BASICS OF COMMUNITY-BASED FAMILY PLANNING TRAINING CURRICULUM

Facilitators Guide

Updated on April 27, 2009

This course was developed by the Child Survival Technical Support Plus (CSTS+) Project at Macro International, with funds from the Office of Population Reproductive Health Flexible Fund.
Acknowledgements

There are many individuals from the USAID Office of PRH, ADRA, and JHU CCP INFO Project, who contributed to the overall design of the community-based FP training curriculum. Flex Fund Technical Support (FFTS) would like to thank Ann Hendricks-Jenkins and Marcie Rubardt, independent consultants for leading the writing on many of the sessions and Bonnie Kittle who assisted with revising and editing the sessions. We also wish to thank Linda Morales for editing this document in 2009.

A special thank you to the ACCESS FP Project, ACQUIRE Project, ESD Project, FHI CRTU, IRH Georgetown, PSI, Save the Children USA, and the Safe Motherhood and Reproductive Health Working Group, who all contributed their ideas and suggestions as well as materials for the curriculum.

Finally, we appreciate the vision of Victoria Graham at USAID, who supported the development of this course.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgements</td>
<td>2</td>
</tr>
<tr>
<td>Course Description</td>
<td>6</td>
</tr>
<tr>
<td>Guide to Workshop Facilitators</td>
<td>10</td>
</tr>
<tr>
<td>Example Agenda</td>
<td>19</td>
</tr>
<tr>
<td>Pre-Workshop Material</td>
<td>21</td>
</tr>
<tr>
<td><strong>Session 1: Workshop Introduction</strong></td>
<td>27</td>
</tr>
<tr>
<td>Handout 1</td>
<td>31</td>
</tr>
<tr>
<td><strong>Session 2: Overview of Family Planning (FP)</strong></td>
<td>32</td>
</tr>
<tr>
<td>PowerPoint Presentation: Overview of RH/FP</td>
<td>42</td>
</tr>
<tr>
<td><strong>Session 3: Overview of Contraceptive Technology (CT)</strong></td>
<td>75</td>
</tr>
<tr>
<td>PowerPoint Presentation: Overview of CT</td>
<td>79</td>
</tr>
<tr>
<td>Facilitator’s Notes: Family Planning Jeopardy</td>
<td>157</td>
</tr>
<tr>
<td>Handout 3.1</td>
<td>159</td>
</tr>
<tr>
<td><strong>Session 4: Infection Prevention</strong></td>
<td>160</td>
</tr>
<tr>
<td>PowerPoint Presentation: Infection Prevention</td>
<td>164</td>
</tr>
<tr>
<td><strong>Session 5: Counseling of Family Planning Clients</strong></td>
<td>202</td>
</tr>
<tr>
<td>PowerPoint Presentation: Counseling of FP Clients</td>
<td>207</td>
</tr>
<tr>
<td>Handout 5.1</td>
<td>225</td>
</tr>
<tr>
<td>Handout 5.2</td>
<td>228</td>
</tr>
<tr>
<td><strong>Session 6: Factors Influencing Service Delivery (SD)</strong></td>
<td>229</td>
</tr>
<tr>
<td>PowerPoint Presentation: Overview of SD models for FP</td>
<td>234</td>
</tr>
<tr>
<td><strong>Session 7: Strategies for Community Mobilization</strong></td>
<td>249</td>
</tr>
<tr>
<td>PowerPoint Presentation: Strategies for Community Mobilization</td>
<td>254</td>
</tr>
<tr>
<td>Handout 7.1</td>
<td>269</td>
</tr>
<tr>
<td>Session 8: Strategies for Community Based FP Service Delivery</td>
<td>page 273</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Handout 7.2</td>
<td>page 270</td>
</tr>
<tr>
<td>Optional Evening Activity</td>
<td>page 272</td>
</tr>
<tr>
<td>PowerPoint Presentation: Strategies for CBFP Service Delivery</td>
<td>page 280</td>
</tr>
<tr>
<td>Handout 8.1</td>
<td>page 301</td>
</tr>
<tr>
<td>Handout 8.2</td>
<td>page 305</td>
</tr>
<tr>
<td>Handout 8.3</td>
<td>page 307</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session 9: Behavior Change Strategy</th>
<th>page 311</th>
</tr>
</thead>
<tbody>
<tr>
<td>PowerPoint Presentation: Behavior Change Strategy for FP</td>
<td>page 321</td>
</tr>
<tr>
<td>Handout 9.1</td>
<td>page 335</td>
</tr>
<tr>
<td>Handout 9.2</td>
<td>page 336</td>
</tr>
<tr>
<td>Handout 9.3</td>
<td>page 339</td>
</tr>
<tr>
<td>Handout 9.4 a</td>
<td>page 340</td>
</tr>
<tr>
<td>Handout 9.5</td>
<td>page 347</td>
</tr>
<tr>
<td>Handout 9.6</td>
<td>page 348</td>
</tr>
<tr>
<td>Handout 9.4 b</td>
<td>page 351</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session 10: Quality Improvement Approaches</th>
<th>page 353</th>
</tr>
</thead>
<tbody>
<tr>
<td>PowerPoint Presentation: Quality Improvement for FP Programs</td>
<td>page 359</td>
</tr>
<tr>
<td>Handout 10.1</td>
<td>page 403</td>
</tr>
<tr>
<td>Handout 10.2</td>
<td>page 418</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session 11: FP Logistics Management</th>
<th>page 420</th>
</tr>
</thead>
<tbody>
<tr>
<td>PowerPoint Presentation: Logistics/Supply Management</td>
<td>page 428</td>
</tr>
<tr>
<td>Handout 11.1</td>
<td>page 445</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session 12: Gender/Male Involvement in FP</th>
<th>page 449</th>
</tr>
</thead>
<tbody>
<tr>
<td>PowerPoint Presentation: Gender and Male Involvement</td>
<td>page 466</td>
</tr>
<tr>
<td>Handout 12.1</td>
<td>page 487</td>
</tr>
<tr>
<td>Handout 12.2</td>
<td>page 488</td>
</tr>
<tr>
<td><strong>Session 13: Family Planning for Youth</strong></td>
<td>page 491</td>
</tr>
<tr>
<td>PowerPoint Presentation: Youth-Adult Partnerships</td>
<td>page 497</td>
</tr>
<tr>
<td>Handout 13.1</td>
<td>page 517</td>
</tr>
<tr>
<td>Handout 13.2</td>
<td>page 519</td>
</tr>
<tr>
<td>Handout 13.3</td>
<td>page 520</td>
</tr>
<tr>
<td><strong>Session 14: Field Visit</strong></td>
<td>page 521</td>
</tr>
<tr>
<td>Learning Guide for Field Visit</td>
<td>page 522</td>
</tr>
<tr>
<td><strong>Session 15: Family Planning Integration</strong></td>
<td>page 527</td>
</tr>
<tr>
<td>PowerPoint Presentation: Integration and Partnering</td>
<td>page 538</td>
</tr>
<tr>
<td>Handout 15.1</td>
<td>page 563</td>
</tr>
<tr>
<td><strong>Daily Evaluations</strong></td>
<td></td>
</tr>
<tr>
<td>Day 1</td>
<td>page 564</td>
</tr>
<tr>
<td>Day 2</td>
<td>page 566</td>
</tr>
<tr>
<td>Day 3</td>
<td>page 568</td>
</tr>
<tr>
<td>Day 4</td>
<td>page 570</td>
</tr>
<tr>
<td>Day 5</td>
<td>page 572</td>
</tr>
<tr>
<td><strong>Final Evaluation</strong></td>
<td>page 574</td>
</tr>
</tbody>
</table>
The Basics of Community-Based Family Planning and Program Design, Monitoring and Evaluation Workshop

Course Description

Purpose and Objectives
The two week workshop is organized as follows: Week one includes the key elements of a quality community-based family planning program; and week two takes the participant through the process of program design, monitoring and evaluation of community-based family planning programs.

The workshop is designed for middle to senior level managers working in family planning or interested in integrating community based family planning programming into their current project(s). This workshop aims to bring together managers and specialists in the areas of program design, monitoring and evaluation (PDME) and family planning (FP). The objectives of the course are to:

• Explain key technical and programmatic concepts of FP service delivery;
• Explain a six-step process for developing a project design using a results framework and a monitoring and evaluation plan that is linked to the project design.

Background
The USAID PVO/NGO Flexible Fund was established in 2002 to promote the development of, interest in, and quality of community-based family planning and reproductive health (FP/RH) services worldwide. Currently, there are 21 active projects in 15 countries. More information about the Flexible Fund may be found at the following link, www.flexfund.org.

The CORE Group, a membership association of international nongovernmental organizations (NGOs), promotes and improves the health and well-being of children and women in developing countries through collaborative NGO action and learning. As of November 2006, the CORE Group comprised 47 member organizations working in more than 180 countries. More information about the CORE Group may be found at the following link, www.coregroup.org.

The Flexible Fund Technical Support (FFTS) Project, based at the ICF Macro office, provides a range of services to USAID’s Flexible Fund and its partners including grantees, potential grantees, and the CORE Group.

As a part of the support provided to the Flexible Fund, ICF Macro collaborated with Save the Children and others to develop the “PDME” Curriculum that has been piloted in Mali and Madagascar. The six-day “Basics of Community-Based FP Curriculum” outline was developed after a number of consultative meetings with staff from USAID, PVOs and other collaborating partners and is based upon the work of many individuals and organizations. The curriculum has been using the existing work of Pathfinder, the Catalyst Consortium, ESD Project, MSH, FHI, Population Council, JSI Research and Training Institute, Engender Health and many others.
The five-day PDME Course follows a six-step process for developing project designs using a results framework for developing a monitoring and evaluation plan linked to the project design. Project designs are based upon a situational analysis and an organized process for extracting and analyzing information.

Course Structure
The courses are designed to be participatory by building upon the field experiences of the participants. The Basics of Community-Based FP Course includes the following modules and topics:

1) Overview of FP and Birth Spacing at the Global Level: Gender, Benefits of FP and Birth Spacing at the Population and Individual Levels
2) Contraceptive Technology and FP Counseling
3) FP Service Provision:
   a. Factors Influencing Service Delivery - Barriers to FP Services; Models for Service Delivery;
   b. Strategies for Community-Based FP Programs – Community Mobilization Strategies; Community Based Distribution (CBD) of FP Methods
   c. Quality of Care
   d. Behavior Change and Communication (BCC)
   e. Contraceptive Logistics
4) FP Programming: Male Involvement; Gender; Youth; Integration; and Site Visit to a Community-Based FP Program

The PDME Course walks participants through both the theory and practice for each step of the project design process. The steps are as follows:
1) Performing a Situation Analysis including a policy scan by using data from four sources: a. secondary data; b. participatory qualitative research; c. health service delivery assessments; and d. organizational capacity assessments.
2) Development of a results framework, based on the situation analysis, that includes definitions of a strategic objective and intermediate results
3) Selection of strategies that are linked to the results framework and which take into consideration the sustainability of strategies and interventions
4) Selection of indicators to measure desired results
5) Development of a monitoring and evaluation plan
6) Selection of methods for baseline data collection
The following model represents the structure of the PDME Course:

The PDME Course includes the following modules:
1) Overview of the project design process and introduction to the results framework
2) Using secondary data and a policy environment scan as part of the situation analysis
3) Using participatory qualitative assessments as part of the situation analysis
4) Using health service delivery assessments / health facility assessments as part of the situation analysis
5) Using organizational capacity assessments as part of the situation analysis
6) Constructing a results framework and selecting strategies for impact and sustainability
7) Developing a M&E plan linked to the results framework
8) Selecting methods for systematic collection of baseline data linked to the M&E plan
9) Application of skills learned: Critique of real project designs using a RF approach

Workshop Outputs
The workshop is for mid and senior level managers who will be able to: 1) Apply the skills learned by developing or refining existing program designs, and monitoring and evaluation plans using the results framework; and 2) Explain key technical and programmatic concepts of FP service delivery.

Workshop Partners
[TO BE COMPLETED]

Workshop Location and Logistics
[TO BE COMPLETED]

Workshop Schedule
Workshop Costs
[TO BE COMPLETED]
Guide to Workshop Facilitators
Guide to Workshop Facilitators
Learner Centered Adult Education
The Eight Steps to Curriculum Design

1. Why?
There is a continued high unmet need for family planning and community-based programs are critical to improving access to quality services and ultimately increasing use of family planning and improving related reproductive health practices. Because community-based family planning program implementation entails much more than a technical understanding of contraceptives and because the field of knowledge is growing steadily, it’s important for project designers, implementers, evaluators and technical advisors to keep up to date on the most recent developments in the field.

2. Who?
Participants: The workshop is geared towards managers of community-based FP programs with varying degrees of FP experience and/or program managers interested in integrating community based FP into their current program. Many of the participants may come from NGO projects or from partner organizations such as ministries of health. They may or may not have clinical experience therefore making it challenging to meet the needs of the range of potential participants; however, this curriculum has been delivered for four international workshops and consistently received very positive feedback.

Facilitators: In order to manage a course with approximately 30 participants, there should be at least three facilitators for both weeks with significant technical and field experience for each course. Both the “Basics of Community-based FP” and “PDME” curricula are fairly detailed with links to various resources for each session. An experienced facilitator should be able to read the curriculum and lead the course.

A number of individual sessions contain 1-2 activities. There may be optional activities listed for a session which is an option if time permits (which usually is not the case). Specific sessions require guest presenters as they are an essential supplement to the session. It is highly suggested that you limit the number of guest presenters and only have guest presentations during the following sessions:

1. Community Mobilization
2. Community based Strategies- Representative from FHI to present on CBD of Depo
3. Quality Improvement
4. Logistics
5. Family Planning programming for youth
6. Family Planning Integration
7. Infection Prevention
If there are guest presentations, the facilitators will need to cut more activities and possibly the power point presentation from that standard session. If the standard presentation is cut from the session, the facilitators might just put the “key messages” in the facilitator notes and key points of the slides on two to three slides and quickly review them with the participants to ensure the key points are covered.

Workshop planners should ensure the facilitation team meets for three days in country prior to the workshop to finalize all preparation work and meet the host organization staff.

3. When?

The training is divided into two curricula: Week one is called the “Basics of Community-based FP” and week two is called “Project Design, Monitoring and Evaluation (PDME)”. A one day field trip is scheduled for day five (during the first week) of the training course.

4. Where?

[TO BE COMPLETED FOR EACH WORKSHOP]

5. What?

I. Course Description
Refer to Course Description for general description of the two courses.

II. Cross Cutting Themes of Course

- Gender
- Rights
- Sustainability
III. Facilitation

Community Committees: On the first day of the workshop, the lead facilitator will ask for volunteers for the following three community groups:

1. Environment Committee: This group assists trainers with the logistics of training. The Environment Group helps distribute handouts, sets up equipment and generally keeps the room tidy. This group also reminds fellow participants to be on time and to adhere to other housekeeping details as well as the agenda of the module.

2. Energy/Evaluation Committee: This group is in charge of keeping the group energized and motivated. This group facilitates a 15-20 minute team builder or icebreaker during morning community time that includes content from the previous day’s sessions (as well as any other time needed – often after lunch). This group is also responsible for speaking with the trainers should concerns arise that might affect the group’s energy.

3. Entertainment Committee: Some of the members of this group should come from the city where the workshop is being held. This group comes up with ideas for group outings in the evenings based upon the interests of the workshop participants. Costs for the evening outings will need to be covered by individuals participating.

Note to Facilitators: Trainers and participants may choose to form permanent community groups, meaning the same participants serve the same group role for the entire training. Or, participants can rotate so that each participant gets to serve in each of the three group roles.

6. What for?

Achievement based Objectives for the Basics of Community-based Family Planning (FP) Course

By the end of this course the participants will have:

- Reviewed the rationale for family planning
- Identified, categorized and reviewed the different types of FP methods
- Identified ways to prevent infection related to FP
- Identified the key elements of effective counseling on family planning
- Named factors that influence FP service delivery
- Described strategies for community-based FP programs
- Analyzed the behavior change strategies used in their programs
- Applied elements of quality improvement to a case study
- Assessed the source of FP logistics problems
- Discussed strategies to increase male involvement in FP
• Identified ways to promote FP among youth
• Gathered, shared and analyzed information about a community-based FP program
• Identified entry points for integrating FP
• Reflected and recorded important new information in their Learning Journal

**Achievement based Objectives for the PDME Course**

By the end of the course the participants will have:

• Practiced a six-step process for developing a project design, including a monitoring and evaluation plan, using a results framework

**Note:** Each module has a list of 4-6 learning objectives.

### 7. How?

See session plans for details on how these achievement-based objectives will be met.

### 8. With What Resources?

The following materials need to be available at all times: flip chart paper, colored markers (one per participant and several for the facilitators; wide tipped in a large variety of colors), scissors, stapler, hole punch, masking tape; 2 Flip chart stands for the facilitators, extra paper, large post-its in different colors for each group of participants. Please see the matrix at the end of this document which lists what material is needed for each session.

There are a number of resources to distribute for each session; please select the “Participant Resources” link for a list of them. The workshop organizers should contact the various organizations who have developed these tools and resources to obtain copies of the resources for each of the participants. Electronic versions of the resources may also be burned to CD-ROMs.
### A. Basics of Community-based FP Course:

<table>
<thead>
<tr>
<th>Session #</th>
<th>Session Name</th>
<th>Session Timeframe</th>
<th>Materials Needed</th>
</tr>
</thead>
</table>
| 1         | Introduction to the CBFP Course | Day 1 Session 1   | - Digital camera, color printer, blank copy paper (1 per participant)  
- Nametags  
- Markers - keep several different colors on each participant table  
- Blank index cards on tables – keep a stack on tables throughout the course  
- Tape  
- Pre-assembled binders for each participant  
- Workshop Learning Objectives on flip chart page  
- Day 1 Sessions' Objectives on separate flip chart pages  
- Day 1 Agenda on flip chart page  
- Flip chart page labeled “Parking Lot”  
- New Friend Interview Questions on flip chart page (see below)  
- Printed index cards boldly labeled with pertinent years/decades (1950-2010)  
- Pre-written cards with key events written on one side only (see "Key Messages")  
- Handout – 1.1 Learning Objectives  
- Wall space for timeline |
| 2         | Overview of Family Planning | Day 1 Session 2   | - Flip Chart  
- Markers  
| 3         | Contraception Technology  | Day 1 Session 3   | - Large illustrations (1 on each of 2 flip charts) of male & female reproductive organs  
- Trainers assigned contraceptives; each with a “booth” about their contraceptives and a mini-presentation about their contraceptives  
- Contraceptive Fact-finding Tour Questionnaire on flip chart (see sample questions below)  
- Contraceptive Samples or cut-out of contraceptive methods  
- Handout 3.1 (optional)  
- Cards with Jeopardy question on one side & point totals on the other (see Facilitator's Notes: FP Jeopardy)  
- The Decision Making Tool for FP Clients and Providers, [http://www.who.int/reproductive-health/family_planning/counselling.htm](http://www.who.int/reproductive-health/family_planning/counselling.htm) |
<table>
<thead>
<tr>
<th>Day 2 Opener</th>
<th>Infection Prevention</th>
<th>Counseling</th>
<th>Factors that Influence Service Delivery</th>
<th>Strategies for Community-Mobilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>
| Each day two people from the energy committee will lead the participants in an interactive 20 minute session to review key points from the previous day. | PowerPoint presentations (2 presentations are included for facilitators reference only)  
  - Flipchart  
  - Markers  
  - One copy of the Infection Prevention Manual per Participant - EngenderHealth | PowerPoint presentation (for reference only)  
  - Handouts 5.1 and 5.2 for each participant  
  - flipchart  
  - markers  
  - Role play scenarios written on the flip chart (select 6 or 7 of the most appropriate for your group)  
  - Pelvic and penis model for IUD and condom demonstration (if available)  
  - Copies of the FHI Checklists to rule out pregnancy and for COCs, IUDs and Depo Provera (These may be downloaded from [http://www.fhi.org/en/RH/Pubs/servdelivery/checklists/index.htm](http://www.fhi.org/en/RH/Pubs/servdelivery/checklists/index.htm) or ordered from FHI), and  
  - FHIs, quick reference chart for medical eligibility (this may be downloaded from [http://www.fhi.org/en/RH/Pubs/servdelivery/quickreferencechart.htm](http://www.fhi.org/en/RH/Pubs/servdelivery/quickreferencechart.htm) or ordered from FHI)  
  - Optional tool: The Missed Opportunities Checklist | Matrix from Session 2 (TFR, CPR, Unmet Need)  
  - Powerpoint presentation  
  - Flip charts and markers for groups | Small signs with CBFP strategies written on them (size of construction or A4 paper)  
  - Case study questions written on flip chart (see Community Strategy Case Studies)  
  - Powerpoint presentation (for Facilitators' Reference)  
  - Handout 7.1 – Community Mobilization Definition and Degrees of Participation  
  - Handout 7.2 – Community Mobilization Cycle |
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Strategies for Community-based Programs</td>
<td>Day 3 Session 1</td>
</tr>
<tr>
<td>9</td>
<td>Designing a Behavior Change Strategy</td>
<td>Day 3 Session 2</td>
</tr>
<tr>
<td>10</td>
<td>Quality Improvement</td>
<td>Day 3 Session 3</td>
</tr>
</tbody>
</table>

**8 Strategies for Community-based Programs**  
Day 3 Session 1

- See above session materials

**9 Designing a Behavior Change Strategy**  
Day 3 Session 2

- Small signs with elements of the BC Strategy framework written on them (behavior, priority group, influencing group, determinants, factors, activities, also make some blank (size of construction, A4 paper, or strips of flip chart paper)
- Flip Chart of the Designing for Behavior Change Framework (cover the words)
- Exercise Exercise Statements and Behavior Goal written on flip charts (see below)
- Cards/signs, each with 1 of 7 steps of the Barrier Analysis written on one side only
- Handout 8.1: Blank Designing for Behavior Change (DBC) Framework
- Handout 8.2: Three completed examples of DBC Frameworks (ITNs, HIV Testing, & Coffee production- select one for review during Activity 2, step g. (3)
- Handout 8.3: Seven steps to conducting a Barrier Analysis
- Handout 8.4a & b: BA/DND Data Sheets (a-for Facilitators, b-for Participants)
- Handout 8.5: Identifying Activities to Address Determinants
- Handout 8.6: Going Beyond Awareness Raising
- Markers and tape
- Powerpoint presentation (for facilitators reference only)

**10 Quality Improvement**  
Day 3 Session 3

- Powerpoint slide presentation
- In-country presenter
- Manuals/summary for each of the QI approaches (PDQ, COPE, QIQ):
- Partner Defined Quality: A Toolbook for Community and Health Provider
<table>
<thead>
<tr>
<th>Review</th>
<th>Day 4 Opener</th>
<th>Each day two people from the energy committee will lead the participants in an interactive 20 minute session to review key points from the previous day.</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 Quality Improvement</td>
<td>Day 4 Session 1</td>
<td>See above</td>
</tr>
<tr>
<td>con’t</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 11 FP Logistics        | Day 4 Session 2 | **Contraceptive Insecurity Game**  
  o Envelopes: One per participant  
  o Preprinted small labels “Expires 06/01/03”: Sufficient amount to label ¼ of all contraceptive supplies.  
  o Masking tape for attaching envelopes to bottom of chairs  
  o Condoms: Two times the number of participants (200 pieces for 100 participants)  
  o Pills (cycles): ¼ the number of participants (25 cycles for 100 participants)  
  o PowerPoint Presentation. (Copies should be in participant binders.)  
  o Flip chart with the Delivery Logistics Objective – the Six Rights |
| 12 Gender/Male         | Day 4 Session 3 | **Handout 11.1 (This is a list of statements for the values clarification exercise and should not be given to participants)**  
  **Handout 11.2 for case study analysis (See Facilitator’s notes on case studies)**  
  **Guest Facilitator**  
  **PowerPoint presentation (for facilitator’s reference)** |
| Involvement in FP      |              |                                                                                                                                 |
| 13 Youth Involvement in FP | Day 4 Session 4 | **Handouts 12.1, 12.2, 12.3**  
  **PowerPoint presentation – for reference only**  
  **Guest Facilitator** |
<table>
<thead>
<tr>
<th>14</th>
<th>Preparation for Field Visit</th>
<th>Day 4 Session 5</th>
<th>Learning Guide for Field Visit - Key questions</th>
</tr>
</thead>
</table>
|    | All day field visit         | Day 5          | • Learning Guide for Field Visit  
|    |                             |                | • Note pads & pens  
|    |                             |                | • Transportation to & from field site  
|    |                             |                | • Water & snacks |
|    | Feedback from Field Visit   | Day 5 Session 1|                                                    |
|    | Review                      | Day 6 Opener   | Each day two people from the energy committee will lead the participants in an interactive 20 minute session to review key points from the previous day. |
| 15 | Integration of FP into…..  | Day 6 Session 1| • Written Definition of Integration Entry Points on flip chart  
|    | Closing session and evaluation | Day 6 Session 5| • Handout 14.1 (Integration Entry Points)  
|    |                             |                | • Powerpoint (for Facilitators reference only) |

**B. PDME Course**

The manual for this course may be accessed at [http://www.flexfund.org/resources/training/pdme.cfm](http://www.flexfund.org/resources/training/pdme.cfm). This course is available in English and French. This course is designed to complement the technical content presented during the first week, by helping participants use it for program design, monitoring and evaluation.
Example Agenda
## Workshop Agenda

### Basics of Community-Based FP Workshop

<table>
<thead>
<tr>
<th>Day 1 - Monday</th>
<th>Session</th>
<th>Title</th>
<th>Estimated Time</th>
<th>Facilitators / Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>Introduction</td>
<td>1h 50 min 8:30 – 10:20</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Overview of FP and Birth Spacing at the Global Level (Legal framework and MDG)</td>
<td>1h 25 min 10:35 – 12:00</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Contraceptive Technology Overview</td>
<td>2 hr 1:00 – 3:00</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Overview of Contraceptive Methods (continued)</td>
<td>2 hr 3:15 – 5:15</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Evaluation</td>
<td>10 min 5:15 – 5:25</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Day 2 - Tuesday</th>
<th>Session</th>
<th>Title</th>
<th>Estimated Time</th>
<th>Facilitators / Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4</td>
<td>Infection Prevention</td>
<td>1 h 20 min 8:50 – 10:10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Counseling / Client Provider Interaction</td>
<td>2 hr 10:25 – 12:25</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Overview of Factors Influencing Service Delivery</td>
<td>1h 30 min 1:25 – 3:25</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Strategies for Community Mobilization</td>
<td>1 hr 30 min 3:10-4:10</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Evaluation</td>
<td>10 min 4:40 – 4:50</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Day 3 - Wednesday</th>
<th>Session</th>
<th>Title</th>
<th>Estimated Time</th>
<th>Facilitators / Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8</td>
<td>Strategies for Community-Based Family Planning Service Delivery</td>
<td>1h 55 min 8:50 – 10:45</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>Behavior Change Strategies</td>
<td>2 hr 11:00 – 1:00</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>Lunch</td>
<td>1 hr 1:00 – 2:00</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>Behavior Change Strategies (continued)</td>
<td>1 hr 2:00 – 3:00</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>QI: Introduction to Quality Improvement</td>
<td>40 min 3:00 – 3:40</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>QI: Group Work</td>
<td>1h 30 min 3:55 – 5:25</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Evaluation</td>
<td>10 min 5:25 – 5:35</td>
<td></td>
</tr>
</tbody>
</table>
**Day 4 – Thursday**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Duration</th>
<th>Start</th>
<th>End</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 – 9:00</td>
<td>Energizer and Review</td>
<td>30 min</td>
<td>8:30</td>
<td>9:00</td>
</tr>
<tr>
<td>9:00 – 9:50</td>
<td>QI: Group Work</td>
<td>50 min</td>
<td>9:00</td>
<td>9:50</td>
</tr>
<tr>
<td>9:50 – 11:35</td>
<td>Systems Strengthening – Logistics Management</td>
<td>1 hr 45 min</td>
<td>9:50</td>
<td>11:35</td>
</tr>
<tr>
<td></td>
<td><strong>Pause</strong></td>
<td>15 min</td>
<td>11:35</td>
<td>11:50</td>
</tr>
<tr>
<td>11:50 – 1:15</td>
<td>Family Planning Programming – Gender/Male involvement</td>
<td>1 hr 25 min</td>
<td>11:50</td>
<td>1:15</td>
</tr>
<tr>
<td></td>
<td><strong>Lunch</strong></td>
<td>1 hr</td>
<td>1:15</td>
<td>1:30</td>
</tr>
<tr>
<td>1:15 – 2:15</td>
<td>FP Programming – Gender/Male Involvement (continued)</td>
<td>1 hr</td>
<td>2:15</td>
<td>3:15</td>
</tr>
<tr>
<td></td>
<td><strong>Pause</strong></td>
<td>15 min</td>
<td>3:15</td>
<td>3:30</td>
</tr>
<tr>
<td>2:15 – 3:15</td>
<td>FP Programming – Youth</td>
<td>1 hr 20 min</td>
<td>3:30</td>
<td>4:50</td>
</tr>
<tr>
<td>3:30 – 4:50</td>
<td>Preparation for Field Visit</td>
<td>30 min</td>
<td>4:50</td>
<td>5:20</td>
</tr>
<tr>
<td></td>
<td><strong>Evaluation</strong></td>
<td>10 min</td>
<td>5:20</td>
<td>5:30</td>
</tr>
</tbody>
</table>

**Day 5 – Friday**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Duration</th>
<th>Start</th>
<th>End</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00 – 8:00</td>
<td>Depart for Field</td>
<td>1 hr</td>
<td>7:00</td>
<td>8:00</td>
</tr>
<tr>
<td></td>
<td><strong>Field Visit</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Lunch</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Feedback Session</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Return to hotel</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Day 6 – Saturday**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Duration</th>
<th>Start</th>
<th>End</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 - 8:30</td>
<td>Energizer / Debrief from Field</td>
<td>30 min</td>
<td>8:00</td>
<td>8:30</td>
</tr>
<tr>
<td>8:30 – 9:30</td>
<td>FP Programming – Youth (continued)</td>
<td>1 hr</td>
<td>8:30</td>
<td>9:30</td>
</tr>
<tr>
<td>9:30 – 11:30</td>
<td>FP Programming – Integration and Linkages (pause included)</td>
<td>2 hrs</td>
<td>9:30</td>
<td>11:30</td>
</tr>
<tr>
<td>11:30 – 1:30</td>
<td>Final Review, Closing (Questions, Challenges) &amp; Evaluation</td>
<td>1 hr 30 min</td>
<td>11:30</td>
<td>1:30</td>
</tr>
<tr>
<td></td>
<td><strong>Lunch</strong></td>
<td>1 hr</td>
<td>1:30</td>
<td>2:30</td>
</tr>
</tbody>
</table>
Pre-Workshop Material
Community-Based Family Planning Workshop:
Basics of Community-Based Family Planning and Program Design, Monitoring and Evaluation of FP Programs

Dear Workshop Participants:

We are delighted that you have signed up to join us for this joint workshop offering [TO BE COMPLETED]. We think this offers a unique opportunity to work concurrently on the technical aspects of family planning delivery, particularly at the community level, and on the program design aspects including monitoring and evaluation.

In order for this workshop to be more specific to your project situations, please bring the following:

For All Participants:

Please come to the first day of the workshop ready to provide us with the most recent figures available (please include date and source of data) on your country's Total Fertility Rate (TFR), Contraceptive Prevalence Rate (CPR), and Unmet Need. These can generally be found in your country's Demographic and Health Surveys. Please also note a key event (brief description and its date) in the history of family planning for your country and/or your region.

For All Participants Currently Implementing a FP Project:

We would like to tap into each of your project experiences. However, we do not foresee having time in the workshop schedule for each participant to present their project. As a result, we propose to develop a poster gallery with posters representing each of your family planning projects.

For those of you currently implementing family planning activities, please prepare a poster of your project that includes the following:

- **Definition of your target population** – location of the project, size of the target population, and unique characteristics of your target population.

- **Explanation of your project strategies** – How are you proposing to improve family planning use? Why did you select these strategies?

- **Identify the key partner(s)** - Who are you working with to implement the project?

- **Discuss what is going particularly well with the project** - What is special or innovative that might contribute to improving others’ programs?
Discuss some of the things you find challenging - Why are these things difficult? What are you doing to try and address these challenges?

Bring useful or innovative tools, materials, job aids – Do you have any examples of specific tools, communication materials, job aids that you have found to be very effective and would benefit other programs? Some examples include BCC materials, job aids, training manuals, other manuals, study reports, etc…

For those attending the PDME Section of the workshop (week 2):

As part of this workshop, you will be working on a case study to practice project design skills, and then refining your own project design. In preparation for these exercises, please bring any project materials with you (hard copy and electronic version if possible). Since different projects are at different points in the implementation cycle, you may not have these documents yet. We will work with whatever you have. Following is a list of documents that would be useful for the PDME component of the workshop:

- Project proposal that includes FP component
- Project implementation plan outlining strategies and activities you are undertaking
- Project assessment reports – qualitative and/or quantitative
- Results framework or log frame you may have developed
- M&E plan if you have one
- List of the project indicators
- If you have not yet reviewed secondary data, we will have the DHS for most of the countries represented by the participants that you may use for secondary data.

Along with project specific material, please bring hard copies of secondary data that relates to your country such as national family planning policies, MOH standards/policies, UNFPA studies, health management information system quarterly reports, gender studies/reports, etc.

The workshop organizer will bring 1-2 copies of the DHS survey for each country represented, along with other secondary data sources such as Service Provision Assessments.

Pre-workshop information:

Attached is a learning needs assessment to assist us in finalizing the workshop sessions based upon the learning needs of the participants. Please complete the assessment and return to [TO BE COMPLETED]

Please confirm your participation in the workshop by sending an email to [TO BE CONFIRMED]. We need participants to confirm their attendance as we have limited
space and will most likely need to have a waiting list. Please confirm by [TO BE
CONFIRMED] or we will consider your space available for someone on the waiting list.

Please contact [TO BE COMPLETED] if you need a more specific letter of invitation in
order to secure a visa.

As facilitators and workshop organizers, we would like to thank you in advance for your
efforts to prepare for this workshop, and we look forward to working with you.
Meanwhile, if you have any questions, contact [TO BE COMPLETED].

Sincerely,

Course Facilitators and Workshop Organizers
Pre Workshop: Participant Self-Assessment
Basics of Community-Based FP Programming Workshop
Please return this to the facilitator via email

Are you attending one or both workshops? (Please check the appropriate item)

___ PDME and CB FP     ___ CBFP     ___PDME

Please offer a self-assessment of your knowledge and experience in FP
Programming by completing the following simple questionnaire.

1. What is your job title?

2. What is your previous training/education in public health?

3. What are your current job responsibilities at your organization?

4. How many years have you been in this position?
5. Do you have personal experience leading or working in a family planning program? If so, what is your experience?

5. What is your expectation of the workshop?

Please review the sessions below for both the Basics of Community Based Family Planning and Program Design, Monitoring and Evaluation curricula and indicate (by making an X next to the session) which session(s) you would feel comfortable sharing your project activities and/or experience:

**Basics of Community-based Family Planning:**

A. Contraceptive Technology Update

B. Infection Prevention

C. Counseling/Client Provider Interaction

D. Overview of Factors Influencing Service Delivery

E. Strategies for Community-based Family Planning

F. Behavior Change Strategies

G. Quality Improvement

H. Logistics Management

I. Gender/Male Involvement

J. Family Planning Programming for Youth

I. Family Planning Integration and Linkages
Program Design, Monitoring and Evaluation:

A. Development of project design or logistical frameworks

B. Development of targets and objectives

C. Development of indicators to measure objectives

D. Development of a M&E plan to track indicators

E. Familiarity with RH program strategies

F. Familiarity with standard RH program indicators

G. Use of secondary data to justify project priorities

H. Qualitative Assessment Approaches such as PRA or PLA (participatory learning appraisal), PDI techniques

I. Focus group discussions / Key informant interviews

J. Health service delivery assessments

K. 30 cluster surveys

L. LQAS surveys

Thank you for your input,

The Workshop Facilitators
Session 1: Workshop Introduction
**Session 1 - Workshop Introduction**

**Achievement-based Objectives:**
By the end of this session, the participants will have:
- Discussed the learning objectives of the workshop
- Reviewed and discussed the course model and framework
- Compared the health and FP background interests among fellow participants
- Established norms for workshop conduct
- Shared expectations of the workshop
- Discussed what is expected of them throughout the course including active participation
- Described the history of international family planning
- Described how key international meetings such as ICPD and subsequent conferences and meetings contribute to improving access to family planning

**Duration:** 1 hour, 50 minutes  
**Timeframe:** Day 1 8:30 – 10:20  
**Seating Arrangement:** small groups at tables

**Materials:**
- Digital camera, color printer, blank copy paper (1 per participant)  
- Nametags  
- Markers - keep several different colors on each participant table  
- Blank index cards on tables - keep a stack on tables throughout the course  
- Tape  
- Pre-assembled binders for each participant  
- Workshop Learning Objectives on flip chart page  
- Day 1 Sessions' Objectives on separate flip chart pages  
- Day 1 Agenda on flip chart page  
- Flip chart page labeled “Parking Lot”  
- New Friend Interview Questions on flip chart page (see below)  
- Printed index cards boldly labeled with pertinent years/decades (1950-2010)  
- Pre-written cards with key events written on one side only (see "Key Messages")  
- Handout – 1.1 Learning Objectives  
- Wall space for timeline

**Tasks:**
Design the ceremony as appropriate to the background of the participants or the location of the training (if participants are from different countries). Usually this includes a welcome by political leaders, community leaders, donor officials, ministry of health and a representative from the local workshop host.

NOTE: Review session 1 objectives

1. **Introductions - 60 minutes**
There are a couple of activities you may select from for the introductions:

**Procedure:**

A. **New Friend Interviews**

1) Invite the participants to listen: “Welcome! This training and workshop will focus on ways we can implement quality family planning programs that respond to the needs of the communities we work with. To start we have an activity to help everyone get to know each other. Next, we will discuss what we hope to accomplish during the workshop.”

2) Prepare and post a ‘New Friend Interviews’ Chart with questions on an easel or wall.

3) State “Our first task is to meet and introduce one another. To do this we shall interview each other. First pair up with someone you do not know. (Note: Facilitators can get creative here by asking ½ the participants to take off their right shoes and asking the other half to select a shoe from the pile until everyone finds the owner of the shoe and thus their partner).

4) Distribute one sheet of paper and a marker to each participant

5) Tell participants “Ask the questions on the chart and record the answers on your own piece of paper. (We will be coming around to photograph each of you with a digital camera. Leave some room at the top of your paper for a photo). Once you have completed both interviews, tape what you have recorded to the wall around the room.”

<table>
<thead>
<tr>
<th>New Friend Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Who are you?</td>
</tr>
<tr>
<td>- Where are you from?</td>
</tr>
<tr>
<td>- What do you do?</td>
</tr>
<tr>
<td>- Any experiences with FP programs?</td>
</tr>
<tr>
<td>- Expectations for the workshop</td>
</tr>
<tr>
<td>- Dream trip (or other personal question)</td>
</tr>
</tbody>
</table>

6) After participants have taped their interviews to the wall around the room, ask participants to stand where they can see the interview responses. Ask that persons in each pair introduce their “new friend” to the group by briefly presenting the interview responses.

7) Triage the expectations, identifying those that will be addressed during the workshop and those that will not

8) Optional step: Once all expectations have been addressed, ask participants to now greet the person as if they have just met again after 10 years.
B. **Proverbs**

Ask participants for African Proverbs. Write proverb on 2 cards: one-half per card. Give each participant one card and ask them to find the missing half of their proverb. Once they have completed their proverb, have them discuss how this proverb might be applied to FP. Then ask each pair to introduce themselves to the rest of the group and to share how they feel their proverb might be applied to FP.

### 2. Training Goals, Learning Objectives, Agenda, Volunteers, Learning Journal - 30 minutes

**Procedure:**
- Review purpose, learning objectives, model for community-based FP course, and schedule for workshop, as included in binder (handout 1.1)
- Expectations of participants
- Outline expectations for participant involvement – posters, individual short presentations to supplement sessions as appropriate
- Present key highlights of pre-training assessment.
- Present housekeeping details.
- Note that unanswered questions or pending issues can be posted on the “Parking Lot” flip chart, and/or written on the available blank index cards, to be eventually addressed.
- Request volunteers for the following committees*: 1) entertainment, 2) daily review and timekeeper, and 3) energizer
- Explain how to use the learning journal; ask for a volunteer to help remind participants each day to use their journals
- Field questions.

* See “Guide to Workshop Facilitators” for more information about the committees.

The Entertainment Committee will work with the course organizers to plan special outings for the workshop participants. They should be encouraged to talk with the participants to get their ideas and suggestions. The daily review and timekeeping committee is responsible for identifying 2 people to conduct the daily review each morning. The review should be about 15 – 20 minutes using a participatory approach to review the previous day’s key points. Usually the participants have many participatory activities they have used in their work but the course organizers should be ready to provide suggestions to those who need ideas. Games such as musical chairs, jeopardy, etc... are always a big hit. The energizer committee changes daily and is available to lead energizers as needed throughout the day.

### 3. Timeline Activity: Brief History of Family Planning - 20 minutes

**Procedure:**
1. Post index cards labeled with years/decades on the wall. Ensure that participants have several index cards on their tables.
2. Ask participants the following question: “What do you think are key events in the history of FP?” Take a few responses in plenary.
3. Ask participants to turn to the person to their right (make sure everyone has a partner) & and with their partner, to write one significant FP event on an index card on one side only. Mention that the event may be national (such as the year that a FP policy was adopted) or global in its impact on FP (such as the Mexico City Policy). If they have time, participants should try to identify one national event for each of their countries and one global event.
4. Ask participants to place their cards where they belong on the timeline.
5. After everyone has posted their card, ask if anything is missing. Provide additional cards for individuals to write down any missing events and have them post the cards.
6. As you notice that certain events are missing from the timeline, provide individuals with cards which have been prepared ahead of time.
7. Facilitate discussion as needed around events and dates, asking participants to describe their events and providing a summary of the key events listed below.

You may want to include supplemental discussion questions such as:
1) What was the most significant FP event in the 20th Century and why?
2) What country made the most important contribution to meeting FP needs of their citizens? Globally?
3) What countries have made commitments to FP?

**Key Messages:**
- FP programs have changed over time having been influenced by a number of events including international conferences, individuals, organizations, countries, etc...
- FP is still not receiving needed attention and competing with other priorities and paradigm shift from population control to a family health intervention (MCH) and greater funding priority often placed on HIV/AIDS programming
- Timeline: include key FP events over the past 50 years:
  - **1966:** The U.S. Agency for International Development begins providing contraceptives as an integral part of its overseas development programs.
  - **1973:** Roe vs. Wade- landmark decision to legalize abortion in the US
  - **1984:** Mexico City Policy (aka: Global Gag Rule) In 1984, during a United Nations International Conference on Population in Mexico City, President Reagan announced a ban on U.S. government financial support for certain U.S. and foreign family planning agencies -- those that were involved in any way with the provision of abortion in foreign countries. The ban was suspended by President Clinton, reinstated by President Bush, then partially suspended by President Bush, and in 2009, reversed by President Obama. This ban totally removed all U.S. government funding from international agencies which:
    - Provided abortions anywhere in the world.
    - Provided abortion counseling anywhere in the world.
    - Advocated for women's abortion access anywhere in the world.
  - **1994:** International Conference on Population and Development, Cairo- Delegations from 179 States took part in negotiations to finalize a Programme of Action on population and development for the next 20 years; their goals highlighted the importance of FP and gender equality.
  - **1999:** Tiahrt Amendment; no quotas or incentives could be given to encourage individuals to become acceptors of FP methods; result of Peru's Norplant program.
  - **2009:** Mexico City Policy completely reversed by President Obama
The Basics of Community-based Family Planning Workshop
Learning Objectives

By the end of the workshop, participants will have:

• Discussed unmet need for family planning and its links to broader development goals
• Described the rationale for FP as a part of other programs
• Described the link between gender and FP/RH services and identified strategies to develop gender-sensitive FP programs and services
• Named the service delivery requirements for each method of contraception
• Named and discussed the elements of a quality FP program
• Explained the components of FP service provision
• Practiced providing appropriate client-centered counseling for the FP client
Session 2: Overview of Family Planning
Session 2 - Overview of Family Planning

**Achievement-based Objectives:**
By the end of this session, the participants will have:
- Defined reproductive health
- Defined FP and related terms as birth spacing, birth limiting and unmet need
- Explored FP as a health intervention with a significant impact on maternal, child and infant survival, growth and development
- Briefly described how providing FP services contributes to achieving Millennium Development Goals (MDGs)
- Listed direct and indirect benefits of FP, birth spacing and birth limiting to individuals, societies, and globally

**Duration:** 1 hour, 25 minutes
**Timeframe:** Day 1 10:35 – 12:00
**Seating Arrangement:** small groups at tables
**Materials:**
- Flip chart
- Markers
- Article: Birth Spacing: Three to Five Saves Lives, [http://www.reproline.jhu.edu/english/6read/6issues/6jtn/v5/tn0211ctu.htm](http://www.reproline.jhu.edu/english/6read/6issues/6jtn/v5/tn0211ctu.htm)

**Tasks**

NOTE: Review session objectives first.

1. **Brainstorm terms and meanings in plenary - 25 minutes**

   **Procedure:**
   a) What is the ICPD/WHO definition for Reproductive Health? How does family planning fit within that definition?
   b) What do we mean by unmet need for family planning?
   c) What are some of the key messages we want to tell people of different ages related to family planning and child spacing
   d) Why do women / couples want to space or limit their children in general and in areas where you work?
      1. Health, economic, social benefits...
      2. As a follow-on to the health benefits, briefly discuss the difference between TFR and CPR and rates for different countries
      3. On a flip chart, prepare a matrix with columns labeled TFR, CPR, and unmet need; ask participants from each country to give you the correct rates for their countries & write these in the appropriate spaces; discuss countries with highest and lowest CPR, TFR, & unmet need.
4. What factors contribute to TFR, CPR, and unmet need in the country where you work?
5. What cultural and environmental factors contribute to the current rates in your country?
   e) Why do women/couples not wish to space or limit their children in the areas where you work?
   f) Why do women and men choose NOT to use a method of contraception?
   g) In your opinion, what are some of the components of quality family planning services?
   Note: Add more questions based upon the learner content above

2. Small Group Activity - 20 minutes

Procedure:

Small group work by table:

   a) Ask everyone to write on piece of paper 1 – 2 benefits of FP
   b) Ask them to share those with their neighbor
   c) By tables, assign each group the task of identifying benefits of FP for:
      1. Women
      2. Men
      3. Children
      4. Society / Community
   d) Bring participants together and discuss their answers in a brief plenary discussion
   e) Distribute the HTSP Pocket Guide

3. Group Discussion - 40 minutes

Procedure:
Facilitate a plenary group discussion utilizing the PPT slides as visual support for your key points; skip over any slides that were already discussed during the previous activities.
I. What is Reproductive Health?

“Reproductive health is defined by WHO as a state of physical, mental, and social well-being in all matters relating to the reproductive system at all stages of life. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this are the right of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, and the right to appropriate health-care services that enable women to safely go through pregnancy and childbirth.” (http://www.rho.org/html/definition.htm)

II. Fertility

• Total Fertility Rate means the number of children who would be born per woman (or per 1,000 women) if she/they were to pass through the childbearing years
bearing children according to a current schedule of age-specific fertility rates.
(Flexible Fund Guidance Core Indicator Reference Sheets and Measure Evaluation,
“Compendium of Indicators for Evaluating RH Programs”, Volume 2, 2002)

Three factors that influence fertility at a country level:
1) Age of woman at first birth
2) Birth spacing practices
3) Birth limiting practices

III. Family Planning

• What is family planning?
Family planning is the conscious effort to regulate the number and spacing of births through temporary, long-term and permanent methods including emergency contraception. Put in another way, it is the educational, medical and social activities which enable individuals, including minors, to determine freely the number and spacing of their children and to select the means by which this may be achieved. (U.S. Department of Health and Human Services) It contributes to health, economic, and social well-being at the individual, family, community and global levels.

• What is birth limiting?
Simply refers to situations where women do not want any more births.

• What is birth spacing and delaying?
This concept is best explained in the document entitled “Healthy timing and spacing of pregnancies (HTSP)”,

The key messages are as follows:

HTSP Messages to Achieve Healthy Pregnancy outcomes

After a live birth:
• Couples can use an effective FP method of their choice continuously for at least two years before trying to become pregnant again.
• Couples who choose to use an effective FP method continuously can plan to have their next pregnancy not more than five years after the last birth.
• A general rule is Three to Five Saves Lives (see Popline Report, 2nd link under Materials above)

After a miscarriage or abortion:
• Couples can use an effective FP method of their choice continuously for at least six months after a miscarriage or abortion before trying to become pregnant again.
For adolescents:

- Adolescents need to use an effective FP method of their choice continuously until they are 18 years old before trying to become pregnant.

