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Saving lives. Improving health.
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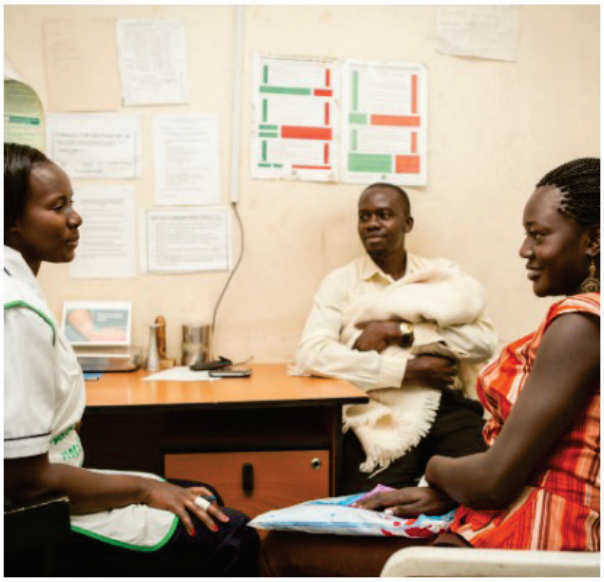
Gender Transformation for Health

A Participatory Toolkit







February 2019

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Jhpiego is a nonprofit global leader in the creation and delivery of transformative health care solutions that save lives.

In partnership with national governments, health experts and local communities, we build health providers' skills, and we develop systems that save lives now and guarantee healthier futures for women and their families. Our aim is revolutionizing health care for the planet's most disadvantaged people.

Jhpiego is a Johns Hopkins University affiliate.

Published by:
Jhpiego Corporation
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Baltimore, Maryland 21231-3492, USA
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Modules

Target Audience

The sessions in this toolkit are geared toward health workers in Jhpiego-supported programs and health facilities. As the session inventory indicates, some activities are also geared toward health programmers and those managing public health programs in low- and middle-income countries. The toolkit aims to provide participants with knowledge and skills to provide high-quality, gender-sensitive, and transformative services to individuals and couples including females, males, and lesbian, gay, bisexual, transgender, and intersex (LGBTI) clients.

Content of the Toolkit

This toolkit includes nine modules with participatory sessions that cover the following topics:

1. Gender and Social Norms
2. Gender-Based Violence
3. Gender as a Health Determinant
4. Sexuality and Sexual Diversity
5. Responding to Sexuality and Sexual Diversity in a Health Facility
6. Gender-Sensitive and Rights-Based Care
7. Gender Analysis
8. Couples Counseling Skills
9. Male-Friendly Services

What We Mean by Participatory

As the toolkit's title suggests, sessions are designed to be participatory. Sessions present situations and problems, and participants are facilitated to come up with creative solutions together. This participatory approach allows for creativity, reflection, and action upon reality. It does not entail a trainer passing on knowledge to passive learners; rather, participants are actively engaged by the facilitator and each other. This approach recognizes participants as thinking, creative individuals with the capacity for action, who bring their own unique experiences and realities to the learning environment.

How to Use the Toolkit

Facilitators may implement the sessions in the toolkit in a variety of ways, depending on time and resources available. They may choose to implement all sessions within a particular module that aligns with the program objectives, or they may choose to select specific sessions from multiple modules. Regardless of how you organize the sessions, the following guidance will ensure participant learning and minimize harm:

- Begin the workshop with exercises that allow participants to feel relaxed and get to know each other. This will ensure that they feel safe and comfortable throughout the workshop.
    - To start the workshop, you may choose to facilitate a discussion on group norms for participants to adhere to during the workshop. As facilitator, you can write the norms that participants suggest on flipchart paper, and display the paper throughout the workshop. You may also wish to use external resources, such as the World Health Organization's *Training Curriculum: Gender*

and Rights in Reproductive Health, which includes a group contract session (page 24) and a welcome and introduction session (page 20).

  - The "Gender-Focused Ice-Breaker" from this Gender Transformation Toolkit is an effective session to begin the workshop with, regardless of whether you facilitate the entire "Gender and Social Norms" module from this toolkit.

- The "Gender Terms and Definitions" session is foundational, and facilitators are strongly encouraged to include it if the session's objectives have not been covered previously.
- The "Violence in Daily Life" session should never be facilitated as a standalone session, and must always be preceded by either the "'What Is Violence?" session or the "Circles of Influence" session. In addition, this session should only be facilitated as part of a broader workshop lasting at least 3 days to allow for trust building within the group, and to ensure participants have had the time to reflect on social norms and their own personal perceptions.

Please note that select sessions from Jhpiego's Gender 101 Training Manual have been included in this toolkit. These sessions, denoted as such in the **session inventory**, provide a basic understanding of gender and its impact on health service delivery and sexual and reproductive health outcomes.

Session Format

Each session is formatted as follows:

- Learning objectives of the session
- Time required for the session
- Materials needed for the session
- Advance preparation the facilitator will need to complete before leading a session
- Steps for leading the session
- Facilitator notes on the session process and important points to be made during the session
- Participant handouts that may be given out during or at the end of the session
- Facilitator resources needed to lead the session

Learning Objectives

- The learning objectives are what participants should learn as a result of completing the session. It is a good idea to begin each session with a description of its learning objectives. This helps participants understand why they are doing the session and what they can hope to get out of it.

Time

- Time indicates how long the session should take. Depending on various factors, such as the number of participants, the time for completing each session could vary. It is important to work at the pace of the participants. It is also important to remember that any agenda for a workshop is usually a full one. Taking too long on one session may mean you do not have time to complete others. Try to stick to the time suggested.
- Note that sessions include steps that require breakout work in small groups (for example, case studies, role plays, and reflection). It is important to help facilitate smooth transitions between plenary discussions and smaller group activities. Ensure that the space is set up in advance with

nearby areas available for breakout work, notify participants when they have 5 minutes left for group work, and rally groups with your co-facilitator when it is time to move from smaller group exercises to plenary.

Materials Needed

- These are the materials you will need for each session. You will need to prepare some of them before the workshop begins. For the most part, they include basic materials such as flipchart paper and markers. In cases where the materials listed cannot be easily accessed, you should feel free to improvise.

Advance Preparation

- This section will inform you about any preparations you should make before conducting the session.

Facilitator Notes

- These notes will help you to facilitate the session. They point out important aspects of the process, as well as background information and tips to help you prepare. Make sure to read these notes before you begin. Some facilitator notes will also indicate whether the session should be delivered only after other sessions have been covered.

Introduction

- This section provides the facilitator with an opening statement for the session. You are free to adapt this to create your own opening statement.

Steps

- These are the steps you should follow to facilitate the session effectively. Follow the steps in the order in which they appear, and remain mindful of the time allotted for each step.

Closing

- This section highlights the key points that participants should retain from the session. It may be helpful to refer to these key points as you facilitate group discussions. You can also use them to sum up the discussion at the end of the session. As with the opening statement, feel free to use your own words to deliver these messages.

Participant Handouts

- Some sessions include handouts with information for participants to take away with them or for you to review with them. Some handouts include information participants need to complete in a particular part of a session. You should refer to the “Advance Preparation” section to determine the number of copies you will need to make of each handout. Handouts will appear at the end of the session description; not all sessions include participant handouts.

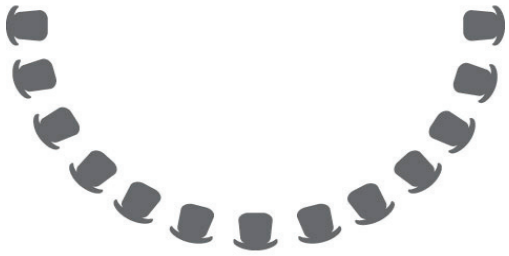
Facilitator Resources

- Some sessions include additional information for the facilitator to review while preparing. Not all sessions include facilitator resources.

Reflective Practice and the Power of the Circle

Reflective practice differs from classic training workshops in that the facilitator leads participants through a process of learning and personal introspection, as opposed to simply delivering information in a didactic manner. Reflective practice acknowledges that participants are also experts by virtue of their personal experiences, and it recognizes that everyone "has a piece of the truth." To enable the learning and self-reflection process, it is useful to seat participants in a large semicircle (see Figure 1). This seating arrangement encourages a sense of community and positions everyone at the same level. You may place a few small tables against the walls at the back of the room and use them to set materials on. Seating participants at a table creates a more formal atmosphere and tends to encourage participants to focus on taking notes rather than interacting with and listening to others. Laptops should not be allowed in a reflective practice workshop as they disrupt the learning process and can be distracting for the facilitator and other participants.

Figure 1. Seating participants in a large semicircle supports learning and self-reflection.



Role of the Facilitator

Leading this workshop is a great opportunity to share awareness, inspiration, healing, and empowerment with others. As workshop leader, your job will be to:

- Help participants feel welcome, valued, and safe
- Encourage respectful listening and dialogue
- Facilitate workshop sessions

What **is not** expected of you as a facilitator:	What **is** expected of you as a facilitator:
• You **are not expected** to be an expert on all of the issues that might arise in this workshop. No one person can know it all. • You **are not expected** to have the answer to every question that might arise. If you do not know the answer, say so! Someone in the group may have an answer, or the group may come up with an answer together. • You **are not expected** to do everything perfectly. You will make mistakes. Use these mistakes as learning opportunities. (It is important for the group to see you acknowledge and work through mistakes, awkwardness, and difficulty. It is an essential part of learning!)	• You **are expected** to guide participants through the workshop. Sometimes, this means actively steering the group's conversation, and sometimes this means stepping back and letting group members develop their own ideas. • You **are expected** to help every member of the group feel welcome, safe, and respected. Everyone should have a chance to share their ideas, experiences, and opinions. • You **are expected** to provide gentle guidance, support, and encouragement to individuals and to the group as a whole, particularly when things get difficult.

What **is not** expected of you as a facilitator:	What **is** expected of you as a facilitator:
• You **are not expected** to be responsible for each participant's learning and change. This is not something you can control; each member is responsible for himself or herself.	• You **are expected** to keep the larger picture in mind. Remember the goals of the workshop and bring the group back to those goals when necessary. • You **are expected** to model gender equality—with your co-facilitator, group members, and everyone with whom you come into contact during the workshop.

Facilitation Guidelines

- **Keep the end in mind.** Know what you are doing and why you are doing it. Be sure that participants are clear about the purpose and goals of the workshop and of each session.
- **Be flexible.** Be prepared to adapt or skip a session to meet the specific needs of a group or situation. Reassure participants that it is okay to leave some of the sessions and discussions unfinished. This is a lifelong process, and participants can continue to meet as a group or individually to talk, learn, and plan together.
- **Encourage participation.** Ask the group questions and encourage participants to ask questions. Show appreciation for all comments (even if you disagree with them).
- **Pay attention to who speaks and who does not.** Ask people to be mindful of sharing speaking time in the group. You may need to ask people who speak up often to hold their thoughts to create space for people who have not yet spoken.
- **Help the group learn and practice dialogue skills.** Listen to each participant with respect and compassion rather than criticism. Explain that differences in experiences and opinions are an opportunity for learning, not judgment.
- **Encourage participants to engage and talk about their emotions.** The deepest, most effective learning involves both the mind and the heart.
- **Everything that happens is a learning experience, especially situations that seem challenging.** Remind participants that you are learning from each other and with each other all of the time.
- **Use yourself and your experiences as examples.** Trust the value of your experience and perspective. The workshop is a learning experience for you too. Share with the group what you are learning.

Benefits of Working with a Co-facilitator

- A co-facilitator equally shares the responsibility of leading and facilitating the workshop. You are encouraged to use two facilitators for this workshop because:
  - You can share the responsibility for the workshop. (It is hard work!)
  - You will have someone to help keep track of the important tasks and details of the workshop and each session.
  - It brings an additional perspective on gender and another set of life experiences and wisdom into the large group.

- It can provide participants with an excellent model of cooperation, connection, and gender equity when things are going well. It can also provide an excellent model of dialogue and conflict resolution when things are challenging.
- Your co-facilitator can help you to check your perceptions about what is happening in the group and to think about and address group dynamics, and provide feedback on your facilitation.
- Having co-facilitators brings a mix of facilitation styles and personalities to the session, helping to keep the energy fresh and engaging.
- Each facilitator can learn from the skills and perspectives of the other.

Co-facilitation Preparation

- The relationship between co-facilitators has a big impact on the workshop. It is important that you meet with your co-facilitator at least twice before the workshop to get to know each other, review the workshop sessions, and work out the details of your workshop plan.
- Discuss your experiences as participants in previous workshops: What was most valuable to you? What seemed most effective for others in the group? What did you notice about the facilitation? Was there anything you did not like?
- If you have previously worked together as co-facilitators, talk about the last time you facilitated together: What went well? What was challenging? What would you do differently? How can you improve the experience for workshop participants?
- Carefully review the workshop and session objectives.
- Review the session descriptions. Discuss their potential challenges, how to avoid these challenges, and how to deal with them if they occur.
- Decide who will serve as lead facilitator for each session.
- Despite our best efforts, things do not always go as planned. Discuss contingency plans for each day. What sessions can you shorten or skip if you run out of time?
- Set times during the day for the two of you to check in with each other.
- Talk specifically about how you will manage the beginning and ending of the workshop.
- Review the **Managing Conflict** section and talk about effective conflict management strategies you have observed.

Co-facilitation During the Workshop

- Be open to thoughts, feedback, and help from your co-facilitator. Your co-facilitator may notice something happening during the workshop that you missed. If you feel stuck or unsure about something, ask your co-facilitator for his or her thoughts. In addition, when you are leading, make a habit of asking your co-facilitator for input or if he or she has anything to add.
- Take time during and after the workshop to check in with your co-facilitator. This will give both of you the opportunity to check your perceptions, give and receive feedback, and strategize about what happens next.
- When you are leading a session, be sure to make eye contact with your co-facilitator. This will give your co-facilitator a chance to get your attention (if necessary) without disrupting the session. It will also give you an opportunity to see if your co-facilitator has something to add to the conversation.

- When your co-facilitator is leading, scan the room to get a sense of what is happening in the group. Check for reactions, participation levels, and nonverbal communication. Gently interrupt you co-facilitator if you think something is happening that needs immediate attention.
- When your co-facilitator is leading a session, pay attention to the time. It is easy to lose track of time, particularly when the group is having a great conversation or significant learning is happening. Helping your co-facilitator to pay attention to time will enable both of you to balance the group's immediate needs with the workshop objectives.

Personal Preparation

As a facilitator preparing to do gender work, you will need to consider your own thoughts and feelings and how they may affect your role as a facilitator. For example, you may feel uncomfortable talking openly about certain topics (e.g., masturbation or other aspects of sexuality). You may also have strong feelings about certain topics (e.g., homosexuality). These feelings may make it hard to facilitate an open or frank discussion. You may also be reminded of painful experiences from your past. Being reminded of these experiences may make it hard to talk about certain topics.

To help women and men discuss these issues as openly as possible, you must first make time to think about your own thoughts, feelings, and experiences. This could involve:

- Meeting with a colleague to discuss your thoughts and feelings about the gender work you will be doing: talk about what you are nervous and unsure about, discuss any issues that make you uncomfortable and why, and make a plan for how you will deal with this discomfort.
- Making time during a team meeting to have the same discussions with your peers. If possible, bring in a skilled outside facilitator to help team members with this discussion.
- Choosing someone you trust and who you think will listen to you and support you (colleague, friend, family member). Tell this person about the past experiences you are concerned about, how you think they may affect your work, and how you would like to be supported in dealing with your memories of them. Make a plan for how to get this support. If you think you cannot get the support you need or that the memories of the experiences are too strong and painful, remember that you have the choice not to do this work.

Active Listening

Active listening is a basic skill for facilitating group discussions. It means helping people feel that they are being understood as well as heard. Active listening encourages people to share their experiences, thoughts, and feelings more openly. It shows participants that their ideas are valuable and important when it comes to solving their problems.

Active listening involves:

- Using body language to show interest and understanding. In most cultures, this will include nodding your head and turning your body to face the person who is speaking.
- Showing interest and understanding to reflect what others are saying. It may include looking directly at the person speaking. In some communities, such direct eye contact may not be appropriate until the people speaking and listening have established some trust.
- Listening not only to what is said, but also to how it is said, by observing the speaker's body language.

- Asking speaker questions to show that you want to understand.
- Summing up the discussion to check that what was said was understood. Ask for feedback.

Be Nonjudgmental

Remember that information should be provided in nonauthoritarian, nonjudgmental, and neutral ways. You should never impose your feelings on the participants.

Effective Questioning

Asking effective questions is also a core facilitator skill. Effective questions help facilitators identify issues, clarify facts, and draw out differing views on an issue. Skillful effective questioning also challenges assumptions, shows you are really listening, and demonstrates that the opinions and knowledge of the group are valuable. Effective questioning also increases participation in group discussions and encourages problem-solving.

Ways to achieve effective questioning include:

- Asking open-ended questions: Why? What? When? Where? Who? How?
- Asking probing questions. Follow up with questions that delve deeper into the issue or problem.
- Asking clarifying questions by rewording a previous question.
- Discovering personal points of view by asking how people feel, not just what they know.

Facilitating Group Discussions

There is no single best way to facilitate a group discussion. Different facilitators have different styles. Different groups have different needs. The following are some common aspects of good group facilitation:

- **Set the rules.** It is important to create "ground rules" that the group agrees to follow. Establish ground rules regarding respect, listening, confidentiality, and participation.
- **Involve everyone.** Helping all group members to take part in the discussion is an important part of group facilitation. This involves paying attention to group members who are dominating discussions and those who are not contributing. Try to involve members who are not participating by asking them a direct question. However, remember that people have different reasons for being quiet. They may be thinking deeply! If a participant is very talkative, you can ask her or him to allow others to take part in the discussion and then ask the others to react to what that person is saying.
- **Encourage honesty and openness.** Encourage participants to be honest and open. They should not be afraid to discuss sensitive issues. Encourage participants to honestly express what they think and feel, rather than say what they think the facilitator(s) or other participants want to hear.
- **Keep the group on track.** It is important to help the group stay focused on the issues being discussed. If the discussion seems to be going off the subject, remind the group of the session's objectives and get them back on track.

Facilitating Mixed-Sex Groups

Facilitating mixed-sex groups can be challenging. As a facilitator, you must ensure equal participation by women and men. This means ensuring that men do not dominate while also making sure that men feel comfortable contributing. It is also important not to assume that all female participants are disempowered and suffering, and that all male participants are powerful and dominating. You must be aware of and address differences among participants in terms of language, race, class, caste, and ethnicity, ensuring that no group feels alienated or insecure, and all groups participate equally. The following pointers will help you to ensure equal participation:

- If the discussion is not going anywhere, use probing questions to deepen the discussion.
- Do not take sides.
- Give practical examples when needed to stimulate discussion.
- Manage discussions and do not get too emotionally invested into issues.
- If the group is spending too long on a small point, push the group forward.
- Draw on people's experiences.
- Help people in conflict understand each other's views, searching for common ground.
- Make everyone feel valued.
- Ensure that all participants have a chance to share their viewpoints, and that no one dominates.

Dealing with Difficult People

People often take on certain roles within groups. Some of these roles can interfere with the workshop learning. Facilitating a group discussion may mean dealing with people who are negative or disruptive or who continue to interrupt the discussion. Reminding the group of the ground rules and asking everyone to be responsible for maintaining them is a good way to deal with difficult people. If someone is always complaining, you can ask for specifics, address the complaint, or refer the complaint to the group. If a participant is disruptive, you can encourage group members to ask the difficult person to help, rather than hinder, the group, or you can deal with the individual apart from the group.

Managing Conflict

- Know the difference between disagreement and conflict: disagreement is healthy and can lead to better understanding; conflict is not healthy and distracts from learning objectives. Disagreement is not always a bad thing. It can be productive and is a normal part of group development. When participants disagree, do not rush to interrupt if they are communicating in a respectful way.
- Reassure the group that disagreement is an important part of the workshop and that it can create a learning and healing experience for everyone.
- Encourage the group to use "I" statements to describe their own feelings, rather than "you" statements that criticize or judge others.
- Tell the group that disagreements do not always have to be resolved. **Learning to allow each other our differences can be even more important than getting everyone to agree.**
- If the disagreement is becoming a problem, the following strategies can help deescalate:
  - Review the group guidelines and talk about the importance of working together.
  - Give the group a 5-minute break so you can confer with your co-facilitator.

- After managing the disagreement, ask the group for examples of what they observed or found helpful. Also, ask if there is anything unresolved about the disagreement. Write the answers to these questions on two pieces of flipchart paper titled “Helpful” and “Unresolved.” It can also be helpful to check in with key individuals during breaks to learn how they feel about the disagreement.

Workshop Supplies and Materials

Note: Required supplies and materials will vary depending on the sessions you will be facilitating. Review the list of materials required for each session beforehand.

- One meeting room large enough to comfortably accommodate 25 persons, allow for small group work, and enable participants to freely move around
- Chairs (enough for participants and facilitators) organized in a large semicircle (see diagram in **Reflective Practice and the Power of the Circle** section)
- Flipchart stand (for some sessions, you may require two stands)
- Flipchart paper
- Plenty of colored markers (at least 30)
- Reams of A4 sized paper
- Construction paper
- Masking tape
- Enough wall space to display flipcharts
- Projector
- Laptop computer
- Speakers
- Notebooks for participants
- Pens or pencils for participants

Advance Preparation

Know the Space

- If you do not know what the room for the workshop is like, it is a good idea to visit it a few days in advance. This will help you create the most positive environment for the training. For example, you may need to move chairs and tables or improve the lighting. The space should also be private in the sense that participants should feel comfortable discussing sensitive topics and personal opinions. If the room is not suitable, an advance visit will give you time to look for another room before the workshop begins.

Read the Toolkit

Read through the toolkit before you begin a workshop. Read through each session once more before you facilitate it. If you are confused or concerned about any of the information in the toolkit, ask another facilitator about it.

Prepare Materials

Prepare handouts and flipcharts in advance. Make sure you have enough copies of the handouts for all participants. Some sessions require you to write information on sheets of flipchart paper before beginning the session. Make sure you have all the materials for each session before you begin. A list of these materials is included in the description of each session.

Research Support Services

For some participants, a gender workshop may bring up painful memories, such as childhood sexual abuse. Some participants may have experienced violence during their adult lives, and some may still be experiencing violence. Facilitators should be able to identify available support services and refer participants if needed.

As Participants Arrive

- Welcome each participant enthusiastically.
- Be sure to spend some time interacting with participants.
- Look out for participants who are not mingling with others and reach out to them.

Final Thoughts

Relax. Breathe. Stay in the moment. Connect with your co-facilitator. Connect with each person in the room. Feel and acknowledge emotions and energy—your own and the group's. **Trust that you can and will be a good facilitator**, that the group will learn and connect, and that the experience will be valuable for everyone!

Sources

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Session Inventory

Topic	Session No.	Session	Objectives
Gender and Social Norms	01	**Gender Terms and Definitions** • 1 hour 30 minutes • Programmers and providers	• Distinguish between gender and sex. • Distinguish between gender equity and gender equality. • Explain the concepts of: gender identity; gender expression; and sexual orientation.
	02	**Exploring Gender and Culture** • 2 hours 15 minutes • Programmers and providers	• Articulate the difference between sex and gender. • Describe different social expectations of women and men and their influence on the lives of women and men. • Identify the ways in which participants' personal perceptions of female clients may influence their interactions with female clients. • Identify the ways in which participants may perpetuate gender stereotypes and gender inequitable norms in their personal and professional lives. • Describe the influence of dominant gender norms on women's and men's personal lives.
	03	**Act Like a Woman, Act Like a Man** • 50 minutes • Programmers and providers	• Describe the differences between rules of behavior that society applies to women and men. • Discuss the impacts of social gender rules on the lives of women and men.
	04	**Gender-Focused Icebreaker** • 30 minutes • Programmers and providers	• To enable participants to get to know one another through the sharing of personal stories.
	05	Vote with Your Feet • 45 minutes • Programmers and providers	• Analyze their personal perceptions about gender differences, roles and inequalities.
	06	Power Walk • 45 minutes • Programmers and providers	• Describe how gender and sexual identities impact access to health services across different populations.
	07	**Power and Gender** • 1 hour • Programmers and providers	• Describe the different forms of power. • Describe how power imbalances limit people's ability to exercise their rights.
	08	**The Space Between Us** • 30 minutes	• Describe the influence of dominant gender norms on women's and men's personal lives.

Topic	Session No.	Session	Objectives
		• Programmers and providers	• Identify the links between gender inequality and GBV.
Gender-Based Violence	09	**Power Imbalances** • 1 hour • Programmers & providers	• Describe unequal power dynamics that often characterize health worker-client interactions. • Describe strategies for restoring power to clients who lack it.
	10	**What is Violence?** • 1 hour 30 min • Programmers and providers	• Define the concept of violence. • Define gender-based violence. • List different types of gender-based violence.
	11	**Circles of Influence** • 45 minutes • Programmers and providers	• Identify the links between gender inequality and intimate partner violence (IPV). • Explain why IPV is never justified.
	12	**Violence in Daily Life** • 1 hour 40 minutes • Programmers and providers	• Describe the many ways in which women's (and men's) lives are limited by men's use of violence. • Reflect on the pervasiveness of violence in their personal lives.
Gender as a Health Determinant	13	**Unmet Needs** • 1 hour 30 min • Programmers and providers	• Describe needs women have related to health that are often ignored. • Discuss possible solutions to addressing women's health needs in the context of the health facility.
	14	**Exploring the Links Between Gender and Other Determinants of Health** • 1 hour 45 min • Programmers and providers	• Explain the links between gender inequality and SRH and MNCAH outcomes.
	15	**Gender Determinants of Health** • 45 minutes • Programmers and providers	• Understand gender as it relates to health outcomes of women, men, and children. • Understand the impact of gender in relation to the health workforce.
Sexuality and Sexual Diversity	16	**Defining Sexual and Reproductive Health** • 1 hour 45 min • Programmers and providers	• To define the terms sex, sexuality, reproductive health, sexual health and sexual and reproductive health. • To explain how the quality of SRH counseling and services can be improved by including a focus on sexuality issues and concerns. • To describe barriers or challenges for providers in addressing sexuality in SRH counseling.
	17	**Circles of Sexuality** • 2 hours	• Describe the intersections of gender and sexuality. • Discuss sexuality from a holistic perspective.

Topic	Session No.	Session	Objectives
		• Programmers and providers	• Define sexual rights.
	18	**Sex Taboos** • 1 hour • Programmers and providers	• Describe how beliefs about what is 'acceptable' or 'proper' sex is one of the root causes of stigma towards key populations. • Discuss sex and their feelings about 'proper' and 'improper or immoral' sex. • Demonstrate discussing sex and sexuality issues in a comfortable manner.
	19	**Identifying Biases and Judgments Related to Sexual Behaviors** • 1 hour 15 min • Programmers and providers	• Identify personal biases and attitudes about various sexual behaviors. • Demonstrate discussing sex and sexuality issues in a comfortable manner. • Explain why it is important to be nonjudgmental about sexual behaviors when counseling clients. • Explain how beliefs about what is "acceptable" sex are root causes of stigma towards sexual minorities.
	20	**What Is the Meaning of Stigma?** • 1 hour • Programmers and providers	• Explain the meaning of stigma with examples.
	21	**Forms, Effects and Causes of Stigma** • 1 hour 30 minutes • Programmers and providers	• Describe the different forms of stigma faced by sexual and gender minorities at the facility level. • Explain how stigma and discrimination against sexual and gender minorities increases their HIV risk. • Explain the root causes of HIV-related stigma. • Recognize the importance of respecting the rights of sexual and gender minorities. • Identify practical solutions that participants can do to stop or reduce stigma.
	22	**Our Own Experience of Being Stigmatized** • 1 hour • Programmers and providers	• Describe some of their own personal experiences of being stigmatized. • Identify some of the feelings resulting from being stigmatized.
Responding to Sexuality and Sexual Diversity in a Health Facility	23	**I Already Have…But I Still Need…** • 1 hour 45 minutes • Providers	• Describe the role of healthcare personnel in terms of delivering sexual healthcare for all clients, including sexual and gender minorities. • Compare expected health worker performance to actual behaviors and identify gaps that must be closed.

Topic	Session No.	Session	Objectives
			• Formulate practical measures for changing the way health workers relate to sexual and gender minorities.
	24	**Health Professionals and Care for Gender and Sexual Minorities** • 1 hour 45 minutes • Providers	• Discuss sexual diversity from a gender and human rights perspective. • Describe the prejudice that exists among healthcare workers regarding sexual orientation and identity that lead to a suboptimal approach during medical consultation with sexual and gender minorities. • Describe key facility-level considerations for ensuring health services are able to meet the basic needs of sexual and gender minorities.
	25	**Identifying Stigma and Discrimination towards Key Populations in the Health Facility** • 1 hour 15 minutes • Programmers and providers	• Explain the meaning of stigma with examples. • Describe the different forms of stigma that prevent key populations from accessing services and that key populations face at the facility level. • Explain how stigma and discrimination against gender and sexual minorities increases their HIV risk. • Describe strategies for providing stigma-free services to key populations.
	26	**Writing a Code of Conduct for a Stigma and Discrimination-Free Health Facility** • 45 minutes • Programmers and providers	• Formulate strategies or guidelines for creating a stigma-free health facility environment.
Gender-sensitive and rights-based care	27	**Value Judgments** • 1 hour 15 minutes • Providers	• Explain how their personal values may impact their counselling sessions with clients. • Describe how comfort with discussing sex and sexuality issues is expressed in body language.
	28	**Why I Am a Health Worker** • 1 hour • Providers	• Explain the reasons why people become health workers, and how these reasons influence their relationship with clients.
	29	**Gender-Sensitive, Respectful Service Delivery** • 2 hours 30 minutes • Programmers	• Describe quality of care through a gendered lens. • Describe standards of respectful care provision. • Identify ways in which their personal perceptions of clients may influence their interactions with them.

Topic	Session No.	Session	Objectives
Gender Analysis	30	**Introduction to Gender Analysis** • 3 hours 15 minutes • Programmers	• Explain the importance of a gender analysis. • Describe the four domains of Jhpiego's gender analysis framework. • Apply Jhpiego's gender analysis framework to identify gender constraints and opportunities.
Couples Counseling Skills	31	**Overview of Effective Counseling** • 1 hour 30 minutes • Providers	• Discuss and practice effective foundational counseling skills.
	32	**Considerations When Counseling Couples** • 2 hours • Providers	• Describe the risks and benefits of counseling couples. • Describe key considerations for effective couples counseling. • Identify considerations that may arise when counseling couples.
	33	**Responding to Issues That May Arise During Couples Counseling Sessions** • 1 hour 15 minutes • Providers	• To respond effectively to issues that may arise when counseling couples on a variety of sexual and reproductive health issues.
Male-Friendly Services and Engaging Men	34	**Creating a Safe and Comfortable Environment for Counseling Men** • 1 hour 30 minutes • Programmers and providers	• Identify ways to make the health care facility environment safer and more comfortable for men.
	35	**Supporting Men's Use of SRH Services** • 2 hours 15 minutes • Programmers and providers	• Describe how bias about providing services to men may affect clients negatively. • Describe characteristics of an effective service provider for men. • Formulate basic strategies for making SRH services male-friendly.
	36	**Addressing Staff Concerns about Working with Male Clients** • 1 hour 15 minutes • Providers	• Describe strategies for overcoming personal concerns about working with male clients.
	37	**Positive Role of Men in SRH Promotion** • 2 hours • Programmers and providers	• Explain the importance of and rationale for including men in sexual and reproductive health (SRH) promotion efforts. • List examples of effective male engagement approaches. • Formulate strategies for including men in a manner that minimizes harm to women.

Module 1

Gender and Social Norms

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Session 1: Gender Terms and Definitions

Learning Objectives

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

- Distinguish between gender and sex
- Distinguish between gender equity and gender equality
- Explain the concepts of gender identity, gender expression, and sexual orientation

Time

1 hour 30 minutes

Materials Needed

- Chairs organized in a semicircle
- Flipchart paper
- Markers
- Masking tape
- Projector
- **Participant Handout: Gender Terms and Definitions I**
- **Participant Handout: Gender Terms and Definitions II**
- **Participant Handout: The Genderbread Person**
- **Participant Handout: Diversity in Human Sexuality Fact Sheet**
- **Facilitator Resource: PowerPoint on Gender Terms and Definitions**
- **Facilitator Resource: Myths and Realities about Sexual Orientation and Gender Identity**

Facilitator note: Sexual orientation can be an extremely sensitive topic, and it is important that the facilitator be accepting and comfortable discussing it. It may be helpful to first identify common myths and stereotypes about sexual orientation that exist in the local context in order to address them during the session. If the facilitator is not comfortable discussing sex and sexual orientation generally, or if she/he is unable to address the topic in a respectful and nonjudgmental manner, then she/he should not facilitate the second portion of this session.

Advance Preparation

1. Make enough copies of the participant handouts for each participant. Do not distribute the **Participant Handout: Gender Terms and Definitions I** until you reach step 10 in the "Foundational Gender Concepts" section.
2. Print one copy of Facilitator Resource: PowerPoint on Gender Terms and Definitions.
3. Save a copy of the PowerPoint on **Gender Terms and Definitions** to your computer, and practice presenting the PowerPoint beforehand to ensure you have a good understanding of the various concepts.
4. Draw the level playing field and equity/equality trees (found on Slide 7 of the Facilitator Resource: PowerPoint on Gender Terms and Definitions) on flipchart paper and only display after the group assigned to define these concepts presents their word web/definition in the first part of the exercise.

Facilitator note: The concepts discussed in this session are foundational to understanding gender and are important for participants to understand before moving on to more advanced sessions. The facilitator should regularly check in with participants by asking if they have any questions related to the concepts discussed or if they need any points clarified.

Facilitator note: Before starting the session, the facilitator should point out to participants the sensitive nature of the subject matter, and re-emphasize the importance of confidentiality (what is said inside the room, stays inside the room), respect for others' opinions, and the right to pass (if a participant is uncomfortable with the topic, she/he may choose not to take an active part in the session).

Steps

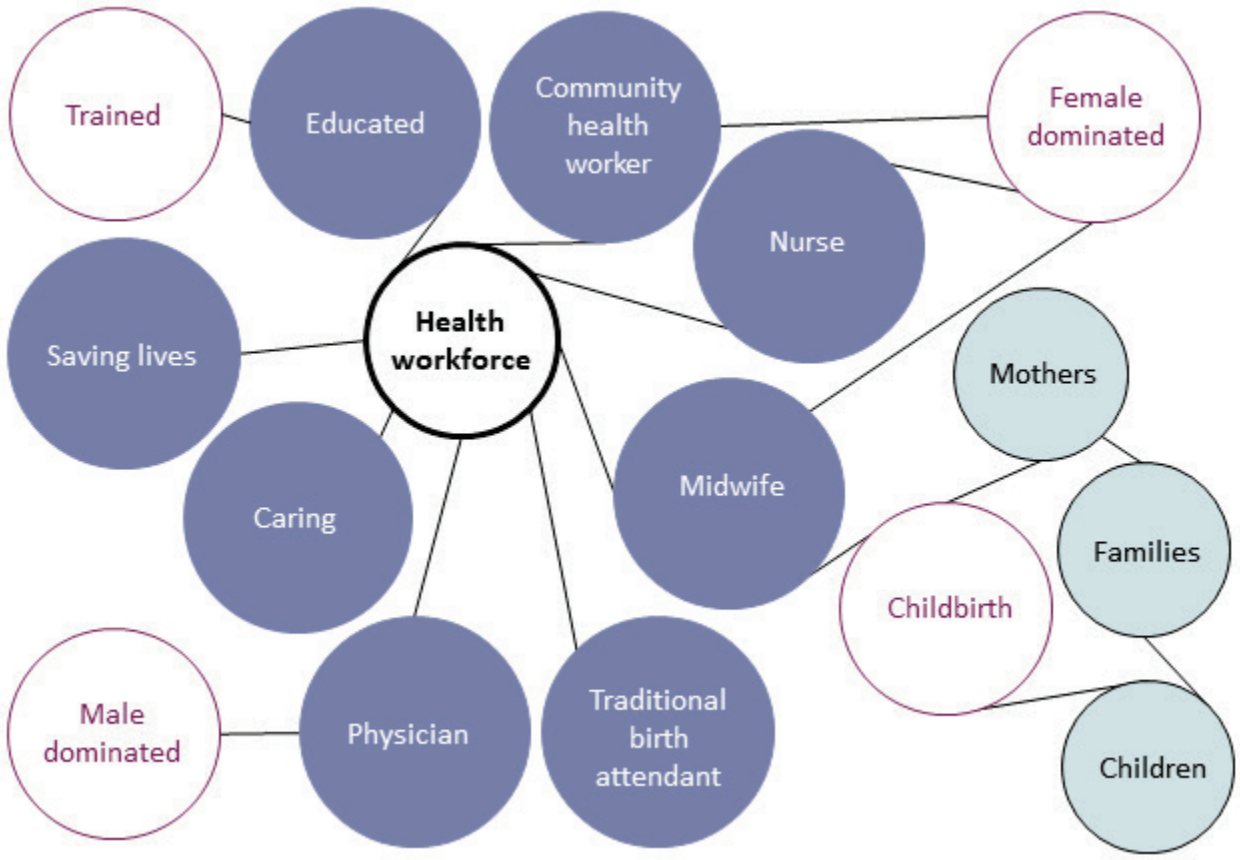
Introduction (5 minutes)

1. Open the activity by explaining to participants that they will spend some time familiarizing themselves with some key foundational terminology related to gender and sexuality.

Foundational Gender Concepts (30 minutes)

1. Divide participants into six groups. Next, explain that each group will be assigned one or two concepts to define or create a word web for as a team. Explain that they will have 10 minutes to come up with a definition or word web for each assigned concept. Explain that if participants choose to create a word web, one way to begin is by writing the assigned concept in a circle in the middle of the paper. Group members then brainstorm words that make up the definition of the assigned concept. The group will draw lines from the circle in the middle of the page to new circles, where they will write the brainstormed words. Explain that a word web is a way to think about the various components that make up complex concepts such as those being discussed in the group activity. Word webs also help participants to understand the connections between the original and related concepts. Explain to the group that there is no wrong way to create a word web, as long as the team is thinking about how to define their assigned concepts.

An example word web for a simple concept is below. You can draw this or a similar example on a sheet of flipchart paper to demonstrate:



2. Assign the concepts as follows:
   - Group 1: Sex and Gender
   - Group 2: Gender Equality and Gender Equity
   - Group 3: Women's Empowerment and Agency
   - Group 4: Male Engagement
   - Group 5: Gender Roles and Gender Stereotypes
   - Group 6: Gender-Based Violence and Violence against Women
3. Next, distribute one sheet of flipchart paper and a marker to each group. Instruct the groups to identify an area of the room to work in and ask them to begin. (Spend no more than 2 minutes on steps 1 to 3.) Explain that they will have 5 minutes to conduct this exercise.
4. After 5 minutes, ask the groups to stop and to post their flipchart pages on a wall in the room.
5. Next, gather all of the participants in front of the wall and ask for a member from the first group to read the group's definition to the larger group. After the group's definition has been read, ask the larger group to share their thoughts about the definition. (Is the definition accurate? Is the definition complete? How might the definition be improved?) Spend no more than 1 minute discussing the group's definition.
6. Repeat step 5 for the remaining concepts.

7. After reviewing all of the concepts, ask participants to return to their seats and distribute **Participant Handout: Gender Terms and Definitions I**. Present the formal definitions in the first half of the **PowerPoint Gender Terms and Definitions**. Allow participants 2 minutes to ask questions and/or make comments.

Facilitator note: When discussing the concepts of gender equity and gender equality, emphasize the following points and remember to display the level playing field and equity/equality trees that you drew on flipchart paper when describing the last point below:

- The goal of **gender equality** is not for women and men, girls and boys, to become the same. Rather, the goal is to ensure that women and men have the same chances to access and benefit from social, economic, and political resources (e.g., have the same opportunities to vote, to be educated, etc.)
- The goal of **gender equity** moves beyond equality in all aspects. Gender equity seeks to ensure that conditions will not prevent equal participation in health promotion activities. It recognizes, for example, that women and men may have different needs, preferences, and interests, some due to biological differences (such as pregnancy) and others due to gender constraints, such as inadequate investment in girls' education or restrictions on their mobility. Achieving equality of opportunity (e.g., gender equality) may require treating women and men differently and/or separately. (For example, an organization may adopt a positive discrimination policy during recruitment to increase women's representation due to gender roles or constraints, such as burden of household care).
- Gender equality differs from gender equity in that gender equity is about how public services meet different population needs, as well as historical inequalities that have mitigated opportunities. Gender equality is about making sure that everyone has the same opportunity to use those services.
- The level playing field and equity/equality trees are useful illustrations of these concepts. In the first illustration, three people are given the same size boxes despite their different heights, and only the tallest of the three can reach the apple on the tree. This illustration displays inequality in outcomes (reaching an apple on the tree) because the boxes are not tailored to the capacities of the individuals (their differing heights). In the second illustration, boxes are equitably distributed and are tailored to the capacities of the individuals (the shortest person has the tallest box), and therefore there is equality since all three people can reach the apples.

Sexual and Gender Identities (40 minutes)

1. With participants seated in a semicircle, explain that the group will spend time exploring some additional important concepts related to how we identify with the norms surrounding our gender, as well as norms related to sexual expression.
2. Acknowledge that some participants may have strong beliefs about sexual orientation. State that you will respect every participant's right to her or his opinion; however, sexual orientation is important to discuss because it is a human rights issue and also an important part of every individual's sexuality.

Facilitator note: It is helpful to remind participants of Article 1 of the Universal Declaration of Human Rights, which states, "All human beings are born free and equal in dignity and rights." The United Nations Human Rights Council interpreted this as, "All people, including lesbian, gay, bisexual and transgender (LGBT) persons, are entitled to enjoy the protections provided for by international human rights law, including in respect of rights to life, security of person and privacy, the right to be free from torture, arbitrary arrest and detention, the right to be free from discrimination, and the right to freedom of expression, association and peaceful assembly" (November 17, 2011; http://www.ohchr.org/Documents/Issues/Discrimination/A.HRC.19.41_English.pdf).

3. Explain that you will read a series of statements aloud, and that for each statement you will ask participants whether they believe the statement to be true or false. Participants should raise their hand for the response they choose. (Spend no more than 2 minutes on steps 1–3.)
4. Refer to **Facilitator Resource: Myths and Realities about Sexual Orientation and Gender Identity**, and read the first statement to the group. Next, ask participants to raise their hands if they believe it to be true. After participants have reacted, ask if any participants think the statement is false. After participants have reacted, ask for one to four volunteers to briefly explain their answers. Allow 1–2 minutes of discussion and then provide the correct answer.
5. Repeat step 4 for the remaining statements, spending no more than 3 minutes on each.
6. Before moving on, explain that many of the statements reviewed are myths that use judgment and fear to maintain rigid ideas about women, men, and "acceptable" sexual desire and behavior. Indicate that an important dimension of the stigma, discrimination, and/or violence that lesbian, gay, bisexual, transgender, queer, and intersex (also known as LGBTQI) individuals experience is related to the fact that they deviate from dominant, normative gender norms in their sexual behavior and in other ways (e.g., gender expression).

Facilitator note: The term "queer" may not be commonly used in the communities where your participants are from. If that's the case, you can provide the definition of queer, but you do not need to use the term throughout the training:

The "Q" in LGBTQI represents "queer," which is an umbrella term to describe individuals who don't identify as heterosexual or who have a non-normative gender identity. It can also be used as a political affiliation. Because it has historically been used in a derogatory manner, not all members of the LGBTQ community embrace or use the term. Often, "queer" and LGBTQ are used interchangeably.

Source: *A Guide to Gender: The Social Justice Advocate's Handbook*, 2nd ed., by Sam Killermann, 2017.

7. After you have read all of the statements, project the second part of the **PowerPoint Gender Terms and Definitions**, "Gender and Sexual Diversity." Refer to the discussion points included beneath each slide during the presentation. (Spend no more than 20 minutes on this step.)

Facilitator note: Discussions about sexual identity can be uncomfortable for some participants, as sexual identity is not often discussed. This discomfort is exactly what this session aims to explore. It can be helpful to relate perceptions about homosexuality to those around race. In many contexts, it was considered unnatural and/or even illegal for people of different races to have sex, marry, have children, etc., but this has changed over time.

8. Next, distribute Participant Handout: Gender Terms and Definitions II, Participant Handout: The Genderbread Person, and Participant Handout: Diversity in Human Sexuality Fact Sheet to each participant.

Group Discussion (10 minutes)

1. Facilitate a 10-minute group discussion using the following questions:
    - What is something that you learned in this session about gender or sexuality?

> **Facilitator note:** Be prepared to deal with religious arguments that claim homosexuality is a sin, and that the Bible and/or the Koran say so. Be careful not to enter into arguments against religious doctrine. Do point out, however, that the tenets of both Christianity and Islam (as well as most other religions) also teach love, respect, and care for all. As a facilitator, you may then ask the following question of the group: "What does it mean on a practical level to love, respect, and care for those in the LGBTI community?"

- What questions do you still have about the concepts we discussed today?
- How do these concepts relate to your work?
    - Probe: How can understanding these concepts help you with your work?
- What expressions of gender identity does society tend to find more acceptable? Which are considered unacceptable? What about sexual orientation?
- How do gender norms shape our attitudes about what is considered "acceptable" and "unacceptable" sexual behavior?
    - Probe: If a woman is known to have sex with multiple partners, how is she perceived in your society and culture? How do gender norms impact that perception?

Closing (5 minutes)

1. End the session by emphasizing the diversity of humans' experiences of gender and sexuality. Explain that while concepts and definitions are helpful for understanding and articulating people's experiences, our experiences and identities cannot (and should not) be limited to mere concepts. We all have the right to define who we are independent of social rules and expectations.

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Participant Handout: Gender Terms and Definitions I

Sex	refers to biologically defined and genetically acquired differences between males and females, according to their physiology and reproductive capabilities or potentialities. It is universal and mostly unchanging, without surgery.
Gender	refers to a socially constructed set of economic, social, and political roles, responsibilities, rights, entitlements obligations, associated with being female and male, as well as the power relations between and among women and men, boys and girls. Ones' gender identity may or may not correlate with ones' sex assigned at birth. The definition and expectations of what it means to be a woman or girl and a man or boy, and sanctions for not adhering to those expectations, vary across cultures, over time, and throughout the life course; they also often intersect with other factors such as race, class, age and sexual orientation.
Gender equity	is the process of being fair to women and men. To ensure fairness, measures must be taken to compensate for historical and social disadvantages that prevent women and men from operating on a level playing field.
Gender equality	is the state or condition that affords women and men equal enjoyment of human rights, socially valued goods, opportunities, and resources.
Gender integration	refers to strategies applied in program assessment, design, implementation, and evaluation to account for gender norms and compensate for gender-based inequalities.
Gender mainstreaming	is the process of incorporating a gender perspective into policies, strategies, programs, project activities, and administrative functions, as well as into an organization's institutional culture.
Gender roles	are the behaviors, tasks, and responsibilities that are considered appropriate for women and men as a result of sociocultural norms and beliefs. Gender roles are usually learned in childhood. Gender roles change over time as a result of social and/or political change.
Gender stereotypes	are ideas that people have on masculinity and femininity: what men and women of all generations should be like and are capable of doing. (For example, girls are allowed to cry whereas boys are expected to be brave and not cry.)
Agency	is a person's capacity to set and act on goals. It often entails bargaining, negotiation, and resistance. (Adapted from Naila Kabeer's [1999] definition of agency.)
Empowerment	refers to the expansion of people's capacity to make and act upon decisions (agency) and to transform those decisions into desired outcomes, affecting all aspects of their lives, including health. It entails overcoming socioeconomic and other power inequalities in a context where this ability was previously denied. Programmatic interventions often focus specifically on empowering women, because of the inequalities in their socioeconomic status. (Adapted from definitions of empowerment by Naila Kabeer [1999] and Ruth Alsop and Nina Heinsohn [2005].)
Male engagement	refers to the involvement of men and boys across life phases in family planning, sexual and reproductive health, maternal and child health, and HIV programs as a) clients/users; b) supportive partners; and c) agents of change to improve health and gender equality outcomes, actively address power dynamics, and transform harmful masculinities. Engaging men and boys also includes broader efforts to promote equality with respect to sexual relations, caregiving, fatherhood, division of labor, and ending gender-based violence (GBV).
Gender-based violence	in the broadest terms, is violence that is directed at individuals based on their biological sex, gender identity, or perceived adherence to culturally defined expectations of what it means to be a woman and man, girl and boy. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private. GBV is rooted in economic, social, and political inequalities between men and women. Although women and girls are the primary victims of GBV because of their subordinate position, men and boys also may be victims of violence when it is perpetrated to uphold or reinforce dominant forms of masculinities (i.e., socially determined roles, expectations, and behaviors associated with being a man or a boy).
Violence against women and girls (VAWG)	involves any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women or girls, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or in private life (Arango et al. 2014). VAWG against someone with whom the perpetrator is in an intimate relationship is referred to as intimate partner violence (IPV).

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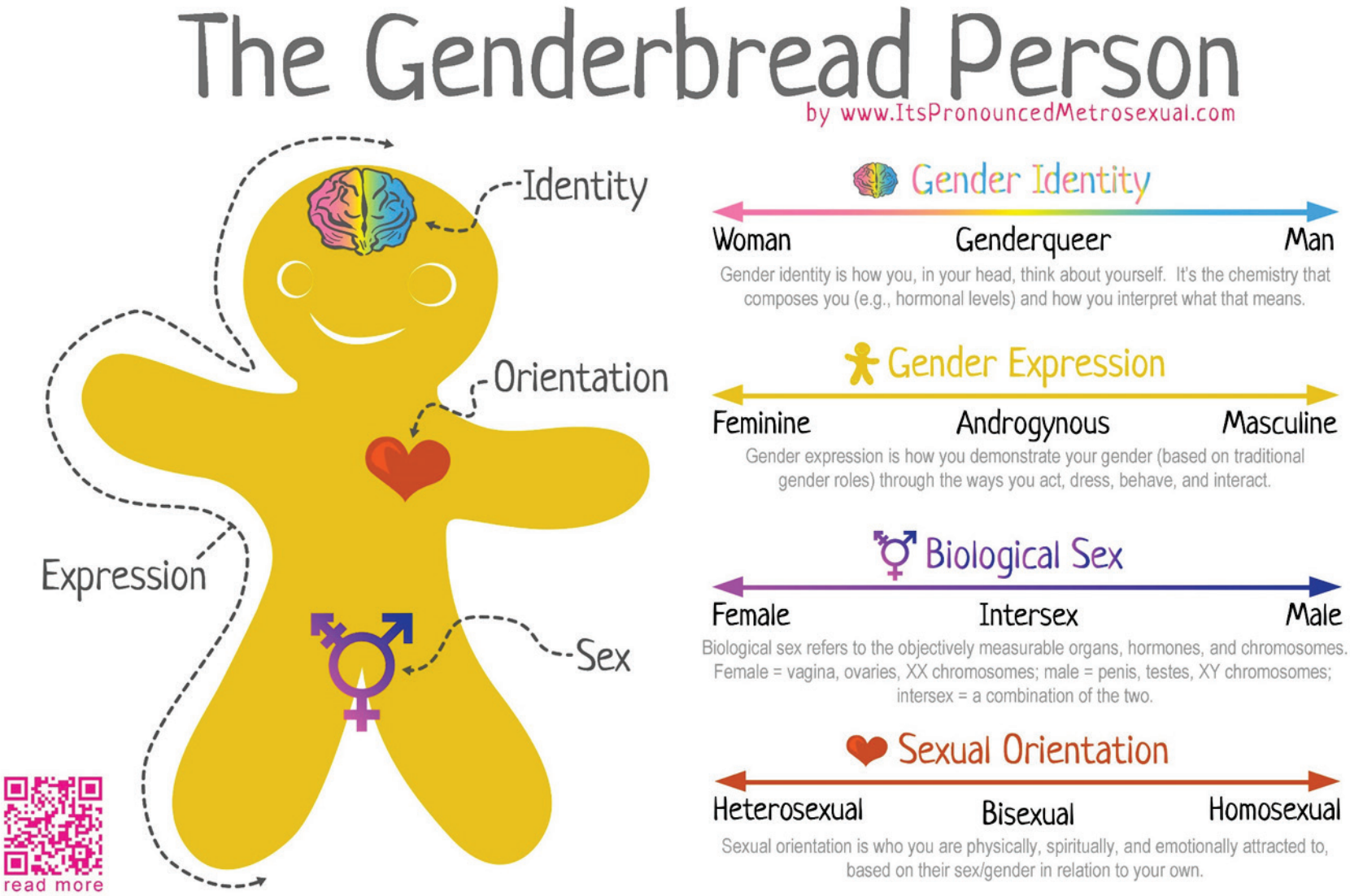
Participant Handout: Gender Terms and Definitions II

Sexual orientation	refers to an individual's physical and/or emotional attraction to the same and/or opposite sex. A person's sexual orientation is distinct from the individual's gender identity and expression. Heterosexuality is attraction to the opposite sex. Homosexuality is attraction to the same sex. Bisexuality is attraction to both sexes.
Gender norms	are the culturally defined roles, responsibilities, rights, entitlements, and obligations associated with being female and male, as well as the power relations between and among women and men, boys and girls.
Gender identity	refers to one's innermost concept of self as male, female, a blend of both, or neither—how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different from their sex assigned at birth.
Gender expression	refers to the external translation of one's gender identity, usually expressed through behavior, clothing, haircut, or voice, and may or may not conform to socially defined behaviors and characteristics typically associated with being either masculine or feminine.
Homophobia	is the fear and hatred of, or discomfort with, people who are attracted to members of the same sex.
Heterosexism	is the presumption that everyone is heterosexual and/or the belief that heterosexual people are naturally superior to homosexual and bisexual people.
Transgender	is an umbrella term for people whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth. Being transgender does not imply any specific sexual orientation. Therefore, transgender people may identify as straight, gay, lesbian, bisexual, etc.

Participant handout: The Genderbread Person

Source: https://www.genderbread.org/



Participant Handout: Diversity in Human Sexuality Fact Sheet

(*Adapted from* Diversity in Human Sexuality: Implications for Policy in Africa, Academy of Science of South Africa, May 2015)

What is the evidence that biological factors contribute to diversity in sexual orientation and gender identity?

- Contemporary science does not support that sexuality is a simple binary of hetero/homosexual (Feinstein et al. 2014; Seto 2012).
- Variations in sexual identities and orientations has always been part of a normal society (Greenberg 1988; Cantu et al. 1999; Halperin 2000; Herdt 1996, 1997; Roscoe and Murray 1997).
- There is substantial biological evidence for the diversity of human sexualities and for sexual orientations in particular. Studies have found significant linkage between male sexual orientation and regions of the X chromosome (Mustanski et al. 2005; Sanders et al. 2014).
- Sociobehavioral research demonstrates unequivocally that both heterosexual and homosexual men and women lack a sense of choice in terms of their sexual attraction (Quinsey 2003; Herek et al. 2010; Savin-Williams and Vrangalova 2013; Worthington et al. 2002; Diamond 2012; Diamond 1995; Dillon et al. 2011; Farr et al. 2014; Savin-Williams 2014).

Does upbringing and socialization explain the diversity of sexual orientations and gender identities?

- There is very little evidence that sexual orientation is directly correlated to family upbringing (Beckstead 2012; Isay 2009; Peplau and Garnets 2000; Rosario and Schrimshaw 2014; Royal College of Psychiatrists 2010).

Is there any evidence for same-sex orientation being "acquired" through contact with others?

- There is no evidence that sexual orientation can be acquired through contact with lesbian, gay, bisexual, transgender, and intersex (LGBTI) persons. There is substantial evidence that tolerance of same-sex orientation benefits LGBTI persons and positively impacts public health, civil society, and long-term economic growth in societies across the spectrum of economic development (Florida 2014; Badgett et al. 2014).
- Peer pressure among young people has not been shown to influence same-sex activity or the development of same-sex sexual or bisexual orientations (Brakefield 2014).
- Same-sex parents are no more likely to produce homosexual children than are heterosexual parents (Bailey et al. 1995; Gartrell et al. 2011; Golombok and Tasker 1996).
- Homosexual parents are not any less fit or able as parents than heterosexual parents. Children of homosexual parents do not experience disparities in mental health or social adjustment (Herek 2006).

What evidence is there that any form of therapy or "treatment" can change sexual orientation?

- There is no evidence that same-sex orientation can be changed through "conversion" or "reparative" therapy. Same-sex attraction is not inherently pathological or an illness. There are documented dangers of this kind of therapy and it is therefore not medically ethical (Haldeman 2002; IOM 2011; APA 2009; PAHO 2009; Nel 2014).

What evidence is there that same-sex orientations pose a threat of harm to vulnerable populations such as children?

- There are no credible studies showing that people with same-sex orientation are more likely to abuse children than heterosexual offenders (Barth et al. 2013; Stoltenborgh et al. 2011). Almost all abusers of children are heterosexual men, many of whom are male relatives of these children.
- There is no evidence that men with same-sex attraction or men who have sex with men (MSM) are responsible for the high rates of childhood sexual abuse in African countries or in other countries (Barth et al. 2013; Roberts et al. 2013; Stoltenborgh et al. 2011).

What are the public health consequences of criminalizing same-sex sexual orientations?

- There is abundant evidence that more repressive environments increase minority stress and negatively influence LGBTI health. LGBTI individuals are often unable to freely access health facilities and health information, primarily due to stigma and discrimination. Most LGBTI populations in Africa also face a higher threat of physical violence than heterosexual populations (Denton 2012; Goldbach et al. 2014; Pascoe and Smart Richman 2009; IOM 2011; Schmitt et al. 2014; Berlan et al. 2010; Burton et al. 2013; Poteat et al. 2014; United Nations High Commissioner for Human Rights 2010; Lee 2014).
- There is overwhelming evidence that this has a direct impact on the general population's health, particularly in terms of HIV/AIDS, TB, and other sexually transmitted infection reduction efforts (Beyrer 2014; Goldbach et al. 2014; Smith et al. 2009; Baral et al. 2014, Berlan et al. 2010; Johns et al. 2013; Ryan et al. 2010; Schneeberger et al. 2014; Semugoma et al. 2012a; Semugoma et al. 2012b; Reddy et al. 2009; Beyrer et al. 2010; Singh 2013).

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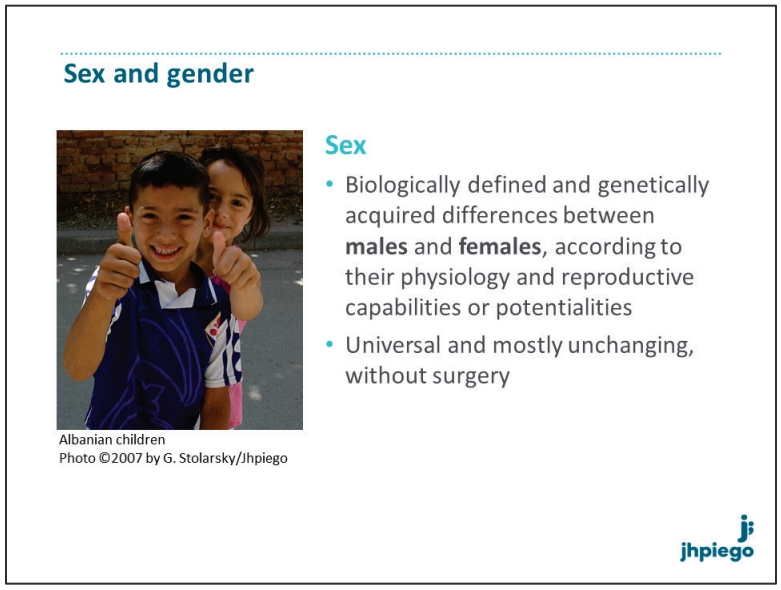
Facilitator Resource: PowerPoint on Gender Terms and Definitions

Slide 1

Slide 2



Slide 3

Sex and gender

Gender

- Social characteristics associated with being a **man** or a **woman:**
  - economic, social, political, and cultural attributes
  - opportunities, roles, and responsibilities
- Socially constructed, constituted differently across the world, and changing over time
- Ones' gender identity may or may not correlate with ones' sex assigned at birth.

Siblings in Kuresoi, Kenya
Photo ©2009 by George Avosa/Jhpiego

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Slide 4

Gender roles

- Behaviors, tasks, and responsibilities considered appropriate for women and men as a result of sociocultural norms and beliefs
- Usually learned in childhood
- Change over time as a result of social and/or political changes

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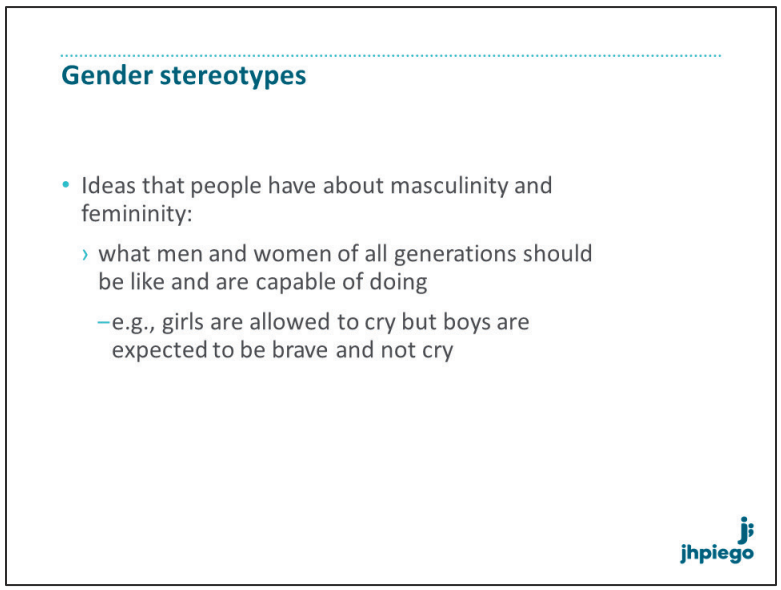
Facilitator discussion points

- Gender roles consist of activities that women and men engage in with varying frequency.
- Gender roles are usually learned during childhood and can change over time as a result of social and/or political changes.
- They often lead to the perception of gender roles as natural, biologically derived, or historically confirmed—and therefore valid. This leads to the creation and perpetuation of gender stereotypes.

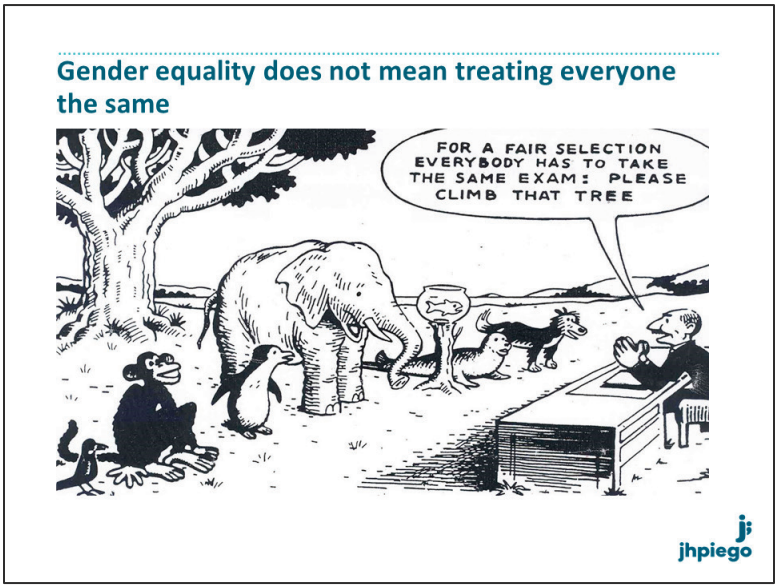
Slide 5



Facilitator discussion points

- A gender stereotype consists of beliefs about the psychological traits and characteristics, as well as the activities and behaviors, appropriate for women and men. Whereas gender roles are defined by behaviors, gender stereotypes are beliefs and attitudes about femininity and masculinity.
- Gender roles and gender stereotypes are related. When people associate a pattern of behavior with either women or men, they may overlook individual variations and exceptions and come to believe that the behavior is inevitably associated with one gender but not the other. As such, gender roles provide the material for gender stereotypes.
- Gender stereotypes are very influential and they establish social categories for women and men. They fulfill the function of maintaining a hierarchical/unequal relationship between women and men. Gender stereotypes change very slowly; this may help to partially explain why gender discrimination persists even though gender roles change.

Slide 6

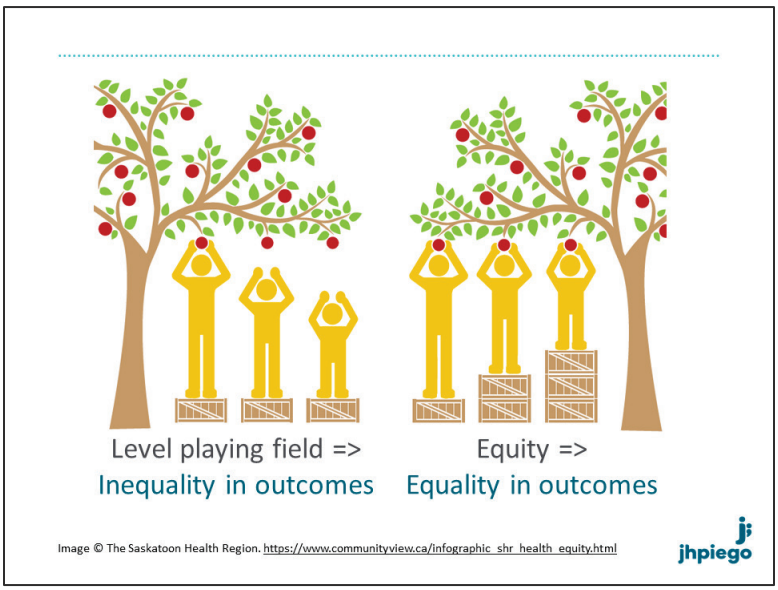


Facilitator discussion points

Ask: Why is treating everyone the same problematic here?

Explain: Like these animals, people have varying biological but also sociological constraints and advantages that must be accommodated.

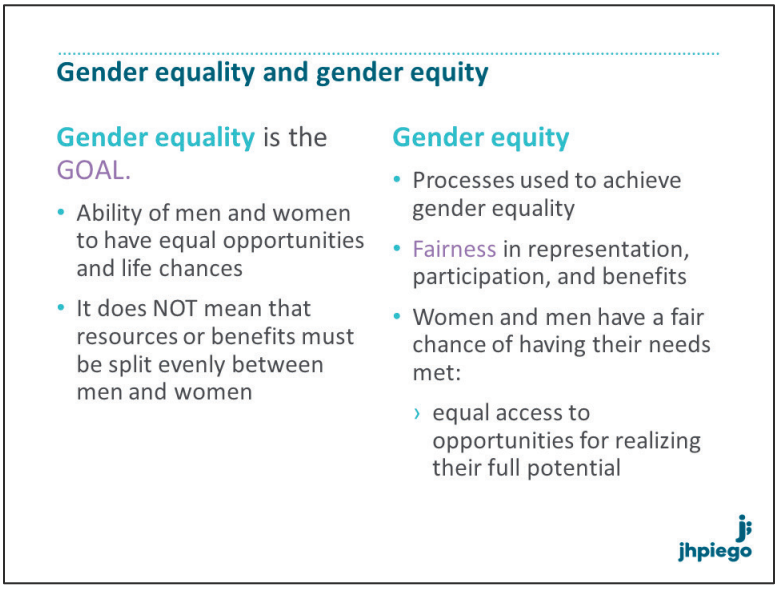
Slide 7



Facilitator discussion points

- Explain that gender equality is the goal. But to reach that goal, sometimes you have to treat people differently, or distribute resources that are not perfectly equal, to make up for disadvantages that individuals may have biologically or because of inequities of the past. For example, in many societies, women do not have the same opportunities for education because of higher preference for the boy child. Thus, girls are often not able to advance educationally, economically, and so forth.
- In the first illustration, the three people are given the same size boxes despite their different heights, and the only person able to reach the apple on the tree is the tallest person. This illustration displays inequality in outcomes (reaching an apple on the tree) because boxes were not tailored to the capacities of the individuals (their differing heights). In the second illustration, boxes are equitably distributed and are tailored to the capacities of the individuals (the shortest person has the tallest box), and therefore there is equality since all three people are able to reach the apples.

Slide 8



Slide 9

Gender integration and gender mainstreaming

Gender integration

- Strategies applied in programmatic design, implementation, monitoring, and evaluation to take into account gender considerations and compensate for gender-based inequalities

Gender mainstreaming

- Process of incorporating a gender perspective into an organization's:
  - policies, strategies, and administrative functions
  - institutional culture
- At the organizational level, ideally results in meaningful gender integration

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Facilitator discussion points

- Gender mainstreaming could include things like gender sensitivity training for staff, offering family leave and flex work policies to recognize caregiving roles, and offering breastfeeding or childcare centers.

Slide 10

Women's empowerment

- Expansion of women's capacity to make and act upon decisions **(agency)** and to transform those decisions into desired outcomes, affecting all aspects of their lives, including health
- Entails overcoming socioeconomic and other power inequalities in a context where this ability was previously denied

Pyay Nursing and Midwifery School, Myanmar, Photo ©2015 by Ann Lolordo/Jhpiego

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Facilitator discussion points

- Read the information on the slide.

Slide 11

Male engagement

- Programmatic approach that involves men and boys as clients and beneficiaries, as partners, and as agents of change in actively promoting:
  - gender equality
  - women's empowerment
  - transformation of inequitable definitions of masculinity
- Engages men and boys in addressing their own, and supporting their partners', reproductive, sexual, and other health needs
- Includes broader efforts to promote equality with respect to caregiving, fatherhood, division of labor, and ending gender-based violence

Father and baby,
Donomulyo Village, Indonesia
Photo ©2009 by Karen Kasmauski/Jhpiego

11

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Facilitator discussion points

- Read the information on the slide.

Slide 12

Gender-based violence

- Violence directed at individuals based on their biological sex, gender identity, or perceived adherence to culturally defined expectations of what it means to be a woman and man, girl and boy
- Includes public or private:
  - physical, sexual, and psychological abuse
  - threats or coercion
  - arbitrary deprivation of liberty
  - economic deprivation
- Rooted in economic, social, and political inequalities between men and women
- Although women and girls are the primary victims of GBV, men and boys also may be victims of violence when it is perpetrated to uphold or reinforce dominant forms of masculinities

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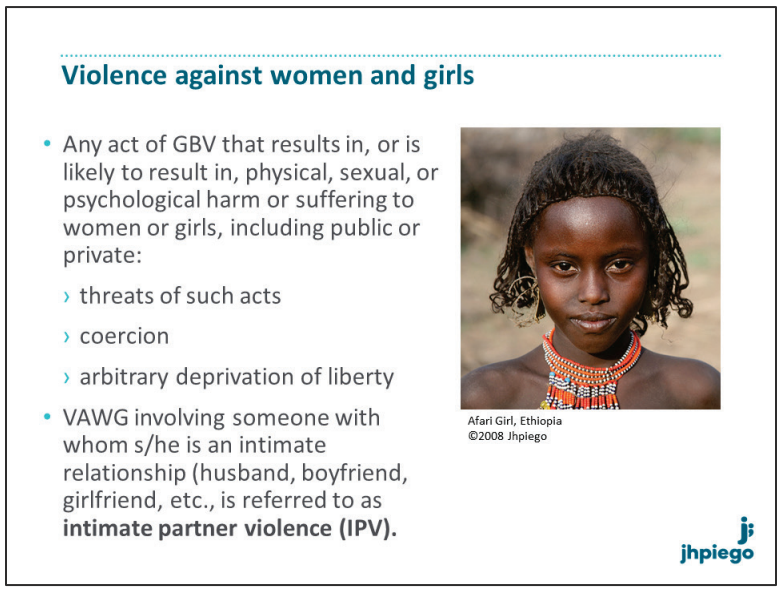
Facilitator discussion points

- Read the information on the slide.

Slide 13



Facilitator discussion points

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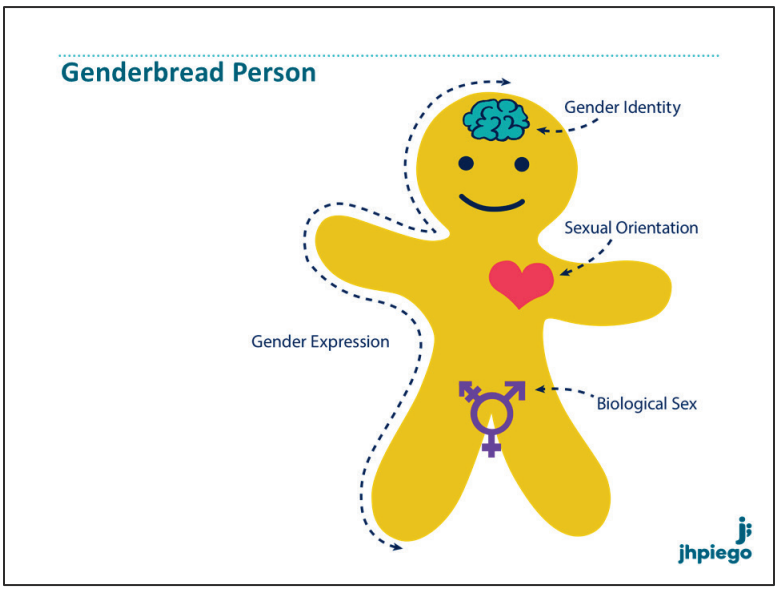
Slide 14

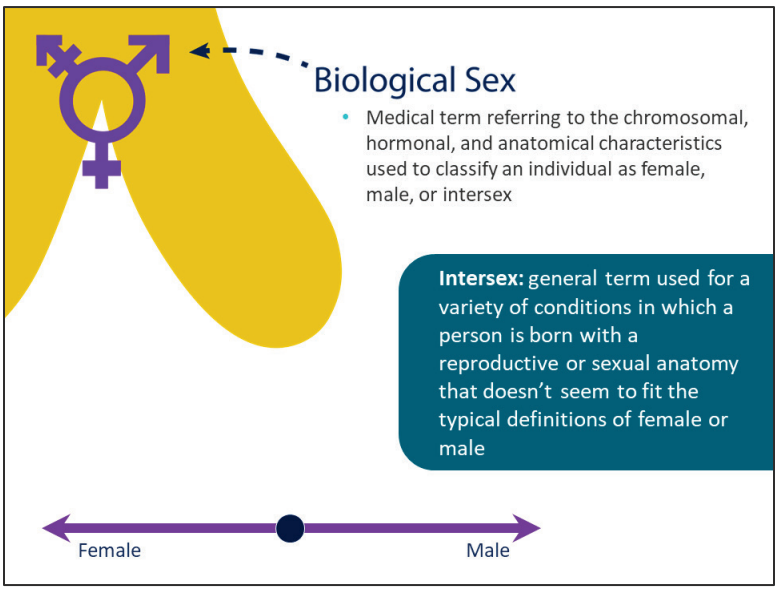
Slide 15



Facilitator discussion points

- Now we are going to learn about the Genderbread Person and the differences between gender identity, sexual orientation, gender expression, and biological sex.

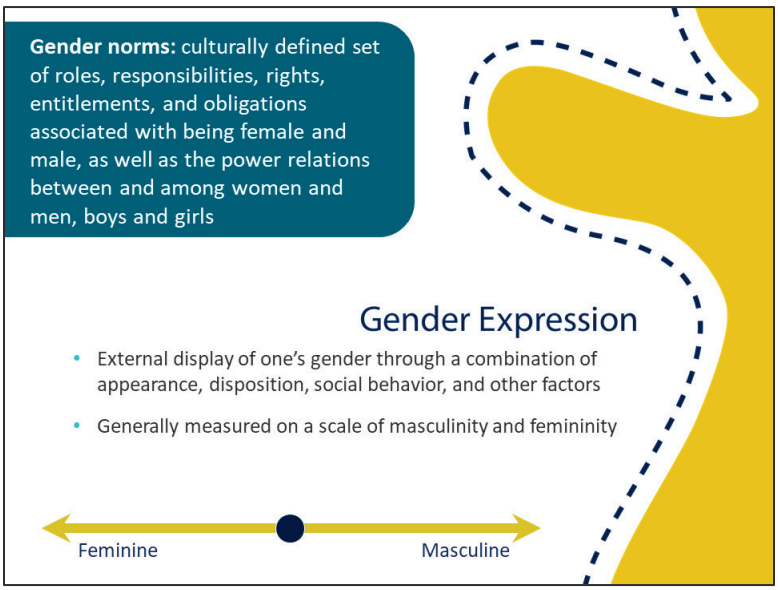
Slide 16



Facilitator discussion points

- Read the definition of biological sex.
- Click, and read the definition of intersex.
- Click to move the dot along the continuum, and explain that biological sex is on a continuum. The left side of the continuum refers to people who are born female meaning they are born with female sexual and reproductive organs (e.g., vagina, ovaries, etc.) and they have a biologically female "configuration" (e.g., two X chromosomes).
- The far right side of the continuum refers to people born male, meaning they are born with male sexual and reproductive organs (e.g., testes, penis, etc.) and they have a biologically male "configuration" (e.g., XY chromosomes).
- In the middle of the continuum are people who are born intersex. The term "hermaphrodite," which many people use to describe an intersex individual, is a negative term that should not be used. An intersex person could be born with a combination of female and male sexual and reproductive organs—for example, a person can be born with the appearance of being physically male (penis, scrotum, etc.) but have a functional female reproductive system inside. There are many ways intersex can present itself.

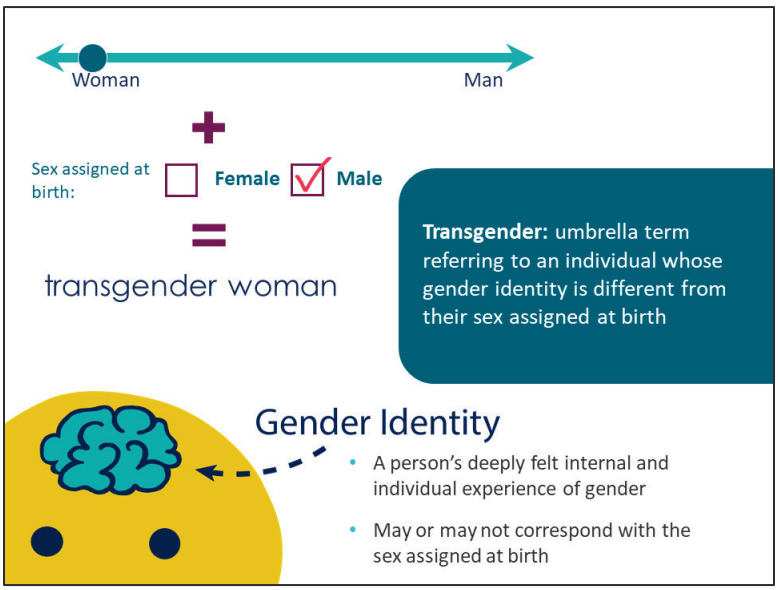
Slide 17



Facilitator discussion points

- Read the definition of gender expression.
- Click to move the dot along the continuum and explain that gender expression is also on a continuum. The left side refers to people who express who they are in a feminine way, by following the messages society communicates about the way women and girls should behave, dress, think, etc. The right side refers to people who express themselves in a masculine way, by following the messages society communicates about the way boys and men should behave, dress, think, etc. Some people may express themselves in ways where they combine both feminine and masculine characteristics—we refer to them as "androgynous."
- Our gender expression changes from year to year, month to month, even day to day, and we don't even think about it. For example: You are a girl. When you leave the house in the morning you are wearing a dress and you make sure to have breakfast ready for your siblings—your gender expression is very feminine and you are very much on the left side of the continuum. At school that same day, you lead a student meeting because you are the class president—here your gender expression leans toward what is perceived as male, e.g., leading a group, being very vocal. You return home at the end of the day and immediately start helping your mother in the kitchen while your father and brothers watch television—you are back to playing a traditionally feminine role again.
- Click and read the definition of gender norms.

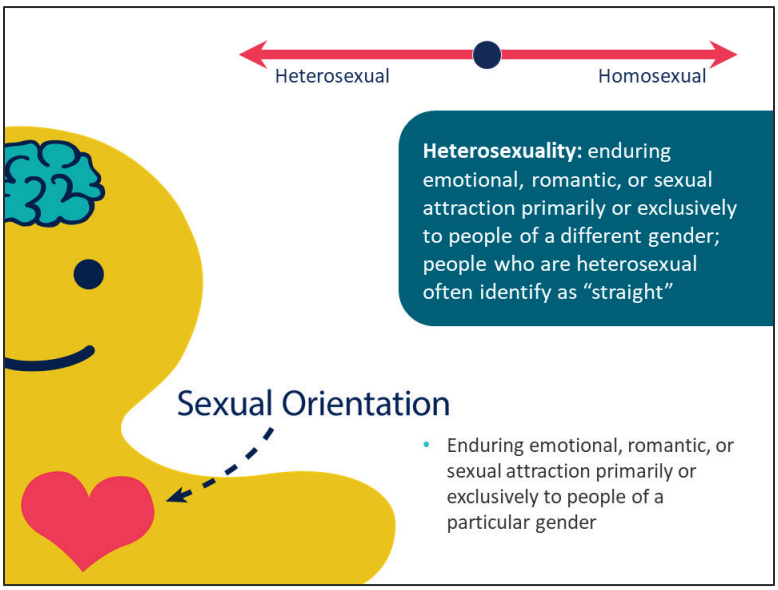
Slide 18



Facilitator discussion points

- Read the definition of gender identity.
- Click and read the definition of transgender.
- Click (to reveal the red check mark on the box labeled "Male") and explain that, for example, if someone is assigned male sex at birth, and their gender identity is woman, they can be considered a transgender woman. Click to reveal the words "transgender woman."
- Explain that gender identity is on a continuum. The far left side of the continuum refers to people who identify with the roles society has set for women, whereas the right side refers to people who identify with the roles society has set for men. Everyone forms their gender identity at around the age of 3 and after that age it is very difficult to change the identity. Our gender identity is formed by the influence of biology, society, and events in our lives.

Slide 19



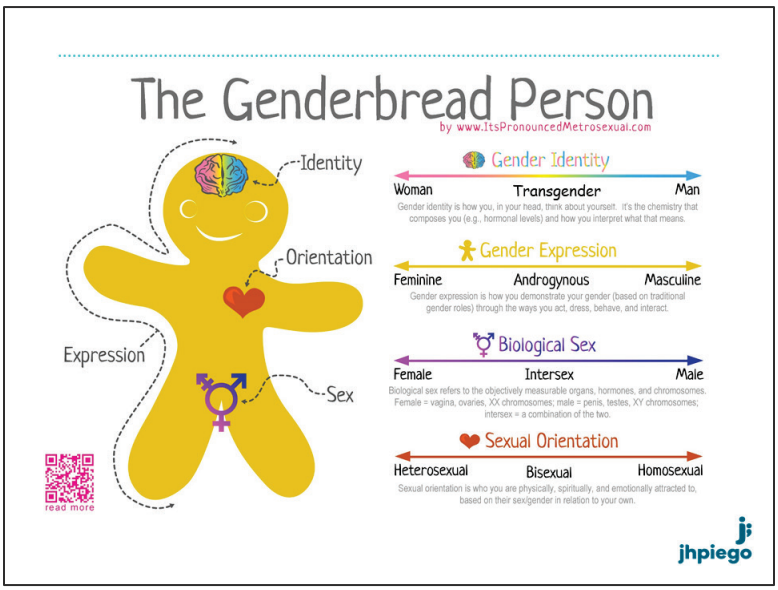
Facilitator discussion points

Read the definition of sexual orientation.

Click and read the definition of heterosexuality.

- Click to move the dot along the continuum, and explain that sexual orientation is on a continuum.
- Explain that people often get "gender" and "sexual orientation" confused. Gender has to do with how you express yourself as a man or a woman, whereas sexual orientation has to do with whom you are attracted to sexually and romantically. We often falsely assume that a man who is considered tough must be straight, or that a man who is considered sensitive must be gay. However, the exact opposite could be true, because gender roles and sexual orientation are two totally different things.

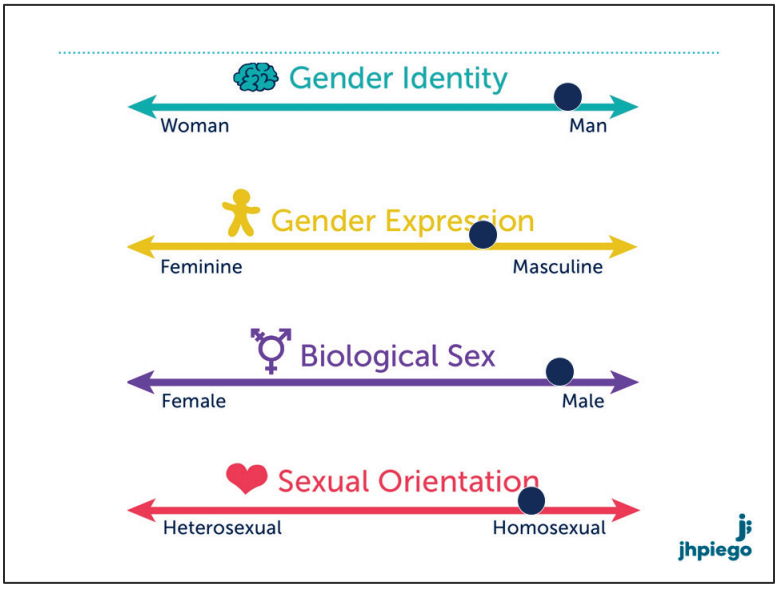
Slide 20



Facilitator discussion points

- This is the Genderbread Person. Now you should understand all of the concepts presented here. It is important to remember that gender identity, gender expression, biological sex, and sexual orientation do not determine one another. Gender identity and expression are not signs that a person is gay or heterosexual. A person's biological sex does not determine their gender identity or how they express their gender (e.g., a transgender person).

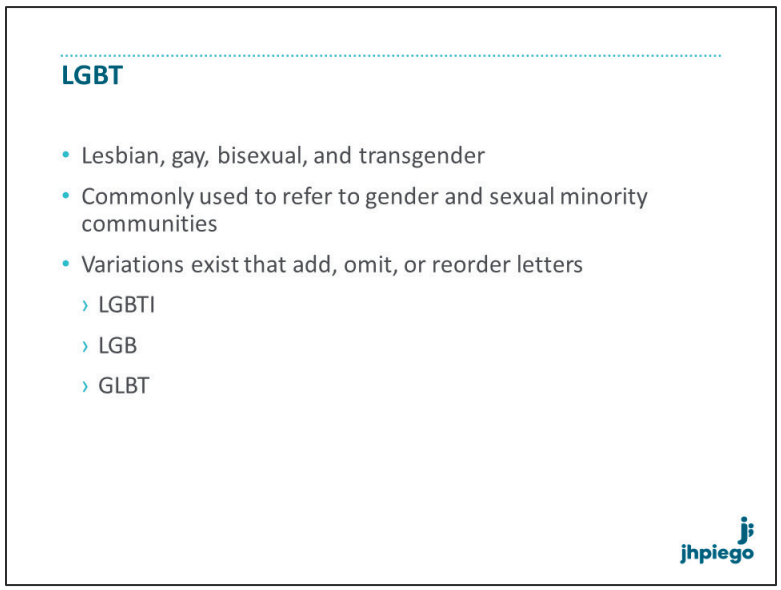
Slide 21



Facilitator discussion points

- Gender identity, gender expression, biological sex, and sexual orientation are all on continuums. This is an example of where someone may fall on the four different continuums.

