELLING TRAINING

Facilitator's Manual

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