IV. Overview of Current Contraceptive Use

- The 1965 average was about 10% of couples using a method, now it is at 60% (UN 2003)
- Contraceptive use is rising in Anglophone Sub-Saharan Africa
- Contraceptive use is much lower in Francophone Sub-Saharan Africa (except for Togo <20%)
- South America and Central America and Caribbean regions show patterns of steady rises in use
- The Middle East/North Africa contraceptive use has risen steadily (six of the 16 countries are at or above 60% of couples using a method)
- East Asia has the highest levels of contraceptive use
- Southeastern and Southern Asia have wide ranges in contraceptive use

Projections for Percentage Using Contraception

- Countries with very high or very low TFRs are projected to change the least
- Countries in the middle range are projected to change more rapidly
- For example:
  - Countries in 2005 with prevalence < 10% improve only by 4.4 points by 2020
  - Countries in the middle at 30 – 39%, improve by a full 15.9 points
  - At 70% or above, the average change is zero

V. Why is Birth Spacing Important?

- 10 million infants and children and more than 500,000 women still die each year from preventable causes and many of these deaths are associated with too short birth intervals
- Worldwide there are 50 deaths / 100,000 live births due to unsafe abortions

1) HTSP Benefits Newborns, Infants and Children under Five:
(See graphs on ppt slides for examples of mortality reduction in a variety of settings with increasing birth intervals)

- Reduces potential risk of pre-term births, low-birth weight, stunting or underweight conditions during growth.
- Reduces potential risk of death for newborns, infants and children under five.
- Allows young children to experience the substantial health benefits of optimal breastfeeding received from the nourishment of their mother’s milk for a full 2 years.
- When mothers wait to have their first pregnancy until they are at least 18 years old, they reduce potential risk of pre-term births and low-birth weight for their babies.
• Waiting at least six months from the time of a miscarriage or abortion until becoming pregnant again reduces babies’ potential risk of pre-term birth and low birth weight.

The Evidence for Benefits of Birth Spacing
Evidence indicates that birth-to-pregnancy intervals of:

- **18 months or less** are associated with significant risk of neonatal and perinatal mortality, low birth weight, small size for gestational age, and preterm delivery;
- **27 months or less** are associated with significant increased risk of stillbirths, and miscarriages relative to birth-to-pregnancy intervals of 27-50 months;
- **51 months or longer** are associated with significant increased odds of stillbirths and miscarriages;
- **59 months or longer** are associated with significant increased risk of low birth weight, preterm birth, and small for gestational age.

Child Health Outcomes
• Many of the 10 million deaths each year from preventable causes among infants and children are associated with too short birth intervals
• For children under age 5, birth-to-pregnancy intervals of 45 months or longer are associated with the lowest risk of dying
• Two-year birth intervals are associated with higher infant and child mortality risks than births occurring at 36-month birth intervals

Infant Health Outcomes
• For infant mortality, birth-to-pregnancy intervals of 24 months or less are associated with significant risk of mortality.
• Improving infant health is important because:
  - there are approximately 4 million newborn deaths and over 3 million stillborn deaths each year
  - neonatal deaths account for 40-60% of child deaths

Nutrition Outcomes
• Malnutrition plays a role in more than half of all child deaths.
• Birth-to-pregnancy intervals up to 60 months are associated with a decrease in the risk of stunting and underweight among children under-five.
• Results were mixed on the relationship between the birth-to-pregnancy interval and maternal nutritional status and anemia.

Maternal Health Outcomes
• Identifying interventions to improve maternal health outcomes are important because over 500,000 women still die each year from preventable causes.
• Many of these deaths are associated with too short birth intervals

HTSP Benefits Men
• Helps men safeguard the health and wellbeing of their wives and children.
• Allows men time to plan financially and emotionally for their next child, if they chose to have one.
• Men may feel an increased sense of satisfaction from supporting their partner in making healthy decisions regarding HTSP and family planning use.

**HTSP Benefits Communities**
• HTSP benefits communities by helping to reduce deaths and illnesses among mothers, newborns, infants and children
• HTSP and the use of natural or modern family planning methods benefits the community by helping to reduce poverty and to improve the quality of life among community residents

2) **Family Planning reduces abortions**
• Of global maternal mortality, 13% is caused by unsafe abortion
• In 2000, about 90% of global abortion-related mortality could have been averted if women wishing to postpone or limit further childbearing had used effective contraception.
• By expanding FP services in Europe and Eurasia, many countries have experienced a dramatic decrease in abortion rates. In Kazakhstan, the Kyrgyz Republic, Moldova and Uzbekistan, modern contraceptive prevalence increased by 50% and abortion declined by 50% during the 1990s.

(FP 101 eLearning Module in the Global Health eLearning Center)

3) **Family Planning Reduces Mother-to-Child Transmission of HIV**
• Enabling HIV-positive women to prevent unwanted pregnancy reduces the numbers of infants who are born to HIV-positive women, thus reducing the number of infants who are HIV-positive.
  o In 2003, approximately 640,000 children in sub-Saharan Africa were newly infected with HIV. Without any contraceptive use, approximately 813,000 children in sub-Saharan Africa would have been newly infected. So, contraceptive use prevented approximately 173,000 new infections in one year.

(FP 101 eLearning Module)

4) **Contributes to Sustainable Rates of Population Growth**
• The world’s population is growing rapidly in many regions, compounding demands on natural resources (e.g., water and fertile soil) as well as on the capacity of nations to provide health care, education and social services to their citizens.
• Population increases are most dramatic in Africa and South Central and Western Asia - often the poorest countries in the developing world, which also have the lowest contraceptive utilization rates.

(FP 101 eLearning Module)
5) Reduces Economic Stress/ Poverty

- Voluntary FP reduces “stress” on the economy.

Evidence from the last 10 – 12 years of the effect of fertility change is clear. Countries with a fertility decline experience an increase in gross domestic product (GDP) per person and improvement in economic distribution following a lag of 10 to 15 years.

The medium projection for human population is nearly 9.2 billion by the year 2050 – up from nearly 6.7 billion today. The population challenges humanity faces in this century and beyond will become harder to address as the number of people continues to increase. Increasing access to FP is one possibility for influencing population growth. (Population in Action 2007 and United Nations 2007 in FP eLearning Module)

6) Addresses Women’s Unmet Need for FP

More than 100 million women in less developed countries would prefer to avoid pregnancy, but are not using any form of FP. These women are considered to have an unmet need for FP.

Unmet need for contraception can lead to unintended pregnancies, which pose risks for women, their children and societies. In less developed countries, about one-fourth of pregnancies are unintended – that is, unwanted or mistimed.

The most common reasons for unmet need are:
- Difficult access to modern contraceptive methods
- Low quality health care services
- Little perceived risk of becoming pregnant – the stated reason for one- to two-thirds of women with unmet need
- Opposition from husbands, families, communities
- Fears about contraceptive side effects
- Lack of knowledge about contraceptive methods or sources of supply

Addresses unmet need among postpartum and young women:

- Only 40% of women who are within one year of their last birth are using a FP method, yet only 3% want a birth within two years
- Based on DHS data from 27 countries, only 3-8% of women want another child within two years of giving birth.
- Young women (Adolescent women) often have less access to contraception, less knowledge about pregnancy risk and less understanding of contraceptive options. Unintended pregnancies may have important adverse effects for the future education and lives of adolescents. Preventing unintended pregnancies among young women (under age 18) also helps prevent the formation of vesicovaginal fistulas that result if the pelvis is too small.

(FP 101 and Youth Reproductive Health eLearning Modules)
Need for Birth Spacing
• The majority of non-first births in developing countries occur after too short an interval: data from 55 developing countries show that 57% of women have spaced non-first births shorter than three years. And 26% have spaced births less than two years apart.

VI. Factors that contribute to use of contraception:

1) Knowledge and Interest in Birth Spacing
• Despite common misconceptions that there is no demand for birth spacing among women who have not yet had a child, recent research found that a demand for spacing does exist among zero-parity women who are interested in postponing a first birth.

Demand for Birth Spacing Among Post-Partum Women
• The demand for birth spacing is high in many countries
• Few post-partum women want another birth within two years, yet many do not use family planning
  – For example, in Latin America, only 3% want to give birth in the next two years. Yet average family planning use in the extended post-partum period is just 40%.

2) Quality of Services

What is included in Quality Family Planning Services?
• A Range of contraceptive methods, including natural family planning (NFP), consistently available
• Geographically accessible and acceptable services
• Organization of care / Integration
• Technical competence
• Facilities and supplies
• Clients rights

Informed and Voluntary Decision Making
• Service options are available
• The decision-making process is voluntary
• Individual have appropriate information
• Good client-provider interaction (CPI), including counseling is ensured
• The social and rights context supports autonomous decision making

3) Access to Services
• Geographically accessible services
• Adequate supplies of all methods offered
• Trained personnel

4) Social and Political Environment
• Existence of FP policy at the national level
• Availability of contraceptives
• Social, cultural, religious context at national and community levels
VII. Common indicators to monitor community-based FP programs:

The following definitions are taken from the Flexible Fund Guidance Core Indicator Reference Sheets and Measure Evaluation, “Compendium of Indicators for Evaluating RH Programs”, Volume 2, 2002:

**CPR** is percent of WRA (15-49) who are using (or whose partner is using) a contraceptive method at a particular point in time, also known as met need.

**CYP** is the estimated protection provided by FP services during a 12-month period, based on the total volume of all contraceptives sold or distributed free of charge to clients during that 12-month period.

**New users** are the number of persons who accept for the first time in their lives any modern method of contraception, aggregated over a 12-month reference period.

**Unmet need** is the number or percent of women currently married or in union who are fecund and who desire to either postpone or end childbearing, but who are not currently using a contraceptive method. Meeting the “unmet need” for contraception would avert 52 million unintended pregnancies annually.

**Key Messages:**

- **Reproductive Health**: complete physical, mental and social well-being in all RH related matters. Satisfying and safe sex life; freedom and ability to reproduce. Access to/informed choice of: safe, effective, affordable and acceptable methods and health care for safe pregnancy and childbirth.
- **Family planning** includes regulating how many children, birth spacing, birth limiting, and addressing infertility.
- **FP services** include educational, medical and social activities. Family planning programs are the backbone of women’s health care.
- **Widespread Int’l Agreement** that Sexual and Reproductive Health directly and indirectly influences all MDG goals.
- At the **1994 Int’l Conf. on Population and Development**, 179 countries agreed on the importance of FP and gender equality.
- **FP has direct and indirect impacts** - Reducing the high global level of unmet need will save many lives.
Overview of Reproductive Health and Family Planning

Basics of Community-Based Family Planning
Learner Objectives

By the end of the session, participants will have:

• Defined reproductive health (RH)
• Defined FP, birth spacing, birth limiting, and unmet need
• Explored FP as a health intervention with significant impact on maternal, child and infant survival, growth and development
Objectives Continued

• Described how FP contributes to achieving Millennium Development Goals (MDGs)

• Listed benefits of FP, birth spacing and birth limiting to individuals, societies, and globally
Reproductive Health (RH) is...

...Complete physical, mental and social well-being in all matters related to the reproductive system.

Ability to have a satisfying and safe sex life, to reproduce & have the freedom to decide if, when and how often to do so.

Right to be informed and have access to safe, effective, affordable and acceptable methods of their choice for the regulation of fertility, as well as access to health care for safe pregnancy and childbirth.

ICPD Programme Of Action, Cairo, 1994
Sexual and Reproductive Rights

• Gender equity
• Right to attain the highest standard of sexual and reproductive health
• Right to safety and dignity
• Right to decide whether and when to have children, how many
• Right to information about and access to a range of SRH services
Sexual and Reproductive Rights (continued)

• Right to make decisions and to exercise control over one’s sexuality and reproduction, free of discrimination, coercion and violence

• Right to protect one’s health and to prevent disease

• Right to choose among available options

• Right to privacy and confidentiality

- *FP directly promotes Millennium Development Goals 3 through 8…*

  MDG 3: Promote Gender Equality & Empower Women
  MDG 4: Reduce Child Mortality
  MDG 5: Improve Maternal Health
  MDG 6: Combat HIV/AIDS, Malaria and Other Diseases
  MDG 7: Ensure Environmental Stability
  MDG 8: Develop a Global Partnership for Development
“AND FP/RH indirectly promotes the other two Millennium Development Goals...”

- MDG 1: Eradicate Extreme Poverty and Hunger
- MDG 2: Achieve Universal Primary Education
What do we mean by....

Family Planning

Birth limiting

Healthy Timing and Spacing of Pregnancies
Family Planning is…

- The conscious effort to regulate the number and spacing of births through temporary, long-term and permanent methods including emergency contraception
Another Definition for FP

• Educational, medical or social activities which enable individuals, including minors, to determine freely the number and spacing of their children and to select the means by which this may be achieved.

US Department of Health and Human Services
Other Related Terms

Birth Limiting
Refers to situations where women do not want any more births

Birth to Pregnancy Interval
Refers to the time between birth and next pregnancy
Healthy Timing and Spacing of Pregnancies

After a live birth:
• Couples need to use an effective family planning (FP) method of their choice *continuously* for at least 2 years but not more than 5 years after the last birth, before trying to become pregnant again.

After a miscarriage or abortion:
• Couples need to use an effective FP method of their choice *continuously* for at least 6 months after a miscarriage or abortion before trying to become pregnant again.

For adolescents:
• Adolescents need to use an effective FP method of their choice *continuously* until they are 18 years of age before trying to become pregnant.
More Terms

- Total Fertility Rate (TFR)
- Contraceptive Prevalence Rate (CPR)
- Couple-years of protection (CYP)
- Number of users new to modern contraception (new users)
- Unmet Need
Unmet Need

Number or % of women (married or in-union) who want to postpone or stop having children but who are not using a FP method
Unmet Need

- 52 million unintended pregnancies could be averted annually by meeting the “unmet need”

- 12 Asian countries: unmet need ranges from 6.9% in Vietnam to 31.4% in Pakistan and 32.6% in Cambodia

- East and Central Africa: unmet need ranges from 6.7% in Mozambique to 35.6% in Rwanda

- West Africa: unmet need ranges from 9.7% in Tchad to 34.8 in Senegal

*DHS, 2001, “Unmet need at the end of the century”*
Unmet Need in Youth (15 – 24)

• Youth make up 1 billion (~20% of the world’s population) and account for 1/3 of the unmet need among married women

• In Sub-Saharan Africa, unmet need for married youth is 7.3% at ages 15-19 and 10.7% at ages 20-24
  – Latin America – 21.9%
  – Asia (except China) – 23.2%
  – Sub-Saharan Africa -- 25.9%
  – Middle East/North Africa – 17.5%
  – Central Asia Republic – 15.5

*Futures Group, 2005*
Family Planning and Infant, Child and Maternal Mortality

• 10 million infants and children still die each year from preventable causes – many are associated with too short birth intervals

• More than 500,000 women still die each year from preventable causes – often these are associated with too short birth intervals

• Worldwide there are 50 deaths / 100,000 live births due to unsafe abortions
What are the Benefits of Birth Spacing, FP, and Birth Limiting?
Thousands of deaths among children under age 5 could be averted annually if births occurred after longer intervals.
• For children under age 5, birth-to-pregnancy intervals of 45 months or longer are associated with the lowest risk of dying.

• Two-year birth intervals are associated with higher infant and child mortality risks than births occurring at 36-month birth intervals.
Benefits of Birth Spacing for Infants

Select Countries: spacing and deaths per 1,000 Infants Under Age One
The Evidence for Benefits to Infants of Birth Spacing

• Evidence indicates that *birth-to-pregnancy intervals* of:
  
  – **18 months or less** are associated with significant risk of neonatal and perinatal mortality, *low birth weight*, small size for gestational age, and preterm delivery;

  – **27 months or less** are associated with significant increased risk of *stillbirths*, and miscarriages relative to birth-to-pregnancy intervals of 27-50 months;

  – **51 months or longer** are associated with significant increased odds of stillbirths and miscarriages

  – **59 months or longer** are associated with significant increased risk of *low birth weight*, preterm birth, and small for gestational age
Infant Health Outcomes

• For infant mortality, **birth-to-pregnancy intervals** of 24 months or less are associated with significant risk of mortality.

• Improving infant health is important because
  – there are approximately 4 million newborn deaths and over 3 million stillborn deaths each year
  – neonatal deaths account for 40-60% of child deaths
Nutrition Outcomes

Nutrition Outcomes

• Malnutrition plays a role in more than half of all child deaths.

• **Birth-to-pregnancy intervals** up to 60 months are associated with a decrease in the risk of **stunting** and underweight among children under-five.
Advantages of Birth Spacing and FP for Mothers

• For mothers, the benefits of spacing births include a lower risk of:
  – Maternal death
  – Puerperal endometritis
  – Premature rupture of membranes
  – Anemia
  – Third trimester bleeding

• FP can prevent at least 25% of all maternal deaths

• FP contributes to prevention of maternal-to-child transmission of HIV
The evidence indicates that birth-to-pregnancy intervals of:

- **Six months or less** are associated with risk of maternal mortality, pre-eclampsia, premature rupture of membranes, puerperal endometritis, third-trimester bleeding, anemia, high blood pressure and 10 times the risk of induced abortion

- **27 months or less** are associated with significant increased odds of induced abortion relative to 27 – 50 months

- **Five years or longer** are associated with significant risk of pre-eclampsia, eclampsia and maternal death
Overview of Current Contraceptive Use

• In 1965, CPR was about 10%, in 2003, it was 60% (UN 2003)

• CPR: is rising in Anglophone Sub-Saharan Africa & much lower in Francophone Sub-Saharan Africa (except for Togo) <20%

• CPR in LAC region shows steady rises in use

• CPR in Middle East/North Africa has risen steadily (6 of the 16 countries are at or above 60% CPR)

• East Asia has the highest levels of CPR

• Southeastern and Southern Asia have wide ranges in CPR

Futures Group, 2005, “Profiles for FP and RH Programs”
Projections for Percentage Using Contraception

• Countries with very high or very low TFRs are projected to change the least

• Countries in the middle range are projected to change more rapidly

• For example:

  Countries in 2005 with prevalence < 10% improve only by 4.4 points by 2020
  – Countries in the middle at 30 – 39%, improve by a full 15.9 points
  – At 70% or above, the average change is zero

Futures Group, 2005, “Profiles for FP and RH Programs”
Why is there such a high Unmet Need???
Barriers to Birth Spacing

Common barriers include:

– Cultural traditions & norms
– Gender inequality, including intimate partner violence
– Lack of knowledge
– Myths, fears and health concerns
– Lack of contraceptives and/or method of choice
– Method failure
– Quality of services: provider bias and poor counseling
– Poor access to services including integration (e.g. with HIV services and post partum care)
– Poverty
– Fear of side effects

Key Components of Quality Family Planning Services

- Range of contraceptive methods, including NFP, consistently available
- Good Counseling
- Geographically accessible and acceptable services
- Organization of care / Integration
- Technical competence
- Facilities and supplies
- Clients rights
Informed and Voluntary Decision Making

- Service options available
- Voluntary decision-making process
- Individuals have appropriate information
- Good client-provider interaction (CPI), including counseling
- Social and rights context supports autonomous decision making
FP Program Elements to Increase Use of FP

• Knowledge and Interest

• Quality and Access

• Social and Political Environment
Session 3: Overview of Contraceptive Technology
Session 3 - Overview of Contraceptive Technology

Achievement Based Objectives:
By the end of this session the participants will have:

- Identified how contraceptive methods physiologically work on the male and female reproductive system
- Compared and contrasted mechanism of action, advantages, disadvantages, special characteristics and instructions for each contraceptive method presented
- Distinguished between short-acting and long-acting contraception
- Described “dual protection” and “emergency contraception
- Identified the contraceptive methods that are particularly appropriate for sexually active youth
- Become familiar with the “Decision Making Tool for FP Clients and Providers” and "Family Planning: A Global Handbook for Providers"

Duration: 4 hours
Timeframe: Day 1 and 2
Seating Arrangement: small groups at tables
Preparation: Contraceptive booths - these are tables operated by trainers/participants to share information about different contraceptive methods. There should be examples of the contraceptives (a few per booth), displays, ways to show how the contraceptive works, etc. Booth operators should prepare a brief presentation about the essentials or new information about the contraceptive (refer to questionnaire).

Materials:
- Large illustrations (1 on each of 2 flip charts) of male & female reproductive organs
- Trainers assigned contraceptives; each with a “booth” about their contraceptives and a mini-presentation about their contraceptives
- Contraceptive Fact-finding Tour Questionnaire on flip chart (see sample questions below)
- Contraceptive Samples or cut-out of contraceptive methods
- Handout 3.1 (optional)
- Cards with Jeopardy question on one side & point totals on the other (see Facilitator's Notes: FP Jeopardy)
- The Decision Making Tool for FP Clients and Providers, [http://www.who.int/reproductive-health/family_planning/counselling.htm](http://www.who.int/reproductive-health/family_planning/counselling.htm)

Tasks

NOTE: Review session objectives first.

1. Introduction - Identifying Contraceptives & How they Work - 60 minutes

Procedure:

Explain:  *We've just done an overview of the advantages of family planning and now we'd like to go into more depth regarding the individual contraceptive methods. How many of you are familiar with different contraceptive methods? (show of hands - making sure that there is at least one knowledgeable person at each table). Many of*
you have been working in Reproductive Health for a long time, so let’s think about all of the contraceptive methods that you know.

A) Post the Method on the Organ
1. Unveil the illustrations of the male & female reproductive organs & ask participants to mention the different methods they know.
2. Alternating responses from different tables, as each method is mentioned, give the person who mentioned the method a sample of that method. Ask the person to tape the method on the male or female diagram showing where the method interacts to prevent pregnancy. Ask the participant to explain to their peers how the method works. Note: After each response, thank each participant and diplomatically correct any errors made during their explanation. Note: When permanent methods are mentioned, ask participants to show where the interventions are made on the reproductive anatomy designs.
3. Continue until all contraceptive methods have been mentioned. Note: If participants miss any methods, mention those and explain briefly how the method works (e.g. emergency contraception).

B) Categorizing the Contraceptives
Note: If time is short, steps 1-3, below, can be incorporated into the above exercise by pointing to the female & male methods posted on the designs & asking how participants would categorize them. You do not need to use the Handout 3.1.
1. Explain that all of the methods can be categorized in multiple ways.
2. Distribute the Categorizing Contraceptives Exercise Handout 3.1 to each participant (see below). Working in pairs, participants should agree on how they would like to categorize the list of contraceptives that was developed in the previous activity. They should then fill in the shaded areas of handout 3.1 with the names of the categories they have chosen and then list the names of contraceptives that fall under each category. Note: there is no right or wrong answers and they can decide on two or more categories.
3. After 15 minutes, facilitate a discussion about how different pairs decided to categorize the contraceptives and why.

2. Family Planning Jeopardy - 60 minutes
(Adapted from USAID MAQ Mini-University, October 2006)

Procedure:
a) Refer to Facilitator's Notes: FP Jeopardy for responses.
b) Ask participants to approach the game board & divide them into 2 teams.
c) Designate a co-facilitator as score keeper and determine which team will go first.
d) Ask the team to state which FP category and number of points they want. Read the statement to the team and ask them to form the question that corresponds to the statement. If the team is not able to give the correct question, offer it to the other team.
e) Congratulate and give prizes to both teams, starting with the winning team.

3. Contraceptive Fact Finding Challenge - 1 hour, 30 minutes
**Procedure:**
**Contraceptive Fact-finding tour:**

a) Prior to starting the activity, facilitators and perhaps some especially knowledgeable participants should set up their booths—see page 1, *Preparation.*
b) Post the questionnaire on a flip chart & ask participants to copy it in their notepads—see below for sample questions.
c) Using their questionnaire, ask participants to visit each booth and learn as much as they can about each contraceptive method. They should complete their questionnaire as they listen to the presentations, ask questions and study any visuals.
d) After about 1 hour, ask participants to take their seats and briefly discuss the highlights/surprises they found when conducting their fact-finding tour. Address any questions.

**Contraceptive Fact-Finding Tour Questionnaire - Sample Questions**

1) How many years of protection does the method provide?
2) Does the method provide dual protection? What about emergency contraception?
3) Can it be used without the partner knowing?
4) Is it OK for use with special groups (youth or nulliparous women)?
5) How does it work?
6) How is it used?
7) What follow-up is required?

**4. Summary Discussion - 30 minutes**

**Procedure:**

a) Facilitate a summary discussion of key messages and any important points which have not been covered in sufficient detail (such as emergency contraception or special issues for youth). You may use the PPT as a basis for discussion.
b) Distribute: 1) the Decision Making Tool for FP Clients and Providers; and 2) Family Planning: A Global Handbook for Providers Encourage; briefly review the resources with participants, showing them how to use the index. Encourage participants to use these resources to find additional contraceptive information.
c) Address any final questions.
Facilitator’s Notes

Refer to the Decision-Making Tool for FP and “Family Planning A Global Handbook for Providers” for learner content to supplement the slides and content below. Ordering information and links to these 2 resources are listed under handouts for participants.

Refer to Appendix 3 of Decision Making Tool for Chart Comparing the Effectiveness of different methods.

Newly available contraceptives that are available in some countries include:
• Vaginal rings
• Transdermal patches
• Implants with 1 or 2 rods
• Combined injectables
• New male condoms from non-latex materials
• New female condoms using latex materials
• IUDs that contain hormones

Key Messages:
• Many contraceptive methods are available, including methods that are short- or long-acting, permanent or reversible, hormonal or non-hormonal, “natural” methods, and for use by women or men.—www.rho.org
• International standards exist to determine whether clients are appropriate candidates for specific methods
• Programs funded by USAID need to ensure compliance with USAID Requirements for FP programs. For more information, refer to the Flexible Fund Guidance to Grantees at http://www.flexfund.org/resources/grantee_tools/guidance_docs.cfm and http://www.usaid.gov/our_work/global_health/pop/index.html#strategy
Overview of Contraceptive Methods

Basics of Community-Based Family Planning
At the end of this session, the participants will be have:

- Identified how contraceptive methods physiologically work on the male and female reproductive system
- Compared and contrasted mechanism of action, advantages, disadvantages, special issues and instructions for each contraceptive method presented
- Distinguished between short-acting and long-acting contraception
- Described “dual protection” & “emergency contraception”
- Identified contraceptive methods appropriate for youth
- Become familiar with the “Decision Making Tool for FP Clients and Providers” and “Family Planning a Global Handbook for Providers”
The main categories of contraception

• Short-acting Contraceptive Methods

• Long-acting and Permanent Contraceptive Methods

• Emergency Contraception
**Female Anatomy**
and How Contraceptives Work in Women

**Internal Anatomy**

**Womb (uterus)**
Where a fertilized egg grows and develops into a fetus. IUDs are placed in the uterus, but they prevent fertilization in the fallopian tubes. Copper-bearing IUDs also kill sperm as they move into the uterus.

**Ovary**
Where eggs develop and one is released each month. The lactational amenorrhea method (LAM) and hormonal methods, especially those with estrogen, prevent the release of eggs. Fertility awareness methods require avoiding unprotected sex around the time when an ovary releases an egg.

**Uterine lining (endometrium)**
Lining of the uterus, which gradually thickens and then is shed during monthly bleeding.

**Cervix**
The lower portion of the uterus, which extends into the upper vagina. It produces mucus. Hormonal methods thicken this mucus, which helps prevent sperm from passing through the cervix. Some fertility awareness methods require monitoring cervical mucus. The diaphragm, cervical cap, and sponge cover the cervix so that sperm cannot enter.

**Fallopian tube**
An egg travels along one of these tubes once a month, starting from the ovary. Fertilization of the egg (when sperm meets the egg) occurs in these tubes. Female sterilization involves cutting or clipping the fallopian tubes. This prevents sperm and egg from meeting. IUDs cause a chemical change that damages sperm before they can meet the egg in the fallopian tube.

**Vagina**
Joins the outer sexual organs with the uterus. The combined ring is placed in the vagina, where it releases hormones that pass through the vaginal walls. The female condom is placed in the vagina, creating a barrier to sperm. Spermicides inserted into the vagina kill sperm.
The Menstrual Cycle

1. Days 1–5: Monthly bleeding
   Usually lasts from 2–7 days, often about 5 days
   If there is no pregnancy, the thickened lining of the womb is shed. It leaves the body through the vagina. This monthly bleeding is also called menstruation.
   Contractions of the womb at this time can cause cramps. Some women bleed for a short time (for example, 2 days), while others bleed for up to 8 days. Bleeding can be heavy or light. If the egg is fertilized by a man’s sperm, the woman may become pregnant, and monthly bleeding stops.

2. Day 14: Release of egg
   Usually occurs between days 7 and 21 of the cycle, often around day 14
   Usually, one of the ovaries releases one egg in each cycle (usually once a month). The egg travels through a fallopian tube towards the womb. It may be fertilized in the tube at this time by a sperm cell that has travelled from the vagina.

3. Days 15–28: Thickening of the womb lining
   Usually about 14 days long, after ovulation
   The lining of the uterus (endometrium) becomes thicker during this time to prepare for a fertilized egg. Usually there is no pregnancy, and the unfertilized egg cell dissolves in the reproductive tract.
Urethra
Tube through which semen is released from the body. Liquid waste (urine) is released through the same tube.

Foreskin
Hood of skin covering the end of the penis. Circumcision removes the foreskin.

Scrotum
Sack of thin loose skin containing the testicles.

Testicles
Organs that produce sperm.

Seminal vesicles
Where sperm is mixed with semen.

Prostate
Organ that produces some of the fluid in semen.

Vas deferens
Each of the 2 thin tubes that carry sperm from the testicles to the seminal vesicles. Vasectomy involves cutting or blocking these tubes so that no sperm enters the semen.
How Effective are Contraceptive Methods?

Comparing Effectiveness of Family Planning Methods

**More effective**
- Less than 1 pregnancy per 100 women in one year

- Implants
- IUD
- Female Sterilization
- Vasectomy

**How to make your method more effective**
- **Implants, IUD, female sterilization:** After procedure, little or nothing to do or remember
- **Vasectomy:** Use another method for first 3 months
- **Injectables:** Get repeat injections on time
- **Lactational Amenorrhea Method (for 6 months):** Breastfeed often, day and night
- **Pills:** Take a pill each day
- **Patch, ring:** Keep in place, change on time

- **Condoms, diaphragm:** Use correctly every time you have sex
- **Fertility awareness methods:** Abstain or use condoms on fertile days. Newest methods (Standard Days Method and TwoDay Method) may be easier to use.

**Less effective**
- About 30 pregnancies per 100 women in one year

- Withdrawal
- Spermicides
- Male Condoms
Short-acting Contraceptive Methods

- Lactational Amenorrhea Method (LAM or Exclusive Breast Feeding)

- Fertility Awareness Methods
  - Calendar-based Methods
    - Standard Day Method (SDM)
    - Calendar Method
  - Symptoms-based methods
    - TwoDay Method
    - Basal body temperature (BBT) method
    - Ovulation method
    - Sympto-thermal
Fertility Awareness Methods
(Natural Family Planning)
Fertility Awareness Methods (also called natural methods)

• Help women know when they are fertile and time sexual intercourse to prevent or achieve a pregnancy.

• Women identify fertile days by observing signs and symptoms that occur during their menstrual cycle or by using a formula.

• Approximately 15% of FP users worldwide report using a natural method (IPPF Medical Bulletin Volume 34 # 3 June 2000)
Fertility Awareness Methods

Calendar-based Methods

On which of day of my cycle am I?

- Standard Day Method
- Calendar Method

Observation-based Methods

What do I feel or see?

- Ovulation/Cervical Mucus/Billing
- TwoDay Method
- Basal Body Temperature (BBT)
- Sympto-thermal Method
Fertility Awareness Methods

• Avoid unprotected intercourse during fertile days to prevent pregnancy.
• Provide an acceptable alternative to groups with varied religious, medical, personal and ethical beliefs.
• Depend on couple’s ability to identify the fertile phase of each menstrual cycle and their motivation and discipline to use condoms or abstain on fertile days.
• May be used in combination with barrier methods during the fertile period.
• Couples who wish to achieve pregnancy can improve their chances of conception if they can recognize the fertile phase of the cycle.
Advantages of Fertility Awareness Methods

- No physical side effects
- Couples gain a better understanding of their fertility
- Responsibility is shared by both partners, which may lead to increased communication, cooperation and intimacy
- Service provider not required
- Low or no cost after initial teaching
- For some, the ability to adhere to religious and cultural norms.
Disadvantages of Fertility Awareness Methods

- Dependent on commitment and cooperation of both partners
- Daily monitoring and recording of fertile days and/or observation for signs of fertility may be bothersome
- Long periods of sexual abstinence may cause marital and psychological stress
- Women with irregular cycles find calendar-based methods difficult
- Signs and symptoms (for symptom-based methods) which indicate fertility are highly variable during breast feeding
Contraceptive Failure

<table>
<thead>
<tr>
<th>Method</th>
<th>Correct Use</th>
<th>Typical Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Method</td>
<td>85</td>
<td>85</td>
</tr>
<tr>
<td>Spermicides</td>
<td>6</td>
<td>26</td>
</tr>
<tr>
<td>Female Condom</td>
<td>5</td>
<td>21</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>4</td>
<td>19</td>
</tr>
<tr>
<td>SDM</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>TDM</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Male Condom</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>LAM</td>
<td>0.1</td>
<td>2</td>
</tr>
<tr>
<td>Pill</td>
<td>0.1</td>
<td>5</td>
</tr>
</tbody>
</table>

Source: Adapted from Contraceptive Technology, 19th edition 2007
Lactational Amenorrhea Method (LAM) is a Highly Effective Method

LAM criteria:

- Menstrual bleeding has not yet returned
- Woman only breastfeeds baby
- Infant less than six months

*If any criteria change, start another method.*
LAM Advantages

- Universally available
- At least 98% effective
- No commodities/supplies required
- Bridge to other contraceptives
- Improves breastfeeding and weaning patterns
- Postpones use of hormones until infant more mature
Recommended Breastfeeding Behavior

A mother should breastfeed:
- Soon after delivery
- Without supplementation up to 6 months
- Frequently, upon request, not on schedule
- Without bottles or pacifiers
- Without long intervals between feeds both day and night
- While maintaining a good diet for herself
Postpartum Contraceptive Options

<table>
<thead>
<tr>
<th>All women</th>
<th>3 weeks</th>
<th>6 weeks</th>
<th>6 months onward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condoms/spermicides</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IUD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diaphragm/cervical cap</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female sterilization</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Breastfeeding women
- Lactational Amenorrhea Method
- Progestin-only methods/Natural Family Planning
- Combined estrogen-progestin

Non-breastfeeding women
- Progestin-only methods
- Combined estrogen-progestin methods/Natural Family Planning
- Male sterilization
LAM & HIV Infection

• Avoid breastfeeding ONLY if replacement feeding is acceptable, feasible, affordable, sustainable and safe.

• If not possible, exclusive breastfeeding is recommended during the first month of life and should then be discontinued as soon as it is feasible.

• Women with HIV or who have AIDS can use LAM. Breastfeeding will not make their condition worse.

• Offer guidance in selecting the best option based on local situation.
Standard Days Method

• Identifies days 8 - 19 of the cycle as fertile.

• For women with menstrual cycles between 26 and 32 days long.

• Helps a couple avoid unplanned pregnancy by knowing which days they should not have unprotected intercourse.

• Client uses a color-coded string of beads to help her track where she is in her cycle and know when she is fertile.
Who Can Use This Method?

- Women with cycles between 26 and 32 days long
- Couples who can use condoms or avoid sex on days 8 to 19 of the cycle

The SDM does not protect against STIs or HIV
How do you use Cyclebeads?

1. The day you get your period move the ring to the RED bead.

2. Also, mark that day on your calendar.

3. Move the ring one bead each day. Move it even on the days when you have your period.

4. Avoid sex or use a condom when the ring is on any WHITE bead. You can get pregnant on those days.

5. You can have sex when the ring is on any BROWN bead. You are not likely to get pregnant on those days.

6. When your next period starts again, move the ring to the RED bead. Skip over any beads that are left.
TwoDay Method

• Uses cervical secretions to indicate fertility.
• Women check daily the presence of secretions.
• Users pay attention to their secretions in the afternoon and evening and decide if they are fertile today.
• If a woman noticed any secretions today or yesterday, she considers herself fertile today and avoids unprotected intercourse today.
• TwoDay method users consider all secretions noticeable at the vulva as a sign of fertility (irrespective of color, consistency, stretchiness, or any other characteristic).
Short-acting Contraceptive Methods

• Barriers
  – Male condoms (Latex, synthetic non-latex e.g. Durex Avanti, eZ-on, Tectylon)
  – Female Condom (Reality/FC female condom, VA female condom, PATH Woman’s condom)
  – Diaphragm (SILCS, Lea’s Shield)
  – Cervical caps (FemCap, Oves)
  – Vaginal rings e.g. NuvaRing
  – Sponge (Today sponge, Protectaid sponge)
  – Spermicides, jellies, creams,
Effectiveness of Condoms as Contraceptives

• Must be used consistently and correctly
  – “typical use,” pregnancy rate: 14-21% (one in 5 to one in 7 users, on average, will become pregnant in 1 yr)
  – [even with] “perfect use,” pregnancy rate 3-5%

In public health programs (i.e., across populations), “perfect use” is not a realistic consideration

Male condom  Female condom
Correct Use of the Male Condom

- Open package carefully
- After intercourse, remove penis, while it is still erect, from vagina, holding onto condom
- Unroll condom all the way to base of erect penis before genital contact
Female Condom

Plastic sheath with ring at both ends

Grasping female condom for insertion

Outer ring
Inner ring
Short-acting Contraceptive Methods

Hormonal Methods:

• Transdermal e.g. contraceptive patch (Ortho Evra), Spray (Nesterone Metered Dose Transdermal System)
• The pill
  – COCs e.g. Microgynon, Nordette, Trinordial, Marvelon, Seasonale, Yasmin (contains drospirenone)
  – POPs e.g. Microlut, Exluton, microval, Cerazette (contains desogestrel)
Oral Contraceptives

- Combined oral contraceptives (COC)
- Progestin-only contraceptives
Combined Oral Contraceptives: Mechanism of action

- Contain estrogen and progestin
- Taken every day – orally
- Combined action hampers production of follicle-stimulating hormone (FSH) and luteinizing hormone (LH)
  ---→ ovulation is suppressed
- Creates thick cervical mucus which hampers sperm penetrability
- Creates thin endometrium preventing implantation
Disadvantages of COCs

- Client dependant – must be taken every day
- Requires regular, dependable supply
- Minor side effects in some clients
- May cause rare but serious circulatory system complications especially in women > 35 who smoke and/or have other health problems
- No protection from STIs/HIV
Progestin-Only Pills (POPs): Characteristics

• Especially suitable for breastfeeding women and others who should not use estrogen

• Contain no estrogen
• Less progestin than COCs
• All pills in pack are active
• Progestin amount same throughout
• Continuous use
• Must be taken at same time every day
Mechanism of action

- Thickens cervical mucus and creates thin endometrium – hampering sperm transport

- Suppresses ovulation in ALL cycles
Key Counseling Topics for POP Users

- Safety and efficacy
- How POPs work
- Possible side effects
- How to take pills and what to do when pills are missed
- How to obtain and use back-up methods and emergency contraception
- No protection from STIs
Counseling About Side Effects Reduces Discontinuation

Percent Discontinuation After 7 Months*

<table>
<thead>
<tr>
<th>Country</th>
<th>Not Counseled</th>
<th>Counseled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Niger</td>
<td>37%</td>
<td>19%</td>
</tr>
<tr>
<td>Gambia</td>
<td>51%</td>
<td>14%</td>
</tr>
</tbody>
</table>

- Clients not counseled about side effects
- Clients counseled about side effects

* includes OCs, IUDs, injectables, barrier methods

Pill Packs to be Given – Initial and Return Visit

• Provide up to one year’s supply, depending upon woman’s desires and anticipated use.

• Balance maximum access to pills with contraceptive supply and logistics

• The re-supply system should be flexible, so that the woman can obtain pills easily in the amount and at the time she requires them.

Client Access and Availability to Oral Contraceptives

- Use many types of trained providers

- Use less formal approaches such as community-based services:
  - health structure linkage desirable
  - initial screening checklists useful
  - training and supervision necessary
  - educational materials recommended
  - functional re-supply system needed
Short-acting Contraceptive Methods

Hormonal

• Injectables
  – Progestogen only
    » DMPA,
    » Uniject – depo – subQ Provera 104 (DMPA – SC)
    » Net en/Noristerat)
  – Combined
    Mesigyna (Norigynon)
  – Cylofem (Nunelle, Lunella, Cyclo-Provera, Novafem, Feminera)
Combined Injectable Contraceptives

Contain progestin and estrogen

- Used by over 1 million women worldwide
- Administered monthly
- Provide more regular bleeding cycles
- May result in estrogen-related side effects
Combined Injectables: Newer Products

- Cyclofem (or Cyclo-Provera):
  - 25 mg DMPA
  - 5 mg estradiol cypionate

- Mesigyna (or Norigynon):
  - 50 mg NET-EN
  - 5 mg estradiol valerate
Progestin-only Injectables

DMPA:
Depot-medroxyprogesterone acetate
administered
every 3 months

NET-EN:
Norethisterone enanthate
administered
every 2 months
DMPA: Advantages

• Safe
• Highly effective
• Easy to use
• Long-acting
• Reversible
• Can be discontinued without providers help
• Can be provided outside of clinics
• Requires no action at time of intercourse
• Use can be private
• Has no effect on lactation
• Has non contraceptive health benefits
DMPA: Disadvantages

• Causes side effects:
  – Menstrual changes
  – Weight gain
    Headache, dizziness and mood change

• Action cannot be stopped immediately

• Causes delay in return to fertility

• Provides no protection against STIs including HIV
Return to Fertility After Stopping DMPA Use

Percent of Women Having Conceived

DMPA: Menstrual Changes

Percent of users (approx.)

Amenorrhea

Prolonged or irregular bleeding

Months of use

0 6 12 18 24
DMPA Effect to fetus and Breastfeeding

• No harmful effect on fetus
• No effect on later development of child
• No effect on:
  – Onset or duration of lactation
  – Quantity or quality of breast milk
  – Health and development of infant

• When to initiate
  – After child is 6 weeks old (preferred)
Effect of DMPA on Bone Density

- DMPA users have lower bone density than non-users, in most studies
- Those initiating as adults regain most lost bone
- Long-term effect in adolescents unknown
  - Concern that osteoporosis may develop later long-term studies are needed
  - Generally acceptable to use
New DMPA

- Subcutaneous depot-medroxyprogesterone (DMPA-SC) (depo-subQ provera 104)
  - Low dose formulation
  - Injected into the tissue just under the skin with a finer, shorter needle
  - Slower and more sustained absorption
  - 30% lower dose of progestin (104mg / 150mg)
Long-acting and Permanent Methods (LAPM) of Contraception

• **IUCDs**
  – Copper e.g. CuT380A (12 yrs), Multiload 375 (7 yrs),
  – Progestin-releasing e.g. Minera (5 yrs), Femilis, Femilis Slim (for nulliparous), FibroPlant (3 yrs)
  – Frameless e.g. GyneFix, FibroPlant – LNG (3 yrs)

• **Implants**
  – Norplant (7 yrs) (to be discontinued by manufacturer)
  – Jadelle (5 yrs)
  – Implanon (3 yrs)
  – Nesterone (2 yrs)
Implants

• Norplant®:
  – 6 capsules, effective 7 years
    1-yr failure rate 0.05% (1 pregnancy / 2000 users)
    5-yr failure rate 1.6%
• Jadelle®
  – 2 rods, effective 5 years
  – 1-yr failure rate 0.05%; 5-yr failure rate 1.1%
• Implanon®
  – 1 rod, effective 3 years
Norplant

silastic tubing
with
silastic medical adhesive

Active ingredient is –
Levonorgestrel
Protects against pregnancy for 7 years

---

34 mm

levonorgestrel

2.4 mm
Jadelle®

- Causes thickening of the cervical mucus, preventing the passage onto the uterus

- Inhibits ovulation in about 45-85% of menstrual cycles

- Suppresses endometrial maturation and removes the hormonal support necessary for fertilization and pregnancy
Implanon®

• Consists of a non-biodegradable, single-rod implant.

• Active ingredient is 68 mg. Etonogestrel

• Protects against pregnancy for 3 years

• Supplied preloaded in a sterile, disposable applicator
“The IUD has the worst reputation of all contraceptives … except among those using it”
Important Programmatic Characteristics of IUDs

- Highly effective/comparable to FS
  - “Reversible sterilization”
    - 12-13 yrs with CU-T
    - Cheaper and easier to provide
    - Quickly and completely reversible
      (much easier to reverse than FS or V)
- Very safe for most women (including: PP, PA, or interval; BF; young; nulliparous)
- More service cadres can provide (because non-surgical)
- Greater availability = greater choice
- Good option for HIV+ women
- Most cost-effective method (potentially)
Dispelling Myths About IUDs

IUDs...

- are not abortificients
- do not cause infertility
- are unlikely to cause discomfort for male partner
- do not travel to distant parts of body
- are not too large for small women
Summary

IUDs are:
- Safe, effective, convenient, reversible, long-lasting, cost effective, easy-to-use

Providers can ensure safety by:
- Careful screening
- Informative counseling
- Aseptic insertion
- Proper follow-up
Permanent Methods of Contraception

Female Sterilization

- Transcervical (through hysteroscopy)
  - Chemicals e.g. Quinacrine
  - Plugs e.g. Adiana procedure
  - Microcoils e.g. Essure

- Tubal Ligation
  - Laparotomy
  -- Laparoscopy
  - Minilaparotomy

Vasectomy

- Classical
- No-scalpel

Other male methods: Longer-acting formulations of testosterone alone or in combination with a progestin
Vasectomy

- No-scalpel technique (preferred)
- Incisional
Vasectomy Effectiveness

• Comparable to Female Sterilization, implants, IUDs

• Not effective immediately—WHO now recommends use of backup contraception for 3 months after the procedure (i.e., no longer “… or 20 ejaculations”).

• Failure (pregnancy) commonly quoted at from 0.2% to 0.4%, but rates as high as 3-5% have been reported. Counseling implications …
Vasectomy Safety

- Very safe, with few medical restrictions
- Major morbidity and mortality rare
- Adverse long-term effects have not been found
- Minor complications (e.g., infection, bleeding, post-operative and/or chronic) pain 5-10%
- No-scalpel (NSV) technique has lower incidence of bleeding and pain than incisional technique
- No long term association with testicular / prostate cancer or cardiovascular disease
- No HIV/STD protection
Vasectomy: Salient Programmatic Facts

• Men in every region, cultural, religious and SE setting show interest in vasectomy, despite common assumptions about negative male attitudes or societal prohibitions.

• However, men often lack full access to information and services, especially male-centered programming, which has been shown to result in greater uptake of vasectomy.
Female Sterilization (FS)

Approaches:

• Transcervical (through hysteroscopy)
  » Chemicals e.g. Quinacrine
  – Plugs e.g. Adiana procedure
  – Microcoils e.g. Essure

• Tubal ligation
  – Laparotomy
  – Minilaparotomy
  – Laparoscopic
Female Sterilization: Effectiveness

Highly effective, comparable to vasectomy, implants, IUDs

No medical condition absolutely restricts a person's eligibility for FS

Risk of failure (pregnancy), while low:
- continues for years after the procedure
- does not diminish with time
- is higher in younger women

Cumulative pregnancy rates:
- at 1 year, 5.5/1000 procedures (994.5/1000 women protected)
- at 5 years, 13/1000
- 18.5/1000 at 10 years reported, i.e., almost 2/100 became pregnant during that interval (982.5/1000 didn’t)

Though pregnancy very uncommon, 1/3 ectopic (e.g., at 10 years, 6 ectopies / 1000 women who underwent FS)
Emergency Contraception (EC)
What is Emergency Contraception?

• Methods of preventing pregnancy after unprotected sexual intercourse

• Regular Oral Contraceptives, used:
  – in a special higher dosage
  – within 72 hours (3 days) of unprotected sex

• IUDs can also be used for up to 5 days after unprotected sex

• ECPs cannot interrupt an established pregnancy
Types of Emergency Contraceptive Pills

• **Progestin-only OC’s** – levonorgestrel - only, in preferred regimen **one dose** of 1.5 mg or 2 doses of 0.75mg, 12 hrs apart
  → **88% reduction in risk** (1/100 will get pregnant)

• **Combined OCs**: 2 doses of pills containing ethinyl estradiol (100 mcg) and levonorgestrel (0.5 mg) taken **12 hrs apart**
  → **75% reduction in risk** (2/100 will get pregnant)
ECPs Are Most Effective When Taken Early

Percentage of pregnancies prevented

Postpartum Contraceptive Options

- **Condoms/spermicides**
- **Diaphragm/cervical cap**
- **IUD**
- **Female sterilization**

**Delivery**
- All women
  - 3 weeks: Condoms/spermicides
  - 6 weeks: IUD
  - 6 months onward: Diaphragm/cervical cap, Female sterilization

**Breastfeeding women**
- Lactational Amenorrhea Method
  - Progestin-only methods/Natural Family Planning

**Non-breastfeeding women**
- Progestin-only methods
  - Combined estrogen-progestin methods/Natural Family Planning

**Male sterilization**
FAMILY PLANNING
AND
HIV/AIDS
Overview: HIV/AIDS Status and Contraceptive Eligibility Criteria

<table>
<thead>
<tr>
<th></th>
<th>COC</th>
<th>CIC</th>
<th>POP</th>
<th>DMPA</th>
<th>Implant</th>
<th>Cu-IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>I</td>
</tr>
<tr>
<td>High risk of HIV</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>HIV-infected</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>AIDS</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Clinically well on ARV therapy</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
For clients with HIV:

- prevent STI and HIV transmission
- prevent acquisition of different HIV strain
- should be used even when HIV infection is controlled by ARVs-
What is Dual Protection?