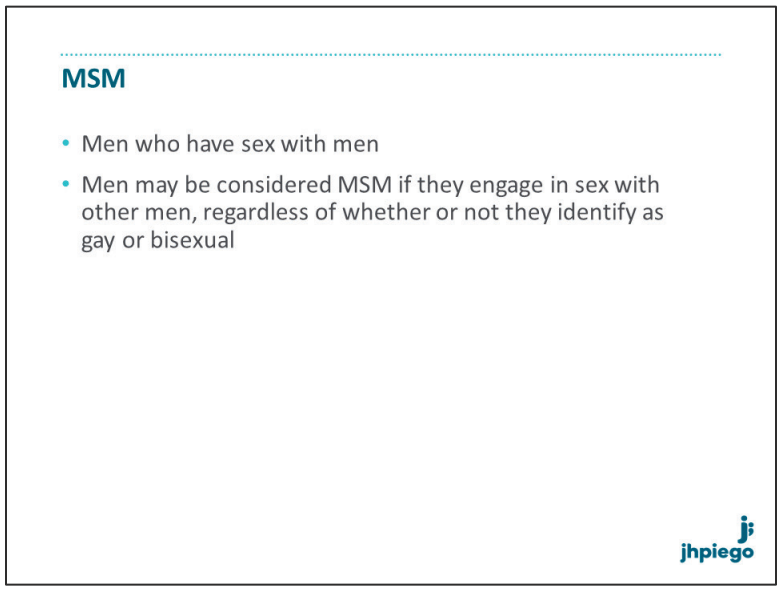
Slide 22



Facilitator discussion points

- Read the information on the slide.

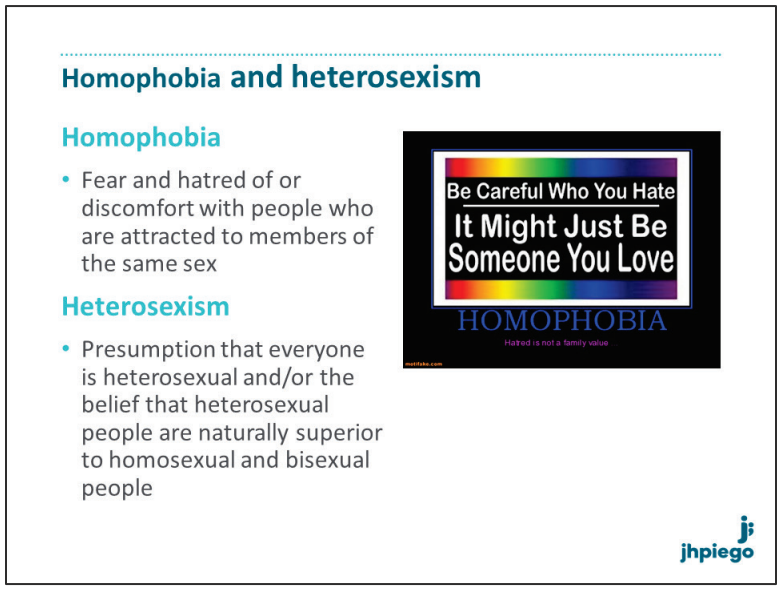
Slide 23



Facilitator discussion points

- Read the information on the slide.

Slide 24



Facilitator discussion points

- Read the information on the slide.

Slide 25

Facilitator Resource: Myths and Realities about Sexual Orientation and Gender Identity

(Adapted from Interagency Gender Working Group (IGWG). 2010. *IGWG Gender, Sexuality and HIV Training Module*. Washington, DC: IGWG. Pages 55–58.*)*

Sex between two men is, by definition, risky.

FALSE—Variance in gender identities, sexual behaviors, and sexual orientations is not inherently harmful. Sexual orientation does not itself determine risk. People's sexual exposure to HIV varies according to patterns of sexual behavior, condom use, other sexual risk-reduction practices, and overall HIV prevalence among sexual partners. People's ability to negotiate safer sex, safer drug use, and access to HIV treatment and care can be influenced by poverty, social and gender inequality, drug use, and other social or structural factors. In other words, various factors make up risk and sex between two men, and it does not necessarily result in greater risk than heterosexual sex. Sex between two men can involve various methods for risk reduction, such as condom use and lubricants, which may ultimately be less risky, for example, than someone having heterosexual intercourse with many individuals without using condoms.

Lesbians have little need for HIV prevention, treatment, or care.

FALSE—Sexual and reproductive health programs and providers have traditionally excluded lesbians because they may not have contraceptive needs and because sexual transmission of HIV between lesbians is relatively low; however, providers should not make assumptions about HIV vulnerability based on sexual orientation alone. Although the risk of sexual transmission of HIV between two women is very low, lesbians nevertheless face risks for HIV. Research shows that many lesbians also have male partners. As women in society, lesbians may be vulnerable to HIV through rape (especially in contexts where sexual violence is used as a "punishment" or "cure" for homosexuality). Lesbians are also at risk for HIV and other sexually transmitted infections (STIs) through the sharing of sex objects. Finally, just like people of any other sexual orientation, lesbians could be vulnerable to HIV transmission through injection drug use. Lesbians should have full access to the same range of reproductive health care as any other woman, including information about sexual and reproductive health, STI and HIV counseling and testing, pap tests, breast exams, and fertility services.

Sex between two men can be motivated by love, sexual pleasure, and/or economic exchange.

TRUE—The same things that motivate sex between a man and a woman motivate men to have sex with other men. The reasons may include love and companionship, sexual pleasure, and as a way of earning money in exchange for sex.

Bisexual people are just sex addicts who will have sex with anyone.

FALSE—Bisexual is the term for people who have affection and sexual attraction toward people of either sex. This does not imply that bisexuals are more likely than anyone else to have multiple partners or to be less "choosy" about sexual partners.

You can spot a homosexual by the way they look or act. "Feminine" men or "masculine" women are usually gay.

FALSE—Gender identity and gender expression do not determine sexual orientation or vice versa. Ideas that link the two are rooted in *stereotypes* meant to preserve rigid distinctions between men and women; that is, by accusing those who diverge from gender norms of being homosexual. Remember: although Lesbian, gay, bisexual, transgender, and intersex (LGBTI) communities sometimes accept or promote gender deviance more than "mainstream" society, almost everyone acts or looks in some way different from the expectations of their sex. Likewise, there is a range of sexual orientation, and many people experience sexual orientation as fluid, or changing over the life course.

Men who have sex with men (MSM) engage in the same sexual practices as other couples.

TRUE—MSM use many of the same sexual practices as heterosexual couples, including kissing, masturbation, touching, anal sex, and oral sex. These activities are not restricted to sex between a man and woman or MSM, but are commonly practiced by both groups. Some of us, for example, assume that all MSM practice anal sex, but in fact, many do not and there are many heterosexual couples who practice anal sex.

Homosexuality is a new phenomenon brought to my region by Westerners.

FALSE—Although homosexuality is more visible in some contexts than others, same-sex intimate behavior is relatively common, having been found in almost every known culture of the world. Further, historians have documented that colonization in many areas altered pre-existing attitudes toward homosexuality, introducing extreme *homophobia* (rather than homosexuality) by naming, categorizing, and even criminalizing same-sex practices and intimacies. Others argue that the invention of the term MSM by the development field similarly collapsed diverse experiences into a singular category of "other"—especially separating MSM in the global South from gay (white) men in the North. Around the world, visibility and acceptance of homosexuality is slowly growing.

Sex between two men is, by definition, coercive.

FALSE—Consensual sex between adults takes many forms, including sex with people of the same and other sexes/genders. So, too, does sexual coercion. Coercion is characterized by a lack of consent, regardless of the sex/gender of those involved.

Session 2: Exploring Gender and Culture

Learning Objectives

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

- Articulate the difference between sex and gender
- Describe the social expectations of women and men and how these expectations influence women's and men's lives
- Identify the ways in which participants' personal perceptions of female clients may influence their interactions with them
- Identify the ways in which participants may perpetuate gender stereotypes and gender-inequitable norms in their personal and professional lives
- Describe the influence of dominant gender norms on women's and men's personal lives

Facilitator note: If participants have participated in the "Gender Terms and Definitions" session, you should move straight to the **Ideal Woman, Ideal Man** portion of this activity.

If you are limited by time (and depending on whether you have already facilitated the "**Gender Terms and Definitions"** and "**Act Like a Man, Act Like a Woman"** sessions), you may wish to facilitate **Ideal Woman, Ideal Man**. If you decide to facilitate only the **Gender vs. Sex** session, you may still find it useful to refer to discussion questions in step 6 of the **Ideal Woman, Ideal Man** session to supplement group discussion.

Time

2 hours 15 minutes

Materials Needed

Chairs organized in a semicircle

Flipchart paper

Flipchart stand

Markers

Masking tape

Enough table or floor space for groups of four to five people to draw large pictures

Advance Preparation

None

Steps

Introduction (1 minute)

1. State that Jhpiego, along with the Ministry of Health in this country, is committed to overcoming gender discrimination and promoting gender equity. Understanding that society's expectations for us as men and women are not necessarily related to our biological differences is a good first step to understanding how gender discrimination affects our lives, our programs, and our project goals. In the following activities, members will explore the difference between sex and gender, consider examples of socially defined gender roles, and discuss how gender stereotypes impact our work.

Gender vs. Sex (45 minutes)

1. Ask participants to think about the first words that come to mind when they hear the words "man" and "woman." List responses from the group in two columns, labeled MAN and WOMAN, on flipchart paper. Below is an example of a list that participants might come up with:

MAN		WOMAN	
Police	Beer	Cooking	Gentle
Father	Bread-winner	Talkative	Passive
Power	Decision-maker	Shopping	Kind-hearted
Strength	Violence	Mother	**Menstruation**
Freedom	Unfaithful	Wife	**Pregnancy**
Businessman	Husband	**Breasts**	**Childbirth**
Penis	**Mustache**	Gossip	Housekeeper
Testicles	**Beard**	Sexy	Obedient
Generous	Lazy	Beautiful	**Vagina**
Selfish	Brave	Tidy	Tolerant
Dominant	**Adam's apple**	Jealous	Doesn't drink heavily or smoke
Loud	Humorous	**Uterus**	
Noble			

2. Make sure to include at least some words describing biological traits (such as “penis” for man and “breast” or “menstruation” for woman) on the list. Biological components are bolded in the lists above. Allow up to 10 minutes to complete steps 1 and 2.
3. When the lists are complete, point to some of the nonbiological words and ask the following questions, allowing up to 10 minutes for discussion:
    - Can any of the “man” words also describe women?
    - Can any of the “woman” words also describe men?
    - What words apply to women or men exclusively?
    - After discussing these points, state that the “woman” and “man” lists illustrate the difference between “sex” and “gender.” Often, gender and sex are understood to be the one and the same. In reality, they are quite different.
4. Next, read the following definitions for sex and gender aloud to the group:
    - **Sex** refers to biological differences between males and females, according to their physiology and reproductive capabilities. It is universal and mostly unchanging, without surgery. *Simply put, sex is determined by our bodies.*
    - **Gender** refers to the sociocultural expression of particular characteristics and roles that are associated with certain groups of people with reference to their sex and sexuality. *In short, gender is socially defined.*
5. Allow participants 5 minutes to ask any questions and/or make comments. Then, facilitate a 20-minute group discussion using the following questions:
    - Looking at both lists, do the differences between women and men tend to be mostly biological or mostly societal?
    - Do you think women can also be “strong,” “brave,” and “head of a household”? Why or why not?
    - Do you think men can also be “caring” and “kind” and can “take care of the children”? Why or why not?
    - Work that women do often revolves around taking care of the physical, emotional, and social well-being of other people, especially their husbands/partners and children. Work that men do is often related to their role as breadwinners/providers for their families, which leads them to seek out paid work. For example, the common perception is that many women love to cook, and many women cook better than men. But then why are cooks at hotels and restaurants mostly men while women cook at home, unpaid?

Facilitator note: During the discussion make sure to emphasize the following points:

- Sex is determined by our bodies. Gender, on the other hand, is socially defined.
- Gender depends on historic, economic, and cultural forces, and by definition it is constantly changing. This means that people have different understandings of what gender is, depending on their context.
- People learn about what it means to be male or female from many places, including their families, communities, social institutions, schools, religion, and media.
- Gender is hierarchical. In most societies, it gives more power to men than to women.

Ideal Woman, Ideal Man (1 hour 25 minutes)

1. Divide participants into four single-sex groups: two groups of women and two groups of men. If you do not have enough men or women to create two groups of each, you may adjust accordingly, but try to keep single-sex groups.
2. Once the groups have been formed, ask one female group to illustrate what they understand to be an "ideal" man in their culture and the other to illustrate what they understand to be an "ideal" woman; and ask one male group to illustrate what they understand to be an "ideal" woman in their culture and the other to illustrate what they understand to be an "ideal" man.
3. Explain that the groups will create their illustrations on flipchart paper. Explain that they can use a combination of drawings and words. They will have 15 minutes to do so. Once you have communicated the instructions and provided clarifications, distribute flipchart paper and markers to each group. Guide each group to separate areas of the room or to spaces outside of the room. Complete steps 1–3 in no more than 7 minutes.
4. After 15 minutes, ask the groups to hang their posters on the walls around the room.
5. Once the posters are on the walls, move as a group to each poster and ask a member of the group to explain the illustration. Allow 5 minutes for each group to present their poster and 5 minutes for other participants to comment or ask questions.
6. Next, bring participants back to the large circle and facilitate a group discussion for 15 minutes using the following questions:

   How are images of the ideal man and woman created? Where do they come from?

   - Who affirms them? Would you like to change the images you created?
   - What are some ways people can challenge these roles? Can you think of a time, when you challenged a gender role?
   - What happens if we challenge these roles? What happens if we do not challenge these roles?
   - How do gender norms that apply to men influence their sexual and reproductive health?
   - How do gender norms that apply to women influence their sexual and reproductive health?
   - How do gender norms influence your own interactions with clients (female and male)?

Closing (4 minutes)

1. End the session by summarizing the following points:
   - Society decides what are considered "normal" behaviors, attitudes, etc., for women and men, and we all operate under the influence of these social gender norms.
   - Often, society defines what is right for men and women. It is not our fault that the system is that way. However, **when we recognize injustice, we can do something to change it**. Society is made up of people, and people are capable of change.
   - Norms can be challenged, broken down (deconstructed), and changed (reconstructed).
   - In our programs and communities, we must encourage gender-equitable behaviors, such as men and women making decisions together about their health; men respecting a woman's right to say no to sex; men and women settling differences without violence; and men and women sharing responsibility for parenting and for care of others.

Acknowledgments

Cooperative for Assistance and Relief Everywhere, Inc. (CARE) and International Center for Research on Women (ICRW). 2007. *ISOFI Toolkit: Tools for Learning and Action on Gender and Sexuality*. Atlanta, GA and Washington, DC: CARE and ICRW.
http://www.endvawnow.org/uploads/browser/files/ISOFI%20Toolkit.pdf

Session 3: Act Like a Woman/Act Like a Man

Learning Objectives

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

- Describe the differences between rules of behavior that society applies to women and men
- Discuss the impacts of social gender rules on the lives of women and men

Time Needed

50 minutes

Materials Needed

- Chairs organized in a semicircle
- Flipchart paper
- Flipchart stand
- Markers
- Masking tape

Advance Preparation

None

Steps

Introduction (1 minute)

1. Explain to participants that this activity is intended to deepen their understanding and awareness of the different social rules/expectations applied to women and men, the ways in which they may unwittingly perpetuate some of these rules/expectations, and the positive and harmful impacts of these rules/expectations on their lives.

> **Facilitator note:** This activity is a good way to understand perceptions of gender norms. Remember that these perceptions may also be affected by class, race, ethnicity, gender identity, sexual orientation, and other differences. It is also important to remember that gender norms are changing in many countries. It is getting easier in some places for women and men to step outside their "boxes."

Man Box, Woman Box, and Hegemonic Masculinity and Femininity (48 minutes)

1. Ask the male participants if they have been ever been told to "act like a man." Ask for a few volunteers to share some experiences in which someone has said this or something similar to them. Ask:
    - Why did the person say this?
    - How did it make you feel?

2. Next, ask the female participants if they have ever been told to "act like a woman." Ask for a few volunteers to share some experiences in which someone has said this or something similar to them. Ask:
    - Why did the person say this?
    - How did it make you feel?
3. Tell participants that they will now spend some time looking more closely at these two phrases. Explain that by studying them, we can begin to see how society can make it difficult to be either female or male. (Spend no more than 5 minutes on steps 1–3.)
4. Label a blank flipchart page "Act Like a Man." Then, ask participants to share some ideas/examples of what it means to "act like a man" in their context. As participants call out ideas, write them on the flipchart page. To get participants started, you might use 1–3 of the following examples (spend no more than 5 minutes on this step):
    - Be tough
    - Do not cry
    - Yell at people
    - Show no emotions
    - Take care of others
    - Be brave
    - Have lots of sex
5. Once the group thinks the list is complete, draw a box around the list. Explain that all of the "male characteristics" listed constitute what can be referred to as the "man box" because the characteristics act as rules intended to confine men and boys to a specific definition of masculinity.
6. Before moving to the next step, tape the "man box" to the wall where it is visible to participants.
7. Next, facilitate a 10-minute group discussion using the following questions and record some of the participants' answers on a blank flipchart page:
    - What are the benefits to men and boys of living inside this box? What are the potential harms to men and boys?
    - In what ways could men's and boys' adherence to the rules of the "man box" impact the lives of women and girls?
    - Can men and boys live outside the box? Is it possible for them to challenge and change the rules?
    - What consequences do men and boys face in stepping out of the box?
    - When is it acceptable for men and boys to step out of the box?
8. After ending the discussion, tape the flipchart page with participants' answers to the wall next to the "man box."
9. Next, label a blank flipchart page "Act Like a Woman." Then, ask participants to share some ideas/examples of what it means to "act like a woman" in their context. As participants call out ideas, write them on the flipchart page. To get participants started, you might use 1–3 of the following examples (spend no more than 5 minutes on this step):
    - Be sensitive
    - Be passive

- Be the caretaker
- Act sexy, but not too sexy
- Be quiet
- Listen to others
- Be the homemaker

10. Once the group thinks the list is complete, draw a box around it. Explain that all of the "female characteristics" listed constitute what can be referred to as the "woman box."
11. Tape the "woman box" to the wall next to the two male flipchart pages.
12. Next, facilitate a 10-minute group discussion using the following questions and record some of the participants' answers on a blank flipchart page:
    - What are the benefits to women and girls of living inside this box? What are the potential harms to women and girls?
    - In what ways could women's and girls' adherence to the rules of the "woman box" impact the lives of men and boys?
    - Can women and girls live outside the box? Is it possible for them to challenge and change these rules?
    - What consequences do women and girls face in stepping outside of the box?
    - When is it acceptable for women and girls to step outside the box?
13. After ending the discussion, tape the flipchart page with participants' answers to the wall next to the "woman box."
14. Next, introduce the concepts of hegemonic masculinity and hegemonic femininity by explaining the following points (spend no more than 3 minutes on this step):
    - The characteristics listed in the "man box" and the "woman box" are forms of hegemonic masculinity and hegemonic femininity, respectively.
    - Hegemonic masculinity/femininity is the social pressure to conform to a singular predominant idea of "what it means to be a woman or a man" in one's culture. Hegemonic masculinity and hegemonic femininity are valued more than other expressions of masculinity and femininity. They are also often defined in opposition to one another; for men to remain dominant, women must be submissive and subordinate.
15. Before closing, allow participants 5–8 minutes to ask questions and/or make comments.

Closing (1 minute)

1. End the activity by stating that throughout their lives, men and women receive messages from family, media, and society about how they should act as men and women, and how they should relate to other men and women. As we have seen, many of these differences are constructed by society and are not part of our nature or biological makeup. Many of these expectations are completely fine and help us enjoy our identities as either a man or a woman. However, we all have the ability to identify unhealthy messages as well as the right to keep them from limiting our full potential as human beings. There are many ways to be a woman or a man. As we become more aware of the ways in which some gender stereotypes can negatively impact our lives and our communities, we can begin to think constructively about how to challenge them and promote more positive gender roles and relations. Therefore, we are all free to create our own "man box" and "woman box."

Sources

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Session 4: Gender-Focused Icebreaker

Learning Objective

To allow participants to get to know one another by sharing their personal stories

Time

30 minutes

Materials Needed

- Flipchart paper
- Markers

> **Facilitator note:** This exercise may be used as an abbreviated version of the session "Act Like a Man, Act Like a Woman" when time is limited. However, it does not include discussion on the links between gender roles and health.

Steps

Introduction (5 minutes)

1. Start by explaining that the activity is intended to help create a friendly and trusting atmosphere for the workshop through sharing their personal stories. Point out that this activity is also useful for initiating personal reflection on gender and its influence in our lives.

Getting to Know One Another (20 minutes)

1. Ask participants to pair up with someone they don't know.
2. After each participant has found a partner, explain that participants will take turns (in their pairs) introducing themselves and answering a question. Explain that each person will have 2 minutes to introduce themselves (e.g., their name, where they are from, and the program/project they work on) and to answer the following question:
    - When did you first become aware that there are certain things you are allowed and not allowed to do as a woman/man? (If workshop participants already have a good level of gender awareness and understanding, use the following question instead: "Describe some things you do in your personal life to step outside of traditional gender roles.")
3. Explain that after 2 minutes you will instruct participants to stop and switch so the person who was speaking becomes the listener.
4. Ask participants if they have any questions, and clarify any misunderstandings (spend no more than 5 minutes on steps 1–4).
5. Next, ask participants to quickly decide with their partners who will introduce themselves first.
6. Once they have agreed on the order, ask participants to begin.
7. After 2 minutes, call time and ask participants to switch.

8. After 2 minutes, ask participants to stop and bring everyone into a large circle.
9. Ask each person to introduce her/his partner and to relate the stories or issues that she/he talked about. Allow no more than 2 minutes per pair.
10. On flipchart paper, list what people shared with the group in two lists, using the headings "Male" and "Female." Under each heading, list the different gender roles, norms, expectations, or constraints participants share as being male or female, respectively. At the end of the introductions, briefly explain that these gender roles, norms, expectations, and constraints are boxes that society imposes on us due to gender. We can call them the "man box" and "woman box." You may refer to this throughout the training for quick reference to gender roles, norms, expectations, and constraints.

Facilitator note: It is important to ask each participant for permission to share their story with the group.

Closing (5 minutes)

1. End the activity by thanking everyone for their openness and for sharing their stories. State that the personal experiences shared help to illustrate the profound influence of gender norms in shaping our social identities.

Source

Cooperative for Assistance and Relief Everywhere (CARE), and International Center for Research in Women (ICRW). 2007. *ISOFI Toolkit: Tools for Learning and Action on gender and sexuality*. PLA Exercise 3. Atlanta, GA: CARE and ICRW.

Session 5: Vote with Your Feet

Learning Objectives

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

- Analyze their personal perceptions about gender differences, roles, and inequalities

Time

45 minutes

Materials Needed

- Chairs organized in a semicircle
- A4-sized paper
- Markers
- Masking tape
- **Facilitator Resource: Statements on Gender Roles**
- **Facilitator Resource: Dealing with Difficult Situations**

Advance Preparation

1. Create two signs by writing AGREE on one sheet of A4-sized paper, and DISAGREE on another sheet of A4-sized paper. Post the signs on two walls facing opposite sides of the room.
2. Select five statements from **Facilitator Resource: Statements on Gender Roles**.

Steps

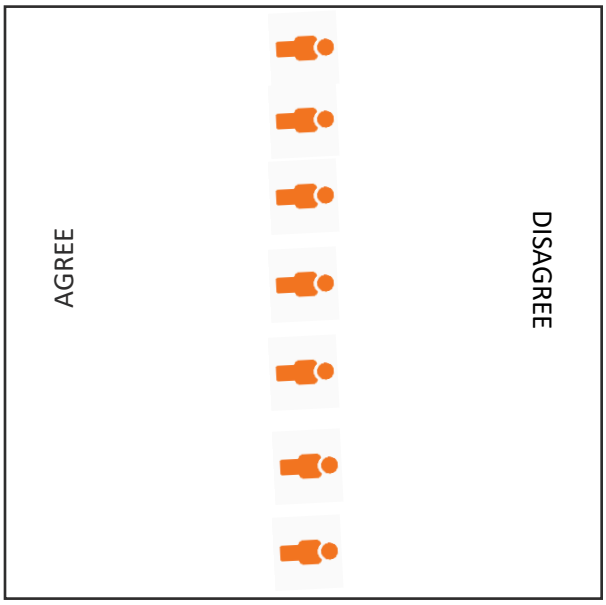
Introduction (1 minute)

1. Explain to participants that this activity is designed to give them a general understanding of their own and each other's values and attitudes about gender. It aims to challenge some of their current thinking about gender issues and help them clarify how they feel about certain issues. Remind participants that everyone has a right to his/her own opinion, and everyone's opinions should be respected.

Values Clarification (23 minutes)

1. Ask participants to stand in a single-file line in the middle of the room facing the wall on which you posted the AGREE sign (see diagram next page). With participants standing, briefly draw their attention to the wall behind them where you have posted the DISAGREE sign.
2. Explain to participants that you will read a series of five statements. Each participant will need to decide (on their own) whether they disagree or agree with each statement.
3. Explain that you will read each statement aloud twice. Participants should move to the AGREE wall if they agree with the statement or the DISAGREE wall if they disagree with the statement. Explain that after they have moved, you will call on a few participants to share their opinions.

4. Tell participants not to discuss their opinions with others and to move silently to the sign that best reflects their opinion.



5. Tell participants that they cannot remain in the middle. They must either agree or disagree.
6. Before beginning, make sure everyone understands the rules.
7. Next, refer to **Facilitator Resource: Statements on Gender Roles** and read the first statement you pre-identified aloud. Allow participants a few seconds to move toward the signs.

Facilitator note: If all participants agree on any of the statements, play the role of "devil's advocate" by walking to the opposite side of the room and asking, "Why would someone be standing on this side of the room?" (i.e., what values would they have that would put them here?).

Facilitator note: Some participants may say that they don't know whether they agree or disagree and don't want to stand next to either sign. If this happens, ask these participants to talk more about their reactions to the statement. Then encourage them to choose a sign. If they still don't want to, let them stand in the middle of the room as a "don't know" group.

Facilitator note: During facilitation, you may address topics that are sensitive and challenging to discuss. You will likely have to deal with participants who make statements that are not in line with the views and values of the program or the organization. These could include sexist, homophobic, or racist remarks or opinions. Everyone has a right to their opinion, but they do not have a right to oppress others with their harmful views. Refer to **Facilitator Resource: Dealing with Difficult Situations** for suggestions on how to address harmful participant views.

8. Once all participants have positioned themselves next to a sign, ask two to three volunteers from each group to explain their opinion to the group. (Spend no more than 3 minutes on this step.) Facilitator's notes are included under some of the statements in the **Facilitator Resource: Statements on Gender Roles**. These notes include helpful talking points and supporting or clarifying information for the facilitator after participants have had the chance to explain their opinions to the group. However, for most of these statements, there is no clear "right" or "wrong" answer, and it is important to make that clear to the group.
9. Next, bring participants back to the middle of the room and read the next statement aloud.

10. Repeat steps 7–9 for the remaining statements.
11. Once you have read all of the statements, ask participants to return to their seats.

Group Discussion (10 minutes)

1. Next, facilitate a 10-minute discussion using the following questions:
    - What statements, if any, did you have strong opinions or not-so-strong opinions about? Why?
    - Did some of the opinions in the room surprise you? Why or why not?
    - How do you think people's attitudes about some of the statements might affect the way they deal with women and men in their lives?
    - How did it feel to talk about an opinion that was different from that of some of the other participants?

Closing (1 minute)

1. End the activity by emphasizing the importance of thinking about our personal attitudes toward gender, and continuing to challenge our own values and beliefs about gender. State that although it is important to respect other people's attitudes about gender, it is also important to challenge them if their attitudes and values can be harmful to themselves and to others.
2. Make the following final points:
    - Even though we may be familiar with gender and the importance of gender-sensitive programming, some questions are still difficult to address.
    - Our own experiences with, and beliefs about, gender can have an impact on how we view and understand our projects/programs.
    - We need to keep all of these challenges in mind as we ask staff and project/program participants to address gender issues.

Sources

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Facilitator Resource: Statements on Gender Roles

Statements on Gender Roles

Facilitator note: When discussing the various statements under this category, you may want to raise the following points:

- Men are generally perceived to have more privileges in society—for example, being favored for educational and economic opportunities. However, men can also have many burdens. Likewise, women face many social pressures.
- Although individuals are born female or male, they undergo a socialization process whereby they learn to conform to social and cultural expectations regarding how women and men should behave, dress, speak, think, etc. Gender roles are learned/acquired and are not biological/innate.
- The goal of gender equality is not for women and men, girls and boys, to become the same. The goal of gender equality is to ensure that women and men have the same chances to access and benefit from social, economic, and political resources (e.g., have the same opportunities to vote, to be educated etc.).

- A woman's place is in the home.
- The most important thing a woman can do is have babies and care for them.
- A man is only valued for his ability to make money and provide for his family.
- A man is more of a man once he has fathered a child.
- Women are naturally better parents than men.
- Men will feel threatened if too many women are in leadership roles.
- For women to succeed in the workplace, special benefits and dispensations must be made available to them.

Facilitator note: Women may be equally capable in the workplace in terms of skills and abilities and should not necessarily be given special advantages over men. However, women may need special considerations for things like leave for childbearing, flexible schedules for childcare, space for breastfeeding and breast pumping, or special considerations (for example, for office setting or travel, or safety and security).

- The burden of accommodating women's needs in the workplace is too costly.
- Gender-equitable relationships should be the goal of a family planning/reproductive health (FP/RH) program.
- Female-controlled contraceptive methods perpetuate gender inequality in sexual relationships (because responsibility for contraceptive protection remains on women).

Facilitator note: In some societies where women typically have little decision-making over family planning use, a female-controlled contraceptive method can help a woman gain more control over her body and family planning. However, in some instances or societies, female-controlled methods may simply continue the norm and burden that women alone are responsible for family planning.

- It is fair and appropriate to expect service providers to mitigate power dynamics between a couple seeking services.

Statements on Men and Reproductive Health

Facilitator note: Keep in mind the following points related to some of the statements under this category:

- All sex must be consensual, meaning that both partners must freely agree to participate in a particular sexual activity. Just because two people are in an intimate relationship (including marriage) does not mean that rape cannot occur.
- Women's and men's sexual and reproductive health (SRH) is relational—a female partner's SRH is dependent upon her male partner's SRH and vice versa. In heterosexual intimate relationships, women are often unable to negotiate the conditions of sex, or make decisions about their own health because they tend to lack power in the relationship. It is therefore important to meaningfully involve men as partners in SRH and reproductive, maternal, newborn, and child health (RMNCH) promotion efforts as a means of contributing to more joint decision-making and shared responsibility (e.g., for childcare) among couples.
- Men are also impacted by sexually transmitted infections (STIs), HIV, and pregnancy (even if indirectly). Social norms, however, tend to discourage health-seeking behavior among men and boys as any call for help by a male is seen as a sign of weakness. Most SRH and RMNCH service sites also tend to target their messaging and services toward women; consequently, SRH and RMNCH are seen as exclusively concerning women. As a result, men become further and further disengaged from their roles as parents and partners. Health programs can encourage more male involvement in SRH and RMNCH efforts by supporting health facilities to offer male and couple-friendly services.

- Increasing men's participation in family planning and reproductive health programs will only further increase men's power over women.
- Family planning will always be a more important issue to a woman than to a man because she is the one who can get pregnant.
- Men are more concerned about STIs than women are.
- Clinics should concentrate on serving older, married men because adolescent males are highly unlikely to seek clinical services.

Facilitator note: Interventions must be carefully designed and monitored to ensure that men's power over women does not increase further. However, involvement of men alone does not necessarily mean their power will increase. The goal is to achieve joint decision-making through promotion of joint dialogue and communication between couples.

- Men are uncomfortable going to a female-oriented health facility or being treated by a female clinician.
- In today's world, a boy child is more valued than a girl child.
- A woman can do any kind of work a man can do.
- Family planning is a woman's responsibility.
- A man is only a real man if he has fathered a child.
- It is normal for a man to look after the children and cook.
- A man has the right to have sex with his wife even if she does not want to.
- It is easier to be a man than a woman in today's world.
- A man should compromise sexual pleasure for contraception or health.

Statements on HIV/AIDS

Facilitator note: Keep in mind the following points related to some of the statements in this category:

- Variance in gender identities, sexual behaviors, and sexual orientations is not inherently harmful. Sexual orientation does not itself determine risk. People's sexual exposure to HIV varies according to patterns of sexual behavior, condom use, other sexual risk-reduction practices, and overall HIV prevalence among sexual partners.
- Stigma and fear can make it difficult for gay and bisexual people, lesbians, transgender people, and men who have sex with men (MSMs) to access sexual health information and services, putting them at greater risk for HIV and AIDS. It is important to work to dispel harmful myths around sexuality, and promote respect for the rights of women and men to express their sexual orientation, free from discrimination.
- HIV can be transmitted through the exchange of a variety of body fluids from infected individuals, such as blood, breastmilk, semen, and vaginal secretions. HIV cannot be transmitted through ordinary day-to-day contact such as kissing, hugging, shaking hands, or sharing personal objects, food, or water.

- An HIV-positive woman should avoid getting pregnant if at all possible.

Facilitator note: Mother-to-child HIV transmission rates in the absence of any intervention ranges from 15%–45%. However, this rate can be reduced to 5% with effective interventions during pregnancy, labor, delivery, and breastfeeding. Interventions typically include antiretroviral treatment for the mother and a short course of antiretroviral drugs for her baby.

- Gender-equitable relationships should be the goal of an HIV/AIDS program.

Facilitator note: Different kinds of HIV/AIDS programs and interventions are tailored to specific populations (e.g., voluntary medical male circumcision for boys and men). Ideally, all HIV/AIDS programs should be gender sensitive, and ideally gender transformative; however, gender-equitable relationships may not always be a main program goal of an HIV/AIDS program. The health goals of most HIV/AIDS programs are around prevention and increasing testing, treatment, and viral suppression. A gender outcome may be gender-equitable relationships. Gender-equitable relationships may also be a secondary goal of a program, or even along a pathway to a health goal.

- HIV behavior change efforts would have greater success if they addressed sexual pleasure.
- MSM are more vulnerable to HIV because, in most countries, they cannot marry.

Facilitator note: The research does not make evident that not being able to marry increases risk; however, MSM who are in multiple concurrent relationships, just as anyone else in multiple concurrent partnerships, are at higher risk for HIV. Likewise, unprotected sex, whether inside or outside marriage, can carry with it some level of risk.

- A more "sex-positive" sociocultural environment—meaning an environment that promotes greater acceptance of sexuality and sexual desires—would decrease HIV risk and vulnerability.

Facilitator note: A "sex-positive" environment could certainly contribute to decreased HIV risk and vulnerability, especially if sex involving populations that are often stigmatized (e.g., MSM and transgender individuals) is accepted in the community. In more conservative societies or in societies where acceptance of sexuality is limited, people from stigmatized populations are often unable to access services without experiencing discrimination. Therefore, they may choose not to seek services at all, which may increase their HIV risk and vulnerability even further.

- In a generalized epidemic, it is important for HIV programs to focus on transgender people because they are driving the spread of the disease.

Facilitator note: A *generalized epidemic* is firmly established in the general population. HIV prevalence in generalized epidemics usually is greater than 1% among pregnant women attending antenatal clinics. A *concentrated epidemic* has spread rapidly in one or more populations and is not as well established in the general population. It is possible that in a setting with a generalized epidemic, certain subpopulations such as transgender people have higher HIV prevalence. However, in generalized epidemics, the heterosexual population also sustains the epidemic.

Statements on Gender and Sexuality

Facilitator note: Keep in mind the following points related to some of the statements in this category:

- Unfortunately, in many cultures, men and women receive different messages about sexuality. Men's sexuality is seen as impulsive and uncontrollable, whereas women's sexuality is seen as passive and controllable. These contrasting messages often have negative implications for how men and women relate to each other in intimate and sexual relationships.
- Both men and women have sexual desires and can feel sexual excitement. This excitement depends on biological as well as social and psychological factors.
- Messages about sexuality, regardless of the source, communicate different attitudes and expectations.
- Often messages, whether from parents, peers, religious institutions, or the media, communicate traditional gender norms and stereotypes regarding sexuality (e.g., it is not "normal" to have anal sex; sex should only happen when both parties are married, etc.).
- When sexual rights are not respected, both women and men are more vulnerable to STIs and HIV and AIDS. It follows, therefore, that respecting sexual rights, as well as other rights, creates a more secure society for everyone.
- Despite the fact that homosexuality is more visible in some contexts than others, same-sex intimate behavior is relatively common, having been found in almost every known culture of the world. Further, historians have documented that colonization in many areas altered pre-existing attitudes toward homosexuality, introducing extreme homophobia (rather than homosexuality) by naming, categorizing, and even criminalizing same-sex practices and intimacies.
- Although we do not know precisely what determines a person's sexual orientation, we do know that it is formed early in life, is not chosen by the person, and cannot be changed, although some may hide it because of social taboos and homophobia.

- Men are more concerned about sexual performance than women.
- Sexual pleasure is more important to men than to women.

Facilitator note: Sexual pleasure is just as important to women as it is to men. Society often focuses on men's sexual pleasure, but women's sexual pleasure is equally as important.

- These days, it's okay for a girl/woman to initiate sex.
- Oral sex is more intimate than intercourse.
- People who have multiple sexual partners concurrently are irresponsible.

Facilitator note: Some people who have multiple sexual partners concurrently did not choose to have multiple partners. Additionally, having multiple sexual partners concurrently is condoned in some religions or cultures.

- It is empowering for a woman to use her sexuality as a bargaining tool (e.g., by offering or withholding sex with her partner or another person).
- A sex worker is a victim.

Facilitator note: Often, women or men choose to sell sex for pleasure, money, goods, or services. People who sell sex come from many different backgrounds and may choose sex work for a range of reasons. A sex worker may be poor and not have the education or training for another type of career. A sex worker may have a middle-class background, college education, and no apparent financial need to engage in sex work. Some sex workers enjoy their work and some may not.

- People in same-sex relationships have equal rights in my community.
- The ability to express one's sexuality and sexual diversity freely is key to contributing fully to society.
- A woman should have sex only with someone she loves.
- A man should have sex only with someone he loves.
- Sex is more important to men than to women.
- A woman should be a virgin at the time of marriage.
- It is okay for a man to have sex outside of marriage if his wife does not know about it.

Statements on Gender-Based Violence

Facilitator note: Keep in mind the following points related to some of the statements in this category:

- No person deserves to be beaten, no matter what they have done. Regardless of the circumstances, violence cannot and should not be justified.
- When there is violence in a relationship between men and women, generally the violence the man commits is more severe. When women use violence, it is generally in response to a partner's violence, and in many cases, their partners react with more violence.
- A violent person is not out of control. Even men who say they lose control when they hurt their partners do not use violence in every situation, nor with every person. They are selectively violent—in other words, their violence is a choice.
- Those who mistreat others do not feel any more rage than other people, but they use their rage as an excuse and a justification for their behavior, against people who have less power than they do.

- Women are just as likely to support wife beating as men. Or, women are just as likely to perpetrate violence as men are.

Facilitator note: Based on demographic and health surveys in various countries, women are often just as likely or more likely to believe wife beating is justified. Women are influenced by the same social and gender norms that make violence acceptable, but their beliefs do not mean that they deserve it or are asking for it. Some studies have found that women use violence in relationships as well, sometimes as much as men. However, in surveys on intimate partner violence that have asked how often, how harsh, and is it in response to violence they experience, men come out more clearly as aggressors. In terms of general violence in society, men are overwhelmingly more likely to be the perpetrators.

- A man has the right to hit a woman.

Facilitator note: Violence is never justified. Everyone has a right to live free of violence.

- In certain circumstances, women provoke violent behavior.

Facilitator note: First, women are never to blame for experiencing intimate partner violence at the hands of their partner. Women may in some cases initiate violence; however, violence is not acceptable from either males or females and should be deescalated.

- Gender-based violence (GBV) is too culturally sensitive an issue to be addressed in reproductive health projects.

Facilitator note: GBV is linked to ill reproductive health outcomes and should absolutely be addressed in reproductive health projects, if there are resources to do so in an adequate manner that complies with World Health Organization clinical guidelines and evidence-based practices. GBV has been linked to STIs, vaginal bleeding and infection, fibroids, decreased sexual desire, genital irritation, pain on intercourse, chronic pelvic pain, and urinary tract infections. GBV during pregnancy has been associated with low birthweight. Some studies have shown associations between abuse during pregnancy and infant outcomes including preterm delivery, fetal distress, antepartum hemorrhage and pre-eclampsia.

- Men sometimes have a good reason to use violence against their partners.

Facilitator note: It is never acceptable for men to use violence against their partners. Women may in some cases initiate violence, but violence is not acceptable from either males or females and should be deescalated.

Statements on Safe Motherhood

- Increasing men's participation in antenatal care will only further increase men's control over women's fertility and health.

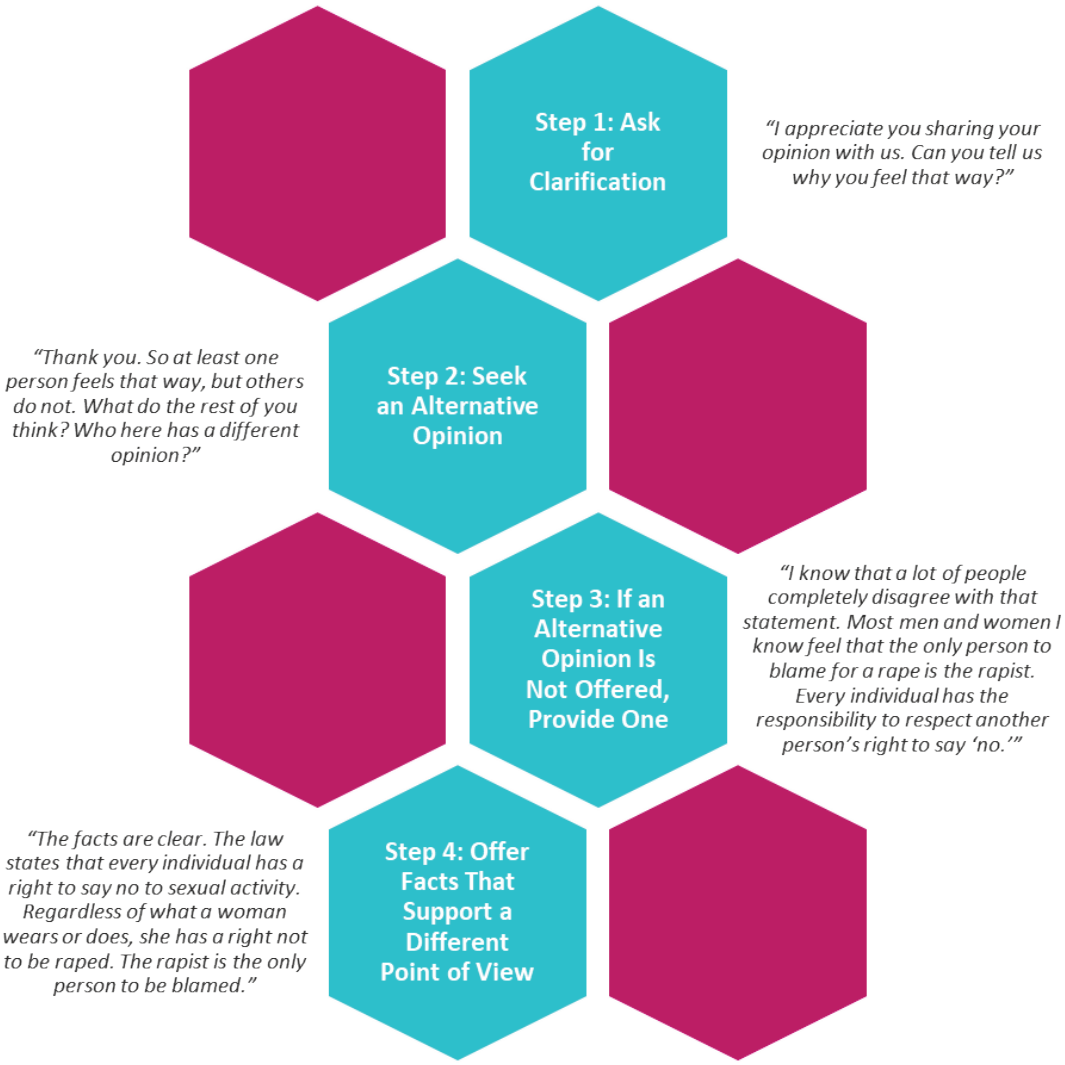
Facilitator note: Interventions must be carefully designed and monitored to ensure that there are no further increases of men's power over women. However, involvement of men alone does not necessarily mean their power will increase. The goal is to achieve joint decision-making and partner support through promotion of joint dialogue and communication between couples.

- Safe motherhood will always be a more important issue to a woman than to a man because she is the one who will give birth and care for the baby.
- Many health workers are uncomfortable counseling men on safe motherhood issues.
- Men are uncomfortable going to a female-oriented health facility.

Facilitator Resource: Dealing with Difficult Situations

During facilitation, the facilitator may address many topics that are sensitive and difficult to discuss. The facilitator will likely have to deal with participants who make statements that are not in line with the program's views and values. These could include sexist, homophobic, or racist remarks or opinions. Everyone has a right to their opinion, but they do not have a right to oppress others with their views.

For example, a participant might say, "If a woman gets raped, it is because she asked for it. The man who raped her is not to blame." It is important that facilitators challenge such opinions and offer a viewpoint that reflects the program's philosophy. This can be difficult, but it is essential in helping participants work toward positive change. The following process is one suggestion for dealing with such a situation:



Note that even after the facilitator takes these four steps to address the difficult statement, it is unlikely that the participant will openly change his or her opinion. However, by challenging the statement, the facilitator has provided an alternative point of view that the participant will be more likely to consider and, it is hoped, adopt later.

Source

EngenderHealth. 2015. *Training on Gender and SRH: Facilitation Manual*. New York, NY: EngenderHealth; 123

Session 6: Power Walk

Learning Objective

By the end of this session, participants will be able to describe how gender and sexual identities impact access to health services across different populations

Time

45 minutes

Materials Needed

- Flipchart paper
- Chairs organized in a semicircle
- Flipchart stand
- Markers
- Scissors
- Cards of various colors to print character labels for each person to carry
- Facilitator Resource: Character Profiles
- Facilitator Resource: Power Walk Statements I: Gender Inequalities in Health Services
- Facilitator Resource: Power Walk Statements II: Gender Inequalities in the Community

Facilitator note: This activity requires a space (indoors or outdoors) large enough to allow participants to line up side by side and to step forward 10 feet and backward 10 feet.

Advance Preparation

1. Refer to **Facilitator Resource: Character Profiles** and select and cut out enough character profiles for each participant (one profile per participant).

Facilitator note: The purpose of this activity is to allow participants to experience the ways in which gender and other health determinants interact. Participants will represent a range of characters to demonstrate varying experiences of vulnerabilities and privileges with respect to health behavior and interactions with the health system. It is important, therefore, to select character profiles that will have maximum impact. Make sure to select profiles that are relevant to the social and cultural context.

Steps

Introduction (1 minute)

1. Explain to participants that they will spend some time reflecting on the links between social norms and sexual and reproductive health outcomes. State that this activity is intended to provide them with greater insight into the ways a person's social position influences her/his capacity to exercise her/his sexual and reproductive rights.

> **Facilitator note:** Regardless of the number of participants present, make sure to always include the character of the heterosexual man with a wife and two children.

Power Walking (22 minutes)

1. Instruct participants to stand and form a straight line facing forward.
2. Next, randomly distribute to each participant one of the character profiles printed on the strips of paper you have cut out.

> **Facilitator note:** It is not necessary to distribute the characters based on participants' sex. Male participants may receive female character descriptions, and female participants may receive male character descriptions.

3. Explain to participants that they have each received a piece of paper with a character profile printed on it. During the exercise, they will represent the character they were assigned. Explain that you will read a series of statements with which participants can either "agree" or "disagree." Their answer will depend on the character they represent—that is, they will answer based on how they believe their character would answer. If their character would be likely to agree with the statement, they should take one step forward; if their character would be likely to disagree with the statement, they should not move. Emphasize that there are only two answers possible: agree or disagree. An uncertain answer will be considered a disagree. Explain that participants will stand in a line and hold hands during the activity. If a participant begins moving in an opposite direction to the people with whom she/he is holding hands, she/he should let go.
4. Next, one by one, ask each participant to read their character profile aloud to the group. As participants share their character profiles, answer any questions they may have about their character.

> **Facilitator note:** Some participants may feel uncomfortable representing characters who do not conform to dominant gender and/or sexuality norms (e.g. transgender and gay characters). It is important to emphasize that this is only an exercise and explain that this activity is intended to explore precisely the types of feelings people may have about non-normative sexual and gender identities.

> **Facilitator note:** Some male participants may feel uncomfortable representing a female character. The facilitator should be sensitive to reactions of discomfort expressed by male participants and, when appropriate, remind them of any previous discussions about gender roles. The facilitator should also encourage the men to reflect on their reactions. If absolutely necessary, male participants who are not comfortable representing a female character may be given a male character description.

Before beginning the activity, check that all participants understand the instructions.

5. Ask participants to line up side by side, all facing one way, across the middle of the room. Instruct them to be mindful of keeping sufficient and equal space both between and in front of them. Once participants are standing in a line, ask them to hold hands with the people on either side of them. (Spend no more than 10 minutes on steps 1–6.)
6. Refer to **Facilitator Resource: Power Walk Statements I and/or II** and read the first statement aloud. After you have read the statement, allow participants a few seconds to decide on their answer. Then, read the next statement aloud. (Spend no more than 15 minutes on this step; you may not be able read all statements.)

> **Facilitator note:** Depending on the focus you desire for the exercise and time available, you may choose to read the statements that focus on health services, on the broader community gender norms and roles, or a mix of both. The latter is recommended.

7. After you have read your last statement, pause. Ask participants to remain where they are. If some participants are still holding hands, tell them they can let go.
8. Ask participants to look around to see where they are standing and where others around them are standing. Instruct participants to take a moment to reflect on their own position and the positions of others.

> **Facilitator note:** At this point, it may be necessary for participants to briefly remind others of their character profile. Alternatively, you can give participants color-coded cards to carry with their identities written on them.

9. Next, instruct the group to face forward again (without changing their positions) and communicate the following instruction: "When I say 'go,' race/walk to the wall in front of you." Give participants a few seconds to get ready (some may want to tie shoelaces, remove shoes, etc.) and then call out, "One, two, three, GO!" (Spend no more than 2 minutes on steps 8–10.)
10. Ask participants to return to their seats.

> **Facilitator note:** If the space you are using is too large, you may draw an imaginary line on the ground and ask participants to run to the line.

Group Discussion (20 minutes)

1. Next, facilitate a 20-minute group discussion using the following questions and the important discussion points related to each statement in **Facilitator Resource: Power Walk Statements**:
    - How did you feel about portraying your character?
    - Who tended to move the most during the exercise? Why?
    - Who tended to move the least during the exercise? Why?
    - How did you feel when you were standing together in the beginning?
    - How did you feel at the end when you saw yourself in relation to where others were?
    - Which questions resulted in the least movement?
    - How did expectations about acceptable/normal female and male behavior affect who was able to move? For which questions?

- How did expectations about proper/normal sexual behavior affect who was able to move? In relation to which questions?
- What benefits do more equal gender roles bring to men's lives? Women's lives?
- What does this exercise tell us about the impact of social expectations on individuals' health?
- What does all of this mean for our sexual and reproductive health (SRH) programming?

Closing (2 minutes)

1. End the activity by making the following points:
   - Gender and sexual norms reinforce each other. Together, gender and social norms enforce power inequalities. The traits most highly valued in society are masculine, heterosexual, white (or the dominant ethnic/racial group in a given context), and financially secure. This reinforces a hierarchy of relations (men over women, more "masculine" men over less "masculine" men, and adult men over younger men). Gender and sexual norms determine which sexual practices are valued or are stigmatized and punished by society, who has the power to make decisions about sex, and whose sexual pleasure and well-being is most important.
   - Gender roles and inequalities drive who has power and who is at greater risk of violence. In general, women typically have less power than men.
   - Social norms that dictate that women should be subservient to men can limit women's access to SRH services and contraception. In some contexts, providers may even refuse to provide women with contraception without the male partner's consent.
   - Social norms dictate acceptable and unacceptable sexual behaviors/practices. "Acceptable" sex is penile-vaginal intercourse, while other sexual practices are often stigmatized and/or discouraged.
   - Social norms also dictate that sex is supposed to occur within the institution of marriage or within stable partnerships. Having multiple sexual partners, having sex before marriage, or paying for sex are generally stigmatized (and in many instances, criminalized). Unmarried and/or young women and men may be discouraged (or prohibited) from accessing SRH centers to obtain contraceptive methods.
   - Social norms that dictate what constitutes "normal" sexual behaviors for women and men also inform the delivery of SRH services, ultimately limiting women's and men's access to SRH services as well as access to services by socially marginalized populations (e.g., transgender, gay, lesbian, bisexual, and intersex persons; men who have sex with men; women who have sex with women; etc.). As such, these individuals cannot exercise their sexual and reproductive rights and ensure their SRH.

Sources

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Michau L. 2008. *The SASA! Activist Kit for Preventing Violence against Women and HIV*. Kampala, Uganda: Raising Voices. http://raisingvoices.org/sasa/download-sasa/.

Facilitator Resource: Character Profiles

Male sex worker
Female sex worker
Transgender woman (born as male sex, but self-identifies as a woman)
Transgender man (born as female sex, but self-identifies as a man)
Single woman living with HIV
Married man living with HIV
Gay man (a man who is sexually, romantically, and spiritually attracted to other men)
Gay woman (a woman who is sexually, romantically, and spiritually attracted to other women)
Man who has sex with women and men (a man who engages in sexual activity with men and women but who does not self-identify as gay or bisexual)
Poor woman who often trades sex for basic necessities
15-year-old girl married to a 45-year-old man
Male religious leader who is sexually active
Married woman who is a victim of domestic violence
Male adolescent who has HIV
Unmarried, 50-year-old heterosexual man who is sexually active
Sexually active single adolescent girl
Sexually active single adolescent boy
Heterosexual man with a wife and two children
Married woman with no children
Sexually active, 20-year-old unmarried woman with three young children
Policeman who frequently pays for sex

Facilitator Resource: Power Walk Statements I: Gender Inequities in Health Services

1. I feel respected by health care workers.

   Important points for the group discussion:

   - Many gay and transgender people are not respected by health care workers when they go for services because in many countries around the world, being gay and/or transgender is socially unacceptable and, in some cases, illegal. Although health care workers are supposed to suspend personal judgment and treat the individual, many allow their personal beliefs to interfere with service provision, which may result in their exhibition of discriminatory behaviors and attitudes toward gay and transgender clients. As a result of this discrimination in health facilities, many gay and transgender individuals may not seek out health services even when they really need them. This has serious implications in terms of their sexual and reproductive health (SRH) outcomes.
   - Many of the other characters might also face judgment and discrimination from health care workers because they are seen as not complying with dominant norms regarding acceptable female and male sexual behavior (e.g., male and female sex workers, single woman with HIV, poor woman who often trades sex for basic necessities, unmarried sexually active woman, sexually active adolescents, boy with HIV, and married woman with no children).

2. I can consult health services when and if I need to.

   Important points for the group discussion:

   - Given the stigma and discrimination faced by many gay and transgender individuals, most may not feel that they can access health services. This discrimination may also limit their ability to speak openly about their health concerns, thereby further limiting the quality of the service provided.
   - Similarly, some of the other characters may also feel unable to consult health services when they need to because they fear stigma and judgment from providers (e.g., female and male sex workers, boy with HIV, single woman with HIV, unmarried woman who is sexually active, etc.). Some other characters may be unable to consult services altogether because they lack the financial means (e.g., poor woman who often trades sex for basic necessities), or because their mobility and decision-making power may be restricted by others (e.g., married woman who is a victim of domestic violence, 15-year-old girl married to a 45-year-old man, sexually active single adolescents).

3. I can easily find a health facility able to address my particular health needs.

   Important points for the group discussion:

   - Given widespread discrimination against non-normative gender and sexual identities, most health facility staff do not possess the required sensitivity, skills, and knowledge required to provide equitable and respectful services to gay and transgender clients.
   - Female victims of domestic violence may not be able to easily access health facilities equipped to address the specific needs (medical, psychosocial) of gender-based violence (GBV) survivors. Similarly, the young characters might also find it challenging to access health services adapted to their needs.

4. It would be easy for me to find relevant information about my sexual health in local health facilities.

   Important points for the group discussion:

   - Given widespread discrimination against non-normative gender and sexual identities, most health facility staff do not possess the required sensitivity, skills, and knowledge to provide equitable and respectful services to gay and transgender clients.
   - Similarly, the young characters might find it challenging to access health services adapted to their needs.

5. I can openly discuss my sexual practices and concerns with a provider.

   Important points for the group discussion:

   - Due to widespread stigma and fear of non-normative gender and sexual identities, many gay and transgender individuals may not feel that they can access health services at will because of the discrimination they are likely to experience from insensitive and ignorant health workers. This discrimination may also limit their ability to speak openly about their health concerns, thereby further limiting the quality of the service being provided.
   - Young clients may also find it challenging to openly discuss their sexual practices with providers because not only are many providers ill-equipped to provide youth-sensitive services, but many also have their own personal judgments about youth and sexuality.

6. I can insist on condom use during sex.

   Important points for the group discussion:

   - Gender norms in many cultural contexts tend to make it more challenging for women (compared to men) to negotiate the conditions of sex. Gender and sexuality norms are interlinked. Social norms that dictate that women should be submissive to men and that men should dominate women contribute to the challenge women face in being able to decide when, where, how, if, and with whom to have sex.

7. I am allowed to be treated by a health care worker of the opposite sex.

   Important points for the group discussion:

   - Depending on the sociocultural context, it may not be socially (or legally) acceptable for clients to be treated by providers of the opposite sex.

8. I can visit a health facility without asking permission from any family members.

   Important points for the group discussion:

   - Depending on the sociocultural context, it may not be socially (or legally) acceptable for women, in particular, to leave the house unaccompanied. Women's limited mobility has implications in terms of their ability to make decisions about their SRH (e.g., ability to access family planning services).
   - Young people may also be limited in terms of their ability to seek health services without parental consent.

9. My sexual practices are respected and accepted by the broader community.

Important points for the group discussion:

- In many countries around the world, non-heterosexual sex is not acceptable because it does not conform to practices that are considered socially acceptable. It is important to note that the perpetuation of dominant norms of masculinity and femininity depends upon the enforcement of specific sexual norms. Dominant masculinity is defined in direct opposition to femininity. This opposition rests on the rationale that masculinity is superior to femininity. Common stereotypes of gay men as feminine therefore challenge the notion of dominant masculinity that society attempts to uphold. Homophobia sustains dominant masculinity since its main goal is to censor in men any expression of feminine characteristics (e.g., tenderness, sensitivity, gentleness, and caring), thereby reinforcing male stereotypes like aggression, physical strength, and dominance.
- Society may judge the sexual practices of many of the other characters as unacceptable because they do not fit within the norms of acceptable sexual practices for women and men (e.g., transgender woman and man, sex workers, poor woman who often trades sex for basic necessities, unmarried sexually active woman, sexually active adolescents, married woman with no children, sexually active single woman with children).

Facilitator Resource: Power Walk Statements II: Gender Inequalities in the Community

1. I was raised in a community where the majority of police, government workers, and politicians were of my gender.
2. I have been in a situation where a teacher has promised me better school results in exchange for sexual favors.
3. I have never been sexually harassed or disrespected.
4. Most doctors, lawyers, professors, and other "professionals" are the same sex as me.
5. People of my gender generally do not fear violence in their relationship or homes.
6. People of my sex can beat a partner and others generally accept this behavior.
7. Scientists have never considered my sex as inferior.
8. People of my sex often pay for sexual favors.
9. I have never been discouraged from pursuing activities of my choice because of my sex.
10. I generally do not fear being attacked if I walk home alone after dark.
11. I generally am not expected to take part in household chores and childcare responsibilities.
12. I have never worried about being called a prostitute.
13. I do not rely on my partner to pay for my clothes and food.
14. I have never been offered presents for sexual favors.
15. I have never worried about how to dress to keep myself safe.
16. It is generally accepted for people of my sex to have different partners.
17. My religious leaders are the same sex as me.
18. I have never feared being raped.
19. My sex is the one who usually makes the decisions about household expenditures.

Session 7: Power and Gender

Learning Objectives

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

- Describe the different forms of power
- Describe how power imbalances limit people's ability to exercise their rights

Time

1 hour

Materials Needed

- Chairs organized in a semicircle
- A4-sized paper
- Scissors
- Markers
- Masking tape
- **Participant Handout: Expressions of Power**
- **Participant Handout: New Planet Rights Cards**
- **Participant Handout: New Planet Life Cards—Squares**
- **Participant Handout: New Planet Life Cards—Circles**
- **Facilitator Resource: New Planet Laws**

Advance Preparation

1. Make enough copies of **Participant Handout: Expressions of Power** for each participant.
2. Make enough copies of **Participant Handout: New Planet Rights** cards for each participant. Cut out each card along the dotted lines and organize the cards into piles of four. Each pile should contain each of the four rights.
3. Print enough copies of **Participant Handout: New Planet Life Cards—Squares** for half of the participants. Cut out each of the squares along the dotted lines.
4. Print enough copies of **Participant Handout: New Planet Life Cards—Circles** for half of the participants. Cut out each of the circles along the dotted lines.
5. Refer to **Participant Handout: Expressions of Power** and write the definitions of each expression of power on blank flipchart pages (one expression of power per page). Do not include the examples.

Steps

Introduction (1 minute)

1. Open the activity by explaining that when working to promote gender equality, it is important to be aware of the power we exercise as individuals, and how we can use our power to empower others in a way that encourages them to make choices for themselves. State that during this activity, participants will spend some time exploring the concept of power.

Defining Power (20 minutes)

1. Start by leading a 10-minute brainstorming session using the following questions:
   - What is power?
   - What are some examples of people or groups who have power? How do you know they are powerful?
   - Is power only control over others? What are other types of power?
2. State that some people define power as "the capacity to bring about change." Power takes many forms, comes from various sources, and is measured in many ways. Power can be considered "positive" or "negative" depending on one's perspective.
3. Next, draw participants' attention to the flipchart page listing the definitions of each of the four expressions of power, and review them one by one. Refer to **Participant Handout: Expressions of Power** for examples of each type of power.
4. After you have walked participants through each expression of power, explain that power is just power; it is not necessarily good or bad, although it can be used both constructively and destructively.
5. Next, explain to participants that they will spend some time reflecting on power imbalance. Explain that understanding power imbalance is fundamental to understating gender inequality. (Spend no more than 10 minutes on steps 2–5.)

The New Planet (38 minutes)

1. Explain to participants that in this part of the activity they will all become citizens of a new planet. The inhabitants of this new planet do one thing all the time: they greet each other. Tell participants that they will walk around the room and introduce themselves by name to each person. Explain that there will be several rounds of introductions so they may end up introducing themselves to some participants more than once. Tell participants that when they meet the same person a second or third time, they should provide new information about themselves. Instruct participants to use their real identities when they are greeting others. (Spend no more than 3 minutes on this step.)
2. Next, ask participants to stand and begin moving around and greeting each other.
3. After 2 minutes, ask participants to stop.
4. With participants still standing, explain that there are special laws on the new planet and that the inhabitants of the new planet always respect the laws. State that you will read the first law. Refer to **Facilitator Resource: New Planet Laws** and read the first law aloud. After you have read the first law, give each participant one set of the four rights referred to in the first law. (Spend no more than 3 minutes on this step.)
5. Once each participant has a set of the four rights, ask participants to go back to greeting one another.

6. After 2 minutes, ask participants to stop greeting each other.
7. With participants still standing, state that you will now read the second law of the new planet. Refer to **Facilitator Resource: New Planet Laws** and read the second law aloud. After you have read the second law, distribute circle life cards to half of the participants and square life cards to the other half. Make sure all participants have some pieces of tape to stick their cards to their chests. (Spend no more than 3 minutes on this step.)
8. Next, instruct participants to continue greeting each other.
9. After 2 minutes, ask participants to stop. With participants still standing, explain that you will read the third and final law. Refer to **Facilitator Resource: New Planet Laws** and read the third law aloud. (Spend no more than 1 minute on this step.)
10. After you have read the law, ask participants to continue greeting each other.
11. Periodically clap your hands. After 7 minutes, ask participants to return to their seats.
12. Facilitate a 15-minute group discussion using the following questions:
    - How did you feel when you received your four rights?
    - How did you feel when you were divided into circles and squares?
    - Squares, how did you feel when the circles were given more power? How did you feel being at risk of having your rights taken away at any time? How did it affect your behavior?
    - What happens when society gives one group more power than another?
    - Is it fair or just for society to give some people more power?
    - Who is usually given more power in society?
    - How do imbalances of power between women and men affect women's lives?

Closing (1 minute)

1. Close the session by reminding participants that how power is used determines whether it is good or bad, constructive or destructive. As we saw in the second part of the activity, power imbalances can restrict individuals' ability to exercise their rights. Power imbalances sustain gender inequality. In many societies around the world, men are more valued than women and, as such, are granted more power than women. Power imbalances between women and men can lead to violence against women, as men attempt to maintain their position of power through the use of force. Power imbalances in relationships also increase women's risk for HIV and other sexually transmitted infections. To achieve gender equality, there must be a balance of power, and this is only possible with commitment, support, and action from both women and men.

Sources

Burden A, Fordham W, Hwang T, Pinto M, Welsh P. 2013. *Gender Equity and Diversity Module Five: Engaging Men and Boys for Gender Equality*. Activity 18. Atlanta, GA: Cooperative for Assistance and Relief Everywhere (CARE).

Michau L. 2008. The *SASA! Activist Kit for Preventing Violence against Women and HIV. Session 2.1*. Kampala, Uganda: Raising Voices. http://raisingvoices.org/sasa/download-sasa/.

Participant Handout: Expressions of Power

Power OVER

The power to dominate others. Power is seen as an external control over something or someone. The source of this power is **authority**. *Examples: parents' authority over children, supervisors' authority over supervisees.*

Power WITH

The power of mutual support, solidarity, and collaboration. This power comes when groups work together toward a common goal. The source of this power is **other human beings**. *Examples: people who support and assist a leader, groups who use collective action to achieve a goal, a person's sense of identity or belonging.*

Power TO

The power that comes from the capacity to accomplish something. The source of this power is one's **knowledge, education, skills, or talent**. *Examples: education, talent, knowledge of a certain thing or of how to do a certain thing.*

Power WITHIN

The power of internal beliefs, attitudes, and habits. This has to do with a person's sense of self-worth and self-knowledge. The source of this power may be **self-confidence, faith, ideology, or a sense of mission**. *Example: a person's ability to stand up for what they believe.*

Source

Burden A, Fordham W, Hwang T, Pinto M, Welsh P. 2013. *Gender Equity and Diversity Module Five: Engaging Men and Boys for Gender Equality*. Cooperative for Assistance and Relief Everywhere (CARE); 72, Figure 1. Reused under Creative Commons license at https://creativecommons.org/licenses/by-nc-sa/3.0/legalcode with some formatting changes.

RESPECT FROM OTHERS

CONTROL OVER YOUR SEXUALITY

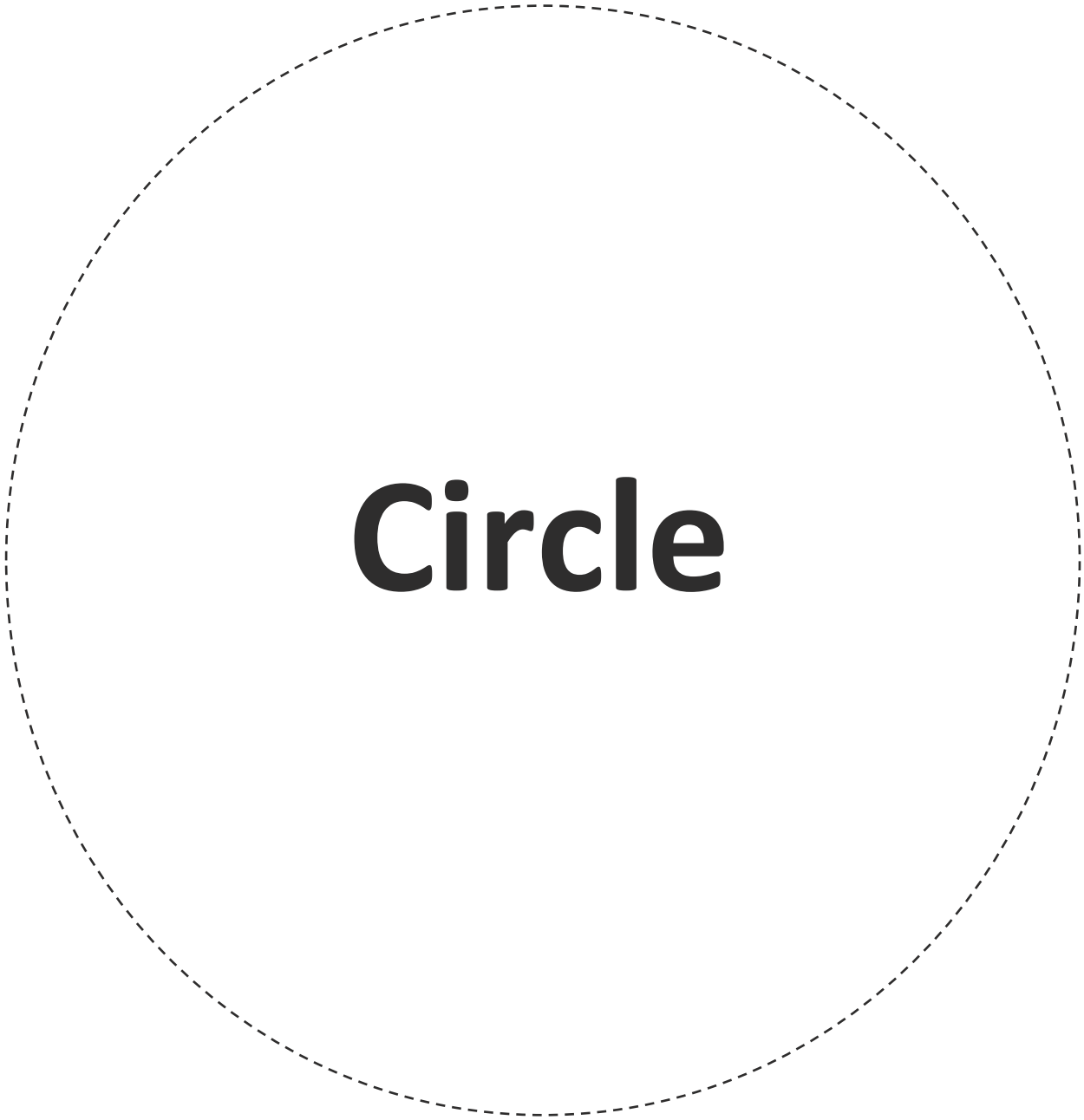
PHYSICAL SAFETY

OPPORTUNITY TO MAKE YOUR OWN DECISIONS

Participant Handout: New Planet Life Cards—Squares

Square

Participant Handout: New Planet Life Cards—Circles



Facilitator Resource: New Planet Laws

Law Number One

Welcome to all noble citizens of our new planet! You are a planet of happy, friendly people, always eager to meet someone new, always ready to tell them something about yourself. As citizens of this planet, you have a right to four things:

- You have a right to **physical safety**, which protects you from being physically hurt. You will each get this card that represents your right to physical safety. (Show the "physical safety" card to the group.)
- You have a right to **respect from others**, which protects you from people treating you unkindly or discriminating against you. You will each get this card that represents your right to respect from others. (Show the "respect from others" card to the group.)
- You have a right to the **opportunity to make your own decisions**, which protects you from people who prevent you from having money or property or access to information. You will each get this card that represents your right to the opportunity to make your own decisions. (Show the "opportunity to make your own decisions" card to the group.)
- You have a right to **control over your sexuality**, which protects you from people forcing you into marriage, sex, commercial sex work, or any type of unwanted sexual activity. You will each get this card that represents your right to control over your sexuality. (Show the "control over your sexuality" card to the group.)

Please come and collect your cards.

Law Number Two

To all noble citizens of our new planet, the whole of our population will now be divided into two parts. Half of you will now become "squares" and the other half will become "circles." You will each be given a card representing one of these groups; it is called your Life Card. You must have a Life Card to survive on this new planet. Please tape your card on your chest.

Law Number Three

To all noble citizens of our new planet, times have changed. We now officially declare that circles have more power than squares. If I clap my hands while a circle and a square are greeting each other, the circle can take one of the square's four rights. If the square has no more rights, the circle can take the square's Life Card. If a square loses his or her Life Card, he or she must stand frozen in place for the rest of the game. Even though squares know of this risk, they must continue greeting circles.

Source

Michau L. 2008. *The SASA! Activist Kit for Preventing Violence against Women and HIV*. Training: Influencing attitudes module. Section 2.1:B. Kampala, Uganda: Raising Voices, 7–11. http://raisingvoices.org/wp-content/uploads/2013/03/downloads/Sasa/SASA_Activist_Kit/AWARENESS/Training/Awareness.Training.InfAttitudesModule.pdf.

Session 8: The Space Between Us

Learning Objectives

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

- Describe the influence of dominant gender norms on women's and men's personal lives
- Identify the links between gender inequality and gender-based violence

Facilitator note: This is an intense exercise that requires sensitivity. Do not conduct this exercise if you feel there is tension or disrespect in your group. Set the tone of this session carefully with participants. Participants must feel safe.

Facilitator note: This session is best conducted in groups with both women and men. If you do not have at least three women and three men in your group, you will need to provide some participants with fictitious identities, such as those included on **Participant Handout: Female Identities** and **Participant Handout: Male Identities**. For example, if you have an all male group, you will need to assign female identities to three of the men; and if you have an all female group you will need to assign male identities to three of the women. Likewise, if you have fewer than three women and/or men in your group, you will need to assign enough fictitious identities to give you at least three participants representing the opposite sex. Bring cards labeled with fictitious identity descriptions in case fictitious identities are required. You may want to write different identities that are more specific or appropriate to your local context.

Time

30 minutes

Materials Needed

- Chairs organized in a semicircle
- **Participant Handout: Female Identities**
- **Participant Handout: Male Identities**
- **Facilitator Resource: Statements**
- Six blank name tags

Facilitator note: Some male participants may feel uncomfortable representing a female character. The facilitator should be sensitive to discomfort expressed by male participants and, when appropriate, remind them of any previous discussions about gender roles. The facilitator should also encourage the men to reflect on their reactions. If absolutely necessary, male participants who are not comfortable representing a female character may be given a male character description.

Advance Preparation

- Print one copy of **Participant Handout: Female Identities** and cut out each of the three identity profiles along the dotted line
- Print one copy of **Participant Handout: Male Identities** and cut out each of the three identity profiles along the dotted line

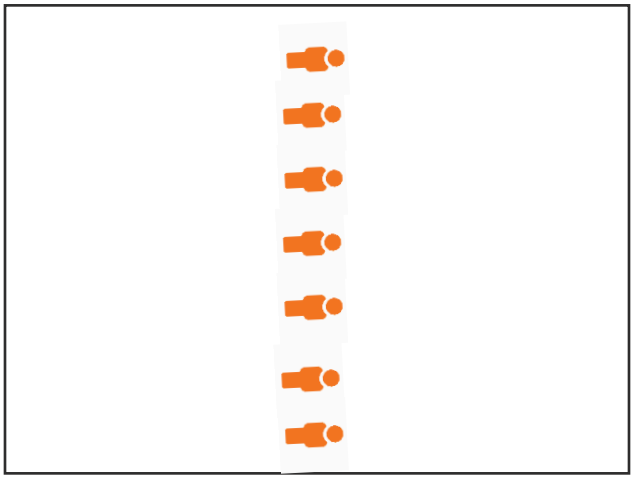
Steps

Introduction (1 minute)

1. Start the session by stating that some people have more power than others in the community and it is important to examine and address these differences because it is unjust that all people do not move through life equally. Explain that this session will help them to understand power differences between men and women.

The Space Between Us (13 minutes)

1. Ask participants to line up side by side across the middle of the room in a straight line (**not** a circle) facing forward, leaving about 10 feet or 3 meters in front of them and behind them. Ask participants to hold hands with their neighbors, if it is acceptable to do so in the setting.



2. Explain to participants that you will read a series of statements. After each statement, based on their personal experiences, participants will move one space forward or backward, or will stay where they are. Explain that if they move in the opposite direction of those with whom they are holding hands, they will have to let go. Tell participants that this is a silent exercise and they should not comment on their own or others' movements. State that if they have not heard a statement clearly, they should say "repeat."

> **Facilitator note:** If a participant is in a wheelchair, instead of taking a step, the individual can move/roll the equivalent.

3. Make sure everyone understands the instructions and then read the first statement on the **Facilitator Resource: Statements** aloud. After reading the first statement, give participants a few moments to decide on their answer and move (or stay) accordingly. Regularly remind participants that this is a silent exercise and individuals should focus on their own response to each statement rather than those of others.

> **Facilitator note:** After reading each statement aloud, ensure that participants understand the directions so they know whether to step forward or backward, depending on the statement. You may need to pause after the first one or two statements to ensure that all participants understand, especially if you suspect any confusion.

4. After you have read all of the statements, pause. Ask participants to remain where they are. If some participants are still holding hands, ask them to let go.
5. Ask participants to look around the room and observe where they are standing and where others are standing. Ask them to take a moment to reflect on their position and the positions of others.
6. Next, communicate the following instruction: "When I say 'go,' race/walk to the wall in front of you." Give participants a few seconds to get ready (some may want to tie shoelaces, remove shoes, etc.) and then call out "One, two, three, GO!"
7. Next, ask the participants to return to their seats.

Group discussion (15 minutes)

1. Facilitate a group discussion using the following questions:
   - How did you feel doing this exercise?
   - How did you feel at the beginning when you were all in the straight line?
   - How did it feel to move forward? To move backward?
   - How did it feel to release the hands of your neighbors?
   - What did you notice about other participants' reactions as the exercise progressed? (Probe: "Did the tone of the game change from playful to serious?")
   - What did you think or feel when you saw where everyone was standing at the end of the game? Was there anything that surprised you about people's positions?
   - What was your first reaction when I asked you to race to the wall? (Contributions could include too far, too close, ran very hard, knew I couldn't win, what was the point, etc.)
   - For participants who represented a member of the opposite sex, what was it like putting yourself in the shoes of someone of the opposite sex? What realizations did you experience?
   - What does this exercise teach you about the power imbalances between women and men?
   - What did you learn about your own power? The power of those around you?

> **Facilitator note:** During the debrief, ensure that neither you nor participants speak specifically about another participant's experiences, as revealed through the exercise. This behavior creates a lack of safety in the group. All participants should speak for themselves.

Closing (1 minute)

1. End the session by making the following points:
    - In our community, women typically have less power than men. This is a social norm—something that is considered normal in our community.
    - The power imbalances between women and men mean that women are at a disadvantage.
    - Violence against women is one way this power imbalance is allowed to continue.
    - It is unjust that women and men do not move through life equally.

Acknowledgments

Raising Voices. (2008). *SASA! Start Training Module: Deepening Knowledge*. Kampala, Uganda: Raising Voices. http://raisingvoices.org/wp-content/uploads/2013/03/downloads/Sasa/SASA_Activist_Kit/START/Training/Start.Training.DeepKnowModule.pdf

Participant Handout: Male Identities

****

Nametag:

Identity description: My name is Juma, and I am 25. I am head of the local clinic. I did not have any major difficulties reaching this position. I have never been sexually harassed in my life.

****

Nametag:

Identity description: My name is Ali, and I am 40. When I was young, I started working as a public transport conductor. I did not like the job, so as soon as I saved enough money, I bought a small stall where I could sell clothes. Now I have a real clothing shop.

****

Nametag:

Identity description: My name is Henry, and I am 55. My father had quite a bit of land. He gave me some, so I started working on it. I have always liked social contacts and everyone in the village knows me. It was logical for me to go into politics. I am now a local leader.

Participant Handout: Female Identities

****

Nametag:

Female Nurse

Identity description: My name is Aminah, and I am 25. I am head of the local clinic. I had to work hard to reach this position because my male colleague was also aiming for it. For a short while when I was a child, my parents lacked the money to pay my school fees, although my brothers continued to attend. As an adolescent, I was very beautiful and smart, which the teachers definitely noticed.

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Nametag:

Female Shopkeeper

Identity description: My name is May, and I am 40. I went to school but never did very well because I was always busy with chores at home. When I was young, I started working as a food vendor. I often had to work late, and sometimes men would harass me. It took me much time to save money, because my husband didn't like that I was earning and often took my earnings from me. I finally saved enough money to buy a small stall for selling clothes. Now I have a real clothing shop.

****

Nametag:

Female Local Government Representative

Identity description: My name is Fatma, and I am 50 years old. My father had quite a bit of land. He gave me some, so I started working on it. I have always liked social contacts and everyone in the village knows me. It was logical for me to go into politics, but many men considered this inappropriate. I had to organize many events to explain my good intentions. It was hard campaigning while also raising children, but I was finally elected the third time I was on the list.

Facilitator Resource: Statements

1. If you were raised in a community where the majority of police, government workers, and politicians were not the same sex as you (i.e., if most police/government workers/politicians are male and you are female), move one step back.
2. If it is generally accepted for you to make sexual jokes in public about the other sex, move one step forward.
3. If you have **never** been harassed or disrespected by police **because of your sex**, move one step forward.
4. If you could be beaten by your partner with little or no reaction from others, move one step back.
5. If most doctors, lawyers, professors, or other "professionals" are of the same sex as you, move one step forward.
6. If people who are the same sex as you often fear violence in their own relationship or homes, move one step back.
7. If people who are the same sex as you can beat a partner because of unfaithfulness and with general acceptance of this behavior from others, move one step forward.
8. If you were denied a job or a promotion because of your sex, move one step back.
9. If people who are the opposite sex from you are often paid for sexual favors, move one step forward.
10. If you were discouraged from pursuing activities of your choice because of your sex, move one step back.
11. If you commonly see people who are the same sex as you in positions of leadership in business, in court and in government, move one step forward.
12. If you fear being attacked if you walk home alone after dark, move one step back.
13. If you could continue school while your siblings of the opposite sex had to stop, move one step forward.
14. If you share childrearing responsibilities with your partner, move one step forward.
15. If you have never worried about being called a prostitute, move one step forward.
16. If you must rely on your partner to pay for your clothes and food, move one step back.
17. If you have never been offered presents for sexual favors, move one step forward.
18. If you have ever worried about how to dress to keep yourself safe, move one step back.
19. If it is generally accepted for people of your sex to have multiple partners, move one step forward.
20. If you have taken care of your partner while she or he is sick, move one step forward.
21. If your religious leaders are the same sex as you, move one step forward.
22. If you have ever feared rape, move one step backward.
23. If your name or family name can be given to your children, move one step forward.
24. If you have ever been refused rest by your partner when you were feeling weak, move one step back.
25. If your sex is the one that usually makes the decisions about household expenditures, move one step forward.
26. If you have never been whistled at (in a sexual way) in public by the opposite sex, move one step forward.

Module 2

Gender-Based Violence

jhpiego
Saving lives. Improving health. Transforming futures.

Session 9: What Is Violence?

Learning Objectives

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

- Define the concept of violence
- Define gender-based violence
- List different types of gender-based violence

Time

1 hour 30 minutes

Materials Needed

- Chairs organized in a semicircle
- Flipchart paper
- Flipchart stand
- A4-sized paper
- Markers
- Masking tape
- Participant Handout: What Is Gender-Based Violence?
- Participant Handout: What Is Sexual Harassment?
- Participant Handout: Myths and Truths about Violence
- Facilitator Resource: Violence Scenarios

Advance Preparation

1. Make enough copies of the participant handouts for all participants.
2. Label a blank flipchart page "WHO Definition of Violence" and write the following definition on the page: "The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation."
3. Write the following words on three separate sheets of paper: "Violence," "No violence," and "Not sure." Tape each labeled page on the wall around the room (post the "Not Sure" page between the other two pages). Leave enough space between each page to allow a group of participants to stand near each one.

Facilitator note: It is likely that some participants, particularly women, have experienced, or are experiencing, violence in their personal lives. It is important for the facilitator to have information about existing national laws and/or policies related to gender-based violence (GBV) so that she/he can refer to this information during the activity (including policies around mandatory reporting for health providers, if applicable). Prior to leading this activity, the facilitator should research local support services for GBV survivors should any participants request such support.

Steps

Introduction (5 minutes)

1. Share with the group that this session will focus on violence. Acknowledge that the topic is challenging, because violence harms many women and men and yet is very common. State that some people in the group, including the facilitators, may have been affected by violence—maybe they witnessed violence with neighbors or family, maybe they experienced it in their own families as a child, maybe they experienced it at some point in their adult lives, etc.
2. Explain that violence is a sensitive topic and that it is important for participants to respect the following group norms as they move through the session:
   - Maintain confidentiality. What is said in the room stays in the room. Gossiping is not tolerated.
   - Everyone has the right to pass. If a participant feels uncomfortable about a particular topic or if she/he feels uncomfortable about sharing on a particular point, she/he has the right to pass.
   - Suspend judgment. Everyone has a right to their opinions and beliefs. Try not to judge others, and try to maintain an open mind and hear what others are saying.
   - Respect the opinions and feelings of others. Avoid interrupting others while they are speaking. Avoid mocking or minimizing a person's contribution.
   - Do not speak for others. Only share what you have said. Do not relate what someone else may have said in the context of this group.
   - Practice active listening. Pay attention when others are speaking and try to listen carefully to what they are saying.
3. Explain that given the sensitive nature of the topic, you would like participants to keep in mind the following options during the session:
   - Take care of yourself, and take a break if you need to do so.
   - Anyone who wants additional support on this issue for themselves, a family member, or a friend should feel free to talk to the facilitator after the session to be connected to support resources.
4. Ask the group if they have any questions or concerns.

Types of Violence (30 minutes)

Facilitator note: Review the scenarios in advance and select the 3–4 scenarios most relevant to your program and context.

1. Draw participants' attention to the three signs taped on the wall and explain that you will read some scenarios out loud and that each participant should decide on his/her own what the answer is:
   - Participant who think the scenario describes a case of violence should physically move and stand by the sign that says "Violence."

- Participants who think the scenario does not depict a case of violence should move and stand near the sign that says "No violence."
- Participants who are undecided should move and stand near the sign that says "Not sure."

2. Once participants understand the instructions, refer to **Facilitator Resource: Violence Scenarios**, and read the first scenario aloud. After you have read the scenario, allow participants a few seconds to move toward the sign that best reflects their opinion. (Spend no more than 1 minute on steps 1–2).
3. Once participants have positioned themselves, ask for volunteers from each group to explain their reason for taking that particular position. Allow no more than 5 minutes of discussion for each scenario. After discussing a scenario, sum up the discussion using the "Key points" provided at the end of the scenario.
4. Repeat steps 2–3 for the remaining scenarios.

Group Discussion (10 minutes)

1. After discussing all of the scenarios, facilitate a 10-minute group discussion using the following questions:
   - Were you surprised that any particular situation was indeed an act of violence? Why?
   - What kinds of violence occur most often in intimate relationships between men and women in your country? What causes this violence? (Examples may include physical, emotional, and/or sexual violence that men use against girlfriends or wives, as well as violence that women use against their boyfriends or husbands.)
   - What kinds of violence occur most often outside relationships and families? What causes this violence? (Examples may include physical violence between men, gang- or war-related violence, stranger rape, and emotional violence or stigmatization of certain individuals or groups in the community.)
   - Are some acts of violence related to a person's sex? What is the most common type of violence practiced against women? Against men?
   - What are the consequences of violence in relation to sexual and reproductive health?
   - What are the consequences of violence in relation to one's overall health and wellness (mental health, disability, etc.)?

Facilitator note: During the discussion, be sure to point out that men are often socialized to repress their emotions and anger is sometimes one of the few socially acceptable ways for men to express their feelings. Moreover, men are sometimes raised to believe that they have the "right" to expect certain things from women (domestic tasks or sex, for example) and the right to use physical or verbal abuse if women do not provide these things. Violence is a learned behavior, and in that sense, it can be unlearned and prevented.