• A strategy to protect against HIV/STIs and pregnancy through:
  – use of condoms alone for both purposes
  – use of condoms plus another FP method or EC (dual method use)
• the avoidance of risky sex, e.g.:
  – abstinence
  – avoidance of all types of penetrative sex
  – mutual monogamy between uninfected partners combined with a contraceptive method
  – for young people, delaying sexual debut
Difference Between Dual Protection and Dual Method Use

- **Dual method** use is use of any effective contraceptive for preventing pregnancy with an additional effective method for protection against STIs including HIV. Usually, male or female condom is used.
- **Use of condoms to protect against STI/HIV and another method to prevent pregnancy**

**Reduces:**
- transmission of HIV to uninfected partner
- transmission of a different strain of HIV to a partner with HIV infection
- risk of acquiring or transmitting other STIs
- risk of unplanned pregnancy
Informed Choice and Informed consent

Informed choice
An individual’s well-considered, voluntary decision based on:

• Options

• Information

• Understanding
Benefits of Informed Choice in Family Planning

• Increases the chances of correct method use, reducing unwanted pregnancy
• Reduces fear and dissatisfaction related to side effects, making continuation more likely
• Increases client’s ability to recognize serious warning signs, reducing health risks
• Increases client satisfaction and promotion of the program by positive word-of-mouth
• Increases a person’s sense of empowerment and self-esteem
• Promotes positive relationships between providers and clients
Clients Who Receive Their Method of Choice Are More Likely to Continue Using the Method

Useful Resources


- Decision-Making Tool, (WHO)

- Checklists, (FHI)
  - Pregnancy checklist
  - CBD – DMPA checklist
  - COC checklist
  - IUD checklist

- Medical Eligibility Criteria (MEC) for Contraceptive Use, (WHO)
Purpose of the Medical Eligibility Criteria (MEC)

- To base Guidelines for Family Planning practices on the best available evidence

- To address and change misconceptions about who can and cannot safely use contraception

- To reduce medical policy and practice barriers (i.e., unjustified by the evidence)

- To improve quality, access and use of family planning services
### WHO Eligibility Criteria

Based on low dose formulations

<table>
<thead>
<tr>
<th>Classification of known conditions</th>
<th>Within clinical judgment (e.g. physicians)</th>
<th>With limited clinical judgment (e.g. CBD workers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Method used without restriction</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>Method generally used</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>Method not usually recommended</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>Method not to be used</td>
<td>No</td>
</tr>
</tbody>
</table>

Facilitator's Notes: Family Planning Jeopardy

(“Test your knowledge on contraceptive technology”)

Adapted from Global Health Mini-University, 2006 session, “Contraceptives: What’s Hot, What’s Not, and What’s in the Pipeline”

(“Jeopardy” style “A&Q” format)

Category #1: BEGINS WITH THE LETTER “I”

For 200 points: A. Spermicides are the most ______ of all contraceptive methods.
Q. What is “ineffective”?

For 400 points: A. This highly-effective, long-acting, inexpensive method is also safe for HIV+ women and nulliparous women.
Q. What is the IUD?

For 800 points: A. These methods last for 3 to 7 years and are more than 99% effective.
Q. What are Implants?

For 1000 points: A. This method may be offered by Community Based Distributors if adequately trained.
Q. What are Injectables?

Category #2: SIDE EFFECTS

For 200 points: A. These methods have no biological side effects and require no technologies.
Q. What are FAMs (Fertility Awareness Methods) and LAM (Lactational Amenorrhea Method)?

For 400 points: A. These methods have side effects such as nausea, headache and weight-gain.
Q. What are hormonal contraceptives?

For 800 points: A. These methods either cause amenorrhea or use amenorrhea.
Q. What are progestin-only methods and LAM?

For 1000 points: A. This method increases temporary cramping and bleeding.
Q. What is the IUD?
Category #3: MALE INVOLVEMENT

For 200 points:
A. The only male method that offers dual protection.
Q. What is the male condom?

For 400 points:
A. This male method takes up to 12 weeks to be completely effective.
Q. What is Vasectomy?

For 800 points:
A. These methods, in particular, require male cooperation.
Q. What are FAMs (Fertility Awareness Methods)?

For 1000 points:
A. This strategy not only increases the % of couples who accept FP methods, but it also increases continuation rates.
Q. What is involving husbands and partners in FP counseling?
Exercise - Contraceptive Category Table

Instructions: Consider each of the types of contraceptives listed and put them in the appropriate category below.

<table>
<thead>
<tr>
<th>Categorizing Contraceptives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
</tbody>
</table>
Session 4 - Infection Prevention

Achievement Based Objectives:
By the end of this session the participants will have:
• Discussed why infection prevention is a critical component of FP programs
• Listed the key components of infection prevention
• Identified what aspects of infection prevention are needed for the different types of contraceptive methods

Duration: 1 hour, 20 minutes
Timeframe: Day 2 Session 1
Seating Arrangement: Small groups at tables
Materials:
• PowerPoint presentations (2 presentations are included for facilitators reference only)
• Guest Presenter
• Flipchart
• Markers
• One copy of the Infection Prevention Manual per Participant


Tasks

NOTE: Review session objectives first.

1. Group Discussion based on Power Point Presentation -1 hr, 20 min.

Procedure: Workshop organizers should arrange to have this session facilitated by a MOH official or other senior level service provider with extensive experience with in-country infection prevention procedures. The session should cover the basic principles of infection prevention and describe the in-country experience. It should be conducted as an interactive discussion with the facilitator utilizing the slides to illustrate certain points. NOTE: The facilitator should incorporate the key PPT slides from the two PPT presentations attached to this module into her/his discussion. One PPT presentation is a presentation from EngenderHealth in Ghana while the other presentation is more general and basic. In addition, the EngenderHealth Manual provides detailed information on the basic principles of infection prevention.

The following questions may be used to introduce the discussion:
a. Why do we worry about the spread of infections in health care facilities?
b. Who is at risk of infection? The patients, health care staff and the community

c. Why are they at risk?

d. What are standard precautions for infection prevention?

**NOTE: Incorporating Infection Prevention Measures into Field Visit**

Ideally, the participants should see the infection prevention procedures in place when they make the field visit to a functioning facility-based FP program. If possible, arrange for them to see the chlorination stands, autoclaves, etc. The facilitator should also brainstorm with participants about what infection prevention procedures are needed for CBDs who are providing injectables, condoms and pills.
Facilitator’s Notes

Along with contraceptive logistics and counseling, infection prevention is an essential component of quality community-based service delivery. Clients, service providers and the community at large are all at risk for infection if standard precautions for infection prevention are not practiced. Infection prevention helps prevent the spread of antibiotic-resistant micro-organisms and keeps the cost of health care services down.

Health care workers are on the front line of protecting themselves and their clients from infectious diseases that may be transmitted during the provision of clinical services. Fortunately, health care staff can perform safe and simple procedures to minimize risk and the spread of infections—practices that can be integrated at minimal cost into the routine workday at clinics and hospitals around the world.

Infection prevention for FP is of most concern for injections, IUD and implant insertions, and for sterilization procedures; however, good hand washing with soap should be practiced with all FP clients and is the most important activity for preventing infections.

Infection Prevention and Community-based FP:

For community health workers:
- Good hand washing with soap before and after each client
- Proper disposal of needles and syringes when providing injectables

For outreach services, satellite clinics and mobile clinics:
- Good hand washing before and after each client
- Sharps containers to dispose of all needles and sharps
- Incinerator or properly protected pit for disposing of contaminated needles, syringes, sharps and other contaminated materials
- System for sterilizing multiple use materials on or off site

For all health facilities:
- All of the above including an onsite system for sterilizing multiple use materials and supplies.

*Infection Prevention: A Reference Booklet for Health Care Providers, http://www.engenderhealth.org/res/offc/safety/ip-ref/index.html,* is a quick desk reference on important infection prevention (IP) topics: hand washing, gloving, aseptic technique, use and disposal of sharps, instrument processing, housekeeping, and waste disposal. Designed for use by a wide range of health care workers in low-resource settings, this comprehensive booklet introduces the importance of good
IP practices and provides step-by-step instructions for performing critical IP procedures.¹

**Key Messages:**

- Key components of infection prevention actions are: hand washing with soap, gloving, aseptic technique, use and disposal of sharps, instrument processing, housekeeping, and waste disposal
- Before providing FP services, programs must have appropriate infection prevention policies and procedures in place

Infection Prevention
Basics of Community-Based FP Workshop
Objectives

At the end of this session, participants will have:

• Discussed why infection prevention is a critical component of family planning programs

• Listed the key components of infection prevention

• Identified what aspects of infection prevention are needed for the different types of contraceptive methods
Exercise

• Who is at risk of infections? Why are they at risk?

• Why do we worry about the spread of infections in health care facilities?

• What are the standard precautions for (Components of) infection prevention?

• What is the importance and purpose of good infection prevention?
Who is at risk of infection?

- Clients
- Service providers and ancillary (support) staff
- The community
The need for infection control in health care settings

• WHO estimates that of the 12 billion injections administered each year for vaccination and curative purposes, unsafe injections lead to:

  • 8-16 million Hepatitis B cases
  • 2-4.5 million Hepatitis C cases
  • 75,000-150,000 new cases of HIV infection
Importance and purpose of good infection prevention

- Prevents post procedure infections
- Results in high-quality, safe services
- Prevents infections in service providers and other staff
- Protects the community from infections that originate from health care facilities
- Prevents the spread of antibiotic-resistant microorganisms
- Lowers the costs of health care services, since prevention is cheaper than treatment.
Standard Precautions

- Practices designed to help minimize clients’ and staff’s risk of exposure to infectious materials

- Help break the disease-transmission cycle at the mode of transmission step
Standard Precautions are:

1. **Hand washing** - Wash your hands with soap
2. **Protective barriers** - Wear gloves, eyewear, and gowns
3. **Instrument processing** - Correctly process instruments and other items
4. **Housekeeping** - Keep the facility clean
5. **Waste disposal** - Properly dispose of waste
6. **Linen processing** - Handle, transport, and process linen correctly
7. **Use and disposal of sharps** - Prevent injuries with sharps
Antiseptics versus Disinfectants

**Antiseptics:**
- Use on skin and mucous membranes to kill microorganisms
- **Not** for use on inanimate objects

**Disinfectants:**
- Use to kill microorganisms on inanimate objects
- **Not** for use on skin or mucous membranes
- High-level versus low-level disinfectants
Aseptic Techniques

Definition

Practices that reduce the risks of post procedure infections in clients. These include:

- Hand washing with soap
- Surgical hand scrub
- Barrier methods
- Proper preparation of clients (Skin, cervical, vaginal preparation before a clinical procedure)
- Sterile field
Hand Washing

Wash Your Hands with Soap:
- Immediately on arrival at work
- Before and after examining each client
- After touching anything that might be contaminated
- After handling specimens
- Before putting on gloves for clinical procedures
- After removing gloves
- After using the toilet or latrine
- Before leaving work
Barrier Methods

- Gloves.
- Surgical attire.
  - Caps.
  - Masks.
  - Gowns.
  - Aprons.
  - Eye and foot wear.
Three kinds of gloves

- Surgical gloves
- Single-use examination gloves
- Utility or heavy-duty household gloves
Proper Preparation of Clients for Procedure

• Shaving is no longer recommended, clip the hair short
  ❖ If shaving must be done:
    1. Use antimicrobial soap or shave dry
    2. Shave in the operating theater, immediately before the procedure

• Clean with soap and water

• Clean surgical site with antiseptic-Iodophors

• Circular motion from the center outwards
To Maintain a Sterile field:

- Place only sterile items within the sterile field
- Open or transfer sterile items without contaminating them
- Recognize what is and is not sterile
- Act in ways that do not contaminate the sterile field
- Recognize and maintain the service provider's sterile area
- Do not place sterile items near open windows or doors.
Prevention of Injuries Due to Sharps

- Handle all sharps minimally after use
- Use extreme care whenever sharps are handled
- Dispose of sharps in puncture-resistant containers
- Pass sharps using the “hands-free technique”
- Use the “one-hand” technique to recap needles
Steps of Processing Instruments and Other Items

Decontamination

Cleaning

Sterilization

High-Level Disinfection

Steam Under Pressure
Dry Heat
Chemical

Boiling
Chemical
Steam

Use or Storage
Decontamination

- The first step in processing items
- Makes items safer to handle
- Makes items easier to clean

- Soak items in a 0.5% chlorine solution for 10 minutes immediately after use; do not soak longer

- Rinse with water or clean immediately
- Replace solution daily or when it becomes heavily contaminated
- Wear heavy-duty utility gloves
Cleaning

- Scrubbing items with a brush, detergent, and water before further processing
- Removes blood, body fluids, tissue, and dirt
- Reduces the number of microorganisms (including endospores)
- Sterilization and HLD may not be effective without proper cleaning

- Wear utility (heavy duty) gloves, goggles, a mask, and protective eyewear
- Hold items under the water, and be sure to get in the grooves, teeth, and joints
- Rinse thoroughly to remove all detergent
- Air-dry or dry with a clean towel
High-Level Disinfection (HLD)

- Eliminates all microorganisms, but does not kill all endospores

- Use for items that will come in contact with broken skin or intact mucous membranes

- Three types:
  - Boiling
  - Use of chemicals
  - Steaming
Chemicals for use in HLD

1. Chlorine
   - Cheapest effective disinfectant
   - Effective against many microorganisms
   - Can be corrosive; do not use on laparoscopes
   - Can be irritating to people
   - Prepare a new solution daily
2. Glutaraldehyde

- Effective against many microorganisms
- Not corrosive when used as directed
- Irritating to people
- Use prepared solution for up to two or four weeks depending on manufacturers instructions.
Sterilization

- Eliminates all microorganisms, including endospores
- Recommended when items will come in contact with the bloodstream or tissue under the skin
Sterilization Continued

- Three types:
  - Steam under pressure
    (Autoclaving or moist heat)
  - Dry heat
  - Soaking in chemicals
Autoclaves/Sterilizers
Storage after Steam or Dry-Heat Sterilization

- Store sterile pack in closed cabinets in low-traffic, dry areas

- Use unwrapped items immediately or store in a covered, sterile container for up to one week.
House Keeping

- General cleaning and maintenance of cleanliness
- Reduces the number of microorganisms and thus, the risk of infections
- Provides an appealing environment
General Guidelines for Housekeeping

- Schedules should be posted and followed
- Wear utility gloves and shoes/boots when cleaning client-care areas
- Minimize scattering of dust and dirt
- Scrub when cleaning
- Wash from top to bottom
- Change cleaning solutions when they are dirty
Housekeeping in Client-Care Areas

Each morning:

- Damp-wipe and/or mop between clients:
- Wipe tables and equipment with cleaning solution
- Clean visibly soiled areas of the floor, walls, or ceiling with cleaning solution.
- Clean up spills immediately
- Remove waste, if necessary
At the end of the clinic session or day:

- Wipe all surfaces and clean floor with cleaning solution
- Remove sharp-disposal containers, if necessary
- Remove waste

Each week

- Cleaning ceilings with cleaning solution
Waste Disposal - Types of Waste

- General waste – nonhazardous, poses no risk of injury or infection

- Medical waste – material generated in a diagnosis, treatment, and/or immunization, including:
Types of Waste (Continued)

- Blood, other body fluids, and materials containing them
  - Organic waste (e.g., tissue, placenta)
  - Sharps

3. Hazardous chemical waste – chemicals that are potentially toxic or poisonous
Four Aspects of Waste Management

1. Sorting
   - General versus medical waste

2. Handling
   - Wear utility gloves and shoes/boots
   - Handle as little as possible
3. Interim storage
   ❖ Place in minimally accessible area

4. Final disposal
   ❖ Burn or bury
Incinerators for burning

Drum Incinerator

Perforated fire bed made from the drum top (holes act as air inlets)

Cut-aways provide ventilation (air inlets) and support the fire bed
Plan for small burial pit

Burial site with fence
Three Main Obstacles to Improving Infection Prevention Practices

- Lack of knowledge
- Resistances to changing old habits
- Inadequate supplies, equipment, and space
Points to Remember

- Do not get discouraged by small steps backward
- Help people adjust to new practices
- Do not give up
- Do not expect others to do things that you do not do yourself
Session 5: Counseling of Family Planning Clients
Session 5 - Counseling of Family Planning Clients

**Achievement Based Objectives:**
By the end of this session, participants will have:
- Defined informed choice
- Described basic concepts of client-provider interaction
- Demonstrated appropriate counseling skills following principles of the GATHER approach to counseling. (Note: Trainer may include the REDI approach described in the EngenderHealth curriculum listed under additional resources.)

**Duration:** 2 hours  
**Timeframe:** Day 2 Session 2  
**Materials:**
- PowerPoint presentation (for reference only)  
- Handouts 5.1 and 5.2 for each participant  
- flipchart  
- markers  
- Role play scenarios written on the flip chart (select 6 or 7 of the most appropriate for your group)  
- Pelvic and penis model for IUD and condom demonstration (if available)  
- Copies of the FHI Checklists to rule out pregnancy and for COCs, IUDs and Depo Provera (These may be downloaded from [http://www.fhi.org/en/RH/Pubs/servdelivery/checklists/index.htm](http://www.fhi.org/en/RH/Pubs/servdelivery/checklists/index.htm) or ordered from FHI), and  
- FHI’s, quick reference chart for medical eligibility (this may be downloaded from [http://www.fhi.org/en/RH/Pubs/servdelivery/quickreferencechart.htm](http://www.fhi.org/en/RH/Pubs/servdelivery/quickreferencechart.htm) or ordered from FHI)  
- Optional tool: The Missed Opportunities Checklist

**Preparation:** The day before, identify 2 volunteers for the role play and work with them to prepare a role play following the scenario in the box below.  
**Seating Arrangements:** Small groups at tables

**Additional Resources:**
Excellent resource: EngenderHealth curriculum  

**Tasks**

NOTE: Review session objectives first.
1. Introductory Activity - Role Play on FP Counseling\(^1\) - 30 minutes

### Client-Centered Communication
#### Role Play Scenario

Miriam has come to the clinic for the first time. She has her two-month-old baby who is crying. She is sitting on her own in the corner, far from the other clients and she looks unhappy. You noticed Miriam sitting in the corner by herself. After some time, Miriam comes into your room, saying she wants to wait before she has her next child.

**Procedure:**

a) Ask the 2 volunteers to act out the above role play scenario. One participant takes the part of Miriam, a distraught mother who wants to delay her next child. The second participant takes the part of the provider.

b) Have the volunteers role play for about 2 to 3 minutes. They may want to play out some of the good characteristics of client-centered communication and care (e.g., treating the client well), and some of the characteristics that do not reflect client-centered care (e.g., provider talking too much, provider telling the client what to do instead of guiding the client to make her own decision).

c) Optional step: The trainer may use the missed opportunities checklist to review the role play.

d) After the role play, ask the group: a) To identify positive and negative characteristics of client centered communication characteristics; b) To discuss how a provider can explore the gender/family-related issues that might keep Miriam from being able to delay the birth of her next child (e.g., Does her husband disapprove of FP, will she be abused for not wanting another child right away, or will clandestine use of FP be an appropriate option for her?); c) Brainstorm a definition for informed choice.

e) Refer participants to the PowerPoint presentation in the binder, making special note of the slides on Informed Choice.

2. Simulated Counseling Session in Triads - 1 hour, 30 minutes

**Procedure:**

a) Using the flip chart, ask participants to help you spell out the GATHER process, briefly discussing each step of the process. Refer them to the GATHER checklist (Handout 5.2) and the FHI checklists for COC, Depo Provera and IUDs.

b) Divide into triads for role plays applying GATHER framework. Ask participants to select at least three different scenarios and to rotate the roles of counselor, client, and observer so that each person practices being the counselor. Encourage participants to use the Decision Making Tool and other FHI checklists during their session. Observers should use the GATHER checklist to observe and provide feedback to the counselors.

**Scenarios for Role Plays:**

1) 25 year old woman using oral contraceptives but suffering from side effects, wants to continue FP.

2) 40 year old mother of 7 children who asks about family planning.

3) 16 year old adolescent who had abortion yesterday, how would you counsel her?

4) 36 year old HIV(+) soldier with a 21 year old HIV(-) partner, how would you counsel them?

5) 18 year old young man interested in condoms because he has heard there are sexually transmitted diseases, how would you counsel him?

6) 30 year old woman with 2 kids, engages in sex work for a living and recently heard about FP, how would you counsel her?

7) HIV(+) woman, 20 years old with no children but is sexually active.

8) 25 year old with 2 children, never used FP

9) 30 year old woman just delivered one week ago and is breastfeeding, how would you counsel her on FP?

10) 30 year old married woman, husband works in another region and comes home twice a year, how would you counsel her on FP?

11) 17 year old young woman in school who is interested in learning about FP, she is unmarried and sexually active, how would you counsel her?
Scenarios for Role Plays (continued):

12) 40 year old woman with four kids, never used FP, how would you counsel her?

13) 20 year old woman has 2 boyfriends and no children, how would you counsel her?

14) 45 year old man whose wife gave birth to fifth child one week ago, how would you counsel him?

c) After about one hour, ask one of the groups to perform their role play in plenary; facilitate a discussion highlighting strengths and points to improve upon.

d) Summarize key points and ask participants to share their perspective regarding use of the tools and the GATHER approach. Address any questions.
**Key Messages:**

- Good counseling should focus on talking with women and men about their fertility desires. Are they wishing to delay pregnancy? Do they wish to have another child? Do they know about healthy timing and spacing of pregnancies? Do they wish to have no more children? Once the provider has answers to the above questions, s/he can tell the client about the various methods, the advantages and disadvantages.

- FP programs should provide information and help clients (or potential clients) make reproductive health decisions based on the clients’ expressed needs and concerns.--MAQ

- “People who make informed choices are better able to use family planning safely and effectively.” --*Pop Reports, Fall 2003.*

- Programs support clients by: balancing the client’s and provider’s roles in decision-making; exploring clients’ thinking about health decisions; addressing clients’ concerns about side effects by counseling them on what to expect before they start a method, and responding to their concerns if side effects develop; and encouraging clients to play an active role in consultations. –*Pop Reports, Fall 2003.*

- Programs can support providers by defining clear expectations for good CPI; giving providers feedback on their performance; offer effective CPI training; provide the space, supplies, and time that providers need to counsel clients effectively; motivate providers; and match workers with jobs. –*Pop Reports, Fall 2003.*

- Tools like GATHER can be used to provide guidance during counseling

- Clients who are given the opportunity to make an informed choice and who are provided with the method of first choice, tend to be satisfied users and to continue longer with the method

- “An integrated approach to FP/HIV counseling is often a key component of integrated programs and services.”

- “Clients' needs related to HIV and FP are often inextricably linked, and addressing sexuality is fundamental to both.” --
Counseling of FP Clients

Basics of Community-Based Family Planning
Client Rights – What are they?

Clients have the right to:

– Information
– Access to services
– Informed choice
– Safety of services
– Privacy and confidentiality
– Dignity, comfort, and expression of opinion
– Continuity of care

Source: EngenderHealth
What is Counseling?

• “…”a special type of client-provider interaction. It is two-way communication between a health care worker and a client, for the purpose of confirming or facilitating a decision by the client, or helping the client address problems or concerns.”

• One person helping another as they talk person-to-person

Source: Comprehensive Counseling for RH – Participant’s Handbook (EngenderHealth); Population Reports
What difference does counseling make?

Research suggests that:

– Good counseling results in higher client satisfaction

– Clients who receive good counseling are more likely to use FP longer and more successfully

Source: FP/RH Technical Reference Materials or Essentials of Contraceptive Technology
The best counseling is tailored to the individual client

<table>
<thead>
<tr>
<th>Client Type</th>
<th>Usual Counseling Tasks</th>
</tr>
</thead>
</table>
| Returning clients with no problems         | - Provide more supplies or routine follow-up  
- Ask a friendly question about how the client is doing with the method                                                                 |
| Returning clients with problems            | - Understand the problem and help resolve it – whether the problem is side effects, trouble using the method, an uncooperative partner or another problem |
| New clients with a method in mind          | - Check that the client’s understanding is accurate  
- Support the client’s choice, if client is medically eligible  
- Discuss how to use method and how to cope with any side effects |
| New clients with no method in mind         | - Discuss the client’s situation, plans and what is important to her about a method  
- Help the client consider methods that might suit her. If needed, help her reach a decision  
- Support the client’s choice, give instructions on use and discuss how to cope with any side effects |

Tips for Successful Counseling

• Show every client respect and help each client feel at ease.
• Encourage the client to explain needs, express concerns, ask questions.
• Let the client’s wishes and needs guide the discussion.
• Be alert to related needs such as protection from sexually transmitted infections including HIV, and support for condom use.
• Listen carefully. Listening is as important as giving correct information.
• Give just key information and instructions.
• Respect and support the client’s informed decisions.
• Bring up side effects, if any and take the client’s concerns seriously.
• Check the client’s understanding.
• Invite the client to come back any time for any reason.

Tasks involved in counseling

• Helping clients assess their own needs for a range of SRH services, information, and emotional support

• Providing information appropriate to clients’ identified problems and needs

• Assisting clients in making their own voluntary and informed decisions

• Helping clients develop the skills they will need to carry out the decision

Source: EngenderHealth
Key principles of quality FP counseling

- Treat each client well and with respect
- Interact
- Tailor information to the client’s needs
- Provide reliable information
- Avoid information overload
- Provide the client’s preferred FP method
- Help the client understand and remember
- Maintain confidentiality

Source: See reference in Essentials of Contraceptive Technology (p. 3-1)
The essential “Cs” in counseling

- Compassion
- Common sense
- Communication skills
- Comprehensive, comprehensible information
GATHER: A FP Counseling Model

- Greet the client
- Ask the client about him/herself
- Tell the client about FP services and FP options available
- Help the client make a decision
- Explain steps
- Return visit scheduled

Source: EngenderHealth
REDI: A counseling model for FP integrated services

- REDI
  - Rapport-building with client
  - Exploration of client’s needs, situation
  - Decision-making with client
  - Implementing the decision and helping the client develop an action plan

- Developed to not lose FP content as part of integration with other services (e.g. HIV/AIDS)

Source: EngenderHealth
What is Informed Choice?

- Personal experience whereby a client makes a voluntary decision after considering the information and options available.

Source: S.M. Palmore, 1999
Principles of informed choice

• Clients...
  – ...have the right and ability to make their own decisions
  – ...are individuals with different needs and circumstances
  – ...need reliable, timely, and understandable information, including risks and benefits
  – ...have the right to a choice of methods, whether through clinics, pharmacies or community distributors
  – ...must decide freely—without stress, pressure, coercion, or incentives
Consequences of NOT ensuring informed choice

• Unwanted pregnancy from improper method use
• Fear and dissatisfaction with side effects, leading to discontinued use of FP method
• Potential health risks caused by failure to recognize serious warning signs, or by insufficient focus on prevention of STIs in method selection
• Dissatisfaction with quality of services or with method given, leading to drop out, poor word-of-mouth, low service utilization
Challenges to making informed decisions

• Provider’s perceived (or real) lack of time
• Provider’s predisposition and skill
• Client’s inexperience with making medical-related decisions

Source: Towle & Godolphin, 1999
Effective clients…

- Participate in personal/social exchanges
- Ask questions
- Clarify points/issues
- State opinions
- Express concerns
- Provide essential information
Effective providers...

• Are responsive
  – Communicate respect
  – Focus on the person
  – Ensure client gets his/her choice

• Manage the medical information

• Help clients plan next steps
Resources for Counseling

- Ministry of Health Tools and Job Aids
- Decision Making Tool, WHO, 2005
- FHI Checklists, 2007
- FHI, Quick Reference Chart for Medical Eligibility
The Rights of Clients

Information: Clients have a right to accurate, appropriate, understandable and unambiguous information related to reproductive health and sexuality, and to health overall. Educational materials for clients need to be available in all parts of the facility.

Access to services: Services must be affordable, available at times and places that are convenient to clients, without physical barriers to the health care facility, without inappropriate eligibility requirements for services and without social barriers, including discrimination based on gender, age, marital status, fertility, nationality or ethnicity, social class, caste or sexual orientation.

Informed choice: A voluntary, well-considered decision that an individual makes on the basis of options, information, and understanding represents his or her informed choice. The process is a continuum that begins in the community, where people get information even before coming to a facility for services. It is the provider’s responsibility either to confirm a client’s informed choice or to help him or her reach one.

Safety of services: Safe services require skilled providers, attention to infection prevention, and appropriate and effective medical practices. This right also refers to the proper use of service-delivery guidelines, the existence of monitoring, supervision, and quality assurance mechanisms within the facility, counseling and instructions for clients, and recognition and management of complications related to medical and surgical procedures.

Privacy and confidentiality: Clients have a right to privacy and confidentiality during delivery of services – for example, during counseling and physical examinations and in staff’s handling of clients’ medical records and other personal information.

Dignity, comfort, and expression of opinion: All clients have the right to be treated with respect and consideration. Providers need to ensure that clients are as comfortable as possible during procedures. Clients should be encouraged to express their views freely, especially when their views differ from those of service providers.

Continuity of care: All clients have a right to continuity of services and supplies, follow-up and referral.

Source: AVSC International, 1999

Client-Provider Interaction

Definition
Client-provider interaction is person-to-person communication (verbal and nonverbal) between clients and health care workers. (“health care workers” can include anyone associated with a service site – e.g., medical and paramedical staff and outreach staff, as well as receptionists, cleaners and drivers).

Client-provider interaction occurs whether we pay attention to it or not – the client interacts with people from the moment he or she enters a service site. It is especially important to use good client-provider interaction with clients who are skeptical or distrustful of sexual and reproductive health (SRH) services. Research has shown that clients are more satisfied and more likely to continue using services when they are treated with respect.

Purposes
The purposes of positive client-provider interaction in SRH services are:

- To contribute to client satisfaction, to the effectiveness with which FP methods or other regimens are used, and to continuation with FP and other regimens or behaviors (e.g., continuously using oral contraceptives, or taking a complete course of medication for an STI or partner referral, among others)
- To help clients and SRH providers develop mutual respect, cooperation, and trust, among each other and with the system. (In many places, the experience has been that the system becomes too provider-dependent and then, service outputs begin to decline when the provider leaves, therefore it is important to undertake a systems approach to garner faith and trust in the system rather than the individual.)
- To help facilitate an appropriate free flow of information between and among SRH providers and clients, and to assist providers in assessing clients’ needs and concerns
- To implement high standards regarding one of the six crucial quality-of-care elements: “interpersonal relations”

Note: Adapted from INTRAH/PRIME, 1997.

Principles
Key principles in client-provider interaction include the following:

- Treat each client well
- Tailor the interaction to the individual client’s needs, circumstances and concerns
- Interact; elicit the client’s active participation
- Avoid information overload
- Provide the client’s preferred method (for FP) or address the client’s primary concern (for other SRH issues)

Counseling
Definitions and Tasks

Definition: Counseling is two-way communication between a provider and client intended to create awareness of and to facilitate or confirm informed and voluntary SRH decision making by the client.

Tasks: When providing counseling, a health care worker is responsible for:

- Helping clients to assess their own needs for a range of SRH services, information and emotional support
- Providing information appropriate to clients’ identified problems and needs
- Assisting clients to making their own voluntary and informed decisions
- Helping clients develop the skills they will need to carry out those decisions

Essentials

Few SRH programs can afford to pay staff whose only responsibility is to be a “counselor”. In addition, few sites have private spaces designated only for counseling. Besides, delivery of FP services involves different steps with different cadres of service providers, all of whom have to be well-informed and able to help the client through the process of accepting a method. Thus, all providers need to develop counseling skills and approaches to incorporate into all of their interactions with clients, including the following essentials:

- Compassion
- Common sense
- Communication skills
- Comprehensive, comprehensible information
- Credibility

Principles

Since counseling is a form of client-provider interaction, the key principles for client-provider interaction also apply to counseling. In addition, the following can be considered key principles or behaviors of the provider:
• Create an atmosphere of privacy, respect and trust
• Engage in two-way communication with the client
• Ensure confidentiality
• Remain nonjudgmental toward values, behaviors and decisions that differ from your own
• Show empathy for the client’s needs
• Demonstrate comfort in addressing sexual and gender issues
• Remain patient during the interaction with the client and express interest
• Provide reliable and factual information
• Support the client’s sexual and reproductive rights

(EngenderHealth, Comprehensive Counseling for RH – Participant’s Handbook)

**What to do and what not to do during counseling:**

**The “do’s” of counseling:**
1. Focus the discussion on information depending on the customer’s need
2. Ensure that the language is user-friendly, so that s/he can remember
3. Make sure that the information given is –
   a. Brief
   b. In easy and understandable language
   c. Necessary to remember
4. Give the important messages first
5. Repeat the important messages
6. Use pictures, models or the actual method during discussion
7. Be specific about instructions
8. Ensure that the customer understands the information given
9. Give the customer pictorial materials, if available

**The “don’ts” of counseling:**

1. Showing no respect to the customer
2. Not listening or being attentive to the customer
3. Giving the wrong information
4. Giving too much or too little information
5. Using language not familiar to the customer
6. **Selecting a method for the customer**
Handout 5.2: GATHER Checklist

Check Your Counseling Skills

GREET — Did you:
- Welcome each client on arrival?
- Meet in a comfortable, private place?
- Assure the client of confidentiality?
- Express caring, interest, and acceptance by words and gestures throughout the meeting?
- Explain what to expect?

ASK — Did you:
- Ask the client's reason for the visit?
- Encourage the client to do most of the talking?
- Ask mostly open questions?
- Pay attention to what the client said and how it was said, and follow up with more questions?
- Put yourself in the client's shoes—understand without expressing criticism or judgment?
- Ask about feelings?
- Ask the client's preferences? (For example, what method?)
- Find out about need for STD/HIV prevention?

TELL — Did you:
- Start discussion with the client's preference?
- Tailor and personalize information?
- Give information important to the client's decision?
- Avoid "information overload"?
- Use words familiar to the client?
- When discussing family planning methods, cover effectiveness, advantages and disadvantages, and STD protection?
- Use samples, drawings, or counseling aids?

HELP — Did you:
- Let the client know that the decision is hers (or his)?
- Help the client identify the full range of possible choices?
- Help the client think how the various choices would affect her or his own life?
- Advise without controlling?
- Let the client decide?
- Ask the client to state her or his decision?

Rate yourself on skills for each GATHER step. Also, you can ask a colleague to watch you (with the client's permission) and check your skills. Study tip: Try to improve one step each week for 6 weeks, until all steps are improved.

You can enter your ratings in the spaces provided below:
0 = Never 1 = Sometimes 2 = Often 3 = Always
These numbers can be added up for a total score and scores on each GATHER step.

Population Reports—Free!
The quarterly journal Population Reports covers important topics in reproductive health and population for health care providers worldwide. Topics include:
- Family planning methods
- STDs including HIV/AIDS
- Family planning programs
- Health communication
- Family planning surveys
- Safe motherhood
- Population & environment
- Other world health issues.

For a free subscription and back issues, write Population Information Program, Johns Hopkins University School of Public Health, 111 Market Place, Suite 310, Baltimore, Maryland 21202, USA.

Population Reports also is published on the World Wide Web at http://www.jhuapl.edu/pdf/
Session 6: Factors Influencing Service Delivery
Session 6 - Factors Influencing Service Delivery

Achievement Based Objectives:
By the end of this session participants will have:
• Used the categorical framework of access, quality, demand, and policies to consider FP service delivery
• Identified barriers with particular emphasis on medical and system barriers for different groups of the population.
• Identified FP service delivery issues and options at each level of the health system: community, facility, and management.
• Identified barriers to FP utilization in their program setting and assess their own programs’ effectiveness in addressing these barriers.
• Identified potential partners / program integration opportunities in their program areas.

Duration: 1 hour, 30 minutes
Timeframe: Day 2 Session 3
Materials:
• Matrix from Session 2 (TFR, CPR, Unmet Need)
• Powerpoint presentation
• Flip charts and markers for groups

Additional Resources:

Preparation:
Use the matrix prepared during Session 2 that includes the TFR, CPR and unmet need.

Develop 2 scenarios for plenary discussion: 1) low CPR but increased demand (and so the program would just need to focus on filling the demand); and 2) contraceptive use is close to demand (need to focus on increasing the demand).
Please refer to the Flexible Fund Guidance Appendix 4 for information on Total Demand calculation, etc...

Tasks

NOTE: Review session objectives first.
1. Group Discussion - 30 minutes

Procedure:

Open the topic by facilitating a general discussion with questions such as:

a) Why don't people use FP? (this is a review from Day 1)
   - Want another child because they do not have many children and they are well spaced
   - Want another child because they do not realize the benefits of limiting and spacing.
   - Not want another child, but are not using a family planning method

b) What types of people do family planning projects focus on?
   - Women who want another child, because they don't realize the benefits of FP and those who don't want another child but are not using FP.

c) What is the definition of unmet need? Those women who do not want another child within 2 years who are not, for whatever reason, using modern family planning. (# of women not wanting a child within the next two years - # of women using modern family planning methods / # of women not wanting a child within the next two years)

d) Projects will use different strategies:
   1) if unmet need is high but CPR is low (high demand but low access)
   2) if unmet need is low and CPR is also low (low demand)

e) What is the CPR in your project areas? Why? What is the unmet need in your project areas? Why?

f) What are some barriers to increasing FP use which may be due to health providers and the health service delivery system?

g) Describe 2 different scenarios:
   1) Contraceptive use is low and demand is high, how would the program focus its activities? Project could just focus on meeting the existing unmet need by improving access and service delivery. (may need to address barriers put in place by providers or the health service delivery system)
   2) Contraceptive use and demand are about the same, how would the program focus its activities? The project needs to focus on demand creation as well as access and service delivery.

2. Small group work - 1 hour

Procedure:

A) Divide participants into six groups and give them each a model of FP service delivery:
1. Community-based distribution;
2. Public Health Facility;
3. Mobile clinics
4. Facility-based Outreach Services
5. Social Marketing; and
6. Private Health Care Providers

Note to Facilitator: Assign someone experienced with the service delivery model to work with the relevant group.

B) Give each group a list of questions which they should discuss in relation to the model of service delivery they were given: (30 minutes)
   1) What are the advantages and disadvantages of this option for service delivery?
   2) What are the opportunities and challenges a program manager faces in implementing this model of service delivery?
   3) How would you take advantage of the opportunities and address the challenges?

C) Have each group share highlights from their discussion with the large group. (30 minutes)

3. Group Discussion - 20 – 30 minutes

Procedure:
Facilitate a discussion using the PPT slides as visual support. Focus on questions on slides 7, 8, 10 & 11 for more in-depth discussion.

Optional Activity:
If there is sufficient time, there might be a brief 15 – 30 minute discussion and or presentation about training and supervision. This topic is not addressed in the rest of the curriculum although it is critical to implementing a quality community-based FP program. See facilitator notes below that talk of training and supervision as cross-cutting activities.
Facilitator’s Notes

- Service delivery strategies need to be tailored to the specific situation: whether there is high or low unmet need (reflecting access) and/or high or low demand

\[ \text{Access} \]
\[ + \quad - \]
\[ \text{Demand} \quad + \quad - \]

(the lower right box benefits most from community programs/ CBD, the upper right box benefits from CBD only if CBD significantly enhances access, and the lower left box needs emphasis on the BC strategy and demand creation. While CBD may contribute to demand creation, there may be cheaper and easier ways to do it.)

Remind participants of the Community-based FP Model posted on the wall and discuss how knowledge and interest (demand), access, quality and socio-political environment all influence the use of FP services.

- Health services and the medical system may be inadvertently contributing to barriers in accessing services through imposition of medical “requirements” for FP service that conflict with people’s cultural or personal sensitivities, implementation of standards limiting the cadres of personnel that can provide different FP services, or provider bias in provision of specific methods.

- Models at different levels for health service delivery have different constraints and benefits which determine their effectiveness. Options include:
  - Community - CBD, peer counseling, male involvement, community mobilization
  - Public / Ministry of Health Facilities - outreach to community, backstopping community programs, receiving referrals, providing good quality basic services, strengthening existing public services, ensuring a supply system
  - Facility-based Outreach Services
  - Mobile Clinics
  - Social Marketing
  - Private Sector - may include private service providers and/or provision of FP services through private companies and employee health programs.
• Cross-cutting themes include:
  o Management – supervision, advocacy, leadership, training
  o Establishing referral systems to provide quality FP services
  o Interfacing with existing programs in health and other sectors
    ▪ Assessing existing activities and opportunities to maximize FP through collaboration with other programs
    ▪ Maximizing partnerships
  o Integration of FP with other health services

**Key Messages:**

• Barriers to using FP come from individual / cultural attitudes, service delivery issues, and medical practice / policy limitations.
• FP programs need to actively identify and address barriers to utilization in all categories.
• “Effective contraceptive use is dependent upon client satisfaction and success with a chosen method. By having a range of affordable methods available coupled with provider counseling, women and couples are more likely to find a contraceptive that suits their individual needs.” -- PSI
• Strategies for FP delivery need to take all four levels (community, public facility, social marketing and private sector) into account.
• Referral systems and communication/collaboration are essential for seamless service delivery.
• Identification of opportunities for partnerships, and integration of FP with other programs are important strategies for increasing FP coverage.
Overview of Service Delivery Models for Family Planning
What do Clients Want?

1) Respect
2) Understanding
3) Complete and accurate information
4) Technical competence
5) Access
6) Fairness
7) Results

* Source: Population Reports Series J, Number 47
Factors influencing Service Delivery

Unmet Need / Met Need

- Knowledge and Interest
- Access and Quality
- Social and Political Environment
Review – Unmet Need

- Women who do not want anymore children or who do not want another child within the next two or more years who are not using a modern family planning method.

  # of women, married or in union, who say that they either do not want anymore children or that they want to wait two or more years before having another child - # of women using modern family planning
  
  # of women not wanting a child within 2 years

- DHS collects unmet need for birth spacing and unmet need for limiting.
Knowledge and Interest

The Client's Perspective: Getting to the Door

1. Socio Cultural:
   - Norms about FP
   - Gender
   - Women's autonomy
   - Fears/Rumors/Myths

2. Physical Access:
   - Time
   - Distance
   - Convenience
   (difficulty getting there)

3. Client's Perception of Services:
   - Effectiveness
   - Costs
   - Knowledge

4. Competing Needs:
   - Food, Firewood
   - Work
   - Childcare

Population Leadership Program
with funding from USAID

9/36
Quality and Access
Social and Political Environment

National Policies
- National FP Policy
- Policies reflecting integration of FP into other services
  - HIV Services (PMTCT, VCT, ART)
  - MNC Services
  - Environmental Programs
  - Others?

Social Policies
- Community Norms
- Religious Practices
- Others?
Levels for FP Service Delivery

- Community
- Public Health Facilities
- Social Marketing
- Private Sector
Cross-Cutting Themes

- Management
  - Supervision
  - Advocacy
  - Leadership
  - Training
- Referral Systems
- Partnerships and interfacing
- Integration with other health services
- FP commodity supply chain
FP services at the community level

- Community mobilization / Health education
- Peer Counseling
- Community Based Distribution
- Interventions for male involvement
- Linkages with other community programs
- Referrals to health services
- Mobile Services
Public Health Facility Level

• Provision of quality basic family planning services:
  – Counseling
  – Screening
  – Follow-up
• Community Outreach / Support for Community FP activities
• Receiving referrals
• Referrals
Social Marketing

• National promotion and distribution of family planning methods through social marketing:
  
  • Behavior change approach
  
  • Assurance of nationally available and attractive products
Referral Systems

- Necessary to ensure access to widest range of contraceptive methods possible

- Community to local health facility

- Local health facility to other facilities for LTPM as necessary
Why Referrals?

- Provides access to more qualified providers
- Provides a mechanism for follow-up in the community
- Strengthens linkages between facilities and the communities they serve
- Contributes to improved client satisfaction and therefore less drop-outs
Maximizing Impact Through Partnerships / Integration

• Identify activities at the community level which could be enhanced by including FP activities and/or which could enhance FP use through integration.

• What are some examples?

• Identify partners at the community, district, or regional levels for collaboration to enhance FP coverage and use.

• What are some examples?
Session 7: Strategies for Community Mobilization
SESSION 7 - Strategies for Community Mobilization

**Achievement Based Objectives:**

By the end of this session, the participants will have:
- Discussed the definition of Community Mobilization, its advantages, and challenges
- Listed steps in the Community Action Cycle
- Named uses of the Degree of Participation levels

**Duration:** 1 hour 30 minutes

**Timeframe:** Day 2

**Seating Arrangement:** Six tables with 5 participants each

**Materials:**
- Powerpoint presentation (for Facilitators' Reference)
- Handout 7.1 – Community Mobilization Definition and Degrees of Participation
- Handout 7.2 – Community Mobilization Cycle
- Community Participation Questionnaire (Optional: see end of session plan)
- Large post-its or index cards, markers, and tape
- **Guest Facilitator:** Community Mobilization

**Additional Resources:**


**Preparation:**

*One guest facilitator is scheduled for this session. This should be a representative from a local program engaged in CBD or another CB approach who will share her/ his organization's experiences in community mobilization around CBFP*

**Tasks**

NOTE: Review session objectives first.

**1. Introduction  - 10 minutes**

**Procedure:**

Open the topic by explaining:

- Up to now we have talked quite specifically about different technical aspects of family planning: the different types of contraceptives and their advantages and disadvantages; how to prevent infection; counseling and factors that influence
service delivery. Now we are going to discuss Community Mobilization. What is community mobilization? (take a few responses and complement the definitions provided if necessary). RESPONSE: CM is a capacity-building process through which individuals, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others.

b) Mention: we have a handout with this definition and we’ll be coming back to that in a moment.

c) CBFP actively engages communities (via CM) in the overall design and implementation of project activities to increase use of FP services by improving demand, access, quality and the sociopolitical environment for FP services. Just having a clear definition of the concept, however, doesn’t make it happen or happen effectively so in this session we are going to consider how to increase community mobilization in order to build interest, ownership, and demand in CBFP.

d) Ask: Why is it important to engage community members in family planning programs? Encourage discovery of the following answers through probing questions.

Advantages of Community Participation
- Increased community support and responsibility for the program
- Increased likelihood of behavior change
- Better opportunities to enhance existing services
- More possibilities for cost recovery
- Increased potential for sustainability
- Better potential for addressing community’s priority needs and concerns
- More likely to design and implement a behavior change strategy that responds to the concerns of the community

d) Ask: What are some of the challenges in including community participation in programming?

Challenges of Community Participation
- Volunteer motivation may not be sustained over time; require support
- It may be difficult to provide/ maintain support for the field work (staff transport, per diem, distance, etc.)
- Lack of volunteer credibility with community
- Lack of supplies for Community Based Distributors/ Contraceptive insecurity
- Less control
- Time and cost
- Your priorities may not be the community’s priorities
- Project stakeholders (MOH, NGO/CBO partners, local government) disagree with each other or you
- Community skills and capacity to undertake project may be limited
- Selection of community participants may be biased by CBO or community leadership

2. Different Community-Mobilization Strategies - 20 minutes

Procedure:
a) Explain: *Now that we have looked at the advantages and challenges associated with community mobilization, let's take a few minutes to talk about the mobilization approaches that we know.*

b) Ask: *What community mobilization strategies do you already know?*

c) As these are named, post a small sign (prepared ahead of time) with the name of the community mobilization strategy on it. (Prepare signs for: ELCO maps, Community Action Cycle, PDQ, Participatory Rural Appraisal, Participatory Learning and Action, Transect Walks and diagrams.)

d) As signs are posted, ask participants to raise their hand if they use this approach. Write the number next to the approach listed.

e) Ask one of the participants who raised a hand to briefly summarize the approach.

3. Steps for Designing a Community-Mobilization Strategy - 40 minutes

**Procedure:**

a) Explain: *In addition to figuring out what community mobilization strategy to use, you also need to identify the steps involved in designing a CBFP program in general. How many of you already have experience designing a project with a Community Mobilization (CM) component (not necessarily related to FP promotion)?* Show of hands. *Before we examine the steps involved, let's review one definition of CM and look at some different levels of participation.*

b) Refer participants to handout 7.1 (Definition of CM and the Degrees of Participation) and ask: *please read the definition of CM and underline the parts you think are particularly important.* Have a few participants share.

c) Ask: *now read the Degrees of Participation section. Ask: Why is this table important? (Various responses) How might you use this table in the design or implementation of your CBFP programs? (Various responses – including: to motivate us to identify ways to increase the level of community participation in our programs, help us in planning, etc.) Ask: what does the arrow represent? In what direction are most of us hoping to go with our communities? Why?*

d) Explain: *A minute ago some of you indicated that you had designed or implemented projects or components of projects with community mobilization activities. Let's brainstorm the steps involved in designing and implementing a CBFP program that has a high level of community participation and mobilization.*

e) As you brainstorm the steps, write them on the flip chart. After about 5 min., ask participants to help you put them in order (place numbers next to each step). Note: Since there may be many different ways to order the steps, don't get bogged down in discussion about the order, but agree that these are the steps that must be followed.

f) Refer participants to Handout 7.2 about the 5 Phases of the Community Mobilization Cycle and ask them to review.

g) Ask the group to compare their steps to those on the handout and identify any similarities and gaps. Take a few responses. Inform participants that they can access the complete manual by going to the website listed on the handout. Respond to any questions.
4. Group Discussion: Community Mobilization- 20 minutes

**NOTE:** Ideally, this would be facilitated by a guest facilitator:

**Procedure:**
Option 1:
Facilitators should identify a program using CBD as a key strategy in the country where the workshop is being held and ask a guest facilitator to facilitate the discussion on the community mobilization activities they implemented. The discussion should provide a brief overview of the key issues, strategies, and lessons learned in using specific community mobilization strategies. The guest facilitator should lead an interactive discussion focusing on his/her experiences with community mobilization. Any PowerPoint slides used should only be for providing visual support and reinforcing key messages. The discussion should be approximately 15 minutes with the remainder of the time for questions and answers.

Option 2:
Facilitate an interactive group discussion summarizing key points of previous discussions. Utilize the PPT slides provided only as a visual support aid, while skipping over any slides that were already discussed during the previous activities.

**Day 2 Individual Evening Activity (Optional): Assessing & Increasing Levels of Current Community Participation**

**Procedure:**
**Note:** Depending on their level of fatigue, at the close of Day 2, you may ask participants to complete the Community Participation Questionnaire when they are back at their hotels/homes during the evening. Refer participants to the Questionnaire and ask each individual to answer the questions as they relate to their FP project (component). Tell them that they should bring the completed questionnaire with them the next day to discuss during Session 8.
Key References on Community Mobilization


How to Mobilize Communities for Health and Social Change, uses the Community Action Cycle process for individual and social change. This may be accessed at http://www.hcpartnership.org/Publications/comm_mob/htmlDocs/cac.htm

http://erc.msh.org/mainpage.cfm?file=2.2.1.htm&module=chs&language=English (working with the community)

Facilitator’s Notes

**Key Messages:**
- Beginning at the strategic planning stage, is essential for effectiveness and sustainability which community mobilization plays a big role.
- There are a variety of community participation strategies (CBD, BC strategies such as Positive Deviance) to choose from, depending upon the local situation (level of demand, availability of services, support systems, etc.)
- This aspect focuses on the demand and community capacity corners of the sustainability triangle
Strategies for Community Mobilization

Basics of Community-based Family Planning
Who are Stakeholders?

Who do you consider to be stakeholders in FP programs?
Examples of Stakeholders

- MOH (National, Provincial/Regional, District)
- Donors, CAs, Associations
- NGO/CBO partners
- Health Facility (service providers, support staff, outreach workers)
- Community (chiefs, religious leaders, women leaders, community group leaders, community resource persons and traditional health workers)
Community Stakeholder Participation

Why is it important to involve community members in FP programs?
Benefits of Community Participation

- Increased ownership, support and responsibility
- More likelihood of, and sustainability for, behavior change
- More cost-effective programming
- Better response to community needs and concerns
Benefits of Community Participation continued:

• More culturally appropriate strategies and messages

• Increased coverage and access to information and services

• Increased demand

• Increased advocacy for service and policy change

• Increased success (results and sustainability)
Community Mobilization

What is community mobilization?
Community Mobilization

A capacity-building process through which individuals, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others.

From *How to Mobilize Communities for Social Change* by Howard-Grabman and Snetro 2004:3
Key Steps in Community Action Cycle

How to Mobilize Communities for Health and Social Change
Preparing for a Community Based Program

1. Collect geographic and demographic data

2. Collect baseline FP data; review research and survey information

3. Contact existing organizations and institutions (NGOs, CBOs, local MOH)

4. Involve national and senior officials
Channels for Reaching the Community

- NGOs
- CBOs
- Local government
- Local leaders – traditional and formal
- Community Resource persons
- Special clubs or interest groups
Community Entry, and Gaining Effective Participation

- Contact meetings with community leadership to establish interest, support and buy-in

- Stakeholder sensitization workshops to determine:
  - community participation
  - involvement of men, women and other target groups,
  - geographic and demographic coverage
  - goals & objectives
  - clear roles and responsibilities and level of commitment (i.e. community participation plan)
Community Action Planning:

Actions should:

1) address problems agreed upon by community partners
2) include strategies that:
   - Address quality
   - Increase access & informed choice
   - Increase demand
   - Increase FP coverage
   - Outline persons responsible, resources needed & where to obtain them
   - Provide a timeline & M&E plan
   - Address partners’ skills & capacity building needs
Challenges

What are some of the challenges or difficulties in including community participation in programming?
Challenges of Community Participation:

- Less control
- Time and cost
- Differing priorities
- Stakeholders disagree
- Community volunteer motivation
- Community skills and capacity
- Selection of community participants may be biased
- Contraceptive insecurity
- Need to plan for sustainability from beginning
Handout 7.1
Planning for Community Mobilization

Community Mobilization - A Definition

A capacity-building process through which individuals, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others.

Varying Degrees of Participation or Involvement

- **Collective Action**
  - Local people set their own agenda & mobilize to carry it out in the absence of outside initiators & facilitation

- **Co-learning**
  - Local people & outsiders share their knowledge to create new understanding & work together to form action plans with outsider facilitation

- **Cooperation**
  - Local people work together with outsiders to determine priorities; responsibility with outsiders for directing the process

- **Consultation**
  - Local opinions asked; outsiders analyze & decide on a course of action

- **Compliance**
  - Tasks assigned with incentives; outsiders decide agenda & direct process

- **Co-option**
  - Token involvement of local people; representatives chosen but have no real input or power
Handout 7.2

How to Mobilize Communities around Health and Social Issues

Phase One: Prepare to Mobilize
Step 1: Select a health issue and define the community
Step 2: Put together a community mobilization team
Step 3: Gather information about the health issue and the community
Step 4: Identify resources and constraints
Step 5: Develop a community mobilization plan
Step 6: Develop your team

Phase Two: Organize the Community for Action
Step 1: Orient the community to the community mobilization Project
Step 2: Build relationships, trust, credibility and a sense of ownership with the community
Step 3: Invite community participation
Step 4: Develop a “core group” from the community

Phase Three: Explore the Health Issue and Set Priorities
Step 1: Decide the objectives for this phase
Step 2: Explore the health issue with the core group
Step 3: Together with the core group, explore the health issue with the broader community
Step 4: Analyze the Information
Step 5: Set priorities for action

Phase Four: Plan Together
Step 1: decide the objectives of the planning process
Step 2: Determine who will be involved in the planning and their roles and responsibilities
Step 3: Design the planning process
Step 4: Conduct/facilitate the planning process to create a community action plan

Phase Five: Act Together
Step 1: Define you team's role in accompanying community action
Step 2: Strengthen the community’s capacity to carry out its action plan
Step 3: Monitor community progress
Step 4: Problem solve, trouble shoot, advise and mediate conflicts

Phase Six: Evaluate Together
Step 1: Determine who wants to learn from the evaluation
Step 2: Form a representative evaluation team
Step 3: Determine what participants want to learn from the evaluation
Step 4: Develop an evaluation plan
Step 5: Develop evaluation methods and instruments and train team members in their use
Step 6: Conduct the participatory evaluation
Step 7: Analyze the results
Step 8: Provide feedback to the community
Step 9: Document and share lessons learned and recommendations for future
Step 10: Prepare to reorganize
Phase Seven: Scale-up – Spreading your Success

Step 1: Have a vision to scale up from the beginning of the Project
Step 2: Determine the effectiveness of the approach
Step 3: Assess the potential to scale up
Step 4: Consolidate, define and refine
Step 5: Build a consensus to scale up
Step 6: Advocate for supportive policies
Step 7: Define the roles, relationships and responsibilities of implementing partners
Step 8: Secure funding and other resources
Step 9: Develop the partners’ capacities and capabilities to implement the program
Step 10: Establish and maintain a monitoring and evaluation system
Step 11: Support Institutional development for scale up

Note: You may access the full manual that takes you through this community mobilization process at http://www.hcpartnership.org/Publications/comm_mob/htmlDocs/cac.htm, HCP, "How to Mobilize Communities for Health and Social Change".
Community Participation Questionnaire - Optional Evening Activity

Organization: _________________   Country: ____________________________

Instructions: Read the question and then circle the response that most closely reflects the level of participation in your Family Planning project/component.

1. To what extent do members of the community work with governmental and non-governmental groups to promote a family planning agenda?
   A lot     somewhat     not at all

   If you answered a lot or somewhat, please provide 2 examples of how communities work with Government or NGO groups.

2. To what extent are members of the community actively engaged in family planning activities, such as distribution of contraceptives, client follow up, and referral services?
   A lot     somewhat     not at all

   If you answered a lot or somewhat, please provide 2 examples of how communities are actively engaged.

3. How often does family planning get on the agenda of public meetings?
   A lot     sometimes     never

   If you answered a lot or somewhat, please briefly explain your response.

4. To what extent do community members help to set family planning program objectives and monitor the program's performance?
   A lot     somewhat     not at all

   If you answered a lot or somewhat, please briefly explain your response.

5. To what extent does the family planning program benefit from human, financial, and material resources available from within your community?
   A lot     somewhat     not at all

   If you answered a lot or somewhat, please briefly explain your response.
Session 8: Strategies for Community-Based Family Planning Service Delivery
SESSION 8 - Strategies for Community-Based Family Planning Service Delivery

Achievement Based Objectives:
By the end of this session, the participants will have:
• Listed advantages and challenges of a community-based FP distribution program
• Enumerated different community-based FP approaches
• Identified ways to reach “hard to reach” audiences
• Categorized CBFP strategies
• Analyzed a case study for community strategies
• Identified two ways to improve community strategies for FP promotion in their own programs (optional)

Duration: 1 hour, 55 minutes (or 2 hours, 15 minutes if optional activity is included)
Timeframe: Day 3
Seating Arrangement: Six tables with 5 participants each

Materials:
• Small signs with CBFP strategies written on them (size of construction or A4 paper)
• Case study questions written on flip chart (see Community Strategy Case Studies)
• Powerpoint presentation (for Facilitators' Reference)
• Handout 8.1 - Strategies for Different Populations
• Handout 8.2 - Case Studies for Community Based FP Service Delivery
• Handout 8.3 - Notes on Case Studies & CBFP Strategies (distribute after session)
• Large post-its or index cards, markers, and tape
• Guest Facilitators: CBD of Depo-Provera

Additional Resources:
2. Case Studies taken from MSH – Beyond Clinic Walls
http://erc.msh.org/mainpage.cfm?file=2.2.6.htm&module=chs&language=English

Preparation:
One guest facilitator is scheduled for this session, a representative from FHI who can discuss the CBD of Depo-Provera and its challenges at the field level.

Tasks

NOTE: Review session objectives first.

1. Introduction - 10 minutes

Procedure:
Open the topic by explaining:
a) Up to now we have talked quite specifically about different technical aspects of family planning: the different types of contraceptives and their advantages and disadvantages; how to prevent infection; counseling and factors that influence service delivery; and how to mobilize communities. Now we are going to discuss Community-based Family Planning Service Delivery:

b) Ask: What are the advantages and disadvantages of community-based family planning services? Encourage discovery of the following answers through probing questions.

Advantages of CBFP Service Delivery
- Services are made available in the community
- Community-based FP workers or community health workers have respect and trust of the community
- Follow-up is easier
- Generally low program maintenance cost (depending on strategy chosen)
- Can improve knowledge and demand for services, along with quality
- Services may adapt to the needs of the community
- Ability to provide LAPM or more facility based methods within the community (Mobile Clinics/Facility based Outreach)
- Better opportunities to enhance existing services-Integration with MCH programs
- Increased potential for sustainability
- Potential for increased privacy

Challenges of CBFP Service Delivery
- Volunteer motivation may not be sustained over time; require support
- It may be difficult to provide/ maintain support for the field work (staff transport, per diem, distance, etc.)
- Lack of volunteer credibility with community
- Lack of supplies for Community Based Distributors/ Contraceptive insecurity
- Less control
- The establishment (schools, government policies) may not support community based distribution or peer educators, etc.
- Time and cost
- Limited range of methods available (CBD)

2. Different Community-based FP approaches (CBFP) - 20 minutes

Procedure:

a) Explain: Now that we have looked at the advantages and challenges associated with CBFP, let’s take a few minutes to talk about the community-based FP approaches that we know.

b) Ask: What CBFP strategies do you already know?

c) As these are named, post a small sign (prepared ahead of time) with the name of the CBFP strategy on it. (Prepare signs for: CBD, peer education, mobile clinics, satellite and facility-based outreach clinics, social marketing and referral systems; as well as blank signs to be completed as participants name other strategies.)
d) As signs are posted, ask participants to raise their hand if they use this approach. Write the number next to the approach listed.

e) Ask one of the participants who raised a hand to briefly summarize the approach. (supplement the descriptions, if necessary- See Handout 7.5)

3a. Community Based Family Planning Service Delivery Strategy Case Studies - 45 minutes

Procedure:

a. Divide the participants into groups of 5 or less and assign each group one of the two community strategy case studies. (Handout 7.4).

b. Review the questions written on the flip chart (see below). Ask the groups to review Handout 7.3 (page 1 only) before they read their case study and to keep some of the strategies in mind as they consider their case studies. Tell the group they will have 20 minutes to work on their case studies and prepare responses on flip chart paper. Respond to any questions regarding group work.

- What CBFP strategy (ies) would you propose for this situation and why?
- What are some of the challenges associated with this strategy/ies?
- How does this strategy address the needs of special target populations or hard to reach groups?
- What are the advantages and disadvantages of the strategies proposed?

c. After 20 minutes ask the groups to post their flip charts on the wall. The groups that have the same case studies will review the other groups' responses (modified gallery walk) and note the similarities and differences.

d. Facilitate a discussion about the similarities and differences. Complement the participants' comments, if necessary and summarize key points (see Handout 7.5 & notes below). After the discussion, distribute Handout 7.5, Notes on Case Studies and CBFP Strategies.

Key Points

- **Potential strategies:**
  - Thailand Case Study: CBD approach, mobile units (though only 25% can be reached this way), satellite clinics, factory-based clinics, facility-based outreach (e.g. on mountain motorcycles), partnering with CBOs, traditional healers, religious groups, etc.
  - Haiti Case Study: CBD approach via peer counselors, youth RH center, school-based clinic &/or educational sessions, reaching youth at places where they congregate (sports clubs, scouts, church youth groups, etc.)

- **Challenges:**
- **CBD/Peer educators**, volunteer attrition & motivation, non-favorable government policies, limited range of methods (no LAPM), etc. If Peer educators are youth, adults may question their abilities and fear increased promiscuity, the establishment (schools, government policies) may not support them

- **Mobile units**, fuel & vehicle costs, vehicle maintenance required, generally cannot access areas with difficult terrain

- **Satellite and Factory-based Clinics**, limited services, days/times may not be convenient or well-publicized, limited privacy, need full support of employers or village leaders, may leave some people underserved (those that work in the field on clinic days or those that do not work in the factory), etc.

- **Facility-based Outreach**, only reaches the accessible villages, rainy season may prevent outreach during those months, difficult to ensure follow-up, may be costly (depending on distance from facility to villages), frequency of visits may depend on the outreach workers' attitudes and supervisory support, etc.

- **Partnering w/ CBOs, traditional healers, mother's groups, religious groups**, requires giving up some control over inputs (sharing resources, information, & decision making), different objectives, attitudes and work styles. Successful partnerships depend on the ability to manage problems jointly, on flexibility in adjusting objectives and strategies, and on a willingness to share responsibility for failures as well as for achievements

- **Youth RH Center**, can be expensive to maintain, volunteers may not be stable as youth graduate from high school or begin careers, need to develop youth-centered, non-health related activities to keep youth involved, parents may not give permission for youth involvement (see Peer Educators above)

---

**Address special target populations or hard to reach groups:**

- **CBD**, because they are from the village, they know the target population & the location of hard-to-reach groups

- **Mobile units**, may be able to plan their visits specifically to areas where special target populations or hard-to-reach groups reside, or because of difficult terrain, they may be unable to provide services to these groups

- **Satellite and Factory-based Clinics**, same as above (mobile units)

- **Facility-based Outreach**, whether or not these groups are reached, depends on distance from the facility, terrain, and motivation of outreach workers

- **Partnering w/ CBOs, traditional healers, mother's groups, religious groups**, same as for CBD above

- **Youth RH Center**, depends on outreach and publicity of youth themselves, but usually provides an excellent way to reach hard-to-reach groups

---

**Advantages and Disadvantages**

- **CBD**, Advantages- if selected by the community, have respect and trust of the community, proximity to community members, usually very dedicated individuals, follow-up is easier, generally low program maintenance cost
(initial costs may be high for training, later costs include refresher training & incentives, primarily); Disadvantages-(see challenges above)

- Mobile Units, Advantages-can provide wider range of methods & services (including LAPM); Disadvantages-(see challenges above)

- Satellite or Factory-based Clinics, Advantages-same as for Mobile Units (depending on skill level of provider/s), convenient for employees, usually lower cost or included as a medical benefit); Disadvantages-(see challenges above)

- Facility based Outreach, Advantages- same as for Mobile Units (depending on skill level of provider/s); also, may be less stigmatized (i.e. services are offered in non-medical facilities, such as a school, community center, at someone's home) ); Disadvantages-(see challenges above)

- Partnering w/ CBOs, traditional healers, mother's groups, religious groups, Advantages- can offer increased access to funding, training, and other resources that could increase the quality and scope of your service delivery strategies, small size gives them the ability to adapt to the changing realities of the groups with which they work, CBOs often respond to very particular needs of specific communities that, for whatever reason, are not being served by government or NGOs, etc. ; Disadvantages-(see challenges above)

- Youth RH Center, Advantages- Enables youth to receive information &/or services in non-threatening, non-stigmatized environment, provides confidentiality and privacy, other non-health related activities may serve as motivational factor to bring youth to the center where their knowledge of RH may be enhanced; Disadvantages- social and cultural barriers make it difficult for sexually active young people to seek services (also, see challenges above)

3b. (Optional Activity): Follow-up on Evening Activity (from Session 7 on Day 2)

Increasing Levels of Current Community Participation - 15 – 20 min.

Procedure:

Working with colleagues from the same project or individually, ask participants to review the Community Participation Questionnaire completed the evening before and reflect on the extent to which community strategies are being used (and used effectively) in their projects. They can use the following questions as a guide.

- Where are you in the process of implementing community-based family planning programs?
- What community mobilization strategies are being used in your project?

4. Group Discussion of Community-based Distribution of Depo- Guest Facilitator

- 40 minutes

Procedure:
Facilitators should arrange to have a representative from FHI to discuss how the organization has advocated for and supported the MOH in rolling out the CBD of Depo in various countries. The discussion should provide a brief overview of the challenges and lessons learned in CBD of Depo. This should be an interactive discussion focusing and any powerpoint slides used should only be for providing visual support and reinforcing key messages. The discussion should be approximately 20-30 minutes with the remainder of the time for questions and answers.
Key References on CBD


[Http://www.popcouncil.org/pdfs/wp/121.pdf](http://www.popcouncil.org/pdfs/wp/121.pdf)

CEDPA. **Training Community-Based Distribution Agents in Family Planning.** 10-day curriculum,
[http://www.cedpa.org/cgi/cedpastore/search.html?id=hoS6qhI3](http://www.cedpa.org/cgi/cedpastore/search.html?id=hoS6qhI3) (There is no pdf file, must be purchased and costs 20 usd). At the Tanzania Workshop, there will be a copy of the Training Manual for CBDs developed in Kenya.

Pop Council. **Best Practices in CBD in Sub-Saharan Africa**

Pop Council. **Best Practices in CBD in Sub-Saharan Africa**

**Facilitator’s Notes**

[http://erc.msh.org/mainpage.cfm?file=2.2.3.htm&module=chs&language=English](http://erc.msh.org/mainpage.cfm?file=2.2.3.htm&module=chs&language=English) (case studies Turkey, Thailand and Haiti – choosing a model)

[http://erc.msh.org/mainpage.cfm?file=2.2.3s.htm&module=chs&language=English](http://erc.msh.org/mainpage.cfm?file=2.2.3s.htm&module=chs&language=English) (Questions to answer for choosing hard to reach group, and check list)

[http://www.coregroup.org/working_groups/MIHV_family_planning.pdf](http://www.coregroup.org/working_groups/MIHV_family_planning.pdf) MIHV Lessons Learned document from working with communities in Uganda on FP

---

**Key Messages:**

- Community-based programs are well-suited to expand client physical access to a program; accommodate socio-cultural/gender/religious norms; and employ resonant outreach and social mobilization activities. (ADRA)
- There are some excellent examples of very basic data collection tools for developing a community-based information system in FP at the following link, (specifically starting on p 95)
[http://seats.jsi.com/publications/05Integrating/pdf/05Integr.pdf](http://seats.jsi.com/publications/05Integrating/pdf/05Integr.pdf)

279
Strategies for Community-Based Family Planning Service Delivery

Basics of Community-based Family Planning
Preparing for a Community Based Program

1. Collect geographic and demographic data

2. Collect baseline FP data; review research and survey information

3. Contact existing organizations and institutions (NGOs, CBOs, local MOH)

4. Involve national and senior officials
Bringing Services to Hard to Reach Populations

Hard to reach, underserved groups:

- Remote and nomadic rural populations
- Adolescents (rural and urban)
- Migrants
- Internally displaced persons
- People who are HIV+ or PLWAs
Effective strategies to reach underserved populations

1. Community Based Distribution

2. Mobile Units or Satellite Clinics

3. Working through partnerships with governmental or non-governmental organizations
Challenges

What are some of the challenges or difficulties in including community participation in programming?
Challenges of Community Participation:

- Less control
- Time and cost
- Differing priorities
- Stakeholders disagree
- Community volunteer motivation
- Community skills and capacity
- Selection of community participants may be biased
- Contraceptive insecurity
- Need to plan for sustainability from beginning
A Closer Look at CBD as an Approach

• Where do we have CBD program experience now & how successful have the programs been?
Community Based Distribution: History

- Significant program experience in Asia, Latin America and Africa
- Demonstrative impact in increasing FP use particularly where unmet need is high, access is low, and there are social barriers to use
- Has increased the acceptability of modern methods
Community Based Distribution: CBD Can Increase Use of FP

- Immediate increase as agents legitimize FP and increase access
- More methods provided increases overall CPR
- Increase in use may take time due to building new social norms
- CBD can augment clinic-based quality improvements

![CPR after introducing CBD in Mali](chart)

<table>
<thead>
<tr>
<th>Time</th>
<th>Condoms and referral</th>
<th>Pill added</th>
</tr>
</thead>
<tbody>
<tr>
<td>No agent</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>One year</td>
<td>11%</td>
<td>1%</td>
</tr>
<tr>
<td>Two years</td>
<td>21%</td>
<td>10%</td>
</tr>
</tbody>
</table>
Community Based Distribution:
When should this strategy be considered?

When there is/are:

- Low contraceptive use
- Low/incorrect FP knowledge (myths & misconceptions)
- Limited geographic access to clinics providing FP
- Barriers to use of services (men, youth)
- CBD strategy supports government goals and objectives
- Organizational capacity to include this strategy in FP or health programming
Community Based Distribution: Reasons for NOT choosing this strategy

- High awareness & knowledge of FP, combined with 45-50% use of modern contraceptives

- There are alternate strategies such as outreach services and mobile clinics to increase access

- It does not meet the unmet need for long-acting and permanent methods
Community Based Distribution: Reasons for NOT choosing this strategy

- Challenges to assuring service quality and continuity of volunteers
- Requires significant commitment in time and resources
- Success and cost-effectiveness are highly variable
- Tends to be small programs with little impact on overall CPR unless it is a national effort
Community Based Distribution: Program Elements

- Official Support
- Data gathering for decision making (review opportunities and obstacles for CBD)
- Community participation and volunteer selection (process and criteria are key)
- Training (traditional, on the job, phased-out, focused on specific groups, regular updates)
- Supervision (supportive, selective)
- Contraceptive supplies and system for getting supplies & managing information (SCM, MIS).
Community Based Distribution: Program Elements

- Targeting potential users (ELCO, MWRAs)
- Ensure contraceptive method mix for CBD agents
- Coordinate with and reinforce existing FP and health services; integration with other strategies and interventions
- Remuneration & motivation of CBD agents (non-monetary or small salary, sustainable & effective)
- Monitoring and Evaluation (agent performance, program results)
- Preparedness for CBD replacement (regular need for training) & potential problems
Community Based Distribution: Planning/Decision Making

- Intervention area (how big), and how many CBD agents to ensure coverage
- CBD program model to follow (government, NGO, voluntary, salaried, allowance, commission, male, female, home visits, depot/post)
- Program staff (existing or new)
- Expanding existing efforts or initiating new ones
Community Based Distribution: Planning/Decision Making

- Assuring ongoing training and supervision
- Assuring re-current costs and support
- Potential for cost recovery
- Donor support (who and for how long) & program requirements
Community Based Distribution: Elements contributing to success

- Focusing on social factors as well as technical aspects
- Community involvement
- Volunteer motivation/incentive plan
- Competency-based, incremental & practical training
- Supportive supervision
- Data & feedback provide motivation & credibility
- Making use of existing networks
- Political will and support
- Broad service regimen, program evolves as RH situations evolve, continuous and participatory M & E
Community Based Distribution: Elements which threaten success

- Failure to recognize the effort and resources required for CBD program
- Failure to capitalize on opportunities and potential for broadening interventions
- Pre-mature emphasis on sustainability and cost recovery before demand is adequately established
- Failure to address quality of care issues
- Limited MOH support/commitment
- Isolation of CBDs & broad responsibilities of job
Community Based Distribution: Challenges

- Policies limiting distribution of injectables
- Distribution of emergency contraception (WHO endorsed)
- Confusion on how to counsel and record LAM users
- Reaching youth and men
- Client concern with confidentiality
- Lack of evidence of added value of using CBD for other services
- Sustainability (community/volunteer motivation, client load, diversification of program role, financial support)
Community Based Distribution:
Why is CBD a Repositioning Strategy for FP?

• Fertility preferences still high & interest in using FP to space or limit births still low
• Access by certain populations is still low (married adolescents, hard to reach groups, people in conflict-affected settings)
• Changing social norms requires education and discussion at individual, family and community level
• Clinic-based services cannot easily stimulate or facilitate such social interactions
• Kenya example: Reduced support of CBD nationwide - drop in CPR.
Community Based Distribution: Recommendations

- Pilot test model first
- Consider CBD of injectables
- Plan for going to scale from the beginning
- Use existing community level workers rather than develop new cadre where feasible
- Work with service providers
- Consider using equal number of men and women (depends upon social context and other factors)
**Handout 8.1**  
**STRATEGIES FOR DIFFERENT POPULATIONS - A Reference List**

**NOTE:** It often takes several strategies working together to reach people who are difficult to reach.

<table>
<thead>
<tr>
<th>Hard to Reach Group</th>
<th>Possible Strategies</th>
<th>Points of Contact</th>
</tr>
</thead>
</table>
| Remote and nomadic rural populations         | • Behavior Change Communication (BCC) depending on level of knowledge and social marketing programs  
• Satellite clinics  
• Depot holders  
• Mobile units  
• Use community leaders and women’s groups to promote health messages  
• Train traditional healers and birth attendants to deliver basic MCH services  
• Train community members to be community-based distribution (CBD) agents  
• Integrate reproductive health initiatives (RHI) into economic development activities such as agriculture | • Village common areas  
• Homes  
• Women’s groups |
| Adolescents                                  | • Peer counseling  
• Plays and dramas dealing with health issues in communities and schools  
• Radio spots  
• Disseminate comics, videos, and songs with health messages  
• Hotline telephone counseling in urban areas  
• Integrate STI and family planning services  
• Train adolescent girls in assertiveness  
• Provide scholarships for adolescent girls to remain in school  
• Provide rural job opportunities for adolescent girls | • Markets  
• Schools  
• Youth centers  
• City streets  
• Places of worship  
• Sport and entertainment events |
| Migrants                                     | • Community-based distribution programs  
• Special events  
• Satellite clinics  
• Depot holders  
• BCC and social marketing programs  
• Integrate STI diagnosis and treatment into family planning services | • Homes  
• Community centers  
• Markets  
• Work sites |
| Internally displaced persons                 | • Integrate family planning and STI services into camp health services | • Community centers in displacement |
Community –based Family Planning Approaches and LAPM

1. **Community Based Distribution (CBD)**

CBD generally refers to enlisting community volunteers who go either house to house or engage clients in the community where they live and provide them with counseling, contraceptives and referrals. CBD programs take contraceptive methods and FP information to people where they live rather than requiring people to visit clinics or other locations for services. CBD agents are able to provide injectables safely with effective training and supervision. CBD programs can increase the acceptability of FP, particularly in traditional societies. Men and women may serve as local distributors of FP methods.

2. **Referrals to Health Facilities**

To increase the use of Long Acting and Permanent Method (LAPM), programs can establish partnerships with health facilities and other projects offering these methods. The training of Community Based Distributors or Community Health Workers should include information on all family planning methods offered in the project area, knowledge of referral sites and how to access them and information on how to collect data to monitor the referral system and overall family planning service delivery.

3. **Mobile Clinics**

When facility-based health centers are located far from communities or if the referral system is weak, mobile clinics can provide long-acting and permanent methods (LAPM) in the community without the need for clients to travel. Mobile clinics arrive in the community from the central or district level in either a medical van or other form of mobile unit transportation, bringing supplies and equipment necessary to perform LAPM insertions or surgeries.

4. **Satellite Clinics**

Besides outreach services, satellite clinics are an option as well for providing LAPM at the community level. A satellite clinic consists of a healthcare provider, usually from a nearby
community, visiting certain areas on certain days. The provider sets up a clinic in a designated structure, usually a building only used for medical purposes, to provide LAPM.

5. Facility-based Outreach

Another strategy for providing LAPM at the community level is through outreach services. Outreach services are provided by trained staff from the local clinic who visits certain communities during a specific time. Usually, the clinic staff will provide the services in a location in the community not usually used for medical purposes, such as schools, churches, or other buildings. Some may even provide services in a location which may not be a building but perhaps under a tree or in the center of the community.

Community Based Distributors (CBD)

- What is CBD?
  - CBD successes – Bangladesh, Zimbabwe, and others (refer to MCDI, Beyond the Clinic Walls or refer to other successful models you are aware of)
  - Areas where access is challenging, demand is low, and short-term methods are acceptable (may or may not be phased out once demand is high enough for people to seek access)
  - Funding for ongoing training and supervision
  - May address particular cultural or religious needs
  - May distribute pills (Most commonly COCs but POPs in some places), condoms, and injectables in some countries. Other methods can include LAM and SDM
  - Tools to improve quality of counseling: The FHI checklists for COCs and Depo Provera, JHUCCP wallchart with all methods of FP, the Decision Making Tool developed by WHO and JHUCCP, GATHER checklist

- Components of CBD program
  - Volunteer selection by community structures – should be respected by the community, be a role model
  - Gender distribution of volunteers (In general it is best to aim for equal representation of men and women as volunteers but this will vary depending upon the culture in each setting)
  - Eligible Couple mapping (ELCO) is one way to identify potential couples (Please refer to the FP Technical Reference Material at www.childsurvival.com for more information on this strategy)
  - Select motivation structure – salary, small stipend, community support, motivational items such as T-shirts, bags, boots, bicycles, etc…
  - Training and supervision (supervisor should serve as role model, be a mentor, provide on-the-job training and supervision)
  - Tools for CBD include checklists for counseling, report forms, referral forms, flipcharts and other job aids
  - Contraceptive stock and re-supply system in place
  - Ensure community support structure in place to support CBDs. For example link CBD with local health or development committee.
  - Potential for integration with other programs e.g. home-based care, TB, PMTCT. Potential to evolve towards more expanded RH role.
Tasks include:

- Individual and community education;
- Be a role model, be a family planning user themselves
- Distribution of methods; and
- Referrals to facilities for other methods of FP and problems

- Management decisions
  - Existing vs. new staff
  - Expanding existing efforts or initiating new ones
  - How to assure recurrent costs
  - Potential for cost recovery
  - Who and how long might there be donor support
  - What are donor program requirements

- Issues to consider
  - Depends on guidance, political will and leadership
  - Cost effectiveness questions are specific to each situation. The main idea is that CBD costs a lot of money and so in areas where demand is low and access is low CBD makes sense but in areas where access is high and demand is high, CBD does not make sense.
  - Motivation models vary: salary, volunteer, stipend, commission
GROUP 1

Working Solutions--Thailand

Reaching Remote, Rural Populations

Nine hilltribe groups totaling a population of 600,000 live in the three mountainous provinces of Mae Hong Son, Chiang Rai, and Chiang Mai in northern Thailand. Each group has its own language and culture, and less than 25 percent of their villages can be reached by car. Government health services for this population are insufficient, and research in 1993 found that hilltribe people had a crude birth rate of 56 (versus 21 for the whole country) and a population growth rate of 4.5 percent (versus 1.4 percent for the country) and that less than 20 percent of the population had been immunized.

1. What CBFP strategy (ies) would you propose for this situation and why?
2. What are some of the challenges associated with this strategy/ies?
3. How does this strategy address the needs of special target populations or hard to reach groups?
4. What are the advantages and disadvantages of the strategies proposed?

GROUP 2

Working Solutions--Haiti

Bringing Reproductive Health Education and Services to Youth

In 1995 the Foundation for Reproductive Health and Family Education (FOSREF), a Haitian NGO, conducted a study of pregnancies among young people in Haiti that showed that only one in ten sexually active young women were using contraception, that nearly 15 percent of women who had delivered at least one baby were less than 20 years old; and that nearly half the women between the ages of 15 and 24 had had at least one abortion.

This study convinced the education community and the community at large of the need to provide family planning and reproductive health services to youth, the first time anyone in Haiti had focused on this group. FOSREF organized a youth program in the capital city, Port-au-Prince, whose objective is to promote the reproductive and sexual health of young people, and to encourage responsible behavior.
1. What CBFP strategy (ies) would you propose for this situation and why?
2. What are some of the challenges associated with this strategy/ies?
3. How does this strategy address the needs of special target populations or hard to reach groups?
4. What are the advantages and disadvantages of the strategies proposed?
Notes on Case Studies & CBFP Strategies

(Note - this should be distributed only after participants have completed Activity 4)

Working Solutions--Thailand

Using Mobile Units to Reach Remote, Rural Populations

Nine hilltribe groups totaling a population of 600,000 live in the three mountainous provinces of Mae Hong Son, Chiang Rai, and Chiang Mai in northern Thailand. Each group has its own language and culture, and less than 25 percent of their villages can be reached by car. Government health services for this population are insufficient, and research in 1993 found that hilltribe people had a crude birth rate of 56 (versus 21 for the whole country) and a population growth rate of 4.5 percent (versus 1.4 percent for the country) and that less than 20 percent of the population had been immunized.

The Planned Parenthood Association of Thailand (PPAT) has been providing family planning and maternal and child health (FP/MCH) services through the Family Planning Northern Project (FPNP) in Thailand since 1987 in cooperation with provincial health officers and hilltribe volunteers. The project covers 180 main and 430 satellite villages. It provides family planning services to 11,600 acceptors (almost 50 percent of men and women of reproductive age in the project areas) and other health services to more than 10,000 clients per year. FPNP serves approximately 16 percent of the hilltribe population.

Since 1993, FPNP has also been reaching 84 area villages with HIV/AIDS prevention education, counseling, and training services. Hilltribe populations have some of the highest rates of HIV infection and many young people migrate to urban areas unprepared to face high risk situations.

FPNP uses four different strategies for providing FP/MCH and HIV/AIDS prevention services:

- **Community-based services**, through village volunteers in cooperation with the Ministry of Public Health (MOPH) and community leaders. From 1993–1995 FPNP worked in 125 villages. The MOPH is now responsible for those villages, and FPNP has begun community-based services in new villages.
- **Mobile units** that serve remote areas and industrial factories. Medical mobile units make 140 trips per year to villages and 12 trips per year to factories in two provinces. Education, counseling, and training mobile units carry out HIV/AIDS prevention activities in 84 villages in two provinces where the population comes in frequent contact with outsiders and is considered to be at high risk.
- **A static clinic** in Chiang Mai city. The clinic provides FP/MCH and counseling on HIV prevention and care to an average of 20,800 family planning clients and 28,600 MCH and other health service clients per year.
- **A training program**. FPNP has organized training on the counseling and care of HIV/AIDS clients for Buddhist monks, who now conduct HIV/AIDS prevention work.
with more than 80,500 people in remote, rural areas. The training received financial support from MOPH.

**Providing Access through Mobile Units.** Mobile service units bring service providers to clients. A mobile unit may be a fully equipped and motorized health center that visits communities on a regular schedule. Units may have film projectors, portable generators, and other audiovisual aids for intensive IEC campaigns. They can be composed of community health workers who offer health information and basic services once a month in different homes. Or they may be set up in village schools, other public buildings, or tents for several days to serve people from a large catchment area.

Mobile units are particularly useful where the health infrastructure is sparse, where the existing infrastructure provides only basic services, or where geographic barriers are extreme (for example, mountainous areas). They can bring services for a fixed period of time to those who want them but will not travel to a facility that provides them. They are also useful in providing surgical services, such as tubal ligation or vasectomy, in areas where demand is potentially high. Mobile units are most effective when the community is informed and enthusiastic about the services and is actively involved in planning the visit.

The most important obstacle to the use of mobile units is the high cost associated with buying or leasing a vehicle, paying for fuel, and keeping the vehicle in good condition. Because of this, the use of mobile units as a strategy is most effective when the units are used as a temporary means of providing access until the services are integrated into another kind of service delivery strategy.

In Thailand, the use of mobile units is one of the strategies being used to bring HIV/AIDS services to clients in mountainous areas where these services would not otherwise be available.

---

**Working Solutions--Haiti**

**Bringing Reproductive Health Education and Services to Youth**

In 1995 the Foundation for Reproductive Health and Family Education (FOSREF), a Haitian NGO, conducted a study of pregnancies among young people in Haiti that showed that only one in ten sexually active young women were using contraception, that nearly 15 percent of women who had delivered at least one baby were less than 20 years old; and that nearly half the women between the ages of 15 and 24 had had at least one abortion.

This study convinced the education community and the community at large of the need to provide family planning and reproductive health services to youth, the first time anyone in Haiti had focused on this group. FOSREF organized a youth program in the capital city, Port-au-Prince, whose objective is to promote the reproductive and sexual health of young people, and to
encourage responsible behavior. The program provides education, motivation, and family planning services to young people between 15 and 24 years of age by training youth facilitators, offering IEC workshops, sponsoring youth clubs, and providing family planning services at two youth centers.

The Youth Program has trained about 3,500 young people as facilitators, and they have conducted educational sessions in more than 100 schools. The youth center provides family planning services to an average of 1,200 young clients each month. More than half the visits are for family planning (one-third new users) and the rest are for psychological counseling and care, diagnosis and treatment of sexually transmitted infections, and other gynecological or reproductive health counseling and services. As the program has expanded, FOSREF has initiated community-based distribution through the recruitment and training of 200 peer counselors between the ages of 18 and 24. FOSREF has been asked to assist other organizations in developing similar youth programs in other urban areas in Haiti.

**Looking Ahead.** The Youth Program staff is asking two key questions as it looks to the future: how to motivate young people to continue volunteering over time, and how to transfer their experience to other organizations in the country.

**Evaluation and Reactions from Young People.** In assessing the Youth Program, FOSREF conducted focus group discussions (FGDs) with youth leaders, students, and young adults who attended sexuality education sessions, and with clients who received services at the youth center. Some significant points that came out of the evaluation and FGDs include:

- **Involve parents** in the program. FOSREF is now experimenting with ways to target parents for education programs.
- **Treat sexually active clients as a couple** (when appropriate) and teach them how to negotiate and make decisions together. This has strengthened the position of girls in negotiating with their partners.
- **Separate education activities by gender.** This has increased the participation of girls in voicing their opinions and has led to design of new peer counselor activities.
- **Give service delivery responsibilities to the peer counselors.** The focus group discussions indicated that the trained counselors were impatient regarding their role and ready for greater responsibilities. They now provide family planning methods during home visits.
- **Expand clinic-based services.** FOSREF has opened a new youth clinic (Delmas Clinic), which is now serving a significant number of youth.

**Working with Government and Non-Governmental Partners.** Partnering with other government ministries, non-governmental organizations (NGOs), the private sector, mothers’ clubs, religious groups, physicians’ and nurses’ associations, community-based organizations (CBOs), and associations of traditional healers, among others, can be an effective way to extend existing strategies to cover hard to reach groups.

If you manage a government clinic, you may be able to join forces with an NGO that works
with an underserved group. If you manage a CBO, you may be able to obtain support from national, provincial, district, or local government programs whose mandate includes outreach, or join with an NGO working in your area. Partnering can offer increased access to funding, training, and other resources that could increase the quality and scope of your service delivery strategies.

Working with partners is challenging. It means sharing resources, information, and decision making. It requires giving up some control over inputs, changing objectives, and getting used to different attitudes and work styles. Successful partnerships depend on the ability to manage problems jointly, on flexibility in adjusting objectives and strategies, and on a willingness to share responsibility for failures as well as for achievements.

CBOs and private sector organizations are two groups with which managers can build successful partnerships.

Community-Based Organizations (CBOs). CBOs first emerged in the 1980s in Africa as a response to the HIV/AIDS epidemic. Their small size gives them the ability to adapt to the changing realities of the population groups with which they work. CBOs often respond to very particular needs of specific communities that, for whatever reason, are not being served by government or NGOs. NGOs such as family planning associations may support CBOs.

Private Sector Organizations. Throughout the world, program managers have found that working with private sector organizations is an effective way to reach underserved groups. In southern Africa, traditional healers participate in delivering family planning methods, diagnosing and treating STIs, and referring patients. In India, where private doctors even in remote, rural areas are the main source of health care for most of the population, they have been trained to deliver oral contraceptives and IUDs, in counseling, and in follow-up services. Indonesia has launched a national program to establish private nurse-midwives in villages to take care of MCH services. In many countries worldwide, social marketing strategies supply condoms to small merchants who market them even in very remote areas.

Clients can also be considered partners in providing services, as the Haitian Working Solution example shows. Providing services is a significant challenge for youth programs in developing countries because of the social and cultural barriers that make it hard to sexually active young people to seek services. As a result, a significant number of programs for young people provide sex education and counseling, but not services. In the example above, an NGO in Haiti trained young people who began providing education and counseling in family planning to their peers. Focus group discussions with the counselors and others led to an evolution in the counselors’ role—they wanted more responsibility and now provide methods as well as education and counseling. They also refer clients to two clinics that serve young people.
Session 9: Designing a Behavior Change Strategy
Session 9 - Behavior Change Strategy

Achievement Based Objectives:
By the end of this session, the participants will have:
• Indicated the steps to follow in designing a behavior change strategy
• Discussed reasons why behavior doesn't necessarily change when knowledge is increased and attitudes change
• Listed the steps required to conduct a Doer/non-Doer Survey (DND) or a Barrier Analysis (BA)
• Explained why behavioral research is necessary for identifying the most powerful determinants
• Analyzed sample DND/BA data to determine the most powerful determinants
• Identified non-communication, non-training activities to address the most powerful determinants

Duration: 3 hours
Timeframe: Day 3
Seating Arrangement: Six tables with 5 participants each

Materials:
• Small signs with elements of the BC Strategy framework written on them (behavior, priority group, influencing group, determinants, factors, activities, also make some blank (size of construction, A4 paper, or strips of flip chart paper)
• Flip Chart of the Designing for Behavior Change Framework (cover the words)
• Exercise Exercise Statements and Behavior Goal written on flip charts (see below)
• Cards/signs, each with 1 of 7 steps of the Barrier Analysis written on one side only
• Handout 9.1: Blank Designing for Behavior Change (DBC) Framework
• Handout 9.2: Three completed examples of DBC Frameworks (ITNs, HIV Testing, & Coffee production- select one for review during Activity 2, step g. (3)
• Handout 9.3: Seven steps to conducting a Barrier Analysis
• Handout 9.4a & b: BA/DND Data Sheets (a-for Facilitators, b-for Participants)
• Handout 9.5: Identifying Activities to Address Determinants
• Handout 9.6: Going Beyond Awareness Raising
• Markers and tape
• Powerpoint presentation (for facilitators reference only)-

Additional Resources:
1. Designing for Behavior Change curriculum. - The curriculum may be downloaded at: http://www.coregroup.org/working_groups/DBC_Curriculum_Final_2008.pdf
2. BA Facilitators Guide. The guide can be downloaded at: http://barrieranalysis.fhi.net/annex/Barrier_Analysis_Facilitator_Guide.pdf
An excel spread sheet to help you input and calculate differences can also be downloaded from: http://www.foodsecuritynetwork.org/resources/food_security/health/BA_Results_Reporting_Tabulation_Template_Aug_07_FH.xls
3. See also Food for the Hungry’s webpage on Barrier Analysis: http://barrieranalysis.fhi.net/how_to/how_to_conduct_barrier_analysis.htm
Note: this website and the Facilitators Guide mention using focus group discussions as an option for conducting the barrier analysis; however, based on their experience using the methodology in numerous countries, Food for the Hungry and many of their colleagues working in health and development no longer recommend this approach; instead, they suggest only individual interviews.
4. For information on Doer/Non-Doer Survey, see The Change Project: http://www.changeproject.org/tools/xchangetools/tx_doer_nondoer_tool.html
NOTE: Review session objectives first.

1. **Introduction: Personal Reflection - 10 minutes**

   **Procedure:**

   a) Ask participants to individually remember a change they have made (tried to make) in their own lives; then try to recall the things they did to make and secure that change. And finally reflect on the success of the change. Next, ask a few people to share their reflection asking:
      1. *What was the change you made/ tried to make?*
      2. *What did you do to facilitate the change?*
      3. *How easy or difficult was it? What made it easier/more difficult?*
      4. *How long did the change take?*
      5. *Were you successful in making the change? Why? Why not?*

   b) Point out that some change comes about easily and doesn’t need to be planned for; whereas other behavior changes are more difficult and need to be planned. In our jobs we are all agents of planned behavior change and as such we need to be cognizant of the steps in the process of planned change and our role in that process.

2. **Brainstorming the Elements of a Behavior Change Strategy - 1 hour**

   **Procedure:**

   a) Ask: *Based on your current programs, what are some of the key elements you should consider when you are designing the behavior change strategy of the project?*

   b) As participants mention anything related to the five decisions (behavior, priority group, determinants, key factors and activities), post the previously prepared signs on the wall. Use the blank signs to write down any additional elements that are relevant. Post all valid responses (regardless of whether they are included in the DBC Framework). (Alternately, facilitators can write the components on the flip chart as they are mentioned)

   c) Congratulate the participants for creating an even more detailed framework, and explain that these elements will remain in the room so that participants can compare them to the framework that we are about to introduce.

   d) Introduce the Designing for Behavior Change (DBC) framework by saying that a tool has been developed to help us think about the different elements that need to be considered when designing/reviewing a behavior change strategy; this is the **Designing for Behavior Change Framework.**

   e) Uncover the words on the previously prepared flip chart of the Designing for Behavior Change framework; point out each element of the framework (behavior, priority group, determinant, key factor, activity), making reference to any similar responses provided by the participants during the brainstorming in Step 1. Ask participants to follow along on their Blank DBC Framework (Handout 9.1).

   f) Give a brief explanation for each of the five decisions, briefly explaining a bit about each element and how they relate to each other. Introduce each of the determinants & give a concrete example of each (see facilitator's notes).
g) Distribute Handout 9.2 - the completed DBC frameworks - and ask participants to refer to the example you have previously selected (See Materials above, 3 examples are included-ITNs, HIV Testing & coffee production- and facilitators should select one to review during this step); guide participants through the example addressing any questions. (Note: facilitators should select which example they will review ahead of time).

h) Summarize by discussing the “Five Principles” (see Facilitators Notes). Respond to questions.

3. Exercise Exercise - 30 minutes
NOTE: Instructions for preparing the flip chart papers for this activity follow this session plan.
Procedure:

a) Explain that project implementers need to conduct in-depth audience research in each community as part of the baseline survey and continuously during the project’s life. If used during project design, the qualitative research can help project designers narrow down the list of behaviors to target.

b) Point out the behavior change goal written on the flip chart paper.

c) Tell the participants that before we decide how to address that goal, we’re going to undertake some audience research—involving all of you as research participants!

d) Ask someone to remove the first blank sheet from each of the three stacks of papers taped to the flip chart or wall. Explain that three different knowledge statements are posted on the walls. Have a participant read them out loud.

e) Ask the participants to stand near the statement that most approximates their knowledge levels. When participants have settled next to a statement, ask: What do you notice about the groups? How many are in each group? Other observations: Demographic observations? By profession? Gender? Age? Nationality? Language group? Region? Other?

f) Tell participants “You’ve just divided yourselves into segments, or subgroups of the community, according to your stated knowledge level about exercise.”

g) Tell the participants “We will now see what happens when we look at your beliefs.”

h) Ask someone to remove the knowledge statement from each of the three stacks of papers to reveal the belief statement. Have a participant read them out loud.

i) Ask the participants to stand near the statement that most approximates their belief levels. When participants have settled next to a statement, ask: What do you notice about the groups? What differences do you see? Other observations?
Tell the participants “We will now see what happens when we look at your behaviors.” Repeat the process, removing the belief statements, and asking participants to reposition themselves according to what they actually did.

Discussion Questions & Points to Emphasize

1. Did your knowledge and belief predict your behavior? Why not?

   What we know and believe is often quite different from what we do. Identifying doers and non-doers (those who do the behavior and those who don’t) is essential for this type of qualitative research.

2. If you had to pick one audience segment to work with first, which group would you pick?”

   Introduce the term: ‘target of opportunity’. Marketers look for targets of opportunity; or “Where can I get the biggest bang for the buck?” (greatest impact from my investment) i.e. looking at groups with the greatest desire to change due to vulnerability or those for whom the transition would not be difficult; we may be more successful at moving the “sometimes exercise” people to the goal than getting the “almost never exercise” people all the way there.

3. What else have we learned from this exercise?

   • Giving people information is generally not enough—even convincing them of a new belief may not move people to take a beneficial action.

   • It is not always necessary or practical to divide by socio-demographic characteristics.

   • It is helpful to identify the competing behaviors that are making appeals to our audience.

   • This activity points us toward the value of doing qualitative research.

4. Seven Steps to Conducting a Barrier Analysis   -20 min

Procedure:

   a) Distribute the cards with the 7 steps to Conducting a Barrier Analysis amongst the participants and ask them to put themselves in order in front of the room
   b) Encourage other participants to help them rearrange themselves if they do not agree with the order.
   c) Explain each step (see details in Facilitators Notes) and respond to questions.
   d) Ask: When during the process of doing a DBC framework should the BA be conducted? Response: prior to determining which activities you will conduct; after you have determined your behavior & priority group; can also be done midterm to readjust BC strategy. Refer participants to Handout 9.3 – “Seven Steps of the Barrier Analysis”.