What Does Violence Mean to Us? (30 minutes)

1. Ask for some volunteers to share with the group what violence means to them. Write the responses on a sheet of flipchart paper. Examples might include "pain," "control," "suffering," etc.
2. Next, draw participants' attention to the flipchart page detailing the World Health Organization's (WHO) definition of violence, and ask for a volunteer to read it aloud to the group.

3. Ask participants if they have any questions or comments about the definition.
4. Next, ask participants to provide some examples of the types of violence the WHO definition is referencing. As participants call out their ideas, write them on a separate sheet of flipchart paper. Elicit examples for the four types of violence (physical, sexual, psychological/emotional, and economic). Spend no more than 10 minutes on steps 1–4.
5. After you have identified the four types of violence, review each one individually using the explanation points below (spend no more than 10 minutes on this step):
    - **Physical violence** involves using physical force, such as hitting, slapping, or pushing.
    - **Emotional/psychological violence** is often the most difficult form of violence to identify. It may include humiliating, threatening, insulting, pressuring, or expressing jealousy or possessiveness (e.g., by controlling decisions and activities).
    - **Economic violence** occurs when a person takes control of or limits a victim's access to individual or family assets, or limits a victim's ability to earn money (e.g., denying access to money or the means of earning money; denying access to work or school; intentionally withholding necessities such as food, clothing, shelter, medication, or personal hygiene products; stealing from the victim; or forbidding a victim from maintaining a personal bank account).
    - **Sexual violence** involves pressuring or forcing someone to perform physical sexual acts (from kissing to sex) against their will. It does not matter if there has been prior consenting sexual behavior. That is, an individual can still be forced to perform sexual acts by a person even if she/he has consented to sex with that person in the past. Sexual violence can also occur within a marriage—being married does not imply consent for sexual acts.
        - **Sexual harassment** is a form of sexual violence that includes unwelcome sexual advances, requests for sexual favors, and other conduct of a sexual nature. Although people tend to think of sexual harassment as occurring between two individuals with different levels of power (e.g., supervisor to supervisee), this is not always the case. Examples of sexual harassment include unwanted sexual looks or gestures; unwanted pressure for sexual favors; looking a person up and down; unwanted sexual teasing, jokes, remarks, or questions; and repeatedly asking out a person who is not interested.
6. Distribute **Participant Handout: What Is Sexual Harassment?** Ask participants if they have any questions about the types of violence reviewed so far.

> **Facilitator note:** When discussing the different types of violence, make clear to participants that physical, emotional/psychological, economic, and sexual violence are not necessarily discrete categories. Emotional/psychological violence always exists in tandem with physical, economic, and sexual violence. Likewise, sexual violence necessarily implies physical violence, although *sexual harassment* does not necessarily imply physical violence.

7. Next distribute **Participant Handout: What Is Gender-Based Violence?** Explain that the group will now examine the concept of gender-based violence (GBV). Spend 10 minutes discussing the following points with participants:
    - GBV encompasses a range of physical, sexual, economic, and emotional/psychological violence that can occur in public or in private. GBV is used to reinforce unequal power dynamics based on gender.
    - Examples of GBV **in the family** include battering, marital rape, sexual abuse of children in the household, dowry-related violence, and female genital mutilation.

- Examples of GBV **within the general community** include rape, sexual violence, sexual harassment and intimidation at work, trafficking, and forced prostitution.
- Examples of GBV that are **state or institution-sanctioned** include rape as a weapon of war.
- Women and girls are the primary victims of GBV because of their subordinate position in many societies. Norms that emphasize men's superior status over women justify men's use of violence against women as a means of maintaining their dominant status.
  - > Men can be victims of GBV when they step outside traditional gender norms or do not express in a masculine enough way.
  - > Explain that most violence between men is gendered (because violence is a way to express masculinity) but not necessarily GBV.
- GBV can lead to serious health consequences including HIV transmission, unintended pregnancies, unsafe abortions, depression, injury, obstetric complications, and death.
- **Special note on intimate partner violence (IPV):** IPV is actual or threatened physical, sexual, psychological/emotional, and/or economic abuse directed toward a spouse, ex-spouse, current or former boyfriend or girlfriend, or current or former dating partner. Typically, women in intimate relationships tend to be victims of IPV. Though more rare, IPV can be committed against male partners.

8. Offer participants an opportunity to ask questions about GBV.
9. Explain that during the second part of the exercise, the group will review a series of case studies to help them reflect on the different meanings and types of violence.

Myths and Truths about Violence (14 minutes)

1. Before ending the session, explain to participants that you would like to spend some time discussing common myths about violence.
2. Refer to **Participant Handout: Myths and Truths about Violence.** Read a myth to the group and ask the group why it is a myth. After a few responses, read the reason provided on the handout. Repeat this process for as many myth statements as time allows.
3. Distribute **Participant Handout: Myths and Truths about Violence** upon conclusion of this section.

Facilitator note: Review the myths in advance and select the 5–10 statements most relevant to your program and context.

Closing (1 minute)

1. End the session by making the following points:
   - In every situation that we discussed, there was some form of violence. Although the violence was clearly evident in some cases, in other cases it was less so.
   - In each case, the person at the receiving end suffered physical pain, emotional pain, economic deprivation, or a combination. Violence is therefore not only causing physical injury.
   - Violence happens all around the world. It is commonly assumed that inflicting violence is a "natural" or "normal" part of being a man. However, violence is a learned behavior, and in that sense, it can be unlearned and prevented.

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World Health Organization (WHO). 2018. Definition and typology of violence. WHO website. http://www.who.int/violenceprevention/approach/definition/en/.

Participant Handout: What Is Gender-Based Violence?

(*From* The ACQUIRE Project/EngenderHealth and Promundo. 2008. *Engaging Men and Boys in Gender Transformation: The Group Education Manual*. New York, NY and Rio de Janeiro, Brazil: The ACQUIRE Project/EngenderHealth and Promundo, 306. http://www.acquireproject.org/archive/files/7.0_engage_men_as_partners/7.2_resources/7.2.3_tools/Group_Education_Manual_final.pdf.)

In many settings, most laws and policies use "family violence" or "domestic violence" to indicate acts of violence against women and children by an intimate partner, usually a man. However, there has been an increasing shift toward the use of "gender-based violence" (GBV) or "violence against women" to encompass the broad range of acts of violence that women suffer from intimate partners, family members, and other individuals outside the family. These terms also draw focus to the fact that gender dynamics and norms are intricately tied to the use of violence against women (Velzeboer et al. 2003).

Below is a definition of gender-based violence and violence against women based on the United Nations General Assembly Declaration on the Elimination of Violence against Women in 1993:

> …any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring **in public or in private life.**
>
> …shall be understood to encompass, but not be limited to the following:
>
> - Physical, sexual, and psychological violence occurring **in the family,** including battering, sexual exploitation, sexual abuse of children in the household, dowry-related violence, marital rape, female genital mutilation, and other traditional practices harmful to women, nonspousal violence, and violence related to exploitation
> - Physical, sexual, and psychological violence occurring **within the general community,** including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution
> - Physical, sexual, and psychological violence **perpetrated or condoned by the state and by institutions,** wherever it occurs.

For reference, the WHO definition of violence is: "The intentional use of physical force or power, **threatened or actual**, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury death, psychological harm, maldevelopment, or deprivation."

Reference

Velzeboer M, Ellsberg M, Clavel Arcas C, García-Moreno C. 2003. *Violence against Women: The Health Sector Responds*. Washington, DC: Pan American Health Organization (PAHO) and World Health Organization (WHO).

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Participant Handout: Myths and Truths about Violence

(*From* Instituto Promundo, Salud y Género, ECOS, Instituto PAPAI, and World Education. n.d. *Working with Young Women: Empowerment, Rights and Health.* Rio de Janeiro, Brazil: Promundo, 43–45.)

Myth	Truth
It is easy for a woman to leave a violent relationship. If a woman remains in a violent relationship, it must be because she enjoys it.	There are personal, social, cultural, religious, and economic reasons that keep a woman in a relationship, even a violent one. Men who are violent against their partners frequently make it difficult for the women to leave. They may make threats (against the woman or their children), ask for forgiveness, promise not to hurt her again, and/or manipulate the victim into thinking that they themselves are the ones to blame.
When a woman says no to sex it is only because she's ashamed to say yes. "No" can mean maybe or even yes.	"No" is always no.
Women provoke rape by the way they behave: wearing provocative clothing, getting drunk, hanging out in the street at night, etc.	No one asks to be sexually victimized. The aggressor is the only one responsible for the crime.
The majority of sexual assaults are committed by strangers.	The majority of sexual assaults are committed by someone the victim already knows. In fact, a large percentage of rapes occur inside the victim's home or at the home of a friend, neighbor, or acquaintance.
Domestic violence is a private matter within the family. No one else should get involved.	Domestic violence is a public health and human rights issue; therefore, it is a problem for all of society. With social support, victims of violence can decide to leave a violent relationship.
Women are safer at home. They are at greater risk from strangers or out of the home.	Contrary to the vision that the family represents a safe refuge, young and adult women are at greater risk of violence in their own homes and at the hands of someone they know.
Sexual violence does not exist within relationships.	Having sex with a woman without her consent is a violation, even if she is a friend, girlfriend, or spouse. Sexual violence is not defined by the type of relationship but by the lack of consent.
A woman who has previously consented to sexual relations with someone cannot be raped by that person.	Any occasion in which a person does not want to have sexual relations but is forced into it is a violation or rape. Accepting kisses and touches does not mean accepting sex. A person can say "NO" to sex at any point, no matter what has happened up to that point.
Violence is caused by drugs and alcohol.	There is no single cause of violence; rather, it is caused by many factors. Drugs and alcohol can increase violent behavior, but many people who use drugs and alcohol are not violent, and many who are violent do not use drugs and alcohol.
Men are violent by nature.	Nearly all researchers of violence agree that although there may be some limited male biological basis for aggressive and risk-taking behavior, the majority of men's violent behavior is explained by social and environmental factors. In sum, boys are not born violent. They are taught to be violent through messages they receive from society and their families. Many men learn to resolve conflicts and maintain their control over other people by using violence. However, just as violence is learned, it can be unlearned.
The media makes boys violent.	Some studies have found that viewing violent media images may be associated with carrying out violence, but the causal connection is

Myth	Truth
	not entirely clear (Bushman and Anderson 2015). Watching violence on TV or in movies probably does not "cause" boys' violence, but it can reinforce some of boys' beliefs—and our general belief as a society—that men's violence is normal, or even cool.
Violent men are out of control.	A violent person is generally not out of control. Even men who say they lose control when they hurt their partners do not use violence in every situation, nor with every person. They are selectively violent—in other words, their violence is a choice.
Anger causes violence.	People who hurt and mistreat others do not necessarily feel more rage than others; rather, they use their rage as an excuse to justify their behavior, against people who have less power than they do.
Violent men are mentally ill.	Only a small number of men who use violence actually suffer from mental illness. In general, men's use of violence is not associated with mental illness but with gender norms that uphold violence as an acceptable, or "masculine" means of resolving conflicts.
Women commit as much violence against men as men commit against women.	When there is violence in a relationship between men and women, generally the violence the man commits is more severe. When women utilize violence it is generally in response to a partner's violence, and in many cases, their partners react with more violence.
Violence is a problem among poor people who lack education.	Violence occurs among all demographic groups, regardless of race, color, class, sexual orientation, occupation, or education.

Reference

Bushman BJ, Anderson CA. 2015. Understanding causality in the effects of media violence. *Am Behav Sci.* 59(14):1807–1821. doi:10.1177/0002764215596554.

Participant Handout: What Is Sexual Harassment?

Sexual harassment is a form of violence that includes unwelcome sexual advances, requests for sexual favors, and other conduct of a sexual nature. Although people tend to think of sexual harassment as occurring between two individuals with differing levels of power (e.g., supervisor-supervisee), this is not always the case.

"Unwelcome" is the critical aspect of sexual harassment. "Unwelcome" does not mean "involuntary." A victim may consent or agree to certain conduct and actively participate in it even though it is offensive and objectionable to them. Sexual harassment is in the eye of the beholder. The way language or behavior makes a person feel is how harassment is defined. In most cases, sexual harassment involves a person using sex to exert power or control over another person, making them feel uncomfortable, threatened or harmed in some way. Sexual harassment is different from sexual assault which occurs when physical, sexual activity is engaged in without the consent of the victim, or when the victim is unable to consent to the activity. Sexual harassment is usually heard about in school or work settings because these are the two main places where sexual harassment is reported. Sexual harassment, however, can occur in other places as well.

Sexual harassment can happen to women, men, transgender persons, intersex persons, and those who are non-gender conforming. Sexual harassment is not limited to sexual orientation.

Sexual harassment includes many things:

Verbal	Nonverbal	Physical
• Referring to an adult as a girl, hunk, doll, babe, or honey • Whistling at someone, cat calls • Making sexual comments about a person's body • Making sexual comments or innuendos • Turning work discussions to sexual topics • Telling sexual jokes or stories • Asking about sexual fantasies, preferences, or history • Asking personal questions about social or sexual life • Making kissing sounds, howling, and smacking lips • Making sexual comments about a person's clothing, anatomy, or looks • Repeatedly asking out a person who is not interested • Telling lies or spreading rumors about a person's personal sex life	• Looking a person up and down (elevator eyes) • Staring at someone • Blocking a person's path • Following the person • Giving personal gifts • Displaying sexually suggestive visuals • Making sexual gestures with hands or through body movements • Making facial expressions such as winking, throwing kisses, or licking lips	• Giving a massage around the neck or shoulders • Touching the person's clothing, hair, or body • Hugging, kissing, patting, or stroking • Touching or rubbing oneself sexually around another person • Standing close or brushing up against another person

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Facilitator Resource: Violence Scenarios

Scenario 1

A woman and her boyfriend are in a hotel room together. They start kissing and caressing each other. The boyfriend begins to take off her clothes. She stops him and says that she doesn't want to have sex. He is furious and tells her that he has spent a lot of money on the room and says, "What are my friends going to say?" He pressures her to change her mind. First he tries to be sweet and seductive, then he begins yelling at her in frustration. Finally, he pulls at her forcefully, pushing her down on the bed.

Key Points

Even if the woman agreed to go to the motel with her boyfriend, and even if she is kissing him, it does not mean that she wants to have intercourse with him. Her boyfriend is pressuring her to have sex, and despite the fact that she has told him she does not want to have sex with him, the man tries to force her by using physical force. It is clear that the man intends to rape his girlfriend. Everyone has the right to refuse sex for any reason or for no reason at all. A person can choose to refuse sex for any reason and at any point—even if it's during a sexual act. All sex must be consensual, meaning that both partners must freely agree to participate in a particular sexual activity. Just because two people are in an intimate relationship together does not mean that rape cannot occur.

Scenario 2

A 12-year-old boy has just come home with his examination results. He has failed. His parents shout at him; his mother refuses to give him any food that day, while his father threatens to teach him a lesson he will not forget. Would you describe what the parents did to the boy as violence? Why?

Key Points

Although the boy's father has threatened physical violence, which will definitely hurt the boy, the mother's behavior can also harm him physically and mentally. Therefore, what the parents did to the boy can be described as violence. It is natural for the parents to be angry at their son's behavior, and they do have a right to scold him and tell him to improve his performance the next time. But "disciplining" their son cannot be an excuse for using physical force or depriving him of basic necessities.

Scenario 3

In a university, and openly gay young man is constantly harassed by his peers who insult and mock him because of his sexual identity.

Key Points

Every individual has the right to be treated equally and fairly, regardless of religion, sex, race, caste, ethnicity, and sexual and gender identities. In this case, the young man is being discriminated against because of his sexual identity. This will result in psychological/emotional harm to the young man.

Scenario 4

A woman and her husband work in the same company. The woman has just got a promotion, while the man has not. As a result, he is upset and has stopped talking to his wife; he taunts her in front of his friends, telling them that she is now "too important" for him. Do you think there is any violence involved in this situation? Why?

Key Points

Yes, the husband's behavior is a form of violence. It will cause emotional and mental harm to the woman. It is his jealousy that is making the man hurt his wife in this manner. Also, most men are brought up to believe that they are "superior" to women; so when his wife does better than him at her job, he probably feels inferior, he feels he is "less of a man." But the fact is that, like a man, a woman has a right to have a career and to secure a promotion based on her hard work and good performance.

Scenario 5

A well-off couple has employed a 13-year-old girl to work as a domestic helper. The girl is expected to do all the housework, including washing the clothes and vessels, cleaning the house, taking care of the couple's 2-year-old baby, and buying things at the market. She is expected to work 7 days a week. She gets a salary and two meals every day. Do you think there is any violence involved in this situation? Why?

Key Points

Yes, this is a form of violence. This is a clear example of child labor. And every case of child labor causes serious mental, emotional, and even physical harm to the child.

The law prohibits child labor. However, this is a common situation in many countries. Children often work in hazardous and extremely harsh conditions. This deprives them not only of basic rights like education, but they also lose out on their childhood. Children are employed because they provide cheap labor; employing a child does not mean that the employer is "helping" the child's family. Employing an adult in the child's place would not only put an end to this practice, but it would also reduce the large-scale prevalence of adult unemployment in our country.

Scenario 6

The wife and husband in a couple both have full-time jobs. When the wife returns home at the end of the day, her husband expects her to cook his dinner, help the children with their homework and prepare them for bed, and tidy up the house. Most nights, the husband also expects his wife to have sex with him. The wife is often very tired at the end of the day and needs sufficient rest to wake up early the next day so she can get the children ready for school before she goes to the office. As a result, she often refuses to sex with her husband. On several occasions, however, her husband has forced himself on her in spite of her protestations. Do you think there is any violence involved in this situation? Why?

Key Points

Yes, this is a form of violence. The type of violence described is marital rape because the husband has been forcing his wife to have sex against her will. All sexual encounters must be consensual; both partners—whether married or not—must be able to provide their consent free from coercion and violence. When partners are not consenting and are forced or coerced into engaging into sexual practices, it is rape.

Session 10: Circles of Influence

Learning Objectives

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

- Identify the links between gender inequality and intimate partner violence (IPV)
- Explain why IPV is never justified

> **Facilitator note:** This activity should only be completed *after* participants have completed the "What Is Violence?" session.

Time Needed

40 minutes

Materials Needed

- Flipchart paper
- Flipchart stand
- Chairs organized in a semicircle
- Markers
- Masking tape
- 1 pair of scissors
- **Participant Handout: Ecological Model of Intimate Partner Violence**
- **Facilitator Resource: Ecological Model**
- **Facilitator Resource: Character Statements**

Advance Preparation

1. Make enough copies of **Participant Handout: Ecological Model of Intimate Partner Violence** for each participant.
2. Refer to **Facilitator Resource: Ecological Model** and reproduce the diagram on a blank flipchart page (do not include the definitions of the various levels).
3. Make one copy of **Facilitator Resource: Character Statements** and cut out enough character statements to have one statement per participant. Make sure Benja's and Betty's statements are among the statements to be distributed to participants, and ensure that you have at least three character statements from each level (e.g., C, R, and S). After you have cut out the statements, fold each in half.
4. If you have enough masking tape, it can be helpful to create a visual of the three circles surrounding Benja and Betty by placing tape on the floor in the shape of a circle for each of the three levels (C, R, and S). See the illustration of the floorplan following step 4 in the "Factors that Perpetuate Violence" section for clarity on how to place the tape.

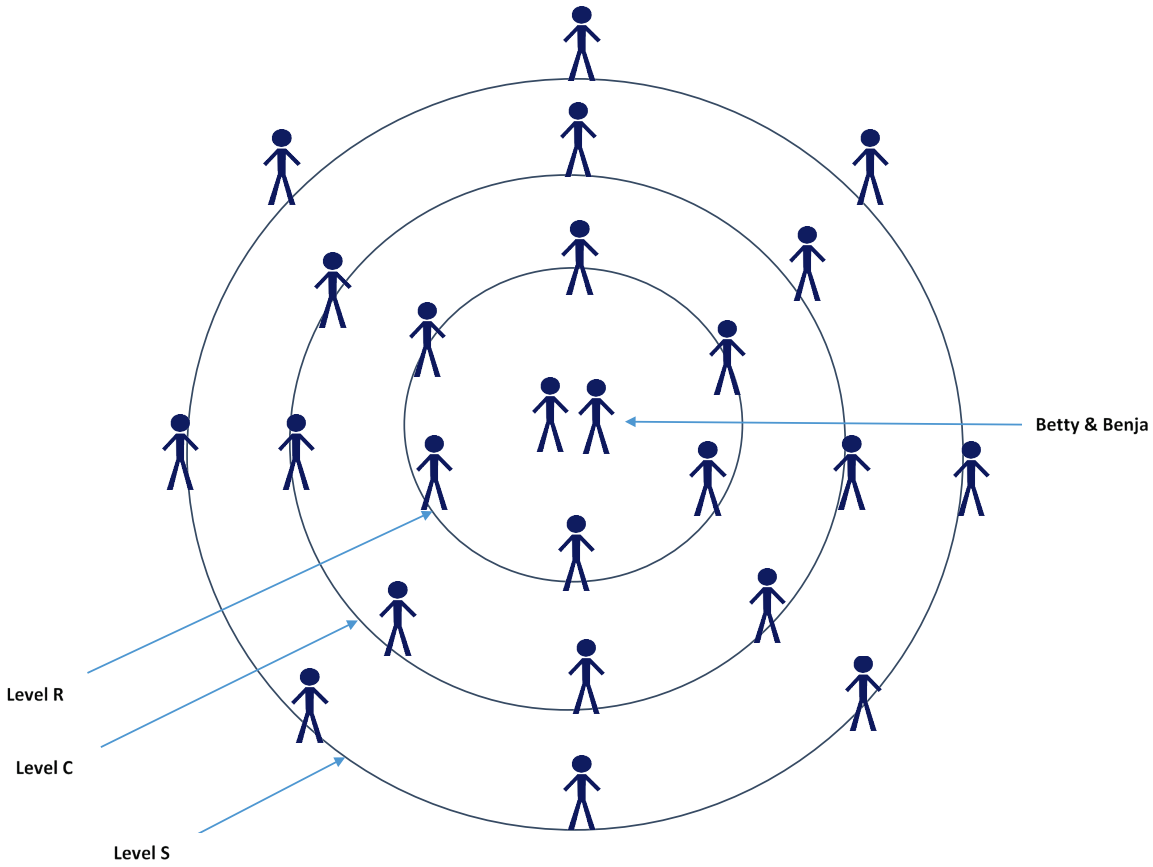
Steps

Introduction (1 minute)

1. Open the activity by stating that gender-based violence (GBV) occurs within a broad social, cultural, economic, and political environment in which factors that drive GBV operate. Explain to participants that this activity will give them the opportunity to explore the various factors that help perpetuate violence, as well as the various levels from which these factors exert their influence.

Factors That Perpetuate Violence (38 minutes)

1. Distribute one character statement to each participant. As you distribute the statements, tell participants they may read what is written on their piece of paper but they should not show it to anyone else.
2. Ask the participants who received Betty's and Benja's statements to come to the middle of the room. Introduce them by explaining that Betty is a woman and Benja is a man. Next, ask both participants to introduce themselves to the group by reading the statement on the piece of paper they received.
3. After the two participants have read their respective statements, ask participants who received papers labeled "Level R" to form a circle around Betty and Benja. (If you were able to place masking tape on the floor in circles around Betty and Benja, ask participants with papers labeled "Level R" to stand on the taped circle closest to Betty and Benja.)
4. After participants have formed the first circle around Betty and Benja, ask participants who received papers labeled "Level C" to form a circle around the first circle. Next, ask those who received papers labeled "Level S" to form a third circle around the second circle. In the end, there should be three circles of people around the Betty and Benja characters (see illustration below). (If you were able to place masking tape on the floor in circles around Betty and Benja, ask participants with papers labeled "Level C" and "Level S" to stand on the corresponding taped circles around Betty and Benja.)



5. Next, explain that you will ask a participant to introduce her/himself by reading the statement on her/his paper. After reading the statement, the participant will tap the shoulder of the person next to them. That person will read their statement and will in turn tap the shoulder of the participant next to them.
6. Make sure everyone understands the instructions, and randomly choose a participant from the innermost circle (the R circle) to introduce themselves by reading the statement on their paper. After everyone in the R circle has read their statements, repeat the same process for circles C and S. (Spend no more than 6 minutes on steps 1–6.)
7. Next, with participants still standing in their positions, facilitate a 10-minute debrief using the following questions:
   - Which circle do you think has the most influence on Betty and Benja? Why?
   - Are there any circles that do not have an influence on Betty and Benja? Which ones? Why?
   - What does this exercise tell us about community norms?
   - How can this exercise inform our efforts to reduce HIV and violence?

8. Next, ask participants to transform their statements into a positive one such that their character takes action to help Betty and/or Benja. Before participants begin this part of the exercise, explain that the positive statement should be one sentence, or a maximum of two sentences. This should not be treated as a role play. Start with circle R, and end with circle S. After all participants in levels R, C, and S have transformed their original statements into positive statements, ask Betty and Benja to transform their original statements into positive statements, taking into consideration all of the new positive statements. Make sure that Benja specifically articulates that he should not perpetrate violence and that violence is never justified. (Spend no more than 6 minutes on this step.)
9. After participants have reframed their statements, ask everyone to return to their seats.
10. Before moving on, explain that the activity was intended to demonstrate factors at various levels that influence individuals' lives. GBV can be perpetrated and perpetuated by any number of actors—intimate partners, family and community members, and the state. However, these individuals can also play a role in preventing GBV. In fact, all individuals in the community can play a role in preventing GBV. Explain that by creating the three circles around the female and male characters, the group recreated an "ecological model."
11. Next, draw participants' attention to the flipchart page illustrating the ecological model. State that researchers developed this model to show how various factors at the individual, relationship, community, and societal levels cause and allow GBV to happen.
12. Explain each of the levels by using the points below:
    - **Individual level:** the two individuals involved in an intimate relationship (woman and man). Individual-level factors contributing to IPV include personality traits, personal experiences, and history of both the victims and the perpetrators (e.g., childhood traumas, acceptance of violence as a means of resolving conflict, alcohol abuse, women's unemployment, etc.).
    - **Relationship level:** close social relationships, most importantly those between intimate partners and within families. Relationship-level factors contributing to IPV include poor communication, inequalities in decision-making, etc.
    - **Community level**: the community context in which social relationships exist, including peer groups, schools, workplaces, and neighborhoods. Community-level factors contributing to IPV include social norms supporting wife-beating, emphasis on family privacy, lack of legal or moral sanctions for violence, etc.
    - **Societal level/macrosocial**: larger societal factors that "create an acceptable climate for violence, reduce inhibitions against violence" (Krug et al. 2002, p. 13). Societal-level factors that contribute to IPV include lack of economic rights and entitlements for women, collectivist versus individual cultural orientation, etc.
13. Explain that women bring to their relationships certain personality traits and many experiences from their childhood and adolescence. They partner with men who likewise bring their own personality traits and personal histories to the relationship. The couple's relationship has its own dynamics, some of which may increase or decrease the risk of abuse, and the relationship is embedded in a household and neighborhood context that affects the potential for violence. In many low-resource settings, this includes the influence of extended family members who interact with the couple in ways that may either increase or lessen the chances of abuse. In turn, both partners engage with various "communities," including those related to work, friendship networks, faith communities, and governance structures. Finally, these various communities are embedded in a macrosystem, which refers to the cultural, economic, and political systems that inform and structure the organization of behavior at lower levels of the social ecology (e.g., community, relationship, and individual) (Heise 2011).

14. Ask participants for examples of factors that perpetuate GBV at each of the four levels. As participants share ideas, write them on the diagram in the corresponding circle (refer to **Participant Handout: Ecological Model of Intimate Partner Violence** for additional examples).
15. Explain that the various factors and levels are linked, and that each level influences the others. Emphasize that understanding GBV requires understanding its underlying causes and contributing factors, as well as the dynamics between the individual and the broader environment (e.g. family, community, society). (Spend no more than 10 minutes on steps 10–14.)
16. Before ending the session, allow participants 6 minutes to ask questions and/or make comments. Distribute **Participant Handout: Ecological Model of Intimate Partner Violence** to each participant.
17. When closing, emphasize that research is ongoing on the causes and risk factors for intimate partner and sexual violence. However, research done by Lori Heise, who initially coined the ecological model for IPV, shows that countries with the most gender-inequitable, patriarchal norms are prone to higher levels of violence.

Facilitator note: The ecological model can sometimes cause debates over how each factor is categorized and what should be considered a factor or not. If that happens, you may emphasize to participants that the model is only intended to demonstrate the various factors influencing GBV, thereby contributing to the design of effective violence prevention interventions.

Closing (1 minute)

1. End the activity by stating that although the sociocultural and political environment is important for understanding why GBV occurs, it does not excuse it. People, mostly men, still make a choice when they use violence. They need to be held accountable for their decision to use violence and for the suffering they cause. GBV is never justified.

Sources

Adapted from "Circles of Influence" in Raising Voices. 2009. PREP Module of *The Sasa! Activist Kit* Kampala: Raising Voices.

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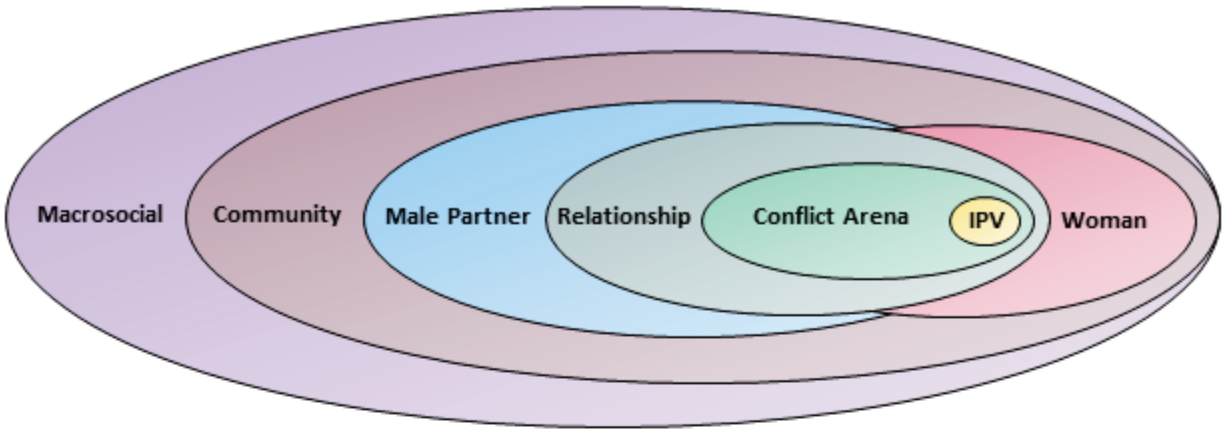
Heise LL. 2011. *What Works to Prevent Partner Violence? An Evidence Overview*. London, UK: STRIVE.

Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R. 2002. *World Report on Violence and Health. Geneva: Switzerland*: World Health Organization, 13.

Participant Handout: Ecological Model of Intimate Partner Violence

(*Source:* Heise LL. 2011. *What Works to Prevent Partner Violence? An Evidence Overview*. Figure 1.2 Revised conceptual framework for partner violence, 8. London, UK: STRIVE. https://www.oecd.org/derec/49872444.pdf)



Gender order
- Lack of economic rights and entitlements for women
- Discriminatory family law
- Composite measures of gender inequality

Cultural factors
- Collectivist versus individual cultural orientation
- Emphasis on women's purity and family honor

Economic factors
- Level of development
- Women's access to formal wage employment

Norms
- Acceptance of wife beating
- Male right to discipline/ control female behavior
- Tolerance of harsh physical punishment of children
- Stigma for divorced or single women
- Norms linking male honor to female purity
- Family privacy

Lack of sanctions
- Lack of legal or moral sanction for violence
- Others do not intervene

Neighborhood
- Community violence
- High unemployment
- Low social capital
- Poverty

Violence in childhood
- Harsh physical punishment
- Witnessing parental violence
- Other childhood traumas
- Psychological dysfunction
- Antisocial behavior
- Adult attachment issues

Attitudes
- Accepting of violence as a means to resolve conflict
- Acceptance of partner violence
- Gender hierarchical or transitional attitudes

Alcohol abuse

Gender role conflict

Delinquent peers

Sociodemographic
- Young
- Low level of education

Interaction
- Inequality in decision-making
- Poor communication
- High relationship conflict

Situational triggers
- Sex/infidelity
- Money/distribution of family resources
- Children or in-laws
- Division of labor
- Male drinking

Patriarchal triggers
- Female challenge to male authority
- Failure to meet gender role expectations
- Assertions of female autonomy

Childhood violence
- Child sexual abuse
- Other childhood traumas
- Witnessing mother being beaten

Attitudes
- Tolerance of wife beating
- Sociodemographic
- Young age (for current violence)
- High education attainment (protective)

Low social support

Factors that operate differently in different settings.
- Women's unemployment
- Participation in credit schemes or other development programs
- Asset ownership

- **Individual level:** the two individuals involved in an intimate relationship (woman and man). Individual-level factors contributing to IPV include the personality traits, personal experiences, and history of both the victims and the perpetrators (e.g., childhood traumas, acceptance of violence as a means of resolving conflict, alcohol abuse, women's unemployment, etc.)
- **Relationship level:** close social relationships, most importantly those between intimate partners and within families. Relationship-level factors contributing to IPV include poor communication, inequality in decision-making, etc.
- **Community level**: the community context in which social relationships exist, including peer groups, schools, workplaces, and neighborhoods. Community-level factors contributing to IPV include social norms supporting wife-beating, emphasis on family privacy, lack of legal or moral sanctions for violence, etc.
- **Societal level/macrosocial**: larger societal factors that "create an acceptable climate for violence, reduce inhibitions against violence" (Krug et al. 2002, p. 13). Societal-level factors that contribute to IPV include lack of economic rights and entitlements for women, collectivist versus individual cultural orientation, etc.

Women bring to their relationships certain personality traits and a host of experiences from their childhood and adolescence. They partner with men who likewise bring personal histories to the relationship. The couple's relationship has its own dynamics, some of which may increase or decrease the risk of abuse, and is embedded in a household and neighborhood context that affects the potential for violence. In many low-resource settings, this includes the influence of extended family members who interact with the couple in ways that may either increase or lessen the chances of abuse. In turn, both partners engage with various "communities," including those related to work, friendship networks, faith, and governance structures. Finally, these various communities are embedded in a macrosystem, which refers to the cultural, economic, and political systems that inform and structure the organization of behavior at lower levels of the social ecology (e.g., community, relationship, and individual) (Heise 2011).

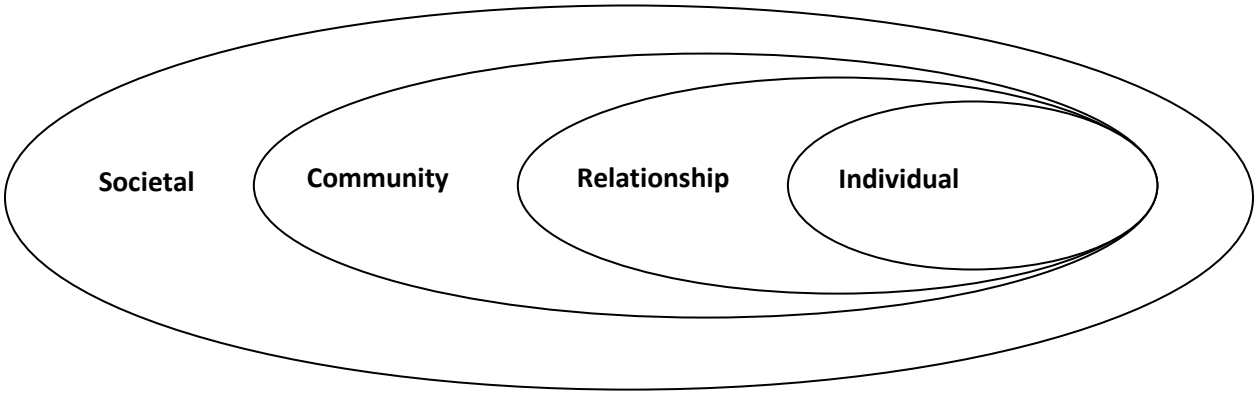
Factors operating at the different levels combine to establish the likelihood of abuse occurring. No single factor is sufficient, or even necessary, for partner violence to occur. There are likely to be different constellations of factors and pathways that may converge to cause abuse under different circumstances. Likewise, the same set of personal history and situational factors (such as abuse in childhood or having too many drinks) may be sufficient to push a particular man toward partner violence in one sociocultural and community setting, but not in another. One can imagine that a man's response to "perceived" provocation may be quite different based on what his expectations are regarding male/female relations; whether his friends, neighbors, and local authorities are likely to find his behavior "acceptable" or shameful; and whether his partner has the social permission and economic means to leave him if he crosses the line (Heise 2011).

References

Heise LL. 2011. *What Works to Prevent Partner Violence? An Evidence Overview*. London, UK: STRIVE. https://www.oecd.org/derec/49872444.pdf.

Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R. 2002. *World Report on Violence and Health. Geneva: Switzerland*: World Health Organization.

Facilitator handout: Ecological model



Facilitator Resource: Character Statements

My name is Betty. I am married to Benja. We used to be okay, but nowadays Benja shouts at me a lot and even sometimes hits me. It's especially bad when he's been drinking. I fear him and so do my children. But my mother endured the same fate as well.

My name is Benja. I am married to Betty. For some time now, things at home have not been so good. My wife annoys me, and I have no choice but to shout at her. Sometimes I even beat her. I guess this is what happens in marriage.

Level: R

I am a relative of Benja's. We were raised knowing that men can discipline women. This is how things should be.

Level: R

I am a friend of Benja's. We go to the drinking joint together. I see how you drink and then go home angry. But it is normal for men.

Level: R

I am a friend of Betty's. You and I discuss everything. My relationship is similar to yours—men are head of the house, and we have to endure.

Level: R

I am Betty's mother-in-law. If you didn't disrespect my son so much, he wouldn't hit you. You are to blame for the violence!

Level: R

I am Betty's mother. Your father and I care very much for you, but it would be a disgrace to the family if you were to leave your husband. As a woman, it is important to be patient and tolerant.

Level: R

I am Benja's brother. After the seeing the way your wife spoke back to you the last time I came to visit, it is no wonder you punish her. My wife would never speak to me that way!

Level: C

I am an elder. You respect me and follow my advice. Men have to make all the decisions for a family.

Level: C

I am your neighbor. I hear your fights at night but say nothing. It isn't my business.

Level: C

I am an adolescent. I keep silent when I see the violence happening. What can I do?

Level: C

I am a priest/imam. I keep silent about violence. God/Allah will take care of things.

Level: C

I am a health care provider. I take care of your injuries but don't ask anything. It is not my business.

Level: C

I am a food seller. I see her bruises but keep silent.

Level: C

I am a police officer. Men sometimes can't avoid using some small violence at home. It is a domestic issue.

Level: C

I am a farmer. I think a woman is not equal to a man. A woman should obey her husband.

Level: C

I am a taxi driver. I think violence should be used against a woman once in a while. Otherwise women start thinking they can do anything.

Level: C

I am a market seller. Women and men are not equal. If a man wants to show that he has more power, then that is a woman's fate.

Level: C

I am a local leader. Violence in relationships is a domestic issue. I don't have time for it!

Level: C

I am a pharmacist. You buy things from me, and ask for my advice. I think women must be patient and endure.

Level: C

I am a teacher. Making jokes about girls is just for fun; it doesn't do any harm.

Level: C

I am your doctor. I advise you on many issues but don't see how violence and HIV/AIDS are connected.

Level: C

I am a social welfare officer. I see violence in the community but I mostly focus on children, as violence between women and men is pretty normal.

Level: S

I am a judge. Sometimes women file cases just for simple violence. I dismiss the cases.

Level: S

I am a parliamentarian. There are no laws in my country specifically about domestic violence. That's a private matter!

Level: S

I am a donor. I fund AIDS prevention programs in Africa. I only fund ABC programs. They're the best!

Level: S

I am a radio announcer. You hear my messages every day. We joke about women and violence. What's the harm?!

Level: S

I am a United Nations official. I monitor countries' progress on international conventions, but I don't see the connection between violence against women and HIV/AIDS.

Level: S

I am a minister of health. I decide which services are available at the health centers. Women's rights issues don't belong in clinics. We prescribe drugs!

Level: S

I am a newspaper editor. I show promiscuous photos of women in my paper, because it sells!

Session 11: Violence in Daily Life

Learning Objectives

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

- Describe the many ways that men's use of violence limits women's (and men's) lives
- Reflect on the pervasiveness of violence in their personal lives

Facilitator note: This activity should only be completed after participants have completed the "What is Violence?" session.

Facilitator note: Given the highly sensitive nature of this activity, it is advisable to include this activity as part of a broader gender training lasting at least 3 days and during which participants have been able to examine social norms. Do not facilitate this activity as a standalone session.

Facilitator note: It is likely that some participants, particularly women, have experienced, or are experiencing, violence in their personal lives. It is important for the facilitator to have information about existing national laws and/or policies related to gender-based violence to refer to during the activity. Prior to leading this activity, research local support services for survivors of gender-based violence in the event a participant requests such support. It is also important to clarify with your organization any ethical or legal aspects related to dealing with situations that might come up during discussions on violence.

Facilitator note: Some people have strong emotional reactions to this activity. These reactions may include (among others) anger, outrage, astonishment, shame, embarrassment, and defensiveness. These may be related to personal experiences of violence at some point in their life. Some female participants may feel frustrated by some men's lack of understanding and/or empathy regarding women's experience of violence. Some women may feel exasperated at having to relive, rehash, and "display" the vulnerability they feel. Some participants may want to share their feelings overtly, which can be emotional and challenging for the entire group, although the outcome can also be therapeutic and healing. Enough time should be given to enable participants to express themselves, even if it means extending the length of the activity. Do not end the session abruptly for the sake of moving on to the next item in the agenda.

Participants should be encouraged to support one another. As participants share their feelings, let them know that their reactions are normal and appropriate. Remind them that anger can be a powerful motivating force for change. Encourage them to identify ways they can use their anger and outrage usefully to prevent violence and promote gender equity and equality.

Time Needed

1 hour 40 minutes

Materials Needed

- Chairs organized in a semicircle
- Flipchart paper
- Flipchart stand
- Markers
- Masking tape

Advance Preparation

None

Steps

Introduction (3 minutes)

1. Open the activity by explaining to participants that they will now move beyond a conceptual understanding of violence to examining the prevalence of violence in individuals' personal lives, as well as the influence of violence on women's and men's lives.
2. Before proceeding further, explain that because the session focuses on a very sensitive topic, participants must observe the following ground rules:
    - Maintain confidentiality. What is said in the room stays in the room.
    - Everyone has the right to pass. A participant who feels uncomfortable about a particular topic or about sharing on a particular point has the right to pass.
    - Suspend judgment. Everyone has a right to their opinions and beliefs. Try not to judge others and try to maintain an open mind and hear what others are saying.
    - Respect the opinions and feelings of others. Avoid interrupting others while they are speaking, mocking speakers, or minimizing a person's contribution.
    - Do not speak for others. Only share what you have said. Do not relate what someone else may have said in the context of this group.
    - Practice active listening. Pay attention when others are speaking and listen carefully to what they are saying.
3. Explain that given the sensitive nature of the topic, participants should keep in mind the following options during the session:
    - Take care of yourself, and take a break if you need to do so.
    - If you [a participant] want additional support on this issue for yourself, a family member, or a friend, feel free to talk to the facilitator after the session to be connected to support resources.
4. Ask the group if they have any questions or concerns.

Sexual Violence in Daily Life (50 minutes)

1. Divide participants into same-sex groups of five to eight persons.

> **Facilitator note:** Even if you have a small number of participants and/or a limited number of participants from either sex, maintain single-sex groups. The purpose of this part of the activity is to highlight the significant contrast between women's and men's daily experiences of sexual violence.

2. Once the groups have been created, explain that each group will have 20 minutes to answer the following questions:
   - What do you do on a daily basis to protect yourself from sexual violence?
   - What do you lack to be able to protect yourself from sexual violence?
3. Instruct participants to write their answers to each question on two separate flipchart pages. Make sure that everyone understands the questions, and then ask the groups to begin (spend no more than 5 minutes on steps 1–3).
4. After 20 minutes, ask the groups to stop and to post their flipchart pages on a wall.
5. After each group has posted its flipchart pages, allow participants 3–5 minutes to read each poster silently.
6. After participants have had a chance to read the posters, ask them to return to their seats. Next, facilitate a 5-minute debrief. First, ask the men in the group, "What did you notice about the women's list(s)? Do you have any questions or comments about the women's list(s)?"
7. After a few men have shared their observations, ask the women, "What did you notice about the men's list(s)? Do you have any questions or comments about the men's list(s)?"
8. Next, facilitate a 15-minute group discussion using the following questions:
   - Did the men list many things pertaining to sexual violence? Why or why not?
   - How does men's use of violence damage men's lives as well?
   - (to the men) How much do you already know about the impact of men's use of violence on women's lives? What does it feel like to have not known much about it previously?
   - (to the men) Do you think some men avoid noticing the impact men's use of violence has on women's lives?

> **Facilitator note:** Be sensitive to the fact that some men may not be aware of the level of consciousness women carry on a daily basis to avoid violence.

> **Facilitator note:** When facilitating the discussion, be careful not to push men into feeling blamed and guilty. Rather, try to ease them into recognizing the reality of the situation and committing themselves to greater responsibility for ending other men's use of violence.

> **Facilitator note:** If men are defensive during the discussion, make it clear that you are not accusing anyone in the room of having created such a climate of fear. Remind the group that you are trying to show how common and devastating violence against women is for everyone. Be sure to challenge participants who try to deny or reduce the significance of violence, particularly violence against women.

Facilitator note: This activity helps to establish a clear understanding of the extent and impact of men's use of violence against women. Be sure to allow sufficient time for discussion in plenary, as the discussion may be quite emotional.

Facilitator note: Be aware that some men may think they need to protect women from violence. If some men in the group say this, remind the group that it is important for everyone to work together to create a world free from violence. Women and men need to work together as allies in this effort. The danger of saying that it is up to men to protect women is that we reinforce the stereotype of men as strong and powerful and women as men's property that must be protected from other men.

Sharing Our Stories (45 minutes)

1. Transition to the next part of the session by explaining to participants that they will complete a listening exercise during which they will reflect on their personal experiences with violence.
2. Explain to participants that they will complete three rounds of active listening. During each round, they will be paired with a different partner and will spend 4 minutes with their partner discussing personal experiences with violence. During the pair work, each person will have the opportunity to be both a listener and a speaker.

Facilitator note: Tell participants they should only share what they are comfortable sharing. Remind them of the various forms of violence that were discussed during the first session on violence and explain that they can share personal experiences with any of the various forms of violence (e.g., emotional, economic, sexual, physical). However, also let them know that they do not have to share their personal experiences if they prefer not to; instead, they may share stories they have heard about friends, neighbors, and families, without using specific names.

Facilitator note: During this activity, you may notice that it is easier for participants to talk about violence they have suffered outside their homes than the violence they have suffered inside their homes, or the violence they have used against others. They may not wish to go into detail about these experiences, and it is important you do not insist they do.

3. Explain that while working in pairs, it is important for the individuals listening to truly listen to their partner and to avoid interrupting their partner with questions. Instruct participants not to take notes while their partner is speaking.
4. Next, ask participants to stand and find a partner. Once each person has been paired, ask participants to find a comfortable place in the room to sit and talk.

Facilitator note: If you have an even number of women and men, instruct the women to pair up with women and the men to pair up with men.

5. Once everyone is seated, state that each person will have 2 minutes to answer two questions; after 2 minutes, the pairs will be asked to switch so that the person who listened has the opportunity to answer the same questions. Tell participants that if the person speaking is done answering the questions before the 2 minutes are up, they should not switch; they should just sit quietly until the facilitator asks them to switch (spend no more than 10 minutes on steps 1–5).
6. Next, ask participants to quickly agree on who will speak first. Then, read the following questions out loud:

- Describe an experience where you or someone you know was a witness to violence
- How did that experience impact you/them?

7. Instruct participants to begin. After 2 minutes, call time and ask participants to stop and switch roles. The person who was speaking becomes the listener, and the person who was listening becomes the speaker. State that the new speaker will have 2 minutes to answer the same questions. Repeat the questions aloud if needed.
8. After 2 minutes, ask participants to stop and stand. Instruct participants to move around the room and identify a different partner.
9. When each participant has identified a partner, ask the pairs to find a comfortable place to sit and speak. Once the pairs are seated, ask them to quickly agree on who will speak first. Remind participants of the guidelines and then read the following questions aloud:
    - Describe an experience where you or someone you know was a victim of violence.
    - How did that experience impact you/them?
10. After 2 minutes call time and ask participants to switch roles so the person listening becomes the speaker, and the person who was speaking becomes the listener. State that the new speaker will have 2 minutes to answer the same questions. Repeat the questions aloud if needed.
11. After 2 minutes call time again and ask all participants to stand and to find another partner.
12. Once each person has identified a partner, ask the pairs to find a comfortable space to sit and speak. Then ask them to quickly agree on who will speak and who will listen. Remind the group of the guidelines once more and then read the following questions aloud:
    - Describe an experience where you or someone you know was a perpetrator of violence.
    - How did that experience impact you/them?
13. After 2 minutes call time and ask participants to switch roles so the person listening becomes the speaker, and the person who was speaking becomes the listener. State that the new speaker will have 2 minutes to answer the same questions. Repeat the questions aloud if needed.
14. After 2 minutes call time again and ask all participants to return to their original seats in the large circle.
15. Facilitate a 10-minute debrief by asking if anyone would like to share what they spoke about with their partner. Be sure to emphasize that they are only to share what they said and not what their partner

Facilitator note: Before proceeding with the debrief, remind participants of the group's agreement about confidentiality—what is said in the room, stays in the room.

Facilitator note: Do not force participants to share what they spoke about with their partners. Make it clear to participants that they should only share if they feel comfortable doing so. If no one wants to share, it is okay to move on to the group discussion.

16. After participants have shared, thank everyone for being open and vulnerable.
17. Next, facilitate a 10-minute group discussion using the following questions:
    - What is the most common type of violence used against us?
    - What is the most common type of violence we use against others?

- How do we know if we are really using violence against someone?
- Where do we learn violence?
- Is any kind of violence worse than another?

Closing (2 minutes)

1. End the activity by making the following points:
    - Violence and the threat of violence is an everyday fact for women. Because most men do not live with the daily threat of violence, they do not realize the extent of the problem that women face.
    - Men often do not understand that violence—actual and threatened—is such a regular feature of women's daily lives. However, men's lives are also damaged by violence against women. The women targeted are men's sisters, mothers, daughters, cousins, and colleagues—women that men care about are being harmed by violence every day.
    - Social acceptance of violence against women gives men permission to treat women as unequal and makes it harder for men to be vulnerable with their partners, wives, and female friends.
    - Violence poses a serious risk to women's sexual and reproductive health. Women in abusive relationships are often unable to negotiate the conditions of sex (e.g., where, when, how, and if sex occurs). Sexual violence makes it impossible for a woman to negotiate condom use and eliminates any element of choice regarding the decision to have sex. Forced sex also increases women's risk of an unwanted pregnancy, sexually transmitted infections, and HIV.

Acknowledgments

EngenderHealth. 2015. *Training on Gender and Sexual and Reproductive Health: Facilitation Manual*. New York, NY: EngenderHealth, 57–60.

Module 3

Gender as a Health Determinant

jhpiego
Saving lives. Improving health. Transforming futures.

Session 12: Unmet Needs

Learning Objectives

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

- Describe needs women have related to health that are often ignored
- Discuss possible solutions to addressing women's health needs in the context of the health facility

Time

1 hour 30 minutes

Materials Needed

- Chairs organized in a semicircle
- Laptop computer
- Projector
- Flipchart stand
- Flipchart paper
- Markers
- Masking tape
- "Why Did Mrs. X Die?" video (for maternal health programs) or the SASA! video (for HIV programs)

Advance Preparation

1. On a sheet of blank flipchart paper, reproduce the following table:

Needs	Met/partially met/unmet	Potential action	By whom?

2. Download the "Why Did Mrs. X Die?" video here:
   - https://www.futurelearn.com/courses/women-children-health/0/steps/8961
   - https://www.youtube.com/watch?v=WNb9pNymuwQ (with French subtitles)

   Or the SASA! video here: https://vimeo.com/128219146

Steps

Introduction (2 minutes)

1. Open by stating the following:
    - Health systems provide services that women need, such as antenatal care and delivery services. However, many things determine a woman's health.
    - Women often delay seeking health care for themselves because they are busy with all of the activities needed to maintain their homes and families. For many women, their own health takes second place to other demands on their time.
    - In this activity, we will explore the social factors that impact women's health and discuss why it is critical to consider these factors when providing care to women and/or designing effective health programs.

Why Did Mrs. X Die? Or SASA! video (1 hour 25 minutes)

1. Tell participants that you will show a video and then they will then spend some time discussing it.
2. Show the video. ("Why Did Mrs. X Die?" is approximately 10 minutes in length; The "SASA!" video is almost 30 minutes.)
3. After you have shown the video, facilitate a 10-minute whole group discussion using the following questions:
    - What were some factors that contributed to the death of Mrs. X?
    - Do men face the same issues?
    - What could have been done to address these factors?
4. Next, tell participants that they will spend some time in small groups exploring Mrs. X's (or Mama Joyce's) problems and needs, as well as strategies for addressing them.
5. Divide participants into three groups (ideally, three to five people in each) and give each group a marker and five sheets of flipchart paper.
6. Next, draw participants' attention to the table you posted on the wall and explain what the various headings mean. Tell participants they will work with their teams to first compile a list of the health problems that affected Mrs. X's (or Mama Joyce's) life. They will then use the remaining flipchart paper to reproduce and complete the table. Tell participants they may add other needs that were not already identified from the story. Challenge participants to consider ways in which health facilities might have responded to Mrs. X's (or Mama Joyce's) unmet needs.
7. After 30 minutes call time and ask the groups to post their flipchart pages on the wall.
8. Invite a representative from each group to present the group's work for 5 minutes.
9. After the group representative has presented, allow for comments and/or questions from participants in the larger group for 2 minutes.
10. Repeat steps 8–9 for the remaining groups. Focus the discussion on points not already covered by previous groups.
11. After all groups have presented, facilitate a 15-minute group discussion using the following questions:
    - Which of the unmet needs may be easiest to change?

- Which unmet needs are more difficult to address? Why?
- Is there anything that you will do differently in your clinical or programmatic practice as a result of today's discussion?

Closing (3 minutes)

1. By moving beyond the identification of immediate contributors to poor health outcomes toward the identification of underlying causes, our programs can become more effective. Gender analysis allows us to uncover underlying causes of poor health outcomes and design more impactful interventions.
2. As appropriate to the context, encourage participants to share their tables with relevant stakeholders for ongoing action planning.

Acknowledgments

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People's Picture Company and Raising Voices. 2007. SASA! A film about women, violence and HIV/AIDS. https://vimeo.com/128219146.

Session 13: Exploring the Links Between Gender and Other Health Determinants

Learning Objectives

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

- Explain the links between gender inequality and sexual and reproductive health and maternal, newborn, child, and adolescent health outcomes

Time

1 hour 45 minutes

Materials Needed

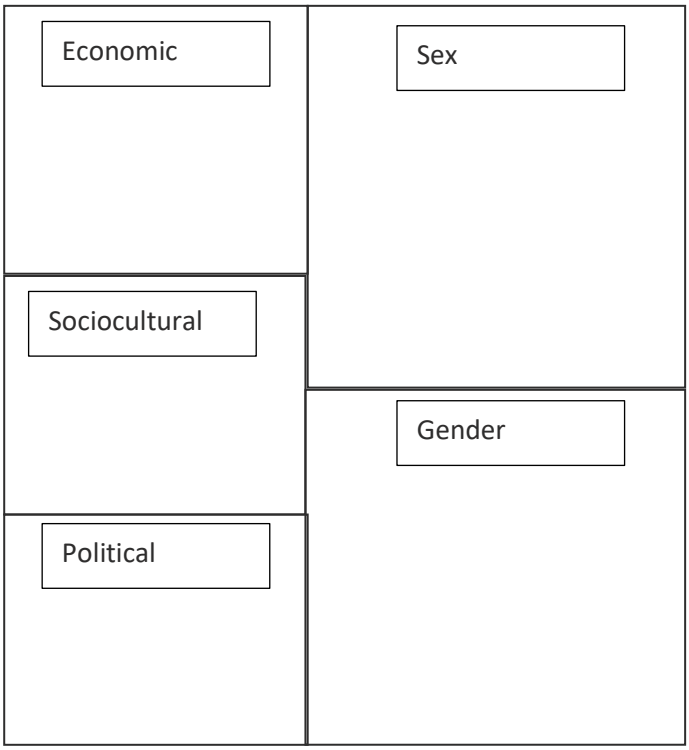
- Chairs organized in a semicircle
- Flipchart paper
- Flipchart stand
- Markers
- Masking tape
- String
- 1 pair of scissors
- **Facilitator Resource: Miriam's Story**
- **Facilitator Resource: Character Profiles**
- "Why Did Mrs. X Die?" or the "SASA!" video
- Laptop computer
- Projector

Advance Preparation

1. Use masking tape to create one large square on the floor. Make the square large enough for all participants to fit comfortably within it. Once you have created the square outline, split it into five smaller squares as illustrated in the diagram below.
2. Print one copy each of **Facilitator Resource: Miriam's Story** and **Facilitator Resource: Character Profiles**.
3. Write the following words on five sheets of A4-sized paper (one word per sheet):
    - Economic
    - Sociocultural
    - Political
    - Sex
    - Gender

4. Download the “Why Did Mrs. X Die?” video here:
   - https://www.futurelearn.com/courses/women-children-health/0/steps/8961
   - https://www.youtube.com/watch?v=WNb9pNymuwQ (with French subtitles)

   Or the “SASA!” video here: https://vimeo.com/128219146



5. Make sure each of the smaller squares is large enough to fit three to five people comfortably. Clearly demarcate the five squares using masking tape on the floor. Next, place the A4-sized sheets of paper you prepared on the floor in the five squares, as the diagram shows.

Facilitator note: Only facilitate the section “Why did Mrs. X Die?” if, due to time constraints or other limitations, participants are **not** first receiving the “Unmet Needs” session.

Steps

Introduction (2 minute)

1. Explain that this session aims to help participants to distinguish between determinants that affect both women and men and those that predominantly affect women’s health due to biological and gender-based differences.

Why Did Mrs. X Die? or SASA! video (25 minutes)

1. Announce that you will show a short film that illustrates the importance of identifying underlying causes as part of our efforts to promote sexual and reproductive health.
2. Start the "Why Did Mrs. X Die" or "SASA!" video.
3. Once the video is over, facilitate a discussion using the questions below:
   - How did gender norms lead to the death of Mrs. X? (Or how did gender norms and roles lead to Mrs. Joyce contracting HIV?)
   - Do we address underlying/root causes in our sexual/reproductive health programs? How?

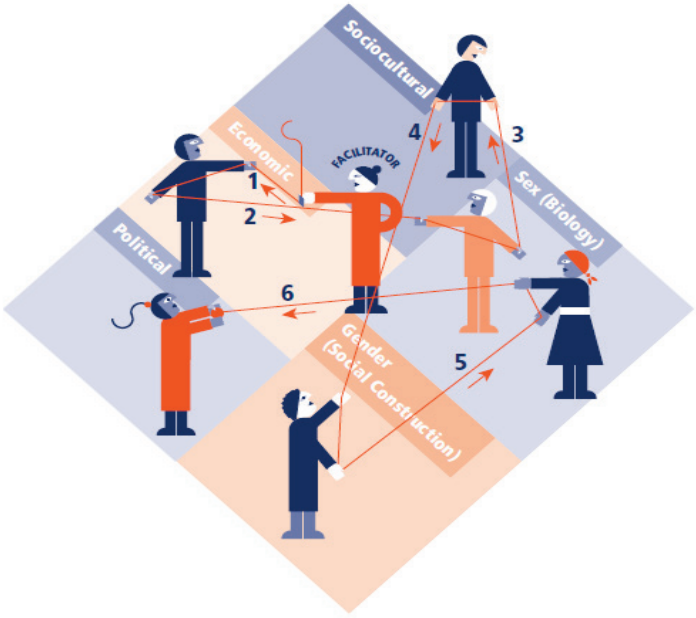
The Spider's Web (40 minutes)

1. Stand in the center of the large square with the ball of string in your hand and a copy of **Facilitator Resource: Miriam's Story** and **Facilitator Resource: Character Profiles**.
2. Ask participants to stand on the outside of the large square. Point to the five squares that you outlined with the masking tape and explain that each square represents a health determinant. Give examples to illustrate each of the determinant categories. Ensure that everyone has a clear understanding before moving on.
3. Explain that you will read a story about a woman and what she experiences in her life. You will pause at intervals and ask participants to identify factors that contributed to the various issues she encounters based on what they heard by asking, "But why?" When you ask, "But why?" a participant must raise his or her hand to answer. You may then ask, "But why?" again to narrow the answer down to a specific determinant, at which point another participant may raise his or her hand and offer an answer. Participants will agree as a group on how to categorize the determinant identified (i.e., sociocultural, economic, political, gender, biological/sex).

> **Facilitator note:** In some cases, the group may decide that a statement represents more than one category. This is acceptable, too. Economic, sociocultural, and political factors that affect women's health are so intertwined with factors related to gender and sex that they seem to mesh into one. Although it is important to see these links, it is equally important to separate them analytically so that later in the session we can identify where it is most feasible and appropriate to cut the web.

4. Once the group has agreed on a category (or, in some cases, up to two categories), the participant(s) who answered last will move and position themselves in the corresponding square, at which point you will toss them the ball of string. Explain that this process will continue until you are finished reading the story and a spider's web has been created. Use the following example to illustrate the process:
   - Facilitator: Miriam stopped schooling after second grade. But why?
     - Participant 1: Her school was three kilometers away from the village.
   - Facilitator: But why?
     - Participant 2: The village was a poor one, far away from the capital city.
   - Facilitator (to the group): To which category does this determinant belong?
     - Group: Economic (participant 2 moves to stand in the "economic" square and the facilitator tosses him or her the ball of string)

- Facilitator: Miriam stopped her schooling because her father did not think education was necessary for girls. But why?
  - > Participant 3: He believes women are inferior.
- Facilitator (to the group): To which category does this determinant belong?
  - > Group: Gender (participant 3 moves to stand in the "gender" square and participant 2 tosses participant 3 the ball of string. (See diagram below for a visual of the spider web.)



5. Make sure that all participants understand the process and allow a few minutes for participants to ask questions and/or make comments. Spend no more than 15 minutes on steps 1–4.
6. Next, standing in the center of the circle, refer to **Facilitator Resource: Miriam's Story** and begin reading. Stop and ask, "But why?" wherever indicated. As individual participants give answers, probe as needed to get to a specific health determinant.

Cutting the Web (15 minutes)

1. After you finish the story, tell participants that they will now think about points in Miriam's experience at which they might intervene to change her story and "cut her free" from her web.
2. Next, refer to **Facilitator Resource: Character Profiles**, select three to four character profiles, and randomly assign the profiles to three to four of the participants standing inside the squares. After assigning the profiles, ask each participant to think of a way their character could intervene to make a difference in Miriam's situation. For example, as the facilitator, you would ask the participant with the nurse profile, "As a nurse at the local clinic, where would you cut the web?" The participant might reply, "I would be sensitive to signs and symptoms of battering in women who come to my clinic. I would help Miriam find shelter and social support through a suitable agency."
3. As each participant answers, write down the interventions on the flipchart paper and then cut her or him free.
4. Next, ask participants to return to their seats.

Group Discussion (15 minutes)

1. Facilitate a discussion using the questions below:
    - How did you feel when you were entangled?
    - What do you think the entanglement signified?
    - Were there parts of the spider web that would be more difficult to cut through than others?
    - What lessons did you draw from the exercise?
    - Which determinants affect women exclusively?

Facilitator note: During the group discussion, raise the following points:

- The key to cutting the complex web may lie in starting with the woman herself. This would create greater space for her to reflect on her situation, interact with others, and facilitate her empowerment, helping her see that change is possible.
- In the spider web exercise, many gender factors were also classified also as sociocultural, for example, the reason for Miriam's circumcision or her early marriage. Culture and tradition are not gender neutral and may become tools for discriminating against women. They are likely to be the parts of the spider's web that are the most difficult to cut through.
- Unless one carries out an analysis to unravel gender and sex from other factors underlying a problem, interventions may not address the causes, and may in fact further undermine women's position. There are many examples of such interventions: targeting women for health education assuming that ignorance is the cause of their malnutrition; not dealing with men and safe sex, but testing and treating women for sexually transmitted infections; and so on.

Closing (8 minutes)

1. End the session by making the following points:
    - It is useful to distinguish between health determinants common to women and men and those that are sex and gender related, because each of these sets of factors requires a different type of intervention.
    - Often there are several factors causing a problem, and a multipronged strategy is required to address them simultaneously.
    - Our programs can become more effective by moving beyond identifying the immediate contributors to poor health outcomes toward identifying the underlying causes.
    - Gender analysis allows us to uncover underlying causes of poor health outcomes and design more impactful interventions.

Acknowledgments

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Facilitator Resource: Miriam's Story

Miriam is 36 years old and the mother of six children. She grew up in a village 400 kilometers away from the capital city of her country. She stopped schooling after second grade. Her parents were poor, and the school was 3 kilometers away from her village. Her father believed that educating a girl was like "watering the neighbor's garden."

STOP AND SAY: "Miriam stopped school after second grade. But why?"

When she was 12, Miriam was a victim of female genital mutilation, as was the custom in her tribe. At 16, she was married to a man three times her age. Her father received a substantial dowry.

STOP AND SAY: "As a child, Miriam was a victim of female genital mutilation and forced marriage. But why?"

The very next year, she gave birth at home, to a baby boy. The baby was stillborn. The health center was 10 kilometers away, and anyway, did not attend deliveries. Miriam believed that the baby was born dead because of the repeated beatings and kicks she had received throughout her pregnancy. Miriam was blamed for not being able to bear a healthy baby.

STOP AND SAY: "Miriam's baby died. But why?"

Miriam's husband considered it his right to have sex with her, and regularly forced himself on her. Miriam did not want to get pregnant again and again, but had little choice in the matter. She had no time to go to the health clinic, and when she went because her children were sick, she was hesitant to broach the subject of contraception with the nurses.

STOP AND SAY: "Miriam did not use contraception. But why?"

Her life with her husband was a long saga of violence. Miriam struggled to keep body and soul together through her several pregnancies and raising her children. She had to farm her small plot of land to feed the children because her husband never gave her enough money. She approached the parish priest several times for help. He always advised her to have faith in God and keep her sacraments.
One day her husband accused Miriam of "carrying on" with a man in the village. He had seen Miriam laughing and chatting with the man, he claimed. When she answered back, he hit her knees repeatedly with firewood saying, "You whore! I will break your legs." Miriam was badly injured; she thought she had a fracture. For weeks she could not move out of the house. But she did not have any money to hire transport to go to the health center. Unable to go to the market to trade, she had no income and literally starved.

STOP AND SAY: "Miriam was a victim of violence in her marriage. But why?"

Miriam was terrified of further violence. She had had enough. As soon as she could walk, she took her two youngest and left the village. She now lives in a strange village, a refugee in her own country, living in fear of her husband finding her and bringing her back home.

Facilitator Resource: Character Profiles

- Health provider
- Neighbor
- Community health worker
- Religious leader
- Teacher

Session 14: Gender Determinants of Health

Learning Objectives

By the end of this session, participants will:

- Understand gender as it relates to health outcomes of women, men, and children
- Understand the impact of gender in relation to the health workforce

Time

45 minutes

Materials Needed

- Projector
- **Facilitator Resource: PowerPoint on Gender Determinants of Health**

Advance Preparation

1. Save a copy of the **PowerPoint on the Gender Determinants of Health** to your computer, and practice presenting the PowerPoint beforehand to ensure you have a good understanding of the various concepts.

> **Facilitator note:** This session assumes that participants have a basic understanding of gender concepts. Ideally, this session will come after **Gender Terms and Definitions**.

Steps

Introduction (1 minute)

1. Project the **PowerPoint on Gender Determinants of Health**.
2. Explain that in this session, participants will learn about the gender determinants of health. This PowerPoint provides a thorough introduction to how gender impacts health outcomes of women, men, and children. Explain that throughout the presentation, participants should be thinking about how the concepts introduced in this presentation relate to their work.

Gender Determinants of Health (30 minutes)

1. Refer to the discussion points included beneath each slide during the presentation.

Group Discussion (12 minutes)

1. Facilitate a 12-minute group discussion using the following questions, which are also on slide 18 of the PowerPoint:
    - Have gender norms been a challenge to your work?
    - What do you think you can do to address gender in your programs?

Closing (2 minutes)

1. End the session by explaining that we've learned through this lesson the many ways in which gender influences health outcomes. Gender inequality is a barrier to the success of health programs, contributes to maternal mortality and morbidity, exacerbates poor maternal and child health, and contributes to early marriage and gender-based violence. Rigid norms around masculinity and stigma from failure to adhere to these norms contribute to men's morbidity and mortality related to HIV. Gender inequality also affects human resources for health in pre-service and in-service, and the health workforce. Women dominate in nursing and nonphysician medical roles, and are underrepresented in health management positions.

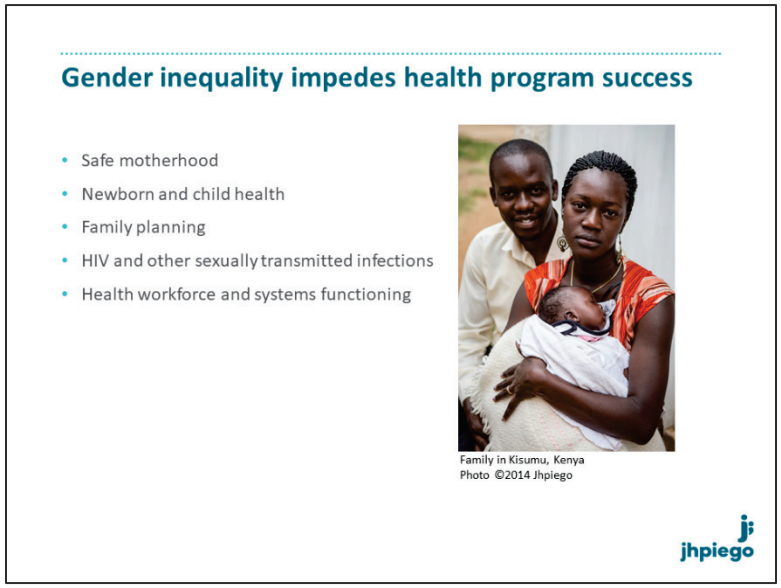
Facilitator Resource: PowerPoint on Gender Determinants of Health

Slide 1

Facilitator discussion points

- Introduce the PowerPoint presentation.

Slide 2



Facilitator discussion points

To make visible how gender inequities between women and men limit the effectiveness of health-promoting behaviors, technologies, and interventions, we can consider several key areas of health programming:

- Safe motherhood—Gender norms and the low status of women play a large role in shaping vulnerabilities associated with pregnancy and delivery. For instance, women's overall status—especially when it comes to level of education and decision-making—can affect their access to maternal health care. Such lack of access to and control over resources often prevent women from recognizing danger signs in pregnancy, or from being able to actively seek emergency care on their own. Men are more likely to control household expenditures and other household decisions, yet often know little about pregnancy. Although it is changing, many cultures have norms that exclude men's involvement in pregnancy, postpartum care, or child rearing.
- Family planning—As many program experiences and evaluations have documented, unequal gender roles present powerful obstacles to use voluntary family planning. Family planning efforts are often less successful when women do not have the power to decide when and how many children to have. When women are unable to use family funds for their health care or are discouraged from leaving home without permission, they face difficulties in learning about and obtaining family planning services. Furthermore, gender norms about female subservience and male virility may discourage couples from limiting the number of children they have.
- Sexually transmitted infections (STIs)/HIV—As recent efforts highlight (such as the law reauthorizing PEPFAR, among others), gender norms around women's and men's sexuality can increase the risk of STIs/HIV. These norms include, for instance, men being expected to have multiple partners and women being expected to be passive and ignorant about sex. Such norms increase vulnerability to STIs, including HIV.

Facilitator note: You may want to acknowledge the health implications for non-normative gender and sexual identities and practices by saying that some cultures are more accepting than others of nonbinary gender constructs. However, in many contexts, those who challenge normative ideas about gender experience severe stigma, discrimination, and even violence. It is thus important to consider, in RH programming, that both gender conformance and nonconformance can influence health behaviors, vulnerability, and access to information and services.

Slide 3

Gender inequality contributes to maternal mortality and morbidity

Maternal mortality and morbidity are exacerbated by women's:

- Low status
- Lack of access to information
- Limited mobility
- Lack of decision-making and choice
- Early age of marriage
- Vulnerability to violence

Mother near Bharatpur in Rajasthan, India
Photo ©2011 Indrani Kashyap/Jhpiego

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Slide 4

Gender inequity exacerbates poor maternal and child health

In 8 African countries where women had high participation in household decision-making, women were were (after controlling for wealth and education):

- Less likely to have low body mass index (BMI)
- More likely to take a child sick with an acute respiratory infection for treatment

In 8 African countries where wife beating is not considered justifiable, women were (after controlling for wealth and education):

- Less likely to have low BMI
- More likely to have a facility delivery
- More likely to have a fully immunized child

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Facilitator discussion points

- Explain that these findings are from a Demographic and Health Survey cross-sectional study.

Slide 5

Girl in the village of Gore, Chad
Photo ©2016 Karen Kasmauski/Jhpiego

Facilitator discussion points

- Gender inequalities also impact safe motherhood. For example, the practice of early marriage is linked with maternal and infant mortality and morbidity. Although both girls and boys may be married at very young ages in some areas, on average girls are married earlier, and are more likely to be married to someone much older. In some cases, girls are married under coercive conditions, whereas others may simply be too young to give their fully informed consent. The consequences of early marriage for girls are also more severe: marriage usually means premature childbearing, and early marriage increases a girl's chances of experiencing domestic abuse.

References

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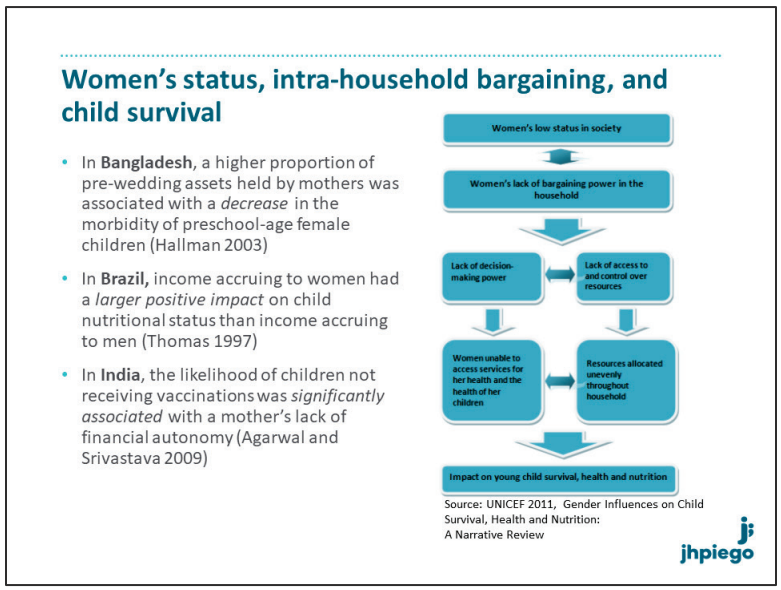
Slide 6



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Slide 7

Facilitator discussion points

- Sex selection was previously driven through girl child neglect or infanticide; however, technology has advanced to allow sex determination from an early stage in pregnancy.
- In Asia and Gabon, Cote d'Ivoire, Ethiopia, and Sierra Leone, girls are less likely to be immunized, while in Nigeria, Madagascar, and Namibia, boys are less likely to be fully immunized (Jones et al. 2008).
- In eastern Kenya there was greater prevalence of malnutrition in girls than boys (0–60 months) due to differences in food intake and higher prevalence of disease (Ndiku et al. 2011).
- A study in Nairobi slums found more boys than girls (0–42 months) to be stunted, but no reason was given, although there were several other associations with stunting, including birthweight and mother's education (Abuya et al. 2012).

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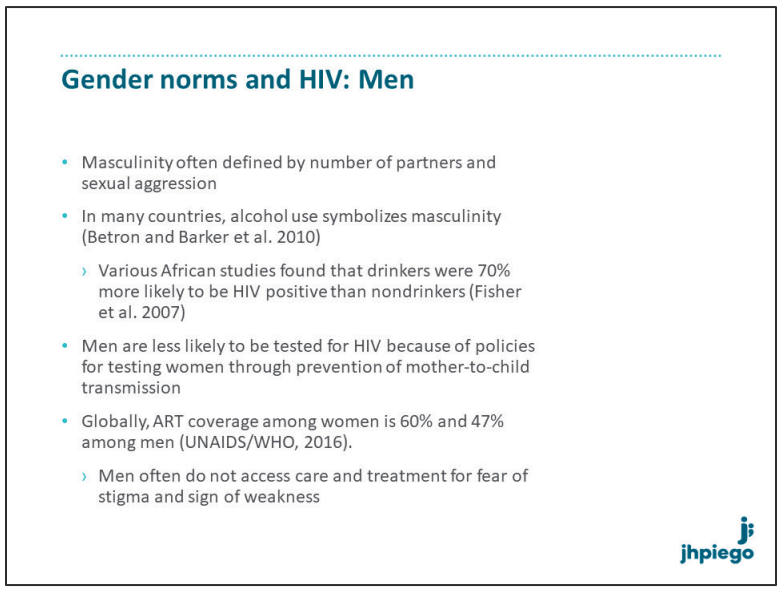
Slide 8



Facilitator discussion points

- A study in Swaziland found that people who had six or more discriminatory gender attitudes were more than twice as likely to have multiple sex partners than those without such attitudes (Physicians for Human Rights 2007). Having multiple partners still drives the HIV epidemic in many sub-Saharan contexts.
- Qualitative studies have found that men use women's antiretrovirals (ARVs).

Sources

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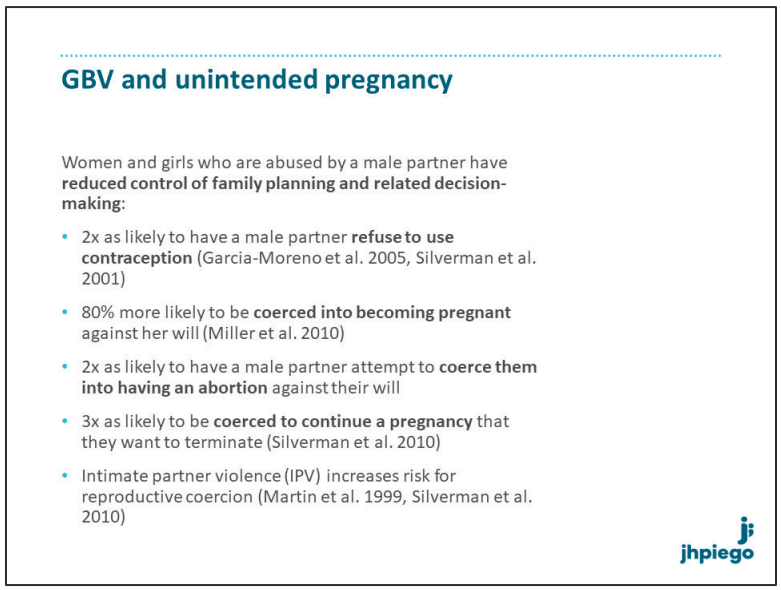
Slide 9

Facilitator discussion points

- Empowerment was measured in various ways, including household decision-making on expenses and other issues, decision-making on health, sex negotiation, and attitudes on violence.
- The study concluded that intervention programs aimed at increasing contraceptive use may need to involve different approaches, including promoting couples' discussion of fertility preferences and family planning, improving women's self-efficacy in negotiating sexual activity, and increasing women's economic independence.

Slide 10



Facilitator discussion points

Reproductive coercion: Behaviors that directly interfere with contraception and pregnancy, reducing female reproductive autonomy:

- **Pregnancy coercion:** Behaviors to coerce compliance with a male partner's desire that a woman/girl become pregnant, or his desire that she continue or terminate a pregnancy against her will
- **Contraception sabotage:** Behavior that purposely interferes with a woman's attempts to contracept:
  - Hiding, withholding, destroying or removing female-controlled contraceptives (e.g., oral contraceptives, intrauterine devices, contraceptive patches)
  - Breaking or removing a condom during sex
  - Failing to withdraw in an attempt to promote pregnancy despite a female partner's wishes to contracept (Martin et al. 1999, García-Moreno et al. 2005, Fanslow et al. 2008).

Obviously, we need to engage men productively in the family planning discussion, as they are key influencers and at times sole decision-makers on whether to use family planning.

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Miller E, Decker MR, McCauley HL, et al. 2010. *Pregnancy coercion, intimate partner violence, and unintended pregnancy*. Contraception. 81(4):316–322.

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Slide 11

Facilitator discussion points

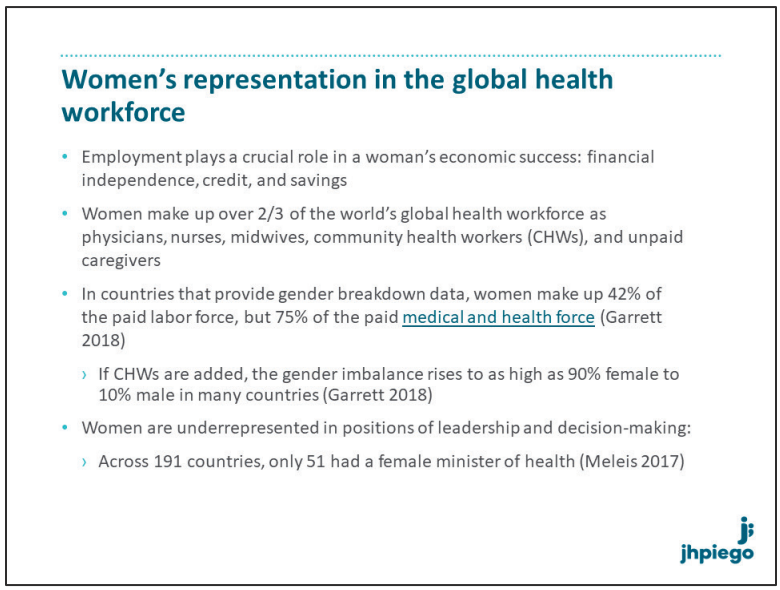
- Same constraints as many other health issues
- Some studies have found that on the malaria worker side, there is bias toward men to do seasonal chemotherapy (spraying) because of the assumption that women cannot physically handle the job.

Slide 12

Facilitator discussion points

- Explain that gender plays a role at pre-service, in-service, and in the health workforce.
- Read the factors on the right side of the PowerPoint slide.

Slide 13



Facilitator discussion points

- Female health workers are still paid substantially less than men, even if they have the same qualifications and responsibilities.
- Traditional norms around women's independence, mobility, and working outside of the home make it hard for women to pursue higher education or careers in health.
- In Pakistan, midwives report that their husbands do not want them to leave the home in the middle of the night to birth a baby (Mumtaz 2003).
- In Bangladesh, nursing students study full time, hold a job to pay their tuition, and also shoulder most of the unpaid labor at home (Blum 2006).
- A study in Pakistan found that male supervisors demanded sexual intercourse with trainees, causing many women to leave the training program.

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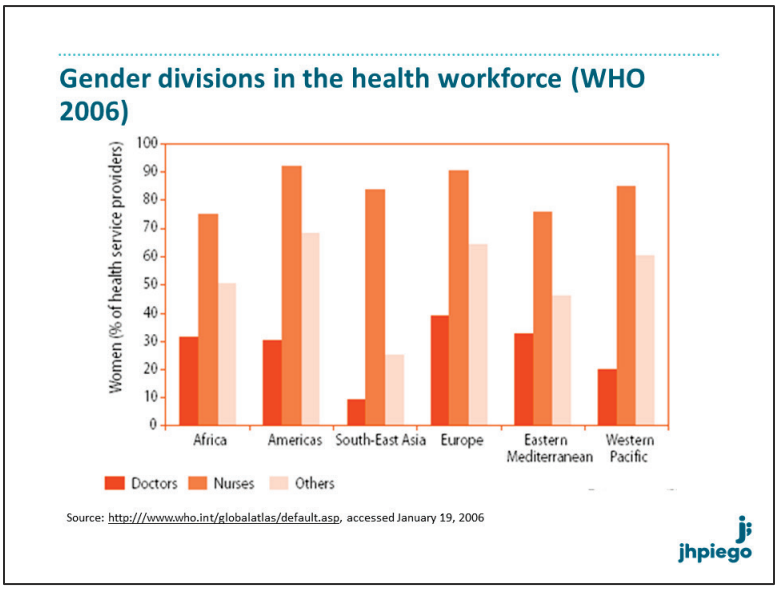
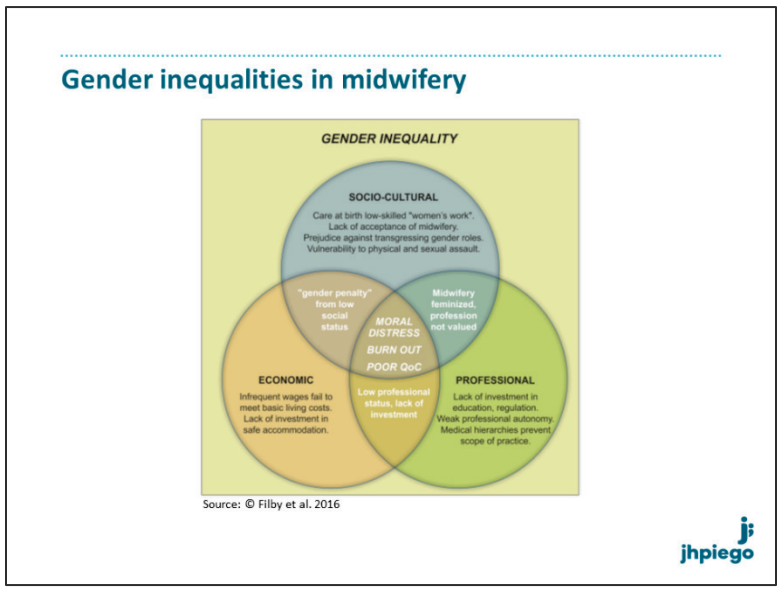
Slide 14



Facilitator discussion points

- Women dominate in nursing and nonphysician medical roles (in Europe, getting to parity)

Slide 15



Facilitator discussion points

- A systematic 2016 mapping on barriers to quality midwifery care found that significant social and cultural, economic, and professional barriers (see in the framework on this slide) prevent quality midwifery care in low- and middle-income countries and that they arise from gender inequality.

Source

Filby A, McConville F, Portela A. 2016. What prevents quality midwifery care? A systematic mapping of barriers in low and middle income countries from the provider perspective. *PLoS ONE*. 11(5):e0153391. doi:10.1371/journal.pone.0153391

Slide 16

Health care management and leadership: Where are the women?

In these countries, women make up the majority of the health care workforce, but hold few management positions:

- 15% of management positions in Ghana and Tanzania
- 9% of management positions in Zimbabwe
- 10% of management positions in Indonesia

This is a common trend.

Source: George A 2007. *Human Resources for Health: A Gender Analysis.* WHO Commission on the Social Determinants of Health.