314
5. Analyzing BA/DND Data - 40 min.

**Procedure:**

a) Refer participants to Handout 9.4- BA/DND Data Sheets.
b) Using the sample on p. 1 of the handout, show participants how to search for the greatest differences (largest gaps) between same responses for Doers and Non-Doers. Explain that when we are analyzing the data from our DND or BA, this is what we are looking for. The responses with the largest gaps in percentages points indicate which determinants are the most powerful for that behavior, and thus give us direction in terms of the activities that should be selected (e.g. ORS is not available at the health post near my home- Determinant: self-efficacy or Access & we know that we need to develop an activity that ensures access to ORS for mothers, for example CBD approach). *(Note: Refer to Facilitators version of the same handout for, but only distribute this at the end of the activity.)*
c) Write the following questions on the flip chart & review with the participants:
   1. What are the 2-3 responses which show the largest gap (most significant difference between % of Doers & Non-Doers)?
   2. What are the determinant categories they represent? (Perceived positive consequences, social norms, etc.; see below for the list of determinants)
   3. What activities or types of activities would you design to address these most powerful determinants to help this population change this behavior?
d) Working in their small groups, ask participants to analyze the data set on the reverse side of 9.4 by answering the questions on the flip chart.
e) After groups have worked for 20 minutes, facilitate a group discussion on their findings, comparing similarities and differences between the groups' findings.

6. Identifying appropriate Activities to Address Determinants - 20 min.

**Procedure:**

a) Explain: *We are often tempted to design BC programs by starting first with communication and training related activities; but let's think for a minute about a project who's KPC (that's Knowledge, Practices, and Coverage) shows high knowledge levels of contraceptives & through our desk review & discussions with other local groups, we know that previous NGOs have spent huge portions of their budgets training local health workers in FP, but still we see low CPR.*
b) Continue: *To help us think a bit outside of the communication, materials development and training box, let's take a look at handout 9.5.*
c) Explain: *Working in pairs, determine which activities would best address the determinant category and key factor identified.*
d) After 15 minutes, ask for volunteers to share their responses. Congratulate participants for "thinking outside the box". If necessary, complement participants' responses with the following: Potential Responses:
   - Key Factor 1 Men's Support Groups, Use of Positive Deviants
- Key Factor 2 Social Marketing approach, Specific Radio Messages
- Key Factor 3 Community-based Distributors
- Key Factor 4 Training of Providers in Counseling/CPI
- Key Factor 5 Renovate clinic to improve privacy
- Key Factor 6 Advocate w/ MOH for Policy to allow CBD of Depo

Distribute handout 9.6 and tell participants that the handout provides them with suggestions for other non-communication, non-training related activities they can adapt for their programs.
e) Summarize by referring participants to the DBC curriculum available through the coregroup.org website (coregroup.org, working groups, Social and Behavior Change, Working Group Tools/Resources, Designing for Behavior Change Curriculum). Refer them also to the Barrier Analysis Facilitators Guide and other additional resources as appropriate.
f) Address any final questions.

**Guide for Preparing Flip Charts - The “Exercise” Exercise**

Write the following on a large piece of flip chart paper & tape it to a wall:

**Behavior Change Goal:** All adults will engage in at least 30 minutes of moderate physical exercise 4-6 times a week.

Three SETS of flip charts are needed for this game. Each set has three pages as follows and page 1 should be on top of page 2 which is on top of page 3 for all sets. A blank sheet should be taped on top of page 1, so all pages are hidden. Tape them to the wall so it is easy to remove each page.

**Set 1**

p. 1: I know that getting exercise is very important. I have read multiple studies that prove it. I have also heard many advertisements promoting good health through exercise.
p. 2: I believe that getting exercise is very important. I think that everyone should exercise regularly, at least four times a week.
p. 3: Last week, I exercised between 4-6 times for 30 minutes at a time.

**Set 2**

p. 1: I have heard only that exercising can reduce your chance of heart disease
p. 2: I believe exercise is somewhat important; most people should exercise 1-2 times a week
p. 3: I exercised at least twice last week.

**Set 3**

p. 1: I know that many people are in shape because they exercise, but I’m not sure how they do it
p. 2: I think that we get enough exercise with the routine activities of the day.
p. 3: I did not do any exercise last week.
Facilitators Notes

The Five Principles of behavior change
- Know exactly who your group is and look at everything from their point of view;
- Action is what counts (not beliefs or knowledge);
- People take action when it benefits them; barriers keep people from acting
- All your activities should maximize benefits and minimize barriers
- Base decisions on evidence, not conjecture, and keep checking

Steps for developing a Behavior change strategy
- Determine your behavior
- Define priority groups - primary and influencing
- Conduct formative research to identify determinants influencing adoption of new behaviors - benefits, barriers, and readiness to change (Barrier Analysis or Doer/Non-Doer Survey)
- Analyze results, identify most powerful determinants, and write key factors
- Identify activities and strategies, including message content, to address key factors, select indicators
- Develop and test messages (if including a communication component)
- Implement and monitor the interventions
- Evaluate the success of the messages and strategies
- Adjust as needed

Stages of readiness to change
- Pre-awareness
- Awareness / contemplation
- Preparation - deciding to change
- Action - changing the behavior
- Maintaining the new behavior

Assessment / Formative Research as evidence basis for making decisions
- Review of differences between doers and non-doers
- Questions to assess determinants, readiness to change, barrier analysis
Some Determinants that Influence Behavior *

The 3 Most Powerful Determinants (Identified through Doer/ Non-Doer and Barrier Analysis Surveys):

Perceived Self-efficacy, Skills: an individual's belief that he or she can do a particular behavior; the set of skills or abilities necessary to perform a particular behavior (e.g. women believe they can put condoms on their partner correctly).

Perceived Social Norms: perception that people important to an individual think that s/he should do the behavior; norms have two parts: who matters most to the person on a particular issue, and what s/he perceives those people think s/he should do. (e.g. young mothers think that their in-laws are against their using FP)

Perceived Positive or Negative Consequences: what a person thinks will happen, either positive or negative, as a result of performing a behavior. (e.g. women perceive that husbands will beat them if they use FP methods)

Other Determinants (Identified through Barrier Analysis):

Perceived Action Efficacy: belief that the action is actually effective in addressing the problem. (e.g. the extent to which the audience thinks immunizations actually prevent communicable diseases; a mother's belief that using contraceptives will be effective in preventing pregnancies).

Perceived Susceptibility (also known as Perceived Risk): a person's perception of how vulnerable they feel (Could their child get diarrhea, malaria? Could they become pregnant, get HIV, STIs, etc.)

Perceived Severity: belief that the problem is serious. A mother may know that immunizations will prevent measles, but if she doesn't perceive measles to be a serious disease, she will probably not take her child for immunizations. (e.g. she may not believe that she can die from becoming pregnant too early, too late, or too soon after the birth of her last child)

Perception of Divine Will: a person's belief that it is God's will (or the gods’ will) for her/him to have the problem; and /or to overcome it (e.g. The number and timing of my children are in God's hands, C'est Dieu qui donne.).

Cues for Action: whether or not a person can remember to do a particular behavior or remember the steps involved in doing the behavior (a cue is something that helps you remember something else). (e.g. a radio announcement reminding people of the date and location of a vaccination post or putting the pill packet next to her toothbrush or some other place where she knows that she will look each day).

*This handout is adapted from materials originally developed by AED.
Barrier Analysis

**Number of Categories of Determinants:** Barrier Analysis examines 8 behavioral determinants. The 3 most powerful of these are Perceived Positive and Negative Consequences, Social Norms, and Perceived Self Efficacy. In addition, are: Perceived Susceptibility (also known as Risk), Perceived Severity, Perceived Divine Will, Perceived Action Efficacy, Cues for Action, etc.

**Who is interviewed:** In BA, the questions are asked of individuals from the priority group; their responses are compared based on whether they are Doers or Non-Doers (if they practice the behavior, they are considered “Doers”)

**Sample size:** Barrier Analysis requires a sample size of 60-85 individual interviews of Doers & 60-85 individual interviews with Non-Doers for the best results.

**Resources:** Compared to some other qualitative research methods (such as Doer/Non-Doer Analysis), Barrier Analysis requires more human and financial resources to conduct since it requires a larger sample size and a longer questionnaire taking into account an additional 5 categories of determinants; nonetheless, if the target population is accessible (and both Doers & Non-Doers can be easily identified), research on one behavior can be done using either method with a team of 2-4 people in about 2 days.

**When to use the method:** Barrier Analysis can be used at project start-up (for example prior to detailed implementation planning) which is the ideal time to plan a behavior change strategy, or at midterm or at final evaluation for a project which will have a follow-on if a BC strategy is needed or needs adjustment at that time. In addition, some organizations conduct a BA more frequently in order to research many behaviors during a longer project (e.g. Food for the Hungry conducts a BA on the behavior they intend to promote, such as Exclusive Breast Feeding, before each 4-month teaching module).

**Quality of data:** Because BA uses a large sample and looks for statistically-significant differences between Doers and Non-Doers, it is probable that the determinants found to be different between the two groups are true differences (not just due to chance). Also, BA looks at more determinants, interviews more people, and is more likely to find important differences between the two groups.

**Analysis:** A questionnaire is developed and used, then a coding guide is developed after collecting data from doers and non-doers; the project team compiles the data from all doers and non-doers, using the totals as the denominator and the number of individuals who responded in the same way as the numerator. The team calculates the percentages and looks for the largest gaps between doers and non-doers for each type of response - the larger the gap, the more likely you are to identify determinants that are important for the priority group. A 30 point difference between the two groups for the same response is more likely to be significant than an 8 point difference for example. See pp. 65-70 of the BA Facilitator’s Guide for more information.
Note: An excel spread sheet to help you input and calculate differences can also be downloaded from:
http://www.foodsecuritynetwork.org/resources/food_security/health/BA_Results_Reporting_Tabulation_Template_Aug_07_FH.xls

Example from the field: In Mozambique, program staff looked at determinants related to Exclusive Breastfeeding behaviors by comparing 45 Doers & 45 Non-Doers. They found 9 important differences between Doers. 84% of Doers said that having the mothers eat a balanced diet made it easier for them to exclusively breastfeed, vs. 49% of Non-Doers. 84% of Doers believed they could do the preventive action if they wanted to, vs. 42% of Non-Doers. 64% of Doers thought that doing the preventive action would help their child avoid getting the disease (diarrhea) vs. 47% of Non-Doers (while this was a 17 point difference between the 2 groups, there was a 9% probability that this difference was purely due to chance (p=.09), so the project personnel decided not to focus as heavily on this determinant.

NOTE: Handouts 9.1, 9.2 and 9.4 are included in a separate file

Additional References

Core Group Website – Behavior Change Working Group
http://www.coregroup.org/working_groups/behavior.cfm

Child Survival Technical Resource Materials on Behavior Change Interventions
http://www.coregroup.org/working_groups/TRM_SBC_2005.pdf

Website overviews of behavior change strategies and tools:
http://barrieranalysis.fhi.net/what_is/behavior_change_theory.htm
*Please note that behavior change planners no longer recommend the use of focus groups for conducting the barrier analysis, but rather individual interviews only.

http://www.changeproject.org/behave_reg.htm
Development of a Behavior Change Strategy for Family Planning

Basics of Community-Based Family Planning
What is a Behavior Change Strategy?

A comprehensive approach to achieving behavior change
- Based on data and formative research
- Integrated with comprehensive project design
- Focuses on the desired behaviors and determinants that influence them
Principles of Behavior Change

- Know the priority and influencing groups and consider everything from their point of view
- Action is what counts – NOT beliefs or knowledge
- People take action when it benefits them / Barriers keep people from acting
- All behavior change activities should maximize benefits and minimize barriers
- Base decisions on evidence – Keep checking
Steps to Developing a Behavior Change Strategy

– Analysis / formative research
  • Identifying benefits, barriers, and level of readiness

– Developing and testing messages and strategies as integrated part of project design

– Implementing and monitoring the interventions

– Evaluating the success of the messages and strategies

– Adjusting as needed
4 Decisions for the BEHAVE Framework

What do we need to consider when developing a behavior change strategy?
5 Decisions for the Designing for BC Framework

- Clearly defining targeted behaviors
- Describing priority target groups and influencing groups
- Researching most powerful determinants: benefits and barriers to adoption
- Identifying which factors to address
- Determining strategies / channels, activities, and messages
Selecting the Priority Behavior

• This focuses the behavior change strategy on only the information and interventions needed to achieve the desired behavior – What we want people to **DO**.

• Factors determining the selection:
  – Level of associated health risk
  – Impact of the behavior on health - effectiveness
  – Operational feasibility
  – Political feasibility
  – Behavioral feasibility
Who – Identifying the Audiences

Priority – primary audience – Those who will practice the behavior

Influencing – secondary group – Those who influence the behavior of the priority audience.

For each of these groups:
- We may need to define behaviors and develop strategies separately
- We need to understand their perspectives and world view.
Key Determinants that influence behavior change

• Determinants that contribute to or detract from people’s ability to adopt new behaviors –

• Think “outside the box” - these can include factors beyond pregnancy or health

Brainstorm – what are the determinants or factors that influence our own choices around the use of family planning?
Some key determinants that influence behavior change

External Determinants – Actual Benefits and Barriers
- Skills – knowledge and the ability to practice
- Access
- Religious / cultural issues
- Economic issues
- Gender expectations

Internal Determinants - Individual perceptions
- Actual and perceived consequences to practicing / not practicing the new behavior
- Self-efficacy – The ability to do the behavior
- Social Norms – What do my friends think?
- Personal attitudes
- Levels of readiness to adopt the new behavior

Some of the most effective messages and strategies may have nothing to do with health.
Stages of Readiness for Change

- Pre-awareness
- Awareness / knowledge
- Preparation – Deciding to change
- Action – Changing
- Maintenance – Maintaining the new behavior

What are some examples of these different levels of readiness in relation to family planning?
Need for Formative Research

Needed in addition to standard KAP data on our target population:

– Review differences between doers and non-doers

– Questions to assess determining factors, readiness to change, barrier analysis or doer/non-doer survey
Developing Behavior Change Strategies and Interventions

• Assessing people’s readiness to change

• Messages and strategies that address the identified key factors – even if they don’t have to do with health.

• Identification of creative channels for reaching people

• Coordination and consistency with other interventions and activities
DBC Framework

<table>
<thead>
<tr>
<th>Priority behavior</th>
<th>Priority Group / Influencing Groups</th>
<th>Determinants</th>
<th>Key Factors</th>
<th>Strategies / Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Handout 9.1**  
**BLANK Designing for Behavior Change framework** – Priority Group

**Program Objective:**

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Priority or Influencing Group</th>
<th>Determinants</th>
<th>Key Factors</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>To promote this behavior:</strong></td>
<td><strong>among this audience:</strong> (circle one)</td>
<td><strong>We will research these determinants:</strong></td>
<td><strong>and address these key factors (priority benefits and priority barriers):</strong></td>
<td><strong>By implementing these activities:</strong></td>
</tr>
</tbody>
</table>
| **1** | **2** | (Circle the most powerful)*  
Access, Self-Efficacy, Perceived Social Norms, Perceived Positive Consequences, Perceived Negative Consequences, Perceived Severity, Perceived Susceptibility, Action Efficacy, Perception of Divine Will Cues for Action * To be determined only after conducting qualitative research | | |

1. What is the feasible and effective behavior to promote?  
2. Who are the priority groups and influencing groups?  
3. What are the most powerful determinants?  
4. What key factors need to be addressed?  
5. What activities will be implemented to address the key factors?

*Adapted from AED’s BEHAVE Framework
**Handout 9.2: Example 1. Designing for Behavior Change Framework – ITN use for Children >5 in Mali**

**Project Objective:** Increase the practice of malaria prevention behaviors

<table>
<thead>
<tr>
<th><strong>Behavior</strong></th>
<th><strong>To promote this behavior……</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Children under-five (CU5) sleep under an insecticide treated mosquito net consistently</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Priority or Influencing Group</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Among this audience….</strong></td>
</tr>
<tr>
<td><strong>Priority Group</strong></td>
</tr>
<tr>
<td>Mothers of children under five years of age, who all speak Bambara, are illiterate and live in the rural areas in Kolendiaba District. Most mothers work at home and in the fields; some are in families of multiple wives. They all want to have healthy children and to be perceived as good mothers and wives; most do not have access to bed nets and some are not convinced that they can prevent malaria. They are not all aware that malaria is caused by being bitten by mosquitoes but they know that malaria is a serious disease especially for children. They know that lots of people get malaria.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Influencing Group</strong> (identified through research)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husbands of women with &lt; 5 children - are heads of the household, proud to be fathers, most are subsistent farmers; some have more than one wife, they are not very involved in the decisions related to raising small children; they control most of the money in the family - they get preferential treatment in the household.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Determinants</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>We will research these determinants...</strong></td>
</tr>
<tr>
<td>After research, underline the most powerful determinants Access, self efficacy, perceived social norms, perceived positive consequences, perceived negative consequences, perceived severity (risk), perceived susceptibility, action efficacy, perception of divine will, cues for action.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Key Factors</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>And address these key factors…</strong> (priority benefits &amp; barriers)</td>
</tr>
<tr>
<td>1. Improving availability of ITNs</td>
</tr>
<tr>
<td>2. Increasing perception that ITNs are affordable- worth the price</td>
</tr>
<tr>
<td>3. Improving the equitable distribution of ITNs to households</td>
</tr>
<tr>
<td>4. Increasing specific knowledge regarding the connection between malaria and mosquitoes &amp; that nets can prevent malaria</td>
</tr>
<tr>
<td>5. Increasing perception that nets are effective in preventing malaria</td>
</tr>
<tr>
<td>6. Improving availability of retreatment kits</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Activities</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>By implementing these activities...</strong></td>
</tr>
<tr>
<td>1. Establish credit mechanisms for the purchase of ITNs through village cotton producers associations and their promoters</td>
</tr>
<tr>
<td>2. Establish a multi channel behavior change communication strategy which includes health talks, household visits, and radio broadcasts</td>
</tr>
<tr>
<td>3. Offer single use retreatment kits through the village drug kit</td>
</tr>
</tbody>
</table>
**Handout 9.2: Example 2. HIV testing during prenatal visits in El Salvador- Designing for Behavior Change framework**

**Program Objective:** Increase the number of women who receive HIV testing during prenatal care visits

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Priority Group</th>
<th>Determinants</th>
<th>Key Factors</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>To promote this behavior:</td>
<td>among this audience: Priority Group:</td>
<td>*We will research the most powerful determinants:</td>
<td>And, we will address these key factors:</td>
<td>By implementing these activities:</td>
</tr>
<tr>
<td>Women who attend antenatal care accept an HIV test during their visit</td>
<td>All pregnant women who attend antenatal visits; most lack knowledge about antiretroviral availability &amp; many doubt effectiveness</td>
<td><strong>Access</strong></td>
<td>• Increasing the availability of test kits</td>
<td>1. Advocacy (budget allocation/donation)</td>
</tr>
<tr>
<td>Indicator</td>
<td>% of women who accept an HIV test during antenatal care visits</td>
<td><strong>Self-Efficacy</strong></td>
<td>• Increasing perception that all pregnant women get tested (that it is “the right thing” to do to protect your baby)</td>
<td>Indicator: % of budget allocated to local HIV activities (for purchase of test kits)</td>
</tr>
<tr>
<td></td>
<td>(Numerator: # of pregnant women who accept an HIV test; Denominator: Total # of pregnant women in project area)</td>
<td><strong>Perceived Social Norms</strong></td>
<td>• Improving perceived consequences of HIV+ diagnosis (it’s not equal to death sentence)</td>
<td>2. Utilize BF &amp; + women’s support groups to inform pregnant women that getting tested is “the right thing to do” &amp; HIV is not a death sentence</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Perceived Positive Consequences</strong></td>
<td>• Reducing the perception that everyone will know my status because there is no privacy at the clinic</td>
<td>Indicator: # of active members of support groups who report giving correct message to &gt; 5 pregnant women; % pregnant women who state HIV is not a death sentence</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Perceived Negative Consequences</strong></td>
<td></td>
<td>3. Improved Logistics Management</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Perceived Severity</strong></td>
<td></td>
<td>Indicator: % of antenatal sites which have been improved to include a private physical space for VCT</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Perceived Susceptibility</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Action Efficacy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Perception of Divine Will</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Cues for Action</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*These can only be determined after conducting qualitative research</td>
<td></td>
</tr>
</tbody>
</table>

*We will research the most powerful determinants:* Access, Self-Efficacy, Perceived Social Norms, Perceived Positive Consequences, Perceived Negative Consequences, Perceived Severity, Perceived Susceptibility, Action Efficacy, Perception of Divine Will, Cues for Action.
Example 3. Coffee Producers in Honduras - Designing for Behavior Change framework for Desired Agricultural Practice

<table>
<thead>
<tr>
<th>Decision</th>
<th>Response</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavior</td>
<td>Appropriate and timely pruning of coffee trees</td>
<td>- Number or percent of coffee producers pruning trees two years in a row. - Number of hectares being pruned annually.</td>
</tr>
</tbody>
</table>
| Priority Group | • Small scale coffee producers:  
• Very low levels of education  
• Low incomes  
• From small under-developed communities |  |
| Determinant (Underline the most powerful)* | Access, Self-Efficacy, Perceived Social Norms, Perceived Positive Consequences, Perceived Negative Consequences, Perceived Severity, Perceived Susceptibility, Action Efficacy, Perception of Divine Will, Cues for Action  
*These can only be determined after conducting qualitative research |  |
| Key Factor | - Decrease the perception of risk - risk of losing some product, risk of investing effort for no significant return.  
- Increase the perception of positive consequences - increased production.  
- Increase the understanding of cost-benefit of pruning coffee.  
- Increase the capacity of coffee growers to develop long-term plans for pruning coffee trees. | - Number of producers who have long-term maintenance plans for pruning |
| Activities | - Train the coffee producers in the cost-benefit of pruning, in the technical aspects, and in market analysis and alternative markets.  
- Arrange cross-visits between coffee growers to learn from the positive experience of other producers.  
- Promote planning improved varieties of coffee including messages about the pruning care needed by each variety. - demonstration sites  
- Strengthen the local producers' organizations as channels of information, training, and to make small producers aware of the funds due to them through the national Coffee Fund.  
- Promote staggered pruning to alleviate time stress, and teach producers basic planning.  
- Orientation of coffee producer associations and cooperatives and provision of training materials. | - Number of family producers of coffee who have participated in the training package. - Number of producers who demonstrate pruning techniques, can explain cost-benefits, and have identified better markets. - Number of producers and number of hectares pruned during first year after training.  
- Number of producers who have visited other producers with successful experiences.  
- Number of training replications by producer associations and cooperatives |
Handout 9.3

7 Steps to Conducting a Barrier Analysis

Q: Why should we conduct a Barrier Analysis or a Doer/Non-Doer Survey?
R: It enables us to identify which are the most powerful (influential) determinants.

First, select the method (Barrier Analysis or Doer/Non-Doer Survey) which is most appropriate according to your budget, timeframe, and available human resources; the following steps are those required for the Barrier Analysis:

1) **Define the Goal, Behavior and Priority Group** - what you want to happen as a result of your BC strategy. For example, “increase the percentage of well-nourished under-fives in the community”, “increase the number of women who receive prenatal care during the first trimester”, etc.

2) **Develop the Behavior Question** - this question or questions will help you determine if your respondent is a Doer or a Non-doer. For example, “what did you feed your baby during the last 24 hours?” “What do you do after you clean a baby who has defecated?” “…before you prepare food?” Researchers must be consistent in how they define Doers and Non-Doers.

3) **Develop Questions about Determinants and Pretest the Questionnaire** - identify 1-2 questions for each of the determinant categories (see BA Facilitators Guide, pp 65-66) and prepare the questionnaires/coding guides with potential responses. Test the questionnaire on a few members of the priority group.

4) **Organize the Data Collection** - Brainstorm as to where you may find Doers & Non-Doers. Seek authorization from appropriate gate keepers (village chief, clinic managers, etc.) Practice interviewing colleagues using the questionnaire. Make sufficient copies of the questionnaires. Arrange transportation and interviewing locale.

5) **Collect Field Data for the Barrier Analysis** - Conduct at least 60-85 individual interviews of priority group members who regularly do the behavior that you wish to promote (the “Doers”) and 60-85 interviews with “Non-Doers.” Record the responses on the questionnaire. Specify any “other” responses (write them in their own words).

6) **Organize and Analyze the Results** - Once you have completed the interviews, organize and analyze your results. Prepare the coding guide. Using the same denominators for each, compile results from other team members and calculate the percentages of Doers and Non-Doers on the coding guide. Compare the answers of the Doers and Non-Doers for each question/response. Where are the largest gaps between percentages of Doers and Non-Doers for the same response?

7) **Use the Results of the Barrier Analysis** - This is the most important part. After analyzing your data, decide what changes you need to make in your program design, what key factors must be addressed through your activities? Which messages should be used and how will you address influencing groups? You will also need to decide how to monitor changes in the determinants during the life of your project.
**Handout 9.4a BA/ DND Data Sheets**

**Example 1**

**DESIRED BEHAVIOR**: Mothers administer ORS to their children when they have diarrhea to prevent dehydration

<table>
<thead>
<tr>
<th>Research Findings</th>
<th>Doers %</th>
<th>Non-Doers %</th>
<th>Differences/Key Factors/Activities</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Perceived Susceptibility</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My child can get diarrhea</td>
<td>25</td>
<td>29</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My child can become dehydrated</td>
<td>72</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Severity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea is a killer disease</td>
<td>78</td>
<td>81</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea is listed 1 or 2 in list of severe diseases</td>
<td>74</td>
<td>68</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Action Efficacy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORS prevents dehydration</td>
<td>93</td>
<td>73</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORS prevents dehydration “a lot”</td>
<td>78</td>
<td>62</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Self Efficacy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know how to make ORS</td>
<td>98</td>
<td>63</td>
<td></td>
<td></td>
</tr>
<tr>
<td>It would be easy for me to make ORS</td>
<td>92</td>
<td>59</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORS is available at the health post near my home</td>
<td>88</td>
<td>43</td>
<td>45% pts, Improve Access to ORS (e.g. CBD approach)</td>
<td>X</td>
</tr>
<tr>
<td>ORS costs too much</td>
<td>45</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORS takes too long to prepare</td>
<td>22</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I could easily remember to make ORS</td>
<td>95</td>
<td>91</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can remember the steps</td>
<td>98</td>
<td>63</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Social Norms</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My mother agree with using ORS</td>
<td>81</td>
<td>83</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My husband agrees with using ORS</td>
<td>53</td>
<td>57</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Divine Will</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It’s often God’s will that children with diarrhea die</td>
<td>31</td>
<td>72</td>
<td>41% pts, Increase perception that mothers can ensure their child’s survival (e.g. recruit support of religious leaders)</td>
<td>X</td>
</tr>
<tr>
<td>Children sometime get diarrhea because of neighbor’s curses</td>
<td>34</td>
<td>41</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children often get diarrhea due to other supernatural causes</td>
<td>45</td>
<td>84</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Positive Consequences</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORS reduces chance of dehydration</td>
<td>91</td>
<td>84</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Will spend less money on visits to the health center</td>
<td>54</td>
<td>62</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Negative Consequences</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tastes bad</td>
<td>27</td>
<td>16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doesn’t stop diarrhea</td>
<td>80</td>
<td>38</td>
<td>42% pts, e.g. BCC – ORS prevents death due to dehydration</td>
<td>X</td>
</tr>
</tbody>
</table>
**Handout 9.4 BA/ DND Data Sheets**

**Example 2**

**DESIRED BEHAVIOR:** Pregnant women receive at least 4 prenatal consultations during their pregnancy.

<table>
<thead>
<tr>
<th>Research Findings</th>
<th>Doers %</th>
<th>Non-Doers %</th>
<th>Differences/Key Factors/Activities</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Perceived Susceptibility</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I will not have any problems with my pregnancy</td>
<td>38</td>
<td>78</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being pregnant is a natural process; I don’t need any help with it</td>
<td>45</td>
<td>85</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Severity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being pregnant doesn’t pose a serious health threat</td>
<td>35</td>
<td>85</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I will not have a miscarriage</td>
<td>38</td>
<td>63</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Action Efficacy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The prenatal consultations will really help me and my baby be healthy</td>
<td>85</td>
<td>50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The nurse/midwife really knows what she’s doing</td>
<td>95</td>
<td>75</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Self Efficacy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can make time to go to the health center to have a PNC</td>
<td>83</td>
<td>43</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can remember when I need to go for my PNC</td>
<td>78</td>
<td>23</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Positive Consequences</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I will not have any health problems if I have more than 4 PNC</td>
<td>90</td>
<td>35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I will not have a miscarriage if I attend PNC</td>
<td>98</td>
<td>43</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Get to see my friends</td>
<td>62</td>
<td>43</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Get to go into town and do my shopping too</td>
<td>85</td>
<td>89</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Negative Consequences</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>long wait time</td>
<td>63</td>
<td>68</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The health center is far away</td>
<td>45</td>
<td>48</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I will have to spend money to get to the PNC</td>
<td>58</td>
<td>60</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Social Norms</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My mother will approve if I attend the PNC</td>
<td>85</td>
<td>35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My husband will approve if I attend the PNC</td>
<td>78</td>
<td>23</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Divine Will</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes God causes miscarriages as a punishment</td>
<td>45</td>
<td>55</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Risk</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The PNC could cause me to go into labor too early</td>
<td>22</td>
<td>61</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The TT vaccination makes me sick</td>
<td>10</td>
<td>20</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Handout 9.4 BA/ DND Data Sheets**  
**Example 3**

**DESIRED BEHAVIOR:** Children < 2 years of age sleep under insecticide treated bednets every night.

<table>
<thead>
<tr>
<th>Research Findings</th>
<th>Doers %</th>
<th>Non-Doers %</th>
<th>Differences/Key Factors/Activities</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Perceived Susceptibility</strong></td>
<td></td>
<td></td>
<td>H M L</td>
<td></td>
</tr>
<tr>
<td>My child can get malaria</td>
<td>75</td>
<td>50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My child can easily get malaria</td>
<td>70</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Severity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My child can die from malaria</td>
<td>80</td>
<td>75</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Action Efficacy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleeping under a ITN will prevent malaria</td>
<td>87</td>
<td>50</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Self Efficacy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know where to get an ITN (for my child)</td>
<td>98</td>
<td>83</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can afford to buy an ITN (for my child)</td>
<td>74</td>
<td>35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can remember to use the ITN (for my child)</td>
<td>85</td>
<td>62</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Positive and Negative Consequences</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My child will feel hot sleeping under the ITN</td>
<td>30</td>
<td>73</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My child will sleep better under the ITN (not being bitten)</td>
<td>95</td>
<td>35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can’t sleep with my husband because the net is too small for all three of us</td>
<td>23</td>
<td>75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People will think that I’m rich</td>
<td>5</td>
<td>23</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Social Norms</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husband approves of ITN use</td>
<td>87</td>
<td>45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother approves of ITN use</td>
<td>35</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Divine Will</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes children get malaria as God’s punishment</td>
<td>48</td>
<td>52</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Risk</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The ITN could smother you if it falls</td>
<td>12</td>
<td>35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The chemical on the net is harmful to people</td>
<td>5</td>
<td>23</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**DESIRED BEHAVIOR:** Mothers wash their hands with soap after defecating, before cooking, and before eating (to avoid diarrhea).

<table>
<thead>
<tr>
<th>Research Findings</th>
<th>Doers %</th>
<th>Non-Doers %</th>
<th>Differences/Key Factors/Activities</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Perceived Susceptibility</strong></td>
<td></td>
<td></td>
<td>H M L</td>
<td></td>
</tr>
<tr>
<td>my child can get diarrhea if I don’t wash my hands</td>
<td>83</td>
<td>41</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If I don’t wash my hands, my child can easily get diarrhea</td>
<td>71</td>
<td>35</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Severity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea is a killer disease</td>
<td>78</td>
<td>81</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea is listed 1 or 2 on list of serious illnesses</td>
<td>74</td>
<td>73</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Action Efficacy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washing my hands will reduce the incidence of diarrhea</td>
<td>78</td>
<td>43</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are other things that more likely cause diarrhea</td>
<td>85</td>
<td>83</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Self Efficacy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is easy to wash my hands regularly</td>
<td>58</td>
<td>32</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can remember when to wash my hands</td>
<td>85</td>
<td>42</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have access to water for hand washing</td>
<td>60</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Social Norms</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My husband will approve of frequent hand washing</td>
<td>72</td>
<td>61</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My mother in law will approve</td>
<td>75</td>
<td>45</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Divine Will</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>God expects us to be clean</td>
<td>85</td>
<td>82</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometime God punishes us by causing illnesses</td>
<td>73</td>
<td>70</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Risk</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>We might not have enough water for drinking/cooking</td>
<td>43</td>
<td>52</td>
<td></td>
<td></td>
</tr>
<tr>
<td>We cannot afford to buy soap</td>
<td>35</td>
<td>52</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Positive Consequences</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My hands will feel nice</td>
<td>45</td>
<td>50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My hands will smell good</td>
<td>83</td>
<td>85</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Negative Consequences</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I will spend more time fetching water</td>
<td>83</td>
<td>90</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Takes extra time to wash hands at every moment</td>
<td>73</td>
<td>79</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Handout 9.4 BA/ DND Data Sheets
Example 5

**DESIRED BEHAVIOR:** Mothers seek health care for their child when the child has a fever or diarrhea for more than 3 days.

Based on responses to Doer – Non-doer questionnaire

<table>
<thead>
<tr>
<th>Research Findings</th>
<th>Doers %</th>
<th>Non-Doers %</th>
<th>Differences/Key Factors/Activities</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advantages</strong></td>
<td></td>
<td></td>
<td></td>
<td>H M L</td>
</tr>
<tr>
<td>Child has a good chance of getting better faster</td>
<td>81</td>
<td>53</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child can get treated by trained health care staff</td>
<td>45</td>
<td>28</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Disadvantages</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child may die anyway</td>
<td>42</td>
<td>33</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long distance to walk to health center</td>
<td>67</td>
<td>85</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation is expensive</td>
<td>27</td>
<td>72</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Takes time from work</td>
<td>40</td>
<td>27</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child may not survive the trip to health center</td>
<td>37</td>
<td>69</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Easier</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husband gives me money for bush taxi/bus</td>
<td>60</td>
<td>52</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husband says he agrees it’s a good thing for the child</td>
<td>58</td>
<td>44</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If I saw that other mothers did the same thing</td>
<td>22</td>
<td>67</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If health center were a lot closer or health worker came to my house</td>
<td>72</td>
<td>86</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>More Difficult</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If husband says no</td>
<td>5</td>
<td>33</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If mother-in-law says should stay home and child will get better</td>
<td>22</td>
<td>58</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If no one can take care of my other children</td>
<td>15</td>
<td>47</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Approves</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My husband approves</td>
<td>80</td>
<td>32</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My mother/mother-in-law approves</td>
<td>65</td>
<td>72</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Disapproves</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My husband disapproves</td>
<td>0</td>
<td>63</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My mother/mother-in-law disapproves</td>
<td>10</td>
<td>45</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Handout 9.4 BA/ DND Data Sheets**  
**Example 6**

**DESIRED BEHAVIOR:** Husbands use condoms when having sex with a non regular partner.

<table>
<thead>
<tr>
<th>Research Findings</th>
<th>Doers %</th>
<th>Non-Doers %</th>
<th>Differences/Key Factors/Activities</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advantages</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can keep myself from getting sick with AIDS or another disease</td>
<td>79</td>
<td>75</td>
<td></td>
<td>H</td>
</tr>
<tr>
<td>I can keep my other relationship a secret (by not getting a disease)</td>
<td>67</td>
<td>85</td>
<td></td>
<td>M</td>
</tr>
<tr>
<td>Won’t risk getting my non-regular partner pregnant</td>
<td>55</td>
<td>44</td>
<td></td>
<td>L</td>
</tr>
<tr>
<td>Won’t risk giving my wife/regular partner a disease</td>
<td>88</td>
<td>90</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easy to use</td>
<td>45</td>
<td>33</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Disadvantages</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Makes sex less fun (doesn’t feel the same)</td>
<td>65</td>
<td>73</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost</td>
<td>57</td>
<td>55</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have to plan ahead</td>
<td>48</td>
<td>0</td>
<td>48% pts, Increase perception that men can plan ahead (e.g. BCC campaigns, male support groups)</td>
<td>x</td>
</tr>
<tr>
<td>Dangerous to not let sperm pass freely</td>
<td>58</td>
<td>62</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My non-regular partner might distrust me (think I have a disease)</td>
<td>55</td>
<td>65</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hard to put on when you’re in a hurry</td>
<td>33</td>
<td>56</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Easier</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-regular partner makes it fun/part of foreplay</td>
<td>75</td>
<td>27</td>
<td>48% pts, Increase perception that condoms are fun for everyone (e.g. BCC Campaigns)</td>
<td>x</td>
</tr>
<tr>
<td>Available for free where we meet</td>
<td>60</td>
<td>0</td>
<td>60% pts, Increase access to free condoms (e.g. Hotels, Truck Stops, etc.)</td>
<td>x</td>
</tr>
<tr>
<td><strong>More Difficult</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-regular partner says no</td>
<td>78</td>
<td>89</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Approves</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My friends approve</td>
<td>65</td>
<td>48</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My colleagues approve</td>
<td>61</td>
<td>54</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My non-regular partner approves</td>
<td>88</td>
<td>10</td>
<td>78% pts, Increase perception that condoms protect those you love (e.g. BCC Campaign)</td>
<td>x</td>
</tr>
<tr>
<td><strong>Disapproves</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My non-regular partner disapproves</td>
<td>10</td>
<td>79</td>
<td>69% pts, same as above</td>
<td>x</td>
</tr>
</tbody>
</table>
### Research Findings

<table>
<thead>
<tr>
<th></th>
<th>Doers %</th>
<th>Non-Doers %</th>
<th>Differences/Key Factors/Activities</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>My friends think I’m less of a man</td>
<td>20</td>
<td>88</td>
<td>68% pts, Increase perception that real men use condoms (e.g. BCC Campaign)</td>
<td>x</td>
</tr>
</tbody>
</table>

### Handout 9.4 BA/ DND Data Sheets

**Example 7**

**DESIRED BEHAVIOR:** Mothers feed their children of 7 months 5 small nutritious meals per day.

<table>
<thead>
<tr>
<th>Research Findings</th>
<th>Doers %</th>
<th>Non-Doers %</th>
<th>Differences/Key Factors/Activities</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advantages</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Babies gain weight</td>
<td>85</td>
<td>64</td>
<td></td>
<td>H</td>
</tr>
<tr>
<td>Babies develop better (mental, physical, emotional…)</td>
<td>15</td>
<td>0</td>
<td></td>
<td>M</td>
</tr>
<tr>
<td>Babies seem happier</td>
<td>72</td>
<td>55</td>
<td></td>
<td>L</td>
</tr>
<tr>
<td><strong>Disadvantages</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Takes time from work in the fields</td>
<td>47</td>
<td>32</td>
<td></td>
<td>H</td>
</tr>
<tr>
<td>Don’t have enough money to buy nutritious food</td>
<td>26</td>
<td>48</td>
<td></td>
<td>M</td>
</tr>
<tr>
<td>My other children will be jealous, want to eat more</td>
<td>0</td>
<td>67</td>
<td></td>
<td>L</td>
</tr>
<tr>
<td><strong>Easier</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If mother in law or mother helped with preparation</td>
<td>86</td>
<td>45</td>
<td></td>
<td>H</td>
</tr>
<tr>
<td>If husband were supportive</td>
<td>97</td>
<td>58</td>
<td></td>
<td>M</td>
</tr>
<tr>
<td>If I had more money to buy food</td>
<td>26</td>
<td>48</td>
<td></td>
<td>L</td>
</tr>
<tr>
<td><strong>More Difficult</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have no time</td>
<td>50</td>
<td>74</td>
<td></td>
<td>H</td>
</tr>
<tr>
<td>My husband expects all of us to eat together 2x daily</td>
<td>16</td>
<td>65</td>
<td></td>
<td>M</td>
</tr>
<tr>
<td><strong>Approves</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My husband thinks it makes sense for the baby</td>
<td>87</td>
<td>55</td>
<td></td>
<td>H</td>
</tr>
<tr>
<td>My mother approves</td>
<td>60</td>
<td>65</td>
<td></td>
<td>M</td>
</tr>
<tr>
<td>My mother in-law approves</td>
<td>40</td>
<td>40</td>
<td></td>
<td>L</td>
</tr>
<tr>
<td>My baby approves</td>
<td>68</td>
<td>33</td>
<td></td>
<td>H</td>
</tr>
<tr>
<td><strong>Disapproves</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My husband thinks that 5 times a day is too much and the baby will get sick</td>
<td>0</td>
<td>58</td>
<td></td>
<td>M</td>
</tr>
</tbody>
</table>
Handout 9.5
Identifying Activities that Address the Most Powerful Determinants

<table>
<thead>
<tr>
<th>BA Response (Determinant)</th>
<th>Key Factor</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;My husband might beat me because he thinks that using FP will make me run around on him&quot; (Perceived negative consequences)</td>
<td>Increase women's perception that their partners are supportive; that they will not beat them; increase men's perception of wives' fidelity &amp; of positive economic impact</td>
<td></td>
</tr>
<tr>
<td>&quot;I will have to spend too much money on FP&quot; (Perceived negative consequences)&quot;</td>
<td>Increase the perception that contraceptives are affordable (&amp; less expensive than a high-risk pregnancy or raising an unplanned child)</td>
<td></td>
</tr>
<tr>
<td>&quot;If it wasn't so far to get to the health post&quot; (Self-Efficacy or Access)</td>
<td>Improve the availability of contraceptives</td>
<td></td>
</tr>
<tr>
<td>&quot;If the doctor wasn't in such a rush all the time&quot; (Perceived negative consequences)</td>
<td>Increase the perception that service providers do not have time for clients</td>
<td></td>
</tr>
<tr>
<td>&quot;If everyone at the clinic didn't hear me talking about my private issues&quot; (Perceived negative consequences)</td>
<td>Improve privacy at the clinic</td>
<td></td>
</tr>
<tr>
<td>&quot;If I could use something without my partner knowing&quot; (Perceived social norms or perceived negative consequences)</td>
<td>Increase access to discreet methods of contraception</td>
<td></td>
</tr>
</tbody>
</table>
Introducing a New Product/ Promoting a Commodity Rather than Communication

• **Condom Carrying Case** (for promoting safer sex)

• "**Tippy Tap**" During a midterm evaluation for a health project in Kenya, staff saw large changes in hand washing before eating, but not at the other critical moments. Mothers had agreed to increase hand washing prior to eating, but they had so little water, they reported that it was difficult to wash their hands at all the other times (self-efficacy related to resources). Health staff thus encouraged the promotion of the Tippy Tap as a way to conserve water, making it easier for them to do the behavior. (Tippy Taps are simple and economical hand washing stations, made with commonly available materials and not dependent on a piped water supply.)

• **Improved water storage containers** for drinking/cooking water (Haiti)

• **Small bottles** that project staff regularly refilled with small amounts of chlorine bleach for people to treat their drinking water.

• **Hand-washing stations** next to the latrine and ‘kitchen’ in Madagascar to increase hand washing with soap

• **PUR** (for water purification)

• **Soap** (for hand washing)

• **ITNs** (for malaria prevention)

• **Bowl** (rather than eating from the family plate) so a mother can monitor quantities of semi-solid foods actually going to the child for infant feeding

• **Thermos** (provided to health centers to keep the open vials fresh to the next day)

**Activities to Increase Access**
• **Increasing the supply of HIV test kits** at health center level

• **Creating a counseling corner** away for the earshot of other waiting clients (for increasing uptake of HIV counseling (in antenatal visits or otherwise)

• **Increasing/improving supply of vaccines** to health center

• **Providing micro-loans** to start small businesses that sell soap in local markets

• **Advocating for Policy Changes:** convincing private sector soap companies or the government to either reduce prices, subsidize, or make soap tax free; convincing clinics to support baby friendly initiatives (to encourage women who deliver to exclusively breastfeed); encouraging clinics to eliminate restrictions saying they cannot open a vaccine vial to immunize just one infant at a time; working with employers to provide nursing breaks; working with schools to stipulate that children must be vaccinated to enter school; convincing hospital administrators to reject free formula in hospitals & to encourage rooming-in; changing legislation so that AIDS orphans are able to inherit their parents’ land

**Environmental Changes**

• **Negotiating Practices:** the agents of change are the mothers, fathers, or children who agree to try something new for a specific period of time. An example from Malawi: parents and 8-11 year olds agreed to talk twice a week for three months about sexual and reproductive health issues. Parents and children were supported with some initial training about how to talk about sensitive subjects with each other, and a booklet to stimulate discussion. Follow up visits from project staff were to learn how it was going and give encouragement-not to communicate any new messages. The result was that each group came away feeling like they could talk to the other much better on every day topics as well as the project related topics.

• **Training people on legal issues** in communities where there are problems with coercive sex, etc. In these cases, there may be a set of messages that you want to get out to people, but in addition to that, you need to have people who know their rights and can help others get justice.

• **Training nurses to give tablets** as opposed to always giving injections

• **Promoting Values:** some organizations (like FH) promote certain values to try to help behavior change happen. For example, they might promote the value that women and men are both made in the image of God and have value, or that each child’s life is sacred. For example, in some cultures, the word for woman is the same as the word “tool.” In a culture such as that, we need to go deeper than behavior, to the values
level, if we want to see changes happen. The target is still on behavior change, but the level of intervention will be deeper in the psyche.

- **Using role plays** to practice negotiating safer sex, or talking with your doctor, or talking with your patients.
### Handout 9.4b BA/ DND Data Sheets

#### Example 1

**DESIRED BEHAVIOR:** Mothers administer ORS to their children when they have diarrhea to prevent dehydration

<table>
<thead>
<tr>
<th>Research Findings</th>
<th>Doers %</th>
<th>Non-Doers %</th>
<th>Differences/Key Factors/Activities</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Perceived Susceptibility</strong></td>
<td></td>
<td></td>
<td></td>
<td>H M L</td>
</tr>
<tr>
<td>My child can get diarrhea</td>
<td>25</td>
<td>29</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My child can become dehydrated</td>
<td>72</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Severity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea is a killer disease</td>
<td>78</td>
<td>81</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea is listed 1 or 2 in list of severe diseases</td>
<td>74</td>
<td>68</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Action Efficacy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORS prevents dehydration</td>
<td>93</td>
<td>73</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORS prevents dehydrations “a lot”</td>
<td>78</td>
<td>62</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Self Efficacy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know how to make ORS</td>
<td>98</td>
<td>63</td>
<td></td>
<td></td>
</tr>
<tr>
<td>It would be easy for me to make ORS</td>
<td>92</td>
<td>59</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORS is available at the health post near my home</td>
<td>88</td>
<td>43</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORS costs too much</td>
<td>45</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORS takes too long to prepare</td>
<td>22</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I could easily remember to make ORS</td>
<td>95</td>
<td>91</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can remember the steps</td>
<td>98</td>
<td>63</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Social Norms</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My mother agree with using ORS</td>
<td>81</td>
<td>83</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My husband agrees with using ORS</td>
<td>53</td>
<td>57</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Divine Will</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It’s often God’s will that children with diarrhea die</td>
<td>31</td>
<td>72</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children sometime get diarrhea because of neighbor’s curses</td>
<td>34</td>
<td>41</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children often get diarrhea due to other supernatural causes</td>
<td>45</td>
<td>84</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Positive Consequences</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORS reduces chance of dehydration</td>
<td>91</td>
<td>84</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Will spend less money on visits to the health center</td>
<td>54</td>
<td>62</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceived Negative Consequences</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tastes bad</td>
<td>27</td>
<td>16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doesn’t stop diarrhea</td>
<td>80</td>
<td>38</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Desired Behavior:** Husbands use condoms when having sex with a non regular partner.

<table>
<thead>
<tr>
<th>Research Findings</th>
<th>Doers %</th>
<th>Non-Doers %</th>
<th>Differences/Key Factors/Activities</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advantages</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can keep myself from getting sick with AIDS or another disease</td>
<td>79</td>
<td>75</td>
<td></td>
<td>H M L</td>
</tr>
<tr>
<td>I can keep my other relationship a secret (by not getting a disease)</td>
<td>67</td>
<td>85</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Won’t risk getting my non-regular partner pregnant</td>
<td>55</td>
<td>44</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Won’t risk giving my wife/regular partner a disease</td>
<td>88</td>
<td>90</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easy to use</td>
<td>45</td>
<td>33</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Disadvantages</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Makes sex less fun (doesn’t feel the same)</td>
<td>65</td>
<td>73</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost</td>
<td>57</td>
<td>55</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have to plan ahead</td>
<td>48</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dangerous to not let sperm pass freely</td>
<td>58</td>
<td>62</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My non-regular partner might distrust me (think I have a disease)</td>
<td>55</td>
<td>65</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hard to put on when you’re in a hurry</td>
<td>33</td>
<td>56</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Easier</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-regular partner makes it fun/part of foreplay</td>
<td>75</td>
<td>27</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available for free where we meet</td>
<td>60</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>More Difficult</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-regular partner says no</td>
<td>78</td>
<td>89</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Approves</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My friends approve</td>
<td>65</td>
<td>48</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My colleagues approve</td>
<td>61</td>
<td>54</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My non-regular partner approves</td>
<td>88</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Disapproves</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My non-regular partner disapproves</td>
<td>10</td>
<td>79</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My friends think I’m less of a man</td>
<td>20</td>
<td>88</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Session 10: Quality Improvement
Session 10 - Quality Improvement Approaches

Achievement-based Objectives:
By the end of this session, participants will have:
• Identified reasons for improving quality (QI) of FP programs
• Identified steps in the QI process
• Described different QI methodologies/approaches

Duration: 3 hours
Timeframe: Day 3 Session 3 and Day 4 Session 1
Seating Arrangement: Six tables with 5 participants each
Materials:
• Powerpoint slide presentation
• In-country presenter
  • Manuals/summary for each of the QI approaches (PDQ, COPE, QIQ):
  • Handout 10.1 - Case study & how to guide for problem identification and analysis (for reference use only)
  • Handout 10.2 - matrix comparing different QI approaches for group work
  • MAQ check list for monitoring FP quality in primary care setting (to be used during the PDME training as well): http://www.maqweb.org/maqchecklist/FamPlan1.pdf
  • Organizing Work Better: http://www.infoforhealth.org/pr/q02/

Additional Resources:
• More on COPE: http://erc.msh.org/mainpage.cfm?file=2.05.htm&module=toolkit&language=English
• MSH, UNICEF. The Guide to Managing for Quality. Uses a case study to work through the steps of managing for quality (supplement to Handout 10.1): http://erc.msh.org/quality/
• Global Health eLearning Center. Site contains 20 eLearning modules, many on FP: http://www.infoforhealth.org/elearning/?PHPSESSID=728ebae2d18d98cd064e639278f6d300
  • Organizing Work Better: http://www.infoforhealth.org/pr/prf/fq02/q02.pdf (French Version)
• MAQ French Training Curriculum: http://www.maqweb.org/franco/franco.shtml#present
• MAQ FP check list http://www.maqweb.org/maqchecklist/FamPlan3.pdf (French version)

NOTE: Review session objectives first.
1. QI Overview - Group Discussion - 40 minutes
   **Procedure:**

   Facilitate a large group discussion using the powerpoint slides to provide visual support.

2. Group Work – Problem Analysis in the QI Process - 1 hour, 20 min.
   **Procedure:**

   a) Refer to slides 34 & 35.
   b) Form small groups of 5-6 people and assign each group one of the problem statements (slide 34)
      - Frequent shortage of contraceptive methods
      - Women come for immunization and child wellness visits but do not attend FP clinic
      - Young people are not using the FP clinic yet many young girls are admitted for PAC (post-abortion counseling)
      - Clients are not using LAPMs (long acting and permanent methods)
   c) Ask each group to identify a facilitator and reporter
   d) Explain the following steps (slide 35):
      1. Define the problem.
      2. Choose the appropriate team to work on the problem.
      3. Analyze the problem using the fishbone analysis or problem tree and choose the main root causes.
      4. Develop solutions and decide on the priority ones to act on.
      5. Develop action plan.
   e) Ask groups to conduct their fishbone analysis or problem tree on flip chart paper (be sure to provide groups with flipchart paper and markers) & post them on the wall when they are finished.
   f) Once flip charts have been posted, ask groups to take a gallery walk to learn from the work of the other teams.
   g) Conduct a plenary discussion based on the following questions:
      - What were the benefits in analyzing the problem using your tool? Challenges?
      - What did your group learn from this exercise?
      - How would you apply this tool in your own program?
   h) Refer participants to Handout 10.1 which they may wish to adapt for use with their own teams as it provides a case study and detailed information regarding the ways to conduct problem identification and analysis.

3. Discussion – Review of different QI Approaches - 20 min.
   **Procedure:**

   Utilizing the slides (#36-46) to provide visual support, facilitate a discussion of the different approaches to QI (PDQ, COPE, etc.)
4. In-country Discussion/ Presentation - 40 min.

Procedure:

A representative from a local organization or the MOH who is working directly with Quality Improvement issues should provide a 20-30 minute discussion presenting their organization's approach to QI. The entire session should be interactive and the final 10-15 minutes should be dedicated to Q & A.
Facilitators Notes

Overview of QI
- Presentation of framework for elements of quality in FP
- Health facility assessments reflect these elements since their purpose is to provide data for quality improvement
- The commitment of leaders and managers is essential for creating a “culture of quality”.
- Importance of client-oriented and technically sound approaches - different approaches may be mixed
- Measurement against performance standards - as identified by whom - balance of technical standards and more client-oriented standards.
- Development of interventions to address different elements of quality

QI Approaches

External review / peer review
- Depends on people coming from “outside” to assess quality against standards
- May be done through supervision

Facility / Provider driven review
- Implies self review process, but may incorporate elements of the other approaches.
  - Continuous Quality Improvement (CQI) (Pathfinder)
    - Self evaluation leads to more commitment, ownership, and less judgment
    - Cyclical problem solving process
    - Characteristics – leadership / commitment, involves all staff, client oriented, variety of tools to assess different aspects

  - COPE Client-oriented Provider-efficient (Engender Health)
    - Self evaluation approach
    - Involvement of all staff in performance review
    - Cyclical approach - assessment - problem prioritization - action - evaluation
    - Set of tools for self review

Community / Provider Collaborative Review
- PDQ
  - Partnership Defined Quality - partnership between providers and community (both users and non-users) working together to identify and address priority problems.
• Recognition that quality may be defined from different perspectives (client / provider)
• Recognition that providers and clients can work together as allies to address problems – overcomes blame
• Process for identifying areas for improvement separately, bringing providers and community members together, and establishing QI teams to address problems and continue to identify new needs in cyclical review.
Key Messages:

- “Having a customer orientation is at the heart of quality management.” -- http://www.maqweb.org/magslides.shtml

- The more people are involved in their own quality improvement process, the more likely a culture of quality will be created with commitment to truly improving quality.

A quality family planning program carefully offers a mix of methods that it can consistently supply with proper counseling. Managers need to “examine the entire method mix, clients’ and other community members’ needs and perspectives and the capacity of the service delivery system to provide quality services prior to making decisions about contraceptive introduction.” http://www.who.int/reproductive-health/publications/rhr_02_11_contraceptive_introduction/making_decisions_contraceptive_introduction.pdf

- “New technologies must be introduced within a quality of care and reproductive health framework, and strategies for introduction should incorporate the perspectives of a broad range of stakeholders, including those of users and other community members, providers, program managers, policy-makers, and women’s and youth advocates.” http://www.who.int/reproductive-health/publications/rhr_02_11_contraceptive_introduction/making_decisions_contraceptive_introduction.pdf

- Perspectives on quality may be gender specific. Consideration of quality issues is not complete without also considering how gender influences the different elements of quality.
Session 10: Quality Improvement for Family Planning Programs

Basics of Community-Based FP Workshop
Session Objectives

By the end of the session, participants will have:

- Identified reasons for improving quality (QI) of FP programs
- Identified steps in the QI process
- Described different QI
What is Quality Improvement?
What is Quality Improvement?

Set of activities carried out to set standards and to monitor and improve performance so care is as effective and safe as possible.

Quality Assurance Project Monograph
Defining Quality

Doing the right thing, the right way, the first time and ....

...doing it better the next time using a minimum of resources and to the satisfaction of the community
Client Rights

- Information
- Access to services
- Informed choice
- Safety of services
- Privacy and confidentiality
- Dignity, comfort, expression of opinion
- Continuity of care

Source: Engender Health
What are some of the elements of Quality in FP?
Elements of Quality

- Choice of FP methods – variety and reliable supply
- Information given to clients
- Technical competence
- Interpersonal relations
- Infrastructure / Equipment
- Appropriate constellation of services
- Mechanisms to encourage continuity
- Effectiveness
- Efficiency

Source: Judith Bruce, MAQ, ADRA, QAP
4 Principles

• Meets patient and community expectations and needs
• Focuses on systems and processes
• Uses data to analyze service delivery processes
• Encourages team approach to problem solving and quality improvement.

Quality Assurance Project Monograph
Role of Managers in Supporting QI

- Establishing a culture of excellence
- Quality improvement as a priority
- Team approach
- Embracing change / innovations
General Principles of QI

• Self-evaluation leads to more commitment, less judgment, and more ownership
• Cyclical problem solving
• Characteristics
  – Leadership / commitment
  – Involves all staff
  – Client oriented
  – Variety of tools to assess different aspects
Quality Improvement Cycle

Identify Problem

Monitor & Evaluate

Develop action Plan

Analyze problem

Develop Solutions

Source: QAP
Step One- Problem Identification

• What is the problem?
• How do you know that it is a problem?
• How frequently does it occur, or how long has it existed?
• What are the effects of this problem?
• How will we know when it is resolved?
Step #2 – Problem Analysis

-- Who is involved or affected?
-- Where – When – Why does the problem occur?
-- What happens when the problem occurs?

= Root Cause Analysis
   --Identify root cause(s)
   --Analyze root cause(s)
   --Prioritize root cause(s)
QI Step #3
Root Cause Analysis

• Correctly identify the cause of the problem

• Process of identifying, analyzing, and prioritizing cause(s) is Root Cause Analysis

• To solve a problem, the chosen solution must address the root cause
  – Do not be distracted by peripheral causes! They will be solved when you solve the root cause.
  – Investing resources in solving a cause other than the root cause will prolong the problem.
Tools for Root Cause Analysis

- Fishbone Diagram
  - Visual representation of causes that feed into identified problem
  - Systematic brainstorming process
  - Digs deeper into source of problem to uncover the root cause

- Other tools include
  - Flowchart
  - Process Map
  - Moment of Truth Analysis
  - Client Flow Chart
Fishbone Diagram

- Policies
- Procedures
- People
- Materials/Equipment

PROBLEM
Policies

- Insufficient staffing
- Nurse over-worked
- Inadequate training
- Nurse inexperienced
- Inadequate staffing
- No refresher trainings
- No training in counseling
- Clinical capacity limited

Procedures

- Midwife not allowed to dispense certain methods
- Inadequate training
- Job dissatisfaction
- High turnover
- Infrequent clinic protocol
- Unfamiliarity w/ HMIS
- Inaccurate forecasting
- No transport
- Delayed ordering
- Inadequate training

Materials/Equipment

- Long waiting time in FP clinic
- Stock-outs
- Cumbersome HMIS
- Inadequate training
- Clinical capacity limited
- No staff trained in LT methods
- Insufficient staffing
- High turnover
- High client load
- No refresher trainings
- Inadequate training
- Delays
People

- Nurse over-worked
- Insufficient staffing
  - Nurse inexperience
- Nurse over-worked
  - High turnover
- Insufficient staffing
  - No refresher trainings
  - No training in counseling
- Clinical capacity limited

Procedures

- Midwife not allowed to dispense certain methods
- Inadequate training
- Job dissatisfaction
- High turnover
- Insufficient staffing
- No staff trained in LT methods
- Clinical capacity limited
- Unfamiliar clinical protocol
- Infrequent clinic hours
- High client load
- High turnover

Materials/Equipment

- Inadequate training
- Unfamiliarity w/ HMIS
- Cumbersome HMIS
- Delayed ordering
- Inadequate training
- Inaccurate forecasting
- Stock-outs
- No transport
- No counseling training

Long waiting time in FP clinic
Step 3: Develop Solutions

Changes, interventions, or solutions that will reduce the problem and thus improve the quality of care

As a team, define criteria for selecting solutions,

Is the solution:
- affordable?
- free from negative effect on other on-going activities?
- feasible to implement?
- efficient?

Does the solution have:
• management/community support for its implementation?
• a time frame for its implementation?

Select solutions based on the criteria

Tools: Brainstorming, Forcefield analysis, Benchmarking

Test solutions – will the proposed solution solve the problem? Or does the proposed solution yield expected results?
--No change --------start over
--Minimal change --------modify and test again
--Expected results--------begin implementation
Step 4: Develop Action Plan

• List the detailed activities that need to be implemented

• Identify the resources human, financial and other that are required to implement the solutions

• Set a timeline for implementing activities

• What is to be done? Who is to do it? How it is to be done? (management of change) How it will be monitored? When will the activity be completed?
Step 5: Implement activities

- Implement activities according to the action plan
Step 6: Monitor and evaluate

Monitor activities that are being implemented to address the problem

- Are activities being implemented as planned?
- Are activities producing results?
- What more needs to be done to achieve results?
- Who else need to be engaged to achieve results?
Who is involved in the QI process?

- Team composition
- How long will the team function?
- Will composition change over time?

The team should consist of people who are:
  - Affected by the problem.
  - Involved in the process in which the problem exists.
  - Can influence problem solving.
  - Have expertise in the process in which the problem exists.
QI team

• Client Perspective
  – Broad range of factors
  – Emphasis often on social and interpersonal elements
  – Expect service to get better, but may not appreciate technical details unless oriented
  – Users and non-users

• Technical Perspective
  – Review care against professionally accepted / defined standards of care
  – Do no harm
• What are some of the tools you have used to improve quality in your own programs?
QI Tools & Approaches

- **Quick Investigation of Quality (QIQ)**
  - External review with inputs for improvement
  - Old peer review approach

- **Service Provision Assessment (SPA)**

- **Client Oriented Provider Efficient (COPE)**
  - Staff and clients cyclically involved in identifying and addressing problems

- **Partner Defined Quality (PDQ)**
  - Community members work with providers to identify and address problems
Essential Elements for the Institutionalization of QA

• **Internal enabling environment:**
  – Policy
  – Leadership
  – Core values
  – Resources

• **Organizing for quality (structure)**

• **Support functions:**
  – Capacity building
  – Communications
  – Rewarding quality
Challenges with QI

- Poor leadership: lack of skills in QI
- Lack of commitment to QI process
- Limited understanding of QOC issues
- Donor dependency
- Provider
Health Facilities Assessments and QI

- HFA components designed to investigate elements of quality

<table>
<thead>
<tr>
<th>HFA Component</th>
<th>QI Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infrastructure &amp; Supplies</td>
<td>Inventory and infrastructure assessment</td>
</tr>
<tr>
<td>Management System</td>
<td>Management interviews</td>
</tr>
<tr>
<td>Client Perspective</td>
<td>Exit interviews</td>
</tr>
<tr>
<td>Provider Perspective</td>
<td>Provider interviews</td>
</tr>
<tr>
<td>Technical Competence</td>
<td>Observations</td>
</tr>
</tbody>
</table>
Quick Investigation of Quality (QIQ)

• Facility audit
• Observation of client-provider interaction
• Client exit interview
Service Provision Assessments (SPA)

- Community Questionnaire
- Facility Inventory Questionnaire
- Health Worker Questionnaire
- New FP Client Consultation Protocol (Observation)
- FP Client Exit Interview Questionnaire
  - May add:
- STI Client Consultation Protocol
- STI Client Exit interview Questionnaire
Service Provision Assessments (SPA)

- Sick-Child Consultation Protocol
- Sick-Child Visit Exit Interview Questionnaire
- Antenatal Care Consultation Protocol
- Antenatal Care Client Exit Interview Questionnaire
Problem statements
1. Frequent shortage of contraceptive methods
2. Women come for immunization and child wellness visits but do not attend FP clinic
3. Young people are not using the FP clinic yet many young girls are admitted for PAC
4. Clients are not using LAPMs
Group Work

• Define the problem.
• Choose the appropriate team to work on the problem.
• Analyze the problem using the fishbone analysis or problem tree and choose the main root causes.
• Develop solutions and decide on the priority ones to act on.
• Develop action plan.
PDQ: Partnership Approach to QI

• Partnership Defined Quality – PDQ is a methodology to improve quality and accessibility of services with greater involvement of the community in defining, implementing and monitoring the quality improvement process.

• Providers and community members working together to identify and address priority problems.

• Recognition that quality may be defined from different perspectives (client / provider)

• Recognition that providers and clients can work together as allies to address problems – overcomes blame

• Process for identifying problems separately, bringing providers and community members together, and establishing QI teams of providers and community members to address problems and continue to identify new ones in cyclical review.
Use of PDQ?

Why Use PDQ?
- Enhances QI process by looking for answers outside health system.
- Focuses on health issues that most affect community.
- Engages both clients and non-clients
- Empowers community and providers
- Gains commitment for community resources
- Enhances equitable use of services.

When to Use PDQ?
- When action is needed - not just information sharing
- When stakeholders - both providers and community want change
- When there is a willingness to listen and change how things are done locally
Features & Value Added of PDQ

◆ PDQ can be a complementary strategy to other QI
◆ Creation of quality improvement partnerships
◆ Emphasis on mutual responsibility for problem identification and problem solving

Beyond QI, PDQ:
◆ Helps eliminate social and cultural barriers to better health
◆ Strengthens community’s capacity to improve health
◆ Creates mechanism for rapid mobilization around health priorities
PDQ Process

Building Support

Community Defined Quality

Health Worker Defined Quality

Bridging the Gap

Working in Partnership for Quality Improvement

Increase communities’ sense of ownership of health facility

Improve provider job satisfaction

Shared rights and responsibilities for better health outcomes

Better Health

Improve client satisfaction

Increase community capacity for social change

Better Health Improvement

Increase client satisfaction
The QIT is comprised of providers and community members working together to determine causes, solutions and create a joint plan of action.
Rationale

- Centralized QI effort based on national standards had not reached peripheral facilities
- Low utilization rates even after 6 years of health service strengthening
- Need to reach the minority groups and other non-users of the Health Facilities
- Despite training and QI efforts, improvements were not sustained at the local health posts
Assessing Facility Functioning:
- Presence of all Health workers throughout clinic hours
- Proper disposal of biohazard waste
- Observance of queue in patient consultations (except during emergencies)
- Sterilization of syringes

Health care quality improvement: Clinic Management

<table>
<thead>
<tr>
<th>Percentage</th>
<th>0</th>
<th>25</th>
<th>50</th>
<th>75</th>
<th>100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-time presence of health worker</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>p=0.056</td>
</tr>
<tr>
<td>Proper disposal of biohazard waste</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>p&lt;0.005</td>
</tr>
<tr>
<td>Observance of queue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>p=0.538</td>
</tr>
<tr>
<td>Syringes sterilized</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>p=0.019</td>
</tr>
</tbody>
</table>

Legend:
- PDQ Preintervention
- PDQ Postintervention
- Control Preintervention
- Control Postintervention
PDQ: Challenges

- Time commitment
- Maintaining political will and process
- Gaining true community representation and participation at all levels
- Finding partners/facilitators for roll-out
- Testing at higher levels (district team responsiveness to facilities?)
COPE: Facility-Based approach to QI

- Self-evaluation approach
- Involvement of all staff in performance review
- Cyclical approach
  - Assessment – Problem prioritization – Action – Evaluation
- Set of tools for self review
Figure 1-2. COPE at a Glance

**Self-Assessment Guides**

**Self-assessment teams:**
- Schedule meeting and pick a team member to present Team Action Plan
- Meet to review self-assessment questions
- Conduct self-assessment and record review
- Prepare Team Action Plan: identify problems and root causes, recommend actions, assign responsibility for actions, and establish completion dates

**Introductory Meeting**

**Facilitator:**
- Describes quality in real terms
- Explains COPE components

**Facilitator and all participants:**
- Form teams
- Assess progress on previous action plans (if a follow-up exercise)

**Client Interviews**

**Interview team:**
- Meets with facilitator to review interview instructions and obtain interview guide
- Conducts interviews
- Prepares Team Action Plan: identifies problems and root causes, recommends actions, assigns responsibility for actions, and establishes completion dates
- Picks a team member to present Team Action Plan

**Client-Flow Analysis (CFA) (for follow-up exercises)**

**All participants:**
- Meet with facilitator to review CFA instructions
- Establish entry points
- Assign team members to distribute Client Register Forms at entrances, collect Client Register Forms before clients leave, and present findings at the Action Plan Meeting
- Number Client Register Forms
- Track client flow
- Prepare summary sheets, charts, and graphs
- Analyze client flow and staff utilization
- Meet to prepare Team Action Plan: identify problems and root causes, recommend actions, assign responsibility for actions, and establish completion dates

**Action Plan Meeting**

**Facilitator and all participants:**
- Discuss strengths
- Discuss Team Action Plans: problems, root causes, and recommendations
- Consolidate and prioritize problems
- Develop facility Action Plan with problems, root causes, recommended actions, staff responsible for actions, and completion dates
- Form COPE Committee
- Schedule follow-up

**Site Preparation**

**Facilitator:**
- Orient key managers
- Selects and orients site facilitator
- Prepares materials and room
- Selects participants

**Follow-up**
COPE – Lessons Learned

- Requires input from managers, staff and clients
- Creates forum for open discussion and problem solving
- Expands managers role to implement solutions
- Requires some financial inputs
- An on-going process
Welcome to the Santa Rosa Health Center

Introduction
The Santa Rosa Health Center is a publicly funded clinic that serves a community of 15,000. The staff is made up of: a director, a doctor, a nurse, a health assistant, a pharmacist, an accountant, one laboratory technician, one secretary, and several cleaning staff. All services are provided on an outpatient basis. The most common illnesses for which the population visits the center for treatment include malaria, respiratory infections, diarrhea, parasitosis, and skin problems. Services provided by the clinic include: laboratory services, family planning, primary health care, immunization, preventative maternal and child health activities, dentistry, and the pharmacy.

Improving Quality of Services to Attract More Clients
Mrs. Alvarez, the Health Center Director, recently attended a training program on quality improvement at the Health Ministry in the capital. She was invited to the training program because the MOH staff had noticed that while the Santa Rosa Health Center was busy, it was reaching only a small proportion of the eligible clients in the catchment area. For example, coverage for prenatal care and immunization was below 80%.

Mrs. Alvarez is interested in using some of the new techniques she learned in the quality improvement training to try to determine why her clinic has been reaching such a small proportion of its eligible clients. She decides to carry out a quality improvement process with the participation of a team drawn from the health center staff and users. The objective of the process will be to improve the quality of the services offered. In carrying out the exercise, the team will first identify the primary reason why users are not using the services. They will then establish the causes for the problem and define a strategy and a plan of action for solving it. Mrs. Alvarez expects this quality improvement process to take six months.

Quality Improvement Steps
The steps of the quality improvement process are listed below. Groups will work with the steps in bold, but all steps are important in the process.

- establishing a quality improvement team
- creating the vision and mission statements
- developing a strategic plan
- identifying the problem
- describing the problem
- analyzing the problem
- planning the solution
- implementing the solution
- monitoring and evaluating the solution
Group 1 - Identifying the Problem

Determine Users' Needs

Mrs. Alvarez decides to analyze why health services are not being utilized, despite the fact that other health centers are located farther away from the community than this one. She discusses her idea with the team, and they realize that there are two ways of identifying the problems according to the users: a consensual process, such as brainstorming or a prioritization matrix, or a data-gathering process, such as a user survey. The team decides to use both processes by utilizing three different tools to understand why people have not been using the health center's services. These three tools are:

- Brainstorming
- Prioritization Matrix
- User Survey

Each team member agrees to participate in exercises using these tools after thinking through how these tools help to understand the users' needs and how the users' needs define quality.

Brainstorming To Identify Problems

As a first step in identifying the problems that are affecting the quality of the services offered through the health center, the team conducts brainstorming with users chosen randomly in the health center. Mr. Diaz is in charge of the brainstorming session.

After grouping about 10 users in a room together with the team, Mr. Diaz asks them the following question: "In your opinion, what are the problems of quality that the health center is facing?" He asks them to take a few minutes to think to themselves about this issue, and assures them that there are no right or wrong answers.

Next, each participant states his or her ideas, one at a time, and Mr. Diaz writes the ideas on a large pad of newsprint so everyone can see the ideas. The participants add to the list when new ideas come to mind during the discussion. Mr. Diaz groups all the ideas together, and asks the group to clarify ones that are not clear. After the list of ideas is finished, the group discusses the ideas together. Mr. Diaz leads them to consensus on which ideas to keep and which to eliminate.

The result of the brainstorming session is a final list of the problems that are reducing the quality of the health center services. The problems identified by the users are:

- no appointments in the afternoon
- delays in registration
- incomplete laboratory
- insufficient care in dentistry
- not enough doctors
- not enough material for labs
- broken-down ambulance
- segregation of patients
- long waiting time
- patients feel that they are not treated with respect

This list is circulated to all staff to educate them on the work of the team members and the challenges facing the clinic to improve the quality of services.
**Brainstorming**

**What is it?**
Brainstorming is a lively technique that helps a group generate as many ideas as possible in a short time period.

**Who uses it?**
The team members, the management, or the users can all participate in brainstorming. If you invite people with different perspectives to brainstorm, you are more likely to see innovative ideas generated by the group.

**Why use it?**
To identify problems, analyze causes, select alternative solutions, do strategic planning, generate ideas for marketing change, and handle many other situations.

**When to use it?**
In the facility, with community or user groups, in meetings.

**How to use it:**

1. **Explain the objective of the session:** for example, to select problems, analyze causes, or generate ideas.
2. **Explain the technique** to the group. Tell them that you are looking for a lot of ideas, and that you want their thoughts and ideas to flow freely. There is no right or wrong answer. The idea of brainstorming is to produce as many innovative ideas as possible.

   In countries where participation in meetings is structured, brainstorming takes practice. (If you set up a brainstorming session in which many participants have no real experience in expressing their opinions and many levels of staff are present, it can produce a deafening silence.)

3. **Silent reflection:** Ask the participants to think about the proposed objective or topic for a few minutes. Time: approximately 5 minutes.
4. **Brainstorm:** The participants call out their ideas and add those that come to mind during the discussion. Annotate them on a flip chart in the order they are mentioned. Write down the ideas using the words of the speaker. Ask for clarification only if the meaning is not clear. Time: approximately 20 minutes.
   *(For groups with little or no experience in brainstorming, it is often useful to have them practice in small subgroups before convening before the entire group.)*
5. Once the list is finished, **discuss** it with the group to:
   - Clarify the meaning of some ideas
   - Combine similar ideas that are worded in different ways
   - Eliminate those ideas which are not related to the objective of the session

6. **Do all this by group consensus.** Time: 5-15 minutes. At the end of this stage, you will have reduced the list of ideas to those that represent most of the major ideas of the group.
**Prioritization Matrix**

**What is it?**
A Prioritization Matrix is a useful technique you can use with your team members or with your users to achieve consensus about an issue. The Matrix helps you rank problems or issues (usually generated through brainstorming) by a particular criterion that is important to your organization. Then you can more clearly see which problems are the most important to work on solving first.

**Who uses it?**
Members of your team, or a group of users, can participate in the process.

**Why use it?**
To determine what your users or your team members consider to be the most pressing problem with your program or health service.

**When to use it?**
When you need to prioritize problems, or to achieve consensus about an issue.

**How to use it:**

1. Brainstorm--Conduct a brainstorming session on problems users or team members have with your program or service. Go to the Brainstorming tool to learn how to conduct a group brainstorming session.
2. Fill out the Prioritization Matrix chart with the group:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Frequency</th>
<th>Importance</th>
<th>Feasibility</th>
<th>Total Points</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. In the first column, write down the problems that were mentioned in the brainstorming session.
4. In the second to fourth columns, define your criteria. Examples of some typical criteria are:
   - Frequency: How frequent is the problem? Does it occur often or only on rare occasions?
   - Importance: From the point of view of the users, what are the most important problems? What are the problems that you want to resolve?
   - Feasibility: How realistic is it that we can resolve the problem? Will it be easy or difficult?

You can choose other criteria if they better fit the situation you are discussing. For example, for a more quantitative comparison, you could use cost, amount of time, or other numerical indicators as the criteria.

5. Rank/Vote--Each participant now votes three times for each criteria. Each participant votes nine times in total.
6. Total all the votes together. The totals help you see clearly how to prioritize the problems.
User Survey

A survey tool has not been included; however, please refer to the Flexible Fund Survey Questionnaire for an example.
Group 2 - Describing the Problem

Using a Flowchart

The quality improvement team reviews the data they have collected from the users to identify the problem. There are many issues that affect the users, yet through the brainstorming, prioritization matrix, and user survey, one major problem is revealed. Users wait too long when they come to the health center for services. Since they feel that they waste time by waiting too long, most of them decide to use the health center services less regularly, or not at all.

Mrs. Alvarez encourages the team to solve this problem. Thinking back on her training, she remembers that the second step in solving a problem is to fully describe the problem to understand its causes and roots.

Many tools can be used to help the team describe the problem. Tools that the team will use include:

- flowchart
- moment of truth analysis
- client flow analysis
- indicator matrix
- table
- bar graph
- line graph
- histogram
- pie chart

Note: It is important to keep in mind that any direct observation must be thoroughly reviewed with the staff in the clinic beforehand. Inevitably however, people will feel as if they are under a microscope. The results are better received if the clinical personnel feel that they are not being singled out.

The team decides to use a flowchart to analyze the process the users go through in using the health center's services, and to visualize when the waiting time occurs.

The team decides to observe the process of a user who comes to get health care from the health center. They will observe the user from his or her arrival in the center to his or her departure. Through a direct observation technique, they observe all the steps taken by the users in the health center.

The team draws the process that users follow from their arrival at the health center to their departure by putting each activity in a rectangle and each decision point in a diamond, and connecting all these rectangles and diamonds in order. The flow chart allows the team to replicate the steps each patient goes through.

The flow chart allows the manager and the team to visualize the process as it actually occurs in their health center and helps them to understand where and when they should make changes to reduce the users' waiting time. Later on, the team will conduct a Client Flow Analysis so they can obtain more detailed information about the amount of time users spend with each provider in the health center.

*****
Moment of Truth Analysis

What is it?
Moment of Truth Analysis is a technique that helps you graphically map out all of the contacts, or "moments of truth," that a user has with the organization, and analyze the type and quality of these contacts.

Who uses it?
The managers and the team members, with the participation of other staff.

Why use it?
Moment of Truth Analysis will help you systematically analyze all contacts that a user has with your organization. In this way, you can find processes and procedures that need improvement.

How to use it:

1. Invite all clinicians and support staff to help determine the specific situation you will analyze. Involvement of staff may reduce tension that can arise during this activity. You may also want to include users in this process. Examples of specific situations are: a female user comes in for birth control or a mother comes in with her sick child for care.
2. Together, create a list or diagram (flowchart) of the contacts that users have with the organization. For example, what contact do users have before they come to the organization? When they first walk in the door? Who do they see next? And so on.
3. Using the True Cases Map (see illustration below), fill in the information you have gathered from your list or diagram.

Example of True Cases Map:

<table>
<thead>
<tr>
<th>User Contacts with Organization</th>
<th>Current Situation</th>
<th>Desired Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>sees outside of health center</td>
<td>peeling paint</td>
<td>professional-looking facility</td>
</tr>
<tr>
<td>enters reception area</td>
<td>acceptable</td>
<td>acceptable</td>
</tr>
<tr>
<td>speaks with receptionist</td>
<td>busy, unfriendly</td>
<td>friendly, welcoming</td>
</tr>
<tr>
<td>waits for nurse</td>
<td>often a long wait</td>
<td>a brief wait</td>
</tr>
<tr>
<td>visits with nurse</td>
<td>nurse is often busy and tired</td>
<td>helpful and friendly visit</td>
</tr>
</tbody>
</table>

4. Analyze the current situation and determine what the desired situation is. If you have users working with you, ask them what they would like, or ask yourself: "If I were the user, what would I like?"
Group 3 – Analyzing the Problem

Cause and Effect Diagram

Now that the team has identified and described the problem of waiting time in the health center, the next step is to analyze the problem. Analyzing the problem has two steps: first, analyzing the causes of the problem, and second, choosing the most important causes to solve.

To analyze the causes of the problem, the team decides to use a Cause-and-Effect Diagram. To choose the most important causes, the team will use a Pareto Analysis.

A Cause-and-Effect Diagram is useful in examining the factors that have contributed to the problem. To develop the Cause-and-Effect Diagram, Mrs. Alvarez and the team have to go through four steps, namely:

1. identify the problem's characteristics
2. brainstorm the reasons why the problem is occurring using a Causal Table (also known as the Why-Because Technique)
3. group the causes by relationship using an Affinity Technique
4. create a Cause-and-Effect Diagram

Step 1: Identifying the Problem's Characteristics

First, to define the problem more precisely, Mrs. Alvarez poses several questions to the team. These questions revolve around identifying some of the specific characteristics of the problem, identifying the people who are affected by this problem, and pinpointing when the problem occurs. The team refers to the Client Flow Analysis and to other information they gathered while they were describing the problem to answer these questions.

Identifying Problem Cause and Effect

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is this problem about?</td>
<td>Delay in attending to users.</td>
</tr>
<tr>
<td>2. Who is affected by this problem?</td>
<td>One-fourth (25%) of patients wait more than 90 minutes for care.</td>
</tr>
<tr>
<td>3. When does this problem occur?</td>
<td>Waiting time increases beginning midmorning on Mondays and Fridays.</td>
</tr>
<tr>
<td>4. Where does it occur?</td>
<td>In the health center, mainly at the registration desk, in the doctor's waiting room, and in the laboratory.</td>
</tr>
</tbody>
</table>
**Cause-and-Effect Diagram**

**What is it?**
A Cause-and-Effect Diagram (also known as a "Fishbone Diagram") is a graphical technique for grouping people's ideas about the causes of a problem.

**Who uses it?**
The team, the users, the manager.

**Why use it?**
Using a Cause-and-Effect Diagram forces the team to consider the complexity of the problem and to take an objective look at all the contributing factors. It helps the team to determine both the primary and the secondary causes of a problem and is helpful for organizing the ideas generated from a brainstorming session.

**When to use it?**
It is used after the causes have been grouped by relationships (for example, by using a Causal Table or "Why-Because" Technique). It is a useful diagram for problem analysis. Therefore, a Cause-and-Effect Diagram should be used before deciding how to deal with the problem.

**How to use it:**
Before constructing the Cause-and-Effect Diagram, you need to analyze the causes. The steps are as follows:

1. Re-examine the problem by asking:
   - What is the problem?
   - Who is affected?
   - When does it occur?
   - Where does it occur?

2. Brainstorm the team's ideas about the causes of a problem using the Causal Table or "Why-Because" Technique.

3. The list of causes should be grouped by relationships or common factors using an affinity technique.

4. You can now illustrate graphically the causes grouped by relationships by using a Cause-and-Effect Diagram where:
   - The problem under investigation is described in a box at the head of the diagram.
   - A long spine with an arrow pointing towards the head forms the backbone of the "fish." The direction of the arrow indicates that the items that feed into the spine might cause the problem described in the head.
   - A few large bones feed into the spine. These large bones represent the main categories of potential causes of the problem. Again, the arrows represent the direction of the action; the items on the larger bones are thought to cause the problem in the head.
   - The smaller bones represent deeper causes of the larger bones they are attached to. Each bone is a link in a Cause-and-Effect chain that leads from the deepest causes to the targeted problem.
Affinity Technique

What is it?
The Affinity Technique is a consensus-building technique that you can use with your team to systematize brainstorming and involve community members and staff.

Who uses it?
The team, the manager, and the users can use this technique.

Why use it?
This technique allows the team to quickly create and organize a large number of ideas, with minimal conflict or power struggle. It is also used to involve the community in quality improvement issues.

When to use it?
To explore the mission of the institution, to analyze the causes of a problem, or to generate indicators.

How to use it:
Form groups of five to eight participants.

1. First phase: individual work
   - The facilitator asks the group a specific question.
   - Instruct each participant to write their ideas on four or five cards.
   - Each card should have only one idea containing five to seven words.

2. Second Phase: ordering of cards
   - The cards are posted on the wall, and the ideas are reordered in groups, by "affinity" (category). Each person can move any cards to group them into a category, until all participants agree about the grouping of ideas.

3. Third Phase: group consensus.
   - When the cards are not being moved anymore, the facilitator and the group should try to summarize the central idea of each group of cards into one simple and short phrase. If the summary is longer than one phrase, it is probable that the groupings are too broad. Try to split the groupings into smaller categories.
   - After summarizing each group of ideas, the facilitator can put the central ideas in sequence to form a series of phrases, to answer the main question.

Pareto Analysis

The Pareto Principle states that a problem can be solved by focusing on solving the most frequently occurring causes. Usually, there are four to six causes that lead to 80% of the problems. These are called the "vital few" causes.

Step 2: Ranking Causes

To identify the "vital few" causes, the team ranks the causes based on the frequencies they found in their survey. Mrs. Alvarez helps the team calculate the cumulative percentage (each percentage added to the one before it) so they can build a pareto graph.

The team constructs a chart with the cause, percentage, and cumulative percentage:
<table>
<thead>
<tr>
<th>Cause</th>
<th>Percentage</th>
<th>Cumulative Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic personnel don't follow the schedule</td>
<td>16%</td>
<td>16%</td>
</tr>
<tr>
<td>Delay in handing over lab results to doctors</td>
<td>14%</td>
<td>30%</td>
</tr>
<tr>
<td>Inadequate schedules</td>
<td>13%</td>
<td>43%</td>
</tr>
<tr>
<td>Outdated methods</td>
<td>12%</td>
<td>55%</td>
</tr>
<tr>
<td>Procedures take too long</td>
<td>11%</td>
<td>66%</td>
</tr>
<tr>
<td>Lack of automation</td>
<td>9%</td>
<td>75%</td>
</tr>
<tr>
<td>Clinic personnel lack punctuality</td>
<td>6%</td>
<td>81%</td>
</tr>
</tbody>
</table>

Making the chart brings a lot of tension out into the open. Mrs. Alvarez decides to stop here and use some of the Team Building Tools to alleviate the stress arising between the quality team and the staff, as well as within the quality team itself.

**Step 3: Pareto Graph**

Now the team is ready to draw the pareto graph. They draw a horizontal axis (x) that represents the different causes, ordered from the most to least frequent. Next, they draw a vertical axis (y) with percentages from 0 to 100%.

Now, they construct a bar graph based on the percentage of each cause. They construct a line graph of the cumulative percent. Finally, they draw a line from 80% on the y-axis to the line graph, and then drop the line down to the x-axis. This line separates the important causes from the trivial ones.

Now it is easy to see that approximately six factors are responsible for 80% of the waiting time problem. The other 14 factors are responsible for only 20%. Mrs. Alvarez decides to focus her attention on the most important (most frequently occurring) causes and begins working toward choosing the interventions that will be effective and cost-effective at solving this problem.
Group 4 - Planning the solution

**Force Field Analysis**

Now that the team has identified the most important causes for the waiting time problem, they begin to work on identifying and selecting appropriate interventions to resolve them. The team will now function as a task force to develop strategies and possible solutions.

The team will use the following tools to plan the solution:

- force field analysis
- generating alternative solutions (benchmarking)
- viability analysis
- program matrix

Mrs. Alvarez focuses the team first on the single most important cause of the waiting time problem, which seems to be the fact that the health center's schedule is not followed. Other related causes include poorly planned schedules and lack of staff punctuality. Mrs. Alvarez is confident that if the team solves these scheduling issues, the waiting time problem will be well on its way to being solved.

So all clinic personnel can be present, the task force schedules the exercise for when the clinic is not open. The team decides that to develop a plan of action to solve the problem of staff not following the schedule, they will use the same strategic planning process they used earlier in the quality improvement process when they were defining a strategic plan to fulfill the mission statement.

Mrs. Alvarez reminds the team to keep in mind that the ultimate goal is to decrease the waiting time of the users. She also reminds them that each vital cause will become a specific expected result of the interventions they decide to carry out. The first specific result they should expect to achieve, then, is: adherence to the schedule by the personnel. All of the forces in the table that follows will drive or resist the achievement of this result.

To begin the force field analysis, the team starts with a brainstorming session to determine the different forces that promote or hinder staff adherence to the schedule. Nurse Cruz draws two different columns on newsprint, one for the driving forces (the factors that promote adherence to the schedule), and the other for restraining forces (the factors that hinder adherence to the schedule). As the brainstorm continues, Nurse Cruz puts the ideas in the appropriate column.

<table>
<thead>
<tr>
<th>Driving Forces</th>
<th>Restraining Forces</th>
</tr>
</thead>
<tbody>
<tr>
<td>The law permits attendance control</td>
<td>Personnel have another job</td>
</tr>
<tr>
<td>Motivated personnel</td>
<td>Resistance to change</td>
</tr>
<tr>
<td>High felt need of the users</td>
<td>Personnel cannot be forced</td>
</tr>
<tr>
<td>Competition from the private sector</td>
<td>Users are used to waiting</td>
</tr>
<tr>
<td>Community participation</td>
<td>Organizational philosophy</td>
</tr>
<tr>
<td>Fear of privatization</td>
<td>Lack of budget</td>
</tr>
</tbody>
</table>
Pride in doing a good job | Government-mandated work hour limits
---|---
Incentive to do a good job | Low wages
| No data on attendance

**Benchmarking**

Keeping the driving and restraining forces in mind, Mrs. Alvarez conducts a *brainstorming* session with the group and generates the following alternative solutions for solving the problem of the staff's lack of adherence to the schedule:

- **Attendance control**: use a time clock to ensure adherence to the schedule.
- **Flexible schedule**: ask the personnel to work eight hours daily on a flexible schedule, developed according to their scheduling needs as well as taking into account the users' needs.
- **Motivation**: motivate the personnel through incentives (such as trips), more training, and better resolution of problems, so that they will feel motivated to follow the schedule.

Before going any further, Mrs. Alvarez decides to seek some outside help. The Santa Rosa Health Center is not the only one in the country: there are other health centers situated in the same kind of area, with the same type of users, and of the same size and offering similar services. At this point in the planning process, it seems logical to find out what another similar health center is doing to solve this problem, using benchmarking.

Mrs. Alvarez decides to contact Health Center Y about some of their scheduling problems and how they solved them. She creates a list of questions that she wants to ask:

- Have you had a problem with user waiting time due to staff not following the schedule?
- How did you face the problem?
- Do you think that a flexible schedule can be helpful to solve the problem?
- What other solutions have you used?
- How do you motivate your staff to arrive on time?

Mrs. Alvarez set up a meeting with Health Center Y and asked the questions to the staff there. She learned a great deal from the Health Center Y staff about how to solve the scheduling problems.

Upon her return, Mrs. Alvarez presented her findings to the team:

- The benchmark health center set up an employee task force to figure out ways to increase staff satisfaction with their work.
- The task force came up with many different solutions, such as: more flexible schedules, more employee control over processes and procedures, salary increases based on merit, increased opportunities for training, and longer breaks.
- To motivate the staff to follow the schedule, the benchmark health center administration agreed to let staff have more flexible schedules, but in exchange, staff were required to follow the arranged
schedule and were disciplined if they arrived late more than once per month, or if they did not follow their schedule.

- The administration is also considering some of the other solutions posed by the task force.

The team is pleased with these new ideas. They like the idea of an employee task force. They decide to include some of the ideas from the benchmark health center along with the ideas they generated themselves previously.

**Benchmarking**

**What is it?**

Benchmarking is a technique in which you compare the processes of one organization with those of similar organizations to study ways to improve those processes.

**Who uses it?**

The team and the managers. It is important to include in the team someone who has expertise in the process you are comparing.

**Why use it?**

To develop new ideas about how to modify and improve the selected process.

**When to use it?**

For analyzing strategies to improve a process.

**How to use it:**

1. **Select another organization to use as a "benchmark."**
   Identify an organization that provides similar health services (ideally, a noncompetitor) or that is a leader in the process and is also willing to share information with you.

2. **Contact the benchmark organization** to explain the purpose of your proposed visit, gain their support for the visit, and to set a date.

3. **Make a site visit to collect data:**
   - Determine in advance the kind of information you want.
   - Send a list of questions to your benchmark contact so that he or she can prepare for your visit.
   - Agree on an agenda for the visit.
   - Arrange a meeting, tour the benchmark organization, and obtain answers to your questions.
   - Ask about the organization's future plans for the process you are investigating.
   - Be prepared to share comparable information about your own organization.

4. **Determine any important differences** between the process used by your organization and the process used by the benchmark organization.

5. **Present your findings to the team,** set new goals, and use the results to propose improvements in the process.

**Viability Analysis**

Mrs. Alvarez and the team (along with other clinic staff) then decide to review the possible alternatives they have generated to determine their viability, given the political and economic context of the health center and the community. In analyzing the viability of the solutions suggested, the team uses three criteria:
1. **Effectiveness**: fulfillment of the mission of the health center
2. **Cost**: cost-effective in terms of both the investment and the recurring costs
3. **Technical feasibility**: ease of implementation

The team is now comfortable with voting to rank solutions and readily applies the process. Using a prioritization matrix or table, Mrs. Alvarez and the team rank the solutions by attributing to them a value from three (highest) to one (lowest). The solution that has the highest total number of points will be the most viable solution with which to begin.
## Handout 10.2  DIFFERENT APPROACHES TO QUALITY IMPROVEMENT

<table>
<thead>
<tr>
<th>Source of Quality standards</th>
<th>Heath Facility Assessment Approach – e.g. QIQ, SPA</th>
<th>COPE – Client oriented but facility generated</th>
<th>PDQ – Provider / community collaboration for QI</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Identification of priority problems</th>
<th>Facility staff priorities based on a few developed assessment tools to identify problems.</th>
<th>Participant priorities based on root cause analysis and feasibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Many possible tools and statistical analyses to determine frequency, impact, and feasibility for identified problems</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Problem solving – who does it</th>
<th>QI team of facility staff representing all staff cadres</th>
<th>Facility and community (both user and non-user) representatives on QI team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usually staff external to the facility such as project or government, may be in collaboration with facility staff</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Improvement process</th>
<th>Depends on facility QI team with external support where needed. May come from implementing project.</th>
<th>Depends on facility / community QI team and advocates for external support where needed. May come from implementing project.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Often as a guide for project or government inputs. Improvements selected based on facility needs and capacity.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Duration</th>
<th>Associated with problem solving cycles</th>
<th>Associated with problem solving cycles</th>
</tr>
</thead>
<tbody>
<tr>
<td>May be associated with project implementation cycle. May be done at baseline and periodic evaluations or ongoing as part of supervision</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Role of clients</th>
<th>Should be interviewed as part of assessment and monitoring.</th>
<th>Integral to the problem identification and solution implementation process.</th>
</tr>
</thead>
<tbody>
<tr>
<td>May be interviewed as part of assessment tools.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Role of managers / supervision</th>
<th>May be involved as facilitators or catalysts, but primary implementation at facility level.</th>
<th>May be involved as facilitators or catalysts, but primary implementation at facility level.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involved with primary implementation of QI process</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tools</th>
<th>Largely qualitative tools for identifying and analyzing problems as identified by process participants. Community COPE and PDQ tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>QIQ tools. Other health facility assessment types of tools. May use some of a wide array of QI tools and statistical analyses, supervision checklists</td>
<td>COPE has specific constellation of tools assessing defined elements of quality.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Costs</th>
<th>Up front costs for community mobilization and QI team orientation. Ongoing costs for supervisory support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant up front costs for assessment, analysis, and inputs for QI. Is not an ongoing process.</td>
<td>Up front costs for orient facility team and to do initial assessment. Ongoing costs for supervisory support</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Potential Benefits</th>
<th>Transformed relationships between community members and their providers. Increased utilization due to increased involvement with their health services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carefully compiled problem list with statistical basis. Effective prioritization and use of project inputs for maximum impact.</td>
<td>Ongoing process for QI, with facility staff responsible for the quality of services they deliver. High level of ownership.</td>
</tr>
<tr>
<td>Relevance for CBD Program</td>
<td>Heath Facility Assessment Approach – e.g. QIQ, SPA</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Provides information on health facilities the CBD are referring clients to</td>
<td>Provides information on the health facilities the CBDs are referring clients to</td>
</tr>
</tbody>
</table>

Session 11: Family Planning Logistics
Session 11: Family Planning Logistics Management - Systems Strengthening

Achievement-based Objectives:
By the end of this session the participants will have:
• Identified ways in which they have been disappointed by the failure of logistics
• Experienced the frustration of a failed logistics system
• Participated in a simulation game to personalize the importance of logistics
• Assessed adherence to the 6 rights
• Described the logistics cycle.
• Identified key logistics issues to investigate/address within own program in Participant Action Plan

Duration: 1 hour, 45 minutes
Timeframe: Day 4
Seating Arrangement: Six tables with 5 participants each

Special Preparation:
- Place empty envelopes in approximately one-tenth of the chairs, spread randomly but evenly around the room.
- Label one fourth of the condoms and about one fifth of the pill packets with “Expires 06/01/07” labels. Place them in random amounts (up to twelve pieces) in envelopes. Place these envelopes randomly on chairs around the room, attempting even coverage.
- Open, cut, or mangle a small number of condoms and pills, and place a random amount in envelopes. Include some damaged and undamaged condoms in 2-3 envelopes. Place these envelopes randomly on chairs around the room, attempting even coverage.
- Place random amount of pills in envelopes, with at least one envelope containing three cycles, and one envelope containing six cycles. Place them randomly on chairs around the room, attempting even coverage.
- Count remaining chairs without envelopes, and make sure no chair has more than one envelope.
- Place random amount of condoms in envelopes, with at least two envelopes containing twelve pieces each, and ensuring sufficient number of envelopes to cover all remaining chairs.
- Securely tape all envelopes to bottom of chair seats so that they cannot be seen.

Materials:
- Contraceptive Insecurity Game
- Envelopes: One per participant
- Preprinted small labels “Expires 06/01/03”: Sufficient amount to label ¼ of all contraceptive supplies.
- Masking tape for attaching envelopes to bottom of chairs
- Condoms: Two times the number of participants (200 pieces for 100 participants)
- Pills (cycles): ¼ the number of participants (25 cycles for 100 participants)
1. Introduction - 10 minutes

Procedure:

a) Explain:  We have just spent the last session discussing what it takes to provide quality FP services and some of those elements of quality relate to logistics. When we talk about logistics we’re talking about: Delivering the right product, in the right quantity, in the right condition, to the right place, at the right time, for the right cost. – Logistics Objective for the DELIVER Project (show the previously prepared flip chart).

b) Continue: In your daily lives in what ways have you been disappointed by logistical problems (doesn’t have to be related to health or family planning). (Various answers). So we all realize that to have quality of care we also need to have smoothly functioning logistical systems. To get a better idea of the impact of nonfunctioning logistical systems and to see the problem from the client’s perspective, we’re going to play the Contraceptive Insecurity Game.