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Slide 17

Negative and positive effects of gender discrimination for the healthcare workforce

Negative effects	Positive effects
• Entry into health occupations impeded	• Equal access to professional education, requisite skills, and knowledge
• Clogged health worker education pipeline	• Increased health worker pipeline
• Workers' career progression impeded	• Equal chance of being hired, fairly paid, and enjoying equal treatment and advancement opportunities
• Workers experience work/family conflict, low morale, stress, lower productivity	• Female health workers better able to juggle life events
• Recruitment bottlenecks	• Better work/life integration for all health workers, less stress
• Worker maldistribution	• Better morale and productivity
• Workplaces experience absenteeism, attrition	• Increased retention
• Limited pool of motivated health workers to deal with today's health challenges	• More health workers
	• More health services

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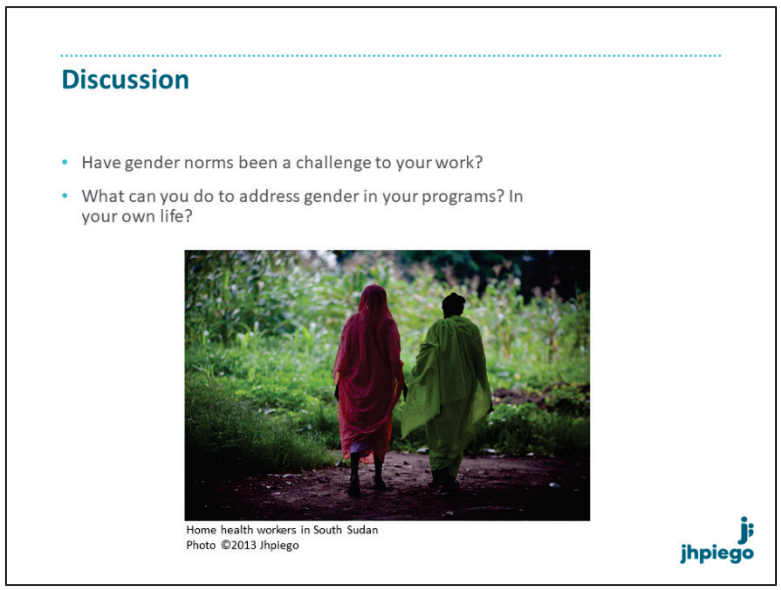
Slide 18



Facilitator discussion points

- Facilitate a 12-minute discussion on the points in this slide.

Slide 19

Facilitator discussion points

- Thank participants for the rich discussion.

Module 4

Sexuality and Sexual Diversity

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Saving lives. Improving health. Transforming futures.

Session 15: Defining Sexual and Reproductive Health

Learning Objectives

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

- Define the terms "sex," "sexuality," "reproductive health," "sexual health" and "sexual and reproductive health"
- Explain how the quality of sexual and reproductive health counseling and services can be improved by including a focus on sexuality issues and concerns
- Describe barriers or challenges for providers in addressing sexuality in sexual and reproductive health counseling

Time

1 hour 45 minutes

Materials Needed

- Chairs organized in a semicircle
- Flipchart paper
- Flipchart stand
- Markers
- Masking tape
- A4-sized paper
- Projector
- **Participant Handout: Key Definitions Flashcards**
- **Participant Handout: Key Messages**

Advance Preparation

1. Make enough copies of **Participant Handout: Key Definitions Flashcards** and **Participant Handout: Key Messages** for each participant.
2. Cut along the lines in the **Participant Handout: Key Definitions Flashcards**.
3. Label four flipchart pages with the following titles (one per sheet of paper), and then post the pages side by side on a wall:
    - Sex
    - Sexuality
    - Sexual health
    - Reproductive health

Steps

Introduction (5 minutes)

1. Introduce the session by noting that some participants may be thinking, "I know about reproductive health, but why are we always hearing about **sexual** and reproductive health?" Explain that if they are confused, many other people probably share their confusion and that the purpose of this session is to explore key terms and the importance of comfortably discussing sexuality issues and concerns in our work with clients.

Small Group Work (1 hour 5 minutes)

1. Divide participants into four groups.
2. Give each group several sheets of A4-sized paper and a marker.
3. Assign one of the following concepts to each group (one concept per group):
   - Sex
   - Sexuality
   - Sexual health
   - Reproductive health
4. Ask participants to spend 8 minutes in their small groups formulating a definition for their assigned concept. Instruct participants to write (using the marker) their definition on the sheets of paper provided. Tell participants they may use as many sheets of paper as they choose. Explain that they should write large enough so people can read the definition from a distance. Instruct participants to avoid using the words "sex," "sexual," or "reproduction" in their definitions.
5. After 8 minutes, call time and ask the groups to tape their definitions on the labeled flipchart page corresponding to their assigned concept.
6. After all groups have posted their definitions, ask a member from one group to volunteer to come to the front of the room and read the group's definition. Next, ask the other participants if they have different ideas about the concept. Allow up to 3 minutes for discussion. Repeat a similar process for the remaining three groups.
7. Next, distribute the **Key Definitions Flashcards** to participants and ask for a participant to volunteer to read one of the definitions to the group. Repeat this step 3 times until all four definitions have been read aloud.
8. Facilitate a 15-minute group discussion using the following questions:
   - What are some similarities between "sex" and "sexuality"? What are some differences?
   - What are some similarities between "sexual health" and "reproductive health"? What are some differences?
   - Based on the various definitions (i.e., "sex," "sexuality," "sexual health," and "reproductive health"), how might we define "sexual and reproductive health"?
9. Next, write "Sexual and reproductive health care services" at the top of a blank flipchart page and ask participants to share their thoughts about the health services that would be included in sexual and reproductive health. As participants call out their ideas, write them on the flipchart page. Spend no more than 15 minutes on this step.

Group Discussion (30 minutes)

Facilitator note: In advance of the discussion, review the participant handout. As you facilitate, be sure to raise any additional points that participants have not already addressed.

1. Facilitate a 25-minute group discussion using the following questions:
    - Why is it important to understand the differences between these terms?
    - Why is it important to address sexuality as part of sexual and reproductive health counseling?
    - What barriers or challenges might providers experience in discussing sexuality issues with clients?
    - What barriers or challenges might clients face in discussing sexuality issues with providers?
    - How can providers feel more comfortable and better equipped to address issues related sexuality?
    - How can providers help clients feel more comfortable raising and discussing issues related to sexuality?
2. Before closing, distribute **Participant Handout: Key Messages**. Allow participants to review and ask questions, as needed.

Closing (5 minutes)

1. End the session by summarizing the following key points:
    - Discussing sexuality may reveal underlying issues and concerns that affect clients' sexual and reproductive health-related needs and decisions.
    - Discussing sexuality can improve the overall quality of care by fostering comfort and trust between clients and providers.
    - Providers often shy away from discussions of sexuality because of their own discomfort or because they fear that such discussions may be culturally inappropriate or may offend clients.
    - Providers must take the initiative by introducing sexuality-related issues in counseling.
    - Providers can use many strategies to increase their comfort in discussing sexuality concerns with clients.

Acknowledgments

EngenderHealth. 2003. *Comprehensive Counseling for Reproductive Health: An Integrated Approach* (Trainer's Manual). New York, NY: EngenderHealth. https://www.engenderhealth.org/files/pubs/counseling-informed-choice/ccrh_tm.pdf.

Participant Handout: Key Definitions Flashcards

Sex

- Refers to the **biological** characteristics (anatomical, physiological, and genetic) that make us female or male
- Can also refer to sexual activity, including sexual intercourse

Sexuality

- A central aspect of being human; encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction
- Experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles, and relationships
- Shaped by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious, and spiritual factors

Sexual Health

- Includes aspects of sexuality not necessarily related to reproduction
- Recognizes the fact that people may have sex for pleasure, not just reproduction, and that people have health needs related to such sexual activity
- The basic elements of sexual health include:
  - Physical, emotional, mental, and social well-being in relation to sexuality
  - A sexual life free from disease, injury, coercion, discrimination, violence, unnecessary pain, and risk of death
  - A sexual life free from fear, shame, guilt, and false beliefs about sexuality
  - The capacity to enjoy and control one's own sexuality and reproduction

Reproductive Health

- State of physical, mental, and social well-being in all matters related to the reproductive system
- Implies that people have a safe and satisfying sex life and can control their own reproduction choices
- Women and men have a right to be informed of and have access to safe, effective, affordable, and acceptable family planning methods, and the right to access health services that enable women to go safely through pregnancy and childbirth, with the best chance of couples having a healthy infant.

Participant Handout: Key Messages

Summary of Essential Ideas

- Sexuality issues are directly related to informed choice and continuation in family planning services, and to the effectiveness of efforts to reduce the risk of HIV and sexually transmitted infections (STIs).
- Discussing sexuality may reveal underlying issues and concerns that affect clients' sexual and reproductive health-related needs and decisions.
- Discussing sexuality can improve the overall quality of care by fostering comfort and trust between clients and providers.
- Providers often shy away from discussions of sexuality because of their own discomfort or because they fear that such discussions may be culturally inappropriate or may offend clients.
- Providers must take the initiative by introducing sexuality-related issues in counseling.
- Providers can use many strategies to increase their comfort in discussing sexuality concerns with clients.

Why is it important to address sexuality as a part of integrated sexual and reproductive health counseling?

- Pregnancy and STIs are both outcomes of sexual activity.
- Reproductive health programs will have a limited impact if they do not consider the context in which people make decisions about their sexual lives and reproduction. Sexuality and sexual practices can have implications for a client's decisions about contraceptive method use and HIV and STI risk reduction, as well as the client's ability to make decisions and to negotiate with her or his partner.
- Clients may have underlying concerns about sexuality that are the real reason for a clinic visit or that are more important than the stated reason.
- Providers who make assumptions about their clients' sexual practices may provide inappropriate services. For example, they might promote family planning methods because they incorrectly assume the client is having sex with people of the opposite sex. They may also assume that a woman only engages in vaginal sex and not anal sex, and therefore may fail to provide sufficient information about the risks of HIV and STIs. They might misdiagnose a vaginal infection as a reproductive tract infection (i.e., an infection that was not sexually transmitted) when it is in fact an STI (i.e., one that was sexually transmitted).
- It is difficult to discuss STI prevention without discussing the specific sexual practices that place a person at risk, as well as the range of sexual practices that are safer.
- A client's needs may be related to sexual abuse or coercion, rape, or incest—issues that must be addressed to provide effective services.
- People may stop using a contraceptive method if they perceive it to interfere with the sexual act or if it decreases sexual pleasure.
- Clients may be reluctant to try a certain method (e.g., vasectomy or condoms) out of fear that it will affect sexual pleasure or response (for themselves, their partner, or both).
- Offering counseling about sexuality may help to improve client satisfaction and attract new clients.

What barriers or challenges might providers experience in discussing sexuality issues with clients?

- Providers may feel personally uncomfortable about discussing sexuality with anyone.
- Providers may feel that it is culturally inappropriate to discuss sexuality with clients.
- Providers may fear that clients will be offended if they are asked about their sex life.
- Providers may not know how to initiate a discussion about sexuality with their clients.
- Providers may feel that there is not enough time to address sexuality issues in a counseling session.
- Providers may fear that clients will bring up topics or have questions that they are unprepared to address.
- Clients may feel uncomfortable discussing sensitive subjects such as sexuality with providers.
- If the client and provider are of different sexes, or if there is a significant age difference, they may find it awkward to talk about sexuality.

How can providers feel more comfortable and better equipped to address issues related to sexuality?

- They can learn more about sexuality to increase their comfort talking about it.
- They can talk with other providers about their experiences in speaking with clients about sexuality.
- They can explain to the client the reason for discussing sexuality issues, focusing on the importance of sexuality to the client's health and assuring the client that they are not asking out of their own curiosity.
- They can use language (e.g., terminology) that is comfortable for them and understandable to the client.
- If the provider is of the opposite sex of the client, they can ask another staff person of the same sex to be present during the discussion (with the client's permission).
- Focus groups or interviews with community members or clients can be conducted to better inform providers about the sexuality concerns and service needs of the community.

Session 16: Circles of Sexuality

Learning Objectives

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

- Describe the intersections of gender and sexuality
- Discuss sexuality from a holistic perspective
- Define sexual rights

Time

2 hours

Materials Needed

- Chairs organized in a semicircle
- Two flipchart stands
- Flipchart paper
- Markers (black and multicolor)
- **Participant Handout: Circles of Sexuality**
- **Participant Handout: Circles of Sexuality Definitions**
- **Participant Handout: WHO Working Definitions of Sexuality and Sexual Rights**
- **Facilitator Resource: Circles of Sexuality**

Advance Preparation

1. Refer to **Facilitator Resource: Circles of Sexuality** and reproduce the circles on a blank flipchart page.
2. Print enough copies of **Participant Handout: Circles of Sexuality** for each participant.
3. Print enough copies of **Participant Handout: Circles of Sexuality Definition***s* for each participant.

Steps

Introduction (5 minutes)

1. Begin the session by asking participants if they have ever heard the word “sexuality.” For those who acknowledge that they have, ask them what they think it means. After participants have shared a few ideas, explain that they will spend time exploring the idea further during this session.
2. Explain to participants the sensitive nature of the subject matter, and re-emphasize the importance of confidentiality (what is said inside the room, stays inside the room), respect for others’ opinions, and the right to pass (participants who are uncomfortable with the topic may choose not to take an active part in the session).

Brainstorm on Sexuality (1 hour 30 minutes)

1. Set up two flipchart stands a few feet apart and ask two volunteers to come to the front of the room to write down ideas from the group.
2. Explain to the group that they will spend some time brainstorming words they think are associated with sexuality. Ask participants to call out words and have both volunteers write the words on their respective flipchart pages (both lists should be identical). Spend no more than 5 minutes creating the list. Examples of words that participants may mention include:

Kissing	Date aggression	Withdrawal method
Massage	Masturbation	Getting pregnant
Caring	Passion	Lesbian, gay
Infertility	STIs	Body image
HIV	Ovaries	Caressing
Touching	Female genital cutting	Impotence
Fantasy	Contraception	Bisexual
Sharing	Need to be touched	Anal sex
Child spacing	Pornography	Communication
Rape	Sperm	Emotional vulnerability
Hugging	Self-esteem	Flirtation
Sexual harassment	Orgasm	Incest
Loving/liking	Sexual attraction	Unwanted pregnancy
Abortion		

3. Next, draw participants' attention to the prepared flipchart page illustrating the five circles of sexuality. Explain that words related to human sexuality can fit in one or more of these circles. Refer to **Participant Handout: Circles of Sexuality** and use the definitions to explain each circle. Drawing from the previous brainstorm, ask participants for a few examples of sexuality concepts, thoughts, or behaviors that would fit in each circle. Once the instructions are clear, explain that participants will continue working in small groups on this activity. Allow up to 15 minutes to complete this step.
4. Next, split the participants into two groups. Provide each group with the following: one sheet of flipchart paper, one of the two flipchart pages created during the group brainstorm, **Participant Handout: Circles of Sexuality** (one copy for each group member), **Participant Handout: Circles of Sexuality Definitions** (one copy for each group member), one black marker, and one marker of a different color (for example red, green, etc).
5. Tell participants to identify a workspace, and explain that they will spend 30 minutes thinking with their group members about how the words that the large group brainstormed to describe sexuality fit into the five circles. The group will draw the five circles on their flipchart paper. As the group identifies words from the brainstorm that they believe apply to the various circles, they will write them inside the relevant circles using the black marker.
6. Explain that each group will be assigned a black marker as well as a marker of a different color. After they have used up all of the words on the brainstorm list, they will use the non-black marker to include any other words that would fit into the circles but were not mentioned during the brainstorm. Remind participants that a word may fit in more than one circle; the circles are not mutually exclusive.
7. After 30 minutes, ask the groups to post their flipchart pages on the wall. After the groups have posted their lists, ask participants to stand and visit the other group's poster.

8. Next, facilitate a group 40-minute discussion using the following questions:
    - Were any circles easier to fill? Less easy? Why do you think this occurred?
    - Do any circles not feel part of sexuality? Why?
    - Are all the circles important to our work? Are some more or less important? If so, why?
    - Which circles carry the heaviest silence (are hardest to talk about)?
    - Do we tend to focus our work around some circles but ignore others? Why?
    - Which of the five sexuality circles feels most familiar? Least familiar? Why do you think that is so?
    - Is there any part of these five circles that you never before thought of as sexual? Please explain.

Facilitator note: It is helpful to provide programming examples of how one's sexuality may be intrinsically linked to our work in development (though not immediately obvious). For example:

- In HIV prevention programming, if we assume that community members are all heterosexual (e.g., as reflected in our terminology) but in reality many are not, the key HIV prevention messages may be lost because participants do not feel that the message is relevant to them.
- If we assume that sexual relations only happen within marriage and therefore target our sexual health communication to married couples (or women), we might miss important other groups of people such as adolescents or single people.

Sexual Rights (20 minutes)

Facilitator note: The topic of sexual identity includes the concepts of sexual orientation and gender identity, both of which can be extremely sensitive. It is important that the facilitator is accepting and comfortable with the topic. It might be helpful to first identify common myths and misunderstandings about sexual orientation that can be addressed and integrated into the discussion. Prior to the session, the facilitator should research local laws and movements that promote the rights of gay individuals and couples, as well as such resources as websites related to sexual orientation and local organizations supporting their rights. The facilitator should then share this information with the participants.

1. Distribute the **Participant Handout: WHO Working Definitions of Sexuality and Sexual Rights**. Read the following World Health Organization working definitions of what constitutes sexuality and sexual rights, and ask participants to follow along on their handouts:

The working definition of **sexuality** is:

"[A] central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors."

The working definition of **sexual rights** is:

> "The fulfilment of sexual health is tied to the extent to which human rights are respected, protected and fulfilled. Sexual rights embrace certain human rights that are already recognized in international and regional human rights documents and other consensus documents and in national laws.

Rights critical to the realization of sexual health include:

- the rights to equality and non-discrimination
- the right to be free from torture or to cruel, inhumane or degrading treatment or punishment
- the right to privacy
- the rights to the highest attainable standard of health (including sexual health) and social security
- the right to marry and to found a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage
- the right to decide the number and spacing of one's children
- the rights to information, as well as education
- the rights to freedom of opinion and expression
- the right to an effective remedy for violations of fundamental rights

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

The application of existing human rights to sexuality and sexual health constitute sexual rights. Sexual rights protect all people's rights to fulfil and express their sexuality and enjoy sexual health, with due regard for the rights of others and within a framework of protection against discrimination."

2. After you have read the definition, facilitate a 15-minute discussion by reading the following talking points and corresponding questions:

- Many people consider sexual rights to be a subset of reproductive rights. These two sets of rights are, however, conceptually different in significant ways, and hence require different remedies.
- First, ask the group, "What are reproductive rights?" Solicit two or three ideas from group members before reading the answer below.
    - **Answer:** Reproductive rights are the "basic rights of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right to make decisions concerning reproduction free of discrimination, coercion, and violence."
- Ask, "Based on what we've just discussed, what do you think are the key differences between sexual rights and reproductive rights?" Solicit two or three ideas from group members before reading answer below.
    - **Answer:** Sexual rights create the conditions that enable individuals to determine if and what type of sex they want to engage in, whether or not it is linked to reproduction. Sexual rights

reinforce people's right to engage in a range of nonreproductive sexual practices, some of which are illegal in many countries, for example, anal sex. Put simply, sexual rights are concerned more broadly with sex and sexuality, not only for the purposes of reproduction.

- Ask, "Sometimes one hears practitioners saying 'We just put it all under reproductive rights.' What is a potential problem with this thinking?" Solicit two or three ideas from group members before reading answer below.
  - **Answer:** The problem is that it can mean that the needs of people who fall outside the arena of reproduction are ignored (i.e., older women, women and men who do not have children, individuals in same-sex partnerships).
- People have sexual relations from adolescence into old age. As long as they are having sexual relations, they have sexual health needs—related to information, education, services, and protection from sexually transmitted diseases, and to problems of sexual function. The term "sexual rights" includes the right to sexual health irrespective of one's reproductive status. Sexual rights include the full range of protections across rights, over and above health concerns alone.

Closing (5 minutes)

1. End the session by emphasizing the following points:
   - Sexuality encompasses more than just sexual intercourse.
   - Individuals' sexual and reproductive health is largely influenced by their social and cultural environment.
   - People make decisions about sexual activity throughout their lives. Many factors go into making the decision to have or abstain from sex.
   - For women, the fear of losing their partner, societal expectations, or low self-esteem might lead them to agree to sex.
   - Among men, the decision to have sex might come from peer or social pressure to prove their manhood. Furthermore, communication styles, emotions, self-esteem, and unequal power relations all play a role.
   - All individuals have a right to make their own decisions about sex, decide if and when they want to become sexually active with their partner, and decide if and how many children they want to have. Under no circumstances should these rights be denied to an individual or should these decisions about sex be made by others.

Acknowledgments

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Participant Handout: Circles of Sexuality

Participant Handout: Circles of Sexuality Definitions

Sensuality

Sensuality is how our bodies derive pleasure. It is the aspect of our body that deals with the five senses: touch, sight, hearing, smell, and taste. Any of these senses, when enjoyed, can be sensual. Think of how a person might enjoy each of the five senses in a sensual manner. The sexual response cycle is also part of our sensuality because it is the mechanism that enables us to enjoy and respond to sexual pleasure.

Our body image is part of our sensuality. Whether we feel attractive and proud of our bodies influences many aspects of our lives. Our need to be touched and held by others in loving and caring ways is called *skin hunger.* Adolescents typically receive less touch from family members than do young children. Therefore, many teens satisfy their skin hunger through close physical contact with a peer. Sexual intercourse may result from a teen's need to be held, rather than from sexual desire.

Fantasy is part of sensuality. Our brain gives us the capacity to fantasize about sexual behaviors and experiences, without having to act upon them.

Intimacy/Relationships

Intimacy is the part of sexuality that deals with relationships. Our ability to love, trust, and care for others is based on our levels of intimacy. We learn about intimacy from relationships around us, particularly those within our families.

Emotional risk taking is part of intimacy. To experience true intimacy with others, a person must open up and share feelings and personal information. We take a risk when we do this, but intimacy is not possible otherwise.

Sexual Identity

Every individual has his or her own personal sexual identity. Sexual identity can be divided into five main elements:

- **Biological sex** is based on our physical status of being either male or female.
- **Gender identity** is how we feel about being male or female. Gender identity starts to form at around age 2, when a little boy or girl realizes that he or she is different from the opposite sex. Some research has shown that it starts even earlier. People who identify with the opposite biological sex often considers themselves transgender. In the most extreme cases, a transgender person will have an operation to change his or her biological sex (often called gender reassignment surgery) to correspond to his or her gender identity.
- **Gender roles** are society's expectations of us based on our biological sex. Think about what behaviors we expect of men and what behaviors we expect of women. These expectations are gender roles.
- **Sexual orientation** refers to the biological sex to which we are attracted romantically. Our orientation can be heterosexual (attracted to the opposite sex), bisexual (attracted to both sexes), or homosexual (attracted to the same sex). People often confuse sexual orientation and gender roles. For example, if a man acts feminine or a woman acts masculine, people often assume that these individuals are homosexual. Actually, they are expressing different gender roles. Their masculine or feminine behavior has nothing to do with their sexual orientation. A gay man may be feminine, masculine, or neither. The same applies to heterosexual men. Also, people may engage in

same-sex sexual behavior and not consider themselves to be homosexual. For example, men in prison may have sex with other men but may consider themselves to be heterosexual.

- **Sexual behavior** refers to sexual practices that we engage in consensually. Sexual behavior does not always indicate sexual orientation. For example, not all individuals who have had one or more sexual experiences with members of their own sex define themselves as homosexual or are considered homosexual by society. Some adolescent boys who experiment sexually with other boys (for example, masturbating in a group) and some men who have sex with other men in isolated settings, such as prisons, do not consider themselves, and are not considered by others, to be homosexual. Thus we use more neutral terms, such as "women who have sex with women" (WSW) and "men who have sex with men" (MSM), because they refer to sexual behaviors without specifying a particular sexual identity.

Sexual Health

Sexual health involves our behavior related to producing children, enjoying sexual activities, and maintaining our sexual and reproductive organs. Issues such as sexual intercourse, pregnancy, and sexually transmitted infections are part of our sexual health.

Sexuality to Control Others

This circle is a negative aspect of sexuality and can inhibit an individual from living a sexually healthy life. This element is not a healthy one. Unfortunately, many people use sexuality to violate someone else or get something from another person. Rape is a clear example of sex being used to control somebody else. Sexual abuse and forced prostitution are others. Even advertising often sends messages of sex to get people to buy products.

Participant Handout: WHO Working Definitions of Sexuality and Sexual Rights

The working definition of **sexuality** is:

> "[A] central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors."

The working definition of **sexual rights** is:

> "The fulfilment of sexual health is tied to the extent to which human rights are respected, protected and fulfilled. Sexual rights embrace certain human rights that are already recognized in international and regional human rights documents and other consensus documents and in national laws.

Rights critical to the realization of sexual health include:

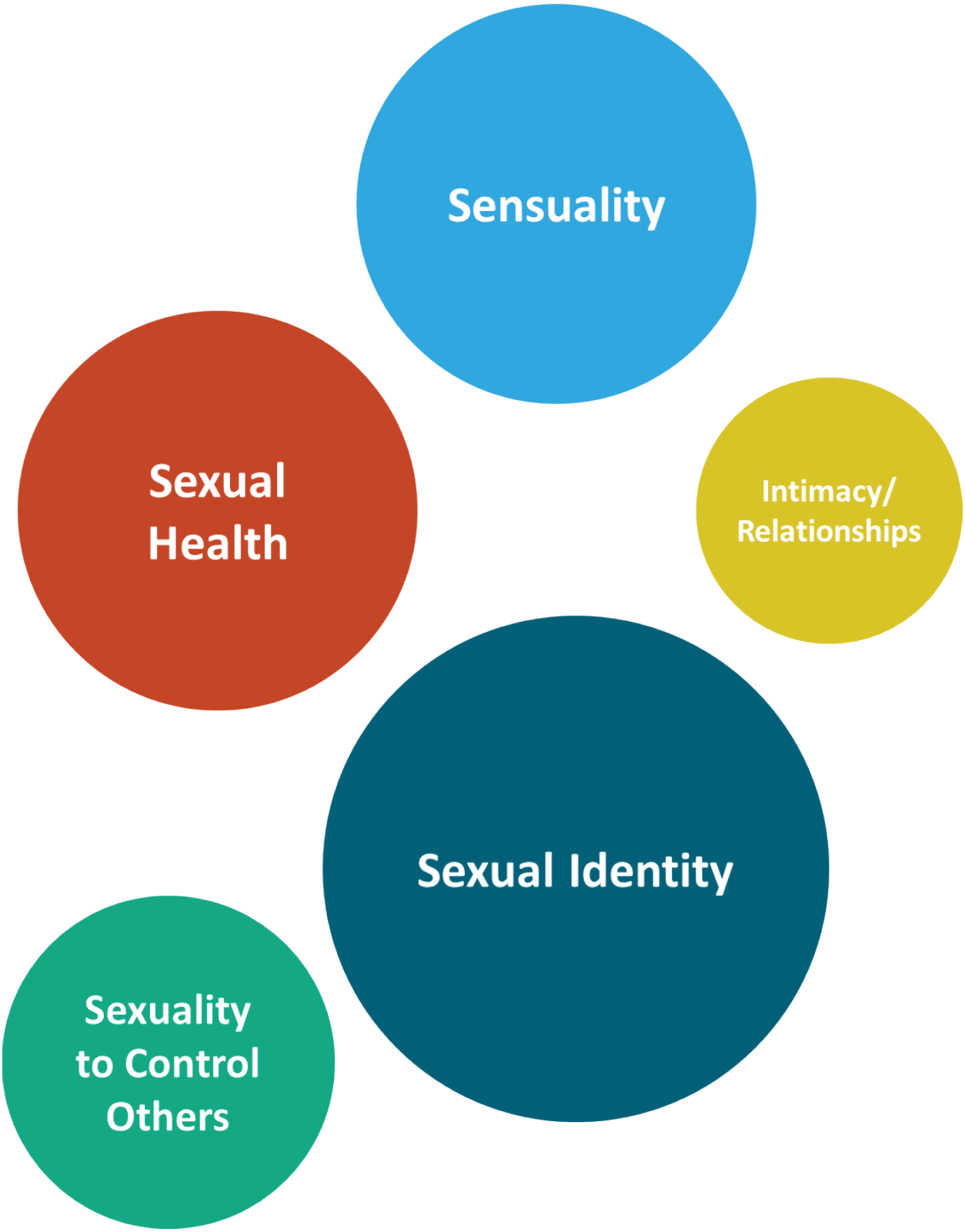
- the rights to equality and non-discrimination
- the right to be free from torture or to cruel, inhumane or degrading treatment or punishment

- the right to privacy
- the rights to the highest attainable standard of health (including sexual health) and social security
- the right to marry and to found a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage
- the right to decide the number and spacing of one's children
- the rights to information, as well as education
- the rights to freedom of opinion and expression, and
- the right to an effective remedy for violations of fundamental rights.

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

The application of existing human rights to sexuality and sexual health constitute sexual rights. Sexual rights protect all people's rights to fulfil and express their sexuality and enjoy sexual health, with due regard for the rights of others and within a framework of protection against discrimination."

Facilitator Resource: Circles of Sexuality



Session 17: Sex Taboos

Learning Objectives

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

- Describe how beliefs about what is "acceptable" or "proper" sex is one of the root causes of stigma toward key populations
- Discuss sex and their feelings about "proper" and "improper" or "immoral" sex
- Demonstrate discussing sex and sexuality issues in a comfortable manner

Facilitator note: Do not facilitate this session at the start of the training. Wait a few days until participants are comfortable with each other and feel free to openly share. Avoid small group sizes to avoid breeches in confidentiality—if, for example, all participants answer "yes" or "no" to a particular question(s) in the anonymous survey.

Time

1 hour

Materials Needed

- Chairs organized in a semicircle
- Flipchart paper
- Flipchart stand
- Markers
- Masking tape
- A4-sized sheets of paper (a sufficient amount to produce 11 strips of paper per participant)
- Pencils or pens
- Index cards (enough to give five cards to each participant)
- **Facilitator Resource: Sex Survey**

Advance Preparation

1. Write the word "sex" on a sheet of A4-sized paper and tape the page to a wall.
2. Cut several sheets of A4-sized paper into strips (11 strips per participant).
3. On a blank flipchart page, reproduce the table below:

Question	Yes	No	Total
1			
2			
3			
4			

Question	Yes	No	Total
5			
6			
7			
8			
9			
10			
11			

Steps

Introduction (2 minutes)

1. Open the session by stating that sexuality is a taboo subject—particularly sex that is viewed as "immoral" or "abnormal" or breaks social norms. Our views about what is "appropriate" sex lead to a lack of acceptance of people who do not conform to our own, or society's, views about what is proper sexual behavior, and this fuels stigma against certain populations (e.g., men who have sex with men; lesbian, gay, bisexual, transgender, and intersex; sex workers; etc.). One barrier is the embarrassment we feel when discussing sex. This session is intended to build some comfort around discussing sex and develop a common vocabulary for talking about sex.

First Thoughts about Sex (15 minutes)

1. Divide participants into pairs. Give each pair five cards and a marker.
2. Explain to participants that they will spend 5 minutes in their pairs writing down the first things they think about when they hear the word "sex" (one idea per card).
3. After 5 minutes, call time and ask the pairs to tape their cards to the wall around the page labeled "Sex."
4. Next, facilitate a group discussion using the following questions:
   - Why is it difficult to talk about sex?
   - What are the social norms around sex?

Facilitator note: Ensure the following points are raised during the group discussion:

- Talking about sex or certain types of sex is a taboo. We have been socialized not to talk about sex, especially in our families, between generations, or even between couples.
- Parents find it hard to talk about sex with their children, teachers with their students, and health workers with their clients. Sexual partners often don't talk about sex.

Anonymous Participatory Sex Survey (40 minutes)

1. Explain that participants will complete a survey about sex. State that the survey is completely anonymous and that no one—not even the facilitator—will know how participants answer.
2. To ensure confidentiality and help participants feel confident that responses will be confidential, have participants put their completed surveys in an envelope or box in front of the room rather than having a volunteer collect the surveys.
3. Ask a volunteer to assist with tallying the answers.
4. Next, distribute 11 strips of paper to each participant.
5. Tell participants that you will read some questions aloud and participants will write their answers (either yes or no) on their strips of paper. State that they each received 11 strips of paper as there are 11 questions. Explain that after participants have written their answer to a specific question, they should fold the piece of paper so no one can see what they wrote. Participants will then stand and put their folded strip of paper on the table (point to the table in question). Participants will follow this procedure for each question.
6. Make sure everyone understands the process, then read the first question on **Facilitator Resource: Sex Survey** aloud. After you have read the question, pause and allow participants to write their answers, fold their pieces of paper, and set them on the table. Once all participants have set their papers on the table, instruct the volunteer to mix up the pieces of paper and to then unfold them and record the results on the flipchart page labeled "Survey Scores." Repeat this process for the remaining questions.
7. After you have read all 11 questions, review the scores and then lead a group discussion using the following questions:
   - How did you feel answering the questions?
   - What did you learn from the exercise?
   - How do our beliefs about what is acceptable or proper sex facilitate stigma toward key populations?
   - Why is it important to talk about sex?

Facilitator note: Make sure that the following points are raised during the group discussion:

- The more we talk about sex, the more comfortable we will become in talking about it, educating our clients about it, and providing appropriate sexual and reproductive health services.
- Our views about the sexual practices of clients (particularly key populations and adolescents) is a major factor in stigma.
- Social norms (what the community views as "normal") often dictate that only sex between married heterosexuals is acceptable. We judge or stigmatize some clients for having "immoral" or "abnormal" sex (male-to-male sex, oral sex, anal sex, sex for money, sex during adolescence or before marriage). However, they have sex for the same reasons as heterosexuals—to have pleasure, express love, and to give others pleasure.

Closing (3 minutes)

1. End the session by reinforcing the following points:
    - We learn about sex at an early age from parents, siblings, friends, etc. Often we don't question these messages because they come from parents or we are too young to fully understand them. These messages are internalized and shape how we think about sex (e.g., embarrassment).
    - It is important to challenge and change negative messages. Sex is not something dirty or secret—it is something beautiful. We need to challenge the idea that sex is taboo and not to be discussed if we are going to learn more about sexuality and offer high-quality care to all clients.
    - HIV can be transmitted sexually, so if we are to control this epidemic, we must become better at talking about sex and learn to talk about sex in a nonjudgmental way.
    - Sexual activity with mutual consent and that does not cause harm to one's health, economic condition, or dignity, should be respected—whether it is heterosexual, homosexual, or bisexual.

Acknowledgments

Health Policy Project. 2013. *Understanding and Challenging HIV and Key Population Stigma and Discrimination: Caribbean Facilitator's Guide*. Washington, DC: Futures Group, Health Policy Project. https://www.healthpolicyproject.com/pubs/134_CaribbeanFacilitatorsGuideFINAL.pdf.

Facilitator Resource: Sex Survey

Questions

1. Can you talk openly about sex to close friends?
2. Do you enjoy sex?
3. Have you ever masturbated?
4. Have you ever participated in vaginal sex?
5. Have you ever participated in oral sex?
6. Have you ever had a sexually transmitted infection?
7. Have you ever been tested for HIV?
8. Did you use a condom (female or male) the last time you had sex?
9. Have you ever known someone who paid for sex?
10. Have you ever known someone who has been paid for sex?
11. Have you ever been sexually attracted to someone of the same sex?

Example of tallied answers

Question	Yes	No	Total
1	16	8	24
2	20	4	24
3	22	2	24
4	22	2	24
5	14	10	24
6	12	12	24
7	12	12	24
8	18	6	24
9	8	16	24
10	3	21	24
11	5	19	24

Session 18: Identifying Biases and Judgments Related to Sexual Behaviors

Learning Objectives

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

- Identify personal biases and attitudes about various sexual behaviors
- Demonstrate discussing sex and sexuality issues in a comfortable manner
- Explain why it is important to be nonjudgmental about sexual behaviors when counseling clients
- Explain how beliefs about what is "acceptable" sex are root causes of stigma toward sexual minorities

Time

1 hour 15 minutes

Materials

- Chairs organized in a semicircle
- A4-sized paper
- Flipchart stand
- Flipchart paper
- Scissors
- Markers—one for each participant, ideally all the same color to ensure confidentiality
- Masking tape
- **Participant Handout: Essential Ideas**
- **Facilitator Resource: Different Types of Sexual Behavior**

Advance Preparation

1. Make enough copies of *Participant Handout: Essential Ideas* for each participant.
2. Refer to **Facilitator Resource: Different Types of Sexual Behaviors** and select 25 to 30 examples to use in this session.

> **Facilitator note:** Select a mixture of behaviors—some that participants will be familiar with and some they will not. Add or omit behaviors based on the local situation. The exercise should include some behaviors that are outside of the mainstream or that are taboo, even if these behaviors are not generally acknowledged in the local setting.

3. Once you have selected 25 to 30 sexual behaviors, write each of the behaviors on a separate sheet of A4-sized paper and fold it—one sexual behavior per sheet of paper. Write the behaviors clearly using a large marker and large letters so the words can be read from a distance (see example below).

4. On a piece of flipchart paper, write a list with three bulleted phrases and hang at the front of the room:

- OK for me
- OK for others but not to me
- Not OK

Steps

Introduction (2 minutes)

1. Introduce this exercise by saying that the group will explore the range of sexual behaviors that people engage in and the attitudes and values that we have about those behaviors. Explain that this interactive exercise will allow everyone to examine their personal values, beliefs, and attitudes about different sexual behaviors in a completely confidential way. It will also help participants understand how their own beliefs and values might affect their attitudes and behaviors toward clients and the way they discuss sexual behaviors with them.

Personal Biases and Judgments Related to Sexual Behaviors (1 hour 5 minutes)

1. Tell participants that you will give each person one or more folded sheets of paper with a sexual behavior written on it. Instruct them to think about how they personally feel about the particular behaviors on the papers they receive and to indicate this by writing one of these phrases on the back of the sheet:
   - **OK for me** (it is a behavior that I personally would engage in)
   - **OK for others but not for me** (it is a behavior that I personally would not engage in but that I have no problem with other people doing)
   - **Not OK** (it is a behavior that no one should engage in because it is morally, ethically, or legally wrong)
2. Remind participants that this exercise is meant to be completely confidential, so they should not show the behavior on their sheet(s) of paper or their responses to anyone. To ensure confidentiality, you might ask the participants to rearrange their seats or spread around the room so that no one can see their papers and responses. Ideally, all participants should also use the same color markers.
3. After you have explained the rules of the exercise, distribute the sexual behavior sheets and one marker to each participant, attempting to give each person the same number of papers, until all have been distributed.

4. Invite participants to unfold their sheet(s) of paper and think about the behaviors written on them. Remind participants that this exercise is about values and judgments related to sexual behaviors in general; it is not about risk of contracting HIV or some other sexually transmitted infection.
5. Tell participants they will have 1 minute to write on the back of each sheet their response to the behavior, without showing their papers to anyone. Instruct them not to write their names on the sheets of paper. Repeat what is meant by "OK for me," "OK for others but not for me," and "not OK," and ask if everyone understands. Remind participants that the three phrases are also listed on flipchart paper at the front of the room. When they are done, they will fold their sheets of paper and place them in a pile in the center of the room (or a trainer can collect them, without looking at what is written on them).

Facilitator note: Instruct participants that if they receive a sheet of paper with a behavior that they do not understand, they should signal you to ask for an individual explanation. Explaining the behavior in front of the group will compromise the confidentiality of the exercise.

6. Mix up all of the sheets of paper and pass them out to participants, asking them to take as many sheets as they put into the pile (i.e., if they received two, they should take two).
7. Once you have redistributed all of the papers, have participants take turns reading aloud each of the sexual behaviors written on their sheets of paper and then taping them on the wall under the appropriate category ("OK for me," "OK for others but not for me," or "not OK"), according to what is indicated on the back of the paper. Remind them to place the behavior sheets under the appropriate category, even if they personally do not agree with the placement. Encourage them to line (queue) up to read and post their sheets of paper and to move quickly, one after the other. Allow no more than 15 minutes to complete steps 1–8.

Facilitator note: Have participants take turns, if possible, allowing each to read the behaviors listed on their sheet of paper aloud and then tape it onto the wall. Although this process takes time, reading aloud is part of the learning process. The activity contributes to the participants' comfort with pronouncing terms about sexual practices. However, if time is short, the exercise can be completed faster by asking all participants to approach the wall at once and to place their sheets of paper in the appropriate category on the wall, without reading the listed sexual behavior.

8. Once all of the sheets of paper have been posted, instruct participants to gather around the wall and give them 2 minutes to observe the placement of the behaviors.
9. After 2 minutes, ask participants, "Why do you think I asked you to read aloud the sexual behaviors as you taped the sheets of paper on the wall?"
10. After a few responses, tell them that you have done this to increase their level of comfort with using these terms.
11. Facilitate a group discussion (30 minutes) based on the following questions. Do not move the sheets of paper even if there is disagreement as to where they are placed. Simply acknowledge the difference of opinion and leave them as they are.

Facilitator note: If some participants indicate that a particular sexual practice does not exist in their culture (e.g., anal sex), ask other participants whether they agree. Some participants are more aware of variations in sexual behavior than others and can help their colleagues understand the range of behaviors. Do not ask the participants to identify who placed any one response in a particular category. If participants would like to volunteer such information to explain their answer, they may do so, but asking might make participants uncomfortable and would take away the anonymity of the exercise.

- Are you surprised by the placement of some of the behaviors? Which ones surprised you and why?
- How would you feel if someone placed a behavior that you engage in yourself in the "not OK" category?
- How would you feel if someone placed a behavior that you engage in yourself in the "OK for others but not to me" category?
- How would you feel if someone placed something you felt was wrong or immoral in one of the "OK" categories?
- How did you feel placing someone else's response on the wall? Would you have felt comfortable placing your own responses in front of the group?
- What does this exercise tell us about how clients might feel when providers ask them about their sexual practices?
- How can this exercise inform providers' provision of family planning counseling?

Facilitator note: During the group discussion, make it clear that although the session is about exploring personal judgments related to sexual practices, it is important to acknowledge that some sexual practices, regardless of personal preference, are harmful and constitute forms of sexual violence (e.g., sexual harassment, rape, sex with children). Other sexual practices may seem more ambiguous in terms of their harmful impacts (e.g., sadomasochism, being tied up by your partner, tying up your partner). Ultimately, for any sexual practice to be considered healthy, there has to be consent from all partners involved. Therefore, practices such as anal sex or sadomasochism, while perhaps not a personal preference for some, are not harmful when all partners involved have given their consent, free from coercion.

Sexual practices become harmful when partners do not consent and are forced or coerced into engaging in them. Rape is a clear example of sexual violence, as there is an absence of consent. Sex between teachers and students, sex with children, and sex between a child and an adult relative are other examples of harmful sexual practices, because the power imbalances inherent in these relationships make it impossible for those with less power (e.g., children, students) to give consent freely.

Facilitator note: A note on pornography if the topic arises: Pornography can be part of a healthy intimate and sexual relationship between freely consenting individuals. For example, some couples may choose to view pornography as part of sexual foreplay. This is a choice that both partners in the relationship make.

Another, more detrimental aspect of pornography, however, is its construction of women as sexual objects to be used by men. Most pornographic materials objectify women and promote unhealthy images of and messages about women, such as all women want sex all the time from all men, women enjoy all sexual acts performed or demanded by men, and even though a woman may resist at first, she can easily be turned on with the use of sexual force. Most pornographic materials build off gender inequalities and power imbalances between women and men by communicating and perpetuating the belief that men should exercise sexual dominance over women. Although pornography does not in itself cause men to be sexually violent toward women, it nonetheless promotes harmful beliefs and norms about women—and men—and about the acceptability of nonconsensual sexual relationships.

Facilitator note: A note on the behaviors of selling sex for pleasure, money, goods, or services, or paying for sex (also known as transactional sex, exchange sex, commercial sex, or sex work): People who sell sex and pay for sex come from all different backgrounds. People may choose sex work for a range of reasons, or they may be forced into sex work. People who sell sex may or may not identify as a sex worker. A person who sells sex may be poor and not have the education or training for another type of career. A person who sells sex may have a middle-class background, college education, and no apparent financial need to engage in sex work. Some people who sell sex really enjoy their work and some may not. When counseling for family planning or other health areas, it is important to consider the vulnerabilities of people who engage in selling or paying for sex.

12. Summarize by stating that as providers, we should not question or judge different sexual behaviors or practices as right or wrong. Rather, we must recognize that these behaviors exist and that they need to be considered during clients' decision-making about family planning.

Closing (8 minutes)

1. Refer to **Participant Handout: Essential Ideas** and summarize the session. Be sure to highlight any ideas listed on the handout that may not have been covered during the discussions. Allow participants to ask any final questions.
2. Before closing the session, distribute **Participant Handout: Essential Ideas** to each participant.

Acknowledgments

ACQUIRE Project/EngenderHealth. 2008. *Counseling for Effective Use of FP: Trainer's Manual*. New York, NY: EngenderHealth. Located at: http://www.acquireproject.org/archive/html/10-training-curricula-and-materials/resources.html

Facilitator Resource: Different Types of Sexual Behaviors

This list includes a wide range of sexual activities and behaviors. **Facilitators should feel free to add or omit behaviors, depending on the local situation.** For the average-sized group (12 to 15 participants), select 25 to 30 behaviors to allow enough time for discussion. If there is more time (e.g., 1 hour), you can increase the number of behaviors.

- Hugging
- Paying someone for sex
- Kissing
- Having premarital sex
- Giving oral sex
- Having sex with animals (bestiality)
- Receiving oral sex
- Having sex with a relative considered too close (incest)
- Having group sex
- Having anal sex
- Swallowing semen
- Having sex with someone of the same sex
- Having sex with children (pedophilia)
- Using objects or toys during sex
- Telling someone a lie just to have sex
- Getting paid for sex
- Having sex with someone of another race or ethnicity
- Having sex in public places
- Being faithful to one partner
- Having sex whenever your partner wants it
- Having sex with a person who is much younger
- Having sex with someone who is married
- Having sex with a disabled person
- Masturbating
- Having sex under the influence of drugs or alcohol
- Manually stimulating your partner (using your hand)
- Selling sex for money, goods, or services
- Paying for sex with money, goods, or services
- Watching other people have sex
- Having vaginal sex
- Sharing sexual fantasies with others
- Watching pornographic movies
- Being celibate
- Having sex with many partners
- Having sex in exchange for money to support your children
- Having sex with people you do not know
- Having sex without pleasure
- Initiating sexual encounters
- Having sex with your spouse because it is your duty
- Practicing sadism and masochism
- Sexual harassment
- Having sex with someone only because they promised to give you something in return for sex
- Sex between a teacher and a student
- Rape
- Having oral-anal sex
- Using a vibrator for sexual pleasure
- Engaging in “dry sex”
- Placing objects in the rectum
- Sex between a child and an adult relative
- Placing objects in the vagina
- Having sex with someone other than your spouse (adultery)
- Placing devices on the penis to maintain an erection
- Agreeing to have sex with someone who will not take no for an answer
- Tying up your partner
- Being tied up by your partner

Participant Handout: Essential Ideas

- Gender norms can influence women's and men's sexual identity and practices and this in turn can influence clients' choice of family planning methods and continued use of the method they choose.
- Discussing sexuality might reveal underlying issues and concerns that affect clients' family planning needs and decisions. Sexuality is closely related to one's individual risk of contracting sexually transmitted infections and ways of reducing that risk.
- Discussing sexuality can improve the overall quality of care by fostering comfort and trust between clients and providers.
- Providers often shy away from discussions of sexuality because of their own discomfort or because they fear such discussions might be culturally inappropriate or offensive to clients.
- The provider is responsible for being comfortable with introducing the subject of sexuality and helping clients feel comfortable enough to respond to questions concerning their sexual behavior. The provider should not question or judge sexual behaviors or practices. Rather, providers should recognize the behaviors that clients might engage in and help clients consider those behaviors when they are making decisions about family planning.
- It is important to acknowledge that some sexual practices, regardless of personal preference, are harmful and constitute forms of sexual violence (e.g., sexual harassment, rape, sex with children). Other sexual practices may seem more ambiguous in terms of their harmful impacts (e.g., sadomasochism, being tied up by your partner, tying up your partner). Ultimately, for any sexual practice to be considered healthy, all partners involved must consent. Therefore, practices such as anal sex or sadomasochism, while perhaps not a personal preference for some, are not harmful when all partners involved have given their consent, free from all coercion.

  Sexual practices become harmful when partners do not consent and are forced or coerced into engaging in them. Rape is a clear example of sexual violence, as there is an absence of consent. Sex between teachers and students, sex with children, and sex between a child and an adult relative are other examples of harmful sexual practices, because the power imbalances inherent in these relationships make it impossible for those with less power (e.g., children, students) to give consent freely.

A Note on Pornography

Pornography can be part of a healthy intimate and sexual relationship between freely consenting individuals. For example, some couples may choose to view pornography as part of sexual foreplay. This is a choice that both partners in the relationship make. Another, more detrimental aspect of pornography, however, is its construction of women as sexual objects to be used by men. Most pornographic materials objectify women and promote unhealthy images of and messages about women, such as all women want sex all the time from all men, women enjoy all sexual acts performed or demanded by men, and, even though a woman may resist at first, she can easily be turned on with the use of sexual force. Most pornographic materials build off gender inequalities and power imbalances between women and men, by communicating and perpetuating the belief that men should exercise sexual dominance over women. Although pornography does not in itself cause men to be sexually violent toward women, it nonetheless promotes harmful beliefs and norms about women—and men—and about the acceptability of nonconsensual sexual relationships.

Sexuality

Sexuality is an expression of who we are as human beings. Sexuality includes all of the feelings, thoughts, and behaviors related to being male or female, to being attractive and being in love, and to being in relationships that include intimacy and physical sexual activity.

Sexuality begins before birth and lasts throughout a person's life. Our sexuality is shaped by our values, attitudes, behaviors, physical appearance, beliefs, emotions, personality, likes and dislikes, religion, and all of the ways that we have been socialized. Consequently, ethical, spiritual, cultural, and moral factors influence how individuals express their sexuality.

Sexuality:

- Is an expression of who we are
- Involves the mind and the body
- Is shaped by our values, attitudes, behaviors, physical appearance, beliefs, emotions, personality, likes and dislikes, and the ways we have been socialized
- Is influenced by social norms, culture, and religion
- Involves giving and receiving sexual pleasure as well as enabling human reproduction
- Spans our lifetimes

How Sexuality Relates to Family Planning Counseling and HIV or STI Counseling

(Why is it important to address sexuality as a part of family planning counseling?)

- Pregnancy is one possible outcome of sexual activity; sexually transmitted infections are another.
- Sexuality and sexual practices can have implications for a client's decisions about contraceptive method use and sexually transmitted infection risk reduction.
- People might stop using a contraceptive method or HIV prevention method if they perceive it as interfering with the sexual act or decreasing their sexual pleasure.
- Clients might feel reluctant to try a certain method (e.g., vasectomy, male circumcision, or condoms) out of fear that it will affect sexual pleasure or response (for themselves, their partner, or both).
- Clients might have underlying concerns about sexuality that are the real reason for a facility visit or that are more important than the stated reason for their visit.
- A client's needs might be related to sexual abuse or coercion, rape, or incest—issues that need to be addressed in order to provide effective services.
- Discussing the prevention of sexually transmitted infections must include discussing the specific sexual practices that place a person at risk, as well as sexual practices that are safer.
- Taking sexuality into consideration during counseling might help improve client satisfaction with services and thus help to attract and retain new clients.
- Exploring clients' sexuality—rather than making assumptions about it—enables providers to better tailor counseling to clients' circumstances (e.g., frequency of sex, number of partners, ability to discuss/negotiate with the partner, and so on).

Session 19: What Is the Meaning of "Stigma"?

Learning Objectives

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

- Explain the meaning of stigma and provide examples

Time

1 hour

Materials Needed

- Chairs organized in a semicircle
- Flipchart paper
- Flipchart stand
- Markers
- Masking tape
- **Facilitator Resource: Stigma Circle Diagram**

Advanced Preparation

1. Refer to **Facilitator Resource: Stigma Circle Diagram** and reproduce the diagram on a blank sheet of flipchart paper.
2. Write the following bullets on a blank flipchart page:
   - Definition of stigma
   - Forms of stigma
   - Causes of stigma
   - Process of stigmatization
3. Load the YouTube video "HIV Stigma and Discrimination LGBT Life in Kenya" (https://www.youtube.com/watch?v=fZEYvPk70Fc).

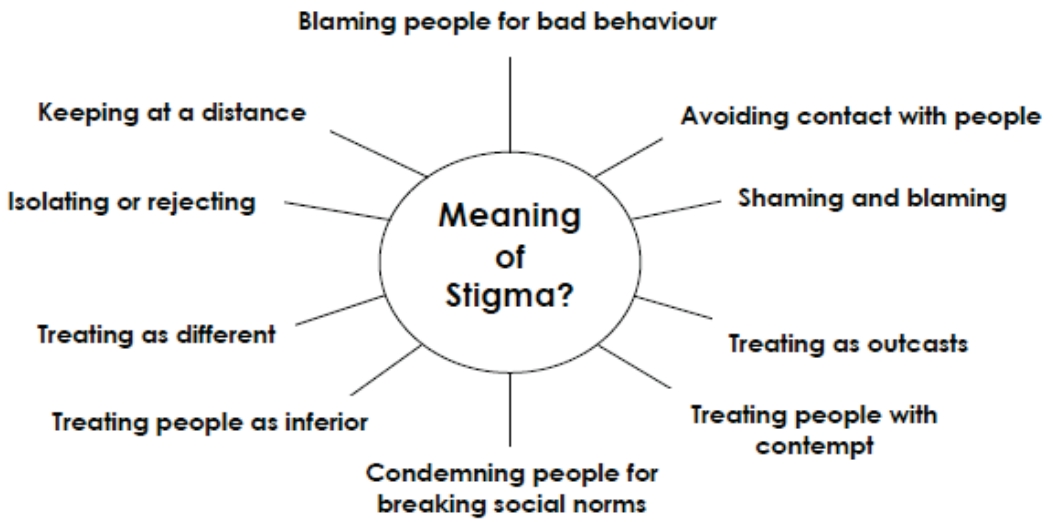
Steps

Introduction (1 minute)

1. Start by stating that this session will explore key aspects of stigma, including what it is, forms it may take, key causes, and how stigmatization occurs.

What is Stigma? (3 minutes)

1. Facilitate a 3-minute brainstorm with participants using the following question:
   - What do you think is the meaning of "stigma"?
2. As participants share their responses, write them in the circle diagram you created prior to the session. For example, the diagram might look like this:



3. Next, draw participants' attention to the flipchart listing the bullets on stigma and discuss each point using the following explanations:
   - Definition of stigma (9 minutes)
     > Stigma is a process through which we create a "spoiled identity" for an individual or group of individuals that attributes a lower value to the person or group. We identify a difference in a person or group—for example, a behavioral (e.g., same-sex relationships), physical (e.g., physical disfiguration), or social (e.g., poor or migrant) difference—and then assign negative connotations to that difference, thereby marking it as something negative—a sign of disgrace. In identifying and marking differences as "bad," we create an "us" and "them" to distance ourselves from a person or group, and this allows and justifies our mistreatment of and discrimination against them. The end result is that stigmatized people often lose status and access to basic human rights, resources, and services because of these assigned "signs of shame," which other people see as a sign that they have done something wrong (sinful or immoral behavior).

     > To stigmatize is to believe that people are different from us in a negative way, or to assume that they have done something bad or wrong. When we stigmatize, we judge people, saying they have broken social norms and should be shamed or condemned, or we isolate people, saying they are dangerous or a threat to us.

     > Stigma is a powerful social process of devaluing a person or group that often ends in discrimination—unfair and unjust treatment. Examples include not hiring people living with HIV or men who have sex with men, kicking a sex worker out of her or his house, clinics refusing to treat key populations or publicly revealing their HIV status or sexual behavior, and communities or health workers ostracizing or judging single pregnant women.

     > Stigma and discrimination cause great suffering.

- **Ask:** "What are some examples of stigmas you have heard of against particular groups in our community?"

- Forms of stigma (7 minutes)
  - Isolation, shaming, blaming, criticizing
  - **Ask:** "Can anyone offer some examples of how this may look in action? Have you seen this behavior at your workplace or in the community?"
- Causes of stigma (4 minutes)
  - Lack of awareness about stigma—what it looks like, what it does—and lack of awareness that we are stigmatizing others
  - Fear and ignorance
  - Moral judgments
  - **Ask:** "What do you think are some causes for the stigma examples we discussed in the first section about forms of stigma?"
- Stigmatization is a process (3 minutes)
  - We identify and name the differences in another person.
  - We make negative judgments about the person (e.g., promiscuity).
  - We isolate or judge/ridicule the person, thereby separating "her/him" from "us."
  - The stigmatized (isolated and judged) person loses status and faces discrimination.

4. After you have discussed these points, allow participants up to 10 minutes to ask questions and/or make additional comments.

Video and Group Discussion (20 minutes)

1. Show the 4-minute YouTube video "HIV Stigma and Discrimination LGBT Life in Kenya" (https://www.youtube.com/watch?v=fZEYvPk70Fc).
2. Facilitate a group discussion using the following questions:
   - How did stigma and discrimination affect the people in the video?
   - How have you seen stigma affect your patients, coworkers, or neighbors?
   - How might stigma affect health issues in our community, such as HIV transmission?

Closing (3 minutes)

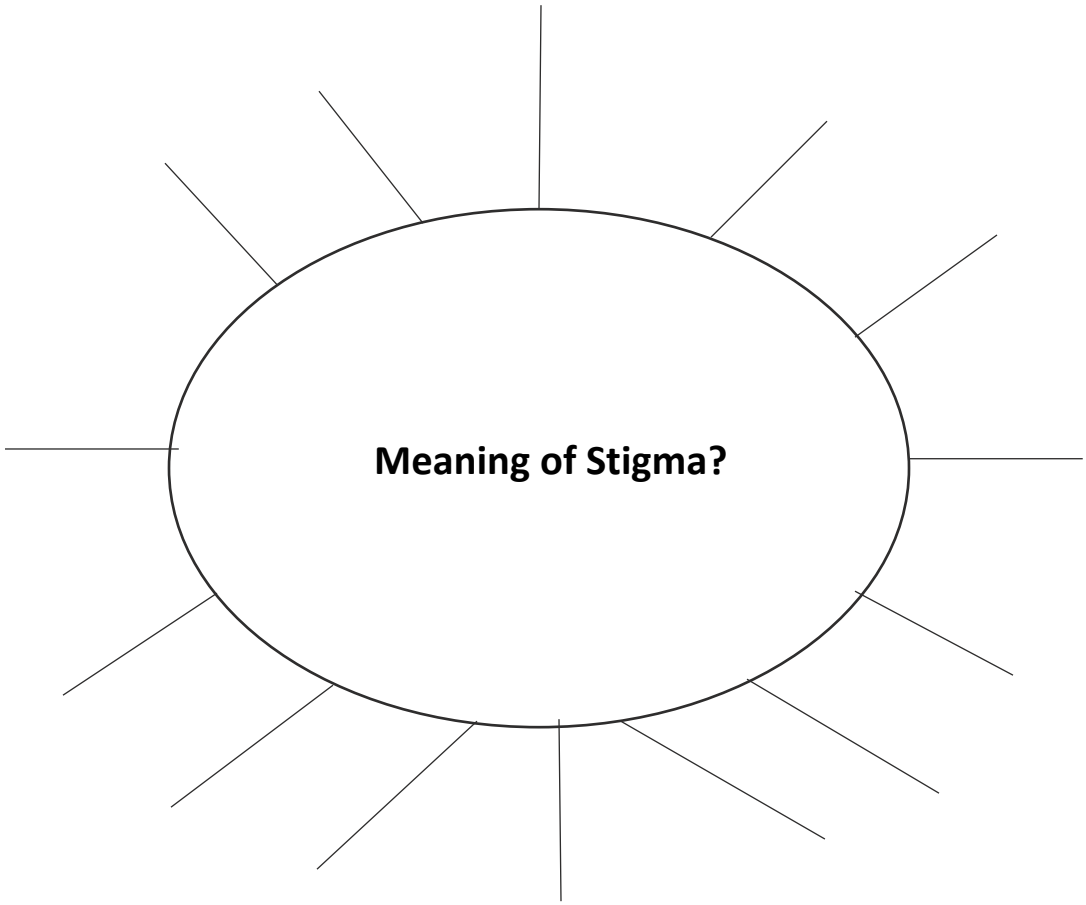
1. End the session with a discussion of the following points:
    - Stigma is often viewed as a tool to "control" behavior and people. People think that it is acceptable to isolate and shame people. People are not aware of how stigma affects people living with HIV and how it affects the HIV epidemic.
    - Stigma is wrong and unacceptable. Stigma can have negative impacts on people's sexual and reductive health. For example, stigma against people living with HIV drives the HIV epidemic underground. Those stigmatized may become silent and, out of fear of stigma and discrimination, might not disclose their status to their sexual partners, which may lead to an increased risk of HIV transmission.

Acknowledgments

Health Policy Project. 2013. *Understanding and Challenging HIV and Key Population Stigma and Discrimination: Caribbean Facilitator's Guide*. Washington, DC: Futures Group, Health Policy Project. https://www.healthpolicyproject.com/pubs/134_CaribbeanFacilitatorsGuideFINAL.pdf.

MTV Staying Alive. 2015. HIV Stigma and Discrimination LGBT Life in Kenya. Video. https://www.youtube.com/watch?v=fZEYvPk70Fc.

Facilitator Resource: Stigma Circle Diagram



Session 20: Forms, Effects, and Causes of Stigma

Learning Objectives

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

- Describe the different forms of stigma faced by sexual and gender minorities at the facility level
- Explain how stigma and discrimination against sexual and gender minorities increases their HIV risk
- Explain the root causes of HIV-related stigma
- Recognize the importance of respecting the rights of sexual and gender minorities
- Identify practical solutions that participants can use to stop or reduce stigma

Time

1 hour 30 minutes

Materials Needed

- Chairs organized in a semicircle
- Flipchart stand
- Flipchart paper
- Markers
- Masking tape
- 58 sheets of A4-sized paper
- **Participant Handout: Effects of Stigma on the HIV Epidemic**
- **Facilitator Resource: Forms, Effects, and Causes of Stigma**
- **Facilitator Resource: Stigma Problem Tree**

Advance Preparation

> **Facilitator note:** This session should be delivered **after** participants complete the "What Is the Meaning of Stigma?" session.

1. Cut 54 sheets of A4-sized paper into three rectangles to give you 162 cut pieces of paper.
2. Refer to **Facilitator Resource: Stigma Problem Tree** and reproduce the drawing on a blank flipchart page. Post the drawing on a wall.
3. Label a blank flipchart page "Possible Solutions" and list the following below the title:
   - Remind health workers of their code of conduct
   - Improve health workers' knowledge about HIV transmission
   - Train health workers and provide ongoing monitoring and support on how to interact with all patients in a nonjudgmental way

   Post the list on the wall next to the drawing of the tree.

4. Write the following types of stigma on the remaining four sheets of A4-sized paper (one type of stigma per sheet of paper):
    - Stigma toward HIV-positive clients by health workers and the community
    - Stigma toward men who have sex with men (MSM) by health workers and the community
    - Stigma toward sex workers by health workers and the community
    - Stigma toward adolescents living with HIV by health workers and the community
5. Print enough of the **Participant Handout: Effects of Stigma on the HIV Epidemic** for to give each participant a copy.

Steps

Introduction (2 minutes)

1. Start by explaining that in this session, participants will divide into groups to analyze stigmas facing various groups of people. Participants will use the "problem tree methodology" to consider effects, forms, and causes of stigma. They will also be challenged to think of practical solutions to stop or reduce stigma.

Analyzing Different Forms of Stigma (1 hour 15 minutes)

1. Divide participants into four groups. Once the groups have been created, distribute the following to each group: one of the sheets of paper labeled with a type of stigma (one sheet per group), one blank flipchart page, markers, pieces of masking tape, and 40 rectangles of paper.
2. Next, explain to participants that they will spend 20 minutes in their small groups completing a problem tree analysis of their assigned stigma.
3. Draw participants' attention to the problem tree you drew on the flipchart page and explain the following points:
    - To combat stigma and discrimination, we need to understand its causes.
    - The trunk of the tree symbolizes the problem—in this case, stigma.
    - The roots of the tree symbolize the underlying causes of stigma.
    - The leaves of the tree represent the consequences/effects of stigma.
4. Next, walk participants through the problem tree analysis example using the following explanations:
    - Point to the trunk: On this tree, the problem is stigma toward HIV-positive women who become pregnant. Forms of stigma associated with this include criticism by health workers and coercion by health workers to terminate pregnancy.
    - Point to the roots: Causes of stigma toward pregnant HIV-positive women include the perception that the mother will transmit HIV to the baby and the perception that when a woman becomes HIV positive she no longer has a life or the right to make her own decisions.
    - Point to the leaves: The effects of stigma toward pregnant HIV-positive women include feelings of shame, depression, and isolation on the part of the women; and the decision by the woman not to return to the health facility.
    - Point to the list of possible solutions and explain each one.

5. Explain that in some cases, when there is ample time and resources, it can be useful to employ contextualized formative inquiry to really dig in to understand the roots of problems rather than making assumptions, as we are in this activity.
6. Before moving on, make sure participants understand the problem tree and its components.
7. Next, explain to participants that they will spend 20 minutes in their small groups completing the same analysis for the stigma problem assigned to their group. Explain that each group will:
    - Draw a tree on the flipchart paper.
    - Write the type of stigma assigned to their group on the trunk of the tree.
    - Use the rectangles of paper they received to identify five to 10 additional forms of stigma related to the type of stigma they were assigned, and tape these pieces of paper to the trunk.
    - Use the pieces of paper to identify five to 10 effects of the stigma they were assigned, and tape these squares to the leaves of the tree. (Emphasize that the effects identified should be specific to the stigma's target population.)
    - Use the pieces of paper to identify five to 10 causes of the stigma they were assigned, and tape these squares to the roots of the tree. Participants should "dig deeper"—look for the reasons behind some of the causes they have listed.
    - Use the pieces of paper to identify five to 10 possible solutions to the problem, and tape the pieces of paper at the bottom of the flipchart page.
8. Make sure that everyone has a clear understanding of the process and then instruct participants to identify a work area inside or outside of the room. Complete steps 1–7 in no more than 15 minutes.
9. After 20 minutes, call time and ask each group to post their drawings on the walls around the room.
10. Next, ask for a representative from one of the groups to present her/his group's work to the larger group. Instruct all participants to stand and then move as a group toward the poster being presented.
11. Allow the group representative 5 minutes to present. Next, give the other participants 5 minutes to make comments and/or ask questions before moving on to the next group presentation. You may refer to **Facilitator Resource: Forms, Effects, and Causes of Stigma** for additional examples of causes, effects, forms, or solutions not mentioned by the group.
12. Repeat steps 10–11 for the remaining three groups.
13. After all of the groups have presented, ask participants to return to their seats.

Group Discussion (10 minutes)

1. Facilitate a group discussion using the following questions:
    - What are the effects of stigma on the HIV epidemic?
        > Answer: Refer to **Participant Handout: Effects of Stigma on the HIV Epidemic**
    - What are three main causes or drivers of HIV-related stigma?
        > Answers include lack of awareness that they are stigmatizing, inadequate knowledge of HIV transmission and fear of getting HIV through casual contact, and judgmental attitudes.
    - What needs to happen to address stigma? As health workers/health programmers, what role can you play?

- Answer: Service providers on their own cannot solve many of the root causes of stigma. However, general awareness of the root causes will help service providers better understand the needs and concerns of people living with HIV and key populations so they can provide better, nonjudgmental services and refer them to other appropriate services.

2. Before ending the session, distribute **Participant Handout: Effects of Stigma on the HIV Epidemic**.

Closing (3 minutes)

1. End the session by discussing the following points:
   - Judgmental attitudes toward key populations bring up issues of:
     - **Gender** (e.g., the common perception that MSM are not real men)
     - **Culture** (e.g., the perception that homosexuality, sex work, or use of drugs is abnormal, breaking social norms)
     - **Religion** (e.g., the perception that MSM relationships, sex work, and use of drugs are immoral, against the teachings of our faith)
   - Stigma leads to low uptake of health services by people living with HIV and key populations. Reducing stigma is key to increasing the uptake of HIV prevention and services; improving HIV disclosure; and improving client follow-up to treatment, care, and support services.

Acknowledgments

Health Policy Project. 2013. *Understanding and Challenging HIV and Key Population Stigma and Discrimination: Caribbean Facilitator's Guide*. Washington, DC: Futures Group, Health Policy Project. https://www.healthpolicyproject.com/pubs/134_CaribbeanFacilitatorsGuideFINAL.pdf.

Participant Handout: Effects of Stigma on the HIV Epidemic

What are the effects of stigma on the HIV epidemic?

Stigma or the fear of stigma **stops** people living with HIV and key populations from:

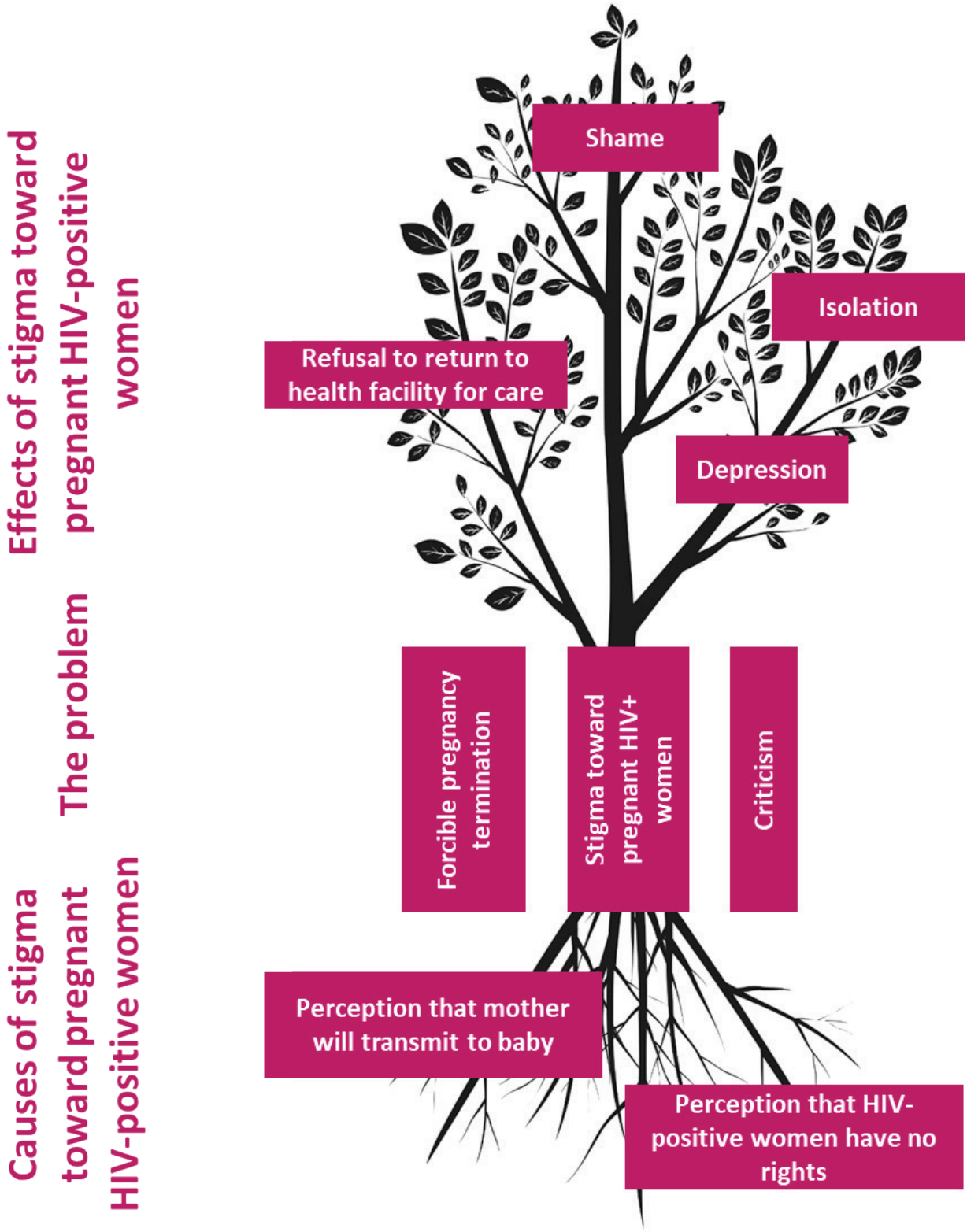
- **Accessing health services**, including getting tested for HIV and sexually transmitted infections (STIs), getting information on how to avoid HIV transmission, and getting condoms and lubricant
- **Openly discussing their sexuality with health workers** and providing complete information about their sexual practices
- **Accessing treatment** such as antiretroviral therapy or treatment of opportunistic infections
- **Using other services**, for example, a pregnant woman living with HIV is discouraged from HIV testing and making use of the prevention of mother-to-child transmission of HIV program
- **Disclosing their status to their partners**
- **Protecting their own health and the health of their sexual partners**, for example, by insisting on condom use with partners, using clean needles and syringes for drug use, and accessing treatment to reduce viral load
- **Disclosing their HIV status and getting counseling, care, and support.** Because of stigma, people living with HIV and other key populations are afraid to tell others about their HIV status. As a result, they may have difficulty negotiating condom use, and accessing services, support, and treatment for HIV, and therefore may be at more risk of transmitting HIV to their partners.

What does this mean?

The fear of being stigmatized stops people living with HIV and key populations from taking appropriate actions to protect their health and the health of their partners. This fear stops key populations from accessing health services, finding out their own status, and negotiating safer sex/drug use practices with partners. This increases the risk that they will contract HIV and will then pass HIV to their partners.

If, on the other hand, people living with HIV and key populations are treated with kindness, support, and care, they will be more likely to access health services and take precautions in their sexual relationships.

Facilitator Resource: Stigma Problem Tree



Facilitator Resource: Forms, Effects, and Causes of Stigma

Stigma Toward HIV-Positive Clients by Health Workers and the Community

- **Forms:** Shaming and blaming clients for getting HIV. Making HIV-positive clients wait. Using gloves for noninvasive tasks. Moving away from clients assumed to be HIV positive.
- **Causes:** Fear of getting HIV through casual contact. Judgmental, moralizing attitudes. Heavy workloads and stress.
- **Effects:** Feeling isolated, ashamed, angry, and depressed. Self-blame. May go to another health facility or to another island for treatment, or may stop treatment. Failure to adhere to antiretroviral medication.
- **Solutions:** Remind health workers of their code of conduct. Improve health workers' knowledge about HIV transmission so they no longer fear getting HIV through casual contact with clients. Orient new health staff on how to treat/interact with all clients.

Stigma Toward MSM by Health Workers and the Community

- **Forms:** Isolation and minimal contact. Gossip, whispering, and finger-pointing. Violence.
- **Causes:** Moral and religious views about men who have sex with men (MSM)—viewed as breaking social norms. People know little about MSM, so out of ignorance, they judge them unfairly or reject them out of fear. They are prejudiced toward people who look and behave differently.
- **Effects:** MSM feel rejected and all alone. Stress, depression, and alcohol abuse.
- **Solutions:** Help community leaders become more informed so they can speak out on behalf of MSM. Teach community to treat MSM like other members of the community. Empower MSM to speak out and participate in community activities.

Stigma Toward Sex Workers by Health Workers and the Community

- **Forms:** Scolding, shaming, and blaming sex workers for their sex work. Using insulting words. Revealing the occupation of sex worker patients to other health workers and clients.
- **Causes:** Moral and religious views about sex workers. Judgmental, moralizing attitudes. Feeling of superiority. Heavy workloads and stress.
- **Effects:** Feeling isolated, ashamed, and angry. Sex workers may stop using health facilities and may not get their STIs treated.
- **Solutions:** Remind health workers of their code of conduct—to treat all patients equally and with respect. Train health workers and provide ongoing monitoring and support on how to interact with all patients in a nonjudgmental way.

Stigma Toward Adolescents Living with HIV by Health Workers and the Community

- **Forms:** Keeping adolescents waiting and treating them last. Blaming adolescents for being sexually active and getting HIV. Blaming their parents for not raising them properly.
- **Causes:** Judgmental, moralizing attitudes. Heavy workloads and stress. Fear of getting HIV through casual contact. Lack of experience in dealing with young people.
- **Effects:** Feeling ashamed and angry. Self-blame. Becoming suicidal. May go to another health facility or stop going to health facilities. Not adhering to treatment.
- **Solutions:** Train health workers on how to interact with adolescent living with HIV. Remind service providers of their code of conduct.

Session 21: Our Own Experience of Being Stigmatized

Learning Objectives

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

- Describe some of their own personal experiences of being stigmatized
- Identify some of the feelings resulting from being stigmatized

Facilitator note: This session requires a lot of trust and openness within the group, so you should not use it at the start of stigma education. Wait until participants are beginning to open up with each other and are ready to share some of their own experiences and feelings.

Facilitator note: This exercise can trigger painful memories for some participants. They are being asked to think and talk about strong feelings. You should be ready to deal with the emotions raised. Ideally, you should implement this session with a trained counselor on the facilitation team or group in case one is needed.

Time

1 hour

Materials Needed

- Chairs organized in a semicircle
- Flipchart paper
- Flipchart stand
- Masking tape
- Markers

Advance Preparation

None

Steps

Introduction (1 minute)

1. Start the session by stating that in this session, participants will be asked to reflect on their personal experience of being stigmatized and how it felt. Explain that these feelings help participants get an insider's view of stigma—how it hurts and how powerful those feelings are. The idea is to use this experience to help participants to empathize with stigmatized groups.

Individual Reflection (58 minutes)

1. Ask participants to sit in silence for 2 minutes and think about a time in their lives when they felt lonely or rejected as a result of being seen as different by others.
2. Explain that the example does not have to relate to HIV or sexual practices. Ask participants to think about what happened, and how they felt.
3. Next, ask participants to pair up with a person with whom they would feel comfortable sharing their experience. Allow the pairs 10 minutes to share (5 minutes per person) and then bring everyone back together in a large circle.

Facilitator note: Emphasize that sharing is voluntary—no one will be forced to give their story—and emphasize the importance of confidentiality. Remind participants about the ground rules—"What is shared should stay in the room." Encourage group members to listen carefully to each other's stories.

4. Ask for volunteers to share their experience with the large group. Remind participants that they should only share if they feel comfortable doing so.

Facilitator note: Participants may feel more at ease if you share your own personal experience first.

5. As participants share, ask the following questions:
    - How did you feel?
    - How did the experience affect your life?

Facilitator note: During the discussion, validate the participants' responses and emphasize the following:

- Stigma destroys our self-esteem. It makes us doubt ourselves and our self-worth.
- Everybody has felt ostracized or been treated like a minority at various times in their lives. It is okay to feel this way and you are not alone. We have all experienced this sense of social exclusion.
- The experience of being stigmatized is very painful. It really hurts. It can last for a lifetime.
- We all stigmatize. It is a part of life. Some people stigmatize without realizing it.
- When we stigmatize, we create separation—"us" and "them."
- We need to recognize the damage we can do to others by stigmatizing and judging them.

6. After a few participants have shared, facilitate a group debrief by asking:
    - What did you learn from this exercise?
    - What might you do differently in the future as a result of this exercise?

Closing (1 minute)

1. End the session by communicating the following points:
    - This exercise gives us an inside understanding of how it feels to be stigmatized—shamed or rejected. It helps put us into the shoes of others, including our clients and colleagues. It helps us to understand how painful it is to be stigmatized.
    - We stigmatize for many reasons—nationality, gender, ethnicity, language, religion, physical, mental abilities or challenges, etc.
    - Once we have been stigmatized, we have a better sense of how key populations may feel to be stigmatized.

Acknowledgments

Health Policy Project. 2013. *Understanding and Challenging HIV and Key Population Stigma and Discrimination: Caribbean Facilitator's Guide*. Washington, DC: Futures Group, Health Policy Project. https://www.healthpolicyproject.com/pubs/134_CaribbeanFacilitatorsGuideFINAL.pdf.

Module 5

Responding to Sexuality and Sexual Diversity

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Saving lives. Improving health. Transforming futures.

Session 22: I Already Have … But I Still Need …

Learning Objectives

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

- Describe the role of health care personnel in terms of delivering sexual health care for all clients, including sexual and gender minorities
- Compare expected health worker performance to actual behaviors and identify gaps that must be closed
- Formulate practical measures for changing the way health workers relate to sexual and gender minorities

Facilitator note: This session should only be completed after participants have completed **both** "Gender Terms and Definitions" and "Health Care Professionals and Care for Gender and Sexual Minorities."

Time

1 hour 45 minutes

Materials Needed

- Chairs organized in a semicircle
- Flipchart paper
- Flipchart stand
- Markers
- Masking tape

Advance Preparation

None

Steps

Introduction (1 minute)

1. Begin the session by stating that the purpose is for participants to explore the roles and needs of health care providers in providing respectful, nondiscriminatory care for all clients.

Creating a Typical Character (48 minutes)

1. Ask participants to briefly brainstorm aloud how an **ideal** health care worker delivers sexual and reproductive health (SRH) services for all clients.

Facilitator note: Be sure the brainstorm includes the following points:

- Sexual diversity is recognized and respected (for example, when inquiring about a client's sexual practices, health workers should consider multiple possibilities and avoid assuming the client is heterosexual).
- Privacy, confidentiality, and informed consent are always ensured for all clients.
- Body language and words demonstrate empathy and compassion for all clients.

2. Next, explain that the group will now explore how a **typical** health worker delivers SRH care services. Divide participants into two teams. Once the teams have been created, explain the following:
   - Each team must create the profile of a **typical** health care worker. The profile should include such details as name, age, sex, duties he/she performs, skills, knowledge, and attitudes (related to SRH for all clients in the community).
3. Emphasize that the goal is **not** to create the ideal health care worker profile. The exercise is about recognizing strengths and areas for improvement. Tell participants they can present the profile in the form of words, images, or a combination of words and images. They will have 10 minutes to complete the assignment.
4. After 10 minutes have passed, call time and ask the groups to post their work on the wall.
5. Ask a representative from one group to introduce their group's character, taking no more than 5 minutes.
6. After the presentation, ask participants to identify specific improvements needed (e.g., improvements related to attitudes, knowledge, information, skills, etc.) to enable the typical health care worker to deliver effective and quality SRH services to clients of diverse gender and sexual identities.
7. Repeat steps 6–7 for the second group. Allow up to 20 minutes (per group) to complete steps 3–8.

Facilitator note: Make sure that the group discussion includes the following key points:

- All workers at the health facility, including administrative staff, should have opportunities to learn about and discuss comprehensive health care delivery from a gender diversity and human rights perspective.
- Using inclusive language (for example, using statements and pronouns that do not make assumptions about a person's sexual identity or orientation) is one important aspect of delivering effective, respectful care.

Our Own Reflection (55 minutes)

1. Next, split participants into four groups. Ask two of the groups to make a list of what they—as individuals—**already possess** (e.g. skills, information, resources, etc.) to meet the needs of sexually and gender-diverse clients in a respectful, nondiscriminatory manner. Ask the two remaining groups to make a list of what each of them **still requires** to meet the needs of sexually and gender-diverse clients and to welcome these clients in their facilities. Encourage participants to reflect honestly about their own attitudes, experiences, and behaviors. You may encourage individuals to reflect on a recent experience caring for someone who belonged to a sexual or gender minority group. Distribute flipchart paper and markers to each group.

2. After 20 minutes, call time and ask a representative from each group to come to the front of the room and present their group's list to the larger group (spend no more than 5 minutes per group).
3. After each group has presented, facilitate a 15-minute group discussion using the following questions:
    - Did any part of the presentations surprise you? Why or why not?
    - What are some ways to ensure that individuals receive what they still need to deliver high-quality care for sexually and gender-diverse clients?
    - Which of these needs will be the easiest to address? Which will be more challenging. Why?
    - Can you think of any key stakeholders who may be able to help you meet these needs?
    - What is a reasonable timeline(s) to put these changes in place?

Closing (1 minute)

1. End the session by emphasizing the following points:
    - By demonstrating empathy and respect, health care personnel pave the way for comprehensive, effective care.
    - When sexual diversity is recognized and respected, the health care system guarantees everyone equal access to health care.

Acknowledgments

United States Agency for International Development (USAID) AIDS Support and Technical Assistance Resources (AIDSTAR-One), Task Order 1. 2015. *Broadening Our Understanding of Diversity: Sexual Health and Sexual Diversity Training Manual for Primary Healthcare Professionals*. Arlington, VA: USAID. https://aidsfree.usaid.gov/sites/default/files/lac_tg_training.pdf.

Session 23: Health Professionals and Care for Gender and Sexual Minorities

Learning Objectives

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

- Discuss sexual diversity from a gender and human rights perspective
- Describe the prejudice that exists among health care workers regarding sexual orientation and identity that lead to a suboptimal approach during medical consultation with sexual and gender minorities
- Describe key facility-level considerations for ensuring health services can meet the basic needs of sexual and gender minorities

Time

1 hour 45 minutes

Materials Needed

- Chairs organized in a semicircle
- Flipchart paper
- Flipchart stand
- Markers
- Pencils or pens (enough for each participant)
- **Participant Handout: General Data Form**
- **Participant Handout: Facility and Provider Considerations for Providing High-Quality Care to LGBTI Clients**
- Projector
- "Vanessa Goes to the Doctor" video

Advance Preparation

1. Download the "Vanessa Goes to the Doctor" video (https://www.youtube.com/watch?v=iIGykm6cm_M)
2. Print enough copies of **Participant Handout: General Data Form** for each participant
3. Print enough copies of **Participant Handout: Facility and Provider Considerations for Providing High-Quality Care to LGBTI Patients** for each participant

Steps

Thinking Outside the Box (45 minutes)

1. Begin the session by distributing a copy of **Participant Handout: General Data Form** to each participant, along with a pen or pencil.
2. Allow participants 5 minutes to complete the questionnaire and then gather the forms.
3. Next, ask participants the following question:
   - Did anyone have any difficulty completing the form?
4. If some participants reply that their name, nationality, and/or professional field were not included, state that the ones listed on the form are the most common names according to international databases. If participants say that none of the nationalities, names, and/or professional fields are theirs, tell them that most of the world's population has one of these nationalities, names, and professional fields and that they are the broadest categories. Next, facilitate a 10-minute group discussion using the following questions:
   - What difficulty do you see?
   - How does it feel when you "don't fit" into the most common categories? (Mention that one of the characteristics of adulthood is being clear and certain about identity, e.g., national, professional, sex.)
   - If this happens with a name, nationality, and occupation, what happens to the box indicating sex?
   - Does everyone fit into one of the two categories of male or female?
5. Next, explain that due to a heterocentric culture (that is, the prevailing belief and perception that most, if not all, people are heterosexual), the health needs of adults of various sexual orientations and gender identities are often overlooked and ignored at the health facility level. Although providing inclusive health care services for sexual and gender minorities requires a number of changes in health facilities' policies and procedures, adapting the client intake process is a good place to start.
6. Next, instruct participants to keep in mind the points discussed as they watch a video.
7. Show the video. It is approximately 9 minutes long.
8. After showing the video, facilitate a 15-minute group discussion using the following questions:

> **Facilitator note:** During the discussion, emphasize the importance of having clear guidelines that must be followed depending on different needs, in addition to an environment of trust and nonjudgment in provider-client interaction.
>
> Reinforce the idea that the first interview represents a defining moment not only to be able to appropriately meet a specific need, but also for the client to develop trust and remain in the health care system.

   - What did you notice about the way Vanessa was initially welcomed at the health facility and by the doctor? What were or what could have been the consequences of Vanessa's poor treatment by the receptionist and the provider?

- What aspects do you think health care workers need to be mindful of when welcoming and counseling clients? Why?

We Are Already Doing This, but We Need to Be Doing That (58 minutes)

1. Next, split participants into two groups. Once the groups have been created, assign one of the following tasks to each group:
   - Make a list of all of the things that are **already being done** in your health facilities to respond to the specific needs of sexual and gender minorities
   - Make a list of all of the things your health facilities **needs to do** to respond to the specific needs of sexual and gender minorities.
2. Distribute flipchart paper and markers to each group and explain that they will have 20 minutes to complete the task. Instruct the groups to identify a workspace inside or outside of the room.
3. After 20 minutes, ask participants to return to their seats and invite a member of the first group (already being done) to come to the front of the room and share her/his group's list with the larger group. After she/he finishes presenting, allow about 5 minutes for comments and/or questions from other participants. Write any additional ideas on the list.
4. Next, invite a representative from the second group (need to do) to come to the front of the room and present her/his group's list. After she/he finishes presenting, allow about 5 minutes for comments and/or questions from other participants. Write any additional ideas on the list.
5. After both groups have presented their work, facilitate a 20-minute group discussion using the following questions:
   - Why is it so important to work to close these gaps?
   - What do you anticipate may be some of the biggest barriers to making these changes?
   - What are ways that these barriers can be addressed?

Facilitator Note: The **Participant Handout: Facility and Provider Considerations for Providing High-Quality Care to LGBTI Patients** can be distributed after the group discussion, or toward the end of the group discussion if groups seem to be struggling to come up with what facilities can do to respond to specific needs of sexual and gender minorities.

Closing (2 minutes)

1. End the session by stating that although the health care needs of lesbian, gay, bisexual, transgender, and intersex (LGBTI) individuals are no different from those of the rest of the population, they do have specific needs.
2. At the facility level, there are many interventions we can advocate for, and work toward implementing, to ensure that all clients receive adequate health care.

Acknowledgments

Gay and Lesbian Medical Association (GLMA). 2006. *Guidelines for Care of Lesbian, Gay, Bisexual, and Transgender Clients*. San Francisco, CA. https://www.rainbowwelcome.org/uploads/pdfs/GLMA%20guidelines%202006%20FINAL.pdf.

The Joint Commission. 2011. *Advancing Effective Communication, Cultural Competence, and Client- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community. A Field Guide*. Oak Brook, IL. https://www.jointcommission.org/assets/1/18/LGBTFieldGuide_WEB_LINKED_VER.pdf.

Key Considerations to Remember When Biomedical Providers Are Serving the Beneficiaries. From USAID Sauti Tanzania project.

The National LGBT Cancer Network. 2015. Vanessa Goes to the Doctor. https://www.youtube.com/watch?v=iIGykm6cm_M.

National LGBT Health Education Center: A Program of the Fenway Institute. n.d. Affirming LGBT People through Effective Communication. Learning Module. Boston, MA. https://www.lgbthealtheducation.org/learning-module/effective-communication/.

United States Agency for International Development (USAID) AIDS Support and Technical Assistance Resources (AIDSTAR-One), Task Order 1. 2015. *Broadening Our Understanding of Diversity: Sexual Health and Sexual Diversity Training Manual for Primary Healthcare Professionals*. Arlington, VA: USAID. https://aidsfree.usaid.gov/sites/default/files/lac_tg_training.pdf.

Participant Handout: General Data Form

Dear Participant:

So we can keep a record of those attending this workshop, we ask that you please provide us with some general information by checking the applicable boxes below:

Name

- ☐ Jane
- ☐ Mark
- ☐ Eric
- ☐ Mohammed
- ☐ Fatima

Nationality

- ☐ Chinese
- ☐ Brazilian
- ☐ American
- ☐ Russian
- ☐ Togolese

Professional Field

- ☐ Law
- ☐ Business Administration
- ☐ Accounting
- ☐ Engineering
- ☐ Education

Sex

- ☐ Female
- ☐ Male

Thank you in advance for your response!

Participant Handout: Facility and Provider Considerations for Providing High-Quality Care to LGBTI Clients

Facility Considerations

1. Display lesbian, gay, bisexual, transgender, intersex (LGBTI)-inclusive information, education, and communication (IEC) materials.
    - IEC materials should include information relevant to LGBTI clients.
    - IEC materials should include visual representations of LGBTI clients and relationships.
2. Develop and display LGBTI-friendly facility policies.
    - Develop a nondiscrimination policy stating that equal care will be provided to all clients, regardless of age, race, ethnicity, physical ability or attributes, religion, sexual orientation, or gender identity/expression.
    - Ask providers to sign the policy to ensure buy-in and enforcement.
3. Create an environment of accountability.
    - If a colleague makes a mistake or makes insensitive comments, find a confidential environment to politely share your thoughts with the colleague about the communication used. For example:
        > If you hear a health facility staff member or provider comment to other staff or patients about a patient's behavior or clothing, say to the provider: "Those kinds of comments are hurtful to others and do not create a respectful health care environment."
        > If you hear a provider referring to a transgender client by a name that is not their preferred name, say to the provider: "My understanding is that this client prefers to be called 'Jane' and not 'John.'"
4. Train all staff in standards of respect.
    - Train all staff (providers, administrative staff, cleaners, etc.) on standards of respect toward LGBTI individuals.
5. Know where trusted referral sources for LGBTI clients are located.
    - Understand where resources for LGBTI clients are located in your community, so you can refer clients for other needs, including alcohol and substance abuse, mental health, violence, etc.
    - Have a directory available at every clinic/department at the health facility.
6. Collect feedback.
    - Establish feedback mechanisms (e.g., regular confidential client satisfaction surveys for all clients with specific questions related to LGBTI services) so all clients can comment on what your health facility is doing well on and where it can improve.
    - If the health facility has LGBTI peer groups, ad hoc surveys can be offered to such groups to collect more in-depth information and develop focused improvement plans.
    - Conduct focus groups or interview LGBT community members and leaders to identify the community's health needs.
7. Ensure LGBTI-friendly outreach.
    - Outreach services should be provided following the LGBTI standards listed in this guide.

Biomedical Provider Considerations

1. Ensure confidentiality and safety.
    - Encourage openness by explaining that client-provider discussions are confidential. Explain that you need complete and accurate information to understand the client's life and provide appropriate care.
    - Ensure that the space where clients receive services is private.
    - Note: LGBTI individuals may have experienced stigma and discrimination in health care settings and their communities. Therefore, it may take longer for them to develop trust and require added sensitivity from the provider.
2. Prioritize the client's stated need.
    - Address the client's primary concern for accessing services today before offering other services. Facilitate an open dialogue about their past and future needs.
3. Listen to your client's experience about stigma and discrimination.
    - Your clients may have experienced stigma and discrimination by the community, family, peers, police, etc. They may also experience feelings of depression, low self-esteem and anger, or self-harming acts. Explore whether your client has been exposed to stigma and discrimination. Assist them in developing a plan to overcome violence, rejection, and marginalization. Offer them linkage to trusted referral resources in the community (e.g., for HIV or post-GBV care [medical, social, legal] as needed, sexually transmitted infection (STI) testing and treatment, and mental health services.)
4. Screen for mental health disorders.
    - If your facility has trained staff and referral resources, screen for mental health disorders [alcohol, substance use, suicide attempts, depression, anxiety, etc.] Offer linkage to referral services.
5. Offer counseling tailored to the needs of your clients.
    - Depending on your client's needs, offer counseling on sexual and reproductive health and HIV risks.
6. Communicate effectively with your LGBTI clients.
    - As you should with any client, approach client interactions showing empathy, open-mindedness, and without judgment.
    - It is important to discuss sexual health issues openly with your clients. Phrase questions about sexual practices and behaviors in a nonjudgmental manner.
7. Avoid assumptions.
    - **Don't assume** you know a person's gender identity or sexual orientation based on how they look or sound.
    - **Don't assume** you know how a person wants to describe themselves or their partners.
    - **Don't assume** all of your clients are heterosexual and cisgender (not transgender).
    - **Don't assume** that if your client identifies as a lesbian or indicates a female partner, that she has never had sex with a male partner, has never been pregnant, has no children, and has little or no risk of STIs. If a male client identifies as gay or bisexual, don't assume that he has never had sex

with a female sexual partner or has no children. Do not make assumptions about past, current, and future sexual behavior.

8. Use gender-neutral phrases.
    - Don't use words like he, she, sir, ma'am, Mrs., Ms., or Mr. For example,
        - Instead of, "How may I help you, sir?" say, "How may I help you?"
        - Instead of, "She is here to meet with a nurse," say, "The client is here to meet with a nurse."
        - Instead of, "Do you have a wife?" say, "Are you in a relationship?" or "Do you have a partner?"
9. Use the correct names and pronouns for your clients.
    - If you are unsure about a client's preferred name or their pronouns, ask "I would like to be respectful. What name and pronouns would you like me to use?"
    - If you accidently used the wrong term or pronoun, say, "I'm sorry. I didn't mean to be disrespectful."
    - It is important to listen to, understand, and mirror the terms that clients use to describe themselves.
10. Communication "don'ts":
    - **Don't** laugh or gossip about a client's appearance or behavior.
    - **Don't** use stereotypes or ask questions that are not necessary for care. For example, **don't say**:
        - "You're so pretty! I cannot believe you are a lesbian."
        - "Are you sure you're bisexual? Maybe you just haven't made up your mind yet."
        - "So you are gay. How is the club scene these days?"
        - "Wow. You look just like a real woman!"

Session 24: Identifying Stigma and Discrimination Toward Key Populations in the Health Facility

Learning Objectives

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

- Explain the meaning of stigma with examples
- Describe the different forms of stigma that prevent key populations from accessing services and that key populations face at the facility level
- Explain how stigma and discrimination against gender and sexual minorities increase their HIV risk
- Describe strategies for providing stigma-free services to key populations

Facilitator note: This session should only be facilitated **after** you have completed either the session titled "Forms, Effects and Causes of Stigma," and/or the session titled "What Is the Meaning of Stigma"?

Time

1 hour 15 minutes

Materials Needed

- Chairs organized in a semicircle
- Flipchart paper
- Flipchart stand
- Markers
- Masking tape
- A4-sized paper
- **Participant Handout: Case study 1**
- **Participant Handout: Case study 2**
- **Participant Handout: Case study 3**
- **Participant Handout: Case study 4**
- **Participant Handout: Stigma in Health Facilities—Forms, Causes, and Solutions**

Advance Preparation

1. Make enough copies of **Participant Handout: Stigma in Health Facilities—Forms, Causes, and Solutions** for each participant.
2. Make one copy of each of the case studies.

Steps

Introduction (1 minute)

1. Open the session by explaining that the session will focus on the experiences of key populations in accessing health facilities—how key populations are treated, the specific forms of stigma and discrimination they face, how it makes them feel, and the effect of stigma on their health-seeking behavior. Explain that key populations are at higher risk of HIV, and factors such as stigma and discrimination drive these populations away from health services that they may need. Key populations include men who have sex with men (MSM), transgender people, sex workers, and people who inject drugs. In this session, we will primarily focus on the stigma and discrimination experienced by MSM and sex workers.

Case Studies (1 hour 5 minutes)

1. Divide participants into four groups. Once the groups have been created, give one of the case studies to each group (one per group).
2. Tell participants they will spend 15 minutes in their groups reading the case study they were assigned and answering the questions listed below the case study. Instruct participants to identify a note taker who will write the group's answers on a sheet of paper and report back to the large group.
3. Ask participants to find a space inside or outside of the room to complete the assignment.
4. After 15 minutes, ask the groups to stop, and gather all of the participants together.
5. Divide a blank flipchart page into two columns. Title one column "Stigma" and the other "Effects."
6. Next, start with one of the groups and ask for a representative to read the case study aloud and then to read their group's answers to the questions. As the group representative shares examples of the forms and effects of stigma, write them in the appropriate column on the flipchart page.
7. After the group representative has presented for approximately 5 minutes, ask the other participants if there are any other forms or effects of stigma that were not mentioned. As participants call out ideas, write them in the appropriate column.
8. Repeat steps 6 and 7 with the remaining three groups, avoiding writing the same ideas on the flipchart. Complete steps 5–8 in no more than 25 minutes.

> **Facilitator note:** Review the participant handout in advance of this activity. As you facilitate step 8, be sure to offer any additional key points that are not already addressed by participants on the first two sections of the handout: "Forms of Stigma" and "Effects of Stigma."

9. Next, facilitate a 25-minute group discussion using the following questions:
   - Were the case studies realistic? Why or why not?
   - What happens if we stigmatize key populations who are using the health facility?
   - Why is stigmatizing clients wrong? What effects do stigma and discrimination have on key populations and on the spread of HIV?

     Probe: Reflect on your experiences. Would someone like to share a specific experience of the effects of stigma and discrimination on key populations?

- Why does stigma and discrimination toward key populations occur in the health facility?

  Probe: Reflect on your experiences. Would someone like to share a specific experience of why stigma and discrimination toward key populations occur in the health facility?

- What can we do to make health facilities more friendly/accessible to key populations?

  Probe: Reflect on your experiences. Would someone like to share from their experiences how a facility was made more friendly/accessible to key populations?

10. Before ending the session, distribute **Participant Handout: Stigma in Health Facilities—Forms, Causes, and Solutions**.

Closing (9 minutes)

1. Close the session by discussing the following points:

   - Because of religion or upbringing, some people may believe that people having sex with the same sex or sex work is wrong, but it is not okay to stigmatize MSM and sex workers—to treat them as immoral or evil.
   - We are not saying that the moral values are wrong; we are saying that health workers' judging of clients, such as MSM and sex workers, is wrong.
   - Stigmatizing clients fuels the HIV epidemic. It makes clients hide their sexual behavior and, as a result, they may take less care of their sexual health, increasing the risk of HIV exposure.
   - Health workers' code of conduct requires us to treat all clients without exception.
   - Stigmatizing clients defeats your own mandate as a health worker. If you stigmatize MSM and sex workers, they will stop using the clinic and their health will be negatively affected. If so, you are failing in your role as a health worker.
   - Stigmatizing MSM and sex workers results in their feeling cut off from the family, community, and health services.
   - MSM and sex workers are not bad people. In many parts of the world, MSM and sex workers are accepted as part of the community. This removes the moral condemnation and the source of the stigma that is so damaging.
   - Instead of stigmatizing MSM and sex workers, we need to show care, compassion, and acceptance, so that MSM and sex workers can lead healthy lives and act in their own and other people's interest.
   - If we can stop blaming and shaming, and instead accept MSM and sex workers, we can make a difference!

Acknowledgments

Health Policy Project. 2013. *Understanding and Challenging HIV and Key Population Stigma and Discrimination: Caribbean Facilitator's Guide*. Washington, DC: Futures Group, Health Policy Project. https://www.healthpolicyproject.com/pubs/134_CaribbeanFacilitatorsGuideFINAL.pdf.

Participant Handout: Case Study 1

One day, I started to get painful sores around my anus. I went to the clinic to get tested and obtain possible treatment, but I was worried about how I would be treated by the clinic staff. So I told the nurse that I was constipated, and that it was very painful. The nurse didn't say anything, but she left the room and a few minutes later returned with two other nurses. The nurses looked at me, whispered to each other, and then left.

When the first nurse returned, I challenged her and said, "I've been waiting a long time. Could you examine me and give me some treatment?" She laughed and said, "Who are you to tell me what I should do? You'll just have to wait. We know you people!" She said this in the presence of the other patients and then left. I was told that she and the other nurses had gone off for tea break. I could imagine them gossiping about me over their tea. I wondered who they would tell about me.

After a long break, a doctor entered and, without even examining me, said, "What have you been doing? How did you get this STI [sexually transmitted infection]?" I explained that I had a sore in my anus. He said, "What did you expect to get from this unusual sexual behavior? I normally treat STIs in the front, not the back. Why are you making my life difficult?" Then he told me to take off my pants. I did so, and he looked at my bum from a long distance away, and said, "Why do you have STIs in your anus? What have you been doing?"

He then began to ask me a lot of questions about my sex life: "What kind of sex have you been having? When was the last time you had sex with a woman? Do you have a girlfriend? How do you have sex with a man?" I told him I just wanted to be tested and given treatment, not asked about my sex life. He responded that, "the clinic only did testing for real men, not men pretending to be women."

As soon as the doctor went to the next room, I put my pants on and left the clinic. It was humiliating! I will never go back there again. I went to the clinic with a medical problem to get help from the doctor, but I didn't receive any treatment—all I got was insults and blame!

Discuss and answer the following questions with your group members:

- What forms of stigma appear in this case study?
- What effects could the stigma have on the client?

Participant Handout: Case Study 2

One day, I started to get painful sores and a burning sensation in my vagina. Even though I was worried about how I would be treated by the clinic staff, I went to the clinic to seek testing and, if needed, treatment.

When I arrived at the clinic, I waited a long time. The nurse kept calling patients who had arrived after me. Eventually, I challenged her and said, "I arrived before her. Why can't you treat me now?" She laughed and said, "Who are you to tell me what I should do? You'll just have to wait. We know you, ladies of the night! You wait all night for men, so why can't you wait a few more minutes?" She said this in the presence of all the other patients, and I felt humiliated. She then left and had a long talk with three other nurses, and I could see them looking in my direction.

Eventually, I was called in to see the doctor. Before I went into his room, the nurse had been talking to him, so I suspected she had told him that I was a sex worker. The doctor gave me a funny look and asked, "What is your problem?" I explained that I had sores and a burning sensation in my vagina. He said, "I don't know why we are wasting our time on you. You are just a virus collector. You deserve to get this infection because of your disgusting behavior. It's your own fault sleeping with all these men." Then he told me to take off my dress. I did so, and he looked at my sexual parts from a long distance away.

He then began to ask me a lot of questions about my sex life: "How often do you have sex? What kind of sex do you enjoy the most? Can I see you some time?" I told him I just wanted to be tested and treated, not asked about my sex life. He responded that the clinic only did testing for normal women, not sex workers!

As soon as he left, I put my dress on and left the clinic. It was humiliating! I will never go back to that clinic again. I went to the clinic with a medical problem to get help from the doctor, but I didn't receive any treatment. All I got were bad words and blame!

Discuss and answer the following questions with your group members:

- What forms of stigma appear in this case study?
- What effects could the stigma have on the client?

Participant Handout: Case Study 3

Victor is a 40-year-old man. One day, he started to have rashes and diarrhea, which did not respond well to any treatment. The health staff bullied him into taking an HIV test and he was diagnosed as HIV-positive. He was admitted to the health facility and while he was there, his health got worse. He stayed in the health facility for 4 days without receiving any treatment. During the ward rounds, he complained to the doctor, but the nurses told the doctor to pay him no attention, saying that he was confused, and the doctor did not bother to examine him. Victor's condition became so bad that he could no longer get himself to the toilet and started to soil his bed. The nurses would not give him a bed pan no matter how often he requested one, and they scolded him for spoiling the bed. Finally, he asked to be discharged so that he could go home and die peacefully.

Discuss and answer the following questions with your group members:

- What forms of stigma appear in this case study?
- What effects could the stigma have on the client?

Participant Handout: Case Study 4

Terry is an 18-year-old boy. Since graduating from high school, he has been dating his boyfriend David, who is 20 years old. All through high school, Terry was teased and called names like “batty boy.” Terry has not come out to his family because of the shame he thinks they will feel because he is gay. His other gay friends told him that there is a clinic near his house. They caution him that the clinic is new and they are not sure how the staff will act toward him, but think it will be convenient. Terry went to the clinic to get free condoms. As soon as he arrived, he noticed the whispering from the staff. One nurse asked him why he needed condoms, and told him he was too young to be having sex! Terry was so shocked by the experience that he never returned to the clinic.

Discuss and answer the following questions with your group members:

- What forms of stigma appear in this case study?
- What effects could the stigma have on the client?

Participant Handout: Stigma Against Key Populations in Health Facilities—Forms, Effects, Causes, and Solutions

Forms of Stigma

- Clients are kept waiting a long time, while other clients are treated first.
- Unfriendly looks. Gossip. Name-calling. Blaming clients for "immoral behavior."
- Some health workers refuse to treat the clients or refer them to other staff.
- Break confidentiality, for example, reveal the status of HIV-positive clients or the identity of key populations to other health staff and clients, without the person's consent.
- Use gloves and masks for routine tasks that don't involve the handling of bodily fluids.
- Force clients to be tested without their consent and without adequate counseling, and don't provide the results of the HIV test to the client.
- Give rushed instructions and don't allow the clients to ask questions.

Effects of Stigma

- Feel isolated, humiliated, and demoralized; lose self-esteem.
- Stop going to the health facility and look for other, less stigmatizing health facilities (e.g., private doctors who provide more confidentiality) or do self-treatment.
- Clients who are HIV-positive may hide or stop their use of medication.
- May not access information and services needed for HIV prevention and treatment.
- Undermines self-esteem. As a result, they may take more risks in their sexual behavior (e.g., not using condoms).
- May force key populations to hide their sexual orientation, sex work, or drug use. As a result, they may have sex or use drugs in hidden places where it is difficult to obtain protection (e.g., condoms or clean needles) or negotiate for safer sex.

Causes of Stigma

- Some health workers may not be aware they are stigmatizing
- Judgmental attitudes based on culture or religion
- Fear and lack of accurate information (e.g., misinformation about HIV transmission)

What can we do to challenge stigma in health facilities?

- Ensure that all clients receive the same standard of quality care. Quality assurance/quality improvement approaches can be useful in ensuring high quality of care for all clients, including key populations.
- Provide a friendly, welcoming environment—friendly face, body language, and voices.
- Train health workers on the rights of people living with HIV and other key populations to equal care and confidentiality.
- Train health workers how to counsel key populations, i.e., not judgmental, neutral or supportive language, and appropriate body language.
- Speak up and challenge health workers who are stigmatizing in a polite but firm way.
- Use positive reinforcement to recognize health workers who provide high quality, nonstigmatizing care to key populations.

Session 25: Writing a Code of Conduct for a Stigma- and Discrimination-Free Health Facility

Learning Objectives

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

- Formulate strategies or guidelines for creating a stigma-free health facility environment

> **Facilitator note:** This session should only be facilitated after participants have completed the session on "Identifying Stigma and Discrimination Toward Key Populations in the Health Facility."

Time

45 minutes

Materials Needed

- Chairs organized in a semicircle
- Flipchart paper
- Flipchart stand
- Markers
- Masking tape
- Flipchart listing the major forms of stigma in health facilities and their effects on key populations (from the session on "Identifying Stigma and Discrimination Toward Key Populations in the Health Facility")
- **Participant Handout: Tips for a Stigma-Free Health Facility**

Advance Preparation

1. Post the flipchart listing the major forms of stigma in health facilities and their effects on key populations on a wall
2. Print enough copies of **Participant Handout: Tips for a Stigma-Free Health Facility** for each participant

Steps

Introduction (1 minute)

1. Explain that the purpose of this activity is to develop example guidelines for facility staff to follow to foster environments free from stigma and discrimination. Explain that such an environment helps ensure that all patients, regardless of their sexual or gender identities, receive respectful care.

Finding Solutions to Stigma at the Facility Level (42 minutes)

1. When participants are seated, draw their attention to the flipchart showing the major forms of stigma in health facilities and the related effects on key populations. Briefly review the list with participants.
2. Next, put participants into small groups of three to five people. Once everyone is in a group, explain that each group will spend time formulating a list of actions/strategies to counteract the major forms of stigma that occur at the facility level. You may remind groups that they began to explore this concept during the previous session, "Identifying Stigma and Discrimination Toward Key Populations in the Health Facility." Explain that the groups will have 15 minutes to complete the assignment. Next, distribute flipchart paper and markers to each group.
3. After 15 minutes, call time and ask each group to post their strategy lists on a wall in the room. After the groups have posted their lists, ask participants to stand and move toward the wall to review the lists individually.
4. After 5 minutes, ask participants to return to their seats.
5. Next, distribute **Participant Handout: Tips for a Stigma-Free Health Facility** and facilitate a group discussion using the following questions, emphasizing any points on the handout that did not appear on the participants' lists:
    - Does your facility already follow some of these guidelines? How so?
    - Which of these guidelines are not already being followed? Why do you think that is the case?
    - How can you work to implement all of these guidelines at your facility?
    - How might you involve community members and other stakeholders outside the facility in this effort?
    - What are the benefits of implementing these guidelines? For staff? For clients?
    - What would you do if you observed stigmatizing behaviors at your facility by colleagues, clients, or family members?

Closing (2 minutes)

1. End the session by emphasizing the following points:
    - All health workers have a job that involves helping people. They should not treat men who have sex with men, sex workers, or any other key population differently from any other client.
    - When health workers become more comfortable with key populations and the issues they face, they will be able to provide better service.
    - When key populations become more comfortable talking about their concerns and issues with health workers and other service providers, they will seek help more often, which will improve their own health and therefore the overall public health.
    - Staying silent helps no one. Key populations and service providers must work together to find realistic solutions to problems facing the lesbian, gay, bisexual, transgender, intersex (LGBTI) and sex worker community.
    - Tolerating discriminatory behaviors and not holding people accountable for doing their jobs and treating people equally tears the fabric of the community.
    - Finding ways to provide better services to key population clients is in the best interest of the entire community.

Acknowledgments

Health Policy Project. 2013. *Understanding and Challenging HIV and Key Population Stigma and Discrimination: Caribbean Facilitator's Guide*. Washington, DC: Futures Group, Health Policy Project. https://www.healthpolicyproject.com/pubs/134_CaribbeanFacilitatorsGuideFINAL.pdf.

Participant Handout: Tips for a Stigma-Free Health Facility

Tips for Providing Nondiscriminatory Services to Key Population Clients

- Use respectful body language and empathy to create trust and help the client to feel safe to speak freely. Remember, it takes a lot of courage for clients to be open with you about their situation.
- Emphasize that you will handle the client's information confidentially.
- Let the client talk first and listen attentively. Lean forward and show with your body language that you are listening to what the client is saying.
- Do not probe into the client's sexual activities. Do not ask whether the individual has sex with men or women. Wait until the client is comfortable enough to raise this subject independently. It may take several visits before this occurs.
- To avoid talking about the client directly, make up a "typical" client and discuss how that person could practice safer sex.
- Be aware of your own personal feelings and avoid judging or condemning the client's sexual behavior in words or body language.
- If you do not know that the client is lesbian, gay, bisexual, transgender, intersex (LGBTI) or a sex worker, do not make assumptions about the individual's relationships or sexual behavior and activities.
- You cannot always tell whether someone is LGBTI—and clients will not necessarily be open to you. So, do not assume that a client's partner is the same sex. Instead of referring to the partner as wife/husband, girlfriend/boyfriend, or him/her, use the word "partner."
- Avoid using words like "normal" to describe sex between a man and a woman and "abnormal" to describe sexual activity between the same sex.
- Help clients who reveal that they are LGBTI or sex workers to become aware of the rights afforded these key populations. If appropriate, refer these clients to a local support group.

Participant Handout: Tips for a Stigma-Free Health Facility

Example of a Code of Conduct for a Stigma-Free Health Facility

- Treat all clients with equality, respect, dignity, and privacy.
- Ensure that all clients receive the same high-quality medical care without discrimination, regardless of their HIV status, sexual orientation, gender, employment, or other characteristics.
- Ensure that care for clients is never denied, delayed, or referred elsewhere, and that all clients receive the same quality care.
- Treat clients' medical information as confidential.
- Ensure that all clients receive the necessary information with which to make informed choices regarding their health care and are able to give their informed consent to the services provided to them.
- Respect clients' rights to express their views and be actively involved in their own health care.
- Provide avenues for the effective receipt and resolution of clients' complaints regarding stigma and discrimination.

Module 6

Gender-Sensitive and Rights-Based Care

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Session 26: Value Judgments

Learning Objectives

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

- Explain how their personal values may impact their counseling sessions with clients
- Describe how comfort with discussing sex and sexuality issues is expressed in body language

Time

1 hour 15 minutes

Materials Needed

- Chairs organized in a semicircle
- Flipchart paper
- Flipchart stand
- Markers
- Scissors
- **Participant Handout: Client Profiles**

Advance Preparation

1. Print one copy of **Participant Handout: Client Profiles** and cut out each profile.

Steps

Introduction (1 minute)

1. Begin by stating that this session focuses on how providers' personal values and attitudes can affect the quality of their care. Health workers must have the skills to counsel all clients and must be willing to ensure equal access to these services for all. Explain that this exercise is an opportunity for participants to reflect on their personal values.

Values (17 minutes)

1. Ask participants to describe what the word "value" means to them. After participants have provided a few ideas, ask them how people's values are formed.
2. Next, paraphrase the following explanation:
    - **Values** are what we consider important or of great worth (e.g., health, respecting others, achieving goals). Values can serve as guidelines to help us make decisions about life choices and individual behaviors. As a general rule, when we act in accordance with our values, we feel good about ourselves and about our actions. Our values are based on what we want or desire out of life. Values can be shaped based on our personal experiences or on how we interpret other people's experiences. Although our values can change over time, we often feel as if our values are ingrained in our being.

3. Ask participants, “What is a ‘value judgment’?”
4. Summarize that a **value judgment** is deciding about the rightness or wrongness of someone or something based on a particular set of beliefs. People tend to use words like “ought” or “should” when they make a value judgment about someone else. For example, “She should not dress that way.” Body language and voice tone may also express certain judgments, for example, raising or lowering your voice, rolling your eyes, or glancing away.

Dealing with Personal Values During Counseling (25 minutes)

1. Facilitate a 5-minute brainstorm around the following question:
   - What situations might feel less comfortable to deal with as providers? (Give an example if needed, such as a man talking about being intimate with another man or a woman disclosing infidelity.)
2. As participants call out ideas, write them on a blank flipchart page.
3. Next, divide participants into groups of three. Once the groups have been created, explain that participants will perform counseling role-plays. State that in each group, each member will take on the role of provider, client, or observer. State that those playing the role of client will receive a profile (which should be hidden from the person playing the provider).
4. Explain the roles of provider and observer as follows:
   - The role of the **provider** is to build rapport with the client, ensure confidentiality, and determine the client’s concerns.
   - The role of the **observer** is to note whenever the counselor’s questions or statements contain a value judgment.
5. Ask participants to decide quickly the roles each will play. Next, distribute one client profile to each participant playing the role of client.
6. Instruct the groups to find an area inside or outside the room where they can conduct their role-plays. Inform participants that they will have 5 minutes for the role-play.
7. After 5 minutes, call time and ask participants to return to their seats.
8. Facilitate a 10-minute group discussion using the following questions:
   - (to those playing the role of client) How were you treated? Did you feel you were being heard?
   - (to those playing the role of provider) How did the counseling session go?
   - (to those playing the role of observer) What happened? Did the provider make any value judgments with word, tone, or body language?

> **Facilitator note:** Emphasize that the aim of the session is not to assess counseling skills, but to help everyone become more aware of the ways in which we make judgments about clients when we are counseling.

Facilitator note: Some participants may feel uncomfortable representing characters who do not conform to dominant gender and/or sexuality norms (e.g., a gay character). Emphasize that this is only an exercise and explain that this activity is intended to explore precisely the types of feelings people may have about non-normative sexual and gender identities.

Facilitator note: Some male participants may feel uncomfortable representing a female character. You should be sensitive to discomfort expressed by male participants and, when appropriate, remind them of previous discussions about gender roles. You should also encourage the men to reflect on their reactions. If absolutely necessary, male participants who are not comfortable representing a female character may be given a male character description.

Stop/Start Counseling Practice (30 minutes)

1. Next, ask one pair to volunteer to come to the front of the room and role-play their session for the larger group.
2. Allow 2 minutes of role-play and then shout "Stop!" Ask the following questions to the large group:
   - How did it go?
   - Did the provider make any value judgments?
3. Allow 5 minutes of group discussion and then ask another volunteer to take on the role of provider and continue the role-play (with the same client).
4. Before starting this round of role-play, instruct the other participants to shout "Stop!" when/if they hear the provider make a value judgment or observe body language or tone that points to a judgmental approach. Allow up to 3 minutes of continued role-play.
5. Next, facilitate a 15-minute group discussion using the following questions. Encourage participants to share their role-play scenarios with the larger group.
   - What did we learn from the role-plays?
   - How does our body language reflect our comfort with discussing sex and sexuality issues?
   - How might our own value judgments interfere with the counseling process?
   - What can we do if we find that our personal values are affecting the service we offer to a particular client?

Facilitator note: If needed, use some of the following examples as options for providers when they feel their personal values are influencing the counseling session:

- Ask a colleague to take over.
- Discuss with a supervisor during a supervision session.
- Refer the client to a specialized service.
- Make an appointment so that you have time to research and ask for advice from other people who may have some experience.
- Be honest with the client and say that this aspect is new to you.

Closing (2 minutes)

1. End the session by making the following points:
    - We need to be aware of how our values and judgments can impact our counseling practice.
    - We need to accept and respect clients as they are, since this is one of the cornerstones of counseling.
    - Treat all clients as individuals and be open to what they need to discuss. We need to respect each client's issues and explore the context in which that individual lives to help frame good decisions.
    - All clients have a right to our counseling services and to receive the same quality of care.
    - Remember the key counseling principles: Accept everyone and be nonjudgmental.

Acknowledgments

Health Policy Project. 2013. *Understanding and Challenging HIV and Key Population Stigma and Discrimination: Caribbean Facilitator's Guide*. Washington, DC: Futures Group, Health Policy Project. https://www.healthpolicyproject.com/pubs/134_CaribbeanFacilitatorsGuideFINAL.pdf.

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Participant Handout: Client Profiles

You are a man and have been with your male partner for 2 years. Two days ago, he told you that he had fallen in love with someone else and was leaving you. He also said that you should be tested for HIV. You are feeling very sad and start crying during the counseling session.

You are a sex worker as a way of surviving, but you hate what you do and worry all the time about HIV. You are scared to tell the counselor what you do, but you want to find out if she can help you find a way to get out of sex work.

You sell sex as a way of surviving and you enjoy meeting different people and earning money. There are some sexual practices, e.g., anal sex, that you want to ask the counselor about to find out if there is a risk of HIV and get some advice, but you are not sure how the counselor will react.

You have tested positive for HIV and are feeling very angry. All you can talk about to the counselor is how it is your wife's fault and you will make sure she is "punished" when you get home.

You are a woman and have come to get information about HIV risks. Your husband has started insisting on anal sex. You feel embarrassed to ask, but you need to know how to protect yourself.

You are an 18-year-old, unmarried, and sexually active young woman. You want to find out how to protect yourself against pregnancy and sexually transmitted infections and learn about the risks of different kinds of sex. Your boyfriend is asking to have anal sex and you are unsure how to respond.

You are a prisoner and have been brought to the health facility because you are sick. You want to tell the counselor that you have been forced to have anal sex with other prisoners and find out what you can do.

You are a young man and have realized that you are more attracted to other men than to women. You want to talk to the counselor about how you feel and where to meet other gay men.

You have returned to the clinic after telling your husband that you test positive for HIV last week. Your husband has left you and the children and he is threatening to tell the whole family.

Session 27: Why I Am a Health Worker

Learning Objectives

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

- Explain the reasons why people become health workers, and how these reasons influence their relationship with clients

Time

1 hour 15 minutes

Materials Needed

- Chairs organized in a semicircle
- Flipchart paper
- Flipchart stand
- A4-sized paper (one sheet per participant)
- Pencils or pens
- Markers
- Masking tape

Advance Preparation

1. On a blank flipchart page, draw a river. Label different parts of the river with the various life milestones that led you to be in the profession you are in today. An example river diagram is available at the end of the session description.

Steps

Introduction (2 minutes)

1. Open the session by stating that many forces shape the work we do and influence how we do our work, how we feel about our work, and how we relate to our colleagues and the clients we serve. In this workshop, participants have a space to reflect on the factors in their lives that have affected their choices about the work they do.

River of Life (30 minutes)

1. Start by describing the flow of a river to the participants using the narrative below:

   > "A river winds slowly and turns, goes quickly over rocks, rushes down a waterfall, and reaches a pool where it rests for a while. All these stages of a river have a different feeling. Going down a waterfall can be a turbulent time. Winding through a flat area of land can be a boring time or a quiet, easy time. Going quickly over rocks can be a busy, interesting time or a busy, difficult time. Being in a pool can be a time of recovery or rest or sadness. A person's life can also be like this."

2. Next, explain to participants that you want them to spend some time thinking about their own lives and the various experiences that led them to become and remain health care workers. State that they will represent their lives in the form of a river. Explain that the river should begin with their birth and will include all of the important things that have happened and that led them to become health workers today. To illustrate, show participants the flipchart page you prepared with your river of life.

> **Facilitator note:** If you live in a place where a river does not have much meaning for participants, use a path of life. A path goes from one place to another, up hills, down steep slopes, under the hot sun, through shady areas, where there is water to drink or a place to rest, or where there is no water and it is hot, and so on.

3. Distribute one sheet of A4-sized paper and some pens to each participant and ask them to identify a space inside or outside of the room where they can sit quietly and draw for 15 minutes.
4. Tell participants that the group will not be looking at their individual pictures. Each person's picture belongs to that person alone.

> **Facilitator note:** As participants draw, go around the room and talk with each in turn. Do not scrutinize their drawings, but ask if they understand and are managing the exercise. Ask if they want help. If participants wish to talk privately about their river or path, give them the opportunity to do so.

5. After 15 minutes, call time and ask participants to return to their seats.
6. Next, ask participants to call out the things that influence them in their jobs. Give an example from your own river of life to help facilitate the discussion, if necessary. As participants call out ideas, list them on a blank flipchart page.

> **Facilitator note:** Reinforce the positive points about what keeps health workers in their jobs so there is a balance between positive and negative.

7. After you have completed the list, ask if there are other reasons participants think are important that are not on the list.

Group Discussion (40 minutes)

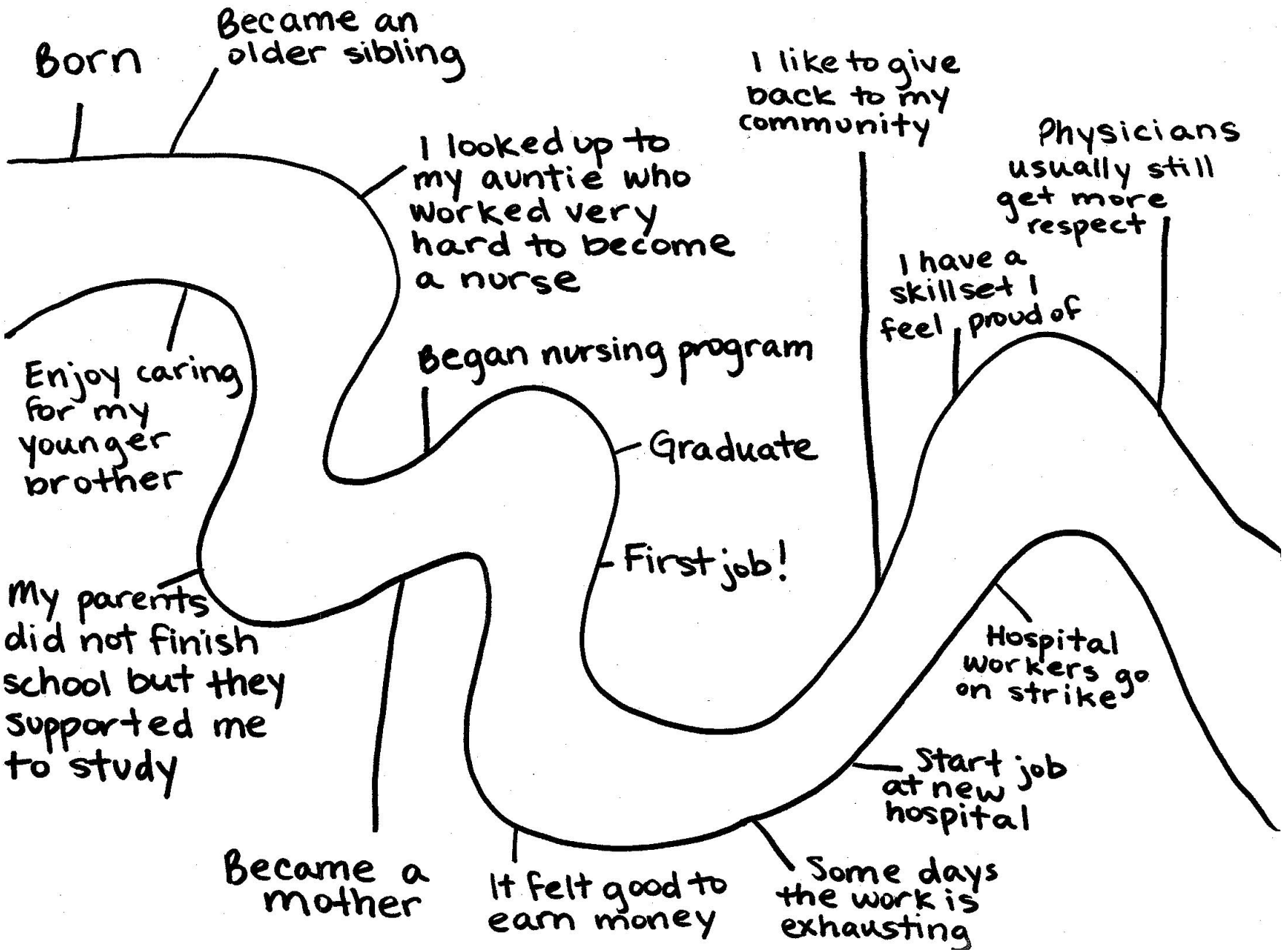
1. Next, facilitate a group discussion about how these factors may influence the way a person relates to clients. Refer to following questions.
    - How do these factors influence the way a health care worker might interact with colleagues (other health workers, supervisors, supervisees)?
    - How do these factors influence the way a health care worker might interact with clients? Female clients? Male clients?
    - How do these factors influence the way a health care worker might interact with clients if the health worker was the opposite gender?
    - For individuals working in pre-service settings: How do these factors influence the way a health worker might interact with students?

Closing (3 minutes)

1. End the session by making the following points:
    - Individuals become health workers for a variety of reasons.
    - It is important to reflect on these factors because they can influence the way health workers interact with male and female clients, colleagues, and students.
    - Summarize the main feeling that came out of the workshop. For example, you might say, "The overwhelming feeling of the workshop was that the factors that make people become health workers have a positive effect on health worker–client relations/OR have a negative effect/OR they have both positive and negative effects and it is about 50/50."

Acknowledgments

UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases. 1995. *Health Workers for Change: A Manual to Improve Quality of Care*. Geneva, Switzerland: WHO. http://apps.who.int/iris/handle/10665/63192.


Born
Became an older sibling
I looked up to my auntie who worked very hard to become a nurse
Enjoy caring for my younger brother
Began nursing program
Graduate
First job!
My parents did not finish school but they supported me to study
Became a mother
It felt good to earn money
Some days the work is exhausting
Start job at new hospital
Hospital workers go on strike
I like to give back to my community
I have a skillset I feel proud of
Physicians usually still get more respect

Session 28: Gender-Sensitive, Respectful Service Delivery

Learning Objectives

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

- Describe quality of care through a gendered lens
- Describe standards of respectful care provision
- Identify ways in which their personal perceptions of clients may influence their interactions with them

Time

2 hours 30 minutes

Materials Needed

- Chairs arranged in a semicircle
- Projector
- Laptop
- Flipchart paper
- Markers
- Masking tape
- **Participant Handout: Scenario 1**
- **Participant Handout: Scenario 2**
- **Participant Handout: Scenario 3**
- **Participant handout: Scenario 4**
- **Participant Handout: Scenario 5**
- **Participant Handout: WHO Quality of Care Framework**
- **Participant Handout: Jhpiego Gender Service Delivery Standards Facilitation Guide** (http://resources.jhpiego.org/system/files/resources/Gender-Standards-Facilitation-Guide.pdf)
- **Participant Handout: Jhpiego Gender Service Delivery Standards** (http://resources.jhpiego.org/system/files/resources/Gender-Service-Delivery-Standards-Tool.pdf)
- **Facilitator Resource: PowerPoint on Jhpiego's Global Gender Service Delivery Standards**

Advance Preparation

1. Make enough copies of **Participant Handout: WHO Quality of Care Framework** for each participant.
2. Make one copy of each of the following:
   - **Participant Handout: Scenario 1**
   - **Participant Handout: Scenario 2**
   - **Participant Handout: Scenario 3**
   - **Participant Handout: Scenario 4**
   - **Participant Handout: Scenario 5**
3. Save a copy of the PowerPoint on Jhpiego's Global Gender Service Delivery Standards to your laptop, and practice presenting.
4. Make one copy of **Facilitator Resource: PowerPoint on Jhpiego's Global Gender Service Delivery Standards**.

Steps

Introduction (1 minute)

1. Explain the increasing focus globally and by the World Health Organization (WHO) on the importance of quality and experience of care as central to reproductive, maternal, newborn, and child health. State that the WHO has indicated experience of care as an important domain of its quality of care framework. Likewise, leading agencies have indicated the importance of gender inequality as an issue for accessing quality care.

Introducing the Issue of Quality of Care from a Gender Lens (8 minutes)

1. Lead a quick 3-minute brainstorm with participants around the question: What do you consider to be the key aspects of quality of care?
2. As participants share their answers, write them on a flipchart page.

> **Facilitator note:** As participants share their ideas, make sure to probe for elements of the WHO quality of care framework.

3. Next, distribute **Participant Handout: WHO Quality of Care Framework**. After giving a general overview of the framework, draw participants' attention to the "experience of care" component. Explain that client experience of care is a core aspect of quality of care. It means providing client-centered care. Experience of care encompasses the variety of interactions clients have with the multiple components of the health delivery process (e.g., client ability to communicate needs to providers and health workers, provision of respectful care, etc.).

4. State that, through its programming, Jhpiego seeks to improve quality of care by promoting improved **experience of care** in addition to improving quality of provision of care. Given our focus on reproductive and maternal health, we need to consider experience of care from a gender perspective. There are various approaches and methods to improving experience of care. A first, important step is to engage health workers in a participatory way to understand the problem and define solutions. Understanding quality of care issues driven by gender inequality is not always so obvious because gender inequality is embedded in sociocultural practices and behaviors. A gender lens is needed to analyze why, and how, women are denied their rights to quality, respectful, and equally accessible care. State that you will begin the analysis using role plays. (Spend no more than 5 minutes on steps 3–4.)

Role-Plays (1 hour 35 minutes)

1. Divide participants into five groups. Once the groups have been created, randomly distribute one of the following to each group:
   - Participant Handout: Scenario 1
   - Participant Handout: Scenario 2
   - Participant Handout: Scenario 3
   - Participant Handout: Scenario 4
   - Participant Handout: Scenario 5
2. Next, explain that each group will have 30 minutes to read through the scenario they were given, assign each group member one of the characters in the scenario, and prepare to act out their scenario. Tell participants that their role-plays must emphasize the gendered aspects of their group's scenario (e.g., gender discrimination, gender stereotypes, gender-discriminatory laws or policies that result in exclusionary or disrespectful behaviors and/or outcomes). Tell the groups they will have 5 minutes to perform their role-play in front of the larger group. (Spend no more than 5 minutes on steps 1–2.)

Facilitator note: If some groups have more participants than the number of characters in the case study they were assigned, they may wish to create additional characters or have the extra group members serve as role play directors as the group practices.

Facilitator note: As the groups prepare, move around the room and provide support as needed.

Facilitator note: Some male participants may feel uncomfortable representing a female character. The facilitator should be sensitive to reactions of discomfort expressed by male participants and, when appropriate, remind them of any previous discussions about gender roles. The facilitator should also encourage the men to reflect on their reactions. If absolutely necessary, male participants who are uncomfortable representing a female character may be given a male character description.

Facilitator note: Some participants may feel uncomfortable representing characters who do not conform to dominant gender and/or sexuality norms (e.g., a gay character). It is important to emphasize that this is only an exercise, and explain that the activity is intended to explore precisely the types of feelings people may have about non-normative sexual and gender identities.

3. After 30 minutes, call time and reconvene participants as a group.
4. Before starting the role plays, instruct the participants in the audience to take note of the following elements during the role-play performance:
   - gender-insensitive, discriminatory and/or disrespectful attitudes and behaviors observed in the role-play
   - underlying gender norms that may contribute to the gender-discriminatory attitudes observed
5. Next, invite a first group to come to the front of the room to perform their role-play. Remind the group that they will have 5 minutes.
6. After the first group has performed its role-play, ask the workshop participants in the audience to share what they observed in terms of gender-discriminatory attitudes and behaviors and the gender norms that might have contributed to these attitudes and behaviors. As participants share their ideas, write them on a blank flipchart page. After participants from the audience have commented, ask the role players to briefly describe what they had intended to express through their role-play. (Spend no more than 3 minutes on this step.)
7. Invite another group to come to the front of the room for their role-play performance. Instruct participants in the audience to once again take note of any gender-discriminatory attitudes and behaviors, as well as gender norms contributing to these attitudes and behaviors.
8. After the second group has performed, ask the workshop participants in the audience to share what they observed in terms of gender-discriminatory attitudes and behaviors and the gender norms that might have contributed to these attitudes and behaviors. As participants share their ideas, write them on the flipchart page. After participants from the audience have commented, ask the role players to briefly describe what they had intended to express through their role-play. (Spend no more than 3 minutes on this step.)
9. Repeat steps 7–8 for the remaining three groups.

Facilitator note: During the role play debriefs, participants may point out actions related to general poor communication or lack of support, but make sure to probe for the gender norms and discrimination that lead to such behavior, for example:

- Scenario 1: Acceptance of women's suffering, gender-based violence (GBV)
- Scenario 2: Inability of midwives to challenge senior, male doctors
- Scenario 3: Homophobia and related stigma, men being able to decide on condom use with wife but not male sexual partner
- Scenario 4: Beliefs about masculinity and fertility
- Scenario 5: Gender stereotypes about girls needing to be chaste, judging the girl for being "loose"

10. Once all five groups have performed their role plays, review all of the gender-discriminatory attitudes/behaviors (and corresponding gender norms) that you listed on the flipchart page. Ask participants if they think there is anything missing and add to the list as needed. (Spend no more than 2 minutes on this step.)
11. Before moving to the next step, facilitate a 5–10 minute group discussion using the following questions:
    - Were the scenarios realistic?
    - Which forms of gender discrimination occur most often during health service delivery?

- How do your programs currently address some of the forms of gender discrimination illustrated in the role plays?

Presentation on Jhpiego's Global Standards for Gender-Sensitive Services (45 minutes)

1. Next, tell the group that Jhpiego's gender unit has developed global standards for gender-sensitive services. Jhpiego programs are expected to work with health facilities to integrate these standards into their quality improvement processes.
2. Project the PowerPoint on Jhpiego's global standards for gender-sensitive services, and use the discussion points under each slide to discuss the standards. (Spend no more than 30 minutes on this step.)
3. After you have presented, allow participants 5 minutes to ask questions and/or make comments.
4. Distribute Participant Handout: Jhpiego Gender Service Delivery Standards Facilitation Guide, and Participant Handout: Jhpiego Gender Service Delivery Standards.
5. Next, facilitate a 10-minute group discussion using the following questions:
   - Are there any standards that would be challenging for health facilities to adopt? Which ones? Why?
   - Are some standards less or more relevant to your program? Which ones? Why?
   - Are any standards missing? What other standards should be included?
   - What support would you require to advance these standards in your program?

Closing (1 minute)

1. End the activity by stating that all individuals, regardless of gender, sexual orientation, age, economic status, ethnicity, or other social identifier, have the right to quality, respectful, and accessible care. Delivery of quality care requires health systems to take into account and address gender disparities and other social inequalities.

Participant Handout: Scenario 1

You are a new midwife who arrives on duty in the hospital where you work. As you take over duty from the previous midwife, Mary, you are told that one of the women in labor, Siah, is 17 years old, gravida 1 para 0 (G1P0), full term, has reportedly been in labor for 8 hours, and was admitted to the hospital 4 hours ago. You are told that she is uncooperative and difficult to examine because she holds her legs together and cries. You observe the 17-year-old lying on a bed in the labor area with only a sheet covering her. The labor area does not have curtains between beds and you know Mary usually takes the sheet off when examining clients and has been known to force women's legs apart when she doing an exam. She usually communicates little with women in labor except to tell them to "be quiet" or "shut up."

You have asked Mary why she treats the patients so rudely. Mary looks at you with a frown and says, "This is how we are all treated, isn't it? Our husbands hit us all the time. We are all abused. It's our duty as women to suffer, especially while giving birth!"

Mary leaves and you take over the care of Siah. Fortunately, you see that you have only two women in labor at this time.

Participant Handout: Scenario 2

You are a midwife who was recently employed in the labor and delivery ward in the county hospital. You have become concerned because you hear from community members that they do not want to go to the hospital in labor because they are treated so poorly. You also observe that:

- On arrival, women are given a bed number and are referred to by that number rather than their name.
- The other midwives make fun of the women, especially those from lower socioeconomic groups.
- The women are given no privacy. There are no curtains separating beds. There are drapes on the ward but there is no attempt to drape women during examinations.
- Women are forced to stay in bed and lie on their backs during labor and birth.
- Women are frequently pushed and shoved if they attempt to sit up or turn over during the birth.
- Women are left alone when their midwife goes out for tea or lunch.

You are quite concerned about the abusive and disrespectful treatment the women receive. You try to raise the issue with your supervisor in charge, a male ob-gyn. He asks why you are worried about such trivial things when women are dying due to hemorrhage and pre-eclampsia.

Participant Handout: Scenario 3

John is 30, single, and lives with his parents. He started having sex with men when he was a teenager. He knew that being gay was natural for him, but he was worried his family would find out and make his life miserable. Other gay friends of his had been "discovered" by their parents and their lives had become hell. To avoid this, John got married.

For 1 year, John stayed with his wife without seeing other men. After 1 year, he felt he could no longer wait, so he started having sex with one of his former lovers. Even when he was with his wife, he was thinking about having sex with this man. In the marriage, he insisted on the use of condoms, but in his sexual relations with his male lover, he found it more difficult to negotiate safer sex. After 2 years of married life, John learned that one of his previous male partners had tested positive for HIV, so he started to worry about his own status. What would people think if he was HIV-positive? Would they find out that he was gay? How would he be treated?

For a while, he avoided getting tested because he was afraid he would be exposed as gay. But he was confused and worried that he might have HIV. Eventually he went to get tested, but the voluntary counseling and testing (VCT) counselor made him feel uncomfortable. She asked a lot of questions about John's sex life, and when John mentioned having had sex with men, she said, "No, you are not one of those! You seem different!" John left the VCT without taking the test and told himself he would never go back.

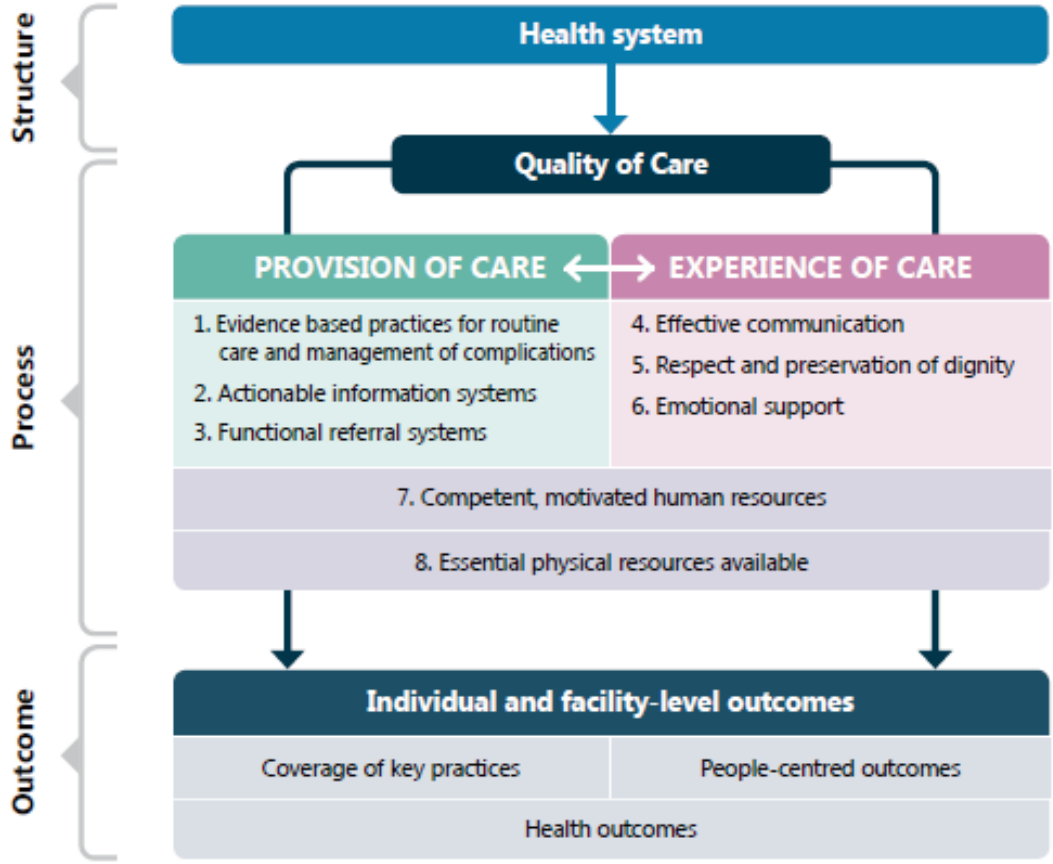
Participant Handout: Scenario 4

You are a nurse advising a couple on postpartum family planning. The couple, Michael and Jaughna, have just had their first child, and you are advising them on long-acting reversible contraceptives. Michael and Jaughna have indicated that they prefer not to have any more children. Their parents each had five children, and they do not want to shoulder the same economic or caregiving burden. Michael has heard from a friend that a vasectomy could more permanently prevent pregnancy. But you are shocked when he suggests this. After all, they just have one child. In your society, children are considered God's gift! Fathering many children is an important sign of manhood. You know that vasectomy is a contraceptive method available in some clinics, but it is not a common practice, nor do you think it should be. You continue to explain other long-acting methods even as Michael tries to ask more about vasectomy.

Participant Handout: Scenario 5

You are a nurse working in the local dispensary. Layla is a 14-year-old girl who comes to the dispensary with many questions about how to prevent pregnancy. You are surprised and not sure what to say. You tell her that she is too young to be asking such questions. She persists, albeit shyly, and eventually asks about some pills she heard that can prevent pregnancy after having sex. You realize she is talking about emergency contraception and suspect that she may have already had sex. You wonder where her mother is and what kind of mother has let her child become loose like this?!

Participant Handout: WHO Quality of Care Framework



Source

Tunçalp Ö, Were WM, MacLennan C, et al. 2015. Quality of care for pregnant women and newborns—the WHO vision. *BJOG* 122:1045–1049. http://www.who.int/maternal_child_adolescent/topics/quality-of-care/who-vision-quality-care-for-pregnant-women-and-newborns.pdf?ua=1.

Participant Handout: Jhpiego Gender Service Delivery Standards Facilitation Guide

JHPIEGO GENDER SERVICE DELIVERY STANDARDS: **FACILITATION GUIDE**

Introduction

Purpose of This Tool

This tool assesses the quality of facility's provision of gender-sensitive, respectful care. It is designed for health providers, facility managers and central, provincial/regional or district health managers who want to improve the services for which they are directly responsible. It is intended to engage providers in a participatory approach to understand their vision of high quality care, and to apply applicable standards to their country context and facility's context.

These gender standards provide an opportunity for facilities to:

1) Understand and apply the key components of respectful, gender-sensitive care,
2) Measure facilities' progress in a way that allows for comparison across facilities, districts and countries,
3) Identify performance gaps that need to be reduced or eliminated in service delivery, and
4) Create action plans for quality improvement.

The tool:

- Lists key performance standards.
    - Each performance standard has verification criteria with "YES", "NO", and "N/A" (not applicable) answer options.
    - Each verification criteria has a recommended means of verification, as described in the next section.
- Objectively establishes the desired level of performance.
- Measures actual level of performance when applied to a facility.
- Helps identify performance gaps and facility challenges.
- Provides an opportunity to recognize and reward high performing facilities to improve motivation and commitment.

Unlike the traditional format of facility guidelines or assessments, the tool uses a format that allows providers to quickly understand and assess the key elements of gender-sensitive, respectful service delivery, and to identify gaps and challenges. Facility managers and providers can then implement appropriate interventions to address any lack of knowledge and skills, an inadequate enabling environment (including infrastructure, resources and policies), and/or lack of motivation to close these gaps.

The results of the implementation of this tool can provide a baseline assessment and measurement of progress over time. Findings can be used as a mechanism to guide the quality improvement process, inform managerial decisions, and reinforce momentum for change. Measurement also makes it possible to present managers and providers with quantitative targets. Achieving and making sustained progress on these targets has an important motivating effect for those involved in the improvement process.

The tool can be used for several purposes:

- **Self-assessments**: these are conducted by a provider on his or her own work. The provider uses the performance assessment tool as a job aid to verify if s/he is following the recommended standardized steps during the provision of care. These assessments can be performed as frequently as desired or needed.
- **Internal assessments**: are implemented internally by facility staff. These can be in the form of **peer assessments** when facility staff use the assessment tool to mutually assess the work among colleagues, or **internal monitoring assessments** when managers and/or providers use the tool more comprehensively to periodically assess the services being improved every three to four months.
- **External assessments**: are implemented by persons external to the facility. These are usually conducted by central/regional/district level of ministries of health, donors, or implementing partners. They can take the form of **facilitative supervision** when the purpose of the visit is to provide support for identification of performance gaps and interventions, or **verification assessments** when the purpose of the visit is to confirm compliance with recommended standards of care, and to recognize achievements. In case of verification assessments, representatives of the clients and communities being served should be involved in the process in an appropriate way. For instance, there could be a community member on the team conducting the assessment of the facility, or the facility scores or quality improvement plans could be shared with them on a regular basis to increase accountability.
- **Integration into other standards**: The tool can be used as a stand-alone method of assessing a facility's provision of gender-sensitive, respectful care. Alternatively, relevant standards can be integrated into other standards documents and quality assurance processes.

Background on Tool Development

Over the last two decades, Jhpiego has been implementing a practical approach for performance and quality improvement, called Standards-Based Management and Recognition (SBM-R). Working with partner organizations, we have obtained very encouraging results in the achievement of standardized, high-quality health care through the use of a streamlined, step-by-step methodology, the creative management of the process of change, and the joint and active involvement of providers, clients and communities in the improvement process.

Jhpiego has developed a range of SBM-R Standards focusing on health areas including, but not limited to, family planning, antenatal care, and immediate postpartum and post-abortion family planning. In developing these standards for gender-sensitive, respectful care, Jhpiego's existing standards were reviewed, as well as gender standards for health services quality assurance developed by the Futures Group and Jhpiego under the USAID funded Afghanistan Health Services Support Project. We also conducted a literature review of international and national

guidance (listed in the Works Cited section below) on integrating and measuring gender-sensitive health service delivery through a quality of care framework. The standards were informally pilot tested in Nigeria, Rwanda, Tanzania, Ethiopia and Mozambique, and were reviewed by experts and practitioners in maternal and child health, neonatal health, gender, male engagement and family planning. This helped determine the estimated length of time to apply the tool, best means of verification, and edits to improve language, reduce repetition, and revise order and flow of the standards and criteria. They are being implemented in Mozambique, Nigeria and Tanzania.

Example of Implementation of the Standards in Tanzania

Jhpiego Tanzania has adapted and integrated the Gender Service Delivery Standards in assessments and quality improvement processes for their reproductive, maternal, newborn, child, and adolescent health (RMNCAH) and HIV key populations projects.

- The USAID Boresha Afya project led by Jhpiego integrated the standards into a formative health facility assessment to understand the gender-related facility barriers and opportunities to achieving quality RMNCAH services in five project-supported regions in the Lake and Western Zones. The verification for clients were adapted into questions to be used in an assessment with clients in the community.
- The USAID Maternal and Child Survival Program (MCSP), the USAID Boresha Afya project and the Global Affairs Canada-funded Uzazi Salama Rukwa project, integrated the Gender Service Delivery Standards across existing Continuous Quality Improvement standards for various health services (e.g., maternal health, newborn health, family planning) of the Ministry of Health, Community Development, Gender, Elderly and Children. Local teams made adaptations according to their context. For example, the criteria of 30 percent women in leadership in health facilities, was revised to at least 50 percent. The standards are implemented quarterly as part of the quality improvement processes of maternal and newborn care in hospitals, health centers, and dispensaries.
- Under the USAID-funded Sauti Project, the standards were adapted to assess the gender-sensitivity of HIV combination prevention services within the quality improvement/quality assurance (QA/QI) processes for mobile Community-Based HIV Testing and Counselling Plus

(CBHTC+) services on a quarterly basis. The standards were adapted with a focus on key populations including men who have sex with men and female sex workers. The full set of standards are assessed quarterly by Gender Program Officers under the supervision of a Gender Advisor. Four standards were adapted to be indicators for quarterly quality assurance (QA) assessments, which a clinical QA Advisor tracks. These standards were prioritized for their proximate relation to project indicators, including:

- Percent of biomedical providers trained on gender equality and rights using Sauti gender, gender-based violence (GBV) and sexuality training manual
- Percent of beneficiaries and providers interviewed who reported having ever observed or experienced an abuse at the site by anyone
- Percent of clients that receive information about all available contraceptive methods and provide informed consent for method implemented
- Percent of HIV infected beneficiaries offered partner counseling/assisted disclosure and partner HIV testing services (HTS).

Description of the Tool

The tool includes 20 standards, organized in 5 sections as follows:

Section	# Standards	# Verification Criteria	Page #
1. Availability & Accessibility of Services	9	36	1-4
2. Male Engagement and Family Inclusiveness	2	9	5
3. Provider-Client Interaction	4	17	6-7
4. Key Aspects of Cordial and Respectful Relationship (information box - not scored)			7-8
5. Health Care Policies and Facility Management	5	15	8-9
TOTAL	**20**	**77**	

Means of Verification

In each section, we list means of verification that should be used to assess whether or not each verification criterion has been achieved.

There are five means of verification which are indicated a letter C, D, I, R or S. They are defined as follows:

- **C:** Client interviews. These should be conducted in private where the provider or facility manager cannot hear the client. The client should be informed about the purpose of the questions, and assured of the confidentiality of her or his responses;
- **D:** Direct structured observation of physical facilities, administrative or clinic processes. This can include reviewing inventories of material resources (e.g., infrastructure, supplies, medications, written materials);
- **I:** Inquiry through key informant interviews with providers or facility managers. The provider and the team should ask questions and probe when necessary to determine if procedure is performed or the item exists as described in the tool. For particularly sensitive questions, the assessor can pose the question as a hypothetical. For example, for standard 9.2, (No client is asked by providers for fees outside of the approved policy, gifts, favors, bribes or sexual acts in exchange for care) the assessor could ask a question such as ""Have you ever heard of a client having to pay a bribe or exchange a sexual favor in exchange for care in this facility or district?" This allows the provider to state whether or not this practice occurs without laying blame on a particular provider, or implicating her or himself.
- **R:** Review of clinical and administrative records that pertain to the provision health services, such as: registers, job aids, guidelines, protocols and policy documents. A small selection of client charts will be reviewed for completeness of reporting and to observe what types of information are being collected on the forms (e.g., gender and age of perpetrator, type of assault, was emergency contraception provided, was post-exposure prophylaxis provided, etc.) Although personal identifiers may be visible to the assessment team when reviewing charts or GBV registers, personal identifiers or any individual client information should not be collected. This is to protect the safety and confidentiality of all clients.
- **S:** Simulation. For standards that are difficult to assess with the means of verification above, ask the provider what s/he would do in a particular situation. To assess provider-client communication, the assessor can ask the provider about what s/he would do in a hypothetical scenario, or, do a short role-play in which the assessor is a client seeking family planning, and the provider should demonstrate his or her counseling approaches.

Please note that multiple means of verification may be needed to assess some criteria. Where the assessor can choose which of the means of verification should be used to verify whether a criterion is met, there is a comma (,) between each mean listed. If multiple means of verification need to be used together, there is a plus sign (+) between each mean of verification.

For example, for verification criterion 1.5 ("There are a referral system and an up-to-date referral directory in place for clients of any gender or age"), we recommend the means of verification "I + R." This means that the assessor should interview the provider to ask if such a directory exists (using the means of verification **I** for interview) and should ALSO ask to see it (using **R** for records review).

Alternatively, to assess the criterion 2.3 (Each inpatient client has her/his own bed and is not

required to share a bed with another person or use the floor), the assessor can EITHER interview the client (**C**) or directly observe (**D**).

Prompts

Some verification criteria are difficult to ask about. For these, we have included *prompts in italic text* with suggested language to use in the tool. For phrasing the questions to ask about other verification criteria, the assessor should use his or her judgment and appropriate local language. If a response is unclear, the assessor should rephrase the question, repeat back what s/he has understood, and/or probe for further information.

Assessment Process

This tool is not meant to be used as a traditional external assessment, but rather an opportunity for providers and facility managers to learn about and establish their own vision for what high-quality care looks like in their facilities, and to set benchmarks against which to continually measure their progress on quality improvement. Towards that end, we suggest the following process:

1. Identify the Facilities and Stakeholders That Will Participate

The assessor should work with the relevant ministries, donors, communities and/or facility managers to introduce and gain shared ownership over the use of the standards, and to select facilities for use of the tool. The tool can be used for any type of facility (e.g. district hospital, health center or rural outpost), but keep in mind that facilities with fewer resources may have greater challenges in meeting all the standards.

2. Organize a Team

A key task of the assessor is to organize teams for the implementation of the improvement process. Most service delivery processes do not depend on the action of single providers, they are the result of team efforts, therefore, it is important to expand the group of committed people beyond champions. Ask the facility manager to identify a quality assurance team or an individual at the facility who will be responsible for applying the tool, filling out the Scoring Sheet, developing and implementing quality improvement action plans based on the results of the tool, conducting on-going supervision and mentorship to improve quality of services, and reporting scores to relevant stakeholders. It is desirable to work with networks of services rather than isolated services. Working in networks of similar services or facilities, which can exchange experiences and provide mutual support usually favors the achievement of positive changes.

The process emphasizes bottom-up action and client and community involvement. A key purpose of the SBM-R process is to provide local health workers and the clients and communities they serve with practical tools that empower them and increase their control on the health delivery process. Clients and communities are not seen as passive recipients of health activities but as

essential partners in the health care process. To the maximum extent possible, client and community representatives should be part of the improvement teams, plans and activities.

3. Prepare the Team

a) Orient the facility teams on the standards through a one-day or half-day workshop, going through each standard to ensure the teams understand the language, context and means of verification. We suggest beginning the workshop with a participatory, open facilitation exercise in which team members or small groups brainstorm 5-8 key elements of gender-sensitive, respectful care. It is helpful to first present or discuss specific scenarios of the treatment of patients in facilities. These can each be written on a sticky note and presented to the group. Through group discussion, the facilitator or volunteer from the audience can organize the sticky notes with key elements of gender-sensitive care into common categories on a flip chart paper.

   Participants can also conduct a role play of a client-provider interaction or counseling session that displays both positive and negative behaviors in relation to gender-sensitive, respectful care, and then allowing facility teams to discuss on what might be important key elements of gender-sensitive respectful care based on the role play. This may allow for deeper reflection of real life scenarios.

   Suggested agenda:

   - SBM-R approach overview and introduction of standards
   - Setting standards for desired performance- group exercise
   - How to conduct the assessment and the scoring process
   - Role play group exercise
   - Developing and implementing action plans, recognizing progress
   - Timeline

b) Through group discussion, the team should come to agreement on standards they would like to apply in their own facilities. They can add new standards to the tool, or use language from relevant standards in the tool to refine their own standards. The intention of this participatory exercise and inclusion of the team's standards is to promote reflection and inspire ownership around the tool and QI process.
c) Present the checklist tool to participants, explaining the rationale for each, and ask them to choose the standards that are relevant and useful for their country and facility's context. If any of the key elements brainstormed by the group earlier is missing, ask the group to write it into the format of a new standard. Participants are also welcome to revise the language of standards if necessary to better align with local terminology and policies while still keeping the principle of the standard. For example, in Tanzania, the pilot team working on the Maternal and Child Survival Project revised language to cite specific laws and policies for Tanzania in relation to age of consent and gender-based violence guidelines for the health sector.

d) Explain the Scoring Sheet and process (details below) to participants, establish a timetable for conducting the assessment, timeline for reporting facility scores to Jhpiego, and recognition/reward system for facilities that achieve measurable progress over time.

4. Adapt the Tool

Based on workshop feedback, update the tool to reflect these changes, review the tool against relevant national guidelines to ensure it is in compliance (e.g., look up the age at which a child or adolescent is legally permitted to give consent without a parent or guardian), and ensure that all participants are using the same tool to allow comparison across facilities if possible. This can be done through a workshop to orient the QA team on the tool, including providers familiar with RMNCAH service delivery, to review the tool and identify areas that need to be adapted to the local context, policies and procedures.

5. Apply the Tool

The first use of the tool should be conducted by providers *in conjunction with* Jhpiego staff (ideally the Gender Advisor, Gender Focal Point, and/or other technical staff who have been trained on gender, including the quality improvement team at Jhpiego and at the facility). This will ensure that providers understand what each the meaning and purpose of each standard, how to ask about it, and how the means of verification can be used. When conducting the visit,

a) Introduce yourself and explain the objectives of the tool, particularly that it is meant to provide assistance to the providers and not to critique their performance
b) Thank the staff for their participation, allow time for cordial introductions and for staff to tell you about their facility (e.g. when it was established, how many GBV cases they receive each month, and anything else they may like to tell you)
c) Explain that the assessment will last approximately 3 hours and includes time to conduct a tour of the facility, the interviews and records review
d) Identify the staff that typically carries out the activities or procedures for interviewing
e) The assessment tool must be used to guide the observation and interviews
f) Be objective and respectful during the assessment
g) Ask clarifying questions to individuals responsible for these areas if needed
h) Probe to get the precise information, do not assume responses
i) Feedback should not be provided during the assessment and should only be shared afterwards
j) Identify correct sources of information (e.g., administrative forms, statistical records, service records)
k) Ask the person to show documents, equipment, or materials as appropriate

After the first use of the tool, conduct a debriefing meeting with the QA team within the next day to clarify any standards that posed difficulty.

6. Score the Tool

Facilities will receive a score of either zero, 1 or N/A (not applicable) for each standard, and an overall facility score (out of a highest possible score of 20) for the level of gender-sensitive service delivery. Scores for each standard should be recorded on the tool, noting any comments or missing items. This will be used to identify the facility's gaps and challenges, set goals and create a quarterly or biannual action plan for quality improvement. Once enough facilities are using the tool, the scores can be used to introduce an element of healthy competition between facilities or districts to increase respectful care.

a) Immediately record the information collected to ensure no data are lost.

b) Mark each verification criteria individually as "YES", "NO" or "N/A" (not applicable). Mark "YES" if the procedure is performed or the item exists as it is described. Mark "NO" if the procedure is not performed, if it is performed incorrectly or if a required item does not exist. Mark "N/A" if this verification criterion is not relevant or cannot feasibly be measured.

c) Provide concise justification for any criteria marked "NO" and "N/A" by recording any gaps, issues, or missing items/elements of care in the comments column.

d) Do not leave any verification criteria blank.

e) In the comments column, write down all pertinent comments, in a concise form, highlighting relevant issues and potential causes or challenges in meeting the criteria.

f) Only if all verification criteria are met should a standard receive a score of 1. Do not give a partial score if only some of the verification criteria are met.[1] Instead, be sure to mark in the Comments section what was missing.

g) If any verification criteria are missed, a standard should receive a score of zero.

h) If a verification score is N/A, and all other verification criteria in this standard are met, this standard should still receive a score of 1 **and not zero**.

i) Add the scores for all the standards and record that number on the Scoring Form in the row "TOTAL." Also record any comments, overall strengths and challenges on the Scoring Form.

Example 1:

PERFORMANCE STANDARD	SCORE	VERIFICATION CRITERIA	MEANS OF VERIFICATION	Y	N	N/A	COMMENTS
1. The facility maintains conditions that ensure		3.1 Separate, private rooms are available for confidential client counseling with auditory and visual privacy (cannot be heard or seen	D	☒	☐	☐	

[1] No partial scores are used in order to keep the scoring process as straightforward and easy to calculate as possible.

and safeguard clients' privacy and confidentiality		from outside)					
		3.2 Women in labor and patients undergoing physical examinations have some visual privacy (curtains, screen or wall)	D, I, C	☐	☒	☐	
		3.3 The registration book is not accessible to anyone other than the providers/ facility managers	D + I	☒	☐	☐	
		3.4 Client records are kept confidential and can only be accessed by the client and her/his providers	D + I	☒	☐	☐	
		3.5 Clients of all gender identities and sexual orientations are treated equally with regard to confidentiality (nondisclosure) of health information	C, D	☒	☐	☐	

In the example above, the assessment team notes that all women in labor deliver together in one large room with no privacy, but all of the other criteria are met. **This standard would then be scored zero**.

Example 2:

PERFORMANCE STANDARD	SCORE	VERIFICATION CRITERIA	MEANS OF VERIFICATION	Y	N	N/A	COMMENTS
10. The facility provides a welcoming, male-friendly environment		10.1 Providers encourage and allow women to bring a companion of any gender with them to FP and ANC visits, labor & delivery, and HCT	D	☒	☐	☐	
		10.2 Providers encourage and allow fathers to accompany their children to clinic visits (for immunization, routine examinations, malaria treatment, etc.)	D, I, C	☒	☐	☐	
		10.3 The facility offers services to men, including vasectomy and male condoms	D + I	☒	☐	☐	
		10.4 The facility has conducted demand creation to increase male utilization of services (e.g.	D + I	☐	☐	☒	

		advertising services and conducting outreach in traditionally male-dominated physical spaces such as taxi ranks, bars, sports facilities, etc.)					

In the example above, the assessment team notes that it partners with a community-based organization that conducts demand creation in traditionally male-dominated physical spaces, and so this verification criterion is marked "N/A" for not applicable. Since all the other criteria are met, **this standard is scored with a 1**.

On the Scoring Sheet, the assessor should record the score for each standard, sum these scores, and provide a total overall score for the facility. The assessor should also copy any notes on missing items or important information onto the score sheet.

Development of Action Plans

After every assessment, the facility staff should develop operational plans in order to implement the improvement process. These plans are relatively simple tools that outline what are the gaps and the causes that need to be eliminated, the specific intervention to be conducted, the person(s) in charge, the deadline for the task, and any potential support that may be needed. The identification of the responsible person(s) and the setting of the deadline are extremely important because they allow better follow up of the activities included in the plan. Operational plans should be developed upon analysis of the results of the baseline or follow-up monitoring assessments by teams of facility providers/managers working in the different areas of service provision being improved. The plans should be shared with relevant stakeholders, partners and donors to document progress.

It is important to understand that the process is usually initiated by a small group of committed persons because it is very infrequent to find widespread support for a new improvement initiative. It is, therefore, key to identify committed champions for the initiative and incorporate them in the initial improvement efforts. Providers are encouraged to focus on action and begin with simple interventions (the "low hanging fruit") in order to achieve early results, create momentum for change, and gradually acquire change management skills to address more complex gaps.

Sample Template for Action Plan

Gap/Challenge	Intervention/Action	Person Responsible	Support	Deadline

How Often To Use the Tool

After the first visit with the Jhpiego assessor's assistance, subsequent quarterly or biannual uses should be conducted by a provider(s) or facility manager(s) responsible for quality improvement. Ideally, it will be the same person each time, and s/he will also be responsible for documenting and sharing facility scores with Jhpiego and relevant ministries/donors. This person should compile and analyze facility scores to present to relevant ministries, partners, communities or donors to show which facilities are succeeding, which need greater support, and any trends in key areas of quality improvement across districts or regions. For example, the facility may score low on provider-client communication, indicating that further training is needed in this area.

The Jhpiego assessor should conduct one assessment in partnership with the facility team each subsequent year to ensure consistency in applying the tool and scoring process described above.

How to Track Performance

The scores and action plans should be shared with relevant stakeholders such as district, state and national ministries of health, facility managers, and providers. Key results from implementation of the action plans, gaps and challenges addressed, etc. can also be summarized and shared with clients and communities.

How to Recognize and Reward High Performance

Facilities showing the greatest improvement should be recognized for their achievements by Jhpiego, the MOH or other stakeholders. This could include simple steps such as sharing feedback and praise via email or a phone call. For significant successes, recognition could include a formal letter, presenting providers with a certificate of recognition, a visit to the facility with a key government or MOH official, and/or a brief article in local news media.

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Glossary of Terms

- **First-line support** is the immediate care a GBV survivor should receive upon first contact with the health or criminal justice system. The WHO defines "first-line support" using the acronym **"LIVES"**: **L**istening, **I**nquiring, **V**alidating, **E**nsuring safety, and **S**upport through referrals.
- **Gender** refers to the economic, social, political, and cultural attributes and opportunities associated with being women and men. The social definitions of what it means to be a woman or a man vary among cultures and change over time. Gender is a sociocultural expression of particular characteristics and roles that are associated with certain groups of people with reference to their sex and sexuality.
- **Gender-based violence (GBV)** is any form of violence against an individual based on that person's biological sex, gender identity or expression, or perceived adherence to socially-defined expectations of what it means to be a man or woman, boy or girl. The most common forms are sexual assault, intimate partner violence and child abuse, but GBV also includes physical and psychological abuse, threats, coercion, arbitrary deprivation of liberty, and economic deprivation, whether occurring in public or private life. GBV is rooted in gender-related power differences, including social, economic and political inequalities. It is characterized by the use and abuse of physical, emotional, or financial power and control. GBV takes on many forms and can occur across childhood, adolescence, reproductive years, and old age.
- **Gender Identity** refers to a person's internal, deeply felt sense of being a man or woman, or something other or in between, which may or may not correspond with the sex assigned at birth. Because gender identity is internal and personally defined, it is not visible to others.
- **Provider** refers in this tool to health care workers in general, and can include any type or level (physician, nurse, social worker, police officer, midwife, psychologist, et al.) This is because the number and type of providers who deliver services will differ across countries and even across facilities.
- **Sex** refers to the biological differences between males and females. Sex differences are concerned with males' and females' physiology.
- **Transgender** refers collectively to people who challenge strict gender norms by behaving as effeminate men or masculine women, adapting "third gender" roles, or embarking on hormonal and surgical treatment to adjust their bodies to the form of the desired sex. Transgender persons often find that the sex assigned to them at birth does not correspond with the innate sense of gender identity they experience in life. Transgender may include **transsexuals** (people whose physical sex conflicts with their gender identity as a man or a woman); **transvestites** (people who cross-dress for sexual gratification but do not wish to be a person of the other sex); and **intersex persons** (people whose sexual anatomy is neither exclusively male nor exclusively female).

Participant Handout: Jhpiego Gender Service Delivery Standards

JHPIEGO GENDER SERVICE DELIVERY STANDARDS

Name of Facility _____

Name of Person Completing This Tool _____

Title of Person Completing This Tool _____

Date _____

Please read the Facilitation Guide for instructions on how to use this tool, available at www.jhpiego.org/gender

PERFORMANCE STANDARD	SCORE	VERIFICATION CRITERIA	MEANS OF VERIFICATION[1]	YES	NO	N/A[2]	COMMENTS
Availability & Accessibility of Services							
1. Services are equally accessible to women, men, adolescent girls and adolescent boys, and other gender identities[3]		1.1. Facility offers emergency services 24 hours a day, including services for obstetric complications, physical trauma, and essential post-GBV care (emergency contraceptives, HIV post-exposure prophylaxis, and first-line support[4]) *Prompt: During what hours are emergency services available? Are the following services available during these hours: post-GBV care including EC, PEP, and GBV first-line support?*	C + I	☐	☐	☐	
		1.2 Facilities offer some evening/weekend hours for routine services for clients (e.g. working mothers/fathers) who cannot attend during typical business hours	C + I	☐	☐	☐	
		1.3 Providers give all clients the full range of information and services they need, regardless of age, marital status, gender identity or socioeconomic status *Prompt: For example, would a married adult woman seeking family planning services receive the same information and services as an unmarried adolescent?*	C, D, S	☐	☐	☐	

[1] Means of Verification are coded in the following format: **C:** interviews with clients; **D:** Direct observation of clinical procedures and physical facilities; **I:** interviews with providers and facility managers; **R:** review of clinical and administrative records, policies and protocols; and **S:** Simulation or role play to demonstrate the interaction or communication. **Choose as appropriate.**

[2] N/A=Not Applicable. If N/A is checked, this verification criterion does not factor into the overall score for the standard. (e.g. if the facility gets an N/A for one verification criteria but meets all the others, this standard should still receive an overall score of 1)

[3] Other gender identities can include: transgender people (people's whose personal gender identity does not correspond with their biological sex), intersex people (people born with both male and female genitalia), agender people (those who do not identify with any gender), et al.

[4] First-line support for GBV includes basic empathetic counseling, documenting violence, conducting safety planning and providing referrals. For more information, please see Jhpiego's GBV Quality Assurance Standards, available at www.jhpiego.org/gender

		1.4 Facility ensures all patients have equal access to care, regardless of sex, gender identity, sexual orientation, marital status, age, disability, race, religion, ethnicity, etc. *Prompt: Have you ever heard of any patient being turned away from the facility due to the ethnic group they were from, because they were unmarried, because they were gay, or for any other reason?*	C, D + I	☐	☐	☐	
		1.5 Facility has a referral system and an up-to-date referral directory in place for clients of any gender or age	I + R	☐	☐	☐	
2. Facilities' infrastructure accommodates needs of all clients		2.1 Location of health services is accessible to clients of any gender and age *Prompt: How long does it take for clients to travel to the health facility? What means of transportation are available and affordable?*	C	☐	☐	☐	
		2.2 Facility has clean restrooms available for clients of any gender with a functioning toilet, water, soap, towels, and privacy	D	☐	☐	☐	
		2.3 Facilities offer each inpatient client her/his own bed and no client is required to share a bed with another person or use the floor	C, D	☐	☐	☐	
3. The facility maintains conditions that ensure and safeguard clients' privacy and confidentiality		3.1 Facility has separate, private rooms available for confidential client counseling with auditory and visual privacy (cannot be heard or seen from outside)	D	☐	☐	☐	
		3.2 Facility offers some privacy (curtains, screen or wall) to women in labor and patients undergoing physical examinations	D, I, C	☐	☐	☐	
		3.3 Facility ensures the registration book is not accessible to anyone other than the providers/ facility managers *Prompt: Who has access to this registration book?*	D + I	☐	☐	☐	

		3.4 Facility keeps client records confidential and can they only be accessed by the client and her/his providers	D + I	☐	☐	☐	
		3.5 Providers treat clients of all gender identities and sexual orientations equally with regard to confidentiality (nondisclosure) of health information	C, D	☐	☐	☐	
4. Clients' agency, autonomy and well-being are respected regardless of gender		4.1 Except for clients who are dependents or minors,[5] providers do not require a client's spouse, partner or family member to give consent for any services *Prompt: Are there any services that a client needs her spouse's consent to receive?*	C, D, I + S	☐	☐	☐	
		4.2 Providers give female clients about their health directly (e.g. provider does not give information to male spouse, partner or guardian *instead* of to the woman herself) *Prompt: Have you ever seen a provider who gives information about a woman's health to her male partner instead of to her directly?*	C, D, I + S	☐	☐	☐	
		4.3 Facility providers care to all individuals according to the facility's triage system or on a first-come, first-serve basis, regardless of whether the client is accompanied by a spouse, partner or family member *Prompt: How does this facility decide whom to see first? Should a woman who is accompanied by her spouse allowed to skip the line?*	C, D + I	☐	☐	☐	
		4.4 Facility prioritizes patients for care based on urgency of the medical condition, regardless of gender *Prompt: Have you ever heard of a man being seen first, even if a woman is waiting with an equally serious need for care?*	C, D + I	☐	☐	☐	

[5] Each country defines "minor", "child" and "dependent" differently. **Provider should follow national law**, or if none exists, minors can be considered children under the age of 12. "Dependents" refers to children or persons who are under the care of a legal guardian who is legally authorized to give consent on the client's behalf (e.g. a mentally or physically-impaired client who cannot voice consent, or a child who is too young to understand a procedure or its implications).

5. Clients have access to— and receive information about— all available contraceptive methods		5.1 Provider explains the different contraceptive methods available, checks that the client has understood, asks if s/he has a method in mind, and lets the client's needs guide the consultation	C, D, S	☐	☐	☐	
		5.2 Providers are knowledgeable and communicate clearly about services and contraceptive methods available at the facility	C, D, S	☐	☐	☐	
		5.3 Providers allow clients of any gender and age to voluntarily choose any available and appropriate family planning method, including permanent methods such as sterilization, regardless of the number of times a woman has been pregnant or given birth, or client's marital status *Prompt: If a woman requests permanent sterilization, would her marital status or the number of children she already has affect whether or not you fulfil her request?*	C, D, S	☐	☐	☐	
		5.4 Providers respect client's choice of method if available. (If **NOT** available, provider offers an alternate, medically appropriate method, or a referral to a facility that offers client's preferred method)	C, D, S	☐	☐	☐	
		5.5 If a client declines to use a method, provider respects her/his choice and further care is not denied *Prompt: What would you do if a client refuses the method you suggest?*	C, D, S	☐	☐	☐	
		5.6 Unless required by national law, providers do not require any client (except minors or dependents) to seek their spouse, partner or family member's consent to undergo voluntary sterilization[6] *Prompt: Can a woman undergo voluntary sterilization without her spouse's consent?*	C, D, I + S	☐	☐	☐	

[6] Unless required by national law. If the facility is in a country where national law requires spousal consent, check the "N/A" box for "not applicable."

		5.7 Providers never sterilize any client without her or his informed consent	C, D + I	☐	☐	☐	
		5.8 Facility ensures contraceptive commodities, supplies and equipment covering a range of methods, including long acting and emergency contraception, are integrated within the essential medicine supply chain to increase continuous availability	D + R	☐	☐	☐	
6. Clients have access to emergency contraception (EC) regardless of their circumstance, gender or age		6.1 When medically indicated, provider offers any client (or their guardian in the cases of minors and dependents) EC regardless of age, marital status, **AND** without another person's consent *Prompt: if a woman has been sexually assaulted, does she need anyone's consent to obtain emergency contraceptives?*	C, D + I	☐	☐	☐	
		6.2 If client requests EC and it is medically indicated, provider identifies whether the client has been exposed to unprotected sexual intercourse within the last 5 days (120 hours), and if yes, provider offers EC	I + S	☐	☐	☐	
		6.3 Provider asks questions and records responses related to sexual behavior and need for EC in a professional and non-judgmental manner *Prompt: How would you ask the client about why she needs EC and what happened? What would you say if she told you she was drinking and out alone at night?*	C, D, I, S	☐	☐	☐	
7. Clients can choose the gender of their provider		7.1 Facility ensures female and male providers are available at the health facility for clients who prefer a particular gender	C, D + I	☐	☐	☐	
		7.2 Providers inform clients that they can choose the gender of their provider if available	C, D	☐	☐	☐	
		7.3 Facility honors client's preference on the gender of their provider	C, D + I	☐	☐	☐	

8. There are information, education & communication (IEC) materials accessible to clients of all genders		8.1 Facility ensures materials (e.g. posters) are available in high-traffic locations in the facility such as waiting rooms, in the local language(s), and accessible to a low-literacy audience so that clients of any gender can see and understand them	D	☐	☐	☐	
9. No client is denied care because s/he cannot pay fees		9.1 Providers never detain any client due to inability to pay fees	C, D + I	☐	☐	☐	
		9.2 Providers never ask any clients for fees outside of the approved policy, gifts, favors, bribes or sexual acts in exchange for care *Prompt: Have you ever heard of a client being asked to pay a bribe or exchange a sexual favour to receive care, or better quality care?*	C + I	☐	☐	☐	

PERFORMANCE STANDARD	SCORE	VERIFICATIONCRITERIA	MEANS OF VERIFICATION	YES	NO	N/A	COMMENTS
Male Engagement & Family Inclusiveness							
10. The facility provides a welcoming, male and family-friendly		10.1 Providers encourage and allow women to bring a companion of any gender with them to FP, ANC, labor & delivery, HCT	C, D + I	☐	☐	☐	
		10.2 Providers encourage and allow fathers to accompany their children to clinic visits (for immunization, routine examinations, malaria treatment, etc.)	C, D + I	☐	☐	☐	

environment and services		10.3 Facility offers services to men, including vasectomy and male condoms	D + I	☐	☐	☐	
		10.4 Facility conducts demand creation to increase male utilization of services (e.g. advertising services through outreach in traditionally male-dominated physical spaces such as taxi ranks, bars, sports facilities, etc.)	I	☐	☐	☐	
11. Provider offers couples/partner counselling on communication and joint-decision making		11.1 Providers have been specially trained to counsel couples on ANC, Family Planning, PMTCT and HCT, couples communication, joint decision-making on FP and birth planning	I	☐	☐	☐	
		11.2 Facility offers sexual and reproductive health counseling to couples/partners, including skills building on couples'/partners' communication and negotiation	C, D + I	☐	☐	☐	
		11.3 Provider asks client if s/he would like to have a companion present **AND** only invites a companion to be present if the client gives permission	C, D, I, S	☐	☐	☐	
		11.4 Providers educate and engage male partners who may influence health-decision making in the relationship and family, on the importance of supporting female partners to seek care, and seeking care for children	C, D, I, S	☐	☐	☐	
		11.5 Provider emphasizes the importance of *shared* decision-making and emphasizes s/he is not asking men to take control	C, D, I, S	☐	☐	☐	

PERFORMANCE STANDARD	SCORE	VERIFICATION CRITERIA	MEANS OF VERIFICATION	YES	NO	N/A	COMMENTS
Provider-Client Interaction							
12. The provider establishes a cordial and respectful relationship with the client and their companion (if present) **(DETAILS IN THE BOX BELOW)**		12.1 Provider treats the client and her/his companion (if present) respectfully **(DETAILS IN THE BOX BELOW)** *Prompt: Can you name a few key approaches you use to treat a client respectfully, how you communicate with him or her, and ensure how you ensure privacy?*	C, D, S	☐	☐	☐	
		12.2 Provider uses empathetic interpersonal communication skills during the entire visit	C, D, S	☐	☐	☐	
		12.3 Provider assures client of confidentiality	C, D, S	☐	☐	☐	
		12.4 Provider ensures necessary privacy during the visit	C, D, S	☐	☐	☐	
		12.5 Provider explains to the client and companion what s/he is going to do and encourages her/him to ask questions	C, D, S	☐	☐	☐	
		12.6 Provider displays non-stigmatizing, non-judgmental attitude to all clients, including unmarried clients/ adolescents seeking reproductive health services *Prompt: What would you say to an unmarried 15 year-old girl seeking condoms?*	C, D, S	☐	☐	☐	
		12.7 Provider does not leave a client unattended or alone when s/he needs care *Prompt: Have you ever seen or heard of a client in need of care who was left unattended?*	C, D, S	☐	☐	☐	

		12.8 Providers never physically, sexually, verbally or emotionally abuses any client *Prompt: Have you ever heard of a client who was physically, sexually, verbally or emotionally abused by a provider at this facility?*	C, D, S	☐	☐	☐	
13. Provider gives appropriate emotional support for post-abortion care, and post-abortion family planning		13.1 Provider shows compassion and addresses any feelings of denial, guilt, shame, anxiety, fear, depression and loss *Prompt: How would you counsel a woman who has come in for post-abortion care?*	C, D, S	☐	☐	☐	
		13.2 Provider treats post-abortion client in a non-judgmental, respectful and professional manner	C, D, S	☐	☐	☐	
		13.3 If/when client is ready, provider gives information on post-abortion contraceptive options, including long-acting methods and emergency contraception	C, D, S	☐	☐	☐	
14. Providers take into account gender barriers that impact health-seeking and utilization of services		14.1 During ANC, provider asks female clients if they can make the decision about whether to deliver in a facility, and if not, encourages her to bring the decision-maker to her next appointment for counseling *Prompt: Do you ask female clients if they can decide on their own where they will deliver? If they say they cannot, do you encourage them to bring the decision-maker, for example their spouse, for counseling?*	C, D, S	☐	☐	☐	
		14.2 During contraceptive counseling, provider asks female clients if they are able to decide for themselves whether or not to use FP, and if not, encourages her to bring her partner to her next appointment for counseling	C, D, S	☐	☐	☐	

		14.3 Provider asks if she would be at risk of GBV if her partner participates in FP. [If **YES**, the provider offers GBV counseling and care according to national guidelines or Jhpiego GBV Quality Assurance Standards.[7] If **NO,** trained provider is available, a referral is made to nearby GBV services.]	C, D, S	☐	☐	☐	
		14.4 During antiretroviral therapy counseling, provider asks if there are any reasons that would prevent the client from taking HIV medication on schedule or for returning for follow up, including influence from spouse, family or others	C, D, S	☐	☐	☐	
15. Providers address myths or beliefs that impact health-seeking and utilization of services		15.1 During ANC or FP counseling, providers ask clients and their companions if they hold any beliefs that would prevent them from using FP, attending ANC, using a male or female condom, breastfeeding, delivering in a facility, seeking an HIV test, or STI treatment	C, D, S	☐	☐	☐	
		15.2 Providers dispel false beliefs or myths held by clients or companions around the provision of care using scientific facts. (For example, some clients falsely believe contraception and abortion affect the ability to conceive in the future)	C, D, S	☐	☐	☐	

[7] The Jhpiego GBV Quality Assurance Standards are a comprehensive checklist that outlines essential components of high quality post-GBV care. Available at www.Jhpiego.org/gender

Key aspects of a respectful relationship (DETAILS OF STANDARD 15- THIS SECTION IS NOT SCORED)		
Treating the client respectfully • Greet the client cordially (and companion if present) • Introduce him/herself • Call client by his/her name or appropriate title • Show concern and respect client's culture, beliefs and ideas • Displays a non-judgmental attitude and avoids judgmental terms, instead using specific, appropriate clinical and counselling terms	**Interpersonal communication skills** • Encourages client to ask questions and answers them • Listens to client • Maintains eye contact • Uses language and terminology that client understands • Speaks in the language of the client, or offers a translator • Uses open and friendly non-verbal communication expressions (smiling, facing client directly, etc.) • Uses visual-aids during counseling • Allows client to repeat the information to verify comprehension • Checks if the client has understood • Summarizes salient (important) points when necessary • Explains to the client what to expect during the clinic visit • Gives information on return visits and invites client to come back any time for any reason • Facility shows concern for clients who have missed appointments and attempts to follow up, as possible • Providers speak up against disrespectful conduct among other providers such as insults, verbal abuse or scolding of clients; • The facility has in place a policy that encourages positive communication and does not allow harsh or abusive language	**Ensuring privacy during the visits** • Keeps the door and curtains closed • Only people/staff authorized by the client can come into the consultation/examination room or area • The client can undress/dress privately • The client remains covered during examination • If possible, the examination is witnessed by a matron authorized by the client • Provider pays special attention to privacy and confidentiality of clients seeking care for GBV or STIs • Facility and providers accommodate companions for women in labor and other clients, to the extent possible and when requested by client

PERFORMANCE STANDARD	SCORE	VERIFICATION CRITERIA	MEANS OF VERIFICATION	YES	NO	N/A	COMMENTS
Health Care Policies & Facility Management							
16. Clients and providers can enjoy an environment free of sexual or other abuse		16.1 Facility has a written zero-tolerance policy or client service charter that expressly prohibits sexual, physical or other abuse of clients and providers	I, R	☐	☐	☐	
		16.2 Providers have received training and are knowledgeable about what constitutes sexual harassment or abuse	I	☐	☐	☐	
		16.3 Facility documents and acts upon any instances of abuse according to facility's policy	C + I	☐	☐	☐	
17. Policies support equal opportunities for providers of all genders for advancement and compensation for comparable work		16.1 Providers, regardless of gender, receive equal pay and benefits for equal work	I, R	☐	☐	☐	
		16.2 Facility has a written non-discrimination policy	R	☐	☐	☐	
		16.3 Facility ensures at least 30% of the facility's leadership team is female or of a non-traditional gender identity	D, I	☐	☐	☐	
		16.4 Providers of any gender have an opportunity to be involved in the facility's planning and policy formulation	I	☐	☐	☐	
		16.5 Regardless of gender, facility ensures that providers of equal seniority and training have equal decision-making and influence *Prompt: Amongst this facility's leadership, do you feel that the most senior men and women have equal decision-making power and influence?*	I	☐	☐	☐	
		16.6 Facility gives providers of any gender equal opportunity to work the same number of hours and shifts, regardless of whether or not they have children	I	☐	☐	☐	
		16.7 Facility ensures providers of any gender have the same opportunities for training, professional development and promotion	I	☐	☐	☐	

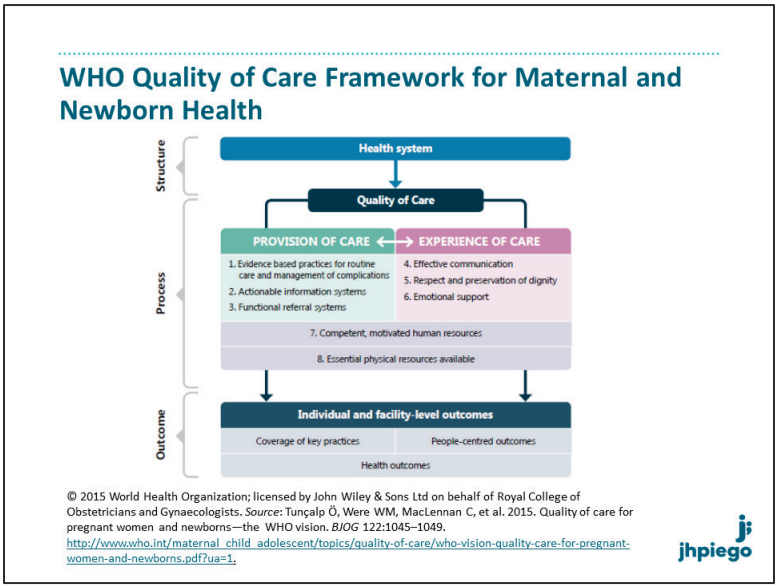
18. Providers are trained on gender equality and human rights		18.1 Facility ensures all providers have received training on gender equality and human rights within the past two years	I	☐	☐	☐	
19. A feedback mechanism exists for clients to report their level of satisfaction, or to file complaints		19.1 Facility ensures there is a hotline, suggestion box, exit feedback form, or ombudsperson (an impartial representative) that clients can use to give anonymous and confidential feedback on their experience at the facility	D, R	☐	☐	☐	
		19.2 Provider informs client of the existence of the feedback mechanism(s)	C, D	☐	☐	☐	
20. Health information systems data are regularly used for gender analyses and evaluation to improve gender-equitable service delivery		20.1 Facility disaggregates all relevant data by sex and age	R	☐	☐	☐	
		20.2 Facility analyzes and uses sex and age-disaggregated data to improve and tailor services offered, approaches used, and commodities stocked	I, R	☐	☐	☐	

TOTAL STANDARDS:	20
TOTAL STANDARDS OBSERVED:	
TOTAL STANDARDS ACHIEVED:	

Facilitator Resource: PowerPoint on Jhpiego's Global Gender Service Delivery Standards

Slide 1

Slide 2



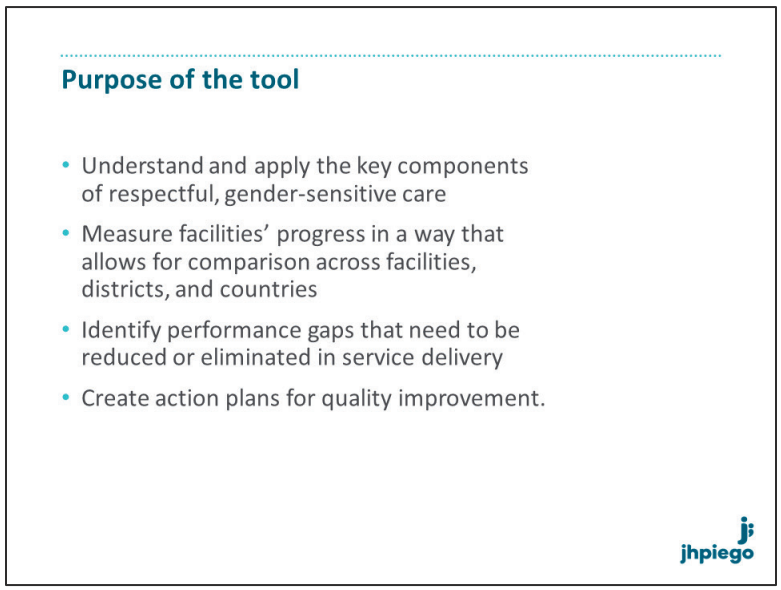
Facilitator discussion points

- This is the WHO's 2016 Quality of Care Framework for maternal and newborn health (Tunçalp et al. 2015).
- Note that gender-related attitudes and behaviors drive a lot of poor communication and disrespect for dignity. Give examples from the role plays:
  - Scenario 1: Acceptance of women's suffering, gender-based violence
  - Scenario 2: Inability of midwives to challenge senior, male doctors
  - Scenario 3: Homophobia and related stigma, men being able to decide on condom use with wife but not male sexual partner
  - Scenario 4: Beliefs about masculinity and fertility
  - Scenario 5: Gender stereotypes about girls needing to be chaste, judging the girl for being "loose"

Reference

Tunçalp Ö, Were WM, MacLennan C, et al. 2015. Quality of care for pregnant women and newborns—the WHO vision. *BJOG* 122:1045–1049. http://www.who.int/maternal_child_adolescent/topics/quality-of-care/who-vision-quality-care-for-pregnant-women-and-newborns.pdf?ua=1.

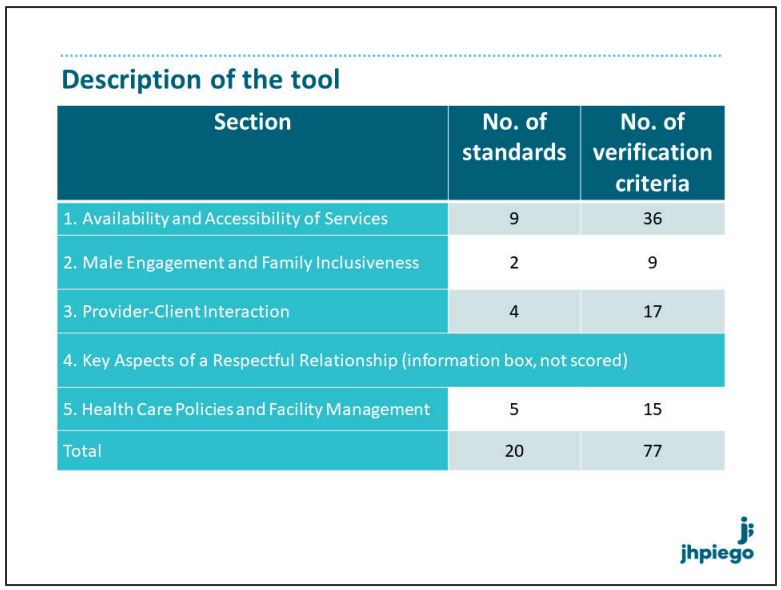
Slide 3



Facilitator discussion points

- In developing these standards, a review of Jhpiego's existing standards for other technical areas was completed. A review was also completed of the gender standards for health services quality assurance developed by the Futures Group and Jhpiego under the United States Agency for International Development (USAID)-funded Afghanistan Health Services Support Project. A literature review of international and national guidance on integrating and measuring gender-sensitive health service delivery through a quality of care framework was also conducted.
- This **standalone version** of gender standards was developed to enable tracking facilities' specific progress on gender, and to help providers and program planners understand how gender directly impacts the provision and uptake of services at the facility level.

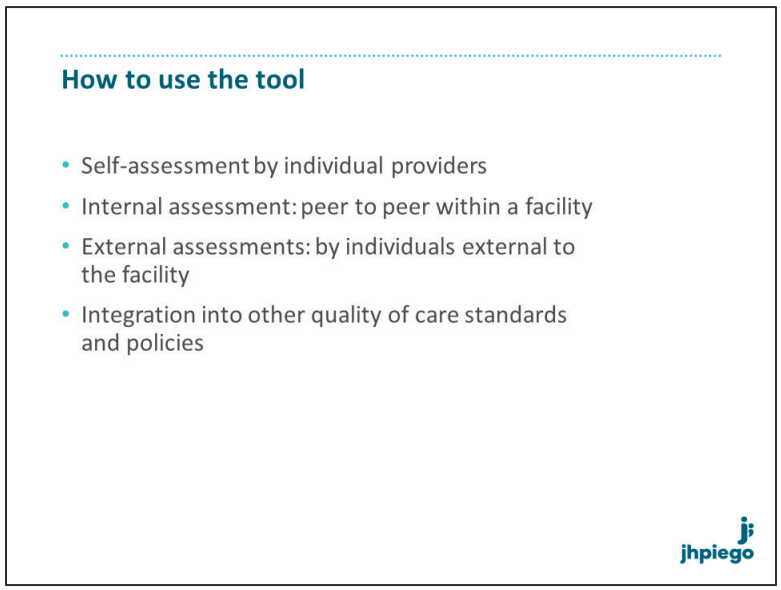
Slide 4



Facilitator discussion points

- The tool lists key performance standards organized by aspect and cross-cutting theme of service delivery
- Each performance standard has verification criteria with “yes,” “no,” and “N/A” answer options
- The tool helps facilities to objectively establish the desired level of performance
- It quantitatively measures actual performance level when applied to a facility
- It helps identify performance gaps and facility challenges that providers can address through action plans

Slide 5



Facilitator discussion points

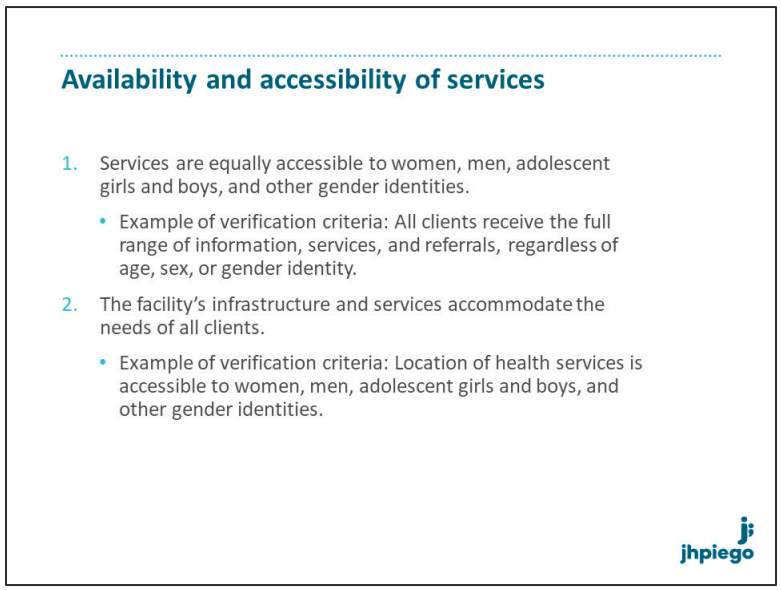
- **Self-assessments** are conducted by providers on their own work. The provider uses the performance assessment tool as a job aid to verify if she/he is following the recommended standardized steps during provision of care. These assessments can be performed as frequently as desired or needed.
- **Internal assessments** are implemented internally by facility staff. They can be in the form of **peer assessments** when facility staff use the assessment tool to mutually assess each other's work, or **internal monitoring assessments** when managers and/or providers use the tool more comprehensively to periodically assess the services being improved. It is recommended that the latter assessment occur every 3 to 4 months.
- **External assessments** are implemented by persons external to the facility. They are usually conducted by central/regional/district-level ministries of health, donors, or implementing partners. They can take the form of **facilitative supervision** when the visit's purpose is to provide support for identifying performance gaps and interventions, or **verification assessments** when the purpose of the visit is to confirm compliance with recommended standards of care and to recognize achievements. In case of verification assessments, representatives of the clients and communities being served should be involved in an appropriate way. For instance, they could have representatives in the team assessing the facility, or the facility scores or quality improvement plans could be shared with them on a regular basis to increase accountability.
- **Integration into other standards:** The tool can be used as a standalone method of assessing a facility's provision of gender-sensitive, respectful care. Alternatively, relevant standards can be integrated into other standards documents and quality assurance processes.

Slide 6

Facilitator discussion points

- Before using the tool, you should first work with the facility to identify a team to implement the tool and quality improvement process. The team should be comprised of providers involved in service delivery. We also recommend involving the facility manager and district health management teams as team members or key stakeholders with whom to share findings.
- After the first assessment in partnership with the team, a debriefing meeting should be completed to clarify any standards that posed difficulty for the team or to the providers who were interviewed.
- In addressing the identified gaps, the teams should remember that there are gaps that do not require significant cause analysis because the solution is obvious and simple (e.g., designation of a person in charge of a task, minor purchases to replace broken pieces of equipment, minor relocation of supplies and equipment to make them more available at point of use); gaps that are likely to be caused by factors under local/facility control that could be eliminated with the mobilization of local resources (e.g., modification of some internal procedures, redistribution of workload within the facility, internal reallocation of resources, some types of training, implementation of some types of incentives); gaps that are likely to be caused by factors outside local/facility control that usually require the mobilization of significant external resources (e.g., changes in policies, salary increases, increases in the number of staff, provision of additional budgets, physical plant remodeling/construction).
- The team should conduct subsequent assessments using the tool on a quarterly basis to improve the quality of service delivery, sharing scores and information on gaps in service delivery with relevant stakeholders. The user should compile and analyze this information to present to relevant ministries to show which facilities are succeeding, which need greater support, as well as any trends in key areas of quality improvement across districts or regions.

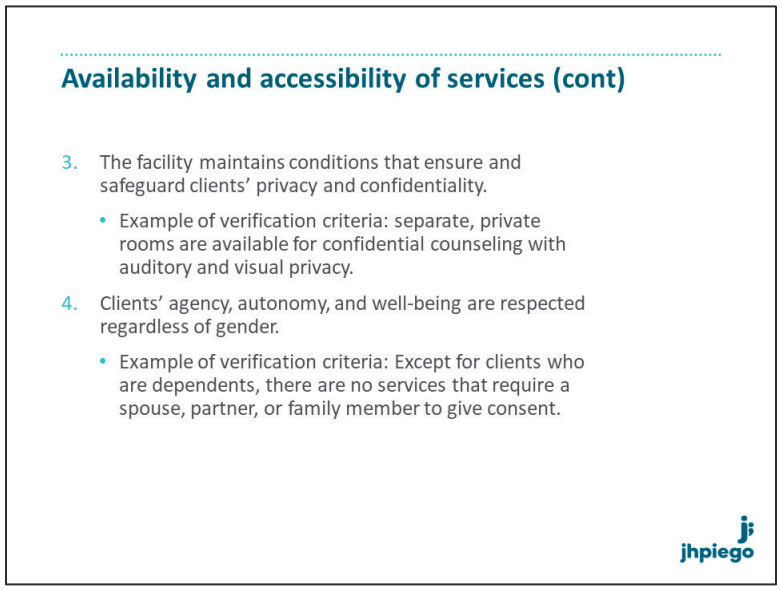
Slide 7



Facilitator discussion points

- State that you will now share the standards and read examples of standards for each cross-cutting theme on the remaining slides.

Slide 8



Slide 9

Availability and accessibility of services (cont)

5. Clients have access to—and receive information about—all available contraceptive methods.
   - Example of verification criteria: Provider explains the different methods available at the facility and checks that the client has understood.
6. Clients have access to emergency contraception regardless of their circumstance, gender, or age (except for minors under age 14).
   - Example of verification criteria: Provider asks questions and records responses related to sexual behavior in a professional and nonjudgmental manner.

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Slide 10

Availability and accessibility of services (cont)

7. Clients can choose the gender of their provider.
   - Example of verification criteria: Clients are informed that they can choose the gender of their provider if a choice is available.
8. Information, education, and communication materials are accessible to clients of all genders.
   - Example of verification criteria: Contraceptive commodities, supplies, and equipment covering a range of methods for men's and women's health, including long-acting and emergency contraception, are integrated in the essential medicine supply chain to increase continuous availability.

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Slide 11

Availability and accessibility of services (cont)

9. No client is denied care because she/he cannot pay fees.
   - Example of verification criteria: No client (adult, newborn, or child) is detained at the facility due to inability to pay fees.

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Slide 12

Male engagement and family inclusiveness

10. The facility provides a welcoming, male-friendly environment.
    - Example of verification criteria: Providers encourage and allow women to bring a companion of any gender with them to family planning (FP) and antenatal care (ANC) visits, labor and delivery, and HIV counseling and testing (HTC).
11. Provider offers couples/partner counseling on communication and joint decision-making on issues of FP, ANC, birth planning, prevention of mother-to-child transmission of HIV (PMTCT), voluntary medical male circumcision (VMMC), and HTC.
    - Example of verification criteria: Sexual and reproductive health counseling is available to couples/partners, including skills building on couples'/partners' communication and negotiation.

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Slide 13

Provider-client interaction

12. The provider establishes a cordial and respectful relationship with clients and their companions (if present).
    - Example of verification criteria: The provider explains to the client and companion what she/he is going to do and encourages her/him to ask questions.
13. The provider gives appropriate emotional support for postabortion care and postabortion FP.
    - Example of verification criteria: Provider shows compassion and addresses any feelings of denial, guilt, shame, anxiety, fear, depression, and loss.

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Slide 14

Provider-client interaction (cont)

14. Providers take into account gender barriers that impact health-seeking and utilization of services.
    - Example of verification criteria: During contraceptive counseling, the provider asks the woman if anything would prevent her from using a particular FP method and if she is able to decide for herself whether or not to use FP.
15. Providers address myths or beliefs that impact health-seeking and utilization of services.
    - Example of verification criteria: During ANC or FP counseling, providers ask clients and their companions if they hold any beliefs that would prevent them from using FP, attending ANC, using a condom, breastfeeding, delivering in a facility, or seeking testing or treatment for a sexually transmitted infection (STI).

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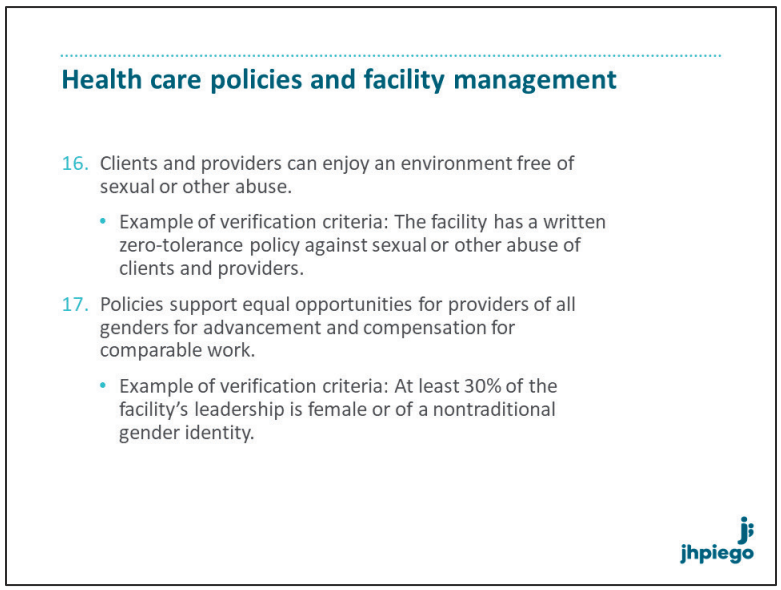
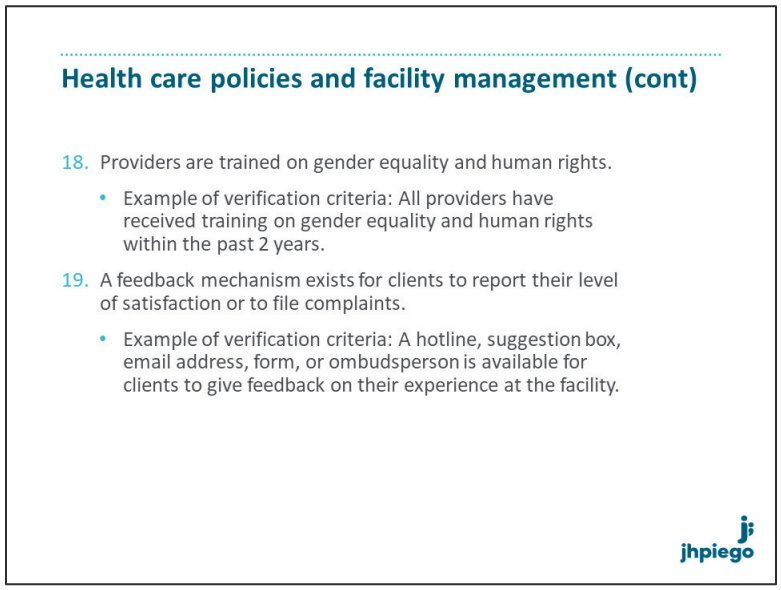
Slide 15



Slide 16



Slide 17

Health care policies and facility management (cont)

20. Health information systems data are regularly used for gender analyses and evaluation.
    - Example of verification criteria: Findings from gender analyses are used to improve and tailor services offered, approaches used, and commodities stocked.

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Slide 18

Scoring

- For one of the 20 standards to be marked as complete, all verification criteria within that standard must be met.
  - If all verification criteria for a standard are met, the facility will receive a score of 1 for that standard.
  - If one or more verification criteria are NOT met for a standard, the facility will receive a score of 0 for that standard.
  - No partial credit for a standard is given if any verification criteria are not met.
- Therefore, a facility can score a **maximum** of 20 out of 20.

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Slide 19

Module 7

Gender Analysis

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Saving lives. Improving health. Transforming futures.

Session 29: Introduction to Gender Analysis

Learning Objectives

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

- Explain the importance of a gender analysis
- Describe the four domains of Jhpiego's Gender Analysis Framework
- Apply Jhpiego's Gender Analysis Framework to identify gender constraints and opportunities

Time

3 hours 15 minutes

Materials Needed

- Chairs organized in a semicircle
- Four small tables for small group work
- Projector
- Laptop
- Paper pads for each participant
- Pens/pencils for each participant
- **Participant Handout: Gender Integration—Table 1**
- **Participant Handout: Gender Integration—Table 2**
- **Participant Handout: Preventing Mother-to-Child Transmission of HIV in Country Z**
- **Participant Handout: MCHIP Yemen**
- **Participant Handout: Gender Analysis Framework**
- **Facilitator Resource: Introduction to Gender Analysis and Integration into Health Programs PowerPoint** OR video: https://www.youtube.com/watch?v=R9zuFQCXAis&feature=youtu.be
- **Facilitator Resource: Gender Integration—Table 1/Completed**
- **Facilitator Resource: Gender Integration—Table 2/Completed**
- **Facilitator Resource: Table 1/Blank**
- **Facilitator Resource: Table 2/Blank**
- "Why Did Mrs. X Die?" video

Advance Preparation

1. Make enough copies of **Participant Handout: Gender Integration—Table 1**, **Participant Handout: Gender Integration—Table 2**, **Participant Handout: Preventing Mother-to-Child Transmission of HIV in Country Z**, **Participant Handout: Gender Analysis Framework**, and **Participant Handout: MCHIP Yemen** for all participants.

2. Place copies of both Table 1 and Table 2 in different corners of the room along with two sheets of flipchart paper and several markers.
3. Download the "Why Did Mrs. X Die" video here: https://www.futurelearn.com/courses/women-children-health/0/steps/8961 or https://www.youtube.com/watch?v=WNb9pNymuwQ (with French subtitles).
4. Save a copy of the **Introduction to Gender Analysis PowerPoint** to your laptop, and practice the presentation beforehand to ensure you have a good understanding of the concepts.
5. Make one copy of **Facilitator Resource: Introduction to Gender Analysis and Integration into Health Programs PowerPoint**.
6. Refer to **Facilitator Resource: Table 1/Blank** and reproduce the table on four sheets of flipchart paper, and then tape the sheets to a wall.
7. Refer to **Facilitator Resource: Table 2/Blank** and reproduce the table on three sheets of flipchart paper, and then tape the sheets to the wall next to Table 1.

Steps

Introduction (1 minute)

1. Start the session by explaining that there is overwhelming evidence pointing to gender as a health determinant. Increasingly, development and health programs are striving to take gender into account as a means of increasing their impact. Addressing gender effectively requires understanding dominant gender norms in a given sociocultural context and their influence on women's and men's health. A gender analysis is fundamental to identifying and understanding gender norms and power relations.

Understanding Gender Analysis (40 minutes)

1. Give one pad of paper and one pen/pencil to each participant. Tell participants they can use the paper pad to take notes during the session.
2. Next, explain that you will begin with a presentation on gender analysis. Instruct participants to hold their questions until the end of the presentation.
3. Project the presentation on gender analysis and talk through each slide using the facilitator discussion points detailed under each slide. Spend no more than 30 minutes presenting.
4. Optional: You may choose to show a video on the Gender Analysis Toolkit, which includes key elements of the gender analysis. Download the video at https://www.youtube.com/watch?v=R9zuFQCXAis&feature=youtu.be.
5. Next, allow participants 10 minutes to ask questions and/or make comments.

Why Did Mrs. X Die? (25 minutes)

1. Explain that identifying and understanding the social determinants of sexual and reproductive health (SRH) is fundamental for achieving positive health outcomes. By moving beyond the identification of immediate contributors to poor health outcomes toward the identification of underlying causes, our programs can become more effective. Gender analysis allows us to uncover underlying causes of poor health outcomes and design more impactful interventions.
2. Tell participants that you are going to show a short film that will illustrate the importance of identifying underlying causes as part of our efforts to promote SRH.
3. Start the "Why Did Mrs. X Die" video.

4. Once the video is over, facilitate a 10-minute discussion using the questions below:
    - How did gender norms lead to the death of Mrs. X? How did her social position impact her health?
    - What were the other factors (not related to the health facility) that led to the death of Mrs. X?
    - Do we address underlying/root causes in our reproductive health programs? How?

Discussion on Applying Gender Analysis and Integration (40 minutes)

Facilitator note: If you are short on time, you may choose to simply use the "Why Did Mrs. X Die?"' video to complete a 15–20 minute domain-specific mapping of the gender issues as a group. To do so, you will need to refer to **Participant Handout: Gender Analysis Framework** and write the titles of the four domains on four separate sheets of flipchart paper (one sheet per domain), which you will then post on a wall.

Start with the first domain: Explain the domain by referring to the definition and examples provided in **Participant Handout: Gender Analysis Framework**. Next, ask participants to list some of the gender issues raised in the video that are relevant to the domain in question. Repeat this process for the three remaining domains. After you have completed mapping all four domains, you may move to the fifth part of the session (Small Group Work on Gender Analysis and Integration).

Note that by skipping to the fourth part of the session (Plenary on Applying Gender Analysis and Integration), participants will miss the detailed explanations for each of the components of **Gender Integration—Table 1** and **Gender Integration—Table 2**. You will, therefore, need to set aside a bit of time to explain Tables 1 and 2 before participants move into the small group work.

5. Next, explain to the group that they will spend some time practicing gender analysis and integration using case studies.
6. Distribute **Participant Handout: Gender Integration—Table 1**, **Participant Handout: Gender Integration—Table 2**, and **Participant Handout: Preventing Mother-to-Child Transmission of HIV in Country Z** to each participant.
7. Tell participants that they will complete a quick gender analysis as a group using a case study.
8. Instruct participants to refer to **Participant Handout: Preventing Mother-to-Child Transmission of HIV in Country Z** and to silently read the case study on their own.
9. Once participants have read the case study, draw their attention to **Participant Handout: Gender Integration—Table 1** and **Participant Handout: Gender Integration—Table 2**. Explain that two worksheets were developed to help guide participants through the process of gender analysis and integration. Explain that you will walk them through the process using the country context description for Country Z.
10. Draw participants' attention to the four flipchart pages you have posted on the wall to represent the four columns of Table 1. Ask participants to imagine they need to design a prevention of mother-to-child transmission (PMTCT) intervention. (Allow no more than 5 minutes for steps 1–6.)

11. Next, walk participants through the first column of Table 1 using the following guiding notes (spend no more than 2 minutes on this step):

    - Column 1: Key gender relations

        > Gender relations are the social, economic, and political relationships between women and men that exist in any family, community, society, or workplace. Gender relations influence people's ability to freely decide, influence, control, enforce, and engage in collective actions. We want to understand the different relations that characterize the lives of women and men (in Country Z) and that may (ultimately) inhibit or facilitate their access to resources and opportunities.

        > As mentioned during the presentation, to understand gender relations, a gender analysis will focus on specific aspects (or domains) of women's and men's relations. In this table, we are going to look at women's and men's gender relations in terms of:
            - their "**practices, roles, and participation**" (e.g., practices/activities and roles that are customary/traditional and/or acceptable (and nonacceptable) for women and men; differences in women's and men's participation in social life, political life, family, community);
            - their "**access to assets**" (e.g., women's and men's ability to access natural resources, productive assets, income, information, knowledge, social networks);
            - "**institutional laws and policies**" and the ways in which women and men are dissimilarly affected by policies and rules governing institutions, including the health system (e.g., how laws and policies affect women's/girls', men's/boys' access to education, health services, employment opportunities, property ownership); and
            - "**knowledge, beliefs, and perceptions**" (e.g., social and cultural expectations about appropriate behavior, individual expectations about appropriate behavior) about women and men.

        > Power pervades all four domains, and informs who has, can acquire, and can expend assets; who can make decisions about their bodies and their health and that of their children; who can take advantage of opportunities, etc.

        > Power also determines the way women and men are treated by different types of institutions, policies, and laws.

12. After you have explained the first column, ask participants to refer back to the description of Country Z and agree on one example of a gender relation for each of the four domains. Refer to **Facilitator Resource: Gender Integration—Table 1/Complete** for examples. As participants agree on the gender relations, write them on the flipchart page under the relevant domain. (Spend no more than 3 minutes on this step.)

13. Next, explain the second column using the following guiding notes (spend no more than 2 minutes on this step):

    - Column 2: Potential missing information

        > After having identified key information about gender relations (by domain), we will need to identify any additional/missing information that might help the program to better ascertain the gender barriers that need to be taken into account during program design (to ensure the success of the program). This analysis is also done across the four domains.

14. After explaining the second column, ask participants to agree on one example of missing/additional information (for each of the four domains) that might be needed to better understand the gender relations and barriers that were just identified in the Country Z case study. Refer to **Facilitator Resource: Gender Integration—Table 1/Complete** for examples. As participants agree on the missing/additional information, write it on the flipchart page under the relevant domain. (Spend no more than 3 minutes on this step.)
15. Next, explain the third column using the following discussion points (spend no more than 2 minutes on this step):

- Column 3: Gender-based constraints
  - > These are gender relations that **inhibit** men's and/or women's access to resources or opportunities of any type. We will need to identify gender-based barriers faced by women and men in Country Z, specifically those barriers that could hinder the success of the project we're designing. This analysis is also done across the four domains.

16. After you've explained the third column, ask participants to agree on one example of a gender-based constraint for each of the four domains that would be important to take into account during the design of the project. Refer to **Facilitator Resource: Gender Integration—Table 1/Complete**
for examples. As participants agree on the constraints, write them on the flipchart page under the relevant domain. (Spend no more than 3 minutes on this step.)
17. Finally, explain the fourth column using the following discussion points (spend no more than 2 minutes on this step):

- Column 4: Gender-based opportunities
  - > These are gender relations that **facilitate** men's and/or women's access to resources or opportunities of any type. We will need to identify gender-based opportunities for women and men in Country Z, specifically opportunities that could contribute to the success of the project. This analysis is done across the four domains.

18. After you've reviewed the fourth column, ask the group to agree on one example of a gender-based opportunity for each of the four domains that would be important to take into account during the design of the project. Refer to **Facilitator Resource: Gender Integration—Table 1/Complete** for examples. As participants agree on opportunities, write them on the flipchart page under the relevant domain. (Spend no more than 3 minutes on this step.)
19. Next, ask participants to refer to **Participant Handout: Gender Integration—Table 2**. Explain that based on the gender analysis in Table 1, we can now begin identifying specific subobjectives, activities, and indicators for PMTCT programs.
20. Draw participants' attention to the flipchart pages posted on the wall to represent the three columns of Table 2. Review the various components of Table 2 using the following talking points (spend no more than 2 minutes on this step):

- Column 1: Step 2: Gender-integrated objectives
  - > This step is directly linked to step 2 of the program cycle (Strategic Planning), which has to do with developing program objectives that strengthen the synergy between gender equity and health goals; and identifying program participants, clients, and stakeholders.
  - > In this column, we need to formulate program objectives to address some of the gender-based opportunities and barriers that were uncovered during the gender analysis.
    The objectives should relate to a change we would like to see with respect to specific

gender-based barriers, and they should leverage identified gender-based opportunities. The objectives should also be formulated by domain.

21. After reviewing the first column, ask the group to agree on one example of a gender-integrated objective for each of the four domains. Refer to **Facilitator Resource: Gender Integration—Table 2/Complete** for examples. As participants agree on objectives, write them on the flipchart page under the corresponding domain. (Spend no more than 3 minutes on this step.)
22. Next, explain the second column of the table using the following talking points (spend no more than 2 minutes on this step):
    - Column 2: Step 3: Activities
        - This step is related to step 3 of the program cycle (Design), and involves identifying key program strategies by domain to address gender-based constraints and opportunities. In this step, we will need to identify activities that could help achieve each of the gender-integrated objectives we've formulated. Activities should also leverage identified gender-based opportunities.
23. After reviewing the second column, ask participants to agree on one activity example per domain for each of the objectives identified. Refer to **Facilitator Resource: Gender Integration—Table 2/Complete** for examples. As the group agrees on the activities, write them down on the flipchart page under the appropriate domain. (Spend no more than 3 minutes on this step.)
24. Next, explain the third column of the table using the following talking points (spend no more than 2 minutes on this step):
    - Column 3: Steps 4 and 5: Indicators
        - These steps also correspond to steps 4 and 5 of the program cycle (monitoring and evaluation). Step 4 has to do with the development of indicators that measure gender-specific outcomes, and monitoring implementation and effectiveness in addressing program objectives. Step 5 involves measuring the program's impact on health and gender equity outcomes, and adjusting program design to enhance successful strategies and mitigate any unintended harmful results. In this column, we will need to identify indicators that would point to a decrease in, or removal of, the gender barriers our program seeks to address. As with the objectives and the activities, indicators will be formulated across the four domains.
25. After discussing the third column, ask participants for one indicator per domain for each of the objectives identified. Refer to **Facilitator Resource: Gender Integration—Table 2/Complete** for examples. As participants agree on the indicators, write them down on the flipchart page under the relevant domain. (Spend no more than 3 minutes on this step.)

Small Group Work on Gender Analysis and Integration (1 hour 20 minutes)

1. Tell participants that they will now work in small groups to complete the same gender analysis and integration exercise they just completed in the large group.
2. Divide participants into four groups. Explain that each group will be assigned the same case study, and one of the four gender analysis domains. In their small groups they will have 30 minutes to:
    - Read the case study
    - Complete Table 1 with information specific to the domain assigned to their group (identify key gender relations, missing information, gender-based constraints, and gender-based opportunities)

- Complete Table 2 with information specific to the domain assigned to their group (identify gender-integrated objectives, activities, and indicators)

3. Next, assign one of the four gender analysis domains to each of the groups such that you have the following groups:
   - Group 1: Access to assets
   - Group 2: Beliefs and perceptions
   - Group 3: Practices and participation
   - Group 4: Institutions, laws, and policies
4. Next, distribute **Participant Handout: MCHIP Yemen** and **Participant Handout: Gender Analysis Framework** to each participant.
5. Instruct participants to use flipchart paper to document their answers. Indicate that each group will have 5 minutes to share their group work with the larger group. (Spend no more than 5 minutes on steps 1–5.)
6. Direct participants to the areas of the room where you have set up the tables with the flipchart paper and markers.
7. After 30 minutes, ask the groups to stop and reconvene participants. Ask for a representative from one of the groups to come to the front of the room to present her/his group responses. (Allow 5 minutes for the presentation.)
8. After the first group representative has presented, allow other participants to ask questions and/or comment on the group's work. (Spend no more than 5 minutes on this step.)
9. Repeat steps 6–7 for the remaining three groups.
10. After all four groups have presented, facilitate a 5-minute debrief by asking the following questions:
    - What did you think of this framework and exercise? Do you think this is something you can do or work with Monitoring, Evaluation, and Research (MER) staff to do?
    - How will/can you apply this framework to your current project?

Closing (1 minute)

1. End the activity by stating that a gender analysis allows for the identification of underlying causes of specific health and development issues and as such is key for achieving programmatic impact. During their design and implementation, programs must be mindful not only of the ways in which gender-based constraints and opportunities might influence programs' ability to achieve sustainable results, but also the ways in which programs might impact (intentionally and unintentionally) the participants they are intended to serve.

Sources

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Population Reference Bureau. 2009. *A Manual for Integrating Gender into Reproductive Health and HIV Programs: From Commitment to Action*, 2nd ed. Washington, DC: Population Reference Bureau.

Participant Handout: Gender Integration—Table 1

(*Adapted from* IGWG. n.d. *Gender Analysis and Integration*. Gender Integration Table 1: Data Collection and Analysis. https://www.igwg.org/wp-content/uploads/2017/05/GendrIntegrExercisTbl1.pdf.)

Program goal and/or overall health objective: _____

Step 1: Conduct a gender analysis of your program by answering the following questions (in the table).

- Be sure to consider these relations in different contexts—individual, partners, family and communities, health care and other institutions, policies.

What are the key gender relations inherent in each domain that affect women and girls, men and boys?	What other potential information is missing but needed about gender relations?	What are the gender-based constraints to reaching program objectives?	What are gender-based opportunities to reaching program objectives?
Practices and participation:	**Practices and participation:**	**Practices and participation:**	**Practices and participation:**
Beliefs and perceptions:	**Beliefs and perceptions:**	**Beliefs and perceptions:**	**Beliefs and perceptions:**
Access to assets:	**Access to assets:**	**Access to assets:**	**Access to assets:**
Institutions, laws, and policies:	**Institutions, laws, and policies:**	**Institutions, laws, and policies:**	**Institutions, laws, and policies:**

Participant Handout: Gender Integration—Table 2

(*Adapted from* IGWG. n.d. *Gender Analysis and Integration*. Gender Integration Table 2: Moving from Analysis to Action. https://www.igwg.org/wp-content/uploads/2017/05/GendrIntegrExercisTbl2.pdf.)

Steps 2–5: Using the information you entered in Table 1 as a reference, answer the following questions.

Step 2. What gender-integrated objectives can you include in your strategic planning to address gender-based opportunities or constraints?	Step 3. What proposed activities can you design to address gender-based opportunities or constraints?	Steps 4–5. What indicators for monitoring and evaluation will show if (1) the gender-based opportunity has been taken advantage of, or (2) the gender-based constraint has been removed?
Practices and participation:	**Practices and participation:**	**Practices and participation:**
Beliefs and perceptions:	**Beliefs and perceptions:**	**Beliefs and perceptions:**
Access to assets:	**Access to assets:**	**Access to assets:**
Institutions, laws, and policies:	**Institutions, laws, and policies:**	**Institutions, laws, and policies:**

Participant Handout: Preventing Mother-to-Child Transmission of HIV in Country Z

(*Adapted from* IGWG. 2010. IGWG Gender, Sexuality and HIV Training Module. Case Study: PMTCT Programming in Country Zed. http://www.healthpolicyinitiative.com/Publications/Documents/1408_1_IGWG_GSHIV_Module_Oct_2010_acc.pdf.)

Like many countries, Country Z continues to find it difficult to facilitate women's access to PMTCT services. These services include testing to determine HIV status, access to drugs to prevent HIV-positive mothers from transmitting the disease to their children, information on exclusive infant feeding options, health care for infants, family planning, and care and treatment for the woman's own health.

Available Background Information

The most recent Demographic and Health Survey (DHS) for Country Z reported high utilization (90%) of antenatal care (ANC) by pregnant women, but only 47% delivered at a health facility. Most women completed at least some primary schooling. More than half of the women reported having a partner or husband. Only 40% had access to piped water or electricity. More than half reported no independent income.

Data from the World Health Organization (WHO) Multi-Country Study on Domestic Violence report that for Country Z, 41%–56% of ever-partnered women ages 15–49 had ever experienced physical or sexual violence from an intimate partner, and 17%–25% had experienced severe physical violence. Of the latter group, one-third to one-half had experienced severe physical violence within the past year. Some recent poster campaigns with slogans such as "Test for the Health of the Next Generation" picture a pregnant woman holding a newborn baby. Although ANC use is high, recent focus groups show that women have limited knowledge of specific PMTCT interventions or their availability at the local health clinic. When asked about the importance and availability of specific medicines and recommended exclusive infant feeding practices, women expressed uncertainty about the effect of these recommendations on their pregnancy and the health of the infant.

A number of women expressed the belief that women who are HIV-positive should not have more children. Regarding testing, women were more interested in knowing their HIV status for the purpose of protecting themselves from infection if they tested negative, or for seeking care if they were HIV-positive. Significantly, only 11% identified concern about infecting their child as a primary reason to learn their HIV status.

Gender Norms

Women are expected to seek permission from their male partners before testing. They believe that testing without a partner's permission will increase conflict. Men feel free to make their own decisions about whether to test or not and rarely disclose their HIV status to their partners. However, men are reluctant to use testing sites near their communities, fearing lack of confidentiality. Men also believe that by the time a woman is pregnant, it is too late for themselves and their partners to be tested. They argue that a woman who is HIV-positive should not have any more children. If a man is HIV-positive, however, he is unlikely to disclose, and will still desire more children. Men say that access to antiretrovirals (ARVs) to prevent transmission would be a great incentive for them to agree to testing for themselves and their partners, even if ARVs were only provided to mothers and babies.

Both men and women in the community report that health information is supposed to be brought into the family by the man. Women are not regarded as reliable sources of information. Men are viewed as the family decision-makers. Men regard health care providers as legitimate sources of information, yet they generally do not accompany their partners to family planning, ANC, or postnatal care (PNC) visits and would not be expected to attend the labor or birth of their child. Birth, delivery, and infant care are seen as exclusively the responsibility of women, although men are increasing their involvement in childrearing responsibilities once children become toddlers or older.

Responding to Local Beliefs

Many people in the community believe that if one parent is HIV-positive, both parents and all children born will be HIV-positive as well. HIV-related stigma in the community remains high and is directed at the person who first tests and discloses his or her status.

Because of antenatal testing, more women than men know their HIV status. It has not been uncommon for women who reveal their HIV-positive status to be abandoned, and many women fear being abused by their male partners. Women do discuss health and relationship issues with other women in the community, and find other women an important source of social support and practical information, especially as related to women's and children's health. However, this information is not brought directly into the household. Health care providers in the public sector have limited time to provide much information and counseling to their clients. Overburdened by the migration of health care staff as well as by absences due to their own and family illnesses, midwives and nurses are stretched too thin to provide even a minimum standard of clinical care.

Participant Handout: MCHIP Yemen

MCHIP Yemen (excerpt)

Yemen presents a severely under-resourced and fragmented health system, where political instability and chronic and seasonal food insecurity are linked with poor maternal, infant, and young child nutrition practices. Health services were further deeply affected by the 2011 Yemeni Revolution, and the ongoing instability and uncertainties of the political situation make long-term planning difficult. Within this context, the Government of Yemen's Ministry of Public Health and Population (MOPHP) drafted the Maternal and Child Health Acceleration Plan 2013–2015 to reduce maternal and under-5 mortality. Other ratified policies and strategies include the National Health Policy 2010–2025, the National Newborn Health Strategy, the National Nutrition Strategy, and the Reproductive Health Strategy. Across the cross-cutting and technical areas relevant to health, the needs and opportunities for intervention are considerable.

USAID's global flagship Maternal and Child Health Integrated Program (MCHIP)—primed by Jhpiego and led operationally in Yemen by John Snow, Inc. (JSI), with support from Save the Children, the Program for Appropriate Technology in Health (PATH), and ICF Macro—is uniquely suited to support the Government of Yemen and USAID/Yemen to fully realize one goal: **reduce maternal and neonatal mortality and morbidity as well as rates of childhood illness and malnutrition, particularly stunting and anemia, in the next 5 years.**

MCHIP's Associate Award activities will be based on an integrated approach that spans reproductive, maternal, newborn, and child health and nutrition (RMNCH/Nut) and will be built on five key objectives: 1) foster an enabling environment to increase coverage of high-impact RMNCH/Nut interventions by leveraging and integrating with other sectors; 2) enhance human resource planning and preparedness of the workforce; 3) support staff at the district level to effectively implement and monitor high-impact health and nutrition interventions; 4) increase access to and quality of service delivery points offering high-impact health and nutrition interventions; and 5) improve health and nutrition practices by families, supported by community health workers and other community members. **MCHIP's objectives in Yemen are designed to achieve progress to meet USAID's central results pathways for decreases in maternal and neonatal mortality, infant and child mortality, and improvements in nutrition status and promote resilience by layering, integrating, and sequencing with emergency relief and other USAID-funded programs to maximize results, reporting on a continuum toward outcomes that lay a foundation toward impact.**

To achieve these goals, MCHIP will work in partnership with the MOPHP to strengthen the existing health system through targeted technical assistance at the district and governorate levels. Consistent with the USAID Mission's vision for its other health and related programs, MCHIP will maximize the strengths of MOPHP partners at governorate levels, and with multiple public, private, and nongovernmental organizations, to improve access to and quality of RMNCH/Nut services. We will address barriers to care-seeking, access, and uptake of optimal health and nutrition behaviors, including gender-related barriers, through the scale-up of proven, evidence-based, high-impact RMNCH/Nut interventions.

In addition, given the sociocultural and geographic challenges of Yemeni society, MCHIP's focus throughout this project will be to support the MOPHP to **improve equity and access to quality health services**. MCHIP will support communities, district health offices, governorate health offices, and other stakeholders to develop innovative solutions to identify and address equity issues specific to the country's cultural context.

Gender: Gender inequalities remain a fundamental constraint to improving health outcomes. Yemen places **last** out of 136 countries ranked according to the World Economic Forum's Global Gender Gap Index, which measures women's economic participation and opportunity, educational attainment, health and survival, and political empowerment (JICA 2009). The low status of women in society is underpinned by gender and cultural norms that devalue women and restrict their freedoms. Poverty exacerbates matters by forcing families to choose whether to invest in a girl child or boy child and whether or not to raise a girl or sell her off to be married. Inequalities are also entrenched within the legal structure: for instance, the personal status law dictates that a woman may not leave the house without the permission of her husband, there is no minimum age of marriage and there are no laws against female genital mutilation or domestic violence (UNICEF 2011, UNFPA 2013).

These norms and practices, often linked to deeply held religious beliefs, affect children and women's health in multiple ways. In particular, they 1) hinder access to and demand for family planning services; 2) undermine the quality of services; and 3) increase various associated causes of health risk, namely early marriage and gender-based violence (GBV). Men generally are the gatekeepers for women's access to health services: they make decisions with respect to health care in general and to family planning (FP) in particular; and they must accompany their partners to the health facilities. Women, on the other hand, have low levels of literacy and formal education, which are correlated with lower levels of awareness and care-seeking behavior. Cultural norms lead women to deliver at home without a skilled birth attendant and those who deliver in a facility leave health facilities within 2 hours of giving birth. In this context, implementation of the World Health Organization's (WHO's) new guidance in Yemen (which includes a postpartum stay of 24 hours and a home visit for all women) has been challenging. Women are discouraged from leaving the home during the first 40 days after childbirth, and in many places male resistance is an obstacle for women to utilize FP services. Similarly, when a child is sick, the decision to seek help outside the household often belongs to the father or to other family members. In addition, women usually have to be accompanied by a male relative (*muharram*) to bring a sick child to a health facility, particularly if the provider is male.

Adolescent pregnancies linked to early marriage remain a widespread phenomenon in Yemen, underpinned by poverty and religious and cultural norms. About 16% of girls ages 15–18 are married in Yemen (World Economic Forum 2013). Early marriage is not only a major development challenge because of its negative impact on girls' education, women's literacy, and women's economic empowerment, it also results in high fertility rates and poorer health outcomes for mother and newborn.

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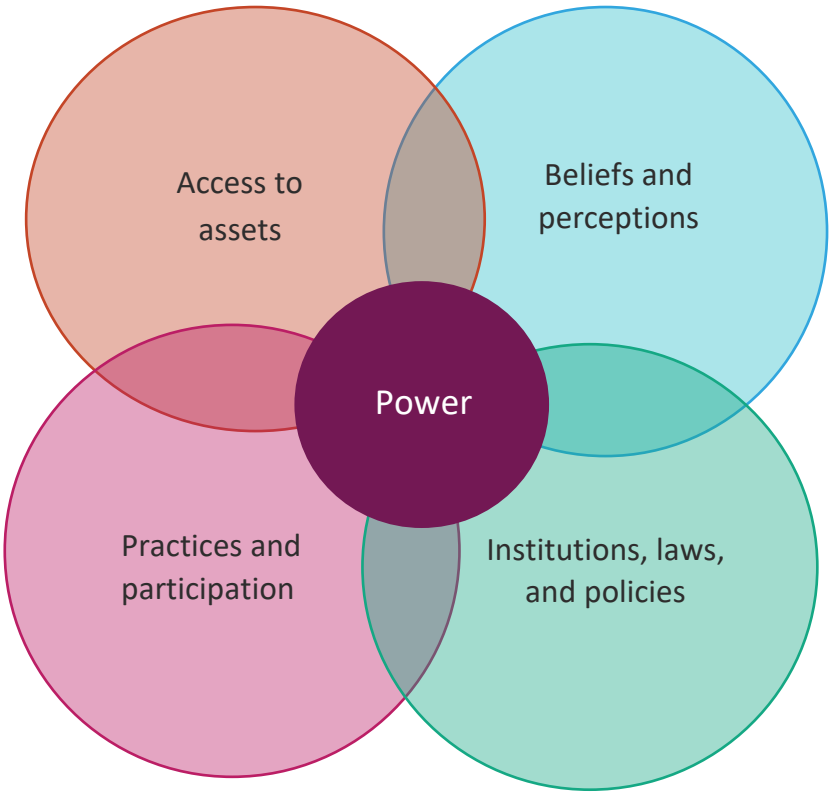
Participant Handout: Gender Analysis Framework



Access to Assets

This domain of the Gender Analysis Framework refers to how gender relations affect access to the resources necessary for a person to be a productive member of society. It includes both tangible assets (e.g., land, capital, tools) and intangible assets (e.g., knowledge, education, information, employment, benefits).

Beliefs and Perceptions

This domain draws from cultural belief systems or norms about what it means to be a woman or a man in a specific society. These beliefs affect women's and men's behavior, dress, participation, and decision-making capacity. They may also facilitate or limit women's and men's access to education, services, and economic opportunities.

Practices and Participation

The norms that influence women's and men's behavior also structure the type of activities they engage in, as well as their roles and responsibilities. This domain captures information on women's and men's different roles; the timing and place where their activities occur; their capacity to participate in different types of economic, political, and social activities; and their decision-making.

Institutions, Laws, and Policies

This domain focuses on information about women's and men's formal and informal rights, and how they are dissimilarly affected by policies and rules governing institutions, including the health system. It includes an individual's right to:

- Inherit and own property
- Legal documents (such as identity cards, property titles, and voter registration)
- Reproductive choice
- Lifesaving maternal health care
- Representation
- Due process

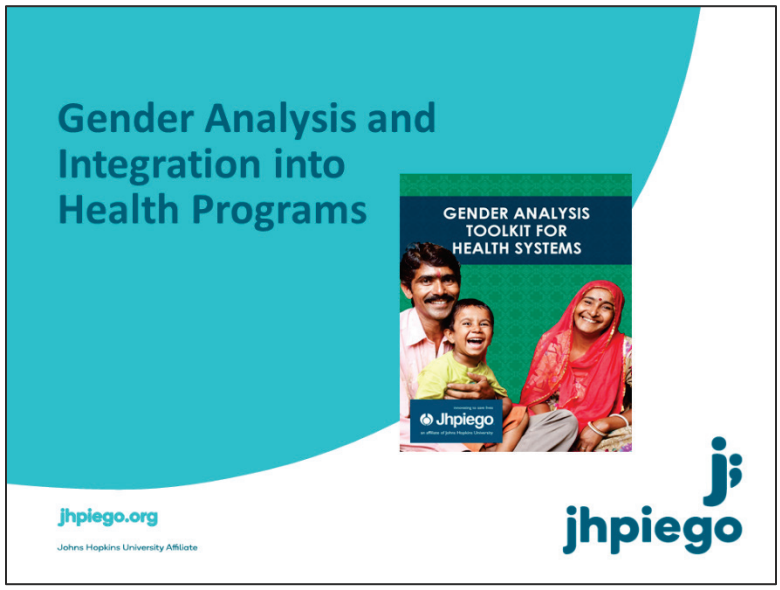
Power

The power domain pervades the other four domains of the framework. It refers to an individual's capacity to control resources and to make autonomous and independent decisions free of coercion. Gender norms influence the extent to which individuals can freely decide, influence, control, enforce, engage in collective actions, and exercise decisions about:

- Acquiring and disposing of resources
- Choosing what to believe
- One's own body
- Reproductive choice
- Children
- Occupation
- Affairs of the household, community, municipality, and the state; voting, running for office, and legislating
- Entering into legal contracts
- Moving about and associating with others

Facilitator Resource: Gender Analysis and Integration into Health Programs PowerPoint

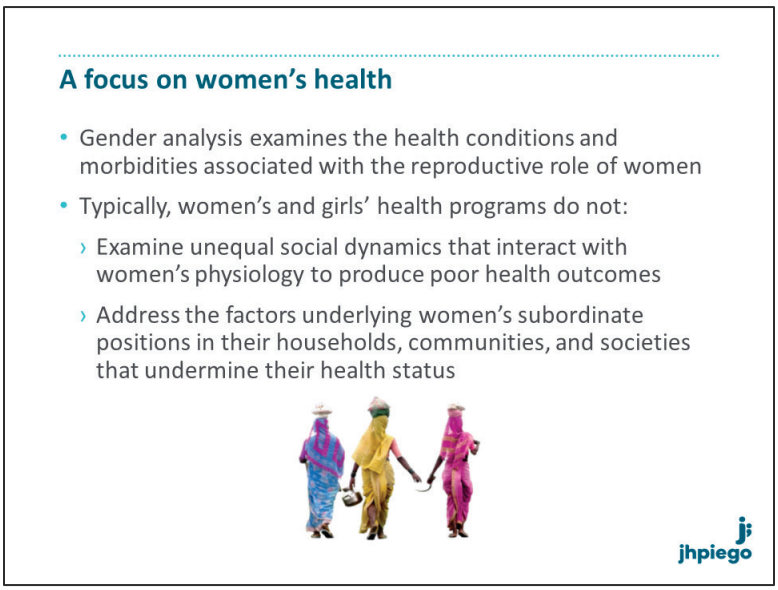
Slide 1



Facilitator discussion points

- Many donors are now requiring gender analysis.
- Jhpiego's Gender team worked with Cultural Practice to develop a toolkit to complement existing guides for gender analysis. The primary purpose of this toolkit is to not only give users an overview of gender analysis and its importance for health systems, particularly in relation to sexual, reproductive, maternal, child, and adolescent health, but also to provide research questions to guide data collection when performing a project-level gender analysis.
- The toolkit provides illustrative questions related to the five domains described in USAID's Automated Directive System 205: 1) laws, regulations, and institutional practices; 2) cultural norms and beliefs; 3) gender roles, responsibilities, and time used; 4) access to and control over assets and resources; and 5) patterns of power and decision-making.
- The tool presents illustrative general and health area-specific questions organized in matrices related to different levels of the health system.

Slide 2



Facilitator discussion points

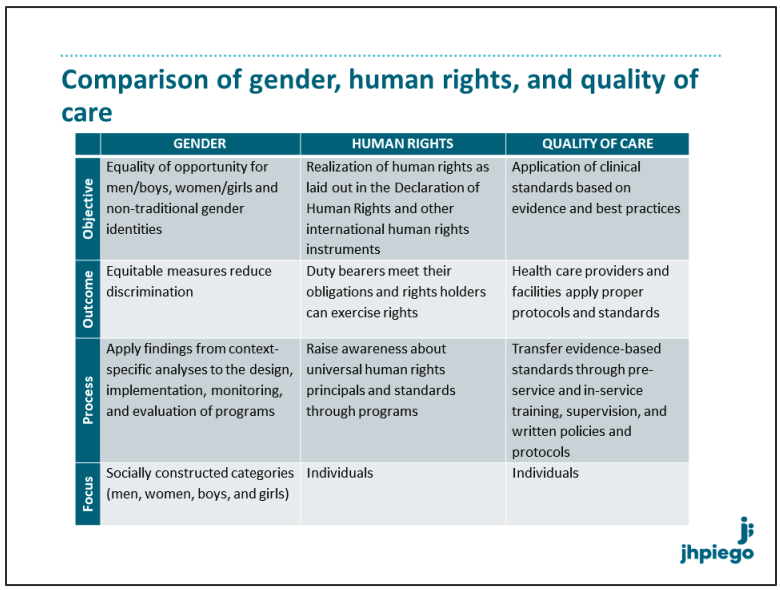
- Gender doesn't mean women. Just because we are working with women or to address women's health, it doesn't mean we are addressing the structural, sociocultural, or relational dynamics that also impact health and health-seeking behavior.
- Women's health is a critical issue, as the burden of many leading killers, such as maternal health complications, HIV, and gender-based violence (GBV), are women's health issues.
  - About 830 women die of pregnancy- or childbirth-related complications around the world every day. In 2015, roughly 300,000 women died during and following pregnancy and childbirth. Almost all of these deaths occurred in low-resource settings, and most were preventable.
  - Girls and young women account for 71% of new HIV infections among adolescents in sub-Saharan Africa.
  - In developing countries, about half of sexually active women of reproductive age, or 818 million women, want to avoid pregnancy, but about 17% of those women, or 140 million, are not using any method of family planning.
- Recognizing these issues and investing in them is a major first step. But women-focused health programs have traditionally had a biomedical approach that often targets women with new practices and messages, without regard for:
  - Their capacity to implement the practices because of potential restrictions on their decision-making, resources, or mobility
  - The additional burdens they may entail
  - Others who could share responsibilities (e.g., husbands, in-laws, or other family members)

Slide 3

Facilitator discussion points

- The reasons for these staggering statistics around women's health vulnerabilities go well beyond lack of health system resources to address postpartum hemorrhage in limited-resource countries; or inability to recognize signs of maternal complications, such as pre-eclampsia. They go beyond not having or wanting to use condoms or contraceptives. Gender and structural inequalities are at the root of many of the causes of these health issues. These include lack of education, resources, and opportunities for women that inhibit access to maternal health services, for example, or that drive many young women into transactional sex relationships or sex work.
- It also includes women's gender and social norms that make talking about sex and negotiating safer sex taboo and that drive forced sex and GBV, all of which increase risk for HIV and unwanted pregnancies. Such gender and social norms also minimize women's value as that of child bearer and define masculinity in terms of the number of sex partners he has and the number of children he fathers, in many settings.
- People often confuse gender to mean women. Certainly, men's norms, attitudes, and behaviors impact women's health. A focus on gender means addressing the structural, sociocultural, and relational dynamics that also impact health and health-seeking behavior.

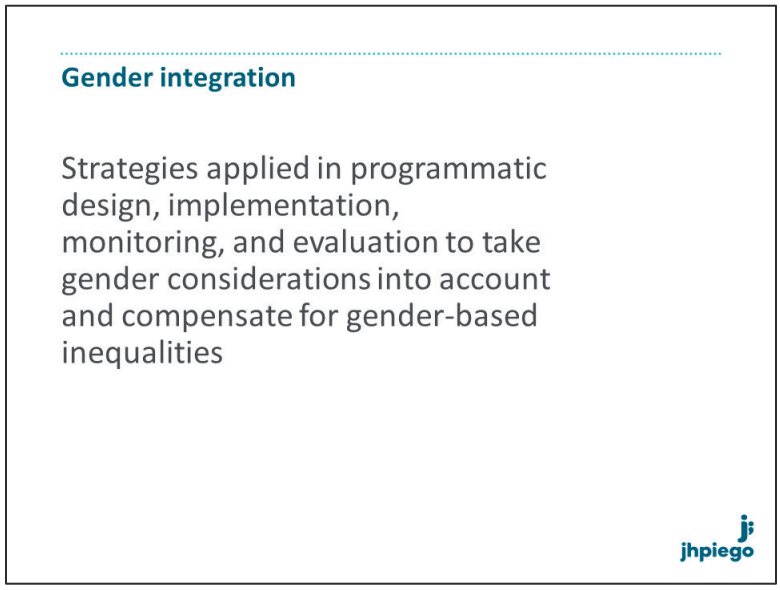
Slide 4



Facilitator discussion points

- To understand these issues fully, we must start with a gender analysis. That is, gender issues—both constraints and opportunities—although often common across countries, are still contextual. So, before we start programming gender, we have to ask questions. This is not something that can be done with a checklist like our other interventions.
- Use respectful maternity care as an example.

Slide 5



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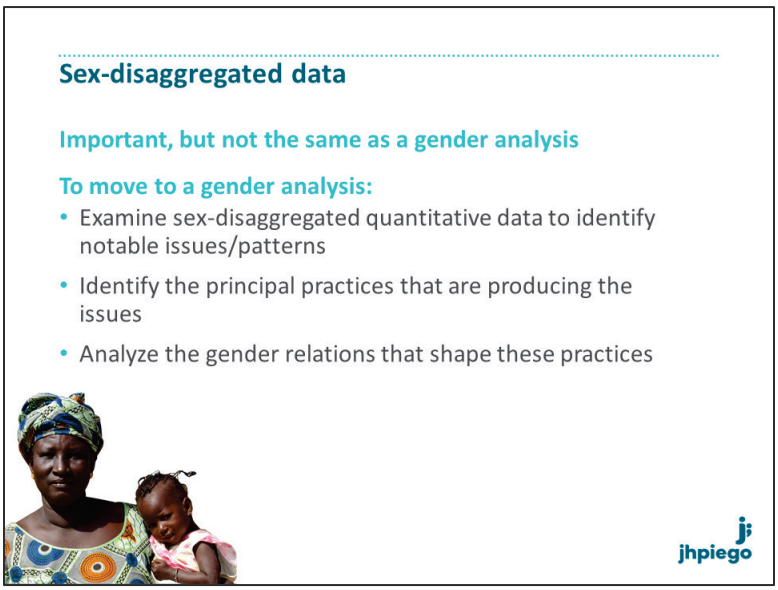
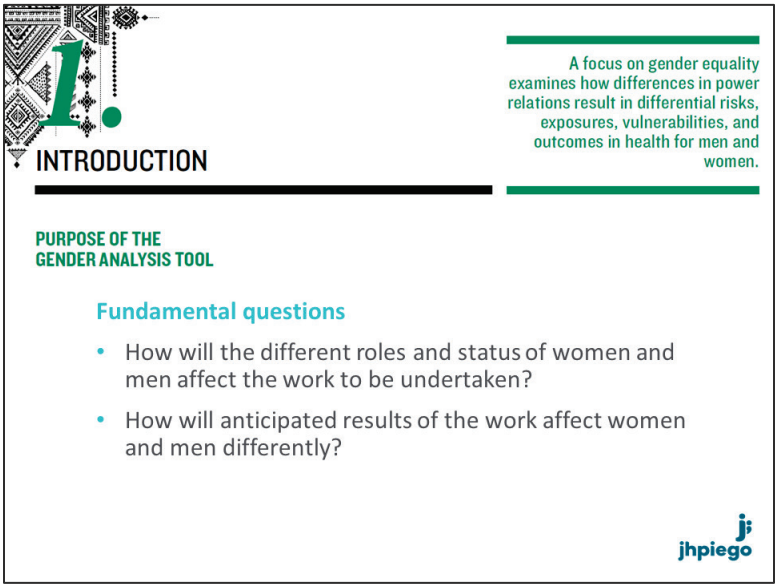


Facilitator discussion points

- Disaggregating data by sex is an important aspect of gender analysis, but it is not sufficient on its own to provide the type of insight needed to design programs/projects that address gender norms. Likewise, having an equal number of males or females is not gender integration.
- In essence, a gender analysis goes beyond the sex disaggregation of data to identify gender inequalities and determine their programmatic implications. From a public health perspective, gender analysis identifies and examines the social constructs of what it means to be a woman, a girl, a man, or a boy, and how these constructs impact the lives and health of women, girls, men, and boys.

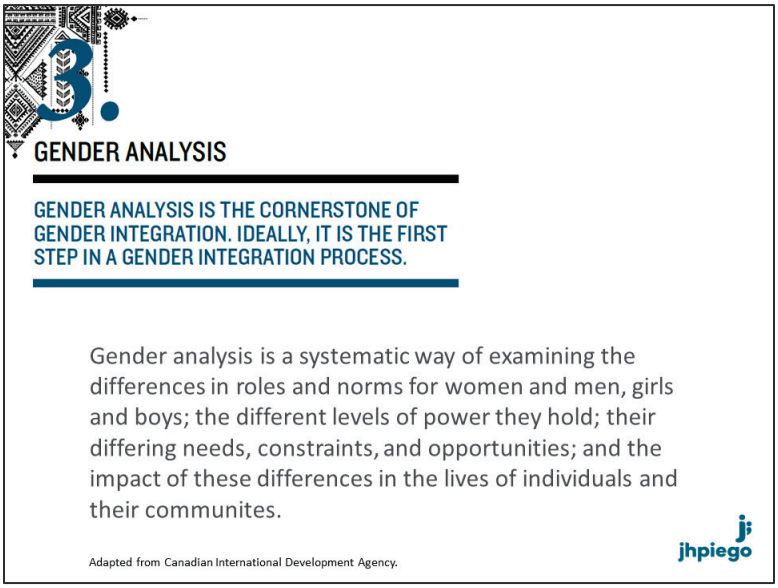
Slide 7



Facilitator discussion points

- At its heart, gender analysis seeks to answer two fundamental questions:
  - How will the different roles and status of women and men affect the work to be undertaken?
  - How will the work's anticipated results affect women and men differently?
- To answer these questions, which come from USAID's automated directive system, you must conduct a gender analysis of the particular cultural and social context in which you work.
- Gender experts have developed several analytical tools to guide you through the analysis. Some are sector-specific whereas others can be used across sectors. Although there are different approaches and emphases across gender analysis tools, gender analyses overall seek to answer these two fundamental questions.

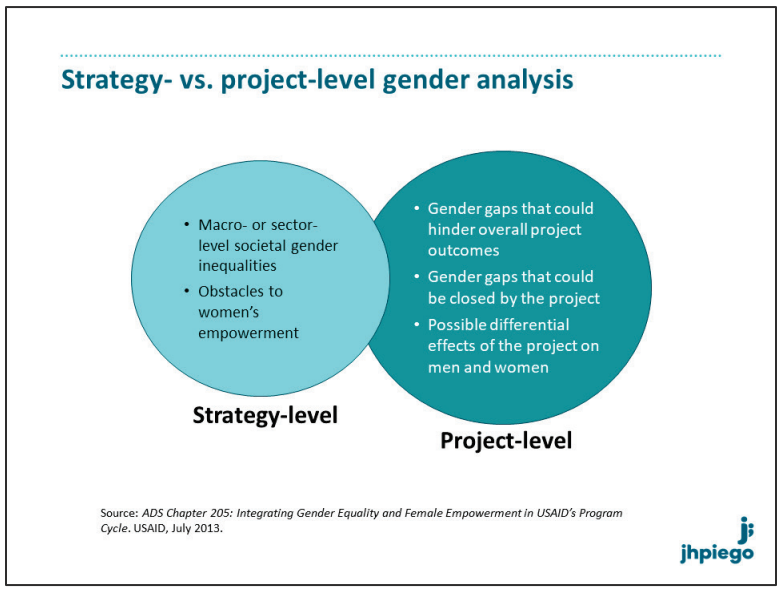
Slide 8



Facilitator discussion points

- In short, gender analysis is the process of identifying gender inequalities and determining their programmatic and developmental implications. That is, gender analysis identifies and examines the social constructs of what it means to be a woman and girl or man and boy—and how these impact the lives and health of women and girls and men and boys.
- This definition was adapted from the Canadian International Development Agency, which is just one of several agencies that now require a gender analysis. USAID also requires projects to complete a gender analysis. Hence, we are now including gender analysis in the program technical standards.

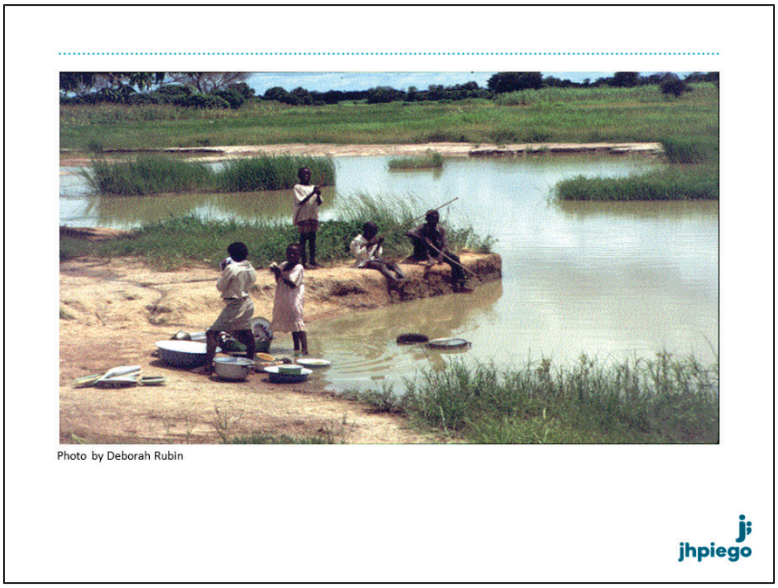
Slide 9



Facilitator discussion points

- USAID has collected evidence illustrating that by addressing gender, programs/projects can achieve more sustainable results.
- According to USAID policy guidelines, gender analysis is required for strategies and projects.
  - At the strategy level (e.g., Country Development Cooperation Strategies [CDCS]), the analysis should identify the macro- and sector-level societal gender inequalities and obstacles to women's empowerment so that gender equality and women's empowerment can be linked to the achievement of the operating unit's CDCS goal, development objectives, and intermediate and/or sub-intermediate results.
  - At the project level, the gender analysis should dig deeper to identify:
    - > Relevant gaps in the status and anticipated levels of participation of women and men (including age, ethnicity, disability, location) that could hinder the project's outcomes
    - > Differences in the status of women and men (e.g., economic, political) that could be reduced/eliminated as a result of the project
    - > Possible differential effects the project might have on women and men
  - At the project level, findings from the gender analysis should influence project design to ensure that the project explicitly addresses any disparities between women and men and includes actions to reduce gender inequalities uncovered by the analysis.

Slide 10



Facilitator discussion points

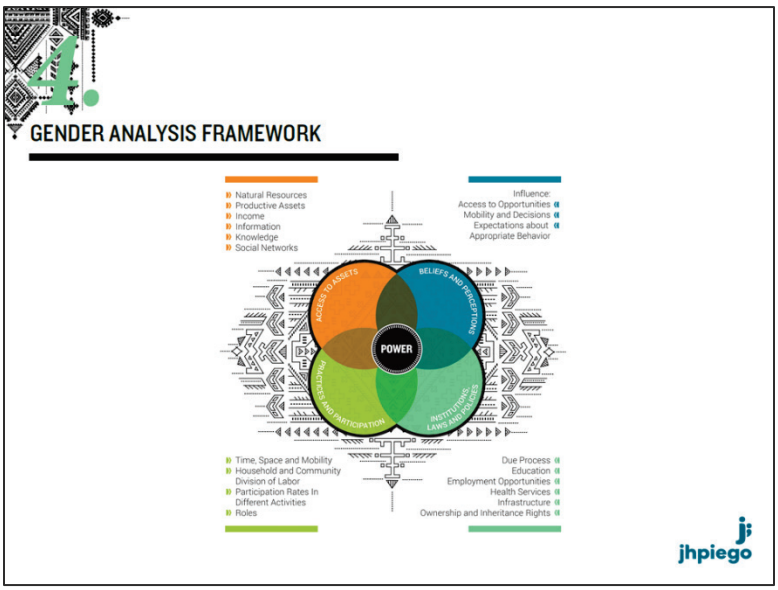
- Ask participants what they see in this photo. Typical responses will likely include, “Boys are fishing and girls are washing dishes.”
- Once you have collected a few responses, ask, “Are you sure? Do you know who the girls are and who the boys are in this photo? How do you know?” Participants will likely respond that the girls are wearing dresses, and the boys are wearing shorts. At that point, ask, “Do you know what community this is? And whether girls typically wear dresses and boys wear shorts there?”
- Make the point that we cannot assume the gender expression or roles of a community when coming in. In this photo, we cannot see biological differences among the individuals in the photo, so it IS hard to say who are the boys and who are the girls.

Slide 11

Facilitator discussion points

- Don’t assume everything you think! We often make assumptions about gender identities, norms, and behavior, but these can vary not only from country to country but also from community to community. Gender analysis pushes us to ask questions that eliminate those assumptions and understand gender and, ultimately, how gender impacts our programs.

Slide 12



Facilitator discussion points

- There are four main domains in which we examine the roles, power, and status of women and men in society:
  - Access to assets, for example, if a man controls the purse strings in a household, he may not allocate funds for a woman to deliver in a facility
  - Beliefs and perceptions, for example, the belief in many sub-Saharan African countries that a "real" man has many children
  - Institutions, laws, and policies, for example, national laws around the age of marriage
  - Practices and participation, for example, countries in which women and girls eat last, even when pregnant

Slide 13

© Farah Riaz, 2007, Courtesy of Photoshare

Facilitator discussion points

- Access refers to being able to use the assets necessary to be a fully active and productive participant (socially, economically, and politically) in society. It includes access to
  - Natural and productive resources
  - Income
  - Services
  - Employment
  - Education
  - Social capital and resources (i.e., social connections between individuals and networks)
  - Information
  - Benefits

Slide 14

Facilitator discussion points

- This domain refers to peoples' behaviors and actions in life (what they actually do) and how this varies by gender. It encompasses not only current patterns of action but also the way that people engage in development activities. It includes attending meetings, participating in training courses, accepting or seeking out services, and undertaking other development activities. Participation can be active or passive:
  - Passive participants may be present in a room where a meeting is taking place and therefore may be aware of information transmitted but do not voice their opinions or play a leadership role.
  - Active participation involves voicing opinions and playing an active role in the group process.
- Gender structures people's behaviors and actions (what they do) and how they engage in reproductive health (and the particular program areas of training, such as safe motherhood) activities.

Slide 15

Facilitator discussion points

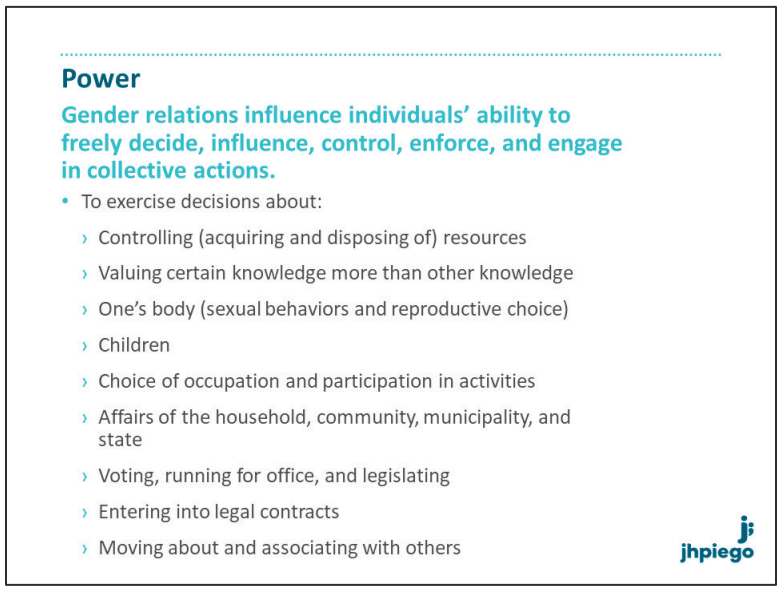
- This domain refers to people's thoughts. It also involves understanding how people interpret aspects of their lives differently according to gender categories. This domain includes:
  - Types of knowledge that men and women are privy to—who knows what based on their experiences and what's seen as appropriate to know
  - Beliefs (ideology) that shape gender identities and behavior and how men and women and boys and girls conduct their daily lives. Many of these beliefs are normative, meaning that they reflect society's expectations about the ways in which women and men and girls and boys should act, dress, speak, etc.—expectations that are collectively referred to as "gender norms"
  - Perceptions that guide how people interpret aspects of their lives differently depending on their gender identity—whether they are women and girls or men and boys

Slide 16

Facilitator discussion points

- Gender differences exist in legal rights and status, including
  - differences in rights accorded to men and women in formal and customary legal systems,
  - differences in how the judicial (or other law and customary systems) enforce or apply the law, and
  - differences in recognition that certain rights even exist (at either the individual level, where women or men may not recognize the existence of certain rights; or at the institutional level, within written or applied laws, where certain rights are not recognized as “rights” in the first place).

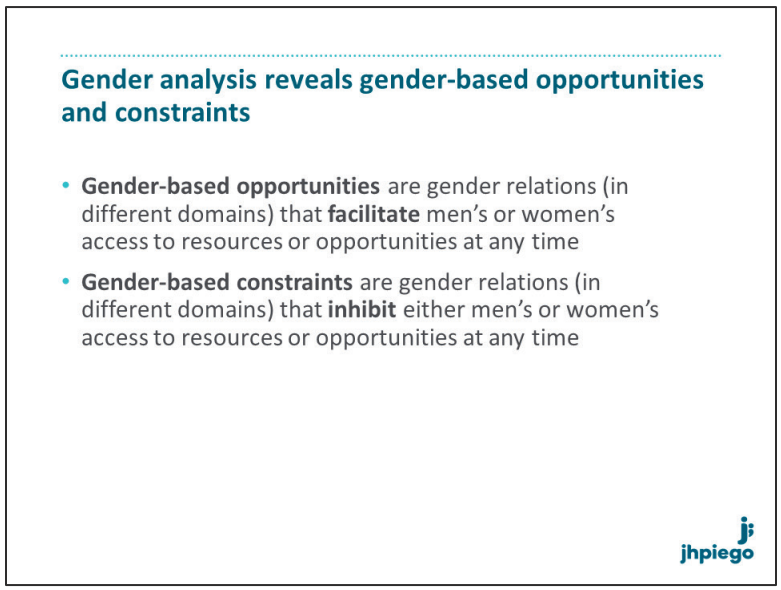
Slide 17



Facilitator discussion points

- Taken together, these four domains ultimately affect the ability of people to decide, influence, control, and enforce a decision—that is, their power to make decisions freely and to exercise power over their bodies and within their household, community, municipality, and state. This includes the capacity of adults to decide how to use household and individual economic resources and income, and their choice of employment. It also encompasses the right to engage in collective action, including the determination of rights to and control over community and municipal resources. Finally, it includes the capacity to exercise one's vote, run for office, be an active legislator, and to enter into legal contracts**.**
- Importantly, some domains can overlap. For example, access to assets such as social networks can at times be defined by an individual's roles and participation.

Slide 18



Facilitator discussion points

- In short, gender analysis seeks to systematically reveal the gender-based constraints (and sometimes opportunities) to achieving a particular program objective. To this end, gender analysis usually focuses on specific domains (such as the four we have just reviewed).

Slide 19

Facilitator discussion points

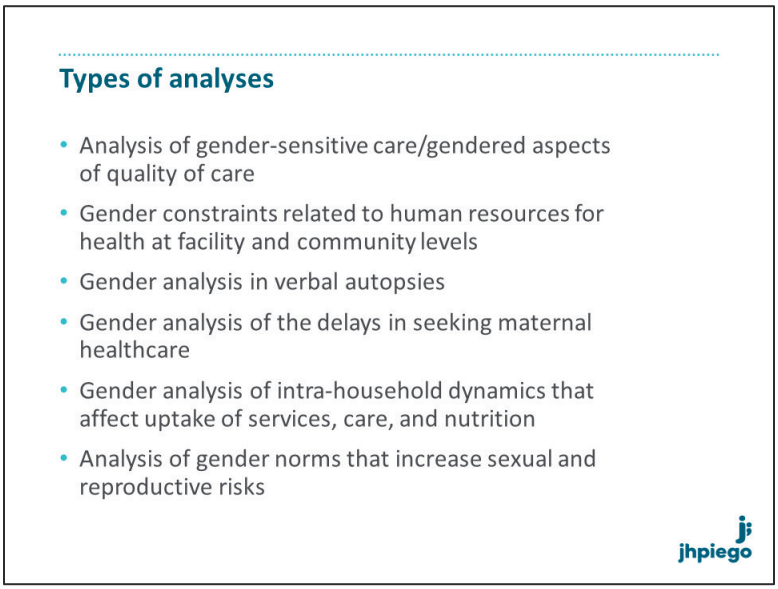
- Trying to figure out what questions to ask is tricky. You cannot go to the community and ask, what are the gender issues? People may not even know what you are talking about when you say gender. It does not even always translate. You have to sometimes start broad, but then also probe for specific issues that you know may be problematic, for example, women's limited mobility.
- A review of the literature or other secondary sources can help you with identifying these issues.
- Then you can start filling in the gaps by collecting additional data that relates to your program's objectives. (For example, USAID has broad gender assessments of each country that often give a general overview of gender disparities based on things like DHS data, but don't necessarily analyze down to the level at which we work. For example, you may want to know more specifically about health service providers' gender attitudes that may inhibit women's or men's health-seeking behaviors.)
- Once you have identified these issues more comprehensively, you must prioritize what you will address based on your project objectives and institutional support among stakeholders (i.e., donors, Jhpiego, governments).

Slide 20

Facilitator discussion points

- Analysis includes trying to understand how gender constraints and opportunities impact your project and objectives, as well as what your project can do to address your constraints, given the specific scope of work that you have since you won't be able to tackle everything, so you need to prioritize.

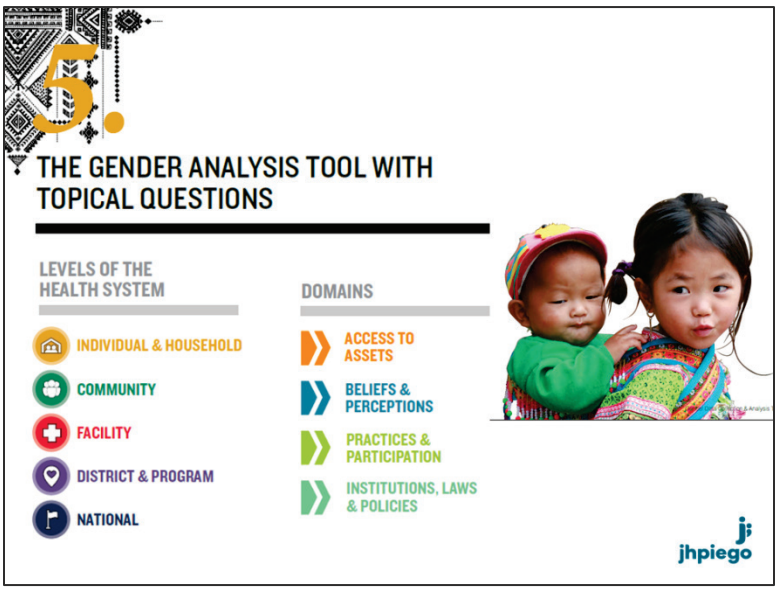
Slide 21



Facilitator discussion points

- These are examples of different types of analyses that may be completed at different levels of the health system.

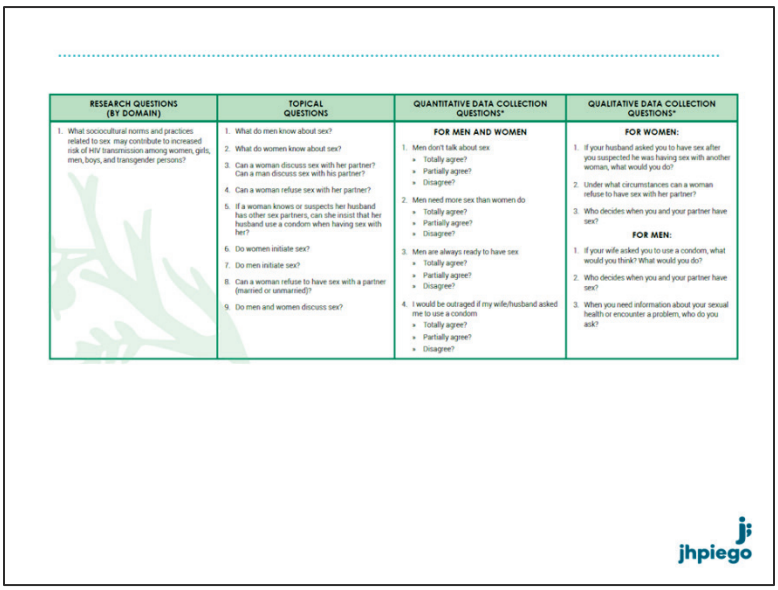
Slide 22



Facilitator discussion points

- Complete an analysis across different levels of the health system. Although we have been talking about gender and power relations, gender relations are linked to a host of other power relations at work in a specific context, such as power relations of ethnicity, class, race, and age. Gender relations also vary by context—that is, the type and degree to which a woman (or man) experiences gender constraints may be very different in a household and in a work context.
- Gender relations and gender analysis vary according to the specific context in which they occur. Therefore, although some gender patterns may appear remarkably similar across contexts, it is critical to understand the specific relations (and ongoing changes and contradictions in these relations) across time, in different organizational contexts and in different sociocultural contexts.

Slide 23



Facilitator discussion points

- These are not questions you would insert directly into a research instrument; they are just topical questions. You still need to look at specific tools and develop your own research instruments or methods for collecting data.

Slide 24

Facilitator discussion points

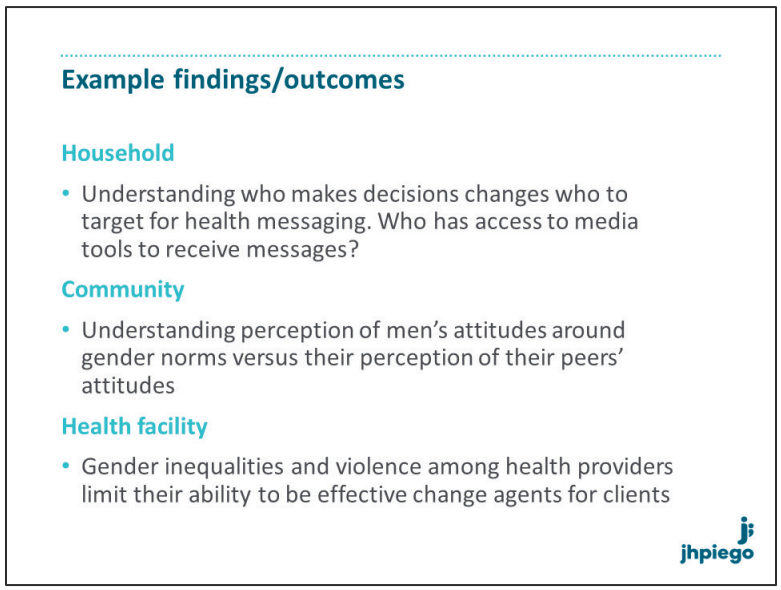
- These are examples of questions that could be asked for each of the four domains of the Gender Analysis Framework. The questions also pertain to a specific level of the health system (e.g., district and program level). Again, you will still need to look at specific tools and develop your own research instruments or methods for collecting data.

Slide 25

Facilitator discussion points

- The toolkit also includes a comprehensive list of resources and tools for conducting a gender analysis.

Slide 26



Facilitator discussion points

- **Household**: In Burma, for example, women are 23% less likely than men to own a mobile phone. Thus, mHealth messaging is less likely to reach them. Likewise, DHS data show that in many countries, the majority of women are not the primary decision-makers for their own health. The 2016 DHS from Afghanistan indicates that just 5% of women are the sole decision-makers for their own health.
- **Community**: In Tanzania, the baseline for the CHAMPION project, which sought to change male norms and behavior that drive HIV (such as multiple concurrent partners, forced sex, and poor uptake of HIV testing and counseling services), found that men perceived themselves to be more gender equitable than their peers. This influenced the design of the program to target not only men as individuals but as men in peer groups and community dialogues to dispel community perceptions of what it is to "be a man."
- **Health facility**: Health workers themselves are part of the same communities and social environment as their clients. As such, they are subject to the same social and gender norms. More and more research is uncovering information about gender-related norms and behaviors that influence health workers. For example, a 2011 study by Constance Newman and colleagues (Newman et al. 2011) in Rwanda found that 39% of health workers had experienced some form of workplace violence in the year before the study. The study identified gender-related patterns of perpetration, victimization, and reactions to violence. Negative stereotypes of women, discrimination based on pregnancy, maternity, and family responsibilities and the "glass ceiling" affected female health workers' experiences and career paths and contributed to a context of violence. Gender equality lowered the odds of health workers experiencing violence.

Reference

Newman CJ, de Vries DH, d'Arc Kanakuze J, Ngendahimana G. 2011. Workplace violence and gender discrimination in Rwanda's health workforce: Increasing safety and gender equality. *Hum Resour Health*. 9:19. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3154143/.

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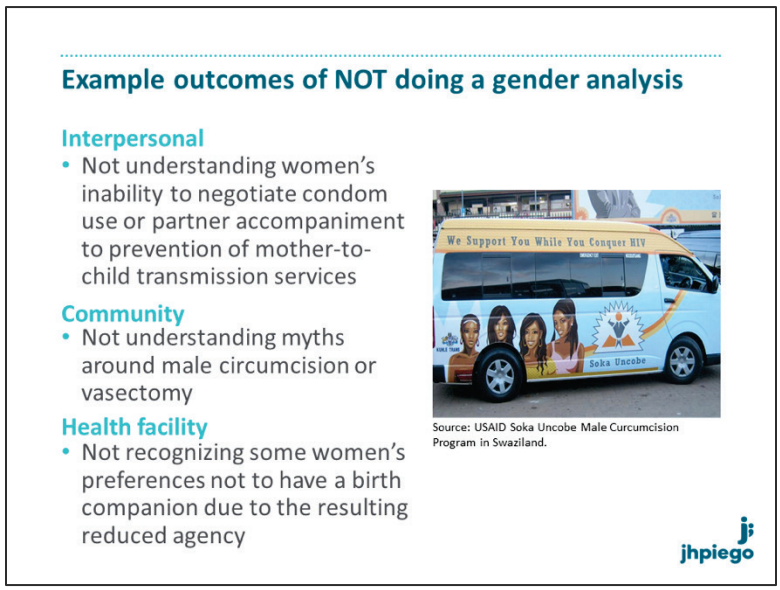

Facilitator discussion points

- **Interpersonal**: Efforts in Thailand included a 100% condom use campaign with sex workers and policies on male involvement in prevention of mother-to-child transmission (PMTCT).
- **Community**: In Malawi, the word for vasectomy is the same as impotent, which conflict with notions of manhood. *Soka Uncobe* means "Circumcise and Conquer" in Swazi. Knowing that female partner preference for voluntary medical male circumcision (VMMC) is a strong motivator of uptake, USAID designed a demand creation strategy that included women's support and preference for VMMC as a main message. However, the program did not perform a gender analysis, and therefore did not take into consideration the Swazi tradition of men (including the king) having multiple wives and female partners (hence Swaziland's highest HIV prevalence of any country in the world). There is also a pervasive myth that VMMC is an "invisible condom" or "magic bullet" that offers complete protection against HIV. The campaign's messaging (seen on the bus) was interpreted by many to mean that VMMC allows men to go out and "conquer" many beautiful women.
- **Health facility**: Many initiatives have identified birth companionship as an indicator for respectful maternity care, but this does not recognize that it could in fact take away women's agency to have a birth companion in the birthing room.

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Facilitator Resource: Gender Integration—Table 1/completed

Program goal and/or overall health objective: Reduce prevalence of GBV

What are the key gender relations inherent in each domain that affect women and girls, men and boys?	What other potential information is missing but needed about gender relations?	What are the gender-based constraints to reaching program objectives?	What are gender-based opportunities to reaching program objectives?
Practices and participation: • Men are the decision-makers in the household. • Men serve as the main sources of health information in the household. • Men are the main breadwinners of the family. • Women are responsible for birth, delivery, and caring for the children.	**Practices and participation:** • What are men taught about their familial responsibilities? • Are there any household decisions that are discussed jointly by women and men? • Are there any informal spaces in which men discuss health and relationship issues with other men?	**Practices and participation:** • Women do not have much decision-making power. • The male is the main source of health information for the family. • Men are not involved during and after pregnancy.	**Practices and participation:** • Women seem to move about with some degree of freedom in the public sphere.
Beliefs and perceptions: • Men are considered more reliable sources of information than women. • There is a belief that maternal and child health should not concern men. • High rates of GBV indicate some community tolerance of GBV. • Women are believed to be inferior to men. • It seems acceptable for men to abandon their HIV-positive female partners. • HIV stigma is high. • Men's fears surrounding lack of confidentiality limits their use of testing services.	**Beliefs and perceptions:** • Do women have knowledge about available services for GBV survivors (e.g., legal counsel, shelters, psychosocial services)? • Are women who experience GBV stigmatized in the community? • Is GBV discussed?	**Beliefs and perceptions:** • Social norms may discourage male involvement in maternal and child health. • Community stigma dissuades men and women from getting tested. • Fear of violence dissuades women from getting tested. • Women are perceived as unreliable sources of information. • Men tend to mistrust health facilities (e.g., belief that confidentiality is not guaranteed).	**Beliefs and perceptions:** • Men view health providers as reliable sources of information.

What are the key gender relations inherent in each domain that affect women and girls, men and boys?	What other potential information is missing but needed about gender relations?	What are the gender-based constraints to reaching program objectives?	What are gender-based opportunities to reaching program objectives?
Access to assets: • Women are able to access ANC services. • Women's use of health facilities for delivery is limited. • Women seem to have limited access to income generation activities/opportunities. (They are highly financially dependent on men.) • Men restrict their female partners' access to testing sites. • Women may have limited access to PMTCT services and information. • Most women have access to primary education. • Services for GBV survivors (health, legal, psycho-logical, etc.) may not exist, or people may not know how to access them. Even if there is knowledge about these services, men may prohibit women from accessing them.	**Access to assets:** • Even though men are not expected to be involved in pregnancy and delivery, do they have any influence over decisions related to where delivery occurs? If, so what role do they play in these decisions? • Are any services available for women who experience violence? • How and where are PMTCT services and information offered? • Are any support services available for individuals who test positive for HIV (e.g., psychosocial services, financial aid services)?	**Access to assets:** • Women are largely financially dependent on their male partners, which may limit their ability to make decisions independently. • Women's limited access to economic opportunities restricts their ability to make health decisions that would incur financial costs (e.g., funds to travel to the health facility, funds to pay for health services). • Availability of PMTCT services appears limited.	**Access to assets:** • ANC services seem to be widely available.
Institutions, laws, and policies: • Men's abandonment of their female partners following disclosure of HIV status may indicate an absence of legal protections for married women and women in domestic partnerships. • There may no law(s) criminalizing GBV. • Health facilities offering maternal and newborn health services may not be welcoming to men.	**Institutions, laws, and policies:** • Do women have the legal right to any sort of financial support after a marriage/domestic partnership, especially if children are involved? • What are health facility policies regarding men's participation in ANC, delivery, and birth? • Is GBV illegal? Are there legal mechanisms for justice, treatment services, etc., available to women who experience GBV?	**Institutions, laws, and policies:** • Men may not be legally obligated to support children they father with partners to whom they are not married.	**Institutions, laws, and policies:** • None are mentioned in the case study.

Facilitator Resource: Gender Integration—Table 2/completed

Step 2. What gender-integrated objectives can you include in your strategic planning to address gender-based opportunities or constraints?	Step 3. What proposed activities can you design to address gender-based opportunities or constraints?	Steps 4 and 5. What indicators for monitoring and evaluation will show if (1) the gender-based opportunity has been taken advantage of, or (2) the gender-based constraint has been removed?
Practices, roles, and participation: • Encourage increased male participation in PMTCT	**Practices, roles, and participation:** • Train male peer educators to facilitate reflection sessions with men on the links between gender norms, GBV, and SRH outcomes • Hold education sessions with fathers-to-be and couples on how men can contribute to a healthy pregnancy and delivery • Offer education sessions with men on their role in PMTCT • Encourage men's involvement in couples counseling	**Practices, roles, and participation:** • Proportion of women reporting that during their pregnancy their male partner carried out at least one household task traditionally reserved for women • Proportion of women reporting that during the 6 months following delivery, their male partner carried out at least one household task traditionally reserved for women • Proportion of serodiscordant couples (male infected) who report use of a female or male condom at every intercourse occurring during pregnancy • Proportion of serodiscordant couples (male infected) who report use of a female or male condom at every intercourse during 12 month period following delivery
Beliefs and perceptions: • Reduce stigma associated with HIV and encourage and support disclosure	**Beliefs and perceptions:** • Increase community awareness on stigma and discrimination, the harm they cause, and the benefits of reducing them • Offer awareness campaigns on HIV stigma and discrimination • Facilitate group discussions with women and men on gender norms, GBV, and HIV	**Beliefs and perceptions:** • Proportion of individuals in the intervention area who express tolerant attitudes toward HIV-positive individuals • Proportion of HIV-positive women who report having disclosed their status to their male partner • Proportion of HIV-positive men who report having disclosed their status to their female partner
Access to assets: • Expand women's access to a full range of PMTCT interventions	**Access to assets:** • Train ANC health workers to systematically provide information on the benefits of HIV testing during pregnancy • Strengthen integration of PMTCT services with ANC services • Train peer counselors to provide education and psychosocial support to HIV-positive pregnant women, and follow-up after delivery	**Access to assets:** • Number of pregnant women who have been tested for HIV • Number of pregnant and breastfeeding women following a PMTCT regimen

Step 2. What gender-integrated objectives can you include in your strategic planning to address gender-based opportunities or constraints?	Step 3. What proposed activities can you design to address gender-based opportunities or constraints?	Steps 4 and 5. What indicators for monitoring and evaluation will show if (1) the gender-based opportunity has been taken advantage of, or (2) the gender-based constraint has been removed?
Institutions, laws, and policies: • Health facilities are strengthened to encourage male participation in maternal and newborn health	**Institutions, laws, and policies:** • Support health facilities to develop and operationalize institutional policies that enable men's participation in ANC, labor, and delivery • Train health workers on the provision of male-friendly health services • Train health workers on couples counseling	**Institutions, laws, and policies:** • Percentage of male partners accompanying female partner for ANC visits • Proportion of male partners present during labor and delivery

Facilitator Resource: Table 1/blank

Gender relations	Missing information	Gender-based barriers	Gender-based opportunities
Practices and participation:	**Practices and participation:**	**Practices and participation:**	**Practices and participation:**
Beliefs and perceptions:	**Beliefs and perceptions:**	**Beliefs and perceptions:**	**Beliefs and perceptions:**
Access to assets:	**Access to assets:**	**Access to assets:**	**Access to assets:**
Institutions, laws, and policies:	**Institutions, laws, and policies:**	**Institutions, laws, and policies:**	**Institutions, laws, and policies:**

Facilitator Resource: Table 2/blank

Gender-integrated objectives	Activities	Indicators
Practices and participation:	**Practices and participation:**	**Practices and participation:**
Beliefs and perceptions:	**Beliefs and perceptions:**	**Beliefs and perceptions:**
Access to assets:	**Access to assets:**	**Access to assets:**
Institutions, laws, and policies:	**Institutions, laws, and policies:**	**Institutions, laws, and policies:**

Module 8

Couples Counseling

jhpiego
Saving lives. Improving health.
Transforming futures.

Session 30: Overview of Effective Counseling

Learning Objective

- To discuss and practice effective foundational counseling skills

Time

1 hour 30 minutes

Materials Needed

- Chairs organized in a semicircle
- Flipchart paper
- Flipchart stand
- Masking tape
- Markers
- **Participant Handout: Job Aid: Overview of Effective Counseling**
- **Participant Handout: Job Aid: Checklist for the Elements of Effective Interpersonal Communication**
- **Participant Handout: Job Aid: Verbal and Nonverbal Communication Techniques**
- **Participant Handout: Job Aid: Using the G-A-T-H-E-R Method**
- **Participant Handout: Role-Play Scenarios 1–4**

> **Facilitator note:** This session introduces foundational techniques and skills in health counseling and should be delivered before more advanced sessions on gender-sensitive care, couples counseling, and male engagement.

Advance Preparation

1. Print and cut out the character profiles detailed on the **Participant Handout: Role-Play Scenarios** role-play descriptions. You will need to print enough copies of each role-play scenario for each group of three to have at least one set.
2. Make enough copies of each of the four **Participant Handout: Job Aids** for each participant to receive a copy of each job aid.
3. Set up equipment and download links to show the video clips.

Steps

Introduction (1 minute)

1. Begin the session by stating that providing clients with effective counseling is a skill that is developed and practiced over time.

2. Explain that this session gives participants an overview of effective counseling techniques and the opportunity to practice counseling in a safe environment and receive feedback to sharpen their skills.

Overview of Effective Counseling (40 minutes)

1. Write the words "information giving" and "counseling" on the top of the flip chart. Ask participants to describe the key components of each activity. During the discussion, be sure to emphasize that information giving is a one-way form of communication whereas counseling involves bidirectional communication between the client and the counselor, and aims to help clients to make informed choices about their health.
2. Next, distribute all handouts and refer specifically to the **Participant Handout: Job Aid: Overview of Effective Counseling**. Facilitate a 5-minute mini-lecture that summarizes the bulleted key points of high-quality counseling. Give participants an opportunity to ask questions.
3. Direct participants to the next **Participant Handout: Job Aid: Using the G-A-T-H-E-R Technique**. Explain that G-A-T-H-E-R is an acronym and each letter stands for a step in the patient-provider interaction. Next, briefly summarize each of the six steps of G-A-T-H-E-R.
4. Tell participants they will now observe examples of effective and ineffective counseling sessions via short videos. Before showing the videos, review **Participant Handout: Job Aid: Elements of Effective Interpersonal Communication** and **Participant Handout: Job Aid: Verbal and Nonverbal Communication Techniques** with the group. Instruct participants to note how the actors in the video do or do not demonstrate these techniques.
5. Show the first video: "Responsiveness and Communication Skills: Unsupportive."
6. Ask participants to reflect on what they observed. How did the provider's verbal and nonverbal communication impact the overall outcome of the visit (refer to **Participant Handout: Job Aid: Elements of Effective Interpersonal Communication** and **Participant Handout: Job Aid: Verbal and Nonverbal Communication Techniques**)? What could be improved?
7. Show the second video: "Responsiveness and Communication Skills: Supportive."
8. Ask participants to reflect on what they observed. How did the provider's verbal and nonverbal communication impact the overall outcome of the visit (refer to **Participant Handout: Job Aid: Elements of Effective Interpersonal Communication** and **Participant Handout: Job Aid: Verbal and Nonverbal Communication Techniques**)? What went well and why?
9. Invite discussion of any outstanding questions around the job aids or content covered thus far before moving on to group role-play activity.

Role-Plays (45 minutes)

1. Explain that participants will now practice effective counseling techniques through role-plays in small groups of three. During each role-play, one group member will play the role of a client, another will play the role of a provider, and the third group member will play the role of an observer. Tell participants everyone will have an opportunity to practice each role at least once.

> **Facilitator note:** Circulate as an observer between groups and make your own observations of how the "providers" interact with the "clients." Note any general feedback about strengths or challenges to reinforce, emphasize, or clarify during group discussion.

2. Ask participants to form groups of three and decide among themselves who will play each role first.
3. Instruct participants playing the roles of client and provider not to share their descriptions with anyone. Ask observers to review **Participant Handout: Job Aid: Elements of Effective Interpersonal Communication** as they watch the interaction and to offer feedback at the end.
4. Allow participants 1 minute to read their descriptions. If any participants have questions about their profiles, meet with them one on one. Encourage the participant playing the role of the provider to refer to the four **Participant Handouts: Job Aids** as needed throughout the practice activity.
5. Next, instruct the participants to carry out their counseling session role-play for 5 minutes.
6. After 5 minutes, stop the role-plays and ask the observers to facilitate a 5-minute debrief (additional details are included in the role-play handouts).
7. Next, ask the participants to rotate roles and decide among themselves who will play each role next. Instruct participants to move on to the next case study. Repeat steps 2–6 at least two more times so each participant has an opportunity to practice each role.
8. After the groups have completed at least three role-plays total (more if you have time and/or feel the group would benefit from additional practice), facilitate a 15-minute group discussion using the following questions:
    - Which role-play was the most challenging? Why?
    - Were the role-play scenarios realistic? Why or why not?
    - How did the providers use verbal and nonverbal techniques to demonstrate empathy to clients?
    - Have you ever been in a situation when you did not know what to say or do during a counseling session? What did you do/what would you do in the future if this happened?

Closing (4 minutes)

1. End the session by summarizing the main strengths demonstrated by service providers during the role-plays, as well as recommended ways to improve counseling that were discussed as a group. Remind participants of the importance of empathy as an element of effective counseling.

Acknowledgments

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Participant Handout: Job Aid: Overview of Effective Counseling

Client-provider interaction

Client-provider interaction is an umbrella term that includes two elements: 1) information giving and 2) counseling. Usually, these elements do not occur independently, but as part of one interaction between a client and provider.

Information giving	Counseling
One-way communication between a provider and a client. Here, the provider explains a reproductive health issue or service to the client, or the client tells the provider about a problem that she or he is experiencing.	**Two-way** communication between a provider and a client aimed at creating awareness of sexual and reproductive health issues and helping clients to reach informed and voluntary decisions about their reproductive health care. Counseling includes asking clients about their needs, exploring various options that are available, and identifying together the solution that best meets the needs of the client.

Informed choice
Informed choice is a voluntary, well-considered decision that a client makes on the basis of options explored, information given, counseling received, and understanding gained during an interaction with a service provider. The client's informed decision must be made free of stress, pressure, or coercion.

Key Points for High-Quality Counseling for Sexual and Reproductive Health

- Counseling should be a two-way dialogue between the health provider and client, one in which both are active participants asking and answering questions.
- Questions are answered honestly and fully, by both the health providers and client.
- Benefits and side effects of the chosen sexual and reproductive health product or service are explained accurately.
- Available alternative options are presented to the client so she or he can make an informed, voluntary decision.
- Adequate time is set aside before and after the provision of a sexual and reproductive health product or service to ask and answer additional questions.
- Empathy is the ability to understand and share another person's feelings or emotions. Empathy is an important element of effective counseling, which will be explored further in the role-plays.

Participant Handout: Job Aid: Elements of Effective Interpersonal Communication

Empathy	Problem-Solving	Counseling
Have you . . .	Have you . . .	Have you . . .
Greeted the client in an open and appropriate way	Listened actively	Explored the client's understanding of his or her illness
Used nonverbal communication to show that you are listening	Encouraged dialogue using open-ended questions	Corrected misunderstandings or misinformation
Invited the patient to tell you how he or she feels both physically and emotionally	Avoided interrupting the patient	Used vocabulary and explanations that the client can understand
Shown the client that he or she is respected and valued	Avoided distractions	Used visual aids if available
Demonstrated concern	Asked the client what they think has caused the ailment	Recommended concrete behavioral changes
Echoed the client's emotions	Probed the client for more information using phrases like "please go on"	Collaborated with the client to select an appropriate and feasible treatment
Expressed support and partnership	Waited until you have all the relevant information to make a diagnosis	Motivated the client to comply with the treatment
Given realistic encouragement and reassurance		Summarized the diagnosis, treatment, and recommended steps in simple terms
Acknowledged any service problems, apologized, and offered a solution		Asked the client to repeat or describe the treatment terms
		Urged the patient to ask additional questions
		Confirmed follow up actions with patient

Source: Health Initiatives for the Private Sector (HIPS). 2008. *Effective Interpersonal Communication: A Handbook for Healthcare Providers*, 8. https://ccp.jhu.edu/documents/EffectiveInterpersonalCommunication_HandbookforProviders_0.pdf.

Participant Handout: Job Aid: Verbal and Nonverbal Communication Techniques

The following techniques help providers improve client-patient interactions.

- **Effective questioning** helps obtain useful information from the client. Questioning is a way to determine what service the client wants or how the client is feeling, what the client already may know, or what problem the client may have. It is also a way to determine whether the client has understood you.
  - **Open-ended questions** encourage the client to offer information, concerns, and feelings freely.
    - Example: How do you feel today?
  - **Closed ended questions** help obtain specific information, especially if there is a limited time, such as in an emergency or when taking a medical history. These questions can be answered in just a few words.
    - Example: Do you have any allergies?
  - **Probing questions** encourage the respondent to give further information and to clarify an earlier point. They require tact in wording and tone to avoid seeming judgmental.
    - Example: Could you tell me more about that?
- **Active listening** helps you get the information you need to assist the patient with problems and help them to make decisions. Active listening means paying attention to what is being said, observing the client's nonverbal communication, and using actions such as having eye contact and nodding.
- **Reflection/echoing** occurs when a provider observes a client's emotions and reflects them back to the client. This helps the provider check whether the emotions he or she has observed are correct. It also helps to show that the provider has empathy and respect for the client's feelings.
- **Summarizing and paraphrasing** means repeating back to the client what you heard him or her say in a short form. It helps to ensure that you have understood correctly and provides an opportunity for clarification.
- **Praise and encouragement** build a client's sense of confidence and reinforce positive behaviors. This occurs when providers use words and gestures that motivate and assure a client of approval.
- **Giving information** clearly and simply with visual aids helps equip clients with accurate, relevant health information that is based on what the client already knows.

Source: Health Initiatives for the Private Sector (HIPS). 2008. *Effective Interpersonal Communication: A Handbook for Healthcare Providers*, 9. https://ccp.jhu.edu/documents/EffectiveInterpersonalCommunication_HandbookforProviders_0.pdf.

Participant Handout: Job Aid: Using the G-A-T-H-E-R Method

G-A-T-H-E-R is a useful tool that helps providers interact with their patients appropriately and effectively. Each letter of the word stands for an important step in the patient-provider interaction.

GREET your clients politely and with a smile.

- Welcome them using local language to make them feel comfortable.
- Introduce yourself and ask how you can help.

ASK your clients about their reasons for coming.

- Help them explain how they feel and what they need.
- Ask them about their experience with past ailments, medications, treatments, and their lifestyles.
- Ask if they have had any medical tests done lately, and if they are willing to share the results with you.
- Listen well, show empathy, and avoid judgments and opinions.

TELL your clients about their choices.

- Tell them that you will not tell others what they say (confidentiality).
- Tell them about the benefits of further testing, including HIV testing.
- Tell them that condoms work as reliable protection against sexually transmitted infections and HIV (re)infection.
- Talk about their possible choices in treatment.
- Show samples of information, education, and communication (IEC) materials, models, and products if possible.

HELP your clients choose treatment options that suit them.

- Help them to understand their available options.
- Find out what they have used before and if they want to switch to another treatment or medication.
- Offer advice or recommend a choice, but avoid making the client's decision.

EXPLAIN fully how to carry out the client's treatment option.

- Give clients printed material to take home.
- Provide all necessary information for carrying out treatment.
- Explain what treatment is, how it works, how to use associated products, the potential side effects and how to manage them.
- Tell clients to come back whenever they wish, or if side effects bother them.
- Ask clients to repeat instructions and make sure they understand.
- Explain when to come back for routine followup or more supplies.

- Provide additional information on how clients can care for themselves, e.g., hygiene, nutrition, rest or exercise.

REFER your clients to other suitable health facilities.

- Think about what other services your clients may need, e.g., voluntary counseling and treatment, antiretroviral therapy, prevention of mother-to-child transmission, and antenatal care, and tell them where to find them.
- Encourage clients to come back for followup visits.
- At followup visit, ask if clients are satisfied and treat all concerns seriously.

Participant Handout: Role-Play 1

Service Provider-1

A 23-year-old female comes to the clinic for information about pregnancy, infertility, and sexual dysfunction. She says she and her husband have been trying to conceive for the last 7 months and she is concerned about the situation. Please greet her and begin a 5-minute role-play counseling session to explore her needs and identify solutions together. Refer to your participant handouts, as needed.

****

Client-1

You are a 23-year-old female and have come to the clinic to get information about pregnancy, infertility, and sexual dysfunction. You have been trying to conceive for the last 7 months and are concerned about the situation. You feel pressured by your mother-in-law to have children and feel shame and worry that something might be wrong with you or your husband. You do not know what to do, and above all else, you are looking for a service provider who will listen to your concerns without making you feel blamed.

****

Observer-1

Observe your peers role-play a short counseling session. Note the types of verbal and nonverbal communication techniques being used. Pay attention to how the provider does or does not show empathy to the client. After 5 minutes, facilitate a 5-minute debrief in which you share feedback about your own observations and also ask your peers the following:

- **To the client:** How did the provider treat you? How did the provider demonstrate empathy? What did the provider do well? How could the quality of the counseling be improved?
- **To the provider:** How did the session go for you? What do you think you did well as the provider? What was most challenging about your role as the provider?

Participant Handout: Role-Play 2

Service Provider-2

Situation: A 17-year-old female comes to the clinic to get information about family planning options. She is not married. You are meeting with her for the first time to discuss the various options, benefits, and drawbacks associated with female methods of contraception. Please greet her and begin a 5-minute role-play counseling session to explore her needs and identify solutions together. Refer to your participant handouts, as needed.

****

Female Partner-2

Situation: You are 17 years old, unmarried, and recently became sexually active with your male partner. You have come to the clinic to get information about and to start using a female method of contraception. The last time you went to a clinic, the provider scolded you for being sexually active before marriage, and above all else, you are hopeful that this provider will be caring and listen to your questions without judgment or telling others.

****

Observer-2

Observe your peers role-playing a short counseling session. Note the types of verbal and nonverbal communication techniques being used. Pay attention to how the provider does or does not show empathy to the client. After 5 minutes, facilitate a 5-minute debrief in which you share feedback about your observations and ask your peers the following:

- **To the client:** How did the provider treat you? How did the provider demonstrate empathy? What did the provider do well? How could the quality of the counseling be improved?
- **To the provider:** How did the session go for you? What do you think you did well as the provider? What was most challenging about your role as the provider?

Participant Handout: Role-Play 3

Service Provider-3

A 25-year-old male comes to the clinic requesting information about sexually transmitted infections. Although he is married, he sometimes has sex with other women. He does not use condoms because he does not have sex with sex workers. The man has been having some discharge from his penis for the last few days, and he is worried about this. Please greet him and begin a 5-minute role-play counseling session to further explore his needs and identify solutions together. Refer to your participant handouts, as needed.

****

Male Client-3

You are a 25-year old male and have come to the clinic to get information about sexually transmitted infections. Although you are married, you sometimes have sex with other women. You do not use condoms because you do not have sex with sex workers. You have some discharge from your penis which you've noticed for the last few days and you are worried about it.

****

Observer-3

Observe your peers role-playing a short counseling session. Note the types of verbal and nonverbal communication techniques being used. Pay attention to how the provider does or does not show empathy to the client. After 5 minutes, facilitate a 5-minute debrief in which you share feedback about your own observations and also ask your peers the following:

- **To the client:** How did the provider treat you? How did the provider demonstrate empathy? What did the provider do well? How could the quality of the counseling be improved?
- **To the provider:** How did the session go for you? What do you think you did well as the provider? What was most challenging about your role as the provider?

Participant Handout: Role-Play 4

Service Provider-4

A woman comes to your clinic for treatment of a sexually transmitted infection for the third time this year. You are determined to offer her the treatment she needs today. Please greet her and begin a 5-minute role-play counseling session to further explore her needs and identify solutions together. Refer to your participant handouts, as needed.

****

Female Partner-4

You have come to the clinic to get treatment of a sexually transmitted infection for the third time this year. You have not had any other partners besides your husband. Lately, your husband comes home smelling of alcohol and you secretly worry that he is having sex with other women.

****

Observer-4

Observe your peers role-playing a short counseling session. Note the types of verbal and nonverbal communication techniques being used. Pay attention to how the provider does or does not show empathy to the client. After 5 minutes, facilitate a 5-minute debrief in which you share feedback about your own observations and also ask your peers the following:

- **To the client:** How did the provider treat you? How did the provider demonstrate empathy? What did the provider do well? How could the quality of the counseling be improved?
- **To the provider:** How did the session go for you? What do you think you did well as the provider? What was most challenging about your role as the provider?

Session 31: Considerations When Counseling Couples

Learning Objectives

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

- Describe the risks and benefits of counseling couples
- Describe key considerations for effective couples counseling
- Identify considerations that may arise when counseling couples

Time

2 hours

Materials

- Chairs organized in a semicircle
- Flipchart Paper
- Flipchart stand
- Markers
- **Participant Handout: Couple Counseling Group 1**
- **Participant Handout: Couple Counseling Group 2**
- **Participant Handout: Couple Counseling Group 3**
- **Participant Handout: Couple Counseling Group 4**
- **Participant Handout: Couple Counseling Group 5**
- **Participant Handout: Couple Counseling Group 6**
- **Participant Handout: Couple Counseling Group 7**
- **Participant Handout: Couple Counseling Group 8**
- **Participant Handout: Couple Counseling Group 9**
- **Participant Handout: Couple Counseling Group 10**
- **Participant Handout: Considerations for Counseling Couples**

Advance Preparation

1. Write "Benefits of providing couples counseling" and "Risks of providing couples counseling" in separate columns on a flipchart page.
2. Make one copy of each participant handout.

Facilitator note: Review the role-play scenarios in advance and select the case studies most relevant to program priorities (at least five). As needed, and depending on participants' experience with counseling, you may want to first facilitate the "Effective Counseling Skills" session.

Steps

Introduction (1 minute)

1. Start the session by explaining that offering effective counseling is an important component of our role as health workers. There are many key considerations when working with couples, which you will explore in this session.

Defining a Couple and Acknowledging Different Types of Couples (13 minutes)

1. Start by presenting the following definition on a flipchart page or slide: "Couple: Two or more persons in a relationship who are having or are planning to have sex." Ask participants if they agree or disagree and what revisions they would make to the definition based on their local context.
2. Explain that there are many types of couples. These can include:
    - Polygamous relationship: A relationship with more than two people, such as a man with more than one female partner or a woman with more than one male partner
    - Presexual
    - Engaged
    - Married or cohabiting
    - Polygamous
    - Reuniting
    - Casual partners
    - Noncohabiting
    - Sex workers and their clients
    - Sex workers and their boyfriends
    - Same-sex couples
    - Couples that do not have children
    - Couples hoping to have their first child
    - Couples that have children and want more
    - Couples that have finished having children
    3. Ask participants if they can think of any other types of couples and list those, too. Next, lead a 10-minute discussion about the different considerations each couple may have in relation to sexual and reproductive health, including HIV testing, family planning, maternal and newborn health, and other topics of concern. Do not go into too much depth here, as these areas will be discussed further in the case studies.

Benefits and Risks of Couples Counseling (15 minutes)

1. Draw participants' attention to the flipchart page showing the "benefits" and "risks" table. Ask participants to identify some benefits of providing couples counseling. List their responses in the "benefits" column. Mention, and add to flipchart, any important benefits the group did not discuss, such as:
    - Better use of condoms

- Better adherence to antiretrovirals
- Improved prevention of mother-to-child transmission when both parents know status and are able to disclose
- Better use of contraceptive methods
- Joint decision-making
- Increased communication between partners
- Better health outcomes
- Couple birth planning
- Male support in the household to facilitate breastfeeding
- Male support newborn care and child health-seeking

2. Next, ask participants to identify some risks of providing couples counseling. Allow them to share their thoughts and write their responses in the "risks" column on the flipchart page. Allow up to 10 minutes to complete steps 1 and 2. Add any important risks that the group did not discuss, including:
   - The potential to expose information the partner does not want to share
   - The potential to inhibit a female partner's right to informed choice
   - The potential to cause conflict between a couple
   - The potential to expose a woman to rejection and violence

   Remind participants that not everyone is part of a couple (for example, a person may be widowed, have multiple partners, or have no long-term partner), and it is important not to make assumptions.
3. Summarize that although there may be risks to counseling couples together, an effective counselor can 1) support couples to address health issues that the couple may otherwise struggle to deal with on their own, and 2) alleviate tension and diffuse blame that may arise for the couple.
4. Explain to participants that the rest of the session will focus on identifying ways to address issues that may arise during a couples counseling session so that providers have the knowledge and skills to help couples get the most out of their session.

Communication and Mediation Skills for Couples (45 minutes)

1. Distribute Participant Handout: Considerations When Counseling Couples.
2. Present the slides on communication and mediation skills for counseling couples and common issues that may arise.
3. Allow time to answer questions before moving onto next activity.

Case Studies (45 minutes)

1. Divide the participants into small groups and give one case study to each group. Tell participants that each group will have 10 minutes to read their case study and answer the question following the case study. Encourage participants to draw from strategies presented earlier in the session.
2. After 10 minutes, reconvene the group.

3. Ask for a representative from one of the groups to come to the front of the room and share the group's answer. Ask the individual to read the assigned case study aloud (just the opening scenario statement, not the entire page) before sharing the answer to the question.
4. After the group member has shared the group's answer, ask the other participants to offer feedback and other ideas, drawing from content discussed earlier in this session and in the presentation. Allow up to 5 minutes for this step.

> **Facilitator note:** Remind participants of the specific approaches and techniques mentioned in the talking points of the "Communication and Mediation Skills for Couples Counseling" presentation. Mention any relevant strategies from that presentation that were not already offered.

5. Repeat steps 9–10 for the remaining groups. Be sure to allot additional time if you are using more than five case studies.
6. Draw participants' attention back to the list of risks and benefits created at the beginning of the session and ask them to share any additional thoughts about the risks and benefits of couples counseling based on the group presentations. Allow up to 5 minutes for discussion.

Closing (1 minute)

1. End the session by summarizing key strategies for successful couples counseling that were presented and discussed. Emphasize that there are benefits, as well as potential risks, to couples counseling and, as health care workers, we must respond respectfully and effectively in these situations. Acknowledge that many couples can find great benefit from this service.

Acknowledgments

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Participant Handout: Considerations When Counseling Couples

Definition and purpose

Couples counseling is the provision of counseling to couples to facilitate open communication and joint decision-making regarding sexual and reproductive health (SRH) products and services. Couples counseling should be structured to promote gender equity and center on the belief that decisions related to SRH are a responsibility that both partners share.

Service Provider Responsibilities

- Set the session's tone by explaining the basic protocols and limitations of the counseling sessions (e.g., it is not a therapeutic session).
- Actively elicit information from both partners.
- Acknowledge the importance of couples working together.
- Raise difficult issues that the couple may need to address.
- Ease tension and diffuse blame.
- Facilitate dialogue between the couple.
- Demonstrate neutrality and nonbiased concern for both members of the couple.
- Convey respect for the couple's relationship.
- Understand relationships in the context of cultural values and norms.

Specific Gender and Safety Considerations

- Ensure that both partners are there voluntarily.
- Respect the initiating partner's decision on whether and how to include a partner.
- Engage both partners and recognize and address power imbalances.
- Engender participation, respect, and active listening between all parties.
- Ensure safety of both parties and do no harm, and recognize power dynamics and the risk of intimate partner violence.
- Promote equity in the couple's decision-making process.
- Provide unbiased service (e.g., toward both members of the couple, methods, etc.) and avoid coercion.
- Respect that each member of the couple has autonomy over his or her own body.
- Provide opportunity for the couple to make an informed choice, by ensuring that each partner actually understands their options, and that both partners have congruent knowledge about these options.
- Refer to other services, as needed. Respect confidentiality for both parties in the relationship.

Participant Handout: Couple Counseling Group 1

During the session with a couple, the man may do all or most of the talking. He may interrupt his partner, always speak first, or speak on his partner's behalf.

Causes:

- The couple may be showing culturally accepted patterns of communication and decision-making for men and women.
- The man may be consciously exerting his power in the relationship, and the woman may be giving up her power to avoid conflict.
- The man may be trying to show that he is competent and knows everything about the issue or situation.
- The woman may be afraid of her partner's response if she asserts her wishes.

What a man might say:

- "We are here because . . . "
- "She does not understand the problem."
- "I make the decisions in the household."

What a woman might say or do:

- "I think that whatever my husband says is best."
- The woman barely makes eye contact and stays silent.

Overall strategy to deal with the situation:

Participant Handout: Couple Counseling Group 2

The man is reluctant to share information or seems disinterested during a family planning counseling session, letting his partner do all the talking.

Causes:

- The man may be hesitant to appear as if he does not understand the information he is getting.
- The man may be unaware of his partner's existing knowledge and/or contraceptive practices.
- The man may perceive this to be a counseling session "for the woman" and thinks that he does not have anything to learn.
- The service provider may be asking questions that are hard for the man to answer, such as "How do you feel about this contraceptive method?"

What a man might say:

- "I do not know."
- "Everything is fine."
- "I do not really have any problems."
- "This is really her job."

What a woman might say:

- This is my concern, not his.
- He does not really care about family planning.
- I want him to understand and agree on different methods for family planning, but he never listens.

Overall strategy to deal with the situation:

Participant Handout: Couple Counseling Group 3

One person reveals information during the session that is a surprise to his or her partner. For example, one partner reveals preference for a particular family planning method, sexually transmitted infection (STI)/HIV status, or pregnancy status.

Causes:

- The partner is using the opportunity or safety of having a third party present to reveal the information.
- The partners may never have talked about this information before and made assumptions about the other's knowledge or attitudes.

What a man or woman might say:

- "Why did you not tell me that before?"
- "I assumed you did not want me to talk to you about that."
- "I cannot believe you hid this from me."
- "I had a former partner who used this method, and it worked for her/him."

Overall strategy to deal with the situation:

Participant Handout: Couple Counseling Group 4

A couple comes in for prenatal care and to be tested for HIV. Their HIV test results are discordant. The woman is HIV-positive and the man is HIV-negative. The man becomes very angry, accuses the woman of cheating, and claims that the pregnancy must not have been his.

Causes:

- The man may not understand that couples can be serodiscordant, even after they have had sex on many occasions.
- There may be suspicions of or actual cases of infidelity by the man, the woman, or both, and this is an opportunity to air those concerns.

What a man might say:

- "This proves this woman has been cheating on me. She is sleeping around, and now she has HIV."
- "I want nothing to do with this woman or her child."

Overall strategy to deal with the situation:

Participant Handout: Couple Counseling Group 5

A couple has been together for 12 years. They have two children, ages 8 and 10 years old. The man had jobs on and off as a construction worker over the last 10 years. Money is tight, but they have always managed to support themselves and their children, who are in school. When the couple got tested for HIV because of the husband's lingering respiratory illness, they found that he was HIV-positive. The wife is HIV-negative. The wife is angry that he has endangered both her health and possibly the health of their children. She is also afraid that he will become increasingly sick and will not be able to work, and they will lose their home. The husband is also afraid that he will not be able to work and that his wife will leave him.

Causes:

- The woman may not understand that couples can be serodiscordant, even after they have had sex on many occasions.
- There may be suspicions of or actual cases of infidelity by the woman, the man, or both, and this is an opportunity to air those concerns.
- The wife and children are dependent on the husband's income.
- The husband's identity and masculinity are dependent on his health and ability to earn an income.

What the woman might say:

- "This proves he has been cheating on me. He is always out late at the bar and comes home late. He probably has a new woman each week."
- "Who will take care of us now?"

What the man might say:

- "I have done my best to take care of my wife and kids."
- "I am in charge of this family and will always be."
- "Everything is always my fault."

Overall strategy to deal with the situation:

Participant Handout: Couple Counseling Group 6

Both partners disagree on the "plan of action" or need for information about, for example, contraception, pregnancy spacing, or treatment options.

Causes:

- One partner may want more children to secure the relationship.
- One partner may not be revealing a condition or information that is relevant to the counseling session (e.g., the man is supporting a second family; during antenatal care or delivery the woman discovered that she is HIV-positive and might not have shared this information with her partner previously).
- The man may be acting on beliefs based on myths or misinformation about family planning or reproductive health.
- The man is acting on cultural, societal, or religious beliefs that favor certain reproductive health behaviors (e.g., large families, virility, prohibition of contraception).

What a man might say:

- "We do not need to worry about that."
- "That method of birth control is wrong (or is a sin, does not work, or is only for prostitutes)."
- "A man is supposed to decide how many children he has."
- "That is her job. It is not really my concern."

What a woman might say:

- "Family planning is a woman's business."
- "He simply wants me to be pregnant all the time."
- "I wish we would talk about family planning, but he just wants to have the fun part."

Overall strategy to deal with the situation:

Participant Handout: Couple Counseling Group 7

The man verbally discounts his partner's abilities or intentions or is discounted by his partner for his abilities and intentions while discussing matters related to sexual and reproductive health during the session.

Causes

- Partners may be reinforcing stereotypes about abilities and attitudes based on gender (e.g., "men do not really care about this stuff," or "women who talk about sex are promiscuous").
- If the man verbally discounts his partner, he may feel threatened by coming into the reproductive health facility, or by the combination of the service provider and his partner, and he may be trying to assert his abilities.

What the man might say:

- "She is so forgetful, she would never remember to take the pill."
- "She is sneaky and only wants to use condoms because she is sleeping around."

What the woman might say:

- "He only wants me to take the pill so he does not have to use condoms, even though I don't like taking this pill every single day."
- "Men don't like talking about this type of thing—he isn't interested in this matter."

Overall strategy to deal with the situation:

Participant Handout: Couple Counseling Group 8

A man goes to the clinic to seek circumcision services to reduce his risk of HIV, after hearing about its benefits in a community outreach campaign. His wife accompanies him and questions his need for being circumcised to reduce HIV risk if they are already married and supposedly in a monogamous relationship.

Causes:

- Wife may suspect infidelity and husband may be having extramarital sex.
- Husband may also be concerned about his own risk of HIV due to his own suspicions that his wife is having extramarital affairs.

What the man might say:

- "This is good for my health."
- "This is man's business, not for a woman to decide."
- "I need to do whatever I can to be protected, especially since she cannot be trusted to be faithful."

What the woman might say:

- "He wants this procedure so he can sleep around with other women."
- "There is no need for voluntary medical male circumcision if he is only with me."

Overall strategy to deal with the situation:

Participant Handout: Couple Counseling Group 9

A young couple comes to the clinic for information about pregnancy and starting a family. During the session, the female client reluctantly reveals that she does not talk much with her husband these days because he becomes easily angered, especially after drinking. She states he acts out violently with shouts and sometimes even uses physical force against her. Her partner looks down at the floor and does not say much during the session.

Causes:

- The man is using violence to reinforce unequal power dynamics based on gender.
- Women and girls are the primary victims of gender-based violence because of their subordinate position in societies. Norms that emphasize men's superior status over women justify men's use of violence against women as a means of maintaining their dominant status.

What the man might say or do:

- "Everyone hits their wife sometimes."

What the woman might say or do:

- Avoid eye contact with her partner.
- "I'm sometimes afraid of him."
- "No matter what I do, he seems upset with me."

Overall strategy to deal with the situation:

Participant Handout: Couple Counseling Group 10

A couple come in together to their last antenatal appointment before their first child will be born. During the session, the woman reveals that she would like to wait at least 3 years before trying to become pregnant again because she would like to complete the degree she started before she became pregnant. Her husband wants to begin having more children right away.

Causes:

- The partners may never have talked about this information before and made assumptions about the other's knowledge or attitudes.
- The man is acting on cultural, societal, or religious beliefs that favor certain reproductive health behaviors (e.g., large families, virility, prohibition of contraception).
- One partner may want more children to secure the relationship.

What a man might say:

- "Other women her age have many children by now."
- "I thought she wanted children right away, too."

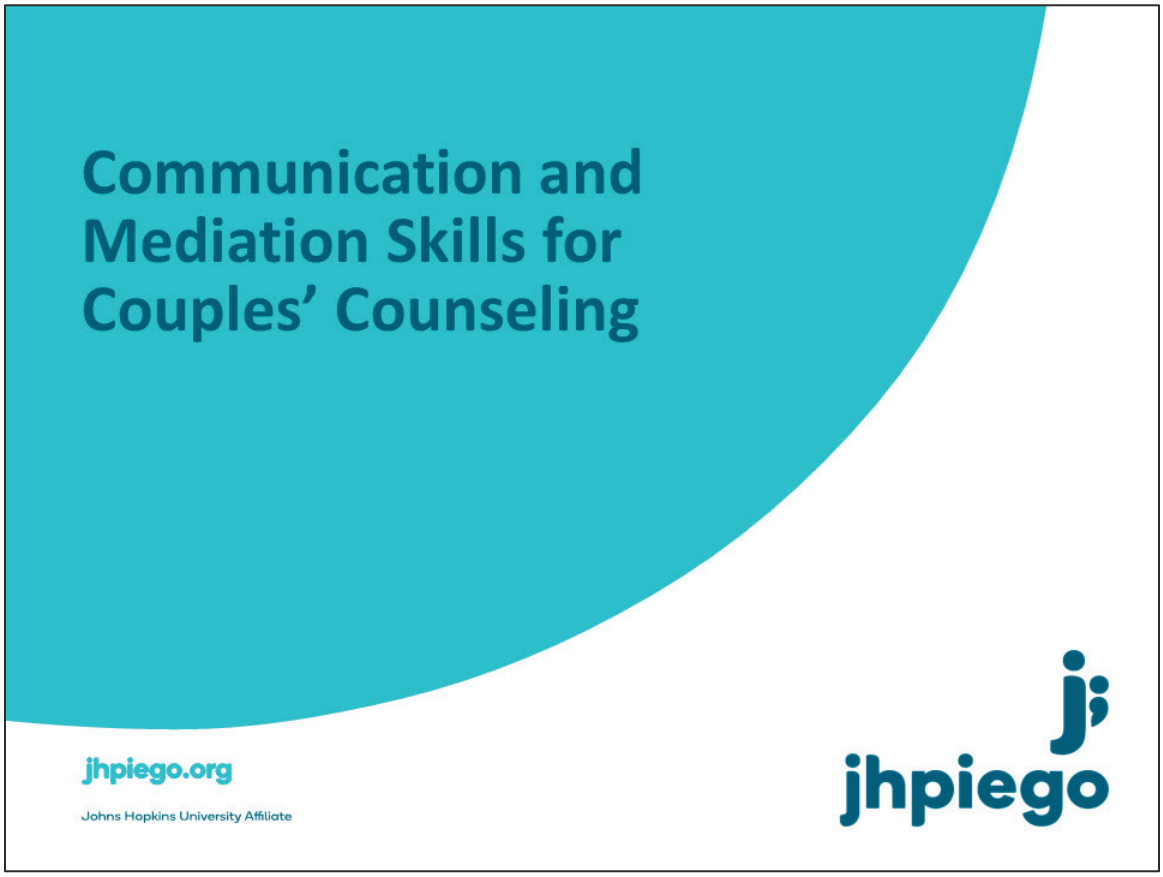
What a woman might say:

- "He simply wants me to always be pregnant."
- "He never asked me what I wanted."

Overall strategy to deal with the situation:

Facilitator's Resource: Communication and Mediation Skills for Couples' Counseling PowerPoint

Slide 1



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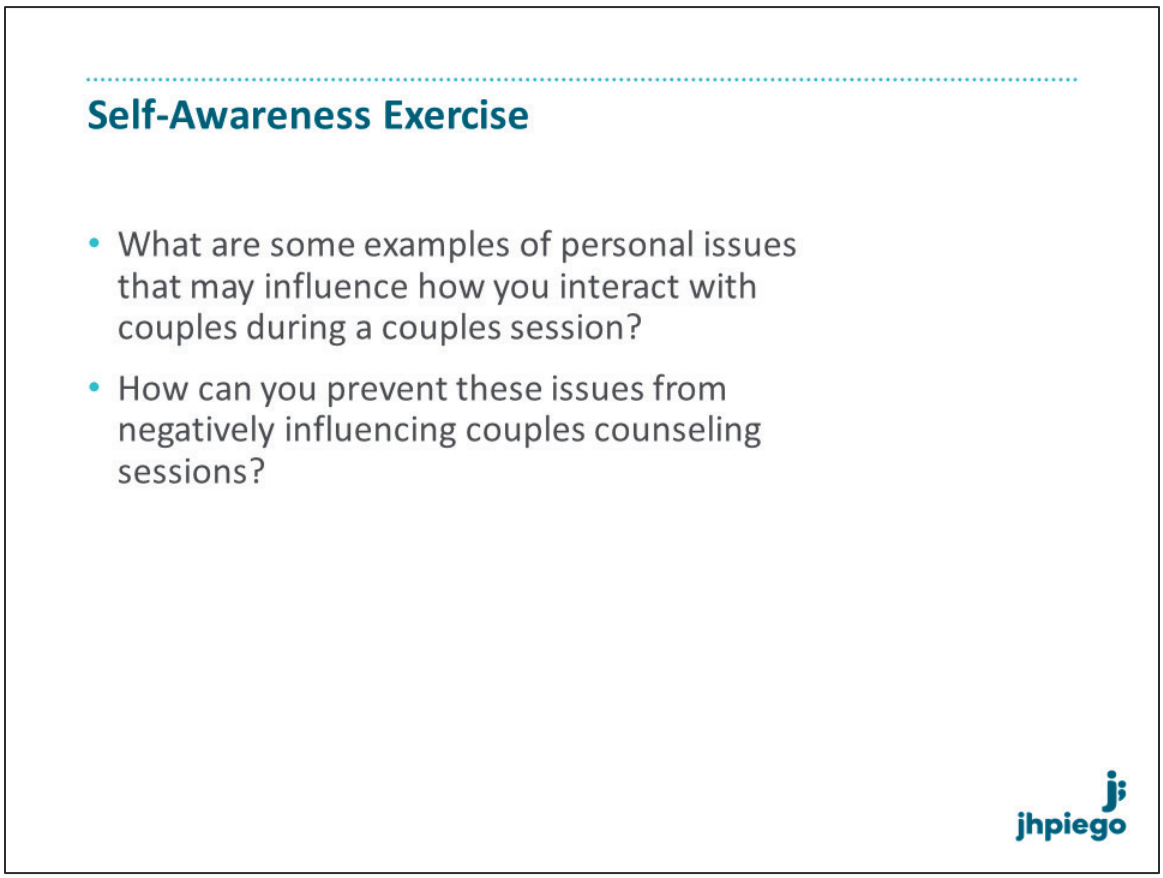


Facilitator notes

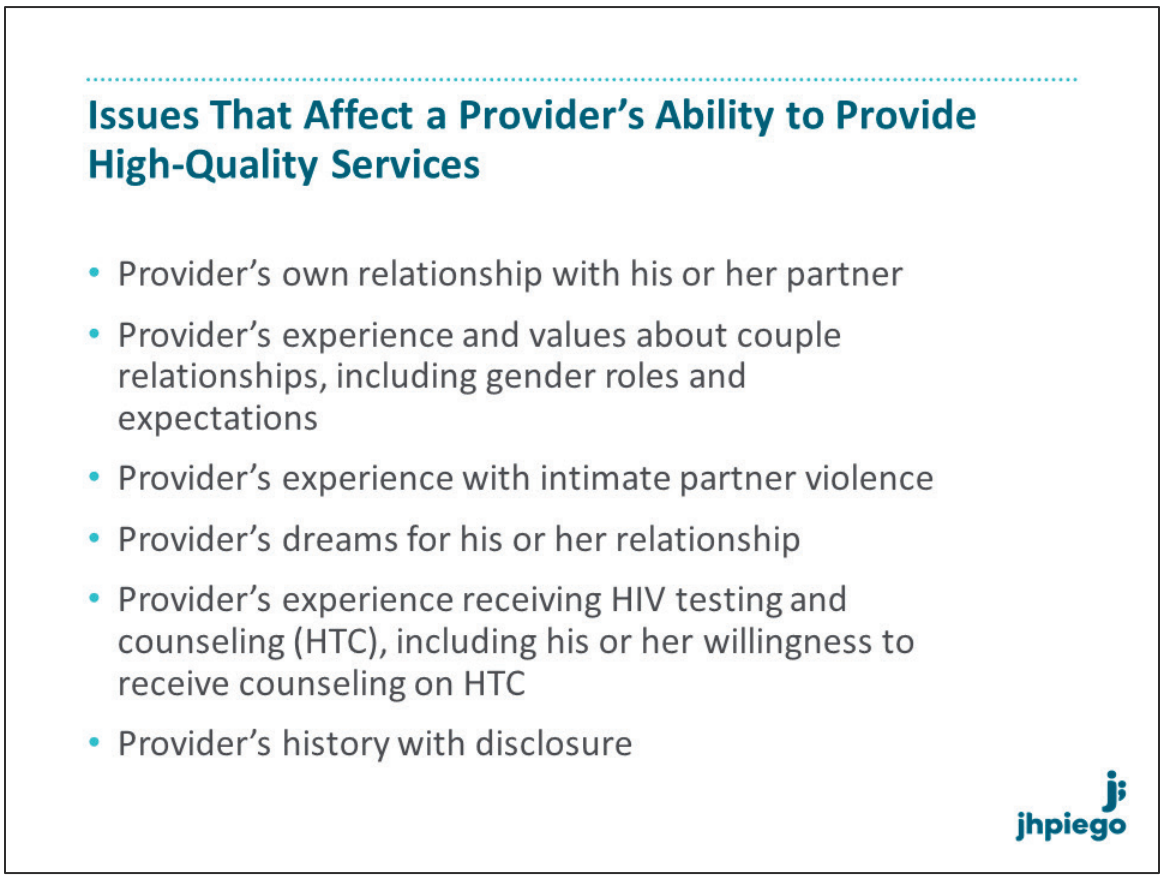
Begin the session by explaining that one of the most important skills/traits of effective counselors, including couples counselors, is self-awareness.

Continue with the following points:

- Counselors must be aware of their own beliefs, biases, feelings, perceptions, and reactions and how their perspective may affect the counseling session.
- Counselors who are in tune with their personal attitudes, biases, and emotions have the ability to gauge their responses to the couple.
- Self-awareness also allows counselors to provide unbiased empathy, understanding, and support.

Next ask the questions on this slide and invite a short group discussion.

Slide 3

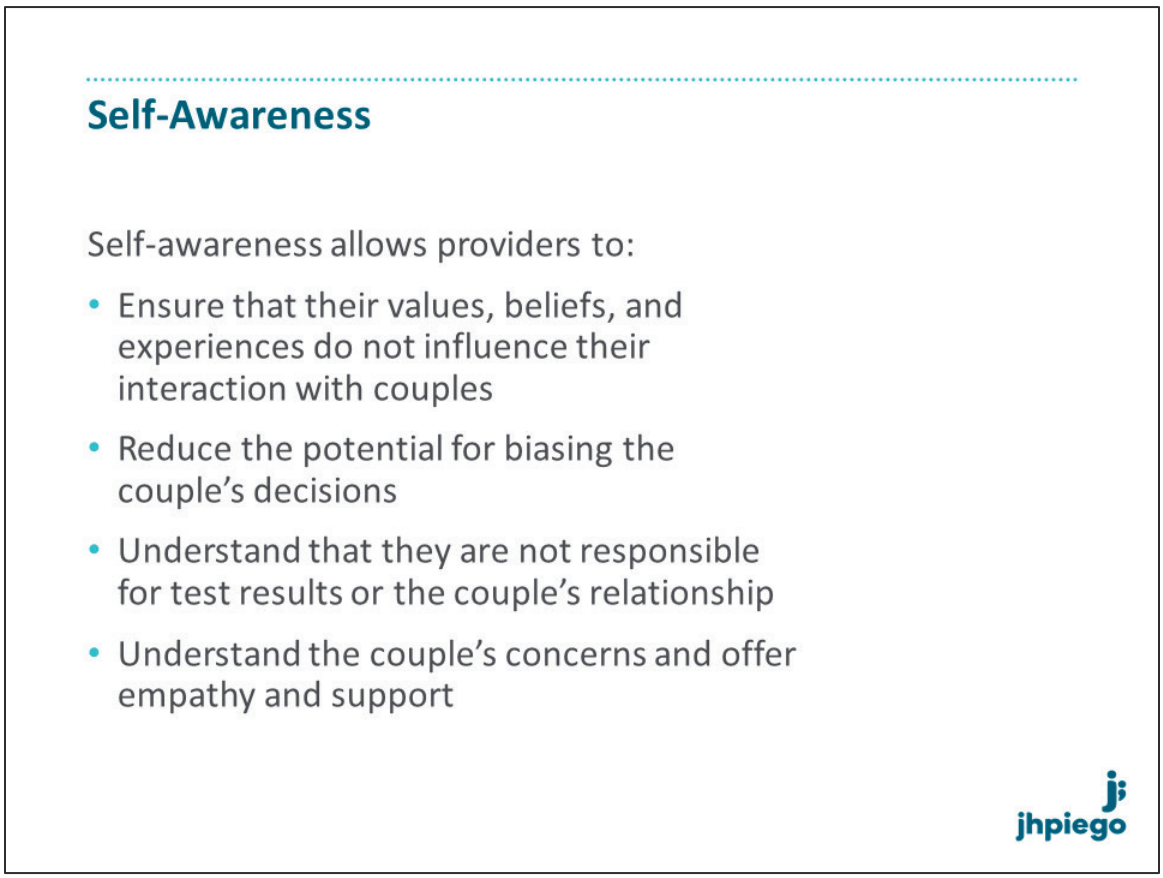


Facilitator notes

Acknowledge that providers may inadvertently bring biases to their work, including assumptions that men are dominating or abusive; women are weak or have not disclosed information to their partners; all couples should be married and have children; or that because something is difficult in their own lives or relationships, it will be the same for the couple in front of them.

[Some of these issues may have been addressed in the group discussion. Be sure to mention any bulleted points not already covered.]

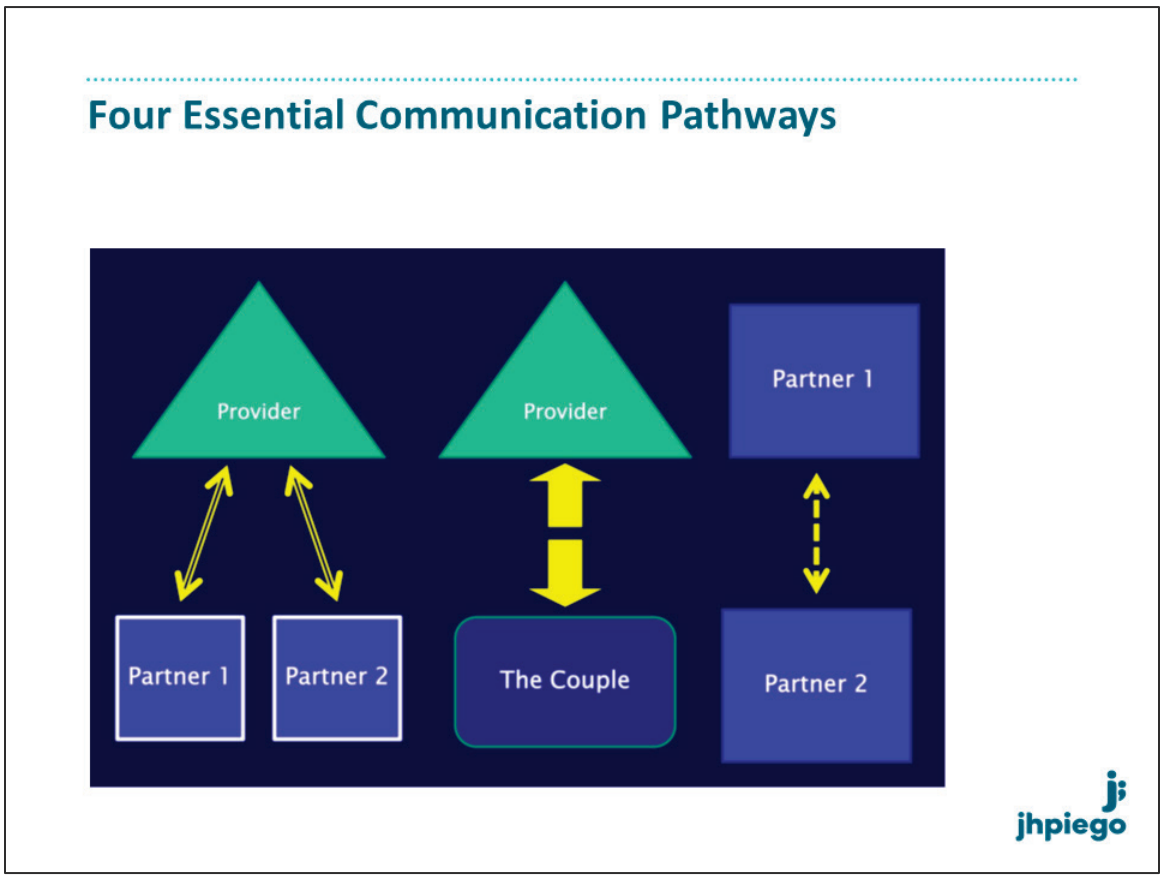
Slide 4



Facilitator notes

Summarize this discussion of self-awareness by reinforcing the benefits listed here.

Slide 5



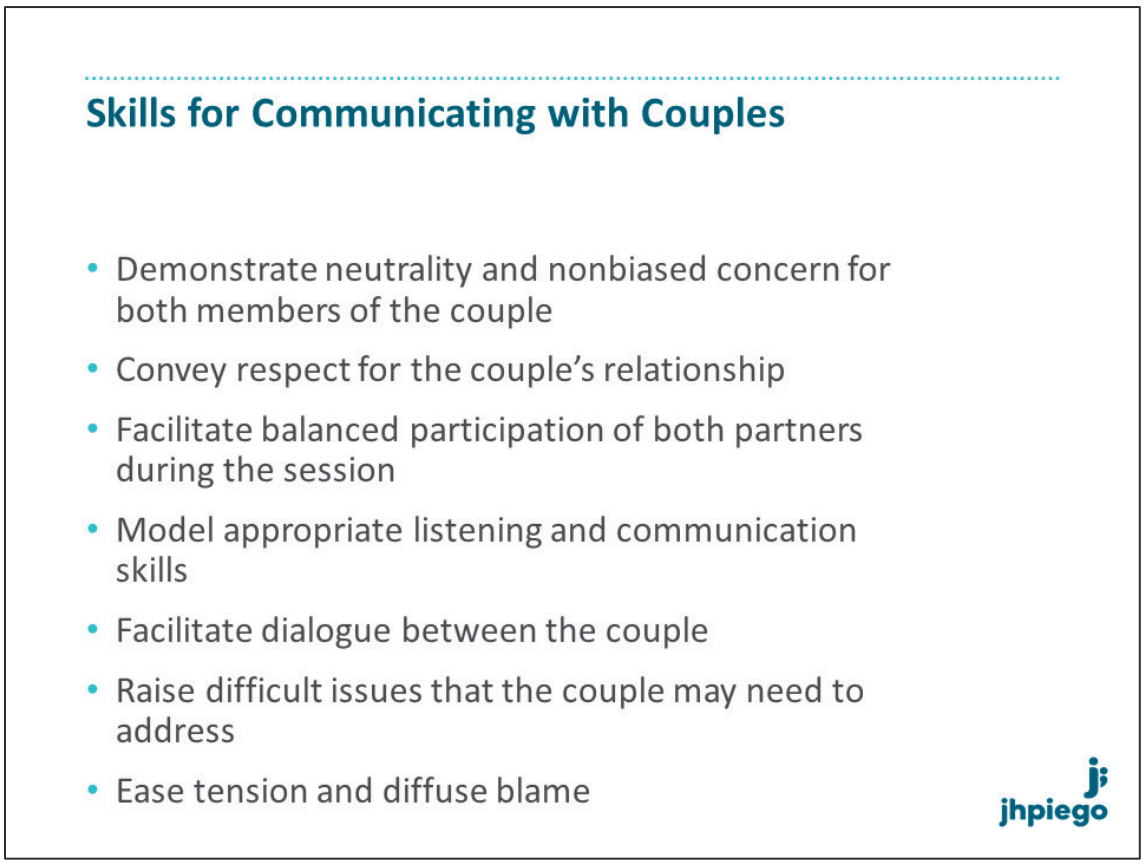
Facilitator notes

Often in couples counseling we say there are four pathways of communication:

- Pathway 1 between the provider and partner 1
- Pathway 2 between the provider and partner 2
- Pathway 3 between the provider and the couple as a unit
- Pathway 4 between partner 1 and partner 2

In couples counseling, the provider strives to strengthen and support communication for Pathway 4 (between the partners).

Slide 6



Facilitator notes

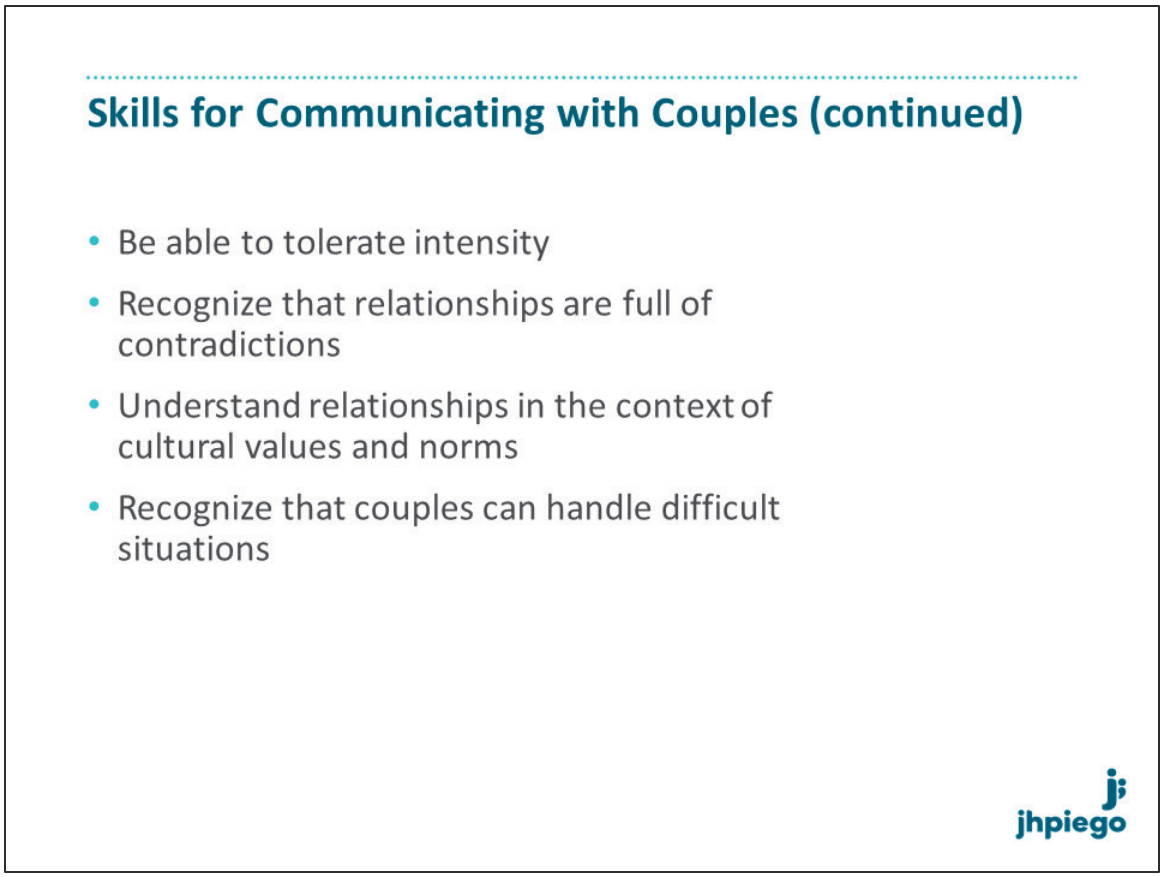
Each of following counseling skills will help maintain a positive atmosphere and balanced couple interactions during the session. We will also have a chance to practice these skills in this workshop. By remaining neutral, conveying respect for the couple's relationship, and facilitating balanced participation by each partner, the provider helps to build and sustain an important and trusting alliance with the couple.

[Review each bulleted item]

Ask participants to raise their hands and offer examples of ways to ensure balanced participation during a couples counseling session. Answers may include:

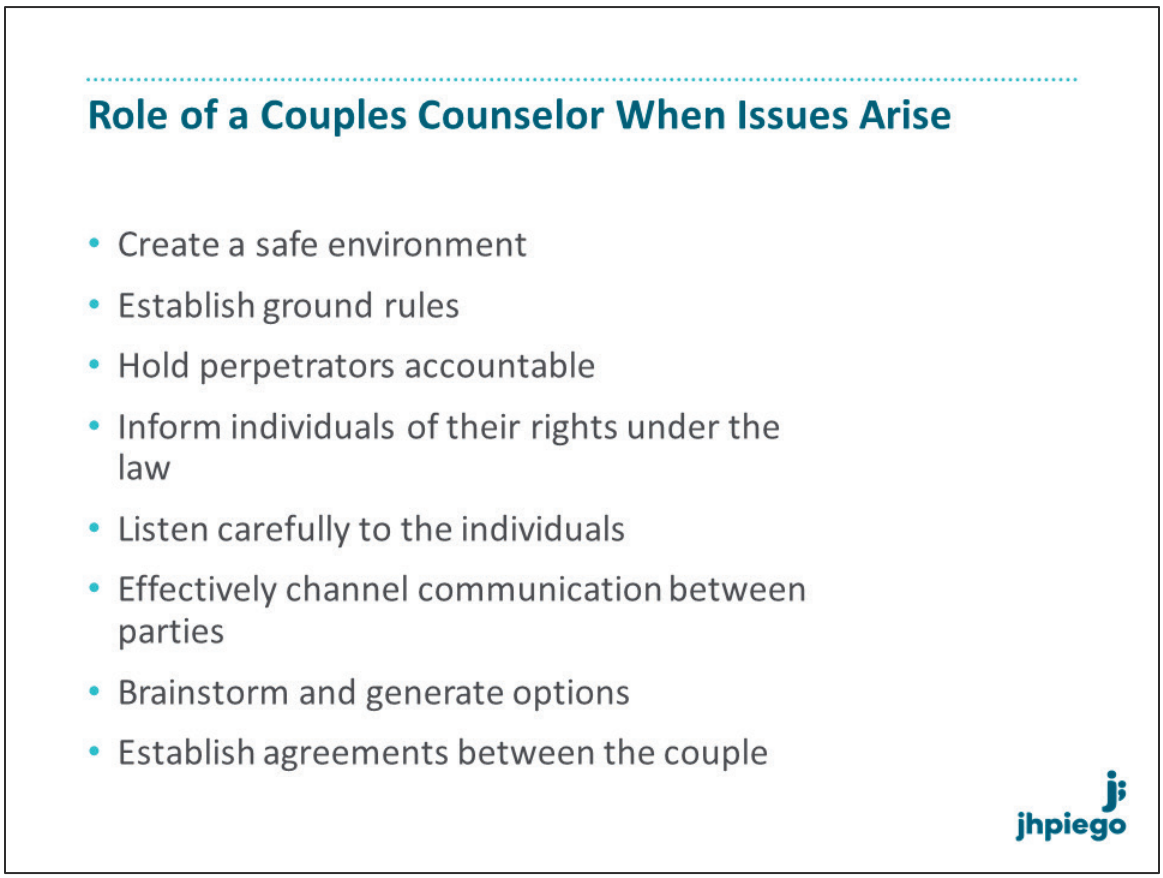
- Form an alliance with each partner in the couple so they both feel comfortable to contribute their thoughts and feelings
- Encourage both partners to speak equally to each other
- Address questions to both partners. If you notice one of the partners is not speaking make her/him feel comfortable.
- Convey genuine interest in both individuals and be neutral
- Convey respect for the couple's relationship by recognizing the bond between them and validating their mutual commitment

Slide 7



Counselors must also be able to anticipate and tolerate intensity, respect the context of cultural values and norms, and acknowledge the great resiliency many couples demonstrate to successfully handle difficult situations together.

Slide 8

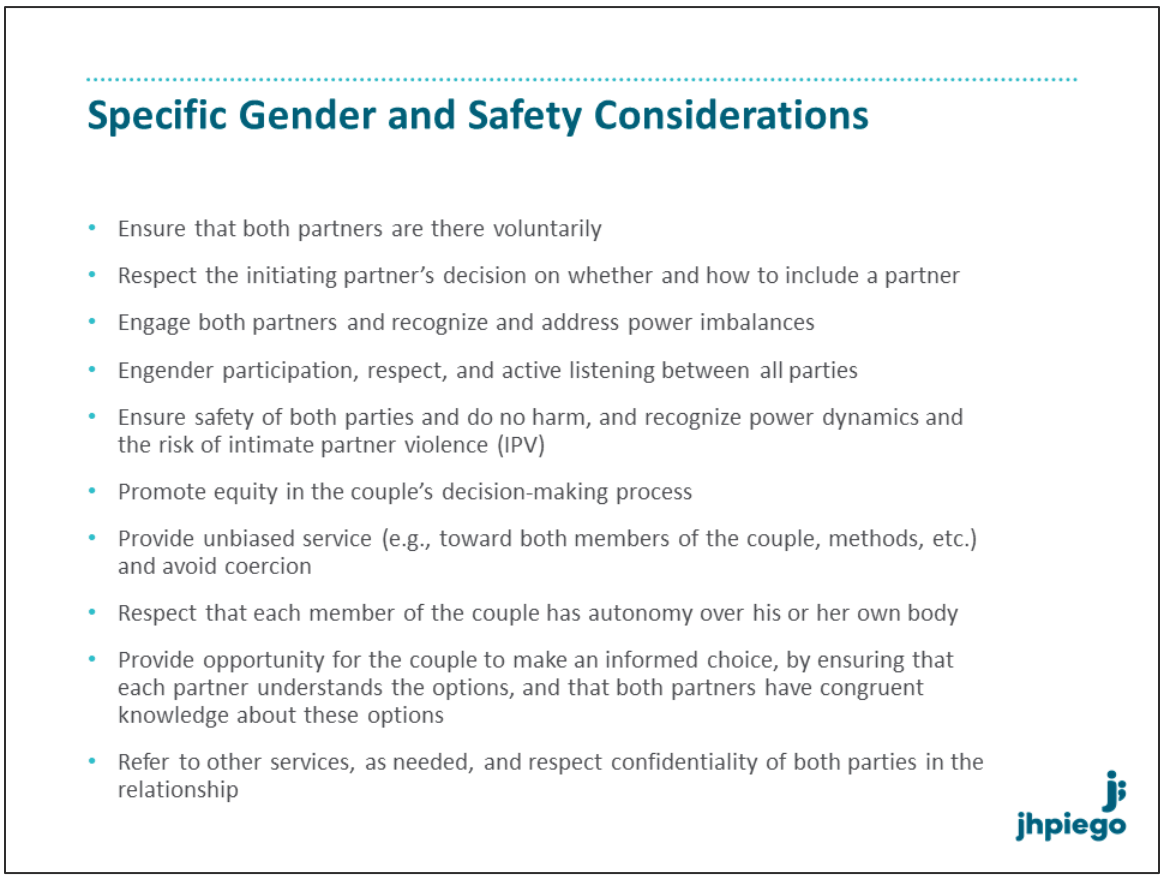


Facilitator notes

Couples counselors must understand their role and responsibilities when issues arise or tensions increase between partners. Supporting a couple through a problem is sometimes referred to as **mediation**. It is important to:

- Create a safe environment
- Establish ground rules
- Hold perpetrators accountable
- Inform individuals of their rights under the law
- Listen carefully to the individuals
- Effectively channel communication between parties
- Brainstorm and generate options
- Establish agreements between the couple

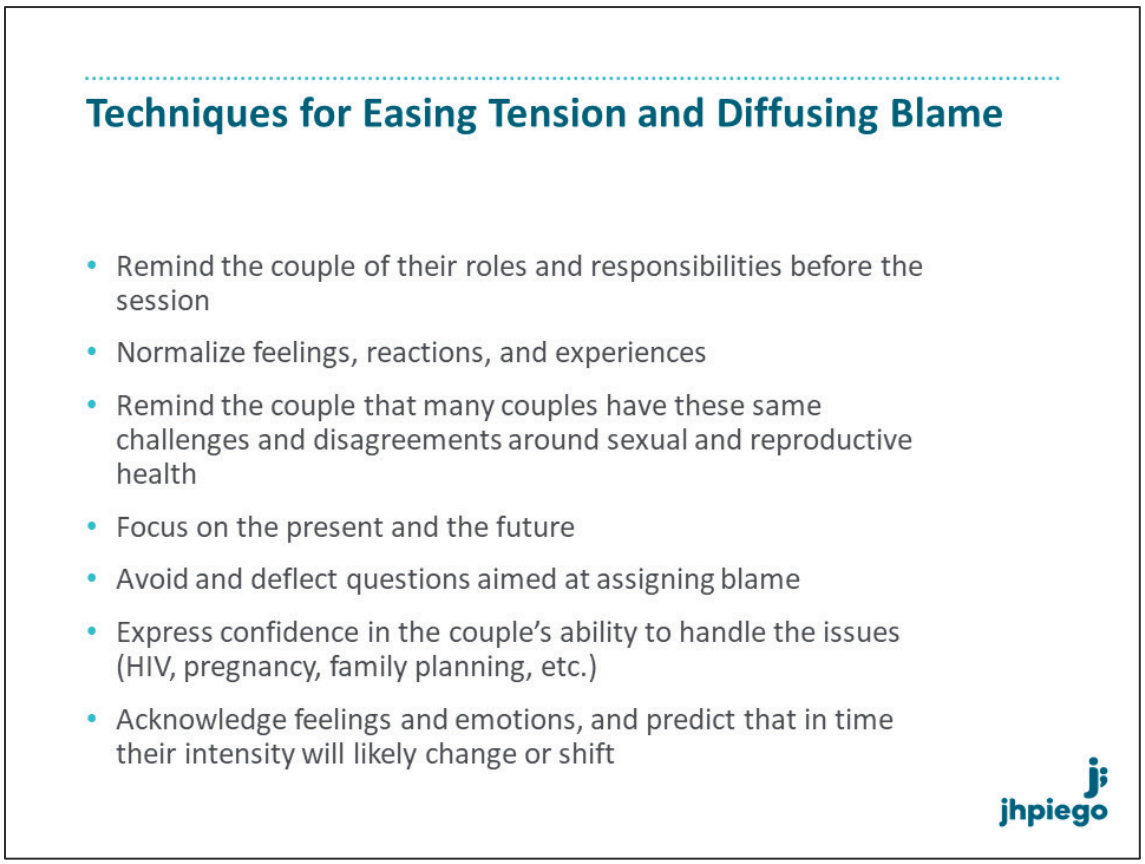
Slide 9



Facilitator notes

It is important to consider specific gender and safety considerations when counseling couples. Invite volunteers to raise their hand and read each bulleted statement aloud. [The content is also listed on the participant handout for this session]

Slide 10

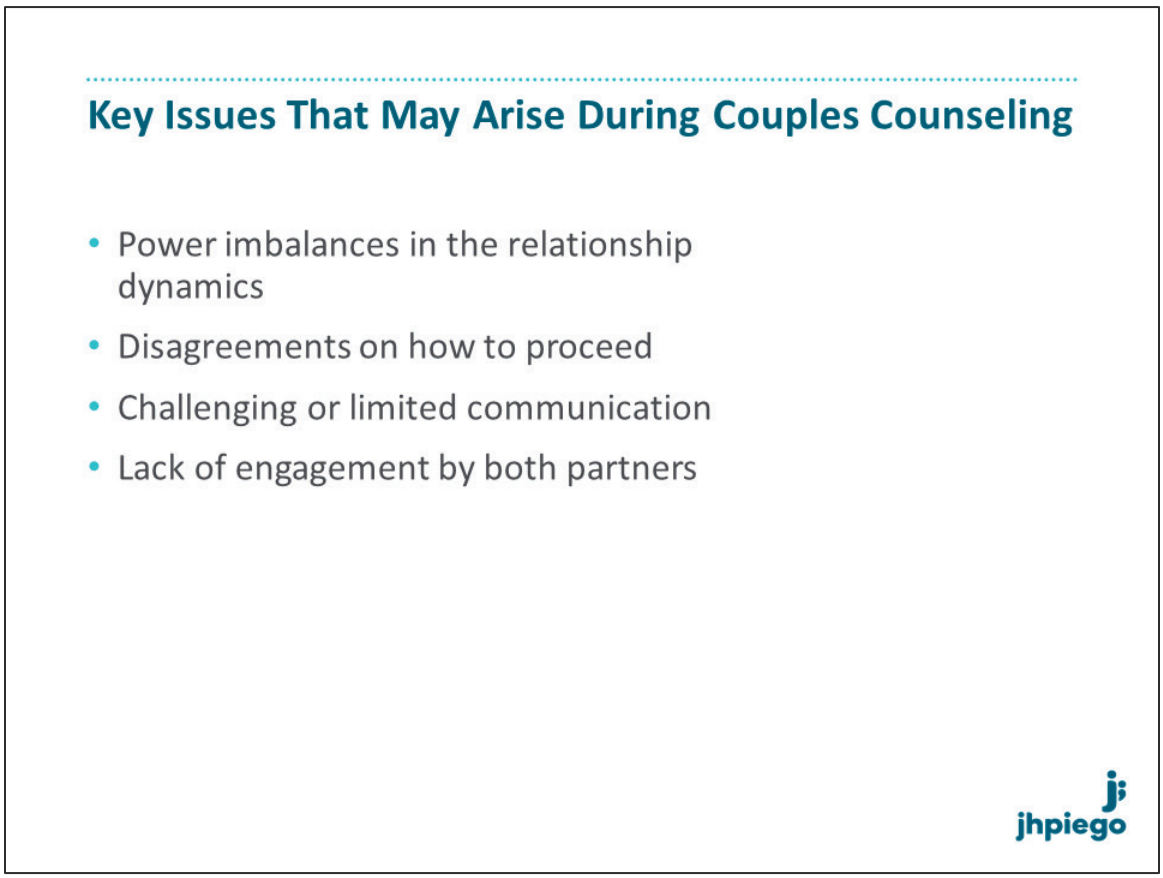


Facilitator notes

The following techniques may help providers to ease tension and diffuse blame while counseling couples:

- **Remind the couple of their roles and responsibilities before the session**
- **Normalize feelings, reactions, and experiences.** Help the couple to recognize that their feelings are common and that many others have had similar experiences. Add that effectively using silence allows couples and individuals to reflect on what is being discussed and to respond or comment accordingly.
- **Remind the couple that they are not alone**
- **Focus on the present and future.** Reinforce that the couples counseling session focuses on the couple's present and future. The past is in the past and cannot be changed.
- **Avoid and deflect questions aimed at assigning blame.** For example, it is not always possible and probably not helpful to determine when or if someone cheated or lied.
- **Express confidence in the couple's ability to handle issues.** Reflect on their strengths and history together and how they have effectively addressed challenges in their shared lives.
- **Acknowledge the feelings expressed and observed.** Recognize the feelings expressed during the session. Let the couple know that the intense emotions will lessen over time and they will begin to adapt and cope.

Slide 11

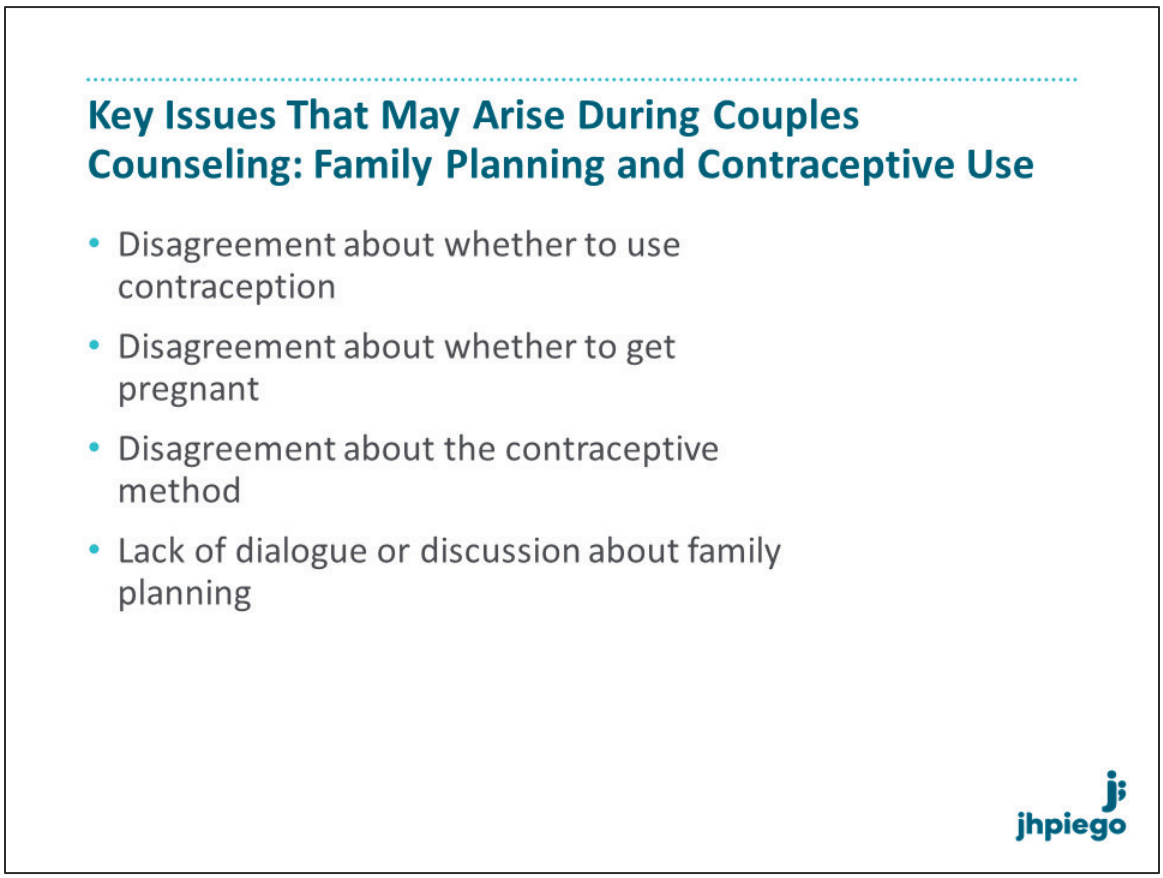


Facilitator notes

Next, read the examples of types of general issues that may arise and then share the following approaches to addressing the issues:

- Providers should take note of obvious or subtle power imbalances between the couple that may be a barrier to equal participation in the session, such as one partner speaking over or interrupting the other repeatedly, raising their voice, making negative comments about the other, or speaking on behalf of the other.
- To manage disagreement, a provider can diffuse tension by helping the couple to realize that their feelings, reactions, and concerns are common. If a decision becomes hostile or one partner blames another, ask them to express what they are feeling through redirecting or reframing questions. Fear and anxiety are sometimes expressed through anger and aggression.
- Counselors may ask questions to both partners and ensure that both partners feel comfortable to contribute their thoughts and feelings.

Slide 12

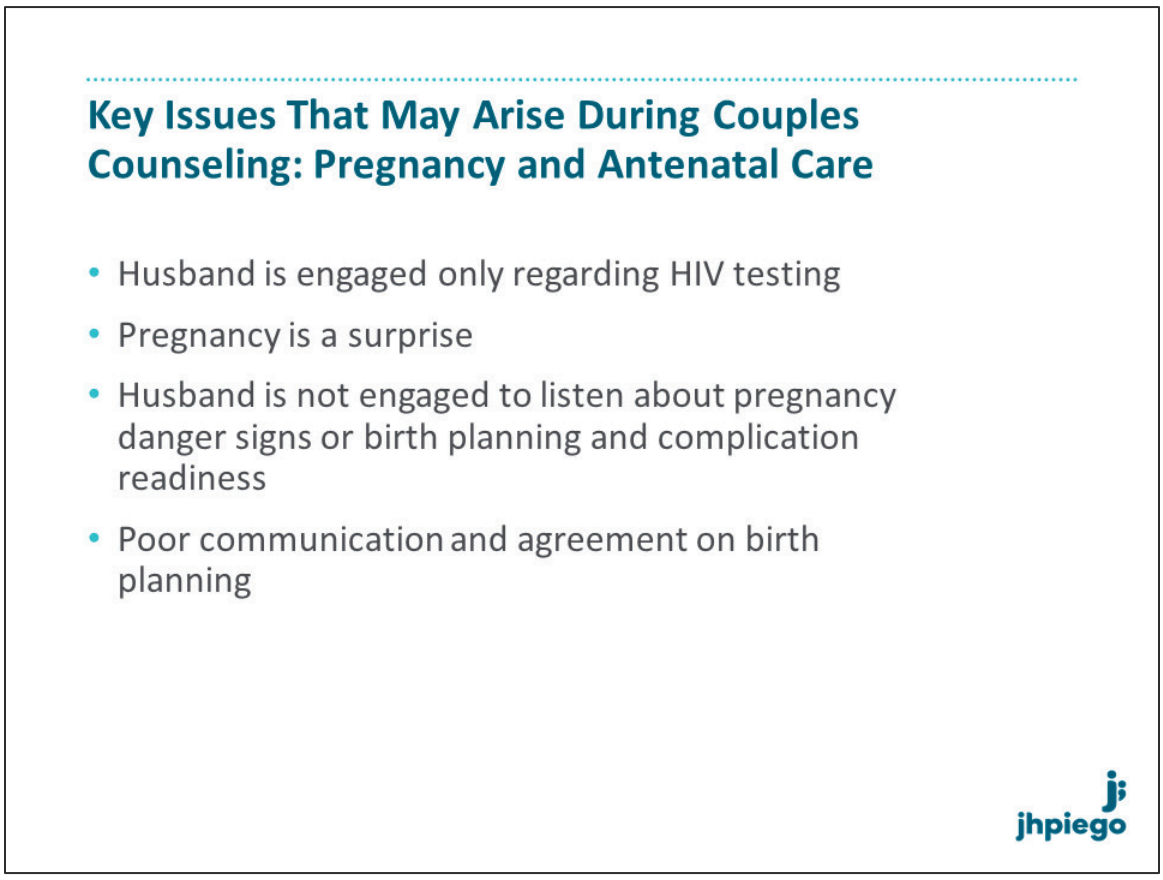


Facilitator notes

Read aloud the bulleted examples of issues that may arise during counseling about family planning and contraceptive use. Discuss a few approaches that providers may use to address these issues with a couple, such as:

- Acknowledge that both partners have the right to contribute to decision-making. However, if the man and woman disagree, the woman has the right to make decisions about her own body, in the same way that a man has the right to make his own decisions about his body (in relation to voluntary medical male circumcision, for example).
- Emphasize to the couple that shared decision-making about starting a family is especially important. Both of you must be willing and ready to assume the responsibility of being parents.
- Point out to male client that by participating in family planning counseling sessions, he can gain a better understanding of the various methods (how long they work, potential side effective, etc.) so he can support his partner in her choice and use of a contraceptive method. By understanding how contraceptives work, the couple can avoid unplanned pregnancies and improve their fertility chances if or when they decide to start a family.
- Make clear to the male partner that when it comes to female contraceptives, the woman must choose the method best suited to her body and needs. Explain that the effectiveness of a contraceptive depends on how well suited it is to the woman.

Slide 13

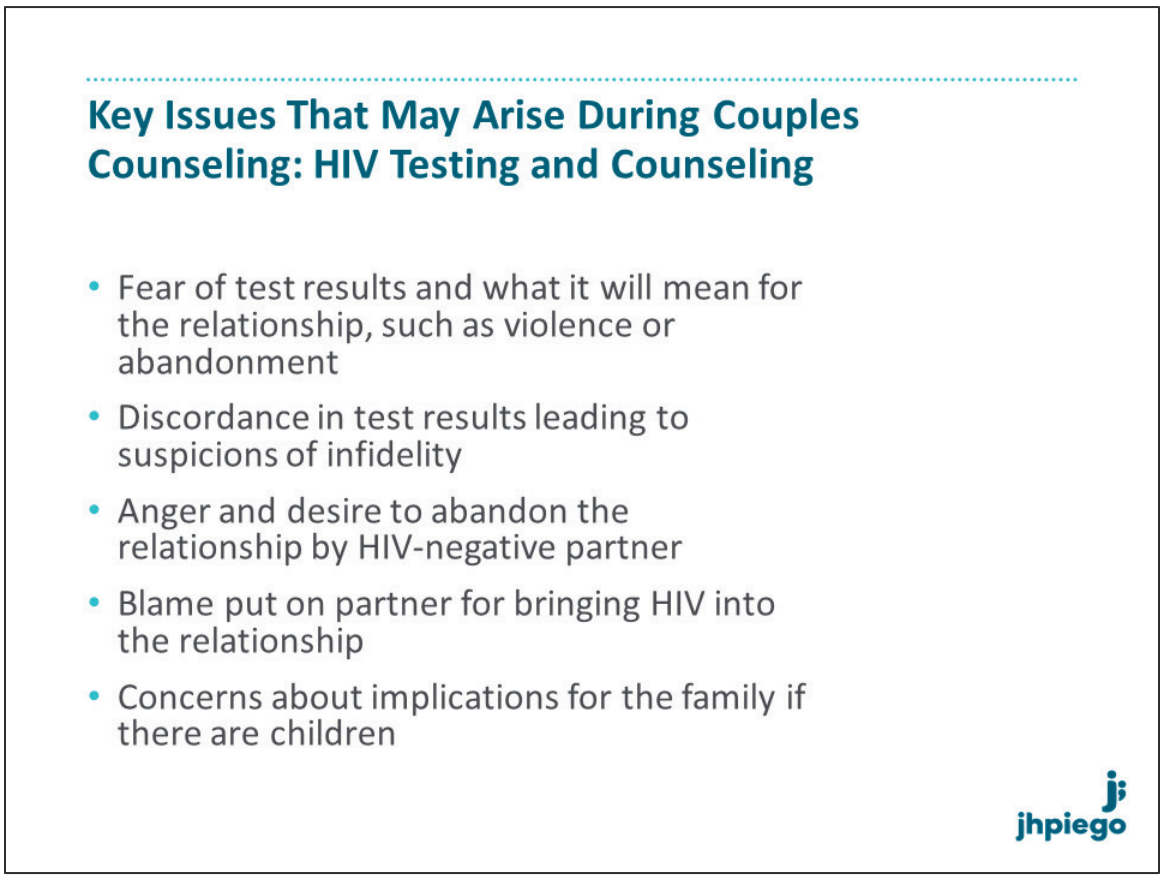


Facilitator notes

Read aloud the bulleted examples of issues that may arise during counseling about Pregnancy and Antenatal care. Then discuss a few approaches providers may choose to address these issues with a couple, such as:

- Emphasize the benefits of male participation for the male partner (e.g., improved spousal communications; stronger bond between father and children; reduced stress, conflict, and violence in the home; increased contact with the health system, allowing men to address their own health needs, too).
- Calmly name and acknowledge the behavior you see to help the couple address the emotions. For example, say "I understand that you may be feeling surprised." Can we talk about this together?
- You might say, "As the male partner you can help to strengthen your relationship and build harmony with your partner by communicating openly with her, listening to her, and respecting her opinions."

Slide 14

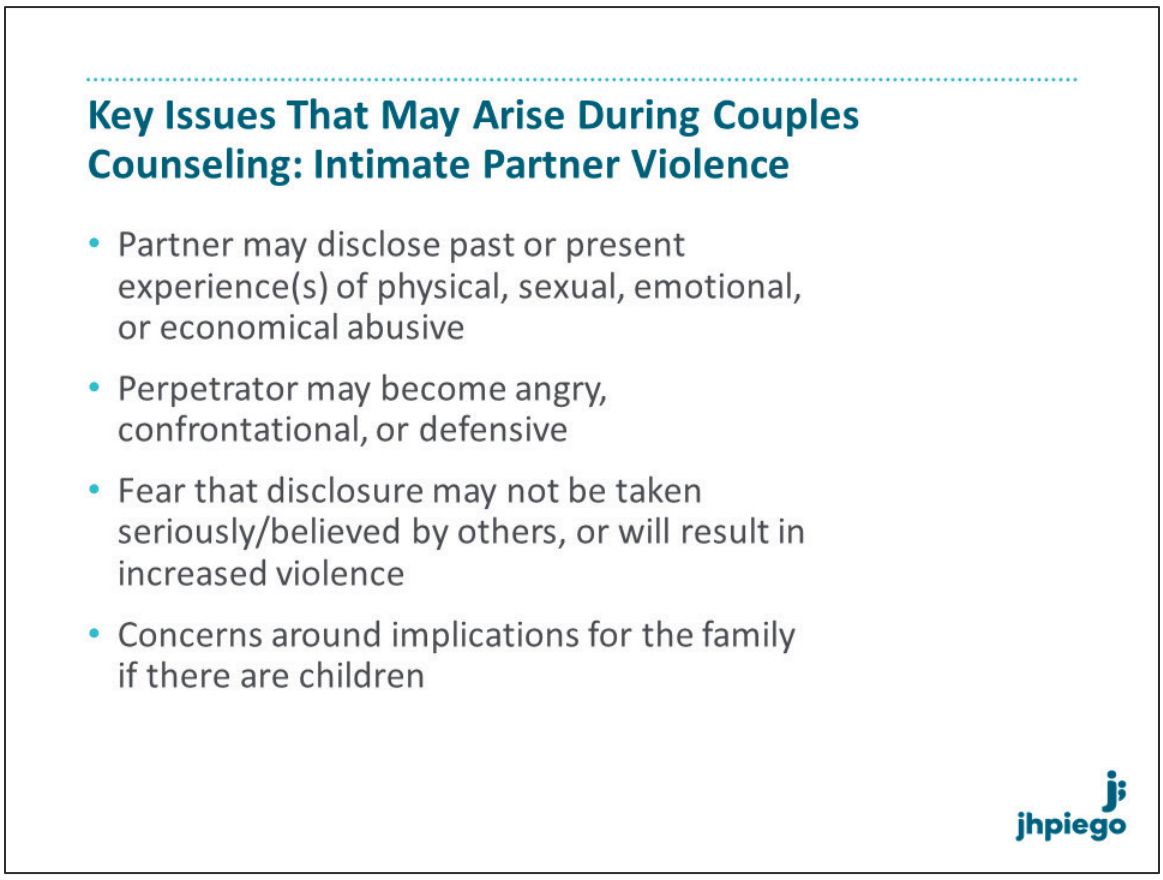


Facilitator note

Read aloud the bulleted examples of issues that may arise during counseling about HIV testing and counseling. Then discuss a few approaches providers may use to address these issues with a couple, such as:

- Emphasize that when both partners know their status, they can take the necessary measures to prevent their infection or the infection of their partner, and transmission to the child
- Educate the couple that most HIV infections happen within relationships
- Explain that medications are available to significantly reduce the risk of transmission to newborns
- Help the couple realize that their feelings, reactions, and concerns are common

Slide 15



Facilitator notes

Read aloud the bulleted examples of issues that may arise during counseling about Intimate Partner Violence. Then discuss a few approaches providers may choose to address these issues with a couple, such as:

- Verbally acknowledge that you have heard and understood and tell the client you are sorry this has happened.
- Do not attempt to probe into the incident and do not attempt to mediate a discussion with the couple about violence. However, do listen to the client and couple compassionately without judgment.
- If it is safe to do so, and if both partners are emotionally able to do so, continue with the session.
- If the partner becomes violent or overly confrontational, end the session and immediately seek help from a colleague.
- After the session, state that you are required to meet with both partners again individually on a later day. This will ensure that the individual has all of the information, is able to ask questions, and can express any concerns.
- You may say, “I am so sorry this is happening in your relationship. This is not healthy for either of you.”

Session 32: Responding to Issues That May Arise During Couples Counseling Sessions

Learning Objective

- To respond effectively to issues that may arise when counseling couples on a variety of sexual and reproductive health issues

Time

1 hour 15 minutes

Materials Needed

- Chairs organized in a semicircle
- **Participant Handout: Role-Play 1—Waiting for a Baby**
- **Participant Handout: Role-Play 2—The Strong Silent Type**
- **Participant Handout: Role-Play 3—The Reluctant Father**
- **Participant Handout: Role-Play 4—Recurring Sexually Transmitted Infections**
- **Participant Handout: Role-Play 5—HIV Testing and Possible Discordance**

Facilitator note: This session should be facilitated after the "Considerations When Counseling Couples" session. At a minimum, participants should have some previous experience and training in basic counseling techniques before participating in this session. You may need to first facilitate the "Overview of Effective Counseling" session, depending on participants' experience level.

Facilitator note: Review the role-plays in advance and select the four scenarios most relevant to program priorities and context.

Advance Preparation

1. Print enough copies of the selected role-plays so each group of four people has at least one complete set of each participant handout.
2. Cut out the profiles detailed on the role-play descriptions.

Steps

Introduction (4 minutes)

1. Begin the session by stating that, as discussed in the previous session, one of the most important skills/traits of effective counselors and couples counselors is self-awareness. Remind participants that counselors may inadvertently bring a number of biases to their work, including assumptions that men are dominating or abusive, women are weak or have not disclosed information to their partners, all couples should be married and have children, or that because something is difficult for themselves in their own life or relationship, it will be the same for the couple in front of them.

2. Effective couples counseling is an important skill that can be challenging at times, especially when discussing sensitive issues related to sexual and reproductive health. Acknowledge that counselors may also experience many rewards when helping couples address issues they may not be able to tackle on their own.
3. Explain that this session offers participants the opportunity to practice counseling couples and receive feedback to sharpen their skills.

Role-Plays (1 hour 10 minutes)

1. Tell participants they will now practice effective couples counseling techniques in small groups of four through role-plays. One group member will play the role of a male client, another will play the role of a female client, another will play the role of a service provider, and the last group member will be an observer. Tell participants everyone will have an opportunity to practice each role at least once.

> **Facilitator note:** Circulate as an observer among groups and make your own observations of how the "providers" interact with the "clients." Note any general feedback about strengths or challenges to reinforce, emphasize, or clarify during group discussion.

2. Ask participants to get into groups of four and decide among themselves who will play each role first.
3. Instruct participants playing the roles of the clients and provider not to share their descriptions with anyone.
4. Allow participants 1 minute to read their descriptions. If any participant has questions about their profiles, meet with them one on one.
5. Next, instruct participants to carry out their counseling session role-play for 5 minutes.
6. After 5 minutes, stop the role-plays, and ask the observers to facilitate a 5-minute debrief (further details are included in the role-play handouts).
7. Next, ask participants to rotate roles and decide among themselves who will play each role next. Repeat steps 2–6 at least three more times so each participant has an opportunity to practice each role.
8. After you have completed at least four role-plays, facilitate a 20-minute group discussion using the following questions:
    - Which role-play was the most challenging? Why?
    - How is couples counseling similar to, and different from, individual counseling? What might the provider do the same or differently during a counseling session with a couple versus a session with an individual?
    - Are there ever times when you have felt uncomfortable or unsafe offering couples counseling? What did you/would you do?
    - Have you ever been in a situation when you did not know what to say or do during a couples counseling session? What did you do/what would you do in the future if this happened?

Facilitator note: This session builds on content presented first in "Considerations When Counseling Couples." During the group discussion, encourage participants to reflect on specific strategies and approaches mentioned in that session as well.

Closing (1 minute)

1. End the session by summarizing the main strengths demonstrated by service providers during the role-plays, as well as recommended ways to improve counseling, that were discussed as a group. Remind participants of the rewards and importance of effective couples counseling.

Acknowledgments

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Participant Handout: Role-Play 1—Waiting for a Baby

Service Provider-1

A young couple comes to the clinic for information about pregnancy, infertility, and sexual dysfunction. They have been trying to conceive for the last 5 months and are concerned about the situation.

****

Female Partner-1

You and your husband have come to the clinic to get information about pregnancy, infertility, and sexual dysfunction. You have been trying to conceive for the last 5 months and are concerned about the situation. You are used to your husband "doing all the talking" and being in charge. Although your husband sometimes has trouble achieving an erection, you worry that the problem is with you and that the reason you cannot conceive is your fault. You are hesitant to say anything about your husband's inability to achieve and maintain an erection.

****

Male Partner-1

You and your wife have come to the clinic to get information about pregnancy, infertility, and sexual dysfunction. You have been trying to conceive for the last 5 months and are concerned about the situation. Usually, you do not have any problems with sex, but sometimes you have trouble achieving and maintaining an erection. You are embarrassed and afraid that something is wrong with you. You do not want to talk about the situation and cover up your embarrassment and fear by blaming your wife for "the problem of not getting pregnant." You are not aware of the relationship between your problem and drinking alcohol.

****

Observer-1

Observe your peers role-playing a short couples counseling session. Note the types of verbal and nonverbal communication techniques being used. Pay attention to:

- How does the provider show empathy and attention to both clients?
- How does the provider promote respect, active listening, and participation among all?
- How does the provider reinforce that both members of the couple have autonomy over their own bodies?

After 5 minutes of observing the role-play, facilitate a 5-minute debrief in which you share feedback about your observations and ask your peers to reflect on their experiences as the clients or provider.

Participant Handout: Role-Play 2—The Strong Silent Type

Service Provider-2

A young couple comes to the clinic together to get information about and start using a female method of contraception. You are meeting with them to discuss the various options, benefits, and drawbacks associated with female methods of contraception.

****

Female Partner-2

You and your male partner have come to the clinic together to get information about and to start using a female method of contraception. You really want him to support this decision to use contraception. You have heard about a variety of contraceptive methods and want more information for the two of you. Your partner told you that he would go to the clinic, but you do not expect him to do much talking.

****

Male Partner-2

You and your female partner have come to the clinic together to get information about and to start using a female method of contraception. You have come to the clinic today at her request. You have been using withdrawal as a contraceptive method, but she became concerned when her sister conceived recently while using withdrawal. You want to support her, but you are not really sure why you need to be here since the two of you have agreed that she will the one to start using contraception. When you were talking to a friend, he said that his wife was on the pill and it seemed to be working fine. You do not really know much about other contraceptive methods and are embarrassed by your limited knowledge. You have decided to just "go along" with your partner and to let her do all the talking.

****

Observer-2

Observe your peers role-playing a short couples counseling session. Note the types of verbal and nonverbal communication techniques being used. Pay attention to:

- How does the provider show empathy and attention to both clients?
- How does the provider promote respect, active listening, and participation among all?
- How does the provider reinforce that both members of the couple have autonomy over their own bodies?

After 5 minutes observing the role-play, facilitate a 5-minute debrief in which you share feedback about your observations and ask your peers to reflect on their experiences as the clients or provider.

Participant Handout: Role-Play 3—The Reluctant Father

Service Provider-3

A young woman comes to your clinic for a pregnancy test, which turns out to be positive. This is an unintended pregnancy, and she wants you to tell her boyfriend about the pregnancy. Her boyfriend is in the waiting room. You want to make sure that he is supportive of his girlfriend and that the couple understands the importance of antenatal care.

****

Female Partner-3

You have come to the clinic to get a pregnancy test, which has turned out to be positive. This was an unintended pregnancy and you have asked the service provider to tell your boyfriend about the pregnancy. You are secretly happy you are pregnant because you really hope that this will push your boyfriend to commit to you. You are worried how he will react to the pregnancy, which is why you have asked the provider to tell him.

****

Male Partner-3

Your girlfriend has missed her period for 2 months and is afraid that she is pregnant. You have been using condoms most of the time that you have been having sex and you do not think that she could possibly be pregnant. This is a really stressful time in your life because you have recently moved out on your own and are having a hard time financially. When your girlfriend told you that she thought she might be pregnant, you started thinking about your own father and how he was never around. You do not want to have a child right now but someday you hope to have a child and give the child a stable home life, which you did not have. You are also a little worried that your girlfriend might have had sex with another man.

****

Observer-3

Observe your peers role-playing a short couples counseling session. Note the types of verbal and nonverbal communication techniques being used. Pay attention to:

- How does the provider show empathy and attention to both clients?
- How does the provider promote respect, active listening, and participation among all?
- How does the provider reinforce that both members of the couple have autonomy over their own bodies?

After 5 minutes of observing the role-play, facilitate a 5-minute debrief in which you share feedback about your observations and ask your peers to reflect on their experiences as the clients or provider.

Participant Handout: Role-Play 4—Recurring Sexually Transmitted Infections

Service Provider-4

A woman comes to your clinic for treatment of a sexually transmitted infection for the third time this year. Her husband is also with her for the first time. You are determined to offer her the treatment she needs today and worry that she may return with yet another infection unless her partner is also treated and the couple is counseled on risks and transmission of sexually transmitted infections.

****

Female Partner-4

You have come to the clinic to get treatment of a sexually transmitted infection for the third time this year. Up until today, your husband has refused to go to the clinic with you because he says he "does not have any problems" and blames you for sleeping with other men "who are giving you this infection." You have not had any new partners and you hope the provider will explain to your husband that he may continue to reinfect you if he does not receive treatment as well. You notice that lately, your husband comes home late smelling of alcohol and secretly worry that he is having sex with other women.

****

Male Partner-4

You have come to the clinic with your wife so that she can be treated for a sexually transmitted infection. This is the first time you have joined her for an appointment. Previously, you told her that you do not need to go to the clinic because you "do not have any problems." Sometimes you have sex with other women outside of your marriage without using protection. You know very little about how sexually transmitted infections are transmitted and you assume that your wife must be having sex with other men who are giving her these infections. Since you do not have any symptoms of a sexually transmitted infection, you do not believe that you should have to take any medications.

****

Observer-4

Observe your peers role-playing a short couples counseling session. Note the types of verbal and nonverbal communication techniques being used. Pay attention to:

- How does the provider show empathy and attention to both clients?
- How does the provider promote respect, active listening, and participation among all?
- How does the provider reinforce that both members of the couple have autonomy over their own bodies?

After 5 minutes of observing the role-play, facilitate a 5-minute debrief in which you share feedback about your observations and ask your peers to reflect on their experiences as the clients or provider.

Participant Handout: Role-Play 5—HIV Testing and Possible Discordance

Service Provider-5

A couple comes into the clinic requesting information about HIV testing for the female partner. She has never been tested before and is anxious. Last week, her male partner shared with her that he is HIV-positive. The male partner is quiet and does not speak much during the session. The couple does not know much about HIV testing, treatment, or transmission.

****

Female Partner-5

You have come to the clinic with your husband to be tested for HIV after you learned last week that he is HIV-positive, which scares you. You have never been tested before and you are worried about your status and that if it is positive he may blame you for infecting him or leave you. You do not know much about HIV testing, treatment, or transmission. Your husband has been quiet lately and barely speaks to you in the house anymore. You are worried that even if your test today comes back negative, he may give you HIV in the future.

****

Male Partner-5

You came to the clinic with your wife so she can be tested for HIV after you learned last week that you tested positively. You do not know when you became infected, although you suspect it is your wife's fault, and you do not feel comfortable talking about the diagnosis because you feel ashamed and angry. You do not speak much during the session. You do not know very much about HIV testing, treatment, or transmission.

****

Observer-5

Observe your peers role-playing a short couples counseling session. Note the types of verbal and nonverbal communication techniques being used. Pay attention to:

- How does the provider show empathy and attention to both clients?
- How does the provider promote respect, active listening, and participation among all?
- How does the provider reinforce that both members of the couple have autonomy over their own bodies?

After 5 minutes of observing the role-play, facilitate a 5-minute debrief in which you share feedback about your observations and ask your peers to reflect on their experiences as the clients or provider.

Gender Transformation for Health
A Participatory Toolkit

Module 9

Male-Friendly Services

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Saving lives. Improving health. Transforming futures.

Session 33: Creating a Safe and Comfortable Environment for Counseling Men

Learning Objective

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

- Identify ways to make the health care facility environment safer and more comfortable for men

Time

1 hour 30 minutes

Materials Needed

- Chairs organized in a semicircle
- Flipchart paper
- Flipchart stand
- Markers
- Masking tape
- Projector
- **Participant Handout: Creating a Safe and Comfortable Environment for Counseling Men**
- **Participant Handout: Facility Walk-Through Checklist**
- **Facilitator Resource: Creating a Safe and Comfortable Environment for Men PowerPoint**

Advance Preparation

1. Make enough copies of the two participant handouts for each participant.

Steps

Introduction (5 minutes)

1. Start the session by asking participants if they have ever wondered how the experiences of a male client might be both similar to and different from those of a female client in terms of accessing and receiving services at their facilities. Ask participants, "Why do you think men might not access health care?" "What are some of the barriers men might face?" Ask for volunteers to raise their hands to answer.
2. State that male clients may not seek care from a facility if managers and providers do not carefully consider sociocultural norms and men's unique needs, including needs around privacy, confidentiality, and comfort. Explain that during this session, participants will be asked to keep the male clients' perspective in mind to identify strategies to ensure a safe and comfortable environment for men while remaining sensitive to women's needs.

Creating a Male-Friendly Environment (50 minutes)

1. Distribute **Participant Handout: Creating a Safe and Comfortable Environment for Counseling Men**. Go around the circle and ask each participant to read one of the questions listed under each category (privacy, confidentiality, and comfort). Explain that participants will answer these questions together in small groups.
2. Next, divide participants into four groups. Once the four groups have been created, assign a category to each group ("privacy," "confidentiality," "comfort-1," and "comfort-2"). Explain that each group will be tasked with creating a list of strategies for improving services for men, in line with their assigned category, while still taking into account women's needs. For example, the "privacy" group will list all the strategies that could be used to ensure the privacy of male clients, while making sure they remain sensitive to the needs of women. Explain that groups should use the questions listed in their category as guidance for formulating the strategies.
3. Make sure everyone understands the instructions and tell participants they will have 15 minutes to complete the assignment.
4. After 15 minutes, reconvene the larger group. Ask for a representative from one of the groups to come to the front of the room and present the group's strategy list for up to 5 minutes. After the person finishes presenting, allow other participants to ask questions and/or make comments. Repeat this process for the remaining three groups.
5. After each group has presented, facilitate a 10-minute discussion using the following questions:
    - Are there any additional strategies you would recommend for the various categories? If so, which ones?
    - Which strategies did you find to be the most helpful?

Facilitator note: Refer to **Participant Handout: Walk-Through Checklist** and mention any points not raised by participants.

Successful Examples of Male-Friendly Environments (30 minutes)

1. Next, tell participants you will share a successful, real-life example of strategies used to encourage men's use of sexual and reproductive health services, and to make facilities and services more male friendly.
2. Project and present the **Facilitator Resource: Creating a Safe and Comfortable Environment for Men PowerPoint**. Spend no more than 20 minutes presenting the slides.
3. After the presentation, facilitate a 10-minute group discussion using the following questions:
    - What were the approaches/strategies used?
    - Which strategies would be easiest for you to replicate in your own facilities? Why?
    - Which strategies would be most challenging for you to replicate in your own facilities?
4. Before closing the session, distribute **Participant Handout: Facility Walk-Through Checklist** and explain to participants that they can use the checklist to evaluate their own facilities when they return, and conduct the walk-through by having staff members and/or male clients use the checklist to evaluate the facility.

Closing (5 minutes)

1. End the session by mentioning the following points:
    - Establishing a safe and comfortable environment for all clients, including males, is essential to ensure that all community members engage with, and are appropriately served by, health facilities.
    - The strategies discussed today, as well as the **Facility Walk-Through Checklist**, will help you continue to formulate approaches for implementing male-friendly services in your own facilities.

Acknowledgments

EngenderHealth. 2003. *Trainer's Resource Book to Accompany Counseling and Communicating with Men: Trainer's Manual*. New York, NY. https://www.engenderhealth.org/files/pubs/gender/mrhc-2/trainer/mrh_2t.pdf.

The CHAMPION Project. 2014. *Healthy Men, Healthy Families: Promoting Positive Health-Seeking Behavior Among Men Through Male-Friendly Health Services*. CHAMPION brief no. 7. Dar es Salaam, Tanzania: EngenderHealth. https://www.engenderhealth.org/wp-content/uploads/imports/files/pubs/project/champion/CHAMPION-Brief-7-MFHS_lowres.pdf.

Participant Handout: Creating a Safe and Comfortable Environment for Counseling Men

Keeping the male clients' perspective in mind, use the following questions to identify strategies for a safe and comfortable environment for counseling men.

Privacy

- When a male client first enters the facility, where does he go to discuss the reason for his visit? What steps does the facility take to make sure that the client can discuss the reason for his visit without being overheard by other clients or staff?
- What steps does the facility take to make sure that the client can talk with a service provider in the counseling area without anyone overhearing?
- What steps does the facility take to make sure that the client can talk with a service provider in the counseling area without being seen by other clients?

Confidentiality

- What steps does the facility take to protect the client's medical record so that only staff who need to see his record have access to it?
- What steps does the facility take to put a protocol in place to ensure that staff do not inappropriately discuss client issues, even if they know a client from the community?
- Do the staff appear to assure clients of their confidentiality?

Comfort-1

- As you approach the facility, is it obvious that it is a suitable place for a man to seek services?
- What steps do staff take to make men feel welcome?
- Do staff appear to be polite and respectful toward men?
- Are the colors and décor in the reception/waiting and counseling areas comfortable for men (as opposed to seeming intended for women and children)?
- What steps does the facility take to allow men to talk with service providers alone? As part of a couple?

Comfort-2

- If a male client prefers to be examined by a male provider, can this request be accommodated?
- How are men engaged in setting up the clinics? Are their preferences taken into account?
- What makes the counseling room seem comfortable for men as individual clients or as partners?
- What brochures, pamphlets, posters, or other client education materials that deal with men's reproductive health issues are readily available in the counseling area?
- Are the brochures, pamphlets, posters, and other client education materials male friendly, i.e. targeting men's interests and needs and directed at them?
- Are the brochures, pamphlets, posters, and other client education materials written at a literacy level that most male clients will be able to understand?

Participant Handout: Facility Walk-Through Checklist

As you walk through the facility, imagine that you are a man coming to the facility for services or information for the first time. Keeping the man's perspective in mind, assess how the facility would appear on the basis of the following criteria.

	Yes	No
Identity		
1. Does the facility's name seem welcoming to men?		
2. As you approach the facility, is it obvious that it is a suitable place for a man to seek services? Is there a sign or poster indicating that men can come with their partner for services?		
3. As you approach the facility, is it obvious that it is a suitable place for men to come with their partner for services?		
4. Does the gatekeeper or guard know about all services that are available for men?		
Services provided		
1. Is there a sign or poster indicating that services are provided for men?		
2. Is there a sign or poster indicating that men can come with their partner for services?		
3. Does the sign or poster indicate the types of services offered for men?		
4. Are brochures or handouts with information about services for men readily available?		
5. Are brochures or handouts on how men can be involved in prevention of mother-to-child transmission of HIV, and/or reproductive, maternal, newborn, and child health (RMNCH), and/or family planning readily available?		
6. Does the receptionist know about all the services available for men or that men can come with their partner for services?		
Reception/waiting area		
1. Is it a comfortable environment for men (as opposed to catering more to women or children)?		
2. Are magazines, newspapers, or other items that appeal to men readily available?		
3. Are brochures, pamphlets, posters, or other client education materials that focus on how men can be involved in reproductive health readily available?		
4. Are brochures or handouts on how men can get involved in sexual and reproductive health readily available?		
5. Is the area clean, neat, and efficient-looking?		

	Yes	No
6. Do you see any other male clients in the area?		
7. Do you see any male staff members?		
8. Is a men's restroom available?		
9. Is it clear where you would go if you were coming for services or coming with your partner for services?		
10. Does the staff appear to be polite and respectful toward men?		
11. If you came in only to get some condoms and did not want an examination, is it clear where you would get them?		
12. Is illustrated literature or a diagram of how to use a condom readily available?		
Service areas and examination rooms		
1. Is it a comfortable environment for men (as opposed to catering more to women or children)?		
2. Are brochures, pamphlets, posters, or other client education materials that focus on how men can be involved in sexual and reproductive health readily available?		
3. Are brochures or handouts on how men can be involved in PPTCT, and/or RMNCH, and/or family planning readily available?		
4. Do you think you could speak confidentially with a service provider or counselor here, without being seen or overheard?		

Additional comments:

Facilitator Resource: Creating a Safe and Comfortable Environment for Men PowerPoint

Slide 1

The CHAMPION Project. 2014. Healthy men, healthy families: Promoting positive health-seeking behavior among men through male-friendly health services *CHAMPION Brief No. 7*. Dar es Salaam: EngenderHealth: CHAMPION Project.

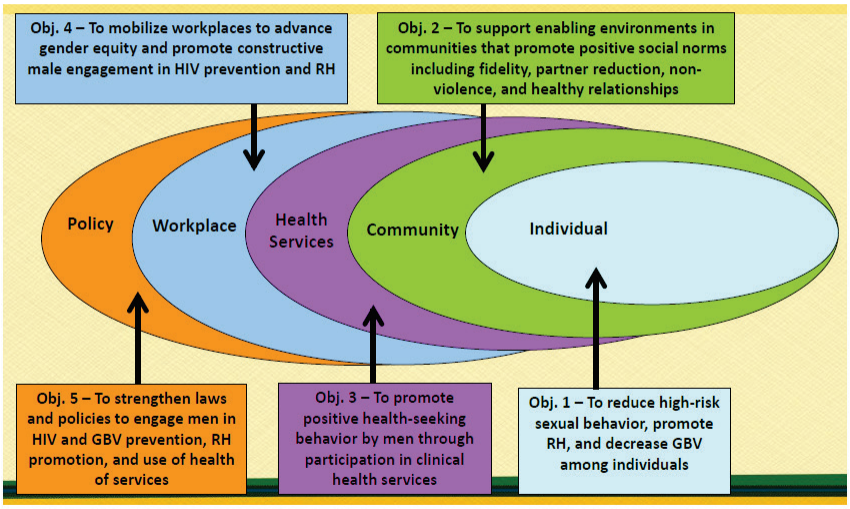
Slide 2

Facilitator Discussion Points

- CHAMPION was a 6-year project in Tanzania (2008–2014) led by EngenderHealth with support from the United States Agency for International Development (USAID) through the US President's Emergency Plan for AIDS Relief (PEPFAR). Partners included FHI360, seven local lead nongovernmental organizations, and the government of Tanzania (e.g., Ministry of Health and Social Welfare [MOHSW], Ministry of Community Development, Gender and Children [MCDGC], Ministry of Labor and Employment [MOLE], and Tanzania Commission for AIDS [TACAIDS]). The project goal was to promote a national dialogue about men's roles and increase gender equity to reduce the vulnerability of men, women, and children to HIV, gender-based violence, and other adverse reproductive health outcomes. The primary target population of the project was men age 25 or older. The secondary target population was women and youth.

Slide 3

CHAMPION's Ecological Model

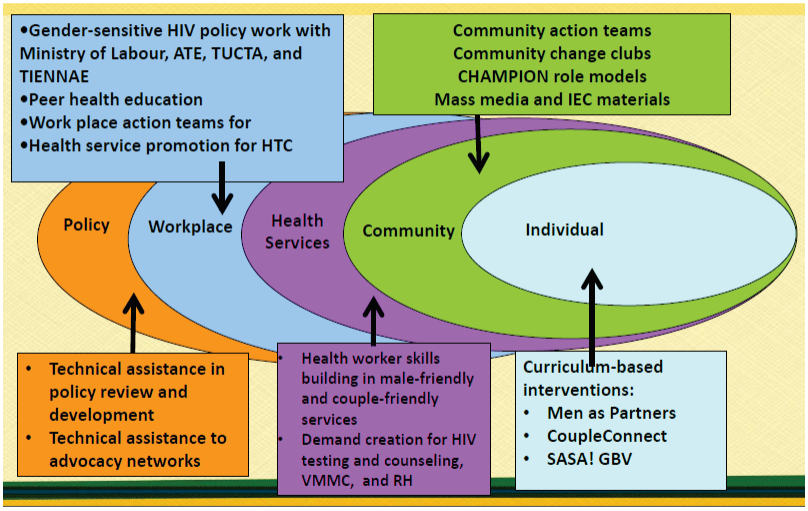


Facilitator Discussion Points

- CHAMPION worked at all levels of the ecological model—individual, community, health services, workplace, and policy—to achieve project objectives.

Slide 4

CHAMPION Interventions



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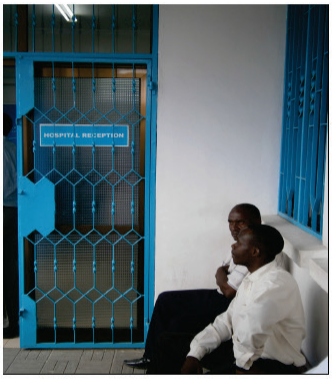
Facilitator Discussion Points

- Interventions targeted each level of the ecological model. In this presentation, we'll focus on the health facility level.

Slide 5

Formative Research: Health Facilities

- 67% of men and 75% of women felt that health facilities are not welcoming to men
- No providers described their services as male friendly
- Only 30% of women reported that their partner had ever accompanied them to a health center during their pregnancy



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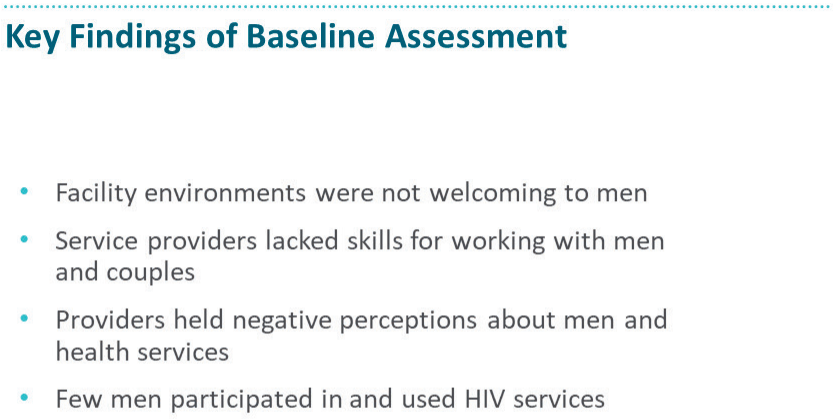
Facilitator Discussion Points

- The project began with formative research to understand current perceptions of male-friendly services.

Slide 6



Facilitator Discussion Points

- The project conducted a baseline assessment of 18 facilities in four districts in 2010 to determine men's current health-seeking behaviors and identify factors associated with men's participation in clinical health services individually and/or jointly with their partners. Quantitative and qualitative methods were employed, including facility observations, key informant interviews with service providers, exit interviews with clients, and review of service statistics in the facilities.
- *Detailed findings are below. You do not need to read all of these aloud.*
  - **Facility environments were not friendly**
    - > Only one of 17 health facilities displayed a sign indicating that both men and women were welcome to receive services
    - > Half of the facilities distributed information, education, and communication (IEC) materials on reproductive health
    - > Only three facilities had brochures for men on HIV
  - **Service providers lacked skills for working with men and couples**
    - > 15 of the 18 facilities had male clinical or nonclinical services providers, but …
      - Only 59% of skilled providers were trained on HIV and reproductive health issues for men
      - Only 41% of skilled providers were trained on HIV and reproductive health issues for couples
  - **Providers held negative perceptions about men and health services**
    - > 65% of service providers believed that men are not interested in HIV services

- 35% of service providers believed that prevention of mother-to-child transmission of HIV (PMTCT) is solely the mother's responsibility
- 41% of service providers believed it is the woman's responsibility to avoid getting pregnant

- **Few men participated in and used HIV services**
  - Men represented less than 7%* of the total number of clients (15,597) accessing family planning
  - Only 36% of those tested for HIV through voluntary counseling and testing in 3 months prior to the assessment were men
  - Only 3% of the 9,062 women accessing PMTCT services were accompanied by their partner
  - Reasons given by men for low participation were:
    - Feelings of shyness and/or shame
    - Lack of awareness of services for men
    - Belief that reproductive health services are for women

*Men's utilization of family planning services could be undergoing a vasectomy or picking up a method (e.g., oral contraceptive pills) for their partners

Slide 7

Formative Research: How Men Described Services

- "You are embarrassed because … going to the clinic is the responsibility of a woman and not a man, so people will see you as if you have been bewitched. They laugh at you."
- "Even when entering the clinic, you find no space specially designed for men. It does not say openly that this is the clinic for parents, including fathers, but mother and child or pregnant women."
- "Yes, a father is not seen … when you go to the clinic, you will be looked at as if you have entered a **female toilet**."

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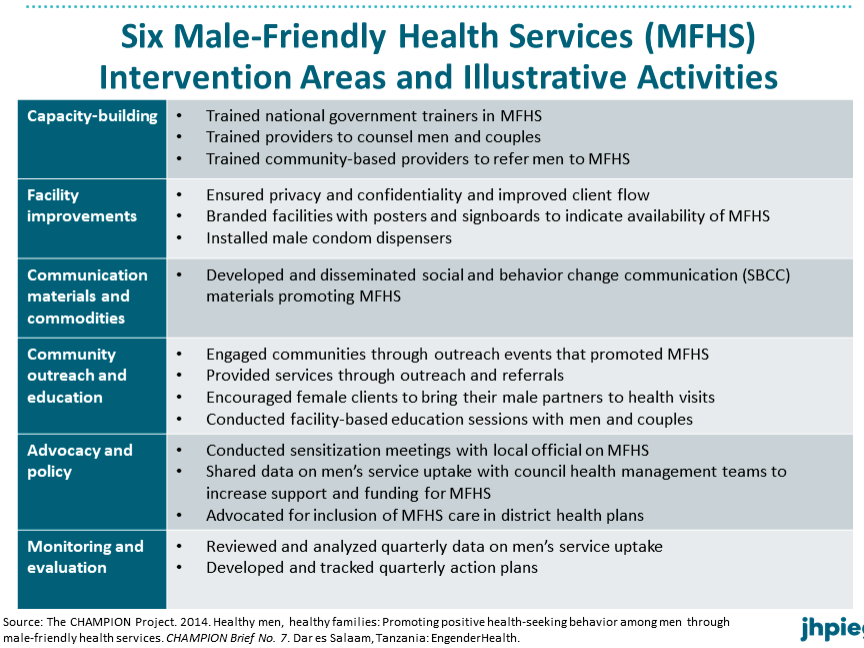
Slide 8



Facilitator Discussion Points

- CHAMPION used a holistic, gender transformative approach to engage with all staff within facilities to improve their understanding of how gender norms negatively affect health and to increase providers' capacity to better serve men and couples.
- *Read through the interventions and illustrative activities on the slide*.

Illustrative Results: Health Services

- Client satisfaction increased from 60% to 78% among men and from 65% to 83% among women
- By 2014, three councils included activities for promoting male friendly services in their annual council health plans

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Slide 10

Key Program Findings

- Men want to be involved in their own and their partners' health care
- Creating male-friendly facilities can improve men's use of and participation in services, especially HIV counseling and testing, antenatal care, and prevention of mother-to-child transmission of HIV
- If services are provided under one roof, men will find it easier to access and use them
- Linkages between the facility and community are vital
- Clinical and nonclinical health workers have a key role in creating a male-friendly environment

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Slide 11

CHAMPION Project, Tanzania

Before intervention

After intervention

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Facilitator Discussion Points

- You can see from these photos that there are many men in the facility after the intervention. The facility after the intervention has male-inclusive posters on the walls.

Slide 12

Session 34: Supporting Men's Use of Sexual and Reproductive Health Services

Learning Objectives

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

- Describe how bias about providing services to men may affect clients negatively
- Describe characteristics of an effective service provider for men
- Formulate basic strategies for making sexual and reproductive health (SRH) services male friendly

Time

2 hours 15 minutes

Materials Needed

- Chairs organized in a semicircle
- Flipchart paper
- Flipchart stand
- Markers
- Masking tape
- **Participant Handout: Case Study 1**
- **Participant Handout: Case Study 2**
- **Facilitator Resource: Important Case Study Messages**

Advanced Preparation

1. Make enough copies of each participant handout for all participants.
2. Print a copy of the facilitator resource for reference.
3. Write "An Effective Service Provider" at the top of a blank flipchart page. Write the following questions beneath the title:
    - What are the characteristics of an effective service provider for men?
    - What knowledge, attitudes, and skills does this person possess?
    - How does this person relate to men?

Steps

Introduction (1 minute)

1. Begin the session by stating that this activity challenges participants to explore individual and facility-level biases about providing services to men. Participants will also be asked to formulate

basic strategies for making SRH services male friendly, and to describe characteristics of an effective service provider for men.

Exploring Biases about Providing Services to Men (58 minutes)

1. Open this activity by asking participants "What is bias?" After you have received a few answers, explain that bias is a prejudice in favor of or against one person, thing, or group to compare with another, usually in a way that is considered unfair.
2. Ask participants to give examples of different groups of people who may experience worse quality care due to facility or provider biases against them. Answers may include men who have sex with men, inmates, or drug users. Emphasize that everyone is worthy of access to quality care and communities are healthier when this is the case.
3. Next, divide participants into four groups of five to six people each. Once the groups have been created, distribute **Participant Handout: Case Study 1** to half of the groups and **Participant Handout: Case Study 2** to the other half.
4. Explain to participants that they will spend 15 minutes in their small groups reading the case study assigned to them, and answering the questions that follow. Instruct each group to identify a reporter to present the group's findings to the larger group.
5. Make sure everyone has understood the instructions and then give each group some flipchart paper and a marker, and ask the groups to identify a workspace inside or outside of the room.
6. After 15 minutes, call time and bring everyone back together.
7. Ask the reporters from the groups that worked on Case Study 1 to come to the front of the room to share their group's work. Instruct the reporters to first summarize the case study (do not read verbatim; participants can refer to their own written copies) and then discuss each group's answers for no more than 10 minutes total.
8. After the reporters have finished presenting, facilitate a 10-minute debrief with the larger group using the following questions:
    - Do you feel the group accurately captured the issues addressed through the case study? Why or why not?
    - What additional strategies would you recommend the health facility adopt to avoid a similar problem in the future?
9. Repeat steps 7 and 8 for the remaining groups working on Case Study 2.

Characteristics of a Male-Friendly Service Provider (15 minutes)

1. Next, direct the group's attention to the flipchart and ask participants to answer the questions.
2. Ask the group to reflect on each of the following three questions:
    - What are the characteristics of an effective service provider for men?
    - What knowledge, attitudes, and skills does this person possess?
    - How does this person relate to men?

Facilitator note: During the discussion, be sure the following points are raised:

- Effective service providers for males …
- Demonstrate knowledge about gender, male sexuality, men's sexual and reproductive health, and the impact gender has on reproductive health (gender norms usually lead to increased power of men over women in society, which has serious implications for reproductive health)
- Explore their own values, attitudes, and perceptions about gender, working with men, and working with couples
- Incorporate a gender perspective in their interactions with clients that support men's participation in HIV and sexual and reproductive health, while safeguarding women's sexual and reproductive health needs
- Exercise effective counseling techniques that cater to men's needs and roles as individuals and/or constructively involve men as supportive partners
- Display genuine caring for men's concerns and needs
- Demonstrate comfort in listening to a male client discuss his sexual behaviors, concerns, or problems
- Demonstrate comfort in listening to a male client discuss his same-sex relationships or same-sex sexual activity.

Overcoming Challenges to Men's Use of SRH Services? (1 hour)

1. Next, explain that participants will now spend time exploring common challenges around men's use of SRH services, as well as strategies for addressing these challenges to make SRH services more male friendly.
2. Divide participants into three groups and distribute flipchart paper and markers to each group. Instruct participants to spend the next 15 minutes brainstorming and recording a list of challenges related to men's use of services for their assigned topic as follows:
    - Group One: Challenges related to men's use of HIV counseling and testing services
    - Group Two: Challenges related to men's use of reproductive and maternal, newborn, and child health (RMNCH) and family planning services
    - Group Three: Challenges related to men's use of voluntary medical male circumcision (VMMC) services (Note: skip this group assignment if not relevant to your program/context.)
3. After 15 minutes, post the flipchart pages on the wall and invite participants to review each group's list. Ask a representative from each team to present to the wider group. Invite questions, feedback, and an opportunity to add points to the list. Spend no more than 15 minutes on this step.

Facilitator note: If participants experience difficulty brainstorming challenges, you may suggest a few examples:

- Group one (HIV counseling and testing services): Fear of positive test results; lack of awareness of treatment options; concerns around confidentiality; discomfort discussing sexual practices, including same-sex sexual activity
- Group two (RMNCH and family planning services): Lack of knowledge around family planning methods available to men including condoms, sterilization; beliefs that reproductive and child health is a "woman's issue"
- Group three (VMMC): Fears around the procedure and healing process; lack of awareness of benefits

4. Next, ask participants to return to their seats and facilitate a 15-minute group discussion to identify strategies to address the various challenges identified. Ask for a volunteer to record the group's ideas on flipchart paper. Encourage participants to consider the following probing questions:
   - What can providers do to address these challenges?
   - What can health facility managers do?
   - How can community members be engaged in solutions to overcome barriers?
5. Close the session by facilitating a 15-minute group discussion using the following questions:
   - Are you aware of data or studies that support what you have said about men and HIV testing, RMNCH, family planning, and VMMC? If not, how can we obtain useful information about the situation?
   - Are there other points worth highlighting about any of these three issues?
   - How do you think societal norms about masculinity and what it means to be a man influence men's use of HIV testing, RMNCH, family planning, and VMMC services?

Closing (1 minute)

1. End the session by answering any final questions and encouraging participants to work with management staff at their facilities to consider implementing some of the strategies discussed for making SRH services male friendly.

Acknowledgments

The ACQUIRE Project and Promundo. 2008. *Engaging Men in HIV and AIDS at the Service Delivery Level: A Manual for Service Providers*. New York, NY, and Rio De Janiero, Brazil: EngenderHealth and Promundo. https://www.engenderhealth.org/files/pubs/acquire-digital-archive/7.0_engage_men_as_partners/7.2.3_tools/service_manual_final.pdf.

EngenderHealth. 2003. *Trainer's Resource Book to Accompany Counseling and Communicating with Men: Trainer's Manual*. New York, NY. https://www.engenderhealth.org/files/pubs/gender/mrhc-2/trainer/mrh_2t.pdf.

Participant Handout: Case Study 1

A rural health care facility employs many local residents as receptionists and clinical assistants. One day, one of the receptionists recognizes a man who has come to the facility to pick up free condoms. The receptionist greets the man, gives him some condoms, and comments, “You look familiar. Do I know your wife?” The man, feeling embarrassed, leaves the facility without saying anything.

The receptionist checks to see if the man has a medical record at the facility and then asks another staff member about him. The two staff remember that the man is married to a woman they know in the community. They carry on a conversation about the man and wonder aloud, “Why is he coming here to get condoms when he is married? What is going on?”

Discuss and answer the following questions with your group members:

- How do you feel about what took place in this case study?
- What privacy and confidentiality issues are present in this case study?
- What can a health care facility do to address what happened in this case study and avoid this in the future?

Participant Handout: Case Study 2

A man comes to a health facility to get information about preventing HIV and other sexually transmitted infections (STIs). He meets with a service provider, who first explains that she needs to ask the following screening questions for his medical records:

- Are you married?
- What form(s) of contraception have you used?
- How many women have you had sexual intercourse with?

When the man tells the provider that he is not married, has never used any form of contraception, and has not had sexual intercourse with any women, the provider acts confused and wonders aloud, "So you are a virgin. I wonder what it is I can help you with today."

Discuss and answer the following questions with your group members:

- How do you feel about what took place in this case study?
- What assumptions does this service provider make about the client's sexuality, sexual orientation, sexual relationships, and sexual behavior?
- What can a health care facility do to address what happened in this case study and avoid this in the future?

Facilitator Resource: Important Case Study Messages

Case Study 1

- All clients should be greeted and treated in a confidential manner, especially when they come for reproductive health services.
- Drawing attention to male clients may make them feel embarrassed, ashamed, uncomfortable, or angry, making it less likely that they will return for care or tell other men to use the services at your facility.
- All medical information about clients should remain confidential. It is inappropriate, unprofessional, and, in some instances, illegal to view clients' medical information out of curiosity. Gossiping about clients should never be tolerated.

Case Study 2

- Reproductive health care staff need to be sensitive to the diverse populations they serve, including providing services to clients who engage in same-sex relationships or same-sex sexual activity.
- Service providers need to use sensitive and inclusive language when asking screening questions. Providers cannot assume that all their clients are heterosexual or engage in heterosexual relationships and heterosexual activity only. They also cannot assume that their male clients are married, use contraception, or only have sex with women.
- Service providers who make assumptions about sexual orientation and sexual behaviors may miss opportunities to discuss, diagnose, and/or treat certain types of reproductive health problems. These providers may also make clients feel embarrassed, ashamed, uncomfortable, or angry, making it less likely that they will return for care or tell other men to use services at your facility.

Session 35: Addressing Staff Concerns about Working with Male Clients

Learning Objective

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

- Describe strategies for overcoming personal concerns about working with male clients

Time

1 hour 15 minutes

Materials Needed

- Chairs organized in a semicircle
- Flipchart paper
- Flipchart stand
- Markers
- Tape
- A-4 sized sheets of paper
- Pencils or pens
- **Participant Handout: Addressing Staff Concerns about Working with Male Clients**
- **Participant Handout: Provider Comfort with Counseling Men**

Facilitator note: The relevancy of this session will vary depending on the context. Be sure to review material in advance and emphasize the concerns that are most relevant to the context for your program or facility.

Advance Preparation

1. Cut several sheets of A4-sized paper in half so you have enough pieces for all participants.
2. Write the following on a blank flipchart page:
    - "What are you personally most concerned about in your job around providing services to men? Having male clients come to your facility? Counseling male clients?"
3. Make enough copies of each participant handout for all participants.

Steps

Introduction (1 minute)

1. Introduce the session by explaining to participants that providing sexual and reproductive health services for men frequently raises a number of concerns for staff and that it is normal to have such reactions. Tell participants that this session is designed to offer participants a space to discuss these reactions and to formulate strategies for overcoming personal concerns about working effectively with men in a way that minimizes harm to women.

Surveys (1 hour)

1. Distribute pens/pencils and **Participant Handout: Provider Comfort with Counseling Men** to each participant. Explain that the survey is intended to help them examine how comfortable they feel about counseling and communicating with men.
2. Instruct participants to read each statement on the survey and check the box that most closely corresponds to their opinion. Tell them that they should not write their names on the handouts and that you will not be collecting them. Assure participants that no one will see their answers, and that they should feel free to answer honestly. Allow 10 minutes for completion.
3. After 10 minutes, call time and facilitate a 10-minute debrief using the following questions:
   - How did it feel to express your opinion about these statements?
   - Which statements did you feel the least comfortable with? Why?
   - How can providers' values, attitudes, and beliefs about men affect their ability to counsel male clients?
4. Next, distribute a piece of paper to each participant. Draw their attention to the flipchart page you prepared with the questions, and instruct participants to write their responses on the paper they received. Allow up to 5 minutes to complete this step.
5. Ask participants to pair up with someone in the room with whom they feel comfortable discussing the questions they just answered individually.
6. After every participant has a partner, state that they will spend 10 minutes in their pairs sharing their answers with each other.
7. After 10 minutes, ask participants to return to the larger group. Ask for some volunteers to share the personal concerns they shared with their partner. As participants share their concerns, write their responses on a blank flipchart page.

> **Facilitator note:** Instruct participants not to share the concerns of their partner, but rather to share their own.

8. Choose three or four responses, and ask participants to brainstorm possible strategies for addressing them. Take notes on flipchart paper.
9. Next, distribute **Participant Handout: Addressing Staff Concerns about Working with Male Clients** and review the strategies with the group.

Group Discussion (13 minutes)

1. Facilitate a 13-minute group discussion using the following questions:
   - Given these concerns, how might staff support each other in the goal of providing sensitive, professional, and respectful care to male clients?
   - Why is the process of verbalizing concerns or fears about working with male clients an important component in the planning of a men's reproductive health service program?
   - Which of these are concerns that staff have are about all clients, not just men?
   - Do you think your concerns are likely to happen? Why or why not?

Facilitator note: Exploring the attitudes of staff and administrators and why they may not always support men's reproductive health services will allow participants to anticipate potential issues around working with male clients. Participants will also be more prepared to effectively address negative attitudes in the facility and within themselves.

Even individuals who generally support the notion of men's reproductive health services may have underlying doubts and concerns. These concerns may not be overtly expressed, but may emerge at critical times, thereby harming the program. For that reason, it is important, during the session, to:

- Let participants express their personal fears and concerns.
- Treat participants' concerns as valid (validate their fears).
- Acknowledge that there are effective ways to address such concerns.
- Acknowledge that as staff members, the participants already have skills and ideas to address problems and can possibly help others at their facility who have concerns.
- Explain to participants that it is normal to have fears and concerns about working with populations with whom they have had little experience or training.
- Explain that facilities and staff may need to devote additional time to address some of the concerns and implement appropriate strategies.

Closing (1 minute)

1. Wrap up the session by summarizing the following key points:
    - Even individuals who generally support the notion of men's reproductive health services may have underlying doubts and concerns.
    - When one acknowledges these concerns, it is possible to develop approaches to address anxieties and remove barriers to providing services to men.
    - Facilities and staff may need to devote additional time to address concerns and implement appropriate strategies.

Acknowledgments

The ACQUIRE Project and Promundo. 2008. *Engaging Men in HIV and AIDS at the Service Delivery Level: A Manual for Service Providers*. New York, NY, and Rio De Janiero, Brazil: EngenderHealth and Promundo. https://www.engenderhealth.org/files/pubs/acquire-digital-archive/7.0_engage_men_as_partners/7.2.3_tools/service_manual_final.pdf.

Participant Handout: Addressing Staff Concerns about Working with Male Clients

For a men's health program to successfully reach men and communicate information to them, it must have the support of facility staff, administrators, and community members. Helping individuals sort through their perceptions of the advantages and challenges of a new program or service takes skill and effort. Addressing concerns and pointing out realistic potential benefits as early as possible in the planning process may help avoid or address problems and reduce false expectations of what a program can deliver.

Staff Concerns

Any change in one's work situation may create circumstances that require some adjustment. Some of these changes may be positive, whereas others may be negative. When men's reproductive health services are initiated or expanded, staff members' anxieties and negative feelings about providing services to men can affect how they view the program.

When one acknowledges these difficulties, it is possible to develop approaches to address anxieties and remove barriers to providing services to men. An effective way of addressing these concerns is to recognize where they come from and focus on the resources available to staff in addressing them. A staff member's straightforward and professional manner will be reassuring to new clients, who are also likely to feel somewhat nervous and uncomfortable.

The chart shows some personal concerns that facility staff may have about offering men's reproductive health services and provides some possible strategies for addressing them.

Concern	Possible strategies
A male client will walk into a restroom or examination room where a woman is being examined.	• Plan separate men's and women's restrooms or ensure that restrooms have locks. • Display clear signs indicating service areas for women and men (if they are separate). • Schedule men's services at different times from women's services, if appropriate to do so. • Ensure that services are organized so clients are carefully clothed in shared spaces; provide exam gowns for clients to cover themselves, if necessary.
A male client will flirt with or make sexual remarks to a staff member.	• Remember that sexual advances or flirtation may reflect anxiety or uncertainty about appropriate behavior in an unfamiliar situation. • Do not make flirtatious remarks or jokes; adopt a formal, businesslike manner at all times. • If the behavior continues, walk away and ask another staff member or a supervisor to deal with the client.
A male client will be reluctant to receive services from a female staff member.	• If a male staff member is available, arrange to have the client see him. • If a male staff member is not available, reschedule the client's appointment for a time when a male staff member is available, or refer the client to another facility for services.

Concern	Possible strategies
A male client will accuse a staff member of being ignorant or incompetent.	• Although instances of incompetence may exist, it is common for individuals to address their feelings of unhappiness or loss of control by blaming others. • Tell the client that you are sorry he is displeased with the service. If you have been acting in accordance with specified facility protocols, tell him so. • Ask the client if he would like to see a different service provider or staff member or be referred elsewhere for care. If the client agrees to see a different staff member, ask the staff member to find out what the client's expectations were—that is, what happened that he interpreted as incompetence? A respectful hearing of his grievances may dissipate the client's negative feelings and offer an opportunity for correcting misconceptions. • After the client leaves, ask your coworkers whether they can think of more effective ways to address the client's problem (e.g., different tests or procedures, better explanations to clients, staff training).
A male client will become disruptive, angry, or threatening when learning that he or his partner is HIV-positive.	• If you feel unsafe, politely ask the client to leave the facility. • Call a supervisor to ask the client to leave. • If the behavior is extremely disruptive, the client refuses to leave, or the client seems threatening, ask a staff to usher other clients and staff out of the facility, and call security or the police. • If a client is regularly disruptive, prohibit him from returning to the facility. If he returns, call for assistance as soon as he appears. • Excuse yourself and leave the room; allow the client to calm down on his own and do not argue with him. Find another staff member to accompany you when you go back into the room. • When you feel more secure (either because the client has calmed down, or because you have a companion), ask the client to explain what was bothering him. Address the anger in a factual, calm manner.
A male client will rape or pose other physical risks to clients or staff.	• Physical risks, such as attacks or rapes, are not specific to facilities where men's services are provided. They are criminal acts and should be treated as such. • If appropriate and feasible, request that police train the staff in addressing personal safety issues.
A male client will develop an erection during an examination or procedure.	• Tell the client that erections can occur in response to anxiety and as a reflex to physical touch during an examination, and then inform him of the examination steps you plan to perform next.
A male client who has sex with men will cause staff and other clients to feel uncomfortable.	• Men who have sex with men need and have a right to the same types of care as other men. Address all clients in a neutral, professional manner.

Participant Handout: Provider Comfort with Counseling Men

Read each statement and check the box that more closely matches your opinion about the statement.

	Agree	Disagree
5. I feel more comfortable with the idea of providing sexual and reproductive health (SRH) services to women than to men.		
6. I believe men would rather receive SRH services from male service providers than from female service providers.		
7. I would feel comfortable listening to a male client discuss his sexual behaviors, concerns, or problems.		
8. I would feel comfortable professionally addressing a male client's flirting with or making sexual remarks to me.		
9. I would feel comfortable talking with a man about his soliciting sex from sex workers.		
10. I would feel comfortable listening to a male client discuss his same-sex relationships or same-sex sexual activity.		
11. I would feel comfortable listening to a male client discuss his extramarital sexual activity.		
12. I would feel comfortable counseling couples about condom use and issues related to their sexual behavior.		
13. I would feel comfortable challenging a male client if he discloses that he beats his wife.		
14. I would feel comfortable challenging a male client if he refers to committing any type of sexual assault.		
15. I would feel comfortable making sure that women are able to assert their voices, needs, and concerns during a couples counseling session.		
16. I look forward to including men in couples counseling for SRH issues (e.g., HIV; reproductive, maternal, newborn, and child health; family planning).		

Session 36: Positive Role of Men in Sexual and Reproductive Health Promotion

Learning Objectives

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

- Explain the importance of and rationale for including men in sexual and reproductive health (SRH) promotion efforts.
- List examples of effective male engagement approaches.
- Formulate strategies for including men in a manner that minimizes harm to women and promotes women's autonomy and empowerment.

Time

2 hours

Materials Needed

- Chairs organized in a semicircle
- Flipchart paper
- Flipchart stand
- Markers
- Masking tape
- **Participant Handout: Case Studies**
- **Participant Handout: Resource Pamphlet *Men Engagement in Reproductive, Maternal, Newborn, Child and Adolescent Health***
- **Facilitator Resource: Important Case Study Messages**

Advance Preparation

1. Make enough copies of each of the participant handouts for each participant in the group.
2. Print **Facilitator's Resource: Important Case Study Messages.**

Steps

Introduction (1 minute)

1. Open the session by stating that men can play a positive role in SRH promotion. Explain that the purpose of this activity is to examine men's role as partners in SRH promotion.

Engaging Men as Partners in SRH Promotion (1 hour 15 minutes)

1. Ask participants to share a few examples from their own experiences about a time when a man showed he supported his family and cared about their health.

2. Distribute the resource pamphlet ***Men Engagement in Reproductive, Maternal, Newborn, Child and Adolescent Health***. Explain to participants that they are going to examine the positive role that men can play in SRH promotion through role-plays.
3. Ask participants to break into five small groups.
4. Assign a different topic to each group, as follows:
    - Pre-pregnancy
    - Pregnancy
    - Labor and delivery
    - Postnatal
    - Infancy and childhood
5. Explain that each team will review the resource pamphlet with particular attention to content on the topic their group has been assigned. Tell participants that they will have 20 minutes to design a short 5-minute role-play that incorporates at least three key messages listed on the resource pamphlet for their assigned topic. For example, the group assigned "Pregnancy" will design a role-play that illustrates at least three ways a male can positively promote SRH during his partner's pregnancy, such as ensure she rests and sleeps well, remind her to take or give her the routine drugs and remind her to perform the recommended exercises, and help her with household chores. Encourage creativity and fun! Groups may decide the setting for their role-play—at the home, in the community, or at a clinic visit.
6. After 20 minutes, call time and reconvene the larger group.
7. Next, ask the first group to present their role-play.
8. Repeat step 7 for the remaining four groups.
9. After all of the groups have shared their work, facilitate a 20-minute group discussion using the following questions:
    - What did you learn from this activity?
    - Why is it important to engage men in SRH promotion?
    - What could you and your facility's management do to promote constructive male engagement in reproductive, maternal, newborn, and child health in a way that minimizes harm to women? In family planning?
    - How could you work with the community to promote constructive male engagement in these areas?

Facilitator note: You may decide whether to facilitate the following case study reviews and discussions as one large group exercise or in smaller groups, depending on the number of participants. Refer to the **Facilitator's Resource: Important Case Study Messages** for key messages and be sure they are raised during the discussion.

Facilitator note: You may share that according to a systematic review published in 2018, male engagement is associated with increased care seeking (e.g., use of antenatal care) and improved home care practices (e.g., birth preparedness), and supports more equitable couple communication and decision-making for maternal and newborn health (Tokhi et al. 2018).

Case Study Review and Discussion (43 minutes)

1. Tell participants that you are going to read three case studies aloud and then discuss collectively as a group. Distribute the **Participant Handout: Case Studies**.
2. Read Case Study 1 aloud:

   A married couple comes to a health care facility to get information about their family planning options. The facility's protocol is to first conduct an examination with the female partner, followed by a counseling session with her alone, and then to invite the male partner to join in couples counseling. When the service provider tells the male client that he needs to meet with the woman privately to discuss her examination and medical history, the man gets angry and suspicious and states, "No man is going to talk to my wife alone about this!"

   The service provider, who is also married, explains to the male client that he will get an opportunity to speak with the provider and his partner after the examination. "Nonsense!" exclaims the male client. "What man would allow his wife to be examined alone by another man?" The provider decides to allow the male partner to stay in the room during the examination and the counseling session. The female client never meets with any staff members alone.
3. Discuss and answer the following questions with participants:
   - How do you feel about what took place in this case study?
   - What bias issues are present in this case study, including provider bias?
   - What gender norm issues are present in this case study?
   - What can a health care facility do to address what happened in this case study in a manner that minimizes harm to women, and avoids this situation in the future?
4. Read Case Study 2 aloud:

   A service provider meets with a young couple to discuss safer sex practices. The provider asks the couple about their relationship and sexual activity. The male client tells the provider that he loves his girlfriend, they were virgins before they met, and he has never had sex with anyone but her. The provider is genuinely touched by the male client's declaration of love and tells the female client, "You are very lucky to have such a nice man in your life. Good ones like him are hard to find!"

   The male client also tells the service provider, "I intend to marry her! But we do not want to have children until we are ready. So we want to get the best form of contraception available." The provider responds, "Wow! The two of you have made a good decision to come here today. Let me tell you about the hormonal contraceptive methods you can use that will offer the best protection against pregnancy." The female client nods in agreement and begins to listen to the provider talk about contraceptive methods.
5. Discuss and answer the following questions with the group:
   - How do you feel about what took place in this case study?
   - What bias issues are present in this case study, including provider bias?
   - What gender norm issues are present in this case study?
   - What can a health care facility do to address what happened in this case study in a manner that minimizes harm to women, and avoids this situation in the future?
6. Read Case Study 3 aloud:

A provider meets with a couple to discuss postpartum family planning options. During a previous antenatal visit, the pregnant female partner expressed privately to the same provider that she already has three children and after this fourth child, she does not want anymore. She is interested in a permanent method of family planning. During today's visit, the male client starts the conversation by saying, "I don't understand why we are here to talk about family planning—we are going to have many more children together after this!" The female client is quiet and avoids eye contact.

7. Discuss and answer the following questions with the group:
   - How do you feel about what took place in this case study?
   - What bias issues are present in this case study, including provider bias?
   - What gender norm issues are present in this case study?
   - What can a health care facility do to address what happened in this case study in a manner that minimizes harm to women, and avoids this situation in the future?

Closing (1 minute)

1. End the session by summarizing the key points discussed during the activities and challenging participants to consider ways to work with management at their facility to support the positive role of men in SRH promotion.

Acknowledgments

The ACQUIRE Project and Promundo. 2008. *Engaging Men in HIV and AIDS at the Service Delivery Level: A Manual for Service Providers*. New York, NY, and Rio De Janiero, Brazil: EngenderHealth and Promundo. https://www.engenderhealth.org/files/pubs/acquire-digital-archive/7.0_engage_men_as_partners/7.2.3_tools/service_manual_final.pdf.

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Participant Resource: Case Study Scenarios

Case Study 1

A married couple comes to a health care facility to get information about their family planning options. The facility's protocol is to first conduct an examination with the female partner, followed by a counseling session with her alone, and then to invite the male partner to join in couples counseling. When the service provider tells the male client that he needs to meet with the woman privately to discuss her examination and medical history, the man gets angry and suspicious and states, "No man is going to talk to my wife alone about this!"

The service provider, who is also married, explains to the male client that he will get an opportunity to speak with the provider and his partner after the examination. "Nonsense!" exclaims the male client. "What man would allow his wife to be examined alone by another man?" The provider decides to allow the male partner to stay in the room during the examination and the counseling session. The female client never meets with any staff members alone.

Case Study 2

A service provider meets with a young couple to discuss safer sex practices. The provider asks the couple about their relationship and sexual activity. The male client tells the provider that he loves his girlfriend, they were virgins before they met, and he has never had sex with anyone but her. The provider is genuinely touched by the male client's declaration of love and tells the female client, "You are very lucky to have such a nice man in your life. Good ones like him are hard to find!"

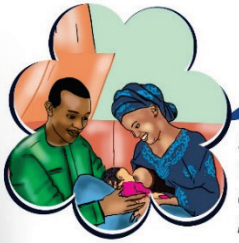
The male client also tells the service provider, "I intend to marry her! But we do not want to have children until we are ready. So we want to get the best form of contraception available." The provider responds, "Wow! The two of you have made a good decision to come here today. Let me tell you about the hormonal contraceptive methods you can use that will offer the best protection against pregnancy." The female client nods in agreement and begins to listen to the provider talk about contraceptive methods.

Case Study 3

A provider meets with a couple to discuss postpartum family planning options. During a previous antenatal visit, the pregnant female partner expressed privately to the same provider that she already has three children and after this fourth child, she does not want anymore. She is interested in a permanent method of family planning. During today's visit, the male client exclaims, "I don't understand why we are here to talk about family planning—we are going to have many more children together after this!" The female client is quiet and avoids eye contact.

- How do you feel about what took place in these case studies?
- What bias issues are present?
- What can a health care facility do to address what happened in the case studies in a manner that minimizes harm to women, and avoids this situation in the future?

Participant Handout: Resource Pamphlet Men Engagement in Reproductive, Maternal, Newborn, Child and Adolescent Health



POST-NATAL CARE

I will support my wife/partner to have enough rest after the birth of our child and to feed the baby with breast milk only.

A Father/Partner should:

1. Support his wife/partner to choose a family planning method that is right for her, to prevent another pregnancy before she and the family are ready.
2. Support his wife/partner to perform domestic tasks after delivery so that she can recover, rest and feed the baby with only breast milk for at least the first six months. Also perform skin-to-skin care for his small baby.
3. Provide a long lasting insecticide treated net for himself, wife/partner and child(ren) to sleep under to prevent malaria.
4. Give his wife/partner time to physically recover after delivery and be ready for sexual activity before initiating sex.
5. Offer to go with his wife/partner to post-natal visits, take the child for immunizations and any other health facility visit.
6. Be kind, loving and collaborative with his wife/partner to create a strong family environment for the child to grow.

INFANCY AND CHILDHOOD

I will share childcare duties with my wife/partner so that we can build a healthy family together.

A Father/Partner should:

1. Express love for his child and wife/partner by doing things like bathing and feeding the child, changing diapers, taking the child to medical visits, etc.
2. Provide, help prepare and ensure that his child(ren) eat nutritious foods to keep his family healthy and well-balanced at all times.
3. Ensure a stress, conflict, and violence-free home environment to raise a healthy, well- balanced children.
4. Use positive means to teach and discipline child(ren) without harming them physically or emotionally.
5. Send his boy and girl children to school so that they can become educated, well-rounded and productive members of society.

Fathers contribute to Healthy Families

I support my family and care about our health

USAID FROM THE AMERICAN PEOPLE

Maternal and Child Survival Program

PRE-PREGNANCY

I will talk to my wife/partner today about visiting a health facility together to learn more about family planning options and make our choice.

A Father/Partner should:

1. Discuss and agree with his wife/partner on how many children they want and can support.
2. Visit a health facility with his wife/partner to learn and decide on the best family planning option to use.
3. Help his wife/partner to provide, prepare and eat nutritious food to ensure a healthy family.
4. Practice, proper hygiene and sanitation with his wife/partner such as hand washing with soap, and keeping the home environment clean to prevent infections.
5. Get tested for HIV and discuss with his wife/partner how they can both protect each other from sexually transmitted infections (STI), by staying faithful or using condoms.

PREGNANCY

I will accompany my wife/partner for ante-natal visit and learn about how to support her to have a healthy pregnancy and a safe delivery.

A Father/Partner should:

1. Encourage his wife/partner to attend all ante-natal visits, offer to accompany her and ensure she has money for transportation costs and fees.
2. Help his wife/partner with household chores and heavy lifting so that she can rest often.
3. Help his wife/partner to provide and prepare nutritious food, especially when she is not feeling strong.
4. Support his wife/partner emotionally with tender loving care/attention to increase her physical and mental strength during pregnancy.
5. Discuss and make a birth preparedness plan with his wife/partner and agree on the health facility to deliver their baby, arrange transport and childcare for other children.
6. Stay faithful to his wife/partner to prevent sexually transmitted infections (STI) and HIV/AIDS.
7. Learn about and watch for signs of pregnancy complications. Visit a health facility immediately if a problem is identified.

LABOUR AND DELIVERY

I will ensure my wife/partner delivers our baby safely in a health facility under the care of a trained provider.

A Father/Partner should:

1. Know his wife's/partner's expected date of delivery to be well prepared in advance for delivery.
2. Make available transportation to the facility during labor to avoid delays and follow his wife/partner to the health facility for delivery.
3. Ensure mother takes with her all necessary mother and baby items e.g. clean clothes, sanitary pads e.t.c. needed for the delivery to avoid last minute purchases.
4. Stay with his wife/partner during labor and delivery (if she wishes) to soothe labor pains and comfort her during the delivery.
5. Reassure his wife/partner that he believes all children are a blessing whether a boy or a girl.
6. Cooperate with the health facility staff during care and feel free to ask questions to clarify any procedure they may not understand.

Facilitator Resource: Important Case Study Messages

Case Study 1

- In some cultures, it may be considered improper for a male service provider to meet privately with a female client to discuss health-related issues. Having the woman meet with a female provider might lessen her partner's concern.
- A health care facility may have a protocol for service providers to meet privately with female clients before a couples counseling session. This will give married female clients the opportunity to raise issues or ask questions they might not feel comfortable bringing up in front of their partners. There may be times when a male partner's power and decision-making role within the relationship could jeopardize the female partner's ability to receive the reproductive health services she needs.
- Service providers need to check their own biases toward men to make sure they are not reinforcing a cultural norm of directing information to men or a traditional notion that men are decision-makers.
- Providers need to be sensitive to efforts by male clients to exert power in the relationship and work to ensure that the female clients' needs are safely and adequately addressed.

Case Study 2

- Service providers need to allow both partners to discuss what is going on in the relationship and their needs.
- Providers need to make sure that they do not pay more attention to the male client during the counseling sessions.
- Sometimes a couple who comes for counseling may wish to discuss more issues than they initially share. It is quite possible that the male client has other sexual partners or that the female client does not want to use a hormonal method.
- Providers need to discuss all contraceptive methods during couples counseling and help clients make informed choices about contraceptive methods.

Case Study 3

- It is critical that a woman's right to decision-making, reproductive choice, and control over her body is honored, even if her male partner disagrees with her choices.
- The provider may wish to hold individual counseling sessions with each partner to offer additional education and support to navigate this sensitive situation.