2. Contraceptive Insecurity Reality Game - 50 minutes

Procedure:

a) Ask participants to carry their chairs to one side of the room and form a circle.

b) Explain:
1. All of you have heard messages promoting family planning. Many of you are existing users of modern methods. Some of you have never used a modern method, but after talking to friends, to your spouse, you have decided to take the step and begin using a modern method. Some of you have decided—now that you have two, five, seven children—that you don’t want any more children. Some of you want more children, but not right now. Some of you don’t want any children.
2. We have three contraceptive methods available here in Pangodougou: Natural Family Planning, condoms, and pills. Now, as I have mentioned, we have three methods available, but you have decided to use a modern method. So please decide right now whether you want to use pills or condoms. According to Securistan’s policy, you are allowed one month’s supply of contraception—either one cycle of pills or twelve condoms.

3. So, welcome to your local family planning clinic.
   - All of you have taken time off work, away from the farm, away from the washing and cooking and gathering fire wood and carrying water and caring for children, to come to get your monthly supply of contraceptives.
   - Some of you have walked for three or four hours to get here.
   - Some of you have spent money to take a bus, and for some of you, taking a bus meant your children didn’t get money for lunch at school, so they’re hungry today.
   - Some of you have come without your husband’s knowledge or consent.

Now let’s get started.

4. Reach under your chair and take the envelope from the bottom of the seat. Do not open it.

5. Now everybody stand up. Open your envelopes and take out your supplies.

6. Everybody who has an empty envelope, hold up your hand.
   - How do you feel now that you’ve come all the way here and have nothing? (Allow a few responses)
   - Those who have nothing, please sit down.

7. Everybody who got a different method from the one you wanted, raise your hands.
   - How do you feel?
   - Of those who got the wrong method, raise your hand if the product was expired or damaged.
   - Everybody who got the wrong method, please sit down.

8. Everybody who got an expired method, raise your hand.
   - How many of you got a full month’s supply of expired methods? Pills or condoms?
   - Everybody who got an expired method, please sit down.

9. Everybody who got a damaged product, raise your hand.
   - What’s wrong with your product?
• Did any of you who received damaged product also get undamaged product? Do you have confidence that those products really are undamaged?
• Everybody who got only a damaged product, please sit down.

10. Now, those who remain standing have protection.
• How long is that going to last you? (Wait for response)
• If you only have one day’s/night’s supply, sit down.
• If you only have two day’s/night’s supply, sit down.
• If you have less than one month’s supply—remember, twelve condoms, or one cycle of pills—sit down.

11. For you few who remain standing, how long will your supplies last? (Wait for response)
Raise your hands if any of you feel that you have some level of contraceptive security.
Of those who got quality contraceptives, raise your hands if you are confident that you will get them again next time?
What went wrong?

c) Processing: Ask: what elements do you think went wrong; where were the system failures? (write these on a flip chart)

These elements should include:
• Forecasting
• Procurement
• Distribution
• Reporting and requisition/Logistics management information systems (LMIS)
• Transport
• Informed choice
• Policies—only one outlet (no private pharmacy or kiosk), one month’s supply at a time
• Stockouts, understock (rationing) or overstock (too many, or expired products)
• Provider training/bias
• Supervision
• Warehouse management
• Leakage/pilferage
• Quality control

d) Closing
Explain: Now you understand how the woman, the man feels when they leave a clinic disappointed that the contraceptive method they wanted was not available, and now you understand and have experienced contraceptive insecurity. That’s why we say that Contraceptive Security is experienced one client at a time.
(OPTIONAL ADDITIONAL QUESTION/REFLECTION)

Explain: *Now consider this question. If, instead of receiving free products under your chair, you had gone outside and purchased a month’s supply of contraceptives, how many of you would feel a greater degree of contraceptive security?*

3. Group Discussion - 45 minutes

**Procedure:**

**NOTE:** *Ideally this should be facilitated by an in-country guest facilitator.* The discussion should provide a brief overview of the key elements of efficient Logistics Management (see Powerpoint slides for these basic elements) and focus on how the in-country organization is applying these basic tenets in their daily field work. The guest facilitator should lead an interactive discussion focusing on his/her experiences in the topic and incorporating the basic elements as mentioned above. Any powerpoint slides used should only be for providing visual support and reinforcing key messages. The discussion should be approximately 20-30 minutes with the remainder of the time for questions and answers.
The Purpose of Logistics:  
the Six Rights

To maximize client access to high-quality contraceptives, a logistics system must get

• the RIGHT goods
• in the RIGHT quantity
• in the RIGHT condition
• to the RIGHT place
• at the RIGHT time
• for the RIGHT cost
Facilitator Notes

Contraceptives and related supplies usually cannot go from their source to the end user automatically. Frequently there are many steps between the source and the end user.

**Logistics** refers to all the activities concerned with selecting, financing, delivering and distributing contraceptives and supplies from the source to the end user.

**Supply chain** describes the many organizations that are linked in the delivery of supplies from manufacturers to clients. In practice the terms Supply Chain Management” and “Logistics” are often used interchangeable.

(Community-based FP eLearning Module)

Only with good supply chain management, can family planning users choose, obtain and use good quality contraceptive methods – this concept is known as **contraceptive security**.

**Community-based FP programs** need to be aware of how the national contraceptive logistics system works in order to ensure appropriate and adequate supplies of contraceptives are available for the end user in the community.

**Assessing the Contraceptive Logistics System:**

An assessment of the contraceptive logistics system should include the following:

- Source of contraceptives and supplies at the national and programmatic levels
- Location of contraceptive storage facilities at the national, regional, district, health facility and community levels
- Transportation system
- Maximum/minimum supplies needed per service delivery point
- Forecasting system
- Length of time for supplies to get from one level to the next
- Seasonal changes that influence any of the above factors

The following conceptual framework is taken from the Population Report listed under resources and may be used to assist participants in conceptualizing the supply chain.
Refer to the JSI Handbook for examples of tools and forms needed to accurate record keeping.

In summary, the following components are required to assure a functioning logistics system at the community level:

- Identify source of contraceptives and ensure initial supply and re-supply is provided in a timely fashion
- Assess supply system for referral sites and advocate for improved logistics for any identified gaps
- Develop sustainable plan for re-supply of all community level distributors and referral facilities
- Identify any locally available expertise in contraceptive logistics to assist the community-based program with setting up a logistics system, training and supervision
- Train CBD agents, community service delivery point personnel, and other appropriate personnel within the health system in data collection, store keeping, forecasting and ordering commodities and supplies
- Ensure records are kept up to date on a monthly basis
- Ensure community level data is submitted on a timely basis to the local health clinic or other pre-determined structure that will ensure orders are submitted to the contraceptive supplier
- Involve community support systems such as health committees in management of the logistics system.

(Community-based FP eLearning Module)
Logistics/Supply Management

Basics of Community-Based Family Planning
NO PRODUCT,
NO PROGRAM
The Purpose of Logistics: the Six Rights

To maximize client access to high-quality contraceptives, a logistics system must get

• the RIGHT goods
• in the RIGHT quantity
• in the RIGHT condition
• to the RIGHT place
• at the RIGHT time
• for the RIGHT cost
Organizing Logistics Activities
The Logistics Cycle

- Serving Customers
- LMIS
  - Pipeline Monitoring Organization & Staffing
  - Budgeting Supervision
  - Evaluation
- Forecasting & Procurement
- Product Selection
- Inventory Management
  - Storage
  - Distribution

POLICY

ADAPTABILITY
Maximizing Access through Product Selection

- Select contraceptive methods and products based on customer demand (unlike drugs).

- Offer widest variety of choices, but consider the management of the number of items.
Maximizing Access through Forecasting

- Forecasting is a central-level exercise
- Forecasts can be prepared using a variety of sources:
  - Population data
  - Service statistics
  - Logistics data
Forecasting Using Multiple Data Sources

- Logistics Data
- Population Data
- Service Statistics

Final Forecast
Activity 1

HOW close are YOU to SECURITY?

Contraceptive Security is a program’s:
• Ability to accurately estimate requirements
• Ability to control financial resources
• Technical capacity to procure products
• Ability to distribute products to the customer for the medium to long-term
Maximizing Quality through Good Storage Practices

- Ensure that we can maximize the quality of the product by maximizing the quality of the storage.

- Store enough product for our needs, being careful of expiration and available space.
Maximizing Quality through Inventory Control

Inventory control systems tell staff when to *routinely* order and how much to order. The goal is to avoid stockouts.
Max-Min
How It Works

• Assumes that products are in full supply (unlike many drug programs)

• Has a maximum level, a minimum level, an emergency order point

Includes safety stock to:

• Prepare for changes in demand (seasonality)

• Prepare for the unknown
Maximizing Quality through Supervision of Supplies

HOW LONG WILL OUR SUPPLY OF THIS ITEM LAST?

\[
\text{Stock on Hand} \div \text{Average Monthly Consumption (AMC)} = \text{Months of Stock on Hand}
\]
Logistics Information
3 Essential Data Items

- Stock on Hand
- Losses/Adjustments
- Rate of Consumption (AMC)
Collecting Essential Data

3 Record Types

- To record consumption
- To record movement of supplies
- To record stored stock of supplies
Collecting Essential Data through Reports

• Reports all essential data items to the next level
• This example also includes a request for supplies
• For this example, one format works for all levels
YOUR STRENGTHS AND WEAKNESSES

• How can your program improve its logistics system to be more client-centered? Which of the Six Rights is most challenging to fulfill?

• Of the activities in the Logistics Cycle, in which are you strongest? Weakest? Why? What can you do to improve?
Logistics Has IMPACT

• No Product, No Program
• Fulfill the Six Rights for Logistics Success
• To Maximize Access
  – Select/Forecast/Procure Based on Client Demand
• To Maximize Quality
  – Follow proper storage
  – Assess stock status
  – Implement Inventory control
• Collect essential data
Logistics Resources

For technical assistance contact:

Project Director
DELIVER Project
John Snow, Inc.
1616 N. Ft. Myer Drive,
11th Floor, Arlington, VA 22209 USA
Phone: 703-528-7474
Memo
To: Acme Chief
From: Noah Tall
Reference: My visit to the Happy Babies NGO Clinic in Medville

Today, I visited Dr. Emily Lead, the director of the Happy Babies NGO clinic in Neigboria's fourth largest city, Medville. She took me on a tour of her facility. The clinic has a nice waiting area with many educational materials and several comfortable chairs.

Dr. Lead told me that they offer a wide variety of reproductive health services that focus on family planning. They also offer antenatal, pregnancy, and post-natal care, and sexually transmitted disease (STD) prevention and treatment, and immunizations.

There are four patient rooms, each set up a little differently. In the first room, Dr. Lead told me that they offer care to pregnant patients, including post-natal care (with immunizations) and pap smears. The room is equipped with a scale, exam table, autoclave, and equipment for gynecological exams. Latex gloves, KY jelly, and antiseptics are available, and there are dozens of pregnancy test kits stacked in a corner of the room.

Two of the patient rooms are set up for contraceptive counseling. In these rooms there are contraceptives and models for counseling. HIV/STD prevention cases are seen in these rooms, as well as testing for pregnancy. While one room has gloves available for examination, the other room has none.

Dr. Lead tells me that the nurses complain that they do not have enough gloves. To respect the privacy of the patients, the nurses do not want to enter a room to take gloves from one room to another.

Dr. Lead explains that they offer condoms, oral pills, vaginal foaming tablets, intrauterine devices (IUD), and injectable contraceptive methods. I asked her about progestin-only contraceptives for women who are breastfeeding. She told me that she ordered the mini-pill Ovrette, but received only the combined oral contraceptive (COC) pill Lo-Ovral.

In the last room, they diagnose and treat STDs. Latex gloves, drugs, STD test kits, and various antiseptics were available. I saw several test kits with expired items.

"We ordered too many pregnancy test kits from the hospital, " Dr. Lead told me, "and now I cannot afford to replace the STD test kits."

This clinic is not fulfilling all of the six rights.
YOUR ASSIGNMENT

1. For each of the six rights, state whether or not it is being followed at this clinic.

2. For each right that is not being followed, suggest how this situation could be improved.
Memo
To: Acme Chief
From: Noah Tall
Reference: My Visit to the Happy Babies NGO Central Office

Today, I visited the central office of the Happy Babies NGO. They operate 25 clinics in Neighboria, including Dr. Lead’s clinic in Medville, and three hospital facilities. The largest hospital, located in Neighboria’s capital, Center City, also houses the NGO’s administrative office and the central warehouse. Happy Babies has 300 community outreach volunteers who receive supplies from the clinics. Head pharmacist Michael Rocher, is in charge of their medical supplies. He explained that his main goal is to “make sure that the products we need are available when they are needed.”

He explained that he and the pharmacists from the clinics meet once each year to determine our needs for future years. “Everything changes,” he told me, “and we want to be flexible in our thinking, so we can respond appropriately.”

I asked him if he was familiar with the activities of a logistics system. He immediately mentioned “quality control.” He said it was very important that they receive good quality supplies. He said they inspect all supplies coming from manufacturers. He also mentioned that it is important to monitor the quality of supplies leaving their warehouse. “It would be wasteful to ship supplies that are about to expire to the clinics,” he explained.

He said that an important logistics activity was to ensure that they did not have either too many or too few supplies. “We do not have the money or space to store large quantities, so we want to ensure that we are making an appropriate order.”

We discussed the importance of monitoring the flow of supplies in the system. “I try to always know which facilities have supplies and where shortages may occur.” He also noted that money is an important consideration. “Without money, we cannot buy our supplies.”

We discussed the importance of other activities in a logistics system. To make our discussion easier to follow, I drew a picture of the relationship among the activities. “This makes sense.” Pharmacist Rocher told me. “Now I understand how our new policy to distribute condoms to sexually active youth might affect our logistics system. The relationship is clear.”
YOUR ASSIGNMENT

1. What activities did Noah and the head pharmacist discuss that support the six rights? Which activities are missing from the pharmacist’s explanation and discussion?

2. What is the picture that Noah Tall drew? What is one reason that Pharmacist Rocher said the drawing helped him understand the new policy for condom distribution?
Session 12: Gender/Male Involvement
Session 12 - Gender/ Male Involvement in Family Planning

Achievement-based Objectives:
By the end of this session participants will have:
• Reviewed the guiding principles for a gender-integrated program
• Reviewed elements of a gender-integrated program
• Listed at least 3 advantages and 3 challenges to involving men in FP programs.
• Cited at least 2 successful male involvement strategies/models.
• Explained how ignoring or excluding men weakens family planning services.

Duration: 2 hours, 25 minutes
Timeframe: Day 4 Session 2

Planning Notes for Values Clarification:
• Values clarification consists of helping participants to: identify their values; feel able to talk about their values; and consider how they will be able to reconcile their own values with those of their work as a family planning manager. Values education can be a sensitive area—as participants express their values and learn about those of others, they may feel some anxiety or discomfort, and they will look to the facilitator for support.
• There is no right or wrong answer. This is not a debate to convince people about beliefs. As a facilitator, you should remain neutral. When appropriate, you might express your personal values, but stress to the group that this is your own personal value and is not the only one or perhaps even the commonly held one.

Materials:
• Handout 12.1 (This is a list of statements for the values clarification exercise and should not be given to participants)
• Handout 12.2 for case study analysis (See Facilitator's notes on case studies)
• Guest Facilitator
• PowerPoint presentation (for facilitator's reference)

Additional Resources:
Gender, Family, and Development: [http://www.popcouncil.org/gfd/index.html](http://www.popcouncil.org/gfd/index.html) (English) and [http://www.popcouncil.org/francais/sante.html](http://www.popcouncil.org/francais/sante.html) (French)
Articles on Male Involvement in Family Planning:
Male Involvement in FP Yields Positive Results:
Assessing the Status of Male Involvement in the Philippines:
Tasks

NOTE: Review session objectives first.

1. A Personal Values Clarification Exercise - Introduction to Male Involvement - 20 minutes

Procedure:

a) Explain: In this activity you will be asked to agree or disagree with specific value statements. We will take reasons for why participants agree or disagree with the statements that are read, but the purpose is NOT to convince one another of an opinion.

b) Continue: there are no right or wrong answers, only opinions. Everyone has a right to express an opinion, and no one will be put down for having a different value than others have. You can change your stand on any particular value at any time. For example, some participants might feel that they disagree with a particular value but change their minds if someone else makes a good case for agreeing with that value.

c) Ask participants to stand up. Identify one side of the room as where people should stand if they agree with the statement that is read, and the other side of the room as where people should stand if they disagree.

d) Read the statements one by one. For each statement, have participants rearrange themselves according to their opinion on that particular statement. Ask 1-2 participants from each “side” to explain why they are standing on that side. (Alternatively, statements can be cut up and put into a hat so that participants can draw and read each statement)

e) Discussion Questions: What did you learn about yourself? About gender values? Any surprises? How might some of the issues touched on affect your work as a family planning manager? How can we avoid imposing our own value system on others?


2. Group Discussion - 15 minutes

Procedure:
Facilitate a discussion on the key concepts of gender integration using the PPT slides (#1-9) for visual support.

3. **Small group case studies on programs with male involvement component** - 40 minutes

**Procedure:**

a) Break the group into four or more small groups.
b) Distribute case studies (select 2 case studies and give the same one to each of two groups) and share the following instructions:
   - Select a recorder and presenter
   - Read the case study and discuss the questions
   - Make short notes of your answers
   - You will have 20 minutes to discuss the questions
   - The presenter will have 3-4 minutes to share the group’s findings

c) Reassemble, and ask groups to report out, reading their case study aloud before reporting on their conclusions. (Refer to trainers notes in box at end of these notes to complement the participants’ findings.) As participants mention different types of male involvement, list these on the flip chart.
d) After all the groups have presented, **ask** them:
   - What lessons have we learned from these real life case studies?
   - Are there intended or unintended outcomes of these programs?
e) Review the list of types of male involvement that you have been developing on the flipchart during the debriefing discussions and explain any new models.
f) If the following points have not been made, **offer** these examples of gender relations in RH programs:

1. With an increased emphasis on modern technology for family planning, RH programs have ignored the important pre-technology role that men have played in using withdrawal or abstinence. In countries, such as Turkey and Pakistan, men took pride in these methods of self-control. The new technology inadvertently undermined some of the responsibility of men and placed it on women.

2. Many programs completely ignore the sexuality of women and assume that only men have sexual needs. This remains one of the most strongly enforced gender stereotypes.

3. By contrast, such practices as FGM reinforce a stereotype that women must be protected for the benefit of their future husbands and that their sexual needs are not affected.
(4) Vasectomy is not a widely used method because of fears about virility, therefore, the emphasis is on sterilization for women, a more risky, invasive and costly operation.

(5) Programs that emphasize condom quality or style often appeal to women’s concern for male satisfaction and can result in eroding the women’s position in relationship to the men. Example: SLAM condoms in Jamaica that suggested rough sex and promiscuity.

(6) Programs that encourage men’s responsibility for children too often focus on financial responsibility rather than caring for the children. This emphasis denies the growth of men in family relationships. However, studies have shown that men’s involvement in pre-natal education and presence at the birth increases their involvement with the children and encourages greater partnership in RH decisions.

(7) Many programs emphasize male awareness of family planning methods, but not participation in family planning or the decisions around it yet men are often key decision makers.

(8) Finally, we should look at indicators for RH programs. They are almost totally focused on condom use and reproduction rates, ignoring all of the social context and the social results of programs. Can you think of some indicators for your programs that acknowledge social impact as well as health impact?

4. Reflection on Strategies for Male Involvement - 25 minutes
   
   Procedure:
   
a) Ask participants to form triads and reflect together on ideas or strategies for strengthening male involvement in a constructive way in their family planning programs.
   - What strategies might be successfully incorporated into your programs?
   - Are your programs falling into any of the pitfalls identified during the case studies?

b) Ask the participants to share some of their more pertinent ideas and observations with the large group.

c) Evening work: ask participants to complete Exercise 1 on the last page of Handout 12.2.

d) Conclude by reminding the group of these points:
✓ Many programs do not involve men at all in RH activities.

✓ Of those that do, many fail to address gender relations and power structures. They focus on health and ignore social outcomes.

✓ With all good intentions, many RH programs perpetuate gender stereotypes that continue the subordinate role of women or support high-risk behavior for men.

✓ Program people must go beyond the health issues to examine the social issues that have serious impact on the success or failure of these programs.

5. Group Discussion – Gender/ Male Involvement in RH/ FP – 45 minutes

Procedure:

NOTE: Ideally this should be facilitated by an in-country guest facilitator. The discussion should provide a brief overview of the key issues, strategies, and success stories in working in gender/male involvement (see Powerpoint slides #10-21, for these basic elements) and focus primarily on how the in-country organization is applying these basic tenets in their daily field work. The guest facilitator should lead an interactive discussion focusing on his/her experiences in the topic and incorporating the basic elements as mentioned above. Any powerpoint slides used should only be for providing visual support and reinforcing key messages. The discussion should be approximately 20-30 minutes with the remainder of the time for questions and answers.

Some of the following key points (that appear in the notes section of the PPT, slides 11-21) should be incorporated into the discussion:

**Why involve men in FP?**
- Contraceptive use and continuation are higher when the husband and wife agree. In 5 Sub-Saharan Africa Countries, average contraceptive use among women was three times higher (18% versus 6%) when husbands approved, BUT women should always have a choice as to whether they want their husband involved in contraceptive decision-making.

**Couple counseling results in better continuation rates**
- In Turkey, couples are more likely to choose a contraceptive method (80%) when the husband is involved in the counseling as opposed to women who are counseled alone (55%).

**Why some men choose vasectomy**
- A very effective strategy is to work with at least one man who has had a vasectomy to promote vasectomy as a method of contraception

**Condoms: Dual protection against pregnancy and STIs**
- Condoms need to be used by anyone who has more than one sexual partner, the provider needs to learn enough about the client’s sexual behaviors and risk and counsel accordingly

**Men’s public approval versus private use**
- Programs need to move beyond knowledge to changing behavior and practice

**Creative outreach efforts reach men in community**
- In Pakistan, EngenderHealth trained barbers to talk to clients; they also encourage community workshops
- One NGO in Brazil does outreach to factories and established men’s clinics

**Examples: Community education successfully involves men**
- Volunteers trained to reach male and female small farmers in rural areas
- In Honduras, messages for low literacy populations on birth spacing, fatherhood, RH, FP, STIs, safe motherhood, breastfeeding led to an increase in use of FP from 37% to 55% in the intervention area and couple communication increased.

**Clinic-based strategies for men**
- Separate services may be necessary in the beginning but integrated services later may be more sustainable
- A study by Profamilia showed no difference in use of services when men had access to integrated services compared to services for men only.
Facilitator's Notes

A. Gender:

Gender integration makes programs and policies responsive to the social, economic, cultural and political environment that affect reproductive health. In other words, gender integration means taking into account both the differences and the inequalities between women and men in program planning, implementation, and evaluation. Roles of men and women and their relative power affect who does what in carrying out an activity and who benefits. Taking into account the inequalities and designing programs to reduce them should contribute not only to more effective development programs but greater social equity/equality. Experience has shown that sustainable changes are not realized through activities focused on either men or women alone.

Outcomes of effective gender integration:
- Quality of RH services is improved
- Meets the needs of program participants
- Programs are more sustainable
- Clients are better informed and empowered
- Improved couple communications
- Improved utilization of services
- Broader development impacts

Contributions to specific RH Outcomes:
- Improved CPR
- Reduced fertility
- Reduced HIV transmission
- Reduced violence against women
- Decreased maternal mortality

What are some examples of strategies to promote the following?
- **Gender equality**: Actively involve women in identifying, prioritizing and resolving their own RH problems and in determining and negotiating the conditions in which RH/HIV/AIDS services are delivered. Women recommend involving their male partners early in the education process.
- **Gender equity**: This is a process to reach the goal of equality. It is the process of being fair to men and women. The involvement of men in FP can promote gender equity. Programs that promote girls education contribute to gender equity.
- **Gender integration**: Attempts to address the many factors that discriminate against men, women, and youth. Fostering participatory dialogue on RH in the context of gender equity/equality promotes shared responsibility and accountability among community members. By involving adolescent boys and
girls and addressing their concerns, more sustainable and equitable RH outcomes are achieved. (Example: Reproductive Health Literacy Program in Guinea that targeted both men and women)

**Guiding principles for a gender-integrated program:**

- Work through local partnerships – Partner with all those at the community level who have a vested interest in improving RH outcomes for men, women and youth. Partnerships early in the program cycle lead to local ownership and sustainability.
- Support diversity and respect – Focus on culture as a resource for change by partnering with the local community.
- Foster accountability – Hold those involved accountable for achievement of gender equity/equality goals, helps modify behavior.
- Promote respect for the rights of individuals and groups – Human rights and reproductive rights
- Empower women, men, youth and communities – Experience and research show that RH programs are more effective when they take steps to improve the status of women while promoting women’s RH decision-making. Such programs also work to increase men’s support of women’s RH and children’s well-being and address distinct RH needs of men. (Example: The RH literacy program would be an example of this)

**Elements of a gender-integrated program:**

- Specific gender equity/equality objectives and indicators for measuring success
- Equitable participation and involvement at all levels – listening to women and other marginalized groups, involve them in decision-making
- Fostering equitable relationships – Unequal power relationships between sex partners, members of a community, between clients and providers often obstruct access to high quality services. Better communication and more equitable decision-making between sexual partners, improved communication between clients and providers leads to more equitable relationships.
- Advocacy – Programs create an environment conducive to change in individual behavior, community norms, regional and national policies.
- Coalition building – This is very effective for policy change. Diverse groups join together in a participatory way to pursue a target set of actions in support of a specific action. Linkages among different groups around common interests.
- Multi-sectoral linkages – with health, literacy, etc...
- Community support for informed individual choice – leads to more successful adoption of change.
- Institutional commitment to gender integration – equitable policies, shared responsibilities that are free of discrimination.
Common mistakes made in programming:
- FP services are only available in MCH clinics
- Baseline assessments only targeting WRA
- CBDs are all men or all women.
- CBD programs that are not designed to respond to social, political, cultural and religious values of the community

B. Male Involvement:

Women are typically the focus of RH interventions; however men are central to sexual and RH decision making. Traditional gender roles often prevent women from making their own RH choices. In addition, the health of both men and women is compromised by risky male behaviors such as violence and seeking multiple sexual partners.

It is important to work with men, women, communities, health care providers and national health systems to constructively engage men to promote gender equity and health in their families and communities. Activities should focus on:
- Raising men’s awareness and support for their partners’ RH choices
- Increase men’s access to comprehensive RH services
- Mobilize men to take an active stand for gender equity and against gender-based violence (GBV)

EngenderHealth has developed tools and resources for engaging men in the “Men as Partners” (MAP) program. This program involves training and technical assistance to health clinics, NGOs and governments and advocates for positive male engagement. Through workshops and community coalition-building efforts that emphasize group participation, the program works to transform the traditional attitudes, behaviors, and social norms that contribute to violence, gender inequalities and negative health behaviors.

Impact for Clients and Program Participants:
- Changed gender attitudes and the ability to play more positive roles in their families and communities
- Access to RH services such as FP
- Increased utilization of HIV/AIDS and STI services, including prevention, testing, care support and treatment
- Education about how men can be supportive partners in RH care

Impact for Health Care Providers:
- Improved quality of health services for men

Impact on Communities:
- Improved health-promoting behaviors and attitudes
Reductions in GBV
The availability of RH services that address men’s needs
Growing organizational networks that tackle social and health concerns

Program Examples:

Example 1: Mobilizing Men to Support Safer Motherhood in Nepal
In partnership with the Nepal MOH, EngenderHealth is reaching men in rural counties by training health providers and building a peer educator network. To address high rates of maternal mortality in Nepal, men are trained to educate their peers on how to recognize pregnancy complications so they can help women access emergency obstetric care, if needed. The project has been very successful to date: Communities have shown an increase in contraceptive use, an increase in the number of men who have accompanied their wives to clinic appointments, and an improvement in men’s knowledge of and attitudes toward their pregnant wives’ health needs.

Training materials may be accessed at www.engenderhealth.org.

In selecting male involvement strategies, program managers should take into consideration the marital and work patterns of women and their partners. For example a focus on increasing couples counseling may be more difficult in settings where most women are not living with their husbands or sexual partners.

Example 2: Impact of a Male Motivation Campaign on FP Ideation and Practice in Guinea

The country is characterized by high rates of fertility and infant and child mortality. Life expectancy is 46 years, CPR was at 4.9% in 1999 while the TFR was 5.5 per woman (DHS 2000). The PRISM Project’s (Pour Renforcer les Interventions en Sante Reproductive et MST/SIDA) objectives were to increase the use of FP and maternal health services and decrease the spread of STDs/HIV/AIDS through appropriate prevention practices. There was a strong BCC component that focused on both knowledge about quality health care services and the use of them, and adopting positive health practices. The Male Motivation Campaign was the major BCC intervention. The first phase focused on religious leaders and focused on advocacy interventions. The second phase focused on married men. Multimedia interventions sought to promote spousal communication about FP to increase the use of available services. In addition to these two primary audiences, the project focused on WRA and service providers.

Among religious leaders, the intervention sought to:
• Increase knowledge about modern contraceptive methods, and
• Increase the frequency of talking about FP during sermons

Among married men, WRA and service providers, the intervention sought to:
• Increase the proportion of married men capable of citing at least one modern contraceptive method,
• Increase the proportion of men who discuss FP with their spouses,
• Increase attitudes that are favorable toward small family size and contraceptive use,
• Increase contraceptive use in the study regions.

**Phase I - Religious Leaders’ Advocacy**
• Three-day conferences led to forming support groups to mobilize the religious leaders to back health centers and RH activities
• Print materials (brochure and poster given to each religious leader)
• Video in Malinkee with French subtitles on Islam and RH issues

**Phase II - Multimedia Interventions**
• National launch of campaign in Conakry and regional launches aired on national and rural radio. The launches featured speeches, parades, music, dance, theater, film and other activities inspiring the mostly male audiences to discuss FP with their wives and encourage the women to use a health center. Question and answer sessions were included in the community mobilization activities. The tag line on printed materials stated, “I talk to my wife about family planning. How about you?” A popular local comedian was featured on a 26-episode radio drama that demonstrated a husband’s dilemma in discussing FP with his wife. The show was called, “La Vie N’est Pas Compliquee”. Publicity materials such as T-shirts, plastic and cloth bags, hats, stickers, water pots, chains, pens and cloth wraps. The health providers and community health agents received existing materials on FP, AIDS, diarrhea, and adolescent health flipcharts; AIDS prevention posters; brochures on FP, AIDS and childhood communicable diseases; and wooden penis models. Health centers received a GATHER poster for counseling, an infection prevention poster in French and English, and contraceptive sample cases.
• The BCC strategy and messages were designed based upon FGD and in-depth interviews with religious leaders, men and women of reproductive age, and service providers. Formal and anecdotal field reports helped identify message production and diffusion problems.
• Evaluation design consisted of two components: a panel study among religious leaders and population-study among men and women of reproductive age.
• Results of evaluation:
  o Impact on religious leaders –
    ▪ Awareness of modern FP methods increased
There was a favorable shift in perceptions about FP and Islam. There was an increase from 55% to 93% of leaders interviewed who reported knowledge of a verse in the Koran or Hadith that favored the practice of FP.

More than 1/3 at follow-up compared to 1/5 at baseline believed the use of FP to limit births was acceptable under Islam.

There was a positive shift regarding the perceived position of Islam on specific methods of FP.

Those who believed Islam supports FP for child spacing increased from 55% at baseline to 94% at follow-up.

There was a dramatic increase in spousal communication regarding FP.

Those who ever preached in favor of using modern FP methods increased from 38% to 96% at follow-up.

Current use of FP methods increased insignificantly from 9% at baseline to 11% at follow-up.

- Impact on the General Population

  Campaign exposure was strongly linked to increased awareness about modern FP methods. Among men, there was an increase from 35% to 64% who could spontaneously cite a modern contraceptive method. For women, the indicator increased from 29% to 65%.

  Approval of FP increased only among the respondents exposed to the campaign.

  Spousal communication about FP (Those who reported discussing FP with their spouse or partner during the 12 months preceding the survey) increased significantly from 0% to 25%. Those exposed to the campaign were more likely than others to experience increase communication.

- Impact on Contraceptive Use

  There was a positive effect in percent using or intending to use a modern FP method by campaign exposure with the most dramatic increase in intent to use and actual use in the groups with the highest level of campaign exposure.

Source: JHUCCP, Field Report Number 13, April 2002, Impact of a Male Motivation Campaign on FP Ideation and Practice in Guinea
**TRAINING'S NOTES ON GROUP WORK**

**Male Involvement: Project Case Studies (Small Group Exercise)**

**[Trainer Note]**: Before Cairo, most programmes were focused totally on women. Since Cairo, there have been many attempts to involve men in RH programmes. This exercise is designed to push participants to examine the subtle or unrecognized negative or positive results of these well-intentioned efforts to involve men. These case studies will help participants realize that programmes addressing RH issues can deliver subtle negative messages, perpetuate power imbalances, and have complicated, unexpected results. You will help them to explore the impact of different types of male involvement programs, such as:

- **Male Only Programmes**: Addressing the RH needs of men (paying attention to the previously unrecognized needs of men, but ignoring women’s needs or perpetuating discrimination against women). Copying women’s programmes but ignoring power relationships in the society and accepting men’s dominant position.

- **Men As Obstacles to Family Planning Programmes**: Treating men as obstacles who must be won over to FP use but failing to address the power and decision-making results that can disempower women. Treats men as a means to increase contraceptive use.

- **Gender Equity: Men & Women As Partners Programmes**: Programs that recognize an equal partnership in RH decisions and power relations. Reflects the spirit of Cairo. Emphasizes **how** services are provided not **who** should get which services.

The group may come up with other categories.

**TRAINING NOTES FOR GROUP #1 (Condom use in Zimbabwe)**

**[Trainer Note]**: This well-intentioned program increased knowledge about family planning methods, male involvement and condom use, but at considerable cost to the wives. But it failed in promoting the idea of joint decision-making. The approach reinforced men’s assumption about control and power and they began to make the family planning decisions for the women, thereby further disempowering the women. It assumes that targeting men as a means for reaching and altering their wives’ reproductive behavior will fare better than one that targets women as a means for reaching their husbands. Many programs have been designed to encourage and “motivate” men to think more favorably of their wives' use of family planning.]

461
After the small groups present their points, ask some of the following questions:

Are there any comments about what this small group found?
Did they miss anything in terms of possible unexpected results for the men?
Did they miss anything in terms of possible results for the women?
How might the decisions and dynamics about family planning have changed within the family?
How do you think the women felt about this effort to involve men?
Did this approach perpetuate and reinforce any gender stereotypes?
How did it affect the empowerment of women? Did it recognize the sexuality and RH health needs of women?
Are there any other ideas for increasing male involvement and condom use without disempowering women?
How would you characterize this type of male involvement program? (Example: Increasing male involvement but at a cost to women.)

**TRAINER NOTES FOR GROUP #2 (Post-abortion Care in Egypt)**

[Trainer Note: Male involvement helps with women’s recovery and increases the likelihood of the couple using contraceptives. However, the needs of the men in this case appear to be neglected. While it involves the men and provides some service for the women, it does not take into account that both may be feeling the loss. It appears to assume that it is primarily women who feel the psychological pain of abortion or miscarriage and need the most support. By drawing men in without considering their needs, this model may perpetuate a view of women as weak and needing protection by the men.]

After the group presents its bulleted points, ask the large group some of these questions:

Are there any comments about what this small group found?
Did they miss anything in terms of consequences for women and consequences for men?
How do you think the women felt about this project?
What messages were being sent to the men?
What messages were being sent to the women?
Was this project perpetuating any stereotypes about women or men?
What are the power relationships here?

Is this programme in subtle ways ignoring the needs of men or failing to recognize the needs of men who may be as sensitive to the loss as women?
Is the program missing an opportunity to build support for men in touch with their own emotions?
What is the larger picture that the project is perpetuating in terms of patriarchy?
and/or gender stereotypes?
How would you characterize this type of male involvement program? (Example: Addressing needs of women primarily, but perpetuating the gender stereotypes for men and women.)

TRAINER NOTES FOR GROUP #3 (Involving Traditional Leaders in Ghana)

[Trainer Note: This well-intentioned program illustrates the potentially mixed consequences of working with gatekeepers when trying to build upon indigenous social structures. The project did not address most ordinary men – the husbands of the women who were seeking out family planning services. These men were often threatened by their wives’ use of services. As a result, women risked social ostracism and punishment for using family planning, and there was a sharp increase in domestic violence. Challenges to male authority can place women at risk of social recrimination, exaggerating traditional values and behavior patterns, such as increased social controls and domestic violence. By dealing with male leaders, the project also appeared to sanction the subordinate role of women.]

After the small groups presents their points, ask some of the following questions:

Are there any comments about what this small group found?
Did they miss anything in terms of possible unexpected results for the men?
Did they miss anything in terms of possible results for the women?
Did this approach perpetuate and reinforce any gender stereotypes?
How did it affect the empowerment of women? Did it recognize the sexuality and RH health needs of women?

Could there have been any unintended impact on them as a result of involving only the male leaders and providing family planning to the women?

Are there any other ideas for increasing male involvement and condom use without disempowering women?

How would you characterize this type of male involvement program? (Example: Increasing male involvement but at a cost to women.)

Trainer Notes for GROUP #4 (Promoting Condoms and Gender Equitable Attitudes among Young Men in Brazil)

[Trainer Note: This carefully designed program has been widely recognized and applauded for its creative work with young men. Because program organizers conducted research among the young men who are their target populations, they knew some important things: although a tough, dominating masculinity was
common, there was also a significant number of young men who questioned this notion of masculinity. The social marketing campaign took advantage of the research findings to reinforce the positive elements of masculinity in ways that have helped young men care for their partners and their own health.

After the small group presents their points, ask some of the following questions.

*Are there any comments about what this small group found?*

*Did they miss anything in terms of possible unexpected results for the men?*

*Did they miss anything in terms of possible results for the women?*

*How might the decisions and dynamics about condom use have changed between couples as well as casual partners?*

*How do you think the women felt about this effort to involve men?*

*Did this approach perpetuate and reinforce any gender stereotypes?*

*How did it affect the empowerment of women? Did it recognize the sexuality and RH health needs of women?*

*Could there have been any unintended effects, negative or positive, of this approach?*

*How would you characterize this type of male involvement program? (Example: Increasing male involvement in ways that promote gender equity.)*
Key Messages:

- “Special efforts should be made to emphasize men’s shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior, including family planning; maternal and child health; prevention of STIs, including HIV.” – ICPD Programme of Action, Paragraph 4.27.

- “Many programs do not involve men at all in RH activities.”

- “Of those that do, many fail to address gender relations and power structures. They focus on health and ignore social outcomes.”

- “With all good intentions, many RH programs perpetuate gender stereotypes that continue the subordinate role of women or support high-risk behavior for men.”

- “Program people must go beyond the health issues to examine the social issues that have serious impact on the success or failure of these programs.”

Interagency Gender Working Group
Gender and Male Involvement

Community-Based FP Workshop
Session Objectives

As a result of this session, participants will have:

- Reviewed the guiding principles for a gender-integrated program
- Reviewed elements of a gender-integrated program
- Listed at least 3 advantages and 3 challenges to involving men in FP programs.
- Cited at least 2 successful male involvement strategies/models.
- Explained how ignoring or excluding men weakens family planning services.
Why Integrate Gender?

- Gender integration makes programs and policies responsive to the social, economic, cultural and political environment that effect reproductive health
Outcomes of Effective Gender Integration

- Improved quality of RH services
- Met needs of program participants
- Improved sustainability in programs
- Better informed and empowered clients
- Improved couple communications
- Improved utilization of services
- Broadens development impacts
Contribution to Specific Reproductive Health Outcomes

- Improved CPR
- Reduced fertility
- Reduced HIV transmission
- Reduced violence against women
- Decreased maternal mortality
What are some examples of strategies to promote the following?

• Gender equality- Goal of equality of the genders or the sexes, especially related to women’s rights (leveling the playing field for girls and women by ensuring that all children have equal opportunity to develop their talents)

• Gender equity- A process to reach the goal of equality; process of being fair to men & women, i.e. the involvement of men in FP

• Gender integration- Taking into account the differences & inequalities between men & women in program planning, implementation, and evaluation
Guiding Principles for a Gender-Integrated Program

• Work through local partnerships

• Support diversity and respect

• Foster accountability

• Promote respect for the rights of individuals and groups

• Empower women, men, youth and communities
Elements of a Gender-Integrated Program

- Specific gender equity/equality objectives and indicators for measuring success
- Equitable participation and involvement at all levels
- Fostering equitable relationships
- Advocacy
- Coalition building
- Multisectoral linkages
- Community support for informed individual choice
- Institutional commitment to gender integration
Process for Gender Integration Throughout Program Cycle

- Examine program objectives related to gender considerations
- Collect data on gender
  - Relations, roles, identities
- Analyze data for gender differences
- Design program elements to address gender issues
- Develop and monitor indicators that measure gender-specific outcomes; evaluate the effectiveness of elements
- Adjust design and activities based on M&E
Involving Men in Family Planning Can Promote Gender Equity

*Women want their partners involved:*

- To support their own contraceptive use
- To share responsibility for contraception and protecting health
- To increase men’s understanding of reproductive health issues
Why Involve Men in Family Planning?

• Male responsibility in reproductive health issues is essential to decreasing HIV/AIDS and other STIs and meeting the unmet need for FP

• Men play a dominant role in decision-making

• Encourage male methods of contraception
Couple Counseling Results in Better Continuation Rates

Percentage of couples contracepting after 12 months

<table>
<thead>
<tr>
<th></th>
<th>One-year contraceptive continuation twice as high when husband counseled with wife (Ethiopia)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husband involved in</td>
<td>33%</td>
</tr>
<tr>
<td>counseling</td>
<td></td>
</tr>
<tr>
<td>Husband NOT involved</td>
<td>17%</td>
</tr>
<tr>
<td>in counseling</td>
<td></td>
</tr>
</tbody>
</table>

Why Some Men Choose Vasectomy

- Simpler, safer and less expensive than female sterilization
- Love for wife and concern for her health
- Desire to take responsibility in family planning
- Greater sexual enjoyment by eliminating worries about unwanted pregnancy
Condoms: Dual Protection Against Pregnancy and STIs

• Can be highly effective in protecting against pregnancy AND preventing HIV/STIs

• Should be promoted in family planning, HIV prevention, and other programs
Barriers to Male Involvement in FP/RH

- Lack of access to information
- Exclusion of males (culture/tradition, service providers)
- Provider bias against male methods
- Limited access to services
Men’s Public Approval Versus Private Use

- Men report high knowledge and support of contraception even where use is low
- Public approval different than private use
- Programs need to change attitudes and practices
  - desire for more children
  - belief that religion prohibits use
  - desire for control over wife

Male Involvement Program Options

• Programs targeting men only

• Programs viewing men as a secondary target population to influence women’s behavior

• Programs viewing men as partners
Creative Outreach Efforts Reach Men in Community

- Conduct formative research involving men as stakeholders and as community participants
- Design BC strategy based upon sufficient assessment information
- Examples of places and activities where more men might be reached
  - Sports events
  - Workplaces
  - Small businesses
  - Truck stops
  - Military bases
  - Media
  - Social drinking
Examples: Community Education Successfully Involves Men

Honduras:

• Agricultural agents and community volunteers reached farmers with reproductive health and family planning information

• Interactive materials for low-literacy clients stressed importance of birth spacing for child health

• Family planning increased from 37 to 55%
Clinic-based Strategies for Men

- Stand-alone male clinics
- Separate hours/entrances for men
- Integrated services
- Male or female counselors
Recommendations for Male Involvement Programs

• Integrate gender and male involvement into every step of the design, implementation and M&E process of a program
• Use the power of positive role modeling
• Open up safe spaces to talk and learn
• Engage men in dialogue to discuss concerns and questions related to FP
• Integrate HTSP messages into programs
• Focus on actions men can take to improve HTSP and increase use of FP
• Nurture a pool of men as gender activists
• Consider men as CBDs of FP
• Offer a range of services that includes FP
Handout 12.1  Gender and Family Planning Value Statements

- Because a man is the head of the household and responsible for economic support, he should decide how many children to have.
- It’s OK for a woman to secretly use a family planning method if her husband doesn't approve.
- Sexual behavior that is acceptable for men is also acceptable for women.
- Clinics should not offer family planning services to unmarried women, especially teenagers.
- Clinics should not allow a husband to accompany his wife on a family planning visit, because that interferes with her privacy.
- It is worse for an unmarried girl to have sex than an unmarried boy.
- Men should have some say about whether a woman has an abortion because it is their baby too.
- Reproduction and pregnancy are primarily women’s issues because they end up taking responsibility for the children.
- We should not provide young people with contraceptives or information about sex because it will lead to increased promiscuity.
Handout 12.2. Case Studies for Group Work

Group 1

ZIMBABWE: Condom use was low. A campaign for male involvement in this patriarchal society brought men into the clinics through the use of sports imagery and an emphasis on men’s primary decision-making responsibility within the family. The program succeeded in impressing upon men the need for family planning. It encouraged the men’s sense of empowerment and the benefits of making these types of decisions within their marriages. Men surveyed after the program were more likely to believe that they should be the primary decision makers where family planning was concerned.

What is the intended objective of this program?
What would be the effect on women?
What are the messages sent to the women?
What would be the effect on men? What are the messages sent to the men?
What do you think happened?
Name some potential, unintended consequences or subtle messages for women in this type of male involvement program. For men?
What do you think of this approach?
For a gender equitable program to address this situation, in what ways, if any, would you improve this project?

Group 2

EGYPT: A programme provided post-abortion counseling for women and their male partners. In addition, a male doctor informed the man of the possible emotional effects on his partner and her need for recovery.

What is the intended objective of this program?
What would be the effect on women? What are the messages sent to the women?
What would be the effect on men? What are the messages sent to the men?
What do you think happened?
Name some potential, unintended consequences or subtle messages for women in this type of male involvement program. For men?
What do you think of this approach?
For a gender equitable program to address this situation, in what ways, if any, would you improve this project?

Group 3

GHANA: In this program, male leaders in very traditional communities were sought out to obtain their blessing for a campaign to increase contraceptive use. Women have very
limited mobility and decision-making power in this community. The program staff dealt only with the male leaders and did not work with ordinary men. After the program had been in place for a few months, family planning use increased but there was resistance to it within families.

*What is the intended objective of this program?*
*What would be the effect on women? What are the messages sent to the women?*
*What would be the effect on men? What are the messages sent to the men?*
*What do you think happened?*
*Name some potential, unintended consequences or subtle messages for women in this type of male involvement program. For men?*
*What do you think of this approach?*
*For a gender equitable program to address this situation, in what ways, if any, would you improve this project?*

**Group 4**

**BRAZIL:** This program works with young men in a poor urban community with high levels of violence and STI prevalence. It works with young men to help them question traditional norms related to masculinity and to encourage them to adopt more gender-equitable attitudes and practices. The program has initiated a lifestyle social marketing campaign for condoms that promotes the positive masculinity of young men who are sexually responsible and care for their partners by communicating about condoms and being prepared when they have sex.

*What is the intended objective of this program?*
*What would be the effect on women? What are the messages sent to the women?*
*What would be the effect on men? What are the messages sent to the men?*
*What do you think happened?*
*Name some potential, unintended consequences or subtle messages for women in this type of male involvement program. For men?*
*What do you think of this approach?*
*For a gender equitable program to address this situation, in what ways, if any, would you improve this project?*
EXERCISE #1
Organizations could try this exercise to see where they stand on integrating the guiding principles and program elements into their programs. This is a good starting point for discussions on how institutions can do this.

**IDENTIFICATION OF GUIDING PRINCIPLES AND ELEMENTS OF A GENDER-INTEGRATED PROGRAM**

<table>
<thead>
<tr>
<th>Principles</th>
<th>Present in this project (give an example)</th>
<th>Absent in this project</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Working through local partnerships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Supporting diversity and respect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Fostering accountability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Promoting respect for the rights of individuals and groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Empowering women, men, youth, and communities</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Elements</th>
<th>Present in this project (give an example)</th>
<th>Absent in this project</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Specific gender equity/equality objectives and indicators for measuring success</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Equitable participation and involvement at all levels</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Fostering equitable relationships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Advocacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Coalition building</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Multisectoral linkages</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Community support for informed individual choice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Institutional commitment to gender integration</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Session 13: Youth Involvement in Family Planning
Session 13 - Family Planning for Youth

Achievement-based Objectives:
By the end of this session the participants will have:
• Named why it’s important to work with youth on FP
• Identified obstacles faced by youth related to FP use
• Discussed strategies for working with youth
• Suggested ways to strengthen the FP youth aspects of their programs

Duration: 2 hours, 20 minutes
Timeframe: Day Four, Session 4
Seating Arrangement - 6 small groups of 5 participants each
Materials:
• Handouts 13.1, 13.2, 13.3
• PowerPoint presentation - for reference only
• Guest Facilitator
Additional Resources:
YouthNet Resource materials available at
http://www.fhi.org/en/Youth/YouthNet/Publications/index.htm#eop

Tasks

NOTE: Review session objectives first.

1. Introduction - 10 minutes
   Procedure:

   Explain: We have spent a lot of time talking about how to involve men in family planning but many of you work with another segment of society that is also important to reach: youth. Why is it important to work with youth on family planning? (take a few responses)

2. Challenges, Benefits, and Obstacles - 20 minutes
   Procedure:

   a) Ask: What are some of the challenges of working with youth? (take a few responses) Explain: Being aware of these unique challenges can help us become more successful in working with this segment of society.
   b) Continue: What do you think some of the benefits are? (brainstorm only)
   c) Ask: What do you think are the obstacles that youth may encounter when deciding whether to use contraceptives? (write participants' responses on flip chart) (service issues, cultural issues, parental and extended family issues, gender issues, peer issues, etc.).
3) **Strategies for working with Youth - 45 minutes**  
**Procedure:**

a) Explain: *Now that we have identified some of the obstacles youth face (and programmers face) in participating in FP programs, let's hear about some of the strategies you are using to address these challenges. How many of you are working with youth? (show of hands)*

b) Ask each participant who raised their hand to briefly describe what strategies they are using to work with youth to address their specific challenges. Encourage other participants to ask questions for clarification or additional details.

c) As each person shares their experience, use the handout 13.1 to probe further to determine how youth have been involved in the program (as partners and not just participants).

d) Distribute handout 13.2, review with the participants, and address any lingering questions.

4) **Wheel of Solutions- Strengthening programs for Youth - 20 minutes**  
**Procedure:**

a) Ask participants to form 2 circles, one inner circle and one outer circle.

b) Ask participants in the inner circle to face their partner in the outer circle (you may need to help them line up so that each person in the inner circle is facing someone in the outer circle and visa versa)

c) Explain: this is called the wheel of solutions and each of you represents a spoke in that wheel. The person on the inside will begin by telling their partner of a specific challenge they currently have or foresee in working with youth in their program. The person on the outside should listen carefully and then provide 1-2 solutions for strengthening their program in order to address this challenge. We will change places after about 3 minutes (the wheel will spin). You may begin.

d) After 3 minutes, ask the participants on the outside to take one step to the right so that they are now in front of a different person; participants on the inside will again tell the same challenge to the new person facing them and hopefully get a series of ways to strengthen the program.

e) Repeat until individuals on the inner circle have had a chance to get solutions from 3 different people and those on the outside have had a chance to explain their challenge and receive suggestions from 3 individuals on the inside circle (after two spins to the right for the outer circle, those on the inside get to take a step to the left for two turns).

f) Ask participants to share some of the best solutions in the plenary.
5) Guest Facilitator Presentation of Quality Youth Program - 30 - 45 minutes

Procedure:

Facilitators should identify a quality youth program that is in the country where the workshop is being held and ask a guest facilitator to present the project from conceptualization to implementation and through evaluation. The focus should be on the process (how-to) of implementation of effective youth programs in order to make it as useful as possible to participants.

The discussion should provide a brief overview of the key issues, strategies, and lessons learned in working with youth. The guest facilitator should lead an interactive discussion focusing on his/her experiences with youth programs. Any powerpoint slides used should only be for providing visual support and reinforcing key messages. The discussion should be approximately 20-30 minutes with the remainder of the time for questions and answers.
Facilitator’s Notes

There are a number of best practices that YouthNet promoted in YRH/HIV programming.

1) Integration of FP services and HIV services for youth. Research and programmatic evidence clearly indicates that basic knowledge of HIV/AIDS is very high. However, knowledge of FP and MCH are still quite low. There is a need for services to prevent unintended pregnancy and STIs. Sexually active young people are more likely to present at HIV services than FP services therefore research has clearly shown that VCT and PMTCT services provide excellent opportunities to reach sexually active young people in need of other RH information and services. Programs should seek to provide integrated services for young people to ensure there are no missed opportunities when young men and women present themselves to health providers.

2) Global, national and local level media in both long- and short-form programming are successful for targeting youth. Short-form programming (especially when it uses humor) keeps messages front and center, while long-form programming allows young people to be drawn into sympathetic stories in which they can see themselves and their peers reflected.

3) Global, national and project level standards in peer education and sex education provide important guidance to program implementers. YouthNet has developed global standards for peer education and sex education. These may be accessed at http://www.fhi.org/en/Youth/YouthNet/Publications/index.htm#eop. These standards provide the field with a compendium of research-tested and experience-based characteristics of effective programs; guidance on program design, adaptation, or selection; a framework for assessment and evaluation; and a means to publicize program progress and foster support.

4) Stand-alone youth friendly RH services have not been found to be the most effective strategy, many advocate for taking prevention services to where young people are already (existing youth clubs, schools, faith community activities, sports teams, etc...) while working to make regular RH services friendly to all, including youth.

5) Youth should be segmented within the target group (for example, they could be segmented by school status, geographic location, socioeconomic status, age and sex).

6) NGOs, governments, CBOs, FBOs need the skills to effectively ensure the participation of youth beyond token participation. YouthNet has developed tools to help organizations more effectively engage youth at all stages of programming.
YouthNet EOP Recommendations:

1) High quality curriculum-based programs change risky RH/HIV behaviors
   a. *Standards for Curriculum-Based RH and HIV Education Programs* (YouthNet) should guide the development and adaptation of curriculum-based RH and HIV programs
   b. Programs should train and motivate teachers to teach these topics
   c. Programs need to increase efforts to reach marginalized urban and rural youth
2) Answers emerge on peer education effectiveness and provide guidance for more rigorous research an program implementation
   a. PE needs to focus on youth-adult partnerships, gender issues, community and parent involvement, training and supervision
   b. PE needs to be designed rigorously and follow the *Peer Education Toolkit*
   c. More research is needed to understand which youth PE program characteristics have the greatest impact on youth seeking HIV related services and reducing risky behaviors
3) Youth, especially those at greatest risk, need integrated RH/HIV services
   a. PMTCT programs should include FP
   b. VCT services should emphasize risk perception and reduction planning and offer contraception
   c. PAC clients should receive FP services and special training to address judgmental attitudes of providers
   d. MCH including infant immunization programs should offer FP options
4) Youth-adult partnership builds alliances to address needs of youth
   a. *Youth participation guide* (YouthNet) offers tools to assess this
5) Continuously seek to update technical information and use the latest findings to inform programming
6) Media shape youth norms, opinions and discourse
   a. Global media should be used to address pregnancy prevention and sexual risk-taking in addition to the HIV/AIDS campaigns
   b. Local programs should take advantage of rights-free programs
   c. Local print media
   d. Youth festivals and similar events should be used for messaging
7) Community based initiatives stimulate supportive actions
8) Policy development and advocacy draws attention to youth needs
9) Addressing social and gender norms facilitates changes in risky behaviors
10) Capacity building and community involvement are key to successful country programs
**Optional Activity**

Trainers may choose to organize a panel discussion of youth involved in ASRH programs to talk about their experiences. This panel can include youth workers, peer health educators, youth board members, etc... Allow each panelist to give a brief five minute talk about what s/he does with the organization, how s/he got involved and how it has enriched and challenged his/her life. After each panelist has presented, allow the participants to ask questions. The panel should be moderated by a facilitator.

**Key Messages:**

- Adolescents, like adults, are entitled to basic sexual and reproductive health rights.
- All staff and managers should think through their own beliefs and attitudes toward adolescent sexuality. Negative beliefs should not interfere with adolescent rights and access to SRH services.
- High quality of care is delivered by program staff who understands cross-cultural adolescent development issues, including autonomy, identity development, body-image concerns, and peer-group identification.
- Adolescents are often particularly vulnerable to exploitation, and lack health information and skills, which puts them at risk for early pregnancy, HIV and other STIs.

---Engenderhealth,

*Youth-friendly services manual*

- Family planning programs should, with youth input, assess their own services from the youth perspective.
- Program managers need to involve youth and their parents in designing their programs.
- Family planning programs should protect the health of youth through effective community activities, which includes partnering with youth to design and implement activities and services.
Youth-Adult Partnership

Basics of Community-Based Family Planning
What is Youth-Adult Partnership?

Youth-Adult Partnership is one that:

1. Integrates youth’s realistic perspectives and skills with professional adults’ experience and wisdom
2. Offers each party the opportunity to make suggestions and decisions
3. Recognizes and values the contribution of each
4. Allows youth and adults to work in full partnership envisioning, developing, implementing, and evaluating programs
Definitions

• Youth-Adult Partnerships are NOT ways to hide the fact that programs are designed, developed, and run by adults.

• Tokenism is not partnership. Examples of tokenism:
  – Having youth present but with no clear role
  – Assigning to youth tasks that adults do not want to do
  – Having youth make appearances without training
  – Having only one youth on a board or council
Spectrum of Attitudes

Youth as Objects

Adults know what is best for young people and control situations in which they allow youth to be involved
Spectrum of Attitudes

Youth as Recipients

Adults allow young people to take part in decision-making because they think the experience will be “good for them”
Spectrum of Attitudes

Youth as Partners!

Adults respect young people as having something significant to offer, recognizing the greater impact youth bring to a project. Youth are encouraged to become involved.
Levels of Youth Participation

**Degrees of participation** (from highest to lowest)

- Youth-initiated, shared decisions with adults
- Youth-initiated and directed
- Adult-initiated, shared decisions with youth
- Consulted and informed
- Assigned but informed
Unacceptable Levels of Youth Participation

• Tokenism
• Decoration
• Manipulation
Benefits, Barriers and Challenges, and Strategies

1. What are the **BENEFITS** of using a youth-adult partnership approach to our work?

2. What are the **BARRIERS and CHALLENGES** to such an approach?

3. Looking at the barriers and challenges, what **STRATEGIES** are needed for effective youth-adult partnerships?
Benefits of partnering with youth

• Involving youth from the start can enhance a sense of ownership in the project

• Youth can:
  - ensure that programs are relevant to their needs
  - identify messages, communication channels and activities popular in their sub-cultures
  - bring new and vital ideas to programs, along with high energy to carry out set tasks
Benefits of partnering with youth cont’d

Youth can also:

- effectively publicize programs activities and help interest their peers

- give credibility to the program and serve as an outreach link to the community

- serve as peer educators thus enhancing their skills, self-esteem and leadership potential

- help us invest in the future
Barriers and challenges

Involving youth:
- in decision-making runs counter to most professional experience (i.e. Adults’ biases and fears about working with youth)

- requires additional training, staff time, costs, adjusting schedules

- may cause discontinuities (due to high turn-over)
Youth Adult Partnerships: Effective Elements

✓ Establish clear goals
✓ Share decision-making power
✓ Get commitment from highest level
✓ Be clear on roles and responsibilities
✓ Be selective in recruitment
YAP: Effective Elements (contd.)

✓ Provide training
✓ Be aware of different communication styles
✓ Value participation
✓ Include room for growth
✓ Remember youth have other interests
Tips for Working with Youth

• Be open and nonjudgmental
• Take advantage of expertise
• Make sure youth participate in meaningful ways
• Be honest about expectations
• Accommodate youth schedules
Tips for Working with Youth (contd.)

- Treat youth as individuals
- Make the work fun
- Avoid intimidating youth
- Avoid assumptions about all youth
- Youth have the right to say “No”
Tips for Working with Adults

• Most have good intentions
• Criticism does not mean condescension
• Adults may not be aware of the capabilities of youth
• Adults often feel responsible for the success or failure of the project
Tips for Working with Adults (contd.)

• Adults may be just as uncertain as youth and hide it better
• Call adults on when they use condescending language
• Do not be afraid to ask for clarifications
• Do not be afraid to say “No” because of other commitments
Goals for Youth Involvement – Not Just Youth Friendly

• Value youth-adult partnerships in reproductive health programs and policies affecting youth

• Integrate youth-adult partnerships into their reproductive health program and policy work
Measures for improvement

• Meaningful participation i.e. involving young people in designing, implementation, evaluation of programs, projects, activities and services

• Consider youth as equal partners when designing interventions targeting them
Advantages and Obstacles to Involving Youth

1. Advantages to Programs that Partner with Youth

- Involving youth from the start can enhance a sense of ownership in the project.
  If young people are brought into program design and decisions at the formation stage of a project, they feel more strongly that the project belongs to them.

- Youth input can help ensure that programs are relevant to their needs.
  Assessing the needs of the target audience is basic to the development of any project. It is perhaps more essential with programs for young people because of the importance of generational differences in styles, language, values and popular culture.

- Youth can help identify messages, communication channels and activities popular in their subculture.
  Language, slang and key messages change with the times. Young people can help craft messages that will be age specific to the current moment. The age-sensitive and age-appropriate approach will lead to higher sustainability of programs, because youth will come to a program that speaks to them, in their language (youth cultural and age appropriate).

- Youth can bring new and vital ideas to programs, along with high energy to carry out tasks.
  Young people have great ideas and a lot of energy, especially when a safe place is created as not to inhibit their creativity.

- Young people can effectively publicize program activities and help interest their peers in becoming program participants.
  One of the best methods of publicity among young people is word of mouth, especially if the mouth giving the message is a young person, well respected among other youth.

- Youth spokespersons can give credibility to the program and serve as an outreach link to the community.
  Youth will often ask their peers if a program is credible, youth friendly, or age appropriate before checking it out. If youth have buy-in, feel involved, think the program is effective, they will tell their friends. This also assures sustainability. If you build an effective youth program, youth will spread the word and more youth will come.

- Training and experience as peer educators enhance skills, self-esteem and leadership potential among those involved youth.
  While behavior change of the group of young people targeted to receive peer education is usually the indicator sought by project managers, the much smaller group trained as peer educators appears to reap significant benefits. Remember the youth in our programs (our youth partners) are also benefiting.

- Involving youth in present activities is an investment in the future
  Assisting young people in their personal and professional development is useful for a society in general and it can also be viewed as a practical strategy within an organization. The young health educators or youth partners of today are the managers and directors of reproductive health programs, tomorrow.

Adapted from:
Senderowitz, J. 1998. Involving Youth in Reproductive Health Projects. FOCUS on Young Adults.
2. OBSTACLES AND ISSUES RELATED TO INVOLVING YOUTH

- Youth involved in program decision making runs counter to most professional experience. Adults have many biases and fears about working with young people. Some cultures or age groups are not accustomed to working with young people and may feel threatened by youth involvement or think that youth involvement takes away from the credibility of a program. They have doubts about successful outcomes. Their fears include that youth will find their work boring or they cannot master the needed skills.

- Involving youth in programs requires additional training, staff time and costs. Yes, additional resources will be needed to support youth involvement efforts, but the advantages and increase in sustainability will make the additional training pay off. Additional training is needed of managers and program coordinators who will work with youth. Additional training is needed of youth who will work with adults. This thorough training will yield positive outcomes and set all involved up for success.

- Involving youth requires adjusting schedules to meet young people’s needs. Most young people are in school or at work during the day and are thus unable to participate in projects during typical working hours. As a consequence, preparation, monitoring, mentoring and implementation must take place at hours when young people can be available. Since the target group of young people has similar hours of availability, special scheduling would be required in any case.

- High turnover of young people causes discontinuities and added costs. Some turnover is an inevitable consequence of age. Young people involved in programs for youth eventually grow out of the appropriate age range. It is important for the organization to think of future opportunities (and training) for the youth once they work their way out of a job (age out).
Handout 13.2

Strategies to Engage Youth in Family Planning

- **Working with existing facility-based RH services:**
  - Most existing facilities and personnel can be the most efficient way to extend YF Services to young people rather than creating new services.
  - In most countries, extensive RH services already exist, and these could, with appropriate adaptation, potentially serve youth needs.

- Integrating or creating services at youth oriented sites e.g. community centers among others.

- Outreach services as an approach should be integrated into existing youth activities or venues.

- Partnership with community service organizations including community based organisations and local government that play a vital role in mobilising young people for services.

- **Youth - Adult partnership.** Where young people have an equal opportunity to design, implement, monitor and evaluate YFS
Handout 13.3
Elements of Quality – Youth Friendly Services

**Information**: What services are available when, which methods, marketing, health education, outreach, educational materials, counseling, address adolescent specific concerns, STI/HIV, pregnancy

**Access**: Full range of services, referral system, convenient times, minimal waiting time, convenient location, accommodate drop-ins, linkages with schools, affordable

**Informed Choice**: appropriate choices available, clients informed of options, good interpersonal communication with provider, provider respects adolescents’ choices – doesn’t judge “best” method

**Safe Services**: protocols and procedures in place and practices, management of complications, management of emergencies, technical skills upgraded regularly, infection prevention practiced

**Privacy and Confidentiality**: situation not discussed with others, consent of parents or spouse not required, records controlled, private space for consultations

**Dignity, Comfort, and Expression of Opinion**: Clients welcomed, treated with courtesy and respect, treated in the order arrived, encourage expression, adequate consultation time

**Continuity of Care**: availability of follow up services, patients informed of warning signs, smooth referrals, reliable supplies, inform patients of lab results

**Staff Need for Facilitative Supervision and Management**: culture of quality, supportive managers and supervision, self review guidelines, record review, team work – staff input encouraged

**Staff need for Information, Training and Development**: regular in-service and training, staff have adequate knowledge and confidence, staff able to complete protocols

**Staff need for Supplies, Equipment and Infrastructure**: water, power, light and heat available, logistic management for supplies, reference materials and resource persons available, IP supplies available, space is adequate, facilities comfortable.

*Adapted from Engender Health: Youth Friendly Services: A Manual for Service Providers*
Session 14: Field Visit
Session 14 - Field Visit

Achievement-based Objectives:
By the end of this session the participants will have:
• Observed the work of the CBDs
• Met with groups of youth, men and religious leaders
• Visited health facilities
• Posed questions of all groups related to the CBFP work

Duration: 4-5 hours (depending on distance to field site)
Timeframe: Day Five - morning only
Materials:
• Learning Guide for Field Visit
• Note pads & pens
• Transportation to & from field site
• Water & snacks
LEARNING GUIDE FOR
FAMILY PLANNING FIELD VISIT

Note: The workshop participants will be divided into groups of 5 – 6 and will use the following learning guide for the field visit activities.

Field Visit

1) Meet with CBD, conduct home visits with CBD and follow the CBD section of the learning guide to help you to get as much as possible out of this visit.
2) Meet with youth group, men’s group, or group of religious leaders. *Method for this meeting will be discussed beforehand at the workshop.*
3) Visit health facility and follow the health facility section of the learning guide to assist you in making the most out of your visit.

- Use OBSERVATIONS – don't just ask questions
- Share responsibility within the group for finding out information
- This is NOT a supervision visit
- You do NOT need to find out ALL this information – this is only a guide

General

1. Who manages this program? (For example, MOH, private company, NGO, etc…)
2. What are the main activities of the program?
3. What kinds of baseline assessments were done to establish the program?
4. What is the M&E system for this program?

Community Level

CBDs / Management Elements

1. Tell us about your work as a CBD – What different activities do you do?

2. Training / Capacity building
   - What training did you have? When
   - What refresher training have you had? When was the last time?
   - Are there topics that you need more information on?

3. Supervision
   - Who is your supervisor?
   - When was the last time you were supervised? What did you discuss?
• What kinds of things does your supervisor help you with?

4. Motivation
• How long have you been a CBD?
• How much time do you spend working as a CBD every week?
• What do you like best about your work? Least?
• What kinds of things motivate you to keep going?

5. Supply availability and management
• What supplies are currently in stock? How many?
• Have there been stock outs during the past 6 months?
• What is the system for getting more supplies? Order form? Transport?
• How do you know when you need more?

6. Referral System / Links with Health Center
• What is your relationship with the health center staff?
• What kinds of things do you refer to the clinic?
• How often do you go to the clinic? How often do they come out?

7. Record Keeping – Clients and supplies (look at her records)
• What kinds of records do you keep?
• What kinds of reports do you turn in? how often?
• Is the work load for record keeping and reporting reasonable?

Community Clients / Members / Secondary Groups

1. Community Mobilization Activities / Channels for Information
• What kinds of activities are being done for education and mobilization? By whom? Targeting whom? How?

2. Involvement of spouses, secondary groups in influencing behavior
• Activities targeting secondary groups

• Activities involving secondary groups in targeting primary groups
3. Understanding and/or use of short and long term methods
   - Role of CBD in use of long term methods

4. Barriers to getting services at the health facility
Facility Level

Infrastructure, Physical Facilities and Equipment
- Are there adequate utilities – power? Water? If not – what alternatives have been developed
- Is the space adequate for confidentiality and privacy?
- Is there enough equipment to do the exams? Insert IUDs? Insert Norplant?

Commodities and supplies
- What commodities are actually available? How many?
- Have there been stock outs during the past 6 months? Why?
- Are commodities stored well? First in first out? Minimum and maximum levels maintained?
- Expired medicines destroyed?

Infection Prevention
- Handwashing before and after each client, after handling soiled instruments, touching body fluids, etc.
- Appropriate equipment for decontamination, cleaning, and disinfection.
- Adequate supplies available for decontamination and disinfection? Changed regularly?
- Glove used with clients, by cleaning staff
- Waste disposed of properly?

Barriers
- Service sites and times accessible
- Methods given out without excessive requirements
- Services affordable

Staff Support
- Training – When were staff last updated? Are there significant gaps in their knowledge? What is the system for in-service updates? Is training competency-based?
• Supervision – When last supervised? By whom? What discussed? Consistent with training content? Helpful?

• Use of protocols and guidelines – Are guidelines available? Used?

Records and Reporting
• How many family planning clients were seen in the last 3 months for each different method?
• How many new acceptors?
• How do they use the information they collect? Who reviews it?

Important – but not to be done today

Client Provider Interaction (this may be difficult to get – Don’t worry)
• Does the provider focus on giving priority information that is tailored to the specific client’s particular needs?
• Is communication between clients and providers interactive? Do personnel attempt to minimize social distance between themselves and their clients?
• Has the counseling staff received counseling training?
• Do providers greet clients respectfully?
• Do providers use appropriate health education job aids?
Session 15: Family Planning Integration
Session 15: Integration

Achievement-based Objectives

By the end of this session, the participants will have:

- Described three logical points of integration for FP services
- Discussed key steps to address when planning to integrate services
- Listed advantages and disadvantages of at least three different types of integration
- Described three possible partnerships between their program and another to provide quality community-based FP services

Duration: 2 hours

Timeframe: Day 6 Session 1

Materials:
- Written Definition of Integration Entry Points on flip chart
- Handout 15.1 (Integration Entry Points)
- Powerpoint (for Facilitators reference only)
- Guest Presenter

Additional Resources:
- FHI website on Integration: http://www.hivandsrh.org/
- Integrating STDs and AIDS services into FP Programs: Training Community Workers, a curriculum: http://cedpa.org/content/publication/detail/716/
- MSH Manager: Forming Partnerships to Improve Public Health http://erc.msh.org/mainpage.cfm?file=2.2.1.htm&module=planning&language=English

Tasks

NOTE: Review session objectives first.

1. Introduction to Integration - 10 min.

Procedure:

a) Explain: Up to now we have been talking almost exclusively about family planning technology and FP projects, but in reality many of us are not involved in programs
that are exclusively focused on FP or we work for organizations that do more than promote family planning:
  • How many of you work for organizations that do more than promote FP? How many of you work on projects that include components other than FP?
  • Why is it important to acknowledge the context in which we work? (Response: Because we might be able to create synergies between FP and other project interventions to gain a greater advantage.)

2. Identifying Integration Entry Points - 45 min.

Procedure:

a) Ask: Working in your small groups, please list all the non-FP projects or activities that your organization is implementing in your country. After 10 minutes go from group to group and make a master list of all of the non-FP intervention areas on the flip chart. Number the responses 1,2,3,....

b) Ask: What do we mean by integration entry points? (various responses) Show the group a written definition on a flip chart and mention some examples of good integration and respond to any questions.

c) Assign each small group a 2-3 intervention areas from the master list. Using handout 15.1, ask each group to discuss integration entry points that exist or could be created to promote family planning in the intervention areas assigned. Ask them to record their discussion on the handout.

d) Alternating from table to table, ask participants to share the results of their group work.

e) Address questions.

3. Reflection and application - 20 minutes

a) Working individually each person will identify 1 - 2 things they can do in their own project to increase integration of FP into non-FP projects or activities.

b) Some participants will share

c) Facilitator will wrap up saying that it's important to take advantage of every opportunity to increase access to information about FP and FP services so we can maximize the benefits that family planning has - even outside of health.

4. Guest Facilitator Discussion - 45 minutes

Facilitators should identify an integrated program that is in the country where the workshop is being held and ask a guest facilitator to present the project from conceptualization to implementation and through evaluation. The focus should be on the process (how-to) of implementation in order to make it as useful as possible to participants.
Facilitator's Notes

Perspectives on Integration:

“FP managers are frequently being asked to add or integrate FP services into MCH, nutrition, women's RH, adult literacy, and other health and development activities. Consequently, managers are asking questions about exactly when, where, and how FP services can be integrated with these other activities. These questions are often answered on the basis of personal beliefs, rather than on a rigorous framework for assessing the specific changes needed to deliver integrated services effectively.”--MSH

FP and HIV Integration

Involves the provision of FP and HIV/STI prevention and care services as part of a unified, coordinated strategy that addresses clients' risks for unintended pregnancy and HIV/STI transmission, as well as for pregnancy and HIV-related care and support. Clients' needs related to HIV and FP are often inextricably linked, and addressing sexuality is fundamental to both. –Engenderhealth

www.fphiv.org provides a wealth of information on this topic.

Programming for FP/HIV integration approaches should be done based upon the HIV situation. In countries with generalized epidemics, integration efforts may occur across a range of interventions, with FP integrated into HIV activities and HIV integrated into FP activities.

In environments where both contraceptive prevalence and HIV prevalence are low, integration activities may actually weaken results and a more vertical approach to voluntary FP, coupled with focusing HIV activities on higher-risk populations may be most effective.

Guiding Principles for FP/HIV Integration

What is the epidemiology of HIV?
- Low-level (HIV prevalence has not consistently exceeded 5% in any defined at-risk sub-population)
- Concentrated (HIV prevalence is consistently over 5% in at least one defined sub-population but below 1% in pregnant women nationwide)
- Generalized (HIV prevalence is consistently over 1% in pregnant women nationwide)

How mature is the FP program?

1 USAID, 2003 FP/HIV Integration Technical Guidance for USAID-Supported Field Programs
• How significant is the unmet need for contraception and where is the need greatest?
  o Strengthening FP programs may be the priority intervention in countries where FP services are critical and unmet need is high
• What is the interplay between HIV and FP programs and does the overall program environment support or hinder integration?
  o If HIV prevalence is high and existing FP infrastructure is strong, integration is a valuable opportunity (Zimbabwe used CBD agents for FP to provide HIV information and referral to VCT services
• Does the FP program address the needs of high-risk populations such as CSWs, transient and mobile populations and injecting drug users?
  o These populations are often not reached by FP programs and integration of HIV prevention with FP programs would be an opportunity

Key Technical Approaches Conducive to FP/HIV Integration

FP/HIV integration is a promising area for future programming:

1. Abstinence, Be Faithful and Correct and Consistent Condom Use (ABC)
2. Integrated interventions should be targeted to youth
3. FP and Prevention of Mother-to-Child Transmission (PMCT)
4. Voluntary Counseling and Testing and FP
5. Integrate with STI prevention and treatment
6. Policies built on cultural values contribute to changing social norms and promoting health behaviors
7. Community-based approaches are central to success
8. Commodities and logistics systems need to be broad enough to cover all program areas which may be challenging when funding streams and sources of commodities are vertical.

**FP and MNC integration** through prenatal care, postpartum care, post abortion care and with well-baby clinics

**FP and Environment Integration** through BCC campaigns about economic benefits of improved farming practices, conservation practices and use of FP to space and limit births. Madagascar provides an example of this through the “Champion Communities” activity. WWF, CI, SanteNet and Voahary Salama Network are all working in this and initial successes are now being scaled up.

**FP and RH Integration**

Male involvement in FP may be accomplished by setting up RH services for men only; however, clinics for men only are not necessary and are not very cost
effective or efficient and clinics that serve men and women contribute more towards improving couples communication.

Men’s reproductive health services were successfully integrated into formerly female-focused services without compromising the quality of care. The addition of services for men increased utilization of clinical services by both men and women. The intervention is being scaled up to additional clinics. The OR Summary on this intervention in Bangladesh may be found at http://www.popcouncil.org/frontiers/orsummaries/ors47.html

REDI is a useful counseling approach to take when providing integrated FP services. This type of counseling is more appropriate than the traditional GATHER approach that is extremely effective in separate FP services.

INTEGRATION: The following overview is adapted from MSH Manager

Integration generally means two or more types of services previously provided separately are offered as a single, coordinated, and combined service. Integrating FP services can be a means of improving the quality of service delivery, expanding access to services, or making services affordable and convenient to clients. Integration can be achieved in a variety of ways:

- Integrating existing programs or divisions;
- Integrating FP services into existing MCH programs: One of the most effective interventions for reducing infant mortality is for women to space the births of their children.
- Adding services to serve a more diverse client population: Many FP managers aspire to serve others in addition to the clients that currently come through the clinic door.
- Adding new RH services to the existing FP program. Often includes diagnosing, treating, and providing information on how to prevent HIV and STIs, providing women with information on women’s health and health risks, providing pre- and post-natal health services, prevention and management of gender-based violence (GBV) and providing contraceptive services to men.

Capitalizing on the Strengths of Vertical and Integrated Programs. Both integrated and vertical programs have significant strengths and weaknesses. Managers should carefully consider the strengths of both approaches for their specific situation. Managers are now finding that a mix of integrated and vertical approaches provides an opportunity to tailor the approach to support their specific program goals.
Integration can help to improve supervision, clinic scheduling, and logistics. For example, having one nurse care for the FP needs of a mother and the health needs of her infant on the same visit means that the mother does not need to come to the clinic twice in order to receive both FP and child health services. For the clinic nurse, it is better to have one supervisor for both FP and child health than two different supervisors for the two tasks.

In the same way, an integrated approach might streamline logistics and make better use of resources. Integrated health and FP services offer managers the possibility of providing *more convenient and comprehensive services to the client and more streamlined and cost-effective systems at the service site.*

On the other hand, FP program managers may find that integrating FP with other health services may weaken program effectiveness by placing too great a burden on service delivery staff and middle managers. Three key reasons why vertical programs are often seen as being more successful are: *staff roles and responsibilities are more clearly defined; results are easier to identify (making progress easier to monitor); and vertical programs invariably get more resources.*

**Being clear about reasons for integrating.** When integrating new services, managers should carefully define the specific health objectives that they wish to achieve. The question of *what* to integrate can only be answered when the overall program objectives have been defined.

**Meeting the Challenges of Integrating Services.** Integrating services requires managers to consider both the potential benefits that will result, such as the possibility of cross-subsidizing services, and the potential complications and new management challenges. Managers will often find that people are reluctant to change and that coordinating logistics and sharing resources is not as easy to do as it would seem. To complicate matters further, as programs become integrated the kind of support donors provide must change. Managers will need problem-solving skills. / Managers may be required to challenge vested interests. / Managers will need to gain donor support.

**Should You Add New Services to Your Program?** Do you want to reach a wider market by offering services that are attractive to a particular sector of the population? Do you want to broaden the services that you are currently offering because you feel it will benefit your clients? Do you want to add more services that are profitable in order to cross-subsidize your existing services? To help you to decide whether a new service is a realistic option for your program, answer the following questions:

- *Will the clients who will use the new service be the same as or different from your current clients?* If different, how will their needs
differ? Consider hours of operation, need for child care during appointments, privacy and confidentiality, and the need for different IEC messages or materials.

- **Will the current physical resources be adequate or will additions be needed?**
- **Will there be a need for new personnel, or can the current staff provide the new services?** Consider what types of new skills will be required.
- **Will the new service require new skills for staff?**
- **Will the current logistics systems cover the needs of the new services, or will new systems be required?**
- **How will the addition of each new service contribute to the financial sustainability of your program?**
- **Will this new service provide an opportunity for your program to cross-subsidize services in your program?** Experience shows that the services that have the best potential of being profitable are laboratory services, curative services, sales of pharmaceuticals, and treatment of STDs. These can be used to cross-subsidize preventive services such as RH, FP services, and CBD services that are generally not profitable.

**STEPS TO INTEGRATION:**

**Planning/ Budgeting.** Focus on developing an integrated plan and budget. If the budget is integrated, the program will be integrated. If the budget is vertical, with separate allocations for each type of activity, those activities will remain vertical.

**Plan at the local level.** Integration requires a good understanding of the local situation with regard to the availability of staff, staff capabilities, the local health and FP situation, and the condition and size of facilities. Managers should involve local staff when they are redesigning how activities will be integrated and carried out.

**Make plans flexible.** Because of the complexity of integrated programs, it is more difficult to anticipate the changes that may be necessary in the future.

**Internal Organization.** Provide equal pay for jobs of equivalent responsibility. Design programs so that form follows function. As programs become more integrated, the organizational structure will need to change to support the integration process. **Take the opportunity to reallocate staff to where they are needed.**
**Staff Roles and Responsibilities:** Staff must have a clear understanding of their roles and how they fit into the overall program. Acknowledge and support staff expertise.

**Training.** Develop a case-based training curriculum. This facilitates integrated service delivery because it focuses on the different needs of individual clients. Case-based training teaches providers to assess each individual client and provide appropriate services for that client. **Select an appropriate training site** so that the training can include participatory patient care as well as theoretical training.

**Supervision:** Limit the number of supervisors. Create supervisors who train and facilitate.

**Logistics and Vehicles.** Integrate the logistics system only when services are operating at similar levels of efficiency. As a general rule, any two systems being integrated will be pulled down to the operating efficiency of the less efficient system. **Allocate local vehicle use based on actual needs.** Allow staff at the level at which the vehicle is used to decide how best to share the vehicles.

**Client Services.** Offer many services to all clients. Clients' needs include the need for specific services whenever they come to the clinic or facility, such as information, referrals, privacy, and brief waiting time. **Be sensitive to the needs of special groups.** Clients coming to the clinic will have different needs. For some clients, especially those seeking MCH services, the waiting room offers social opportunities. However, privacy and confidentiality may be of paramount concern to men who are coming for a vasectomy or adolescents seeking condoms or STD treatment.
**Key Messages for Integration:**

For effective integration, managers must always be clear on the goal of the effort, and monitor progress in terms of meeting the goal(s).

Integration has advantages and disadvantages that should be weighed before integrating services.

Integration requires comprehensive planning that includes addressing program design, budgeting, personnel, training, supervision, logistics, monitoring.

There are numerous possibilities for integration: 1) HIV/AIDS Programs; 2) MNC Program; 3) Environment; 4) Reproductive Health Programs; 5) General Primary Health Care Program

**Understanding Integration** (www.msh.org)

Health and family planning services are integrated in many different ways. For a director of a private family planning organization, integrating services might mean adding pre- and post-natal and obstetric services to the program. For a director-general of a department of health, integration might mean adding family planning services to the existing program of health services. For a health center manager in a district clinic, integration might mean holding maternal and child health (MCH) and family planning sessions concurrently, rather than having separate clinics on different days. These are all examples of integrated services, the common denominator being that two or more types of services previously provided separately are offered as a single, coordinated, and combined service.

Integrating family planning services can be a means of improving the quality of service delivery, expanding access to services, or making services affordable and convenient to clients. Integration can be achieved in a variety of ways:

- Integrating existing programs or divisions;
- Integrating family planning services into existing MCH programs;
- Adding services to serve a more diverse client population;
- Adding new reproductive health services to the existing family planning program.

**Integrating existing programs or divisions.** In the past, government programs in many countries have placed family planning services under ministries other than the Ministry of Health or in divisions separate from other types of health services. As a result, family planning services were not offered at many government health facilities. But as family planning has become a priority of many
governments, and as long-term clinical methods have become more popular, these programs have tended to merge, and now most government health facilities offer a range of family planning services. Although most government programs are now offering family planning services throughout their clinics, the separation of health and family planning services at the administrative level remains. This administrative separation can create a situation in which health and family planning staff are in separate offices, are paid from separate budgets, have completely separate supervisory systems, and even different working conditions. While this administrative separation at the central level is intended to be a temporary organizational arrangement, it often remains in place for many years, thereby undermining the effectiveness of delivering integrated services.

**Integrating family planning services into existing MCH programs.** Traditionally, maternal and child health (MCH) programs have focused primarily on the "C" and given less attention to the "M" in MCH service delivery. However, managers now recognize that improving child health requires paying more attention to the health and needs of the mother, including her contraceptive needs. In fact, one of the most effective interventions for reducing infant mortality is for women to space the births of their children. For this reason, many MCH programs, both governmental and non-governmental, are making family planning services an integral component of MCH services. Some programs accomplish this by simply adding family planning counseling and providing contraceptives at existing mobile and fixed health facilities. Other programs choose to reorganize their services completely to provide a full range of health and family planning services to their clients throughout all their service facilities. In either case, MCH programs of the future will most likely include family planning services.

**Adding services to serve a more diverse client population.** Many family planning managers are recognizing that their organizational mission goes beyond serving only the clients that currently come through the clinic door. These organizations are expanding their scope of services to meet the needs of underserved populations (such as adolescents and urban poor), to actively promote family life education in the schools, or to develop outreach programs to inform and educate potential clients.

**Adding new reproductive health services to the existing family planning program.** Many family planning organizations are adding reproductive health services to their family planning program. These services often include diagnosing, treating, and providing information on how to prevent sexually transmitted diseases (STDs), providing women with information on women's health and health risks, providing pre- and post-natal health services, and providing contraceptive services tailored specifically to men. In particular, the AIDS pandemic has led to high demand for STD/AIDS counseling and treatment of common STDs at family planning clinics. Since these services are often not available through other health
facilities, and since family planning clinics often provide the best access to condoms, many family planning clinics are beginning to integrate these broader services into their existing family planning programs.

As these examples point out, programs can be integrated in different ways, and integration provides an opportunity to expand or improve current services so that you can serve the needs of your clients more effectively and efficiently.
Module 15: Integration and Partnering

Basics of Community-Based Family Planning
Session Objectives

As a result of this session, participants will have:

• Described three logical points of integration for FP services

• Discussed key steps to address when planning to integrate services

• Listed advantages and disadvantages of at least three different types of integration

• Described three possible partnerships between their program and another to provide quality community-based FP services
What is integration?

- Two or more types of services previously provided separately are offered as a single coordinated and combined service.

- May be a means to:
  - Improve quality of service delivery
  - Expand access to services
  - Make services affordable or convenient to clients
When to integrate…

• Do you want to reach a wider market?

• Do you want to broaden the services currently offered because you feel it will benefit your clients?

• Do you want to add more services that are profitable in order to cross-subsidize existing services?
Is the proposed integration realistic?

Consider the following:

• Will the new clients be the same as or different from the current clients?

• Will the current physical resources be adequate?

• Will you need new personnel, or can current staff provide the new services?
Is the proposed integration realistic? (cont’d)

- Will current logistics systems cover the needs of the new services?

- How will the addition of each new service contribute to the program’s financial sustainability?

- Will this new service provide an opportunity for your program to cross-subsidize services?
Steps of integration

- Planning/budgeting
- Plan at the local level
- Make plans flexible
- Internal organization – staffing
- Staff roles and responsibilities
- Training
- Supervision
- Logistics and vehicles
- Client services
Some Sector Areas for FP Integration

- HIV/AIDS Programs
- MNC Programs
- Environment Programs
- RH Programs
- General Primary Health Care Program
Entry Point to Integration

- Look for overlapping activities between the two or more sectors you are wishing to integrate and build on those.
Why Integrate HIV and FP Services

Clients seeking HIV-related services

AND

Clients seeking FP services

Share common needs and concerns:

• are often sexually active and fertile
• are at risk of HIV infection or might be infected
• need to know their HIV status
• need access to contraceptives
Why Integrate HIV and FP Services continued...

Creates programmatic synergies including:

• more attractive to potential clients
  increases access to wider range of services
  – helps overcome HIV stigma

• opportunities for follow-up and support for drug or method adherence
When to Integrate FP with HIV Services

The technical guidelines on FP/HIV integration from USAID (USAID 2003):

• In **Low-Level Epidemic** situations where the HIV prevalence has remained below 5% in any at-risk sub-populations, and has not reached 1% among pregnant women, HIV programming should be targeted to those at-risk groups while FP services should be prioritized for the general population.

• In **Concentrated Epidemic** situations where HIV prevalence exceeds 5% in at least one of the vulnerable sub-populations, FP services should be prioritized for the general population while FP/HIV integrated services should target the at-risk groups.

• In **Generalized Epidemic** situations where HIV prevalence rates exceed 1% among pregnant women, all FP and HIV/AIDS services should be integrated.
Key Technical Approaches Conducive to FP/HIV Integration

- ABC programs
  - Dual protection
- Integrated services targeted to youth
- FP and PMTCT
- FP and VCT
- FP and ART, care and support
- Policies built on cultural values contributes to changing social norms and healthy behaviors
- CB approaches
- Commodities and logistics

(Source: USAID 2003, FP/HIV Integration Technical Guidance for USAID Supported Field Programs)
Birth Spacing

• Birth to pregnancy interval – the interval between the date of a live birth and the start of the subsequent pregnancy

• Healthy timing and spacing of pregnancy
  – Delay first pregnancy until 18 years of age
  – Couples should wait 2 years after the birth of their last baby before trying to conceive
  – Wait six months after an abortion or miscarriage before trying to conceive.

(Source: ACCESS FP, 2007)
Facts from Lancet Series on Sexual & Reproductive Health

• Promotion of family planning in countries with high birth rates has the potential to
  – reduce poverty and hunger,
  – potentially avert 32% of maternal deaths
  – potentially avert nearly 10% of childhood deaths

• BUT, those who drafted the MDGs in 2000 ignored the difficulties posed by sustained rapid population growth in many of the world’s poorest countries and spurned the goal of universal access to reproductive freedom

(Source: ACCESS FP, 2007)
Lancet Series: Maternal Mortality & Morbidity

• In the year 2000, family planning could have averted

  – 90% of abortion related and

  – 20% of obstetric related mortality and morbidity

(Source: ACCESS FP, 2007)
Postpartum Family Planning Facts

For non-lactating women on average, the first ovulation with a chance of conception occurs 45 days after delivery -

Campbell & Gray 1993

For breastfeeding women, return of menses may be delayed six months or longer. However, this is very dependent on breastfeeding practices- and breastfeeding women can and do get pregnant before the onset of their next menses.

ACCESS FP, 2007
Someone will talk to her after…

- Probably not—A minority of women & their babies receive any postpartum/postnatal care
- Nigeria 71%- no care
- Kenya 80%- no care
- Bangladesh 82%-no care
- Haiti 62% -no care

(Source: ACCESS FP, 2007)
Postpartum/Postnatal Priorities

Early detection & management of problems

- Maternal Care/Counseling
  - Nutrition
  - Breast care
  - Hygiene
  - Malaria & tetanus prevention
  - Danger signs & response

- Infant Care/Counseling
  - Nutrition
  - Warmth
  - Early & exclusive breastfeeding
  - Cord & Eye care
  - Immunization
  - Danger signs & response

Source: ACCESS FP, 2007
REDI Counseling Methodology for Integrated FP/RH Programs

• Rapport-building” – with client

• “Exploration” of client’s needs, life…

• “Decision-making” – with client

• “Implementing the decision” – helping client develop action plan

(Source: EngenderHealth, Integrated RH Training Manual)
Exercises

1) FP/MNC Integration
   • Identify key areas for integration
   • Follow the steps for integration and outline activities necessary to integrate FP

2) FP/HIV Integration
   • Identify key areas for integration
   • Follow the steps for integration and outline activities necessary to integrate FP

3) Population Health Environment
   • Identify key areas for integration
   • Follow the steps for integration and outline activities necessary to integrate FP

4) Postpartum FP
Partnerships: Key Factors for Effective Partnerships

- Communication
- Cooperation
- Coordination
- Collaboration
Possible Partners

- International Public such as UN agencies
- International Private such as NGOs, private corporations
- National Governmental Offices
- Community Organizations
Benefits of Partnerships

- Provides opportunities to be more comprehensive in strategies
- Encourages buy-in from the different partners and more sustainability
- Encourages scale-up
- Attracts new resources
- Establishes standards and norms for sectors
- Fills service gaps and increases access to services
Conclusion: For effective integration and partnerships

- Managers must always be clear on the goal of the effort and monitor progress in terms of meeting the goal(s)

- Integration and partnerships have advantages and disadvantages

- Integration requires comprehensive planning that includes addressing program design, budgeting, personnel, training, supervision, logistics, monitoring
Handout 15.1 Potential Entry Points for FP Integration

*Note:* The following matrix includes some of the main child survival interventions where there may be opportunities for effective FP integration. Based upon your experience, please share with us suggestions of entry points for family planning messages and service provision for at least three of the child survival interventions in the matrix below. Please feel free to add any other interventions to this list if you think they might be more relevant points for family planning integration. Thanks for your participation in the discussion and for completing the matrix.

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Activity Entry Points</th>
<th>Benefits of FP to this Intervention (How would FP help achieve the goals of this intervention? What are the benefits of FP to this intervention?)</th>
<th>Potential Results (Please Check Appropriate Box)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Knowledge</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

563
Daily and Final Evaluation
Daily Evaluation- Basics of Community Based Family Planning (Day 1)

1. Please rate how helpful this session was to your understanding of sampling basics.

1  2  3  4  5
Not very  Somewhat  Very helpful

2. What did you like most about this session?

3. What did you like least about this session?
4. Do you have any suggestions for improving this session?

5. How will you use this information in your project?
Daily Evaluation- Basics of Community Based Family Planning (Day 2)

1. Please rate how helpful this session was to your understanding of sampling basics.

1 2 3 4 5
Not very Somewhat Very helpful

2. What did you like most about this session?

3. What did you like least about this session?
4. Do you have any suggestions for improving this session?

5. How will you use this information in your project?
Daily Evaluation- Basics of Community Based Family Planning (Day 3)

1. Please rate how helpful this session was to your understanding of sampling basics.

1 2 3 4 5
Not very Somewhat Very helpful

2. What did you like most about this session?

3. What did you like least about this session?
4. Do you have any suggestions for improving this session?

5. How will you use this information in your project?
Daily Evaluation- Basics of Community Based Family Planning (Day 4)

1. Please rate how helpful this session was to your understanding of sampling basics.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not very</td>
<td>Somewhat</td>
<td>Very helpful</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. What did you like most about this session?

3. What did you like least about this session?
4. Do you have any suggestions for improving this session?

5. How will you use this information in your project?
Daily Evaluation- Basics of Community Based Family Planning (Day 5)

1. Please rate how helpful this session was to your understanding of sampling basics.

   1  2  3  4  5
   Not very  Somewhat  Very helpful

2. What did you like most about this session?

3. What did you like least about this session?
4. Do you have any suggestions for improving this session?

5. How will you use this information in your project?
Basics of Community Based Family Planning
Final Evaluation

1. Please rate your overall satisfaction with this workshop.

1 2 3 4 5
Not Satisfied Somewhat Satisfied Very Satisfied

Comments:

2. I will be able to apply the skills I learned this week to my own project.

1 2 3 4 5
Not Satisfied Somewhat Satisfied Very Satisfied

Comments:

3. Overall, this workshop matched my needs.

1 2 3 4 5
Not Satisfied Somewhat Satisfied Very Satisfied

Comments:
4. What are 3 things you will do or change at your project sites as a result of this workshop?

5. What were the strengths of the training approach?

6. How might the training approach be more effective?

7. In general, how would you rank the following specific training elements?

   A. Level of Material:

   1  2  3  4  5
   Not Satisfied  Somewhat Satisfied  Very Satisfied

   Comments:
B. Level of Interest:

1 2 3 4 5
Not Satisfied Somewhat Satisfied Very Satisfied

Comments:

C. Course Pace:

1 2 3 4 5
Not Satisfied Somewhat Satisfied Very Satisfied

Comments:

D. Proportion of Practical Work (Group Exercises) to Presentation:

1 2 3 4 5
Not Satisfied Somewhat Satisfied Very Satisfied

Comments:
8. How would you rank the specific activities?

A. Benefits of FP at the Global and Individual Level:

1  2  3  4  5
Not Satisfied  Somewhat Satisfied  Very Satisfied

Comments:

B. Contribution of FP to the MDGs:

1  2  3  4  5
Not Satisfied  Somewhat Satisfied  Very Satisfied

Comments:

C. Contraceptive Technology Update (Methods, Side Effects, Advantages, Disadvantages)

1  2  3  4  5
Not Satisfied  Somewhat Satisfied  Very Satisfied

Comments:

D. Counseling in FP Service Delivery:

1  2  3  4  5
Not Satisfied  Somewhat Satisfied  Very Satisfied

Comments:

E. Infection Prevention:

1  2  3  4  5
Not Satisfied  Somewhat Satisfied  Very Satisfied

Comments:
F. Behavior Change Strategies for FP:

1 2 3 4 5
Not Satisfied Somewhat Satisfied Very Satisfied

Comments:

G. How to use and when to use various tools for Quality Improvement:

1 2 3 4 5
Not Satisfied Somewhat Satisfied Very Satisfied

Comments:

H. What is involved in setting up a Contraceptive Logistics System?

1 2 3 4 5
Not Satisfied Somewhat Satisfied Very Satisfied

Comments:

I. Strategies for Male Involvement in FP Programming:

1 2 3 4 5
Not Satisfied Somewhat Satisfied Very Satisfied

Comments:
J. How to Integrate Gender into FP Programming:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Satisfied</td>
<td>Somewhat Satisfied</td>
<td>Very Satisfied</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:

K. How to provide Youth Friendly FP/RH Services:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Satisfied</td>
<td>Somewhat Satisfied</td>
<td>Very Satisfied</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:

L. What is meant by Integration and How to Integrate FP into other Programs?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Satisfied</td>
<td>Somewhat Satisfied</td>
<td>Very Satisfied</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:

M. Field Visit

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Satisfied</td>
<td>Somewhat Satisfied</td>
<td>Very Satisfied</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments: