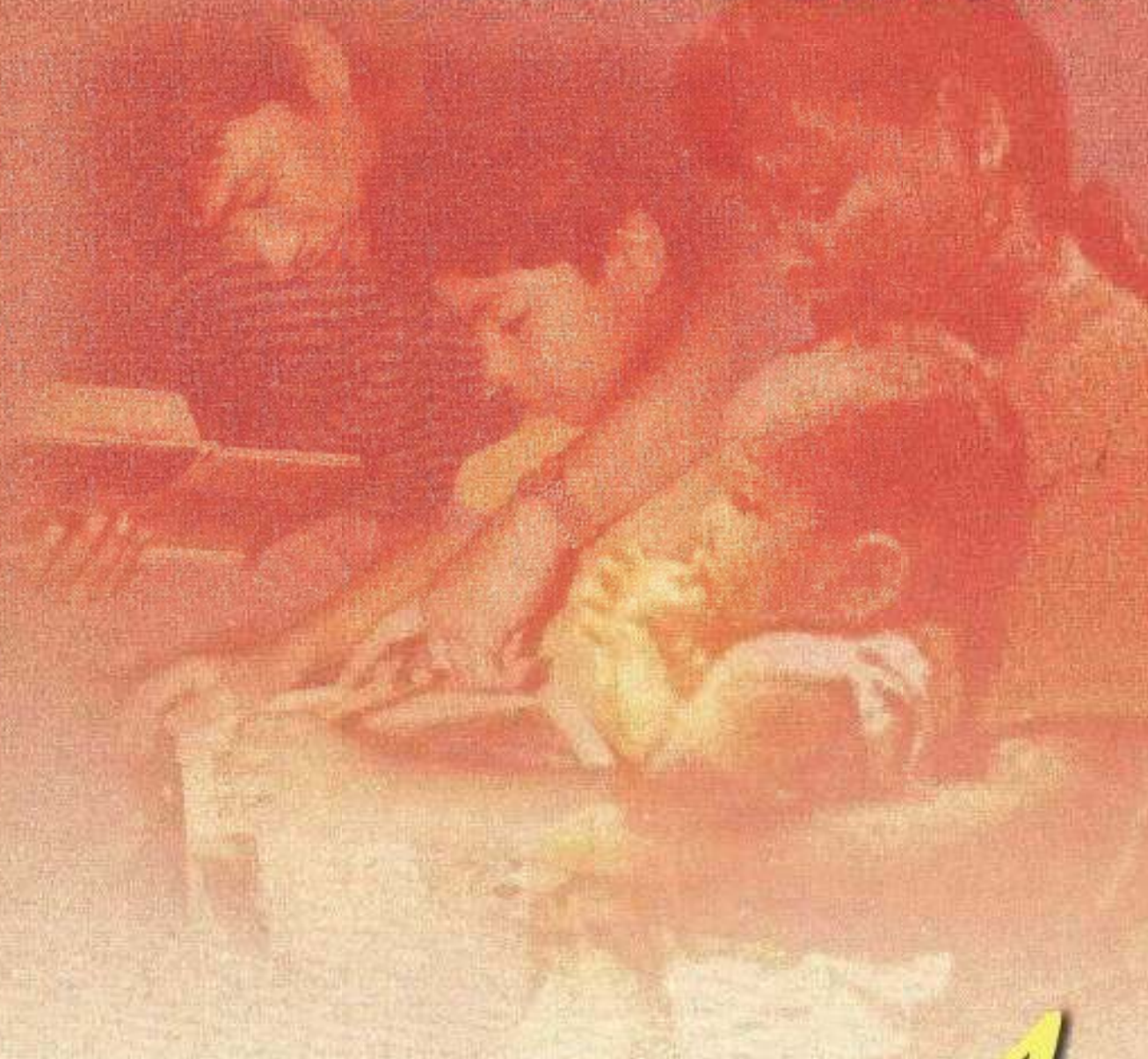


**GENERAL-RESPONSIVE AND  
RIGHTS-BASED  
INTEGRATED REPRODUCTIVE HEALTH  
SERVICE DELIVERY**

**A TRAINING MANUAL**



**VOLUME**

**1**

**THE FACILITATOR'S GUIDE**

Published by the



**National Commission on the Role of Filipino Women**  
*The Philippine Machinery for the Advancement of Women*



**Department of Health**



**United Nations Population Fund**

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**Gender-Responsive and  
Rights-Based Integrated  
Reproductive Health  
Service Delivery**

*A Training Manual*

Volume **1** **THE FACILITATOR'S GUIDE**

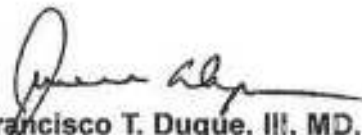


# Foreword

**T**he Philippines is committed in pursuing the principles enunciated in the Cairo and Beijing Conferences for a more comprehensive promotion of the Reproductive Health (RH) agenda. This signifies a paradigm shift in providing a range of services in a more integrated manner. This shift to integrated reproductive health has heightened attention to the rights of clients, the quality of care, informed choice and gender sensitivity.

The integrated provision of quality RH services in recognition of client's broad and inter-related health needs has an implication on the approach of delivering these services among health service providers. Such an approach calls for health service providers to be more sensitive not only to the medical issues but also to other underlying behavioral and socio-cultural concerns as reasons for the client's visit. Thus, the development of the "Gender Responsive and Rights-Based Integrated Reproductive Health Service Delivery: A Training Manual" aims to build capacities of health professionals towards the delivery of an integrated reproductive health services for women, men and adolescents.

I believe that this training manual will contribute significantly to improving the quality of reproductive health services to our people by respecting their rights and being gender-sensitive to their needs and aspirations. Therefore, I encourage all our partners in the public and private health sectors, the local government units and the donor communities to promote and support the use of this manual.



**Francisco T. Duque, III, MD, MSc**  
*Secretary*  
*Department of Health*



# Message

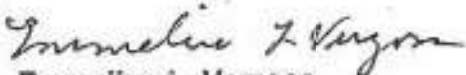
**W**ith great pride, the National Commission on the Role of Filipino Women (NCRFW), in partnership with the Department of Health (DOH), presents this insightful publication, the "Gender Responsive and Rights-based Integrated Reproductive Health Service Delivery: A Training Manual".

This manual hopes to transform the way health professionals think and act as they deal with their clients as women and men, girls and boys. Service providers are expected to give reproductive health services not only with technical competency, but also cognizant of the social, cultural, economic, environmental, religious and even political contexts of clients. The challenge is for the DOH and the local government units to infuse a rights-based approach in all their programs and services and to ensure that the different gender needs of women and men are considered.

This book is a reflection of our commitment to implement international treaties and agreements such as the UN Convention on the Elimination of all Forms of Discrimination Against Women (UN CEDAW), the Cairo International Conference on Population and Development (ICPD), the Beijing Platform of Action (BPFA) and the Millennium Development Goals (MDGs), among others. We, in government, must strengthen our resolve to continue to perform our duty to respect, protect and fulfill women's health rights and to make sure that our clients know their rights.

We would like to thank the DOH, specifically the National Center for Disease Prevention and Control (NCDPC), for the opportunity to take the gender and health journey together. As we grappled with questions, discussions and debates on diverse perspectives, we celebrate the joy of finding common ground with new insights and sharpened viewpoints.

We appreciate the United Nations Population Fund for its continued confidence in the Philippine Government and its full support for this project.

  
**Emmeline L. Verzosa**  
*Executive Director*  
*National Commission on the Role of*  
*Filipino Women (NCRFW)*

# Message

**T**he United Nations Population Fund welcomes the timely publication and launching of the "Gender Responsive and Rights-based Integrated Reproductive Health Service Delivery: A Training Manual". This publication comes at a time when trailblazing, creative and exciting initiatives in reproductive health programmes are being undertaken at the local government level and among civil society actors.

Worldwide, we are all committed to achieve the targets set under each of the Millennium Development Goals (MDGs). It depends, however, on how far we can make a difference in improving the quality of life of all people – primarily in the attainment of equality between and among women and men and in the exercise of sexual and reproductive health rights. These rights are an integral part of human rights. To many, however, it still comes as a surprise that women and men have sexual and reproductive health rights, and that gender equality is a human right.

The right to sexual and reproductive health has been endorsed and strengthened in the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and in successive international fora particularly at the 1994 International Conference on Population and Development (ICPD) and in the Fourth World Conference on Women in Beijing (FWCW) in 1995.

UNFPA supported the development of this training manual to become one of many valuable tools that will help governments at all levels to enact laws and create mechanisms to prevent violation of these rights by state authorities or by non-state actors. It can also assist civil society organizations and the private sector to put in place institutions and procedures, including the allocation of resources to enable people to enjoy to the full the whole gamut of sexual and reproductive rights and avail of reproductive health services and programmes. It is also a way of expressing the organization's social responsibility to all nations and states.

When individuals and groups cannot exercise their rights, and when government does not protect these rights, the consequences could be serious and fatal - one is maternal death and violence committed to women that could also lead to death. Gender – responsive integrated reproductive health programmes promote women's rights to live in dignity and in freedom from want and from fear.

Empowering women is also an indispensable tool for advancing development and reducing poverty. Empowered women contribute to the health and productivity of whole families and communities and to improved prospects for the next generation. Toward this end, this manual serves as a comprehensive yet accessible toolkit for development planners, service providers, champions and advocates. We are confident that this will be maximized for the benefit of the constituents of the local government units concerned, in close partnership with other stakeholders in the respective communities.

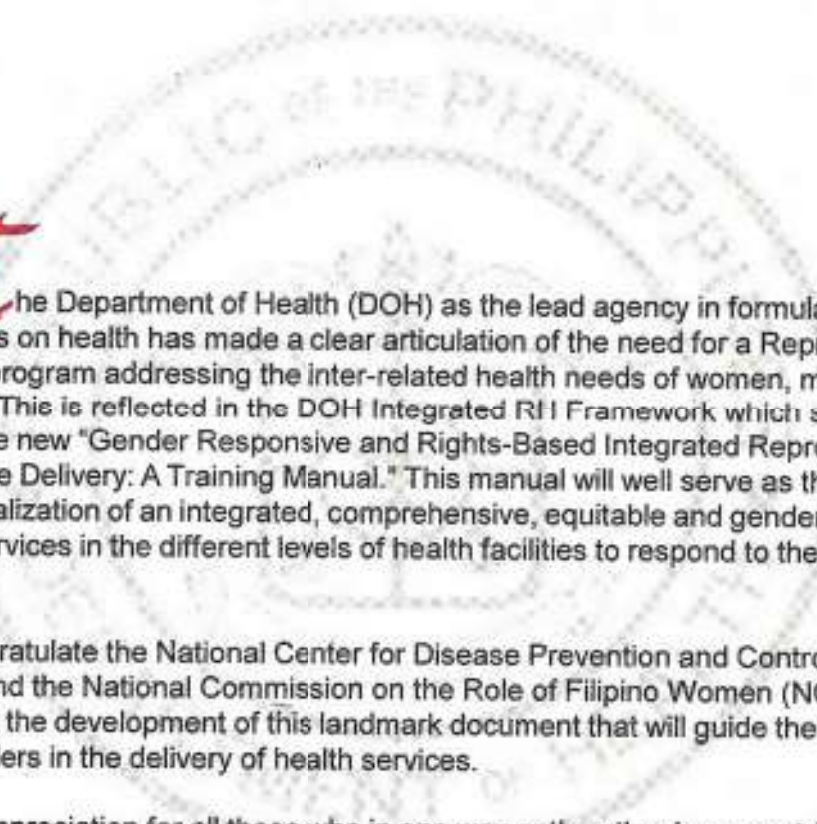
On behalf of the UNFPA, my sincerest congratulations to the Department of Health and the National Commission on the Role of Filipino Women for this useful and valuable tool.



**Suneeta Mukherjee**  
*Country Representative*  
*United Nations Population Fund [UNFPA]*



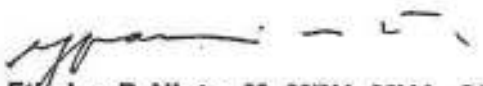
# Message

The Department of Health (DOH) as the lead agency in formulating policies and standards on health has made a clear articulation of the need for a Reproductive Health (RH) program addressing the inter-related health needs of women, men and adolescents. This is reflected in the DOH Integrated RH Framework which serves as the core of the new "Gender Responsive and Rights-Based Integrated Reproductive Health Service Delivery: A Training Manual." This manual will well serve as the basis for the operationalization of an integrated, comprehensive, equitable and gender-responsive quality RH services in the different levels of health facilities to respond to the needs of its clients.

I wish to congratulate the National Center for Disease Prevention and Control (NCDPC) of the DOH and the National Commission on the Role of Filipino Women (NCRFW) in spearheading the development of this landmark document that will guide the health service providers in the delivery of health services.

My deepest appreciation for all those who in one way or the other have contributed their efforts, expertise and valuable time for the development of this manual.

Finally, the DOH would like to take this opportunity to thank the United Nations Population Fund (UNFPA) for their unwavering support and dedication in improving and sustaining the reproductive health of Filipinos.

  
**Ethelyn P. Nieto, M, MPH, MHA, CESO III**  
*Undersecretary*  
*Department of Health*



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Department of Health

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August 9, 2006

**DEPARTMENT CIRCULAR**

No. **2006-0385**

**TO :** ALL UNDERSECRETARIES, ASSISTANT SECRETARIES, DIRECTORS OF CENTERS FOR HEALTH DEVELOPMENT (CHDs), BUREAUS AND SERVICES, CHIEFS OF REGIONAL HOSPITALS AND MEDICAL CENTERS AND OTHERS CONCERNED WITHIN THE DOH SYSTEM.

**SUBJECT :** **Adoption of the Gender Responsive and Rights-Based Integrated Reproductive Health Service Delivery: A Training Manual and Mandating Its Use By Service Providers as a Reference Manual and a Training Tool to Ensure the Delivery of Gender Responsive Reproductive Health Services**

The Executive Committee of the Department of Health (DOH-Execcom) after a thorough technical review, approved the adoption and use of the "Gender Responsive and Rights-Based Integrated Reproductive Health (GR-RB IRH) Service Delivery: A Training Manual", as a training tool and reference for trainers on Reproductive Health. The Executive Committee of DOH likewise adopted the "Integrated Reproductive Health Framework" as it sets into operation the holistic focus of health efforts embodied in the reform agenda under the FOURmula One (F1) strategy.

The GR-RB IRH Service Delivery Training Manual guides trainers towards the direction of improving utilization and access by women and men of reproductive age, particularly the poor to quality RH services through the provision of rights-based client-centered services by a team of gender responsive health human resource and gender sensitive health facilities. Being the core value of the approved framework, it is hereby ordered that the Training on Gender Responsiveness be part of the regular and mandatory Staff Development Program for health service providers using the above-mentioned Manual and Framework as main reference tools.

Please be guided accordingly.

  
**FRANCISCO T. DUQUE, III, MD, MSc**  
*Secretary, DOH*

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- 1.b Background Information on the Training Manual
2. DOH Resolution Approving the RH Framework

# List of Acronyms

|                      |   |  |
|----------------------|---|--|
| <b>AIDS</b>          | – | Acquired Immune Deficiency Syndrome  |
| <b>AIDSCAP/USAID</b> | – | Acquired Immune Deficiency Syndrome Control and Prevention/ United States Agency for International Development |
| <b>AOG</b>           | – | Age of Gestation   |
| <b>APCRH</b>         | – | Asia-Pacific Conference on Reproductive Health   |
| <b>ARH</b>           | – | Adolescent Reproductive Health   |
| <b>ARMM</b>          | – | Autonomous Region for Muslim Mindanao  |
| <b>AYHDP</b>         | – | Adolescent and Youth Health and Development Program  |
| <b>BCG</b>           | – | Bacillus Calmette Guerin   |
| <b>BEMOC</b>         | – | Basic Emergency Obstetric Care   |
| <b>BHS</b>           | – | Barangay Health Station  |
| <b>BHW</b>           | – | Barangay Health Worker   |
| <b>BV</b>            | – | Bacterial Vaginosis  |
| <b>CAP</b>           | – | Complete, Appropriate, Prompt  |
| <b>CAR</b>           | – | Cordillera Administrative Region   |
| <b>CEDAW</b>         | – | Convention on the Elimination of All Forms of Discrimination Against Women                                     |
| <b>CEMOC</b>         | – | Comprehensive Emergency Obstetric Care   |
| <b>COPD</b>          | – | Chronic Obstructive Pulmonary Disease  |
| <b>CVD</b>           | – | Cardiovascular Disease   |
| <b>CWR</b>           | – | Center for Women's Resources   |
| <b>DepEd</b>         | – | Department of Education  |
| <b>DEVAW</b>         | – | Declaration on the Elimination on All Forms of Violation Against Women   |
| <b>DILG</b>          | – | Department of the Interior and Local Government  |
| <b>DOH</b>           | – | Department of Health   |
| <b>DOJ</b>           | – | Department of Justice  |
| <b>DPT</b>           | – | Diphtheria, Pertussis and Tetanus  |
| <b>DSWD</b>          | – | Department of Social Welfare and Development   |
| <b>EDC</b>           | – | Expected Date of Confinement   |
| <b>FGD</b>           | – | Focus Group Discussion   |
| <b>FHSIS</b>         | – | Field Health Service Information System  |
| <b>FLRS</b>          | – | First Level Referral System  |
| <b>F1</b>            | – | FOURmula One   |

|                  |   |
|------------------|---|
| <b>FP</b>        | – Family Planning   |
| <b>FSCAP</b>     | – Federation of Senior Citizen Associations of the Philippines                        |
| <b>GR-RB IRH</b> | – Gender Responsive and Rights-Based Integrated Reproductive Health                   |
| <b>GTI</b>       | – Genital Tract Infection   |
| <b>HACT</b>      | – HIV/AIDS Core Team  |
| <b>HAVEN</b>     | – Hospital-Assisted Crisis Intervention for Victims/Survivors of Violent Environment) |
| <b>HBV</b>       | – Hepatitis B Vaccine   |
| <b>HCP</b>       | – Health Care Provider  |
| <b>HERA</b>      | – Health Empowerment, Rights and Accountability                                       |
| <b>HIV</b>       | – Human Immune-Deficiency Virus   |
| <b>HPV</b>       | – Human Papilloma Virus   |
| <b>HRT</b>       | – Hormonal Replacement Therapy  |
| <b>ICPD</b>      | – International Conference on Population and Development                              |
| <b>IMR</b>       | – Infant Mortality Rate   |
| <b>IRH</b>       | – Integrated Reproductive Health  |
| <b>IUD</b>       | – Intrauterine Device   |
| <b>IDA</b>       | – Iron Deficiency Anemia  |
| <b>KALAKASAN</b> | – Kababaihan Laban sa Karahasan Foundation, Inc.                                      |
| <b>KAP</b>       | – Knowledge, Attitude and Practice  |
| <b>LAC</b>       | – Local AIDS Council  |
| <b>LGU</b>       | – Local Government Unit   |
| <b>LMP</b>       | – Last Menstrual Period   |
| <b>MCHN</b>      | – Maternal and Child Health and Nutrition   |
| <b>MDG</b>       | – Millennium Development Goals  |
| <b>MGIS</b>      | – Maternal Geographic Information System  |
| <b>MHO</b>       | – Municipal Health Office   |
| <b>MMR</b>       | – Maternal Mortality Rate   |
| <b>MSH-LEAD</b>  | – Management Sciences for Health – Local Enhancement and Development for Health       |
| <b>NBI</b>       | – National Bureau of Investigation  |
| <b>NCDPC</b>     | – National Center for Disease Prevention and Control                                  |



- NCRFW** – National Commission on the Role of Filipino Women
- NDHS** – National Demographic and Health Survey
- NEDA** – National Economic and Development Authority
- NFP** – Natural Family Planning
- NGO** – Non-Government Organization
- NSCB** – National Statistical Coordination Board
- NSO** – National Statistics Office
- OFW** – Overseas Filipino Worker
- OPV** – Oral Polio Vaccine
- OSCA** – Office of Senior Citizens Affairs
- PAC** – Post Abortion Care
- PGN** – Practical Gender Need
- PIA** – Philippine Information Agency
- PID** – Pelvic Inflammatory Disease
- PMAC** – Prevention and Management of Abortion and its Complication
- PMS** – Pre Marital Sex
- PNAC** – Philippine National AIDS Council
- PO** – People’s Organization
- POC** – Product of Conception
- POGS** – Philippine Obstetric and Gynecological Society
- POPCOM** – Commission on Population
- PTSD** – Post Traumatic Stress Disorder
- RH** – Reproductive Health
- RHU** – Rural Health Unit
- RTI** – Reproductive Tract Infection
- SGN** – Strategic Gender Need
- SHC** – Social Hygiene Clinic
- SMS** – Safe Motherhood Survey
- SPPR** – State of the Philippine Population Report
- SSESS** – Sentinel STI Etiologic Surveillance System
- STI** – Sexually Transmitted Infection
- TBA** – Traditional Birth Attendant
- TPHA** – Treponema Pallidum Hemagglutination

- TT** – Tetanus Toxoid
- UN** – United Nations
- UNAIDS** – United Nations Program for HIV/AIDS
- UNFPA** – United Nations Population Fund
- UNICEF** – United Nations Children's Educational Fund
- UPPI** – University of the Philippines Population Institute
- VADD** – Vitamin A Deficiency Disorder
- VAW** – Violence Against Women
- VAWC** – Violence Against Women and their Children
- VAWCC** – Violation Against Women Coordinating Committee
- VDPA** – Vienna Declaration and Program of Action
- WCC** – Women's Crisis Center
- WCPU** – Women and Children Protection Unit
- WHO** – World Health Organization
- WID** – Women in Development
- YAFSS III** – Young Adult Fertility and Sexuality Survey III

# Introduction

## Gender equality and reproductive health and rights

**A**wareness of gender issues in reproductive health plays a key role in the choice and implementation of reproductive health services. Health decision makers and service providers need to appreciate gender dynamics, for instance, in discerning unequal decision making power between husband and wife in terms of desired number of children or in birth spacing. For more effective treatment, health service providers in the community need to have the sensitivity and skill to probe deeper into a woman's presenting illness as it may be compounded by other factors that affect her reproductive health of which she may be unaware, or which she may be reluctant to reveal because of fear of being misunderstood. This training manual on gender responsive and rights-based integrated reproductive health hopes to help trainers and practitioners in reproductive health services better understand the dynamics of gender relations in the context of reproductive health services provision.

The concept of reproductive health and rights translates into the "right of women and men to be informed and to have access to safe, effective, affordable and acceptable methods of fertility regulation which are not against the law. It includes the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and to provide couples with the best chance of having a healthy infant" (ICPD, 1994). Gender equality and equitable gender relations, inextricably linked to reproductive health and rights, recognizes that women, as well as men have equal right to make decisions concerning fertility- if, when and how often to do so. At the same time, it directs attention to the importance of paying particular attention to women's special needs as child bearers and of giving them the power to make decisions concerning their own health and their own lives.

A brief review of indicators of reproductive health, particularly those that directly affect women's health is attached as *Annex 1.a*. The data highlight the need for more responsive, better quality, increased availability and affordability of health care services. These services impact more strongly on women and by virtue of their role as child bearers, on the health of their children and of the nation.

## About the Training Manual

**T**his training manual is an updated and enhanced version of the three training modules on the ten elements of reproductive health developed under the 5<sup>th</sup> Country Program by the Department of Health (DOH) with financial assistance from the UN Population Fund (UNFPA).

In the 6<sup>th</sup> Country Program, the National Commission on the Role of Filipino Women (NCRFW) was tasked to enhance the modules to make them more gender-responsive. The DOH would then use the gender-responsive modules to train two batches of trainers and service providers on gender responsive integrated reproductive health from the pilot provinces and municipalities and from DOH. The trained LGUs then conduct the roll-out training in their respective areas.

*Gender as a component of the 6<sup>th</sup> Country Program supported by UNFPA is both a stand alone and a cross-cutting concern. As a stand alone component, it is focused in addressing violence against women as a critical factor to women's reproductive, emotional and physical health. As a cross-cutting concern, the gender component seeks to influence the gender responsiveness of other components in the Program – reproductive health (RH) and population and development strategies (PDS). As component manager for gender, NCRFW endeavors to work closely with the other component managers under the program – with DOH as component manager for RH and with POPCOM as component manager for PDS.*

The DOH, primarily the National Center for Disease Prevention and Control (NCDPC) and NCRFW agreed to enhance the modules and develop a Facilitator's Guide that highlights a gender-responsive and rights-based approach to delivery of integrated reproductive health services. The ten elements of reproductive health were updated and enhanced by the DOH, to form the reference volume of the Facilitator's Guide. NCRFW engaged Health Development Initiatives Institute (HDII)<sup>1</sup> as consultants to lead in the development of the Facilitator's Guide and packaging of the training manual. *(Please refer to Annex 1.b for a more detailed discussion on the manual development process and to the Acknowledgment page for the contributors).*

<sup>1</sup> HDII consultants are Ms. Gladys Malayang, a health and management trainer and Executive Director of HDII and Erlinda Palaganas, PhD, a registered nurse and professor at University of the Philippines in Baguio City.



## **Objectives**

The Training Manual on Gender-Responsive and Rights-Based Integrated Reproductive Health aims to enhance the capacity of health professionals in the delivery of gender responsive and integrated reproductive health services. It specifically targets practitioners, those who are trained in or have some background on reproductive health. It explores the principles behind the need and importance of a gender responsive and rights-based integrated approach, especially at the health facility level.

Specifically, the manual seeks to help participants:

- a. Explain the importance of a gender responsive and rights-based integrated reproductive health;
- b. Revisit the teaching-learning process;
- c. Review and demonstrate facilitation and presentation skills;
- d. Differentiate basic gender concepts related to RH: sex, gender and sexuality;
- e. Discuss the RH Framework;
- f. Apply gender concepts in analyzing RH cases; and
- g. Demonstrate an integrated reproductive health care service at the clinic level.

## ***Integration of gender in reproductive health services***

Integrated reproductive health services happens at the clinic level where service providers treat not only the presenting illness or symptoms but probe for other gender-related problems that affect the client's reproductive health. A woman's sexual and reproductive life is part and parcel of her whole being – her conception, her marriage, her relations, her health, sexual and reproductive life – woven together into sexual and social relationships, interactions and consequences, personal, medical, social. Gender sensitivity contributes to the effectiveness of the overall healing process and ensures that services are truly client-centered.

The manual presents three levels of integration: 1) gender and reproductive health, which considers social constructs that determine how these affect reproductive health; 2) integration of reproductive health elements in the delivery of health services- women and men who seek health care services may have underlying conditions that influence their overall health. e.g. a woman seeking contraceptive services might have STI/HIV/AIDS, a victim of VAW, or she may need information on sexuality; 3) programmatic and process integration. This aspect discusses administration and management of clinic programs and health projects such that the delivery of services and provision of health care occurs in an integrated fashion, i.e., it is client-centered, gender-appropriate, and responsive with a high degree of technical competence.

The manual advocates that by shifting from a medical model to an integrated approach, there is a high degree of possibility to improve interpersonal relations between client and service provider, and establish trust and confidence. This could

enable the service provider and counsel to help clients explore their own reproductive situations, consider their options and act on their own informed decisions. The chart below compares the two approaches to the provision of reproductive health services:

| <i>Medical model</i>         | <i>Gender responsive, integrated model</i>     |
|------------------------------|--|
| Medical approach             | Client centered                                |
| Provider oriented            | Client oriented                                |
| Focus on effective treatment | Focus on facilitating client's decision making |
| Medical /technical skills    | Communication skills                           |
| Disease is central issue     | Sexuality is central issue /gender sensitive   |

The integrated approach allows greater recognition of the client's broad interrelated sexual and reproductive health needs and argues for changes in the health care system to meet them, including linking of services for more comprehensive health care delivery. It calls for health providers to be sensitive not only to medical issues but also to behavioral and socio-cultural issues that may have prompted the client's visit.

## **Content**

The manual consists of two volumes. The first volume (Volume A) is the **Facilitator's Guide** which includes four modules outlines below:

### **Module 1: Gender-responsive and rights-based IRH and the facilitator.**

Reviews the teaching learning process to guide and/or refresh the facilitator's knowledge, attitudes and practice on the training process and provides a common framework in the delivery of gender responsive and rights-based services. It also deals with facilitation and presentation skills of an effective and efficient facilitator for trainers' training

### **Module 2: Towards a gender-responsive and rights-based IRH care services.**

Explains the importance of gender responsive and rights-based IRH services; reviews the RH concept and its ten elements; includes historical and policy developments as well as concepts on rights. It presents the integrated RH, gender responsive and rights-based framework adopted by DOH. The framework incorporates gender, rights and culture as the heart of RH, propelled by the Fourmula One strategy: good governance, regulation, financing and integrated service delivery.

**Module 3: Gender dimensions of reproductive health.** Explains basic concepts on gender, analyses gender issues as they apply to reproductive health and introduces the use of basic tools in gender analysis.

**Module 4: Client-centered, rights-based IRH services.** Illustrates the concept of integrating gender and rights-responsiveness in the delivery of reproductive health services at client and clinic levels; uses case studies and hones participants' skills in analyzing cases from a gender and rights perspective. It introduces an integration framework which stresses the importance of recognizing clients' rights, and which, through a gendered and transformative delivery of health services at the health facility level contributes to client satisfaction. This module includes a session on action planning where participants prepare a) a plan to integrate gender responsive and rights based services in service delivery protocols and in health facility set up; and b) a personal action plan to integrate gender in one's personal life.

The **Reference Manual (Volume 2)** is a compilation of RH materials intended as reference on ten RH elements as specified by DOH. Following the lifecycle approach on reproductive health, the reference manual also contains a unit on the Care of the Older Persons. The list of materials is as follows:

1. Human Sexuality and Sexual Health
2. Maternal Health
3. Family Planning
4. Sexually Transmitted Infection including HIV Infection
5. Adolescent Reproductive Health
6. Reproductive Tract Cancers
7. Prevention and Control of Abortion and its Complications
8. Infertility
9. Violence against Women
10. Male Involvement in Reproductive Health
11. Care of the Older Persons

The manual includes hand outs and powerpoint presentations to enable the facilitator to revise or improvise on the training materials with facility.

## **Approval**

The Executive Committee of DOH headed by Secretary Francisco Duque III approved the manual and the harmonized framework in its meeting of February 8, 2006. (Please see *Annex 2* for a copy of the resolution approving the manual). A *Department Circular* mandating concerned DOH officers at national and sub-national level to use the manual in their training on reproductive health was issued on August 9, 2006.

## **Reflections and Challenges**

1. A participatory and transparent process paved the way for a productive partnership between the NCRFW and DOH. This was done by consultations, peer reviews, joint selection of consultants and sharing of resources and responsibilities. The two agencies agreed on the content of the facilitator's guide, on the design of the TOT, and in the conduct of deepening sessions on gender and RH. Here, DOH identified the participants while NCRFW led in the design of the training and coordinated all other arrangements.

2. Reproductive health is only one of the critical areas being addressed by DOH. The challenge to NCRFW and DOH is ensuring the gender responsiveness of the other programs of the line agency, particularly those that are supported from foreign sources. Firmly convinced that all health issues and programs have gender-differentiated impact, NCRFW welcomes the opportunity to collaborate with DOH in exploring these areas.
3. DOH and LGUs need to ensure that the manual is indeed used by trainers and health service providers. There is need to monitor its impact at the clinic and client levels in communities, and the need for gender sensitive assessment tools and indicators to determine this.
4. The development of the gender-responsive and rights-based training manual on IRH exemplifies gender mainstreaming in an agency like DOH. NCRFW could use the lessons learned from this experience in working with other line agencies.



# MODULE



## **Gender Responsive and Rights-Based IRH and the Facilitator**

*SESSION 1.1* Overview of the  
Teaching-Learning Process

*SESSION 1.2* Facilitation and  
Presentation Skills

# Gender Responsive and Rights-Based IRH and the Facilitator

Module I comprises two parts:

Part I deals with the overview of the Teaching-Learning Process. This portion of the module aims to guide and/or refresh the facilitator's knowledge, attitude and practice (KAP) on the training process. It is important that the facilitators have a common framework vis-à-vis the delivery of Gender Responsive – Rights-Based Integrated Reproductive Health (GR-RB IRH) services.

Part II of the module deals with the facilitation and presentation skills expected of an effective and efficient facilitator for training of trainers.

## **SESSION 1.1: Overview of the Teaching-Learning Process**

This part of the module focuses on tooling and/or re-tooling the trainer by walking through the training process and teaching-learning principles. Trainers acknowledge the fact that training plays an important role in improving effectiveness not only as trainers but as health care providers. A common framework in the delivery of GR-RB Integrated RH services is vital for every health provider to comprehend towards a common understanding.

|                    |  |
|--------------------|--|
| <b>Objectives</b>  | By the end of the session, participants would be able to: <ul style="list-style-type: none"> <li>• Discuss the Teaching-Learning Process; and</li> <li>• Relate the importance of training in the delivery of GR-RB Integrated RH services.</li> </ul> |
| <b>Time</b>        | 2 hours  |
|                    | Liquid Crystal Display (LCD) or Overhead Projector(OHP) computer (if using LCD)  |
| <b>Materials</b>   | Powerpoint Presentation on the Objectives and the Teaching-Learning Process; handouts, meta-cards, manila paper, transparency films/acetates, OHP pens, permanent markers, masking tape  |
| <b>Evaluation</b>  | Return Demonstration; Self/Peer Assessment; Evaluation Tool for Presentation   |
| <b>Handouts</b>    | Teaching-Learning Process; Facilitation and Presentation Skills  |
| <b>Preparation</b> | <ul style="list-style-type: none"> <li>• Meta-cards</li> <li>• Powerpoint Presentations: Objectives, Teaching-Learning Concepts and Process</li> </ul>   |

The general objective of this part of the module is to improve the effectiveness of the trainers in the delivery of an integrated RH program.

## The Training-Learning Process

### Activity 1.1a: Introduction of the Teaching-Learning Process

#### *Notes for the Facilitator:*

1. The facilitator introduces the topic and links the topic with her role as trainer/facilitator. Trainers/facilitators are involved with communicating new knowledge and skills and changing attitudes in their intent to raise awareness and provide people with the opportunity to explore their existing knowledge and skills.
2. The facilitator proceeds by asking the participants about the difference between Training and Learning. What is Training? What is Learning? To be able to elicit responses, each participant can be given six (6) pieces of meta-cards. The facilitator reminds the participants on the proper use of meta-cards namely:
  - write big
  - 3-7 words for each meta-card
  - write clearly

3. The facilitator requests the participants to write down in one meta-card the first word that comes to his/her mind when she hears the word "training". Next, she requests the participant to write the second word that comes to mind when s/he hears the word training, and then the third word that comes to mind. The same procedure is done with the word "learning". The number of meta-cards may vary according to the number of participants per group (e.g., two (2) meta-cards for each concept, or a total of four (4) meta-cards for each participant).
4. The facilitator asks the participants to count off from 1 to 4 (depends on the number of participants, with each group having 5-6 members). All number 1s will constitute Group 1, all number 2s as Group 2 and so on.
5. After the participants have grouped themselves, the facilitator instructs the group to assign a facilitator, a recorder and a reporter. The facilitator oversees that group discussions are "PROMDI" (Participatory, Respectful, Open, Mature, Dialogical and Interactive), the recorder documents the group output, and the reporter shares the group output during the plenary session.

## Instructions for the Activity

6. The facilitator instructs the group to do the following:
  - a. Share the contents of each meta-card in the group for each concept.
  - b. After everyone has shared his/her perspective about the concept, formulate a collective definition of the concept using all the key perspectives of each member of the group.
  - c. Write the definition of each concept on manila paper/kraft paper/flipchart (whichever is available).
  - d. Get ready for the plenary and share the group's output in 15-20 minutes.
7. After the plenary, the facilitator recapitulates the activity, integrating key points cited in the training information box.

### Box 1

## TRAINING INFORMATION: The Training-Learning Process

### What is training?

#### Training...

- is the process of bringing a person to an agreed standard of skill by practice and instruction.
- is a trainer and participant working together to transfer information from the trainer to the participant, to develop the participant's knowledge, attitudes or skills so they can perform work tasks better.



Taken together these definitions say two things:

1. Training is directed towards agreed standards or objectives. These are sometimes called learning outcomes – what you want people to learn from the training.
2. The person being trained participates with the trainer in the training activity, rather than simply receiving instruction.

Training usually involves participation. This means that a person being trained has an active role in the training process, rather than a passive role. Also, it often takes place in the workplace or community where the skills and knowledge being communicated will be used.

### What is learning?

Teaching and training are about communicating information and facilitating learning.

Learning is what people do when they receive that information. But learning is more than collecting information – it must also involve a permanent change in behavior, attitude or understanding. For example, health providers would have only truly learned about gender sensitivity if they fully understand when and how to be gender sensitive in the delivery of SRH services, not just if they have learned the concept of gender sensitivity.

*Source: Exploring the training process: communication initiatives and Healthlink Worldwide*

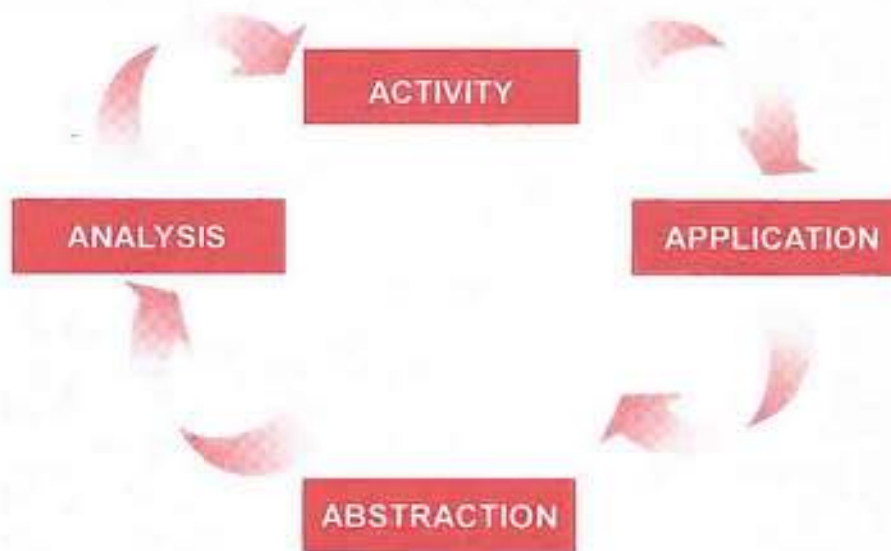
8. Facilitator distributes Handout 1.1.1.
9. For training to be useful for the health providers, the planned objectives must meet the needs of the intended participants. This stage is the basis of setting up successful training.
10. The facilitator at this point introduces the concept of **ADULT LEARNING** using the following training information:

Part of being an effective facilitator involves understanding how adults learn best. Compared to children and teens, adults have special needs and requirements as learners. The field of adult learning was pioneered by Malcom Knowles. He identified the following characteristics of adult learners:

- a. Adults are *autonomous* and *self-directed*. They need to be free to direct themselves, thus facilitators must actively involve adult participants in the learning process. Specifically, facilitators:

- must get participants' perspectives about what topics to cover and let them work on projects that reflect their interests;
  - should allow the participants to assume responsibility for presentations and group leadership;
  - have to be sure to act as facilitators, guiding participants to their own knowledge rather than supplying them with facts; and
  - must show participants how the class will help them reach their goals.
- b. Adults have accumulated a foundation of *life experiences and knowledge* that may include work-related activities, family responsibilities, and previous education. The facilitator:
- connects learning to this knowledge/experience base by drawing out participants' experience and knowledge which is relevant to the topic; and
  - relates theories and concepts to the participants and recognize the value of experience in learning.
- c. Adults are *goal-oriented*. Upon participation in a training or workshop, they usually know what goal they want to attain. Therefore, adult learners appreciate an educational program that is organized and has clearly defined elements. The facilitator must show participants how the training or workshop will help them attain their goals. This classification of goals and course objectives must be done early in the course.
- d. Adults are *relevancy-oriented*. They must see a reason for learning something. Learning has to be applicable to their work or other responsibilities to be of value to them. Therefore, the facilitator must identify objectives for adult participants before the course begins. This means, also, that theories and concepts must be related to a setting familiar to participants. This need can be fulfilled by letting participants choose projects that reflect their own interests.
- e. Adults are *practical*, focusing on the aspects of a lesson most useful to them in their work. They may not be interested in knowledge for its own sake. The facilitator must tell participants explicitly how the lesson will be useful to them and to their tasks/work.
- f. Adult learning therefore involves four As, namely: **ACTIVITY, ANALYSIS, ABSTRACTION** and **APPLICATION** illustrated below.
- g. Facilitator distributes Handout 1.1.2.





**Figure 1. The 4As of Adult Learning**

**ACTIVITY: (Or Experience)**

- Involvement of Participant
- May be direct or vicarious
- Explore new situations
- Use case analysis, simulation exercises, role playing, personal disclosure session

**ANALYSIS: (Reflective Feedback)**

- Observation, comparing situations/data, and reflection of what the situation means to the participant
- Periods of question and answer, discussion or individual time for reflection

**ABSTRACTION**

- Based on reflective feedback, situations are analyzed, insights formulated and theories formed
- Identifies generalizations
- Key Learning Points

**APPLICATION**

From insights and generalizations that surfaced during analysis and abstraction stages, participants translate them to real life concerns.

**It is therefore important to bear in mind the following principles of adult learning (Brookfield, 1986):**

- a. **Participation is voluntary.** The decision to learn is that of the learner.
- b. **There should be mutual respect** between teachers and learners, and also among learners.

- c. **Collaboration is important**, both between learners and teachers and among learners.
- d. **Action and reflection** form a continuous process of investigation, exploration, action, reflection and further action.
- e. **Critical reflection** brings awareness that alternatives can be presented as challenges to the learner to gather evidence, ask questions and develop a critically aware frame of mind.
- f. **Nurturing of self-directed adults is important.**

**Always remember:** As do all learners, adults need to be shown *respect*. Facilitators must acknowledge the wealth of experiences that adult participants bring to the venue. Adult learners should be treated as equals in experience and knowledge and allowed to voice their opinions freely.

## Activity 1.1b The Importance of Training

### *Notes for the Facilitator:*

1. The facilitator elicits from the participants the importance of training. This can simply be a chalk-talk process but highlighting on the participants' experiences. The facilitator writes on the board the participants' experiences. After an exhaustive probing on the importance of training, she recapitulates the topic, integrating key points cited in the training information box.

### Box 2

#### **TRAINING INFORMATION: Why is Training Important?**

##### **For the participants/trainees, training can:**

- Provide new skills and knowledge, and help maintain existing skills
- Increase confidence
- Confirm the value of what they are already doing
- Enable them to pass on new skills to colleagues in the workplace
- Raise general awareness
- Change attitudes
- Improve morale

Training can play an important role in improving health providers' effectiveness. Whether training is part of an ongoing process of professional development or simply about learning a specific skill, it can improve people's skills and knowledge and help them carry out their job more effectively.

*Sources: AIDS Action, Child Health Dialogue, Disability Dialogue and Healthlink Worldwide. 2003.*

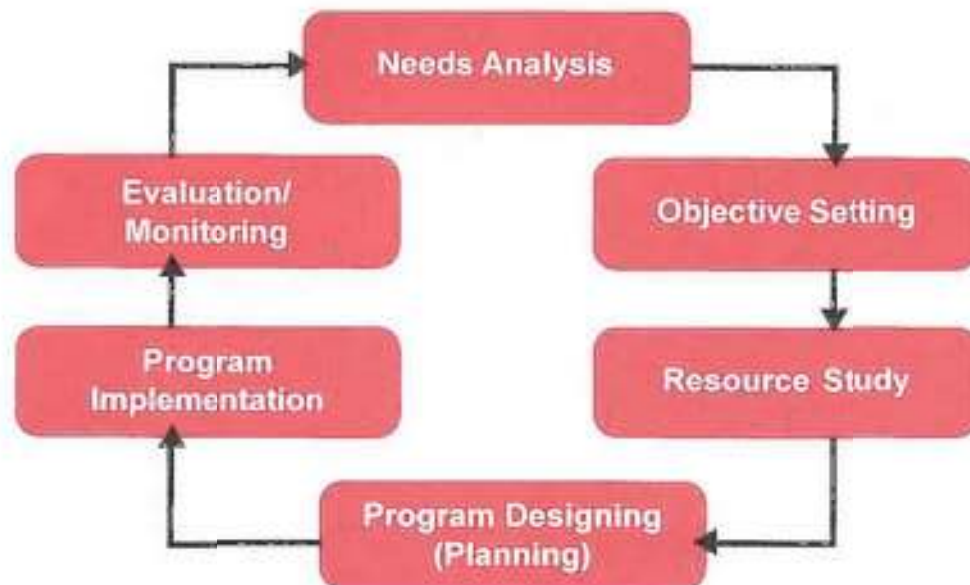


## Activity 1.1c The Training Process: A Group Perspective

### Notes for the Facilitator:

1. The facilitator elicits from the participants the various steps or processes involved in the training process. This can be done by dividing the bigger group into groups of 5 or 6 and then instructing the groups to do the following:
  - a. Choose a group facilitator, a recorder and a reporter.
  - b. Brainstorm on the training process that they have been conducting or participating in. (15 minutes to brainstorm)
  - c. Write the schematic diagram or training paradigm or framework on either manila paper/kraft paper/flipchart or a transparency film for group sharing.
  - d. Get ready for the plenary and present group output in 30 minutes.
2. The facilitator summarizes the group reports, integrating key points cited in the training information box. At this point, she cites training resources that future trainers can utilize to enrich their knowledge, skills and attitudes (KSA). Among the resource materials found useful is the VSO, IIRR and PEPE's publication: *Creative Training: A User's Guide and Helping Health Workers Learn* by David Werner and Bill Bower.

**Figure 2. The Training Process\*** (Handout 1.1.3)



\* Source: Adapted from the Northern Luzon Educational Media Program (NLEMP) and the Regional Development Center-Northern Luzon's (RDC-NL). 1994.

**Note:** Depending on the needs of the participants, an activity can be done for each phase of the training process. The facilitator can elicit their need during the plenary. Activity 1.1d to Activity 1.1j can be done if participants need a more detailed discussion. If participants are well-chosen, a participatory review of each training phase can be adopted.

## Activity 1.1d The Training Process: Assessing Training Needs

### Notes for the Facilitator:

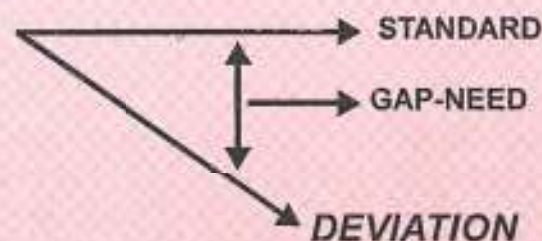
1. Linking it with the previous topic, the facilitator states that the first step in identifying training needs is to assess the current level of knowledge and skills of the participants. The second step is to clarify what skills, knowledge and attitudes (KSA) people need to do their job or tasks.
2. The facilitator elicits from the participants methods they have been using or that can be used to assess the training needs of participants. S/he writes down on the board the various responses. After an exhaustive probing of the various methods utilized by the participants in assessing training needs, the facilitator then recapitulates the topic, integrating key points cited in the training information box.
3. The facilitator distributes Handout 1.1.3.

### Box 3

#### TRAINING INFORMATION: Assessing Training Needs

**Facilitator:** Reiterate the importance of training as a means of communicating new knowledge and skills and changing attitudes. Also, emphasize the value of training in raising awareness and providing people with the opportunity to explore their existing knowledge and skills. Link it with the value effectiveness and base training on the needs of the participants. Highlight on the following points:

- Training needs should be identified by both participants and their managers/supervisors.
- Training should not only meet the needs of participants within their context but should contribute to better service or standards for service users.
- This can be done through a **Training Needs Analysis (TNA)**, a method of finding out what knowledge, skills and attitude a person needs to acquire. A **Training Need** is a deficiency; a lack or absence of something, which is intolerable; a deviation from standard.



A training need is the gap between what somebody already knows, and what they need to know to do their job or fulfill their role effectively. By identifying training needs, trainers can decide what the objectives of the planned training should be; training thus becomes relevant.

- You might encourage the trainee to use a tool to rate their self-assessed levels of knowledge and skills in various areas. Using this, you may agree with the trainee about some key topics they need to know and do in their time with you as a facilitator.



## Methods of Assessing Training Needs

- a. **Questionnaires:** Questions need to be clear, specific and simple. Avoid closed questions (e.g., those having a yes or no answer) as these only identify what people think they know rather than what they actually know. Questions should be geared towards finding out whether people have the skills and knowledge you think they need to do their jobs effectively.
- b. **Group discussions with participants:** These enable participants to share comments and observations about what is happening in their workplaces and what skills they feel they may need.
- c. **Individual discussions with participants:** These give participants the chance to talk in confidence about difficulties they are having and things they need to learn.
- d. **Self-assessment:** This involves asking participants to list the things they think they are good at and what subjects/areas they think they need training on.
- e. **Discussions with managers/supervisors, service users and others:** Trainers/facilitators can gather views on training needs from those who come into contact with the participants of the training.
- f. **Observing participants while they are working:** These methods help trainers/facilitators to assess what the participants already know and what knowledge and skills they may need to acquire to work effectively. It is best to gather as much information as possible, using as many different methods as possible. However, you must decide how much information it is realistically possible to gather within the limits of available time and financial resources. This may mean only being able to carry out one or two of the above.

Sources: NLEMP and RDC-NL, 1994; Chambers and Wall, 2000

## Activity 1.1e Objective Setting

### Notes for the Facilitator:

1. Facilitator links the topic with the previous topic. After identifying the needs of the trainers, s/he has to decide what can realistically be covered during a training session. S/He should aim to ensure that training objectives (what they want people to learn from the training session or program) are very clear. Objectives are things that the learner will be able to do at the end of the course, often written in behavioural terms. Trainers can then plan training so that it addresses only those objectives.
2. An Objective List can be devised such as:
  - a. Make sure your objectives can be achieved.
  - b. Agree on key objectives with trainees and their managers.
  - c. Design training so that activities meet the objectives.



- d. Objectives should describe what participants will be able to do after training (e.g., by the end of the training, participants will be able to... or participants will know how to...)
  - e. Give participants the opportunity to practice new skills.
  - f. Make sure training is relevant to participants' work.
  - g. Encourage participants to be responsible for their own learning.
3. Facilitator provides each participant with a meta-card and asks each one to write down an objective. S/He requests each participant to post her/his objective on the space provided for, then allows each to go over each objective. Participants are encouraged to give their comments or feedback based on their knowledge on objective setting.
  4. After the participants have seen the various objectives and provided their comments, the facilitator recapitulates the activity, integrating points from the training information box.

#### Box 4

### TRAINING INFORMATION: Objective Setting and Formulation

#### Basic Concepts Related to Objective Setting:

- a. **AIM IN TRAINING:** What you, the course designer want to achieve
- b. **OBJECTIVE IN TRAINING:** What the participants are required to know, do or think at the end of the learning process/experience; General or Primary Objective
- c. **BEHAVIOR:** Any overt or visible activity displayed or performed by the learner
- d. **BEHAVIORAL OBJECTIVE:** The behavior the learner demonstrates at the end/conclusion of the training effort; Secondary or Specific Objectives.

Must state what behavior is desired as the outcome of the training. Therefore, behavioral objectives are participant-centered and SMART (specific, measurable, attainable, realistic and time bound).

#### Importance of Setting Objectives:

- Consistency in the design
- Basis for measuring performance
- Minimize "undertraining" and "overtraining"
- Clear instructor and trainee goal
- Selecting most suitable instructional method
- Selecting appropriate content
- Effective communication

Source: NLEMP and RDC-NL, 1994

5. Facilitator may distribute Handout 1.1.4.
6. Facilitator may distribute Handout 1.1.5.



## Examples of Verbs Used in Behavioral Objectives

### A. For Knowledge Area

| KNOWLEDGE LEVEL   | COMPREHENSIVE LEVEL   | APPLICATION LEVEL  | ANALYSIS LEVEL   | SYNTHESIS LEVEL   | EVALUATION LEVEL  |
|---|---|--|--|---|---|
| Define<br>Repeat<br>Record<br>List<br>Recall<br>Name<br>Relate<br>Underline | Translate<br>Restate<br>Discuss<br>Describe<br>Reorganize<br>Explain<br>Express<br>Identify<br>Locate<br>Report<br>Review<br>Tell | Interpret<br>Apply employ<br>Use<br>Demonstrate<br>Practice<br>Illustrate<br>Operate<br>Schedule<br>Shop<br>Sketch | Differentiate<br>Appraise<br>Calculate<br>Test<br>Compare<br>Contrast<br>Diagram<br>Inspect<br>Inventory<br>Examine<br>Solve<br>Categorize | Compose<br>Plan<br>Propose<br>Design<br>Formulate<br>Arrange<br>Assemble<br>Collect<br>Construct<br>Create<br>Set up<br>Organize<br>Manage<br>Prepare | Judge<br>Appraise<br>Evaluate<br>Rate<br>Compare<br>Value<br>Revise<br>Score<br>Select<br>Choose<br>Assess<br>Estimate<br>Measure |

### B. For Attitude Areas

| RECEIVING LEVEL  | RESPONDING LEVEL  | VALUE LEVEL   | ORGANIZATION LEVEL   | CHARACTERIZATION LEVEL  |
|--|---|---|--|---|
| Listen<br>Prefer<br>Receive<br>Favor<br>Attend<br>Accept<br>Perceive<br>Select | State<br>Complete<br>List<br>Derive<br>Answer<br>Write<br>Select<br>Develop | Accept<br>Participate<br>Attain<br>Decide<br>Recognize<br>Increase<br>Indicate<br>Influence | Organize<br>Relate<br>Correlate<br>Form<br>Judge<br>Determine<br>Associate<br>Select | Revise<br>Face<br>Develop<br>Identify<br>Change<br>Judge<br>Demonstrate<br>Decide |

Source: NLEMP and RDC-NL, 1994

7. Facilitator distributes Handout 1.1.6.

### Activity 1.1f Participants of the Training

#### Notes for the Facilitator:

1. Facilitator links the present topic to the previous topic. S/He emphasizes the principle that the success of a training session depends partly on choosing the most appropriate participants. Therefore, the trainer/facilitator must be clear on the reasons for selecting participants and how to do it.

2. The facilitator, requesting the previous groups to come together, and requesting the group to utilize the same group mechanics (assigning a facilitator, recorder and reporter), instructs the group to share their experiences in how they choose participants to a planned training, by asking the following questions:
  - How do you choose participants to a training activity?
  - What are your criteria/bases?
3. Facilitator convenes the group after 15 minutes and requests the group reporter to share the group output. S/He recapitulates, integrating insights from the information box.

#### Box 5

### TRAINING INFORMATION: Guide Questions on Deciding Who Should Attend the Training

Planning the contents of training and deciding who should be trained are linked activities. It is important to be clear about training objectives and to ensure that the objectives are relevant to participants. Once you have identified participants it is important to adapt the training plan to suit their needs.

The following guide questions can help the trainer/facilitator decide who should attend your training:

- **Who will participants work with when they have finished training?** For example, if the training is about antenatal care it may be more appropriate to train female health workers in areas where female modesty is important.
- **Do participants need to have certain skills or knowledge?** Some training courses may require participants to have background knowledge. For example, if the training is about treating opportunistic infections in people with AIDS, then participants need to have some knowledge of HIV and AIDS.
- **Will training be relevant to participants' job?** For example, if the training is about establishing a program for setting up centers or violence against women (VAW) victims-survivors, the most suitable participants are municipal/provincial health officers, rather than community health workers. Participants learn best when they can see clearly how the training can be used in their lives or work.
- **Do participants have the support of colleagues and managers/supervisors?** For training to be used in the workplace, participants need to have the support of managers/supervisors and colleagues so that they can use the skills and knowledge when they return to work.
- **Is it possible to train two people from the same area?** This means that when training has ended and participants have returned to work they can provide each other with support.



- **Do participants need to be able to speak certain languages?**
- **Do participants need to have certain qualities?** For example, are they friendly and approachable? Are they willing to pass on the skills they learn to others?
- **Are the participants motivated and do they want to do the training?** Ensure participants attend training for the right reasons, rather than for 'time off'. Some training courses require a certain level of education or literacy, e.g., finished primary or secondary school, but this may exclude many people who have useful skills and knowledge that they have learned in life rather than in school. People do not always need to be able to read and write to be included in training. Written words can often be replaced by pictures, symbols, role plays or songs.

*Source: AIDS Action, Child Health Dialogue, Disability Dialogue and Healthlink Worldwide, 2003.*

4. Facilitator may distribute Handout 1.1.7.

## Activity 1.1g Resource Study

### *Notes for the Facilitator:*

1. The facilitator poses the question: **"What are the resources/things you consider when you plan for a training activity?"**
2. The facilitator writes down the responses of the participants on a flipchart or on the whiteboard. After all possible responses have been exhausted, s/he summarizes the points raised. Using the training information below, s/he recapitulates the topic by consciously relating the recap points with the participants' responses with insights in the training information box.

### Box 6

## **TRAINING INFORMATION: Some Things to Consider When Working on the Training Project**

The following resources must be carefully planned:

- a. Resources needed to implement the activities in the training, e.g., paper, pens, etc.
- b. Venue and duration of the training
- c. Honoraria/gifts for consultants and resource persons
- d. Travel, research and other expenses which will be incurred during the planning and implementation of the training
- e. Financial capacity of the office/program giving the training
- f. Ability of the participants to pay (if registration fee is indicated)

*Source: NLEMP and RDC-NL, 1994*

## Activity 1.1h Training Program Design

### Notes for the Facilitator:

1. Facilitator links the topic with the previous topics. S/He introduces the concept of the Training Program Design as a detailed sketch or plan that starts with specifically formulated statements of training objectives and how such objectives might be satisfied within a given timeframe through a set or sets of interrelated activities that employ a number of instructional methods and techniques and other training aids.
2. The facilitator also introduces the concept of TRAINING MODE, which represents a set or a unit of interrelated activities in a training program which stands for a given terminal objective.
3. The facilitator can either do one of the following depending on the time available:

**Option 1:** The facilitator requests the participants to bring out the training design of the Training of Trainers (TOT) which they are currently undergoing. S/He goes over the various components of the training design. S/He can be guided by the training information provided below.

**Option 2:** The facilitator requests the previous groups to come together. Requesting the group to utilize the same group mechanics (assigning a facilitator, recorder and reporter), s/he then instructs the group to formulate a training design based on their experience. A sample matrix is expected to be presented in a transparency film or manila paper. Facilitator convenes the group after 30 minutes and requests the group reporter to share the group output in a plenary. S/He summarizes the key points guided by the training information.

#### Box 7

### TRAINING INFORMATION: Basic Conditions in Designing a Training Program

- a. **Contract.** More than a legal document, it is a psychological agreement between the participants and the trainers/facilitators which in the first place is what brings the participants to the training, knowing what to expect, why they are there and what they have agreed/consented to experience.
- b. **Length and Timing** of the training (How much time can the trainees afford?)
- c. **Location** of the training and physical facilities
- d. **Familiarity** of the participants with one another
- e. **Training experience** of the participants
- f. Availability of **Qualified Facilitators** and/or **Training Staff**
- g. **Budget**
- h. **Access** to the training materials and audio-visual aids
- i. Opportunity for follow-up activities
- j. Educational level and intellectual capacity of the participants

4. May distribute Handout 1.1.8.



## SEVEN DESIGN STEPS

- a. Diagnose the problem or need to determine the role of training -- TRAINING NEEDS ANALYSIS (TNA)
- b. Formulate the objectives of the training program in behavioral terms

**Remember:**

- a. A behavioral objective should focus on the goal of the training.
  - b. A behavioral objective should have an action verb.
  - c. In behavioral objective, the trainee should be the subject of the sentence.
- c. Draw up the course content – Activities/Topics – against established terminal objectives.
  - d. Define the *learning objective* per content/activity/topic. Learning objective is also known as *enabling objective* – i.e., through such enabling objectives, a terminal objective might be satisfied or met.

**Remember:** Learning objectives must also be stated in behavioral terms just like terminal objectives.

- e. Select instructional method(s) and techniques which would ensure that the learning objective for any given topic/activity is achieved.

Some things to consider when deciding on methods and techniques:

- a. The instructional method and technique must suit the trainor's ability, skills and interest (the trainor must be comfortable with the training method and technique)
  - b. Learning objective(s)
  - c. Background and interest of the trainees
  - d. Time available to conduct a training activity/topic
  - e. The number of the trainees and the size of the training room
- f. Plan a favorable learning climate. Given the participants' intellectual level, including group climate and other factors, decide on what probably is the best flow or sequencing of activities/topics. Also, unfreezing activities are sometimes needed before each major topic/activity in the training.

**Remember:** Even unfreezing activities have learning objectives and methods/techniques.

- g. Pre-set the evaluation criteria.

Source: NLEMP and RDC-NL, 1994

5. The facilitator distributes Handout 1.1.9.

## **Activity 1.1i Program Implementation: Challenges for the Trainer/Facilitator**

### ***Notes for the Facilitator:***

1. Facilitator links the topic with the previous topics. S/He introduces the topic highlighting the following points:
  - a. Trainers/facilitators need specific skills in order to run a successful training session.
  - b. There are many theories on how to conduct training successfully, but it is often 'easier said than done'. It is crucial that training theory is adapted to practical situations and trainers need the skills to be able to do this.
  - c. It is important that the trainer/facilitator read the guide in advance so s/he does not have to refer to it during the sessions.
  - d. It is helpful for the trainer/facilitator to have a thorough understanding of the participants' background before undergoing the training such as previous trainings received, work assignments, and training needs.
2. Facilitator moves on to the next group activity. Utilizing the same grouping, s/he asks the group to share experiences on the implementation of the training programs. The group can be guided by the following:
  - What usually goes well during training?
  - What usually goes wrong during training?
  - What are the most challenging situations/incidents/activities during trainings?
  - How do you meet/resolve these challenges?
3. The facilitator instructs the group to do the following:
  - a. Share the contents of each meta-card in the group for each concept.
  - b. After everyone has shared her/his perspective about the concept, formulate a collective definition of the concept using all the key perspectives of each member of the group.
  - c. Write the definition of each concept on manila paper/kraft paper/flipchart (whichever is available).
  - d. Get ready for the plenary and share group output in 30 minutes.
4. After the plenary, the facilitator recapitulates the activity, culling ideas from the following training information.

## TRAINING INFORMATION: Common Challenges

### The need for facilitation and presentation skills to run a successful training session:

Facilitation and presentation skills are basic requirements for a trainer to ensure active participation, understanding and meaningful exchanges during trainings and workshops. Conducting training successfully is "easier said than done"

**Note:** Facilitator informs the participants that these training skills will be the focus of the second part of the module.

5. **The following are additional skills and challenges to run a successful training session** (Chambers, Wakley, Iqbal and Field, 2002; Chambers and Wall, 2000; Healthlink Worldwide; EngenderHealth; PAHO 1997).

#### a. Developing Rapport

A facilitator who builds a good relationship with participants is more likely to succeed in engaging and communicating well with participants. Practical ways to build a good relationship with participants include:

- Knowing them by their first name
- Knowing their strengths and weaknesses
- Spending informal time with them during the course.

A facilitator should be able to relate to many types of people and be able to encourage them to contribute. A facilitator who develops a good rapport with participants is in a better position to encourage them to take responsibility for their own learning.

#### b. Ground Rules

Opening impressions have an important bearing on the atmosphere for the rest of the event or the remaining training sessions. Any problems in an initial session may have a lasting effect, whilst a successful start will boost the learning environment in future sessions. It is important to clarify the ground rules, as this helps to create a "safe" environment. Establishing the ground rules is an excellent way of releasing tension and reducing nervousness, as it allows people to shape the culture and boundaries in which they wish to work. Common areas encompassed by ground rules include the following:

- ensure confidentiality, particularly when members from the same organization are present. Nothing heard within the group should be repeated or, if information is given, attributed to a group member without their permission



- encourage mutual respect, allowing all opinions to be heard
- feedback should be constructive and positive, any criticism being helpful and not destructive
- people should be able to opt out of certain exercises. The group may wish to set criteria for how and when this could happen (e.g., whether an explanation is offered to the facilitator or to the group, or is required at all)
- give each other permission to take "time out" or a break if a participant is finding a subject emotionally threatening (e.g., if exercise opens old wounds or if they have been diagnosed with a particular illness, etc.)
- limit interruptions from personal business (e.g., turn off mobile phones, ask individuals to fix other appointments outside the group's meeting times or course timetable)
- be punctual
- do not smoke at the meeting or event, or in the group's vicinity

**Note:** The facilitator can remind the participants about the PROMDI approach of the training.

### **c. Participants' Feedback**

Facilitator should set aside a segment of time at the beginning of each training day to permit the participants to raise issues that might interfere with learning, such as those related to personal situations, accommodations, or content. Depending on the size of the group, a period of 10 to 15 minutes should be sufficient.

Similarly, the facilitator should set aside a segment of time at the end of each training day to allow the participants to share their learning insights and their assessment of what did or did not go well for them that day. This assessment will enable the facilitator to adjust the agenda as needed and will give the participants a chance to comment on how the training course is progressing.

At the end of the day before the last training day (e.g., day 5 of the six-day training or day 2 of the three-day training), the facilitator might ask the participants if they would like anything discussed in the training to be clarified or if they like anything else to be included on the last day.

### **d. Cultural Sensitivity**

Facilitator needs to be aware of what views and approaches are acceptable in different cultures and how to adapt training to reflect these views. For example, in some communities women do not stand to voice views in front of men, and if they do speak in front of men they do not face them. Training could be adapted by sitting participants in small circle, containing either men or women, and for everyone (including the facilitator) to remain seated while speaking.

### **e. Perception**

Good facilitators perceive participants' verbal and non-verbal messages. During training, it is useful to check that facilitators and participants are communicating well and that participants understand the purpose and content of the training course.



**f. Meeting Expectations**

Training usually has an agenda with specific learning outcomes. However, even if objectives and outcomes have been communicated well in advance, some participants may have different expectations. Before training starts, the facilitator should ask participants about their expectations and try to ensure that these are addressed. If expectations cannot be addressed, explain why. Some expectations may go beyond your ability as a trainer; do not hesitate to state your limits.

**g. Group Dynamics**

Group dynamics (how people in the group relate to each other) are a key challenge. In all groups, the levels of skill, competency and responsibility will vary and this is often reflected in people's enthusiasm and level of participation. A facilitator needs to acknowledge these differences and ensure that everyone is involved.

**h. Physical Environment**

Facilitators need to consider the physical environment. Should learning take place in a classroom or outside? How should seating be arranged? In a large circle or several small circles? Do you have the materials you need for practical activities? Are there enough materials for all participants?

**i. Time Available**

Mornings are a good time for learning theory, whereas afternoons and evenings – when people are often tired and find it harder to concentrate – are good for group work, practical activities or site visits. It is also important to build in time for breaks and meals and be aware of any cultural needs (such as a break for prayers). If the course is residential, remember to include time for social activities, so participants can relax.

**j. Choosing Training Methods**

No single method of teaching is the best. Different methods suit different situations and different learners and teachers. There are also good, and not so good, ways of teaching different things. It is very difficult to teach and learn communication skills on a lecture-based course. Most people learn best by "doing", using active methods of learning rather than sitting passively.

6. Facilitators should know and be able to use/employ a variety of active training methods, and to choose the methods carefully to fit it best with what s/he is trying to teach and learn about.

7. In training, the trainer is guided by the following:

- a. People learn better when training includes a variety of training methods.
- b. A trainer's primary role is to help participants learn. A good trainer encourages participants to discover things and learn for themselves. Three things can help to stimulate participants' curiosity:
  - Involving people as active participants in the learning process, rather than passive recipients of information.
  - Ensuring the training is relevant to the participants' day-to-day work.
  - Using a variety of media and methods.
- c. Therefore:
  - When planning a training, the facilitator should always focus on the training objectives or learning outcomes - these are what we want people to learn - and the needs of the participants.
  - When considering what training methods to use, the facilitator should consider which method is best suited to what s/he is trying to communicate. For example, when training on family planning methods, is it best to use pictures, a lecture, handouts or a demonstration using a model or a combination of methods?
  - The training method a facilitator chooses should also reflect the needs and abilities of the participants. For example, there is no point in giving people lots of handouts if they have difficulty reading.

8. Facilitator informs the participants that the key principle to bear in mind when choosing a methodology is to keep in mind an old Chinese saying (Werner and Bower, 1995):

"If I hear it, I forget it".

"If I see it, I remember it".

"If I do it, I understand it".

"If I discover it, I use it".

9. Since adults as learners respond differently to different ways of imparting knowledge, and retention differs according to the medium in which the learning took place, the facilitator is advised to be guided by the following:

In the teaching-learning process, participants will retain:

10 percent of what they read;

20 percent of what they hear;

30 percent of what they see;

50 percent of what they both hear and use;

70 percent of what they do.

Source: VSO, IIRR and PEPE. 1998.

**Note:** Handout on Tips on the Use of Various Training Methods and Materials (pp.56-58)

## Activity 1.1j Evaluation and Monitoring

### *Notes for the Facilitator:*

1. Facilitator links the topic with the previous topics. By way of introduction, s/he mentions that evaluation and monitoring is an important part of the training since:
  - evaluation allows the participants, trainers/facilitators, and program planners to determine whether the training has met its objectives;
  - evaluation can help trainers to improve existing training courses and plan future training; and
  - follow-up and support can help to ensure participants use the skills they have learned in their everyday work.

2. The facilitator can either do one of the following depending on the time available:

**Option 1:** The facilitator informs the participants that an evaluation/assessment of the day's activities will be conducted at the end of the day. The participants, as they go through the process, identify insights that can be processed as the training progresses.

**Option 2:** The facilitator requests the same group that worked on the training methodology to come together to share experiences in evaluating the training process at various phases: during, after the training, follow-up and support. The group will also be requested to develop a simple tool/s that they can utilize in the evaluation of the training.

3. Activity Guide:

- The group will be given 30 minutes to work on the task.
- Their outputs will be posted in the various parts of the training session room.
- The other groups will go around the room to look at the other groups' outputs and write down their comments and suggestions on a paper provided.



## TRAINING INFORMATION: Evaluation and Monitoring

Evaluation is crucial for providing further information about future training. If the training has been well received and has resulted in positive changes in how people do their jobs, then it has clearly been a success and is worth repeating. On the other hand, if participants say they did not like the training and it has no effect on how they do their jobs, then the training needs to be changed. Sometimes evaluating training also might result in further new training needs being identified.

For successful evaluation, the facilitator needs to address four basic questions:

a. What am I trying to find out?

Here are some questions to ask when evaluating training:

- Did you (the trainer) think the training went well?
- Did participants enjoy the training?
- Did participants learn from the training?
- Has training changed how participants do their jobs?
- What insights did I learn today?
- What else would I have wanted the facilitators to have put more emphasis on?

b. How could I go about finding it out?

Participants can share their opinions by filling in questionnaires or having a short discussion about what they have learned. Trainers can use these to assess whether learning objectives have been met.

One way of evaluating training courses is by using a questionnaire at the end of the course, which gives participants the chance to give immediate feedback on course content.

c. When is the best time to find this out?

Evaluation during the training

- Participants' pre-workshop and post-workshop self-assessment of knowledge and attitudes
- Daily wrap-up session
- Workshop evaluation by participants

Evaluation after the training

- Follow-up visits
- Outcome evaluation guidelines

d. What am I going to do with the information?

Evaluation techniques are used to find out:

- How much learning took place
- How effective the training methods were
- How effective and useful each of the different sessions during the training were
- How the facilitators can improve themselves
- If the objectives were appropriate
- If the participants enjoyed themselves
- If the learning can be applied in the participants' job or other situations
- If the training facilities were satisfactory

**Box 10**

### **TRAINING INFORMATION: The Facilitator and the Participants' Feedback**

The facilitator should:

- set aside a segment of time at the beginning of each training day to permit the participants to raise issues that might interfere with learning, such as those related to personal situations, accommodations, or content
- set aside a segment of time at the end of each training day to allow the participants to share their learning insights and their assessment of what did or did not go well for them that day
- at the end of the day before the last training day (e.g., day 4 of the five-day training), the facilitator might ask the participants if they would like anything discussed in the training to be clarified or if they like anything else to be included on the last day.

### **The Facilitator and the Evaluation Process**

An important part of the training, evaluation allows the participants, trainers, and program planners to determine whether the training has met its objectives. Tools are included with this curriculum to cover evaluation during the training and on-the-job evaluation after the training.

*Source: EngenderHealth.*



## SESSION 1.2: Facilitation and Presentation Skills

### Introduction

Facilitation skills are a basic requirement for a trainer to ensure active participation and meaningful exchanges during trainings and workshops.

|             |   |
|-------------|---|
| Objectives  | By the end of the session, participants would be able to: <ul style="list-style-type: none"><li>• Identify strengths and weaknesses in personal facilitation and presentation skills; and</li><li>• Demonstrate facilitation and presentation skills.</li></ul> |
| Time        | 3 hours   |
| Equipment   | LCD or Overhead Projector, laptop computer (If using LCD)   |
| Materials   | Powerpoint Presentation on Facilitating and Presentation Concepts, Preparing and Delivering High Impact Presentations; handouts, meta-cards, manila paper, transparency films/acetates, OHP, OHP pens, permanent markers, masking tape                          |
| Evaluation  | Return Demonstration; Self/Peer Assessment; Evaluation Tool for Presentation  |
| Handouts    | Teaching Learning Process; Facilitation and Presentation Skills   |
| Preparation | <ul style="list-style-type: none"><li>• Meta-cards</li><li>• Powerpoint Presentations: Objectives, Facilitation and Presentation Skills</li></ul>   |

### Activity 1.2a: Facilitation Skills

#### Notes for the Facilitator:

1. Depending on the time available, the facilitator can choose between the following options:

**Option 1:** (Time is a limitation; 15-20 minutes)

**Facilitator:** Probes the following: Concept of facilitation; Who is a facilitator? The facilitator writes down answers on the whiteboard or flipchart. A collective definition of the concept of facilitation and on who is a facilitator, is made.

**Option 2:** (Time is a Limitation; 30 minutes)

Facilitator requests the participants to go back to their respective groups. Each group is given drawing materials (manila paper/kraft paper/ flipchart/transparency



film and pens). The facilitator then instructs the participants to draw a person and using the different parts of the body, to label each part with what makes a good facilitator.

**Option 3:** (Time is NOT a Limitation; 1 hour to 2 hours)

Facilitator gives each participant three pieces of meta-cards. S/He asks each participant to write on each meta-card a phrase (3-7 words) that describes a good facilitator.

2. The facilitator requests the participants to share their answers according to their task/committee group. The group is requested to cluster similar answers. This is done in 10 minutes.

The facilitator requests the group to put all their meta-cards on the floor. S/He then requests each group to post on the board the first three meta-cards that best describes a good facilitator.

The meta-cards on the board that have similar meanings are grouped or clustered. The facilitator moves on to ask for another three (3) sets of meta-cards, have these posted and then grouped/clustered, until all the meta-cards have been posted.

The group now labels the grouped/clustered meta-cards and arrives at a consensus on "what makes a good facilitator".

3. A short input to summarize the activity follows, integrating insights from the training information box. The facilitator calls the attention of the group by saying that what they have just gone through is referred to as the consensus method.

#### Box 11

### TRAINING INFORMATION: Basic Facilitation Skills

#### Who is a Facilitator?

A Facilitator:

- Ensures the effective flow of communication within a group so that participants can share information and arrive at decisions.
- Poses problems and encourages group analysis.
- Provokes people to think critically and motivates them towards action.
- Does not change or ignore any decisions reached by the participants through consensus.
- Is sensitive both to the verbal and non-verbal communications that occur in the group.
- Is sensitive to the feelings, attitudes, culture, interests and any hidden agenda that may be present in the group.

**Remember:** To resolve conflict, a facilitator should be able to sense the ADI, where

- A is for agreement
- D is for Disagreement
- I is for Irrelevance

Agreements should be explored, disagreements respected and any irrelevance identified so that the focus will be on reaching an agreement. Exploring D can also be done to widen A.

**A facilitator should be like a sponge.**

An effective way of learning facilitation is through observing how effective facilitators handle a group in a certain activity. A good facilitator is like a sponge. They are never content with the skills and knowledge they have, and are aware that their capacity for learning is endless.

In keeping with this sponge image, effective facilitators learn from everything. In each course they conduct, they gain new insights and apply these to the next course based on their understanding.

When observing effective facilitators, take note of the following questions:

- What are the facilitators' styles of facilitation?
- How effective are these styles?
- How do they handle their participants?
- How do the participants respond to them?
- What are their strengths and weaknesses?

There are no exact formulas for effective facilitation. More important than having the capacity to liven up the group is to be able to provide a structure within which the group can discuss the agenda in a productive manner.

**Points to remember:**

- a. **Grasp firmly.** Have a good grip over the subject matter being tackled. Facilitator should determine the direction and flow of the discussion. Always be prepared. Have a contingency plan. In cases where invited guest speakers do not turn up, have a plan B.
- b. **Be open.** Encourage an atmosphere conducive to learning and sharing of ideas and where everyone feels welcome and important. Facilitation is like building a team where everyone has something to share and learn. A facilitator should be open and sincere.
- c. **Watch for the point.** By encouraging others to share and participate, the range of discussion may expand and deepen. Without a good grasp of the



subject, the discussion may get watered-down and lose track. Facilitators should see the various points, the pros and cons, the “what ifs” and other considerations. In the end, facilitators should be able to summarize the discussion.

- d. **Know your limits.** Know your own limitations and those of your participants. Have an idea of what is achievable and practical and what is not.
- e. **Learn how to count.** Be aware of how many participants are responding, how many are sleepy, how many frequently leave the hall and how many are no longer listening. This can help you decide whether it is time to change or adjust the discussion.
- f. **Watch your wrist.** Effective management of time is a skill and an attitude you should possess. Time is subjective. A too tight or rigid timetable would make a discussion seem like a military drill. On the other hand, too lax and liberal in handling the session would give the discussion the feel of a drinking party!
- g. **Have an artist’s touch.** Creative approaches and techniques encourage participation. Remember, facilitators do not have to be skilled in theater arts, drawing, etc. Sometimes, providing crayons to participants and encouraging them to express their answers through simple sketches is enough to ensure participation. As a facilitator, you are an artist of compassion and if you are really committed to motivating the community to change, you are also an artist of passion.
- h. **Learn the traffic signals.** An effective facilitator must know when to stop, wait a while and go. S/He should be able to stop, look and listen throughout the discussion. Remember a polite traffic enforcer is well liked by the public.
- i. **Learn how to salute (Learn how to respect and appreciate).** Remember to learn to respect and to have the ability to recognize everybody’s contributions. Practice humility; Facilitators do not have all the solutions. It would be nice if they come from the participants.
- j. **Know your left and right (recognize your strong and weak points).** After every seminar, meeting or training, a good facilitator should assess or evaluate. Whether in formal or informal setting, quantitative or qualitative, oral or written, feedback should be gathered. In doing this, a facilitator is able to tell what parts of the training were successful. There is no perfect score in facilitation. There is always room for improvement.

*Source: VSO, IIRR and PEPE. 1998.*

## **The Facilitator During the Training Course**

### ***Creating a Positive Learning Environment***

Many factors contribute to the success of a training course. One key factor is the learning environment. Trainers can create a positive learning environment by:

- *Respecting frequent positive feedback.* Trainers should recognize the knowledge and skills that the participants bring to the course, and can show



respect for them by remembering and using the participants' names, encouraging them to contribute to discussions, and requesting their feedback on the course agenda.

- *Giving frequent positive feedback.* Positive feedback increases people's motivation and learning ability. Whenever possible, trainers should recognize the participants' correct responses and actions by acknowledging them publicly and making such comments as "Excellent answer!" "Great question!" or "Good work!" "I can understand why you would feel that way..."
- *Making sure that the participants are comfortable.* The training room(s) should be well-lit, well-ventilated, and quiet, and should be kept at a comfortable temperature. Breaks for rest and refreshment should be scheduled.

## **The Facilitator in Presenting Sensitive Content**

Facilitators may face situations in which individual participants (or group of them) hesitate to join in discussions, are judgmental, or inhibit other participants from expressing their feelings freely. To encourage risk-taking and create an environment in which the participants feel comfortable discussing and absorbing new content and ideas, trainers may use the following techniques:

- Acknowledge that it is normal to feel nervous, anxious, or uncomfortable in new and unfamiliar situations.
- Begin with less-sensitive content and build up to content that is more sensitive.
- Use icebreaker activities at the beginning of the training workshop and after breaks to encourage team-building and comfort.
- Use small-group work to allow participants to express their feelings in front of a smaller audience. Similarly, split the groups by sex, if appropriate.
- Use paraphrasing and clarification techniques to demonstrate attention to what the speaker has said, to encourage the speaker to continue speaking, and to ensure understanding.
- Share own experiences, including situations in which were and were not successful.
- Give constructive feedback to reassure the participant that her/his remarks are acceptable and appropriate and to encourage additional participation.

*Source: EngenderHealth. Comprehensive Counseling for Reproductive Health: An Integrated Curriculum Trainers' Manual. 2003.*

## **Activity 1.2b: Presentation skills**

### ***Notes for the Facilitator:***

1. The facilitator introduces the topic by saying that for the lecture to be beneficial, the facilitator should have effective presentation skills.

2. The facilitator asks the participants to think of a presentation they have made in the past or of how they give lectures or training. S/he asks them "what went well and what went wrong?" or "what usually goes wrong or what usually goes well".

Sharing of experiences is facilitated.

3. The facilitator summarizes the sharing through a powerpoint presentation on how to prepare and deliver high impact presentations.
4. A powerpoint presentation on Preparing and Delivering High Impact Presentations: Tips for Presenters culled from various training references, as well as from a lot of experiences, may be utilized to aid the facilitator (*VSO, IIRR and PEPE, 1998; NLEMP and RDC-NL, 1994; AIDS Action, Child Health Dialogue, Disability Dialogue and Healthlink Worldwide, 2003; Werner and Bower, 1995*).

### Box 12

## TRAINING INFORMATION: Delivering High Impact Presentations

### Part I: Preparation

#### a. Getting Started

- Knowing your audience
- Setting your objectives
- Organizing your presentations
  - Objective-based approach
  - Open approach

#### b. Spicing Up Your Presentations

- With anecdotes and humor.

#### c. A Typical Presentation Structure

- The Opening
- The Body
- The Close
- ... and plenty of anecdotes, stories and jokes in between.

#### d. Humor DOs and DONTs

- Don't... unless you can tell it in a humorous way.
  - Don't if you are not in the mood.
  - No green, brown or ethnic joke.
  - Self-depreciating jokes are safe... but might erode your credibility.
  - Don't... if you have to explain it.
  - Don't... if its too long.
  - Control your own laughter.
  - Give your audience time to laugh.
  - Hold the punch line as long as you can.
  - Tell it when it's least expected.
- "Timing is Everything"



**e. Planning for an impressive opening and a high impact closing**

You can win or lose the audience with your opening.  
You can make a good or bad impression with your closing.  
In between, you can fumble.

**f. Closing**

*\*A speech is like a love affair: any fool can start one but to end it requires considerable skills. Lord Mancraft*

**g. Understanding the Attention Span**

Timing for presentations

- ✓ 15-30 minutes: without visual aids
- ✓ 30-45 minutes: with visual aids

**h. Scheduling Breaks and Exercises**

When do you give exercises?  
Nature of Exercises.

**i. Planning for the Venue**

Configuration Options

*Board Room Set-up.*

- good for 12 people or less
- avoid setup of equipment on main table
- landscape better than portrait

*U-Shape*

- 12 to 25 persons
- Ideal for open discussions or negotiations

*Classroom*

- 20 or more people
- For lecture-type seminars and workshops
- Wide is better than long

*Theater*

- To fit a large group into a room
- For presentations where there are no handouts
- For conferences and keynotes

*Banquet*

- For luncheon and dinner presentations
- Good for group exercises/discussions
- Fits in more people than classroom setup
- A third of audience will have to turn their seats around



## ***Part II: The Medium***

- a. "The medium is not the message."  
**A Survey of Audio-Visual Aids**
  - The traditional set
  - The all time favorites
  - The 1st generation electronic media
  - The new electronic medium
  
- b. **Three Key Principles**
  - Keep the text simple.
  - Keep the visuals uncluttered.
  - Guide the eyes to the main point.
  
- c. **Basic Layout: Design Tips**
  - Layout: landscape, not portrait
  - Titles: short and snappy
  - Bullet points: 3-7
  - Hierarchy: up to 2 levels only
  - Wording: phrases not sentences
  - Letters: upper and lower case
  - Alignment: mostly left, sometimes right
  
- d. **Color Selection**
  - Black is preferred over other colors
  - Use other colors to highlight/emphasize a point/idea
  
- e. **Criteria for Font Selection**
  - Is it readable?
  - Does it steal attention from the message?
  - Will it fit space allocated?
  
- f. **My Personal Favorites**
  - **Headings**
  - **Impact**            **ABCDEFGHIabcdef12345**
  - **Arial**              **ABCDEFGHIabcdef12345**
  
  - **Bullet points**
  - **Times Roman** **ABCDEFGHIabcdef12345**
  - **Albertus**        **ABCDEFGHIabcdef12345**
  
  - **Quotes and Definitions**  
**Time New Roman Bold Italics**

**g. When to Use Sounds, Music and Video Clips**

- **Making Special Effects Work for You**
- Use judiciously.
- Use it in clusters.
- Break monotony or stretch attention span.
- Must synch with visual effects.
- Surprise the audience.

**h. Handouts**

- Types
- Additional Materials

**i. When to give the Handouts Materials**

- Don't give any...
- Prior to presentation...
- After the presentation...

**Now, you're really ready!**

***Part III: The Delivery***

**a. Pre-show Checklist**

- Presentation Materials
- Equipment
- The Venue
- Your Contingency
- Yourself

**b. Controlling the Butterflies in your Stomach**

The human brain starts working the moment you're born and never stops until you stand up to speak in public.

**c. Controlling Nervousness: Some Practical Tips**

- Don't fight it
- Think Positive
- Visualize
- Walk
- Breathe Deeply
- Pray
- Talk to somebody
- Don't cross your legs
- Just Do It!!!!



#### d. Oral Communication Skills

- Anatomy of the Spoken word
- Volume
- Pitch
- Tone

□ **Voice** – a speaker should consider not only what s/he is saying but how message the is said. The three main problems are speaking in a monotone, talking too fast, and speaking at an inappropriate volume:

- Most monotonous voices are caused by anxiety, causing the muscles of the chest and throat to tense. It is essential to relax and release tension. This can be aided by upper body movements.

**Note:** A lecture read verbatim from a prepared script sounds stilted. Use flash cards instead with key words to remind you of the important points to cover or try a mind map.

- Talking too fast is also due to anxiety. Many novice lecturers say that they can alleviate their nervousness to some extent by a sound knowledge of their material. A dry run with friends or colleagues is usually more effective than practicing in front of a mirror. A good presenter uses pauses appropriately (for example, to let a point sink in) and it is also an effective way to slow down. Try pausing at the end of each sentence. Periods of silence are not a problem.
- Speaking too quietly can be a problem but this can be corrected with practice. If it is a continuing difficulty or if the speaker is naturally soft spoken, a microphone can be used.

□ **Using the voice for impact**

- To be heard
- To project excitement and enthusiasm
- To emphasize a word
- To make a dramatic point
- To have an impact
- Vary...vary
- Pause...vary...vary
- Speak with feelings

□ **Developing the speaking voice**

- Listen...to others and to your own
- Identify weaknesses
- Practice in day-to-day conversation
- Do breathing exercises
- Sing



#### e. Non-verbal communication Skills

"Your body speaks louder than your voice."

- **Posture** – if standing, a speaker should be erect but relaxed, facing the participants with the weight evenly distributed (placing weight on one hip and shifting it to the other and back can be distracting). If seated the speaker should also be relaxed and facing those s/he is addressing.
- **Movement** – applies mainly if the speaker is standing but is also important if seated. Moving around can be engaging and keep you involved with the participants.
- **Gestures** – the importance of natural gestures cannot be overstated; these are used in normal conversation and using them when addressing a group is appropriate and effective.
- **Eye contact** – this helps the channel of communication, can establish and build rapport and makes the lecture more personal. It is important not to stare at anyone (one or three seconds eye contact is fine) and to move focus among participants. If a group is too large to look at each individual separately, make contact with different individuals in different parts of the audience; those sitting near the individual will feel as if you were looking at them.
- **Dress, Make-up and Hairstyle**  
Appropriateness (venue and audience)
- **Facial Expressions**  
Connecting with your audience
- **The Proper Posture**  
Try not to do the wrong things
  - Slouching
  - Hands in the pocket, genital, or behind

#### f. Handling Questions

- The Q and A session can make or break your presentation.
- Practical Tips
- Anticipate the Question
- Prepare extra slides
- Use question slips to encourage the "shy" types
- If nobody asks a question, ask a question. Ask the first question.
- Remember: "There are no right or wrong answers...only good ones"

**g. Handling Difficult Attendees**

- Mr./Ms. Sleepy
- Mr./Ms. Know-it-all
- Mr./Ms. Combative Debater
- **Handling Difficult Situations**

**h. Ending the Show**

"Even bad things must come to an end."

## Activity 1.2c. Return Demonstration

### *Notes for the Facilitator:*

The facilitator informs the participants that each participant will be given the chance to choose a topic and prepare a 15-minute presentation from any of the contents of the Modules of the TOT. Concurrent presentations will take place during the last day. In this activity, the members of the group and the facilitator will critique the presentations based on an evaluation tool. S/he then moves on to conclude the Module after all the presentations have been completed.

## Conclusion

Facilitator reiterates the fact that training is an ongoing process. Participants need support and encouragement to use their new knowledge and skills in their work. Ideally, facilitators should give participants the opportunity to give feedback on the training they have received and problems encountered in applying it in their everyday work.

The facilitator challenges the participants to strengthen their training/facilitating skills to communicate powerful messages that contribute to the individual's control over their own lives. S/he cautions the participants that an approach to training/education that focuses on content may increase an individual's knowledge but this does not enable him or her to take action. It is not a lack of knowledge or information that keeps people from taking action but rather a lack of confidence or ability in analyzing the information they already know.

In conclusion, the following ingredients of a successful training adapted from Our Approach to Popular Education in NLEMP and RDC-NL, (1994) can be shared:

1. The group size should be limited to thirty participants and sufficient time must be allowed (a minimum of six hours in one block of time or spread over several sessions, days or weeks apart).
2. A degree of trust and familiarity must exist among the participants before honest sharing and discussion can take place. If the seminar is with a group that has not been together before, time should be allowed for people to get to know each other and develop a basis for trust.



3. To ensure that everybody works together, clearly stated, practical and action-oriented goals for the seminar must be agreed to by the whole group. Try to get the group to work out its goals ahead of time so that, if required, additional preparation can take place. Even so, always check the goals out against the beginning and reformulate or modify if necessary. It helps to have the goals posted where everyone in the group can see them so they can be referred to easily during evaluation of the seminar.
4. The agenda or an outline of the program developed and agreed to by the group, should be posted at the beginning of the seminar. This enables the time available to be used efficiently and the goals identified by the group to be accomplished by the end of the session. The agenda need not be inflexible as unforeseen topics or questions may arise and need attention before the group can return to the original plan. But any deviation from the agreed agenda or outline should be decided upon democratically by the group. In addition it is useful to stop periodically and check if the original agenda is still useful or if it needs rearranging.
5. When issues arise over the agenda or the way the training is proceeding, the group should resolve them democratically. It could be a question of what symbol to use or whether a topic should be pursued or noted for later discussion. While the facilitator may propose a particular course of action, we try to involve the whole group in making the decision by consensus.
6. It is critical that everyone in the group participate for the discussion to be most effective. Breaking into smaller groups for part of the seminar can help to broaden participation.
7. Leadership should be a shared responsibility of the group to avoid becoming dependent on one or two people. Encourage shared leadership by asking the group to select from among themselves people who will lead certain parts of the program such as the introduction of the discussion of strategies and follow-up plans. Another way is to ask the group to divide into smaller workshops for part of the program and for each workshop to select a discussion leader and recorder. Other leadership roles can also be rotated for each session. This will help develop the skills of leadership within a group and also help individual participants take a stronger interest in the seminar.
8. It is important to keep a record of the key points of the discussion. It shows that everyone's contribution is valued, and is a way of keeping track of progress made. It is a way of noting questions that a group may wish to come back to later. It also provides an accurate account that can be referred to by individuals or by the whole group later on. The task of recording also forces a group to come to a consensus about the points the group is making.



9. The group should evaluate periodically how the seminar is progressing. They should review the original goals and see whether these goals are being accomplished or if as a result of the discussion they need to be reassessed. It is important also to check the progress on the agenda and modify it if necessary, to evaluate the level of participation, and identify and discuss any other problems that arise. Evaluation is one of the most helpful things for developing group skills and building a group's cohesiveness and effectiveness.
10. Facilitator distributes Handout 1.2.

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MODULE 1

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# Gender Responsive and Rights-Based IRH and the Facilitator

# H A N D O U T S

## MODULE OVERVIEW

**Module I is comprised of two parts.**

**SESSION I** deals with the overview of the Teaching-Learning Process. This portion of the module aims to guide and/or refresh the facilitator's KAP on the training process. It is important that the facilitators have a common framework vis-à-vis the delivery of a GR-RB Integrated RH services.

- **Objectives:** By the end of the session, participants would be able to:
  - Discuss the Teaching-Learning Process;
  - Relate the importance of training in the delivery of a GR-RB Integrated RH services.

**SESSION II** of the module deals with the facilitation and presentation skills expected of an effective and efficient facilitator for training of trainers.

- **Objectives:** By the end of the session, participants would be able to:
  - Identify strengths and weaknesses in facilitation and presentation skills;
  - Demonstrate facilitation and presentation skills.



## Handout 1.1.1

# The Training-Learning Process

## What is training?

### Training...

- is the process of bringing a person to an agreed standard of skill by practice and instruction'.
- a trainer and participant working together to transfer information from the trainer to the participant, to develop the participant's knowledge, attitudes or skills so they can perform work tasks better.

Taken together these definitions say two things:

1. Training is directed towards agreed standards or objectives. These are sometimes called learning outcomes-what you want people to learn from training.
2. The person being trained participates with the trainer in the training activity, rather than simply receiving instruction. Training usually involves participation. This means that a person being trained has an active training process, rather than a passive role. Also it often takes place in the workplace or community where the skills and knowledge being communicated will be used.

## Why is Training Important?

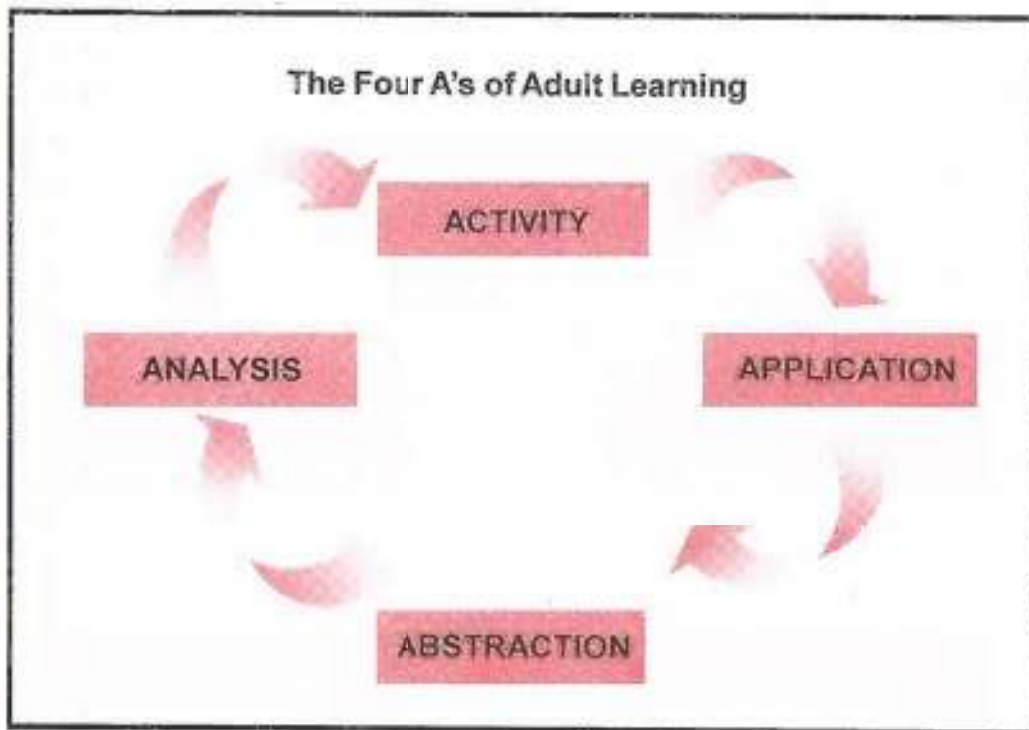
### For the participants/trainees, training can:

- Provide new skills and knowledge, and maintaining existing skills
- Increase confidence
- Confirm the value of what they are already going
- Enable to pass on new skills to colleague in the workplace
- Raise general awareness
- Change attitudes
- Improve morale

Training can play an important role in improving health providers' effectiveness. Whether training is part of an ongoing process of profession development or simply about learning a specific skill, it can improve people skills and knowledge and help them carry out their job more effectiveness.

# The Adult Learning Process

Handout 1.1.2



## **ACTIVITY: (Or Experience)**

- Involvement of Participant
- Maybe direct or vicarious
- Explore new situations
- Use case analysis, simulation exercises, role playing, personal disclosure session

## **ANALYSIS: (Reflective Feedback)**

- Observation, comparing situations/ data, and reflection of what the situation means to the participant
- Periods of question and answer, discussion or individual time for reflection

## **ABSTRACTION**

- Based on reflective feedback, situations are analyzed, insights formulated and theories formed
- Identifies generalizations
- Key Learning Points

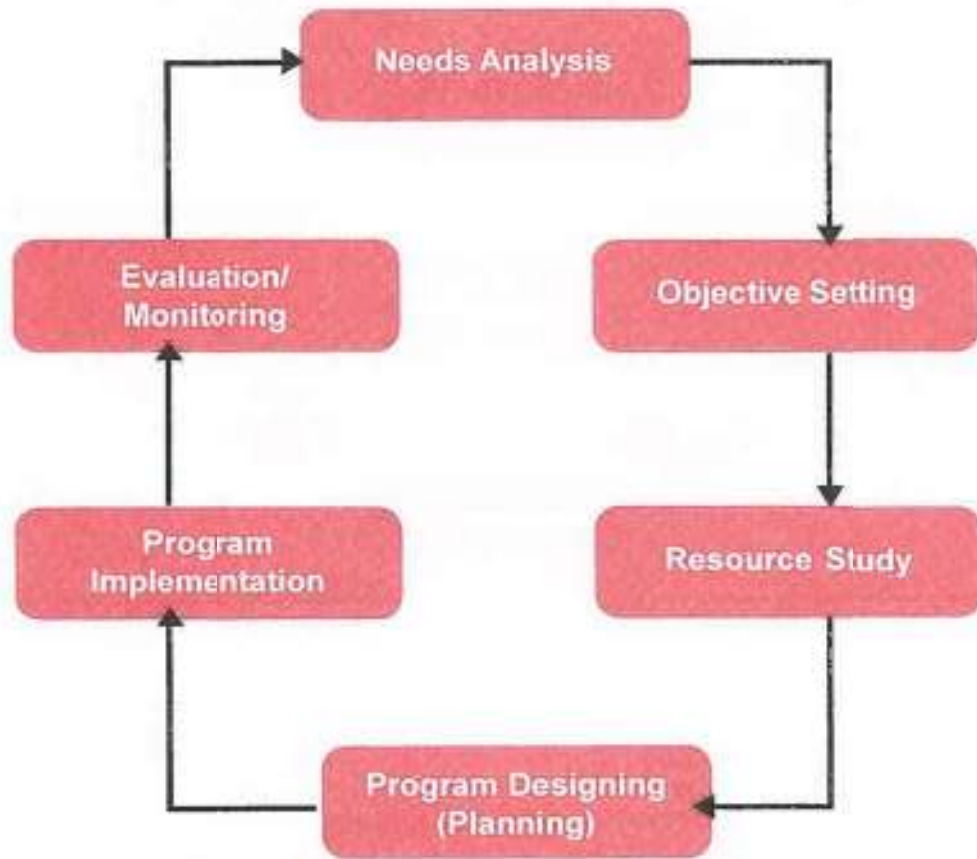
## **APPLICATION**

- From insights and generalizations which surfaced during analysis and abstraction stages, participants translate them to real life concerns.

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# The Training Process

Handout 1.1.3





## Methods of Assessing Training Needs

### Handout 1.1.5

- **Questionnaires:** Questions need to be clear, specific and simple. Avoid closed questions (i.e. those having a yes or no answer) as these identifying what people think they know rather than what they actually know. Questions should be geared towards finding out whether people have the skills and knowledge you think they need to do their jobs effectively.
- **Group discussions with participants:** These enable participants to share comments and observations about what is happening in their workplaces and what skills they feel they may need.
- **Individual discussions with participants:** These give participants the chance to talk in confidence about difficulties they are having and things they need to learn.
- **Self-assessment:** This involves asking participants to list the things they think they are good at and what subjects/areas they think they need training on.
- **Discussions with managers/supervisors, service users and others:** Trainers/facilitators can gather views on training needs from those who come into contact with the participants of the training.
- **Observing participants while they are working:** These methods help trainers/facilitators to assess what the participants already know and what knowledge and skills they may need to acquire to work effectively. It is best to gather as much information as possible, using as many different methods as possible. However, facilitators must decide how much information it is realistically possible to gather within the limits of available time and financial resources. This may mean only being able to carry out one or two of the above.

## Objective Setting and Formulation

### Handout 1.1.6

#### Basic Concepts related to Objective Setting:

1. **AIM IN TRAINING:** What the course designer want to achieve
2. **OBJECTIVE IN TRAINING:** What the participants are required to know, do or think at the end of the learning process/experience; General or Primary Objective
3. **BEHAVIOR:** Any overt or visible activity displayed or performed by the learner
4. **BEHAVIORAL OBJECTIVE:** The Behavior the learner demonstrates at the end/conclusion of the training effort; Secondary or specific objectives.

Must state what behavior is desired as the outcome of the training. Therefore, behavioural objectives are participant centred and SMART (specific, measurable, attainable, realistic and time bounded).

- Note: Provide Handout of **EXAMPLES OF VERBS USED IN BEHAVIORAL OBJECTIVES**

#### Importance of Setting Objectives:

- Consistency in the Design
- Basis for measuring Performance
- Minimize "Undertraining" and "Overtraining"
- Clear Instructor and Trainee Goal
- Selecting Most Suitable Instructional Method
- Selecting Appropriate Content
- Effective Communication



## Examples of Verbs Used in Behavioral Objectives

# H A N D O U T S

### A. For Knowledge Area

| KNOWLEDGE LEVEL | COMPRE-HENSIVE LEVEL | APPLICATION LEVEL | ANALYSIS LEVEL | SYNTHESIS LEVEL | EVALUATION LEVEL |
|-----------------|----------------------|-------------------|----------------|-----------------|------------------|
| Define          | Translate            | Interpret         | Differentiate  | Compose         | Judge            |
| Repeat          | Restate              | Apply employ      | Appraise       | Plan            | Appraise         |
| Record          | Discuss              | Use               | Calculate      | Propose         | Evaluate         |
| List            | Describe             | Demonstrate       | Test           | Design          | Rate             |
| Recall          | Reorganize           | Practice          | Compare        | Formulate       | Compare          |
| Name            | Explain              | Illustrate        | Contrast       | Arrange         | Value            |
| Relate          | Express              | Operate           | Diagram        | Construct       | Revise           |
| Underline       | Identify             | Schedule          | Inspect        | Collect         | Score            |
|                 | Locate               | Shop              | Inventory      | Construct       | Select           |
|                 | Report               | Sketch            | Examine        | Create          | Choose           |
|                 | Review               |                   | Solve          | Set up          | Assess           |
|                 | Tell                 |                   | Categorize     | Organize        | Estimate         |
|                 |                      |                   |                | Manage          | Measure          |
|                 |                      |                   |                | Prepare         |                  |

### B. For Attitude Areas

| RECEIVING LEVEL | RESPONDING LEVEL | VALUE LEVEL | ORGANIZATION LEVEL | CHARACTER-IZATION LEVEL |
|-----------------|------------------|-------------|--------------------|-------------------------|
| Listen          | State            | Accept      | Organize           | Revise                  |
| Prefer          | Complete         | Participate | Relate             | Face                    |
| Receive         | List             | Attain      | Correlate          | Develop                 |
| Favor           | Derive           | Decide      | Form               | Identify                |
| Attend          | Answer           | Recognize   | Judge              | Change                  |
| Accept          | Write            | Increase    | Determine          | Judge                   |
| Perceive        | Select           | Indicate    | Associate          | Demonstrate             |
| Select          | Develop          | Influence   | Select             | Decide                  |



## Guide questions on deciding who should attend the training

### Handout 1.1.7

Planning the contents of training and deciding who should be trained are linked activities. It is important to be clear about training objectives and to ensure that the objectives are relevant to participants. Once participants are identified, it is important to adapt the training plan to suit their needs.

The following guide questions can help the trainer/facilitator decide who should attend the training:

- **Who will participants work with when they have finished training?** For example, if the training is about antenatal care it may be more appropriate to train female health workers in areas where female modesty is important.
- **Do participants need to have certain skills or knowledge?** Some training courses may require participants to have background knowledge, for example, if the training is about treating opportunistic infections in people with HIV/AIDS, then participants need to have some knowledge of HIV/AIDS.
- **Will training be relevant to participants' job?** For example, if the training is about setting up a programme for setting up VAW centers, the most suitable participants are municipal/provincial health officers, rather than community health workers. Participants learn best when they can see clearly how the training can be used in their lives or work.
- **Do participants have the support of colleagues and managers/supervisors?** For training to be used in the workplace, participants need to have the support of managers/supervisors and colleagues so that they can use skills and knowledge when they return to work.
- **It is possible to train two people from the same area?** This means that when training has ended and participants have returned to work they can provide each other with support.
- **Do participants need to be able to speak certain languages?**
- **Do participants need to have certain qualities?** For example, are they friendly and approachable? Are they willing to pass on the skills they learn to others?
- **Are the participants motivated and do they want to do the training?** Ensure participants attend training for the right reasons, rather than for 'time off'. Some training courses require a certain level of education or literacy, e.g. finished primary or secondary school, but this may exclude many people who have useful skills and knowledge that they learnt in life rather than in school. People do not always need to be able to read and write to be included in training. Written words can often be replaced by pictures, symbols, role plays or songs.

## Basic conditions in training program designing

### Handout 1.1.8

1. **CONTRACT.** More than a legal document, it is a psychological agreement between the participants and the trainers/facilitators which in the first place is what brings the participants to the training, knowing what to expect, why they are there and what they have agreed/consented to experience.
2. **LENGTH** and **TIMING** of the training (How much time can the trainees afford?)
3. **LOCATION** of the training and physical facilities.
4. **FAMILIARITY** of the participants with one another.
5. **TRAINING EXPERIENCE** of the participants
6. Availability of **QUALIFIED FACILITATORS** and/  
or **TRAINING STAFF**
7. **BUDGET**
8. **ACCESS** to the training materials and audio-visual aids.
9. Opportunity for follow-up activities
10. Educational level and intellectual capacity of the participants.



## Seven design steps

### Handout 1.1.9

1. Diagnose the problem or need to determine the role of training. –  
TRAINING NEEDS ANALYSIS
2. Formulate the objectives of the training program in behavioral terms.

#### REMEMBER:

- a. A Behavioral Objective should focus on the goal of the training.
- b. A behavioral objective should have an action verb.
- c. In behavioral objective, the trainee should be the subject of the sentence.

3. Draw up the course content – Activities/topics – against established terminal objectives.
4. Define the *learning objective* per content/activity/topic. Learning objective is also known as *Enabling Objective* – i.e. through such enabling objectives, a terminal objective might be satisfied or met.

**REMEMBER:** Learning objectives must also be stated in behavioral terms just like terminal objectives.

5. Select instructional method(s) and techniques which would ensure that the learning objective for any given topic/activity is achieved.

#### Some things to consider when deciding on methods and techniques:

- a. The instructional method and technique must suit the trainor's ability, skills and interest (the trainor must be comfortable with the training method and technique)
- b. learning objective(s)
- c. Background and interest of the trainees.
- d. Time available to conduct a training activity/topic
- e. The number of the trainees and the size of the training room.

6. Plan a favorable learning climate. Given the participants' intellectual level, including group climate and other factors, decide on what probably is the best flow or sequencing of activities/topics. Also, unfreezing activities are sometimes needed before each major topic/activity in the training.

**REMEMBER:** Even unfreezing activities have learning objectives and methods/techniques.

7. Pre-set the evaluation criteria



## Handout 1.2

# Basic Facilitation Skills

## Who is a Facilitator?

### A Facilitator:

- Ensures the effective flow of communication within a group so that the participants can share information and arrive at decisions.
- Poses problems and encourages group analysis.
- Provokes people to think critically and motivates them towards action.
- Does not change or ignore any decisions reached by the participants through consensus.
- Is sensitive, both to the verbal and non-verbal communications that occur in the group.
- Is sensitive to the feelings, attitudes, culture, interests and any hidden agenda that may be present in the group.

**Remember: To resolve conflict, a facilitator should be able to sense the ADI, where**

A is for agreement  
D is for Disagreement  
I is for Irrelevance

Agreements should be explored, disagreements respected and any irrelevances identified so that the focus will be on reaching an agreement. Exploring Ds can also be undertaken to widen the A.

### **A facilitator should be like a sponge**

An effective way of learning facilitation is through observing how effective facilitators handle a group in a certain activity. A good facilitator is like a sponge. They are never content with the skills and knowledge they have, and are aware that their capacity for learning is endless.

In keeping with this sponge image, effective facilitators learn from everything. In each course they conduct, they gain new insights and apply these to the next course based on their understanding.

When observing effective facilitators, take note of the following questions:

- What are the facilitators' styles of facilitation?
- How effective are these styles?
- How do they handle their participants?
- How do the participants respond to them?
- What are their strengths and weaknesses?

There are no exact formulas for effective facilitation. More important than having the capacity to liven up the group is to be able to provide a structure within which the group can discuss the agenda in a productive manner.

### Points to remember:

1. **Grasp firmly.** Have a good grip over the subject matter being tackled. As a facilitator, you should determine the direction and flow of the discussion. Always be prepared. Have a contingency plan up your sleeve, e.g., in cases where your invited guest speakers do not turn up, have a plan B.
2. **Be open.** Encourage an atmosphere conducive to learning and sharing of ideas and where everyone feels welcome and important. Facilitation is like building a team where everyone has something to share and learn. A facilitator should be open and sincere.
3. **Watch for the point.** By encouraging others to share and participate, the range of discussion may expand and deepen. Without a good grasp of the subject, the discussion may get watered-down and lose track. You should see the various points, the pros and cons, the "what ifs" and other considerations. In the end, you should be able to summarize the discussion.
4. **Know your limits.** Know your own limitations and those of your participants. Have an idea of what is achievable and practical and what is not.
5. **Learn how to count.** Be aware of how many participants are responding, how many are sleepy, how many frequently leave the hall and how many are no longer listening. This can help you decide whether it is time to change or adjust the discussion.
6. **Watch your wrist.** Effective management of time is a skill and an attitude you should possess. Time is subjective. A too tight or rigid timetable would make a discussion seem like a military drill. On the other hand, too lax and liberal in handling the session would give the discussion the feel of a drinking party!



7. **Have an artist's touch.** Creative approaches and techniques encourage participation. Remember, you *do not have to be skilled in theater, drawing, etc.* Sometimes, providing crayons to participants and encouraging them to express their answers through simple sketches is enough to ensure participation. As a facilitator, you are an artist of compassion and if you are really committed to motivating the community to change, you are also an artist of passion.
8. **Learn the traffic signals.** As an effective facilitator, you must know when to stop, wait a while and go. You should be able to stop, look and listen throughout the discussion. Remember that a polite traffic enforcer is well liked by the public.
9. **Learn how to salute (Learn how to respect and appreciate).** Remember to learn respect and the ability to recognize everybody's contributions. Practice humility; as a facilitator, you do not have the solutions; they come from the participants.
10. **Know your left and right (recognize your strong and weak points).** After every seminar, meeting or training, you should assess or evaluate. Whether in formal or informal setting, quantitative or qualitative, oral or written, feedback should be gathered. In doing this, a facilitator is able to tell what parts of the training were successful. There is no perfect score in facilitation. There is always room for improvement.

## Delivering high impact presentations

- **Posture** – if standing, you should be erect but relaxed, facing the participants with your weight evenly distributed (placing weight on one hip and shifting it to the other and back can be distracting). If seated, you should also be relaxed and facing those you are addressing.
- **Movement** – applies mainly if you are standing but is also important if seated. Moving around can be engaging and keep you involved with the participants.
- **Gestures** – the importance of natural gestures cannot be overstated; these are used in normal conversation and using them when addressing a group is appropriate and effective.
- **Eye contact** – this helps the channel of communication, can establish and build rapport and makes the lecture more personal. It is important not to stare at anyone (one or three seconds eye contact is fine) and to move focus among participants. If a group is too large to look at each individual separately, make contact with different individuals in different parts of the audience; those sitting near the individual will feel that you were looking at them.



- **Voice** – a speaker should consider not only what s/he is saying but how messages are said. The three main problems are speaking in a monotone, talking too fast and speaking at an inappropriate volume:

Most monotonous voices are caused by anxiety, causing the muscles of the chest and throat to tense. It is essential to relax and release tension. This can be aided by upper body movements.

**Note:** A lecture read verbatim from a prepared script sounds stilted. Use flash cards instead with key words to remind you of the important points to cover or try a mind map.

- Talking too fast is also due to anxiety. Many novice lecturers say that they can alleviate their nervousness to some extent by a sound knowledge of their material. A dry run with friends or colleagues is usually more effective than practicing in front of a mirror. A good presenter uses pauses appropriately (for example, to let a point sink in) and it is also an effective way to slow down. Try pausing at the end of each sentence. Periods of silence are not a problem.
- Speaking too quietly can be a problem but you can correct this with practice. If it is a continuing difficulty or if you are naturally soft spoken, a microphone can be used.

## Using training materials\*

### Adapting training materials

Training materials are usually designed for a well-defined audience. These assumptions can include the age, sex or group profile of the participants or the objective for which the material has been defined. So materials may need to be adapted to suit particular participants or objectives.

Materials make assumptions about the trainer, including their ability to be creative and adapt the materials, to set an appropriate timetable for training, and to think of appropriate methods and questions. They also assume that the trainer knows about their subject matter.

To use training materials effectively, trainers should view using the materials as a means to an end and not the end itself. Training materials are one tool at the trainer's disposal, but in themselves they do not constitute a training session.

Before using any training materials, trainers should ask themselves three questions:

1. Is using the material the best way to help participants understand the facts and so help me achieve my objective?
2. How much time does it need?
3. What adaptations do I need to make the materials fit my objective?

Try to test the material before using it in training. This means discussing it with people you will be training, or their managers, to see if it is relevant and likely to meet their needs.

Training that includes practical activities can be very successful. Most people learn more when they are doing than when they are listening. Selection of training materials and methods is very important. When choosing training activities, trainers should consider the needs of participants (e.g. are they literate, do they have traditions of story-telling or street theatre) and resources available.

Trainers should also consider the practical aspects of using different types of training materials. For example, if you plan to use videos in a training session make sure there is electricity and a television available. Similarly, if you plan to use a CD-ROM or the internet make sure you have access to a computer. In many areas low-cost training aids are the best option.

\* Nds Action, Child Health Dialogue, Disability Dialogue and Healthlink Worldwide. 2003. *Exploring the training process*. London, UK.



## Training manuals and books

Many manuals and activity plans include suggestions that they should be adapted to meet local needs. They can help trainers to get access to the expertise and knowledge of other people. They are useful for participants because they can be referred to after the training course. However, it is often too expensive to give each participant a training manual to take away. Trainers should bear in mind that manuals may need to be adapted to meet local needs.

Many manuals and activity plans include suggestions that they should be adapted to meet local needs. This requires special skills and is very time consuming. Trainers themselves may need training in this area before they can adapt materials effectively. When adapting materials remember the level of information that your participants need and will understand. Do not give them too little or too much information.

Try to use training materials that:

- Look attractive
- Are easy to use
- Are simple, readable and understandable
- Have illustrations that are clear and appropriate

## Visual aids

Pictures, such as drawings, photographs, picture cut outs of books or magazines or other visual aids can help people to remember things. They can also be used to start discussions. Visual aids may be pictures, but they can also be real objects. Never use a picture if you can use the real thing. Visual aids can also be models. Other types of visual aids include:

- **Wallcharts:** Pictures, diagrams or graphs that are put on a wall. They can include more information than posters because the trainer is there to explain them.
- **Flashcards:** A series of cards, with words or pictures, which are shown to a group to stimulate discussion.
- **Flip charts:** Large sheets of paper with key points that can be used to stimulate discussion
- **Slides or overheads:** Shown using a projector.

When choosing visual aids, remember to take into account local, social, cultural and religious beliefs and practices. Also, choose visual aids relevant to the topic of the training session, the experience of the participants and the size of the group.

Sometimes it is best to use visual aids that are specifically designed for teaching. However, sometimes people learn more when they create their own visual aids.



## Videos

Videos are useful for holding the attention of participants and generating discussion. Used on their own, they are not effective as a method of teaching, but they can be used with other methods. They are also useful for introducing a subject. Before showing a video, explain what it is about, and discuss it with participants afterwards. Videos often come with facilitator guides that contain background information, questions to use in a training session and suggestions for activities.

There are practical considerations when showing a video: a video shown on a small screen is not suitable for a group of more than 20 people and films need to be shown in a darkened area.

## CD-ROMs

CD-ROMs (compact disk read-only memory) can be a useful training tool if you have access to computers. CD-ROMs can hold up to 360,000 printed pages of text and are a popular way of storing large collections of information such as database and encyclopedias. Some CD-ROMs include audio and interactive material, and question and answer sessions that can help to assess how much people have learned. Remember, if you have 10 participants and only one computer, not all participants will be able to see the screen if the computer is used in a group activity. Instead, if possible, let participants take turns to use the computer during breaks or after training finishes for the day.

## Handouts

There are many types of handouts. They can be a brief written summary of points made during training or further background information on a subject (this may be a photocopied page from a book). These types of handouts are usually given out after talks. Others, such as those explaining an activity or practical task, are given out at the beginning of a training session. Handouts can usefully include diagrams. Tips for using summary handouts:

- Tell people that you will give them a handout at the end of the talk, so they listen to you rather than spend time trying to write notes.
- Try to give them out after a talk, rather than before, or people might spend time reading the handouts rather than concentrating on what you are saying.
- Handouts should only be used in conjunction with other training methods (i.e. a talk).
- Think of summary handouts as reminders. Keep them short and simple.

## Characteristics of methods often used\*

| WHAT IT IS  | WHEN TO USE  | HOW IT WORKS   | ADVANTAGES  | LIMITATIONS   |
|---|--|--|---|---|
| <p><b>CASE STUDY</b></p> <p>Group discussion of pre-selected case histories which may be presented orally, in picture or on records</p>                             | <ul style="list-style-type: none"> <li>• in presenting and solving a problem</li> <li>• in developing analytical skills</li> <li>• in sharpening and broadening insights and attitudes</li> <li>• in practicing tolerance and respect for others views.</li> </ul> | <ul style="list-style-type: none"> <li>• participants study the case beforehand</li> <li>• analyze facts</li> <li>• determine possible course of action</li> </ul>   | <ul style="list-style-type: none"> <li>• permits participation by all members of groups</li> <li>• develops problem solving ability</li> <li>• gives members chance to test ideas</li> <li>• affords opportunity to work with others</li> </ul> | <ul style="list-style-type: none"> <li>• requires intense advance study</li> <li>• suitable case materials not always available</li> </ul>                  |
| <p><b>DEMONSTRATION</b></p> <p>Showing and explaining how something is done, is used, or works</p>  | <ul style="list-style-type: none"> <li>• to familiarize and fill in the details</li> <li>• provides for clear, simple and realistic understanding</li> </ul>   | <ul style="list-style-type: none"> <li>• trainor shows the step-by-step processes for group to see the action carried out correctly</li> </ul>   | <ul style="list-style-type: none"> <li>• aids motivation</li> <li>• helps clarify important or difficult points</li> <li>• illustrates application of theory or principles</li> <li>• emphasizes correct procedures</li> </ul>                  | <ul style="list-style-type: none"> <li>• requires careful preparation (large group may not be able to know all steps, some points may be missed)</li> </ul> |
| <p><b>FORUM</b></p> <p>Brief presentation by a speaker, followed by group questions, opinions, evaluations or recommendations and attempt for common conclusion</p> | <ul style="list-style-type: none"> <li>• to provide, explore and broaden information which can be used in problem analyses and problem solving</li> </ul>  | <ul style="list-style-type: none"> <li>• speaker clarifies points through questions asked by audience</li> <li>• audience may add information and express opinions</li> <li>• areas of agreement and disagreement defined</li> </ul> | <ul style="list-style-type: none"> <li>• stimulating through provoking</li> <li>• develops different points of view</li> <li>• large number of people reached</li> <li>• greater audience participation</li> </ul>                              | <ul style="list-style-type: none"> <li>• may develop arguments between groups of conflicting views</li> <li>• contributions may be disorganized</li> </ul>  |



# H A N D O U T S

## QUIZ GROUP

A large group is split into several discussion groups followed by report from appointed chairperson of each small group and summary by leader

- for tapping the thinking of a group for possible solution to a common problem
- in developing a procedure
- in testing a set of ideas
- in improving flow of communication

- facilitates understanding and add interest about the subject
- specifically useful for dull subjects
- helps retention of objects
- adds interest in the learning process

- provides variety
- strengthens emotional appeal
- reveals hidden, remote or hard-to-get at process

- entertainment values sometimes interfere with teaching values
- difficult to integrate with other teaching methods and
- expensive

## GUIDED TOUR

Trainees go to actual site of operation being studied, see what goes on, where and under what conditions

- for orientation and increasing understanding of actual operations (operation showing relationship is not possible to show in the training room)

- tour guide explains particulars and answers questions
- relative importance of things seen can arouse participants' interest
- affords deep & meaningful understanding

- gives vivid, real, first-hand experience
- broadens perspectives, understanding
- increases interest
- creates enthusiasm
- provides realism

- difficult to keep within practical life
- requires considerable time, energy, & effort to arrange
- can be physically tiring

## LECTURE

Done by a speaker; the group may not be allowed the question and answer portion; usually somewhat formal

- to ensure the giving of uniform essential information to a large number of people in a limited time
- to speed up learning

- direct contact with audience covers a wide field and deals with many facts
- actual participation achieved by good question and answer during or after lecture

- easy to arrange
- organized and systematic way of presenting material
- assures uniformity of information or giving new facts
- reaches many people in a short time

- difficult to find dynamic speaker
- limited opportunity for group participation
- not suitable for teaching human skills



# H A N D O U T S

## **PANEL DISCUSSION**

One or more specialist present short talks on a given subject, followed by question and discussion

- to facilitate attitude change
- to impart technical information for analyses of particular needs

- gives audience better understanding of the problem.
- the course of action considers advantages
- stimulates spontaneity by participants

- stirs audience interest
- stimulates thinking & analyses
- spotlights issues — reaches a large number of people in short time

- requires careful preparations
- limited to speaker's views
- limits group participation

## **ROLE PLAYING**

Simulated situation involving the trainees playing parts or roles assigned to them

- for solving human relations/ problems
- for practicing newly-acquired skills
- for changing attitudes
- testing ideas

- provides opportunity for innovation and spontaneity
- gives opportunity for increased sensitivity and emergence of new perceptions of frames of reference

- develops social insights and skills
- changes attitudes & behaviors
- facilitates understanding & communication

- requires skillful leadership
- difficult to communicate results
- may be painful way of learning for self-conscious participants

## **WORKSHOP**

Brings group together to develop skills through actual practice in an organized manner

- in determining training needs of both individual & group
- for fact-finding or collecting exploratory information on issues
- modify existing plans

- participants work together to develop further skills in actual practice, i.e. planning & report writing
- the planners, organization and participants needs are readily identified

- participants gain motivation to adapt in particular operations
- helps improve action plans with new insights
- share common experience

- need for prior commitment with participant
- careful planning & post-workshop results
- involves more people in selection of discussion leaders

# MODULE 2

## **Towards a Gender-Responsive and Rights-Based Integrated Reproductive Health Care Service Delivery**

*SESSION 2.1* Why Gender-Responsive  
and Rights-Based Integrated RH Services?

*SESSION 2.2* Reproductive Health Overview

*SESSION 2.3:* The Integrated  
Reproductive Health Framework

# Towards a Gender-Responsive and Rights-Based Integrated Reproductive Health Care Service Delivery

The International Conference on Population and Development (ICPD), held in Cairo in 1994, comprehensively defined reproductive health as a state of “complete physical, mental and social well-being, and not merely the absence of disease or infirmity in all matters relating to the reproductive health system and to its functions and processes” (UN ICPD, 1994). Together with the Fourth World Conference on Women, held in Beijing in 1995, a more comprehensive reproductive health agenda have been embraced leading to the provision of an expanded range of service in a more integrated fashion. This “shift to integrated reproductive health has included heightened attention to the rights of clients, the quality of care, informed choice, and gender sensitivity” (EngenderHealth, 2003).

The shift highlighted the greater recognition of clients’ broad, interrelated sexual and reproductive health needs and the changes required throughout the health care system to meet them. This has implications on the approach of delivering RH services - from maximizing all possible opportunities to identify and meet clients’ RH needs more holistically, to an enhanced client-centered approach, and linking services so as to offer comprehensive care that covers clients’ interrelated needs. This comprehensive and integrative approach calls for health providers to be sensitive not only to medical issues but also to behavioral, and socio-cultural issues that may emphasize the expressed reasons for the clients’ visit. This results to the delivery of gender-responsive and rights-based integrated reproductive health (GR-RB IRH) services.



## SESSION 2.1: Why Gender-Responsive and Rights-Based Integrated RH Services?

|                    |  |
|--------------------|--|
| <b>Objectives</b>  | By the end of the session, participants would be able to explain the importance of a Gender-Responsive and Rights-Based Integrated Reproductive Health Services Approach |
| <b>Time</b>        | 1 hour   |
| <b>Equipment</b>   | LCD or Overhead Projector, computer (if using LCD), whiteboard   |
| <b>Materials</b>   | Powerpoint or transparency presentation of Part 1 of the Facilitator's Guide, handouts, flipchart, permanent markers, whiteboard markers                                 |
| <b>Handouts</b>    | #2.1: Training Information on Why GR-RB IRH  |
| <b>Evaluation</b>  | End of Session Evaluation; Content of Recapitulation   |
| <b>Preparation</b> | Powerpoint presentations on: Activity Objectives; Recapitulation Points on the Activity  |

### Activity 2.1a: Why Gender-Responsive and Rights-Based Integrated RH Training?

#### *Notes for the Facilitator:*

1. The Facilitator poses the question: **"Why do you think is there a need for an Integrated RH Service Delivery?"** or **"Why are we going through a Training for Trainers on GR-RB Integrated RH Service Delivery?"**
2. S/He writes down on the whiteboard or flipchart the responses of the participants while probing answers on the need for an integrated RH Program/ Service Delivery. S/he consciously clusters the responses of the participants by writing similar responses in a column. This will make recapitulation easier.
3. After all possible responses have been elicited, the facilitator summarizes the key points raised by the participants. Using the definition of terms and other information in the Training Information below, s/he recapitulates the topic by consciously relating the recap points with the participants' responses.
4. Facilitator may distribute Handout 2.1.

## TRAINING INFORMATION

### Definitions:

**Gender responsive IRH services** -- refer to a whole range of reproductive health services that have been planned and are being implemented with careful consideration of the different needs of women and men. Such services consider the changing but distinct reproductive health needs of women and men as they go through the various life cycles, e.g. from early adolescent, to motherhood and through post reproductive age, as well as other circumstances that uniquely affect each. For example, IRH services provide special provisions for women victims of abuse.

**Rights based IRH services** -- means that women and men have the right to access a wide range of reproductive health services "without any form of coercion." (ICPD). "All couples and individuals enjoy the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and the means to do so." (ICPD Principle #8.) A rights based approach emphasizes the obligation of government to promote and fulfill these rights to RH services. (See further discussion on Rights on page 70-77 of this Manual).

### Why is there a need for GR-RB Integrated Reproductive Health Services?

- a. Reality shows that health providers, with all their technical knowledge and skills, are not necessarily equipped with a gender perspective or with an integrated approach to reproductive health services.
- b. RH being intensely personal and requiring a high degree of privacy as well as associated with strongly held beliefs and the subject of social, religious, ethical, political and legal structures, need services that recognize these factors.
- c. RH is also significantly affected by behaviors of sexual partners that bear directly on an individual's choices, health status, and treatment outcomes.



- d. Although training resources are available to help providers in the delivery of reproductive health services, most of these resources are technical in nature and often do not include the social context.
- e. There is a need for health providers to address the different areas of reproductive health care in a more integrative manner, taking into consideration what the elements have in common and the linkages among them.
- f. Service providers need to view and approach the clients' reproductive health need in a holistic manner, thus requiring the health provider to be technically adept as well as gender-sensitive, client-oriented, interactive and empowering.
- g. Health providers tend to focus on the presenting need or problems expressed during a client visit. Although they may be aware that such particular need presented by the client may have come from other needs or concerns that contribute to their primary problem, they may fail to identify underlying and other important related needs and problems.
- h. Clients normally seek RH service for one presenting symptom/ complaint such as one aspect of maternal and child health care services (pre-natal and post-natal care, immunization, nutrition) or family planning, delayed menstruation, painful urination, or post-abortion care. This results to missed opportunities of addressing sexual and reproductive health (SRH)-related and other important issues that clients fail or may be constrained to express due to fear, shame and lack of knowledge.

Therefore, health care professionals need high quality training in participatory and integrative teaching methods. A thorough knowledge of the Teaching-Learning Process is integral to program effectiveness. After all, the success of a training activity depends on the quality of the plan, preparation, delivery and review of the training sessions designed for the intended audience.



## SESSION 2.2: Reproductive Health Overview

|                    |  |
|--------------------|--|
| <b>Objectives</b>  | By the end of the session, participants would be able to: <ul style="list-style-type: none"><li>• describe the development of the reproductive health concept</li><li>• explain what is reproductive health</li><li>• name the 10 elements of RH care services</li></ul> |
| <b>Time</b>        | 1.5 hours  |
| <b>Equipment</b>   | LCD or Overhead Projector, computer (if using LCD), whiteboard   |
| <b>Materials</b>   | Powerpoint or transparency presentation of Part 1 of the Guide, handouts, flipchart, permanent markers, whiteboard markers   |
| <b>Handouts</b>    | #2.2: Historical Background of RH<br>#2.3: RH Definitions  |
| <b>Evaluation</b>  | End of Session Evaluation; Content of Recapitulation   |
| <b>Preparation</b> | Powerpoint presentations on: Activity Objectives; Recapitulation Points on the Activity  |

### Activity 2.2a The Historical Background of Reproductive Health

#### *Notes for the Facilitator:*

1. The concept of RH was developed as part of a congruence of two streams of thought in the global arena. One is the development of human rights after World War II and the other is the concept of population management that started in the early 1900s.

#### ■ **Milestones in Population and Development**

- a. **The roots: 1927, 1954, 1965** -- The very first global population conference—where birth control was talked about—was organized way back in 1927 and was held in Geneva. The person who single-handedly spearheaded this conference is Margaret Sanger. What is interesting to note here is that she believed in reproductive rights and women empowerment and her ultimate objective was to grant women these rights.

It was not until 1954 that another Population Conference was organized by the United Nations and this was held in Rome. This was followed by a conference in Belgrade in 1965. Both of these conferences were attended by technical and scientific experts in demography and population.

- b. **1974 World Population Conference, Bucharest** was the first UN conference that gathered representatives of governments and heads of state to deliberate on the global population issue. The Conference in Bucharest was still demographics-driven. The concern was how to slow down the population growth worldwide.
- c. **1984 World Population Conference in Mexico** further developed the program of action developed in Bucharest. The emphasis was still on population control.

■ **MILESTONES IN THE HUMAN RIGHTS:**

- a. **1948, Universal Declaration of Human Rights.** This declaration sets the principles of equal moral value of all human individuals regardless of race, sex, nationality, religion and status in life.
- b. **1966 International Covenant on Economic, Social and Cultural Rights.** Article 3: The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the Covenant.

Article 10: The States Parties to the present Covenant recognize that:

- The widest possible protection and assistance should be accorded to the family, which is the natural and fundamental group unit of society, particularly for its establishment and while it is responsible for the care and education of dependent children. Marriage must be entered into with the free consent of the intending spouses.
- Special protection should be accorded to mothers during a reasonable period before and after childbirth. During such period working mothers should be accorded paid leave or leave with adequate social security benefits.

Article 12: 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

c. **1968 International Conference on Human Rights, Teheran**

Significant provisions of this Conference are:

- The discrimination of which women are still victims in various regions of the world must be eliminated. An inferior status for women is contrary to the Charter of the United Nations as well as the provisions of the Universal Declaration of Human Rights. The full implementation of the Declaration on the Elimination of Discrimination Against Women is a necessity for the progress of mankind;
- The protection of the family and of the child remains the concern of the international community. Parents have a basic human right to determine freely and responsibly the number and the spacing of their children;
- The aspirations of the younger generation for a better world, in which human rights and fundamental freedoms are fully implemented, must be given the highest encouragement. It is imperative that youth participate in shaping the future of mankind;

d. **1979 UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)**. Often described as a Bill of Rights for women: CEDAW obliges States Parties to prohibit discrimination against women and secure their full development and advancement by adopting measures in various areas including social, political, economic, cultural, health, and legal matters. The convention have confirmed the basic right and responsibility of individuals to make choices about the number and spacing of children. Societies have the responsibility to help them achieve their reproductive goals.

e. **1990 Convention on the Rights of the Child** recognized and gave legal protection to adolescents' right to health including reproductive health.

f. **1993 World Conference on Human Rights, Vienna** -- reaffirmed the world's commitments to human rights.

g. **The Merging of Human Rights, Population and Development: 1994 International Conference on Population and Development (ICPD), Cairo** has been marked as a turning point in the whole discourse of population and development. Sixty years after Margaret Sanger organized a conference to bring attention to women's rights in the



discourse of population, the 1994 ICPD managed to do exactly that. A historical event that changed the landscape of population policies worldwide, the conference brought into full circle the objective of Margaret Sanger for women's rights to her body and her person.

1994 ICPD: What was different?

- integrated population issues with development; family planning as part of a constellation of services under reproductive health
  - rights-based approach to providing reproductive health care services and information
  - educating and empowering women as the most effective way to reduce population growth rates and promote sustainable development
  - reaffirmed the global consensus that voluntary family planning decisions are a basic human right of all couples and individuals, and that coercion in any form is unacceptable areas of contention
- h. Closely linked to the 1994 ICPD is the **1995 Fourth World Conference on Women (held in, Beijing)**: "The Conference's final document, the Platform for Action, demonstrates that the agreements reached in Cairo at the International Conference on Population and Development (ICPD) is accepted global policy. And for the second time in 12 months, countries of the world reaffirmed the human rights of women and the critical importance of reproductive and sexual health and rights to women's empowerment and to development."<sup>1</sup>

2. Facilitator may distribute Handout 2.2.

## **Activity 2.2b: Definitions from 1994 ICPD in Cairo**

### ***Notes for the Facilitator:***

1. Having understood the roots of reproductive health, the group will now level off on how they understand the terms that will be used throughout the training. These terms are:
  - Reproductive health
  - Sexual health
  - Reproductive health care
  - Sexual and reproductive rights

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<sup>1</sup> International Women's Health Coalition publication

2. Facilitator informs participants that they will share their own definitions through the use of meta-cards. Meta-cards will be used throughout the training to facilitate sharing of ideas with one another. S/He then enumerates the rules in the use of meta-cards:
  - letters should be written at least one (1) inch in size
  - each card contains only one thought or idea
  - each idea is presented in not more than seven (7) words
3. Each participant is given five pieces of meta-cards (Note: if there are more than 15 participants, they could be divided into groups). Each group can define each assigned word using one meta-card of a different color. Participants write down in one meta-card each the definitions of the words "reproductive health", reproductive health care," and sexual and reproductive rights.
4. The words being defined by the group are posted around the room as headings for the definitions of the participants. Each meta-card defining the word is then placed under the corresponding heading.
5. Participants go around the room to look at the definitions. They are asked to transfer the meta-cards of the others to other headings as they see fit. At the end of the processing, the facilitator notes that the more differently-colored meta-cards are mixed in, the more the differences in opinions among participants is reflected.
6. **Discussion:** Facilitator asks the participants if they are satisfied with the definitions under each word. Discussions and interactions may be allowed if there are some more dissenting opinions. S/He asks where difficulties are and if the concepts are still unclear.
7. PowerPoint/Transparency: Facilitator presents the following accepted definitions:

*Reproductive Health:*

- A condition in which the reproductive functions and processes are accomplished in a state of complete physical, mental and social well-being

*Reproductive Rights:*

- Reproductive rights embrace certain human rights that are already recognized in national laws, international laws and international human rights documents and other consensus documents.

- Recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so.
- Right to attain the highest standard of sexual and reproductive health.
- It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.

*Sexual Health:*

- Healthy sexual development;
- Equitable and responsible relationships and sexual fulfilment; and
- Freedom from illness, disease, disability, violence and other harmful practices related to sexuality

*Sexual Rights:*

- Decide freely and responsibly on all aspects of their sexuality, including protecting and promoting their sexual and reproductive health;
- Be free of discrimination, coercion or violence in their sexual lives and in all sexual decisions; and
- Expect and demand equality, full consent, mutual respect and shared responsibility in sexual relationships

*Reproductive Health Care*

*According to the DOH, reproductive health care includes:*

- Family planning services, counseling and information
- Prenatal, postnatal and delivery care
- Nutrition and health care for infants and children
- Treatment for reproductive tract infections and STDs
- Management of abortion-related complications
- Prevention and appropriate treatment for infertility
- IEC on human sexuality, reproductive health, responsible parenthood
- Male involvement in Reproductive Health
- Adolescent reproductive health
- Management and treatment of reproductive cancers
- Violence Against Women



**TRAINING INFORMATION: Human Rights are governed by the following principles:**

- a. **Universality** – applicable to everyone regardless of race, creed, religion, sex, age
- b. **Accountability** – governments are held accountable to protect, fulfill and respect the rights of all its citizens
- c. **Indivisibility** – all human rights are intrinsic and cannot be divided or selectively applied; there is no lessening or transferring, or alienation of these rights
- d. **Participation** - everything that is construed as a human right guarantees that individuals are allowed to participate at all levels of society - as a human being, as a woman, as a man, and that this participation will be respected

8. Facilitator may now distribute Handout 2.3.

9. The 13 Sexual and Reproductive Health Rights<sup>2</sup>

The following are the identified sexual and reproductive health rights that are also part of the human rights document of the United Nations:

- a. Facilitator distributes the handouts on the 13 SRHR and explains how these rights are part of various human rights documents the Philippines is signatory to. Upholding these rights is important in clinic situations.
- b. As the list of rights is enumerated, facilitator asks for concrete examples from participants on how to make these rights a reality in their work situations.

**1) The Right to Life**

This means, among other things, that no woman's life should be put at risk by reason of pregnancy, gender or lack of access to health information and services. This also includes the right to have a safe and satisfying sex life.

<sup>2</sup> Taken from a powerpoint presentation on sexual and reproductive health rights by the Reproductive Rights Resource Group-Philippines (3RG-Phils.). The 13 SRHR was adapted from the 12 SRHR identified by the International Planned Parenthood Federation (IPPF).

- 2) **The Right to Liberty and Security of the Person**  
This recognizes that no woman should be subjected to forced pregnancy, forced sterilization, or forced abortion.
- 3) **The Right to Equality, and to be Free from All Forms of Discrimination**  
This includes, among other things, freedom from discrimination because of one's sexuality and reproductive life choices.
- 4) **The Right to Privacy**  
This means that all sexual and reproductive health care services should be confidential in terms of physical set-up, information given or shared by the clients, and access to records or reports.
- 5) **The Right to Freedom of Thought**  
This includes freedom from the restrictive interpretation of religious texts, beliefs, principles and customs as tools to curtail freedom of thought on sexual and reproductive health care and other issues.
- 6) **The Right to Information and Education**  
This includes access to full information on the benefits, risks, and effectiveness of all methods of fertility regulation, in order that all decisions taken are made on the basis of full, free and informed consent.
- 7) **The Right to Choose Whether or Not to Marry and to Found and Plan a Family**  
This includes the right of persons to protection against a requirement to marry without his/her consent. It also includes the right of individuals to choose to remain single without discrimination and coercion.
- 8) **The Right to Decide Whether or When to Have Children**  
This includes the right of persons to decide freely and responsibly the number and spacing of their children and to have access to related information and education.
- 9) **The Right to Health Care and Health Protection**  
This includes the right of clients to the highest possible quality of health care, and the right to be free from harmful traditional health practices.



**10) The Right to the Benefits of Scientific Progress**

This includes the right of sexual and reproductive health service clients to available and new reproductive health technologies that are safe, effective and acceptable.

**11) The Right to Freedom of Assembly and Political Participation**

This includes the right of all persons to seek to influence communities and governments to prioritize sexual and reproductive health and rights.

**12) The Right to Be Free From Torture and Ill-Treatment**

This includes the rights of all women, men and young people to protection from violence, sexual exploitation and abuse.

**13) The Right to Development**

This includes the right of all individuals to access development opportunities and benefits, especially in decision-making processes that affect her/his life.

10. Facilitator may now distribute Handout 2.4.

## **SESSION 2.3: The Integrated Reproductive Health Framework**

|                           |   |
|---------------------------|---|
| <b>Session Objectives</b> | By the end of the session, participants would be able to: <ul style="list-style-type: none"><li>• Situate the old RH Framework in the IRH Framework;</li><li>• Describe the DOH Integrated Reproductive Health Framework; and</li><li>• Identify the current health sector thrusts of the DOH (FOURmula One).</li></ul> |
| <b>Time</b>               | 1.5 hours   |
| <b>Equipment</b>          | LCD or Overhead Projector, computer (if using LCD)  |
| <b>Materials</b>          | Powerpoint Presentation on the Framework, manila paper or flipchart paper permanent markers, tape, meta-cards   |
| <b>Handouts</b>           | #2.4: DOH Integrated RH Framework   |
| <b>Preparation</b>        | <ul style="list-style-type: none"><li>• Objectives of the training written out in transparency or part of a powerpoint presentation.</li><li>• Review powerpoint presentation.</li><li>• Make enough copies handouts for distribution to participants.</li></ul>  |





**Introduction:**

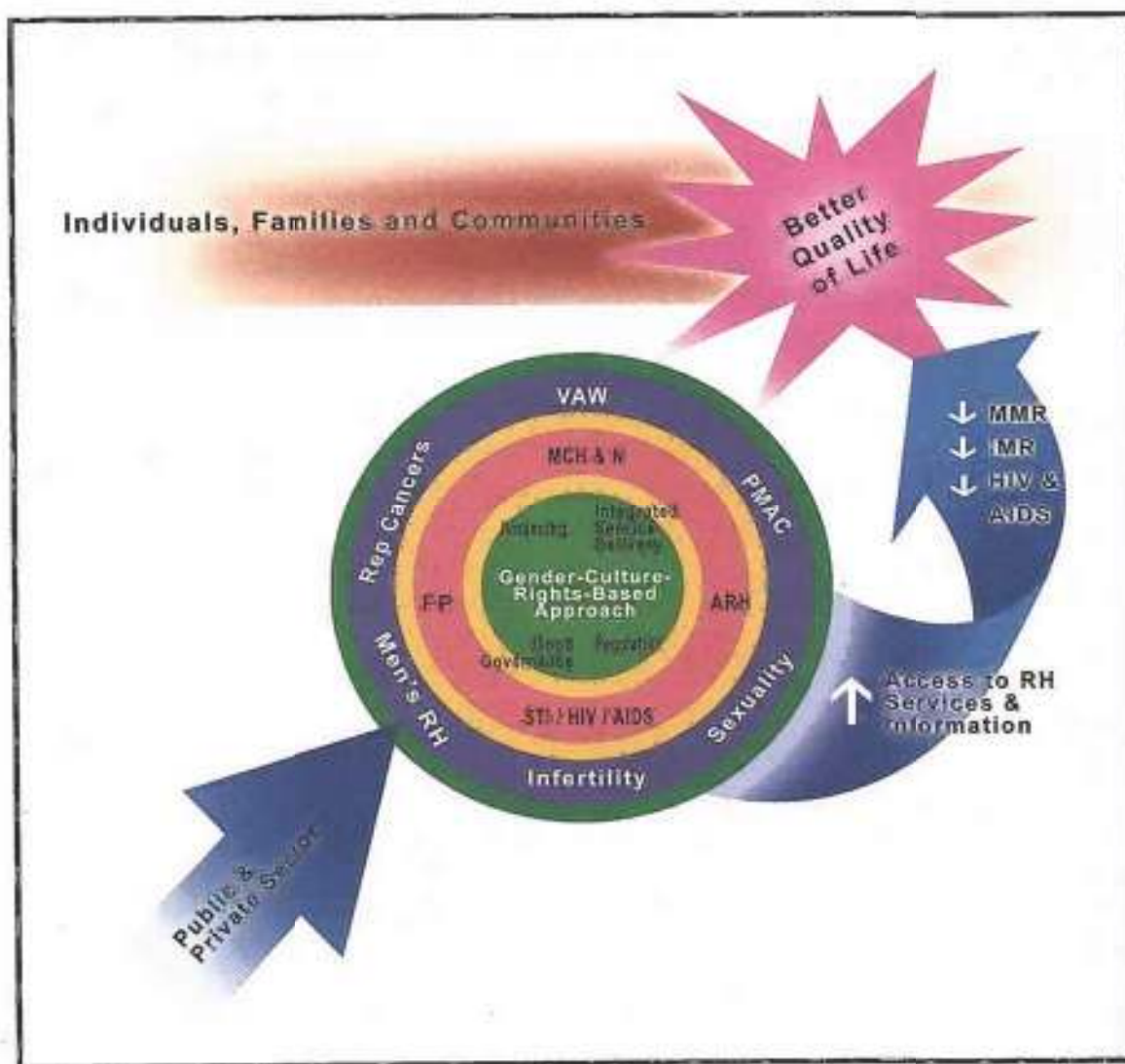
This session will provide an overview of the various elements that go into the Integrated RH Framework developed by the Department of Health (2005).

**Activity 2.3a: The Integrated RH Framework of the DOH [Handout #2.5]**

**Notes for the Facilitator:**

1. The Department of Health (DOH) framework was developed to embody the concepts of the 1994 ICPD and to ensure that the Philippines, as a signatory to the Program of Action, will achieve commitments made during the Conference.

**Figure 3. The Department of Health RH Framework**



The Framework locates reproductive health care services in the mainstream of health programs and interventions. It relates reproductive health to the development goal of better quality life through the achievement of the Millennium Development Goals.

2. The DOH formulated this framework as a basis for the integrated approach to reproductive health. The framework is the result of a multi-level, multi-stakeholder consultation process that sought to integrate the various elements of RH into one framework.
3. Facilitator distributes Handout 2.5 on the DOH RH Framework. S/He shows the framework on a transparency or powerpoint presentation then discusses its elements.
4. Facilitator points out the various elements of the framework as follows:
  - a. **Goal:** Better Quality Life for Individuals, Families and Communities
  - b. **Objectives**
    - Decrease Maternal Mortality Rate;
    - Decrease Infant Mortality Rate; and
    - Decrease HIV and AIDS Prevalence
  - Through:
    - Increased Access to RH Services and Information
  - c. **Input:** Community, Public and Private Sector Resources  
State that reproductive health encompasses a broad range of health concerns and that in order to meet these concerns, there is a need to have a pooling of resources from communities and the public and private sectors. Jointly dealing with reproductive health issues also mean contributing much needed resources to address these issues.
  - d. **Ten Elements of Reproductive Health:** There are two (2) outer circles of the framework: in the inner RH circle are the elements that are currently part of the core programs of the DOH; in the outer circle are the elements that comprise the rest of the ten elements of the reproductive health program of the DOH.

- e. **“FOURmula One for Health”**: The “FOURmula One for Health” is the DOH implementation framework for Health Reforms. It is the engine that will support the RH programs of the Department of Health.
- “FOURmula One for Health” Goals
    - Better health outcomes
    - More responsive health system
    - Equitable health care financing
  - “FOURmula One for Health” Thrusts
    - **Health Care Financing** – to secure more, better and sustained investments in health to improve health outcome especially of the poor
    - **Health Regulation** – to assure access to quality and affordable health products, devices, facilities and services, especially those used by the poor
    - **Health Service Delivery** – to improve accessibility and availability of basic and essential health care for all, especially the poor
    - **Governance** – to improve local health system governance and coordination, enhance public-private partnership and improve central capacities to manage the health sector
- f. **Rights-based, Gender and Culture**: the core of the reproductive health framework. These concepts are **core values** that provide an anchor upon which reproductive health care service delivery and information is based on. These **core values** need to be clearly understood and appreciated by each individual service provider and health information facilitator so as to acquire the qualities of **respect, justice and empowerment** that is the essence of health care delivery.
5. Facilitator briefly explains the terms, for further discussion as the training continues.
- **Rights-Based**: recognizes that reproductive health is part of human rights
  - **Culture**: can be both a facilitating or hindering factor to equity and equality of women and men. Some cultural activities support the oppression of women and promote the patriarchal viewpoint.
  - **Gender**: has to do with differences in how men and women behave, and the ways in which their socially defined role benefits or harms them



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MODULE **2**

# Towards GR-RB Integrated Reproductive Health Care Service Delivery

## Integrated Reproductive Health Training

The overall objective of the training is:

- Describe the Department of Health Integrated Reproductive Health Framework and locate gender, rights, culture and empowerment in the framework

### Session 2.1: Why GR-RB Integrated RH Care Services?

**Objectives**

- By the end of the session, participants would be able to explain the importance of a Gender Responsive and Rights-Based Integrated Reproductive Health Services Approach

### Session 2.2: Reproductive Health Overview

**Objectives**

- By the end of the session, participants would be able to:
- describe the development of the reproductive health concept
  - explain what is reproductive health
  - name the 10 elements of RH care services

### Session 2.3: The Integrated Reproductive Health Framework

**Objectives**

- By the end of the session, participants would be able to:
- Identify the current health sector thrusts of the DOH (FOURmula One)
  - Describe DOH Integrated Reproductive Health Framework



## Handout #2.1

**TRAINING INFORMATION****Definitions:**

**Gender responsive IRH services** -- refer to a whole range of reproductive health services that have been planned and are being implemented with careful consideration of the different needs of women and men. Such services consider the changing but distinct reproductive health needs of women and men as they go through the various life cycles, e.g. from early adolescent, to motherhood and through post reproductive age, as well as other circumstances that uniquely affect each. For example, IRH services provide special provisions for women victims of abuse.

**Rights based IRH services** -- means that women and men have the right to access a wide range of reproductive health services "without any form of coercion," (ICPD). "All couples and individuals enjoy the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and the means to do so." (ICPD Principle #8.) A rights based approach emphasizes the obligation of government to promote and fulfill these rights to RH services. (See further discussion on Rights on page 70-75 of this Manual).

**Why is there a need for GR-RB Integrated Reproductive Health Services?**

- The reality shows that health providers, with all their technical knowledge and skills, are not necessarily equipped with a gender perspective or with an integrated approach to reproductive health services.
- RH being intensely personal and requiring a high degree of privacy as well as associated with strongly held beliefs and the subject of social, religious, ethical, political, and legal structures need services that recognize these factors.
- RH is also significantly affected by behaviors of sexual partners that bear directly on an individual's choices, health status, and treatment outcomes.
- Although training resources are available to help providers in the delivery of reproductive health services, most of these resources are technical in nature and often do not include the social context.
- There is a need for health providers to address the different areas of reproductive health care in a more integrative manner, taking into consideration what the elements have in common and the linkages among them.
- Service providers need to view and approach the clients' reproductive health need in a holistic manner, thus requiring the health provider to be technically adept as well as gender-sensitive, client-oriented, interactive and empowering.
- Clients normally seek RH service for one presenting symptom/complaint such as one aspect of maternal and child health care services (pre-natal and post-natal care, immunization, nutrition) or family planning, delayed menstruation, painful urination, or post-abortion care.
- Health providers tend to focus on the presented need or problems expressed during a client visit. Although they may be aware that such particular need presented by the client may have come from other needs or concerns that contribute to their primary problem, they may fail to identify underlying and other important related needs and problems.
- This results to missed opportunities of addressing sexual and reproductive health (SRH)-related and other important issues that clients fail or may be constrained to express due to fear, shame and lack of knowledge.
- Thus, opportunities for health education and addressing potentially life threatening consequences of unmet SRH problems such as sexually transmitted infections (STIs), violence, and high-risk pregnancies are neglected.



## The Historical Background of Reproductive Health

### 1. Milestones in Population and Development

- The roots: 1927, 1954, 1965 -
- 1974 World Population Conference, Bucharest
- 1984 World Population Conference in Mexico

### 2. Milestones in the Human Rights:

- 1948, Universal Declaration of Human Rights
- 1966 International Covenant on Economic, Social and Cultural Rights
- 1968 International Conference on Human Rights, Teheran
- 1979 UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)
- 1990 Convention on the Rights of the Child.
- 1993 World Conference on Human Rights, Vienna

### 3. THE MERGING OF HUMAN RIGHTS, POPULATION and DEVELOPMENT: 1994 The International Conference on Population and Development (ICPD) in Cairo has been marked as a turning point in the whole discourse of population and development.

### 4. 1994 ICPD: What was different?

- integrated population issues with development; family planning as part of a constellation of services under reproductive health
- rights-based approach to providing reproductive health care services and information
- educating and empowering women as the most effective way to reduce population growth rates and promote sustainable development.
- reaffirmed the global consensus that voluntary family planning decisions are a basic human right of all couples and individuals, and that coercion in any form is unacceptable areas of contention

### 5. Closely linked to the 1994 ICPD is the 1995 Fourth World Conference on Women (September 1995, Beijing): "The Conference's final document, the Platform for Action, demonstrates that the agreements reached in Cairo at the International Conference on Population and Development (ICPD) is accepted as a global policy. And for the second time in 12 months, countries of the world reaffirmed the human rights of women and the critical importance of reproductive and sexual health and rights to women's empowerment and to development."<sup>1</sup>

<sup>1</sup> International Women's Health Coalition publication

**Handout #2.3****DEFINITIONS****Reproductive health**

- A condition in which the reproductive functions and processes are accomplished in a state of complete physical, mental and social well-being

**Reproductive rights**

- Reproductive rights embrace certain human rights that are already recognized in national laws, international laws and international human rights documents and other consensus documents.
- Recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so,
- Right to attain the highest standard of sexual and reproductive health.
- It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.

**Sexual Health**

- Healthy sexual development
- Equitable and responsible relationships and sexual fulfillment &
- Freedom from illness, disease, disability, violence and other harmful practices related to sexuality

**Sexual Rights**

- Decide freely and responsibly on all aspects of their sexuality, including protecting and promoting their sexual and reproductive health;
- Be free of discrimination, coercion or violence in her sexual lives and in all sexual decisions; and
- Expect and demand equality, full consent, mutual respect and shared responsibility in sexual relationships

**Reproductive Health Care**

*Reproductive health care, according to the DOH, includes:*

- Family planning services, counseling and information
- Prenatal, postnatal and delivery care
- Nutrition and health care for infants and children
- Treatment for reproductive tract infections & STDS
- Management of abortion-related complications
- Prevention and appropriate treatment for infertility
- IEC on human sexuality, reproductive health, responsible parenthood
- Male involvement
- Adolescent reproductive health
- Management and treatment of reproductive cancers
- Services to victim/survivors of Violence Against Women



## The 13 Sexual and Reproductive Health Rights<sup>2</sup>

1. ***The Right to Life***

This means, among other things, that no woman's life should be put at risk by reason of pregnancy, gender or lack of access to health information and services. This also includes the right to have a safe and satisfying sex life.

2. ***The Right to Liberty and Security of the Person***

This recognizes that no woman should be subjected to forced pregnancy, forced sterilization or forced abortion.

3. ***The Right to Equality, and to be Free from all Forms of Discrimination***

This includes, among other things, freedom from discrimination because of one's sexuality and reproductive life choices.

4. ***The Right to Privacy***

This means that all sexual and reproductive health care services should be confidential in terms of physical set-up, information given or shared by the clients, and access to records or reports.

5. ***The Right to Freedom of Thought***

This includes freedom from the restrictive interpretation of religious texts, beliefs, principles and customs as tools to curtail freedom of thought on sexual and reproductive health care and other issues.

6. ***The Right to Information and Education***

This includes access to full information on the benefits, risks, and effectiveness of all methods of fertility regulation, in order that all decisions taken are made on the basis of full, free and informed consent.

7. ***The Right to Choose Whether or Not to Marry and to Found and Plan a Family***

This includes the right of persons to protection against a requirement to marry without his/her consent. It also includes the right of individuals to choose to remain single without discrimination and coercion.

<sup>2</sup> Taken from a powerpoint presentation on sexual and reproductive health rights by the Reproductive Rights Resource Group-Philippines (3RG-Phils.).



8. ***The Right to Decide Whether or When to Have Children***  
This includes the right of persons to decide freely and responsibly the number and spacing of their children and to have access to related information and education.
9. ***The Right to Health Care and Health Protection***  
This includes the right of clients to the highest possible quality of health care, and the right to be free from harmful traditional health practices.
10. ***The Right to the Benefits of Scientific Progress***  
This includes the right of sexual and reproductive health service of clients to avail of the new reproductive health technologies that are safe, effective and acceptable.
11. ***The Right to Freedom of Assembly and Political Participation***  
This includes the right of all persons to seek to influence communities and governments to prioritize sexual and reproductive health and rights.
12. ***The Right to Be Free From Torture and Ill-Treatment***  
This includes the rights of all women, men and young people to protection from violence, sexual exploitation and abuse.
13. ***The Right to Development***  
This includes the right of all individuals to access development opportunities and benefits, especially in decision-making processes that affect her/his life.

Handout #2.5

The Department of Health RH Framework



- a. **“FOURmula One for Health”**: The “FOURmula One for Health” is the DOH implementation framework for health reforms. It is the engine that will support the RH programs of the Department of Health.
- **“FOURmula One for Health” Goals**
    - Better health outcomes
    - More responsive health system
    - Equitable health care financing
  - **“FOURmula One for Health” Thrusts**
    - **Health Care Financing** – to secure more, better and sustained investments in health to improve health outcome especially of the poor
    - **Health Regulation** – to assure access to quality and affordable health products, devices, facilities and services, especially those used by the poor
    - **Health Service Delivery** – to improve accessibility and availability of basic and essential health care for all, especially the poor
    - **Governance** – to improve local health system governance and coordination, enhance public-private partnership and improve central capacities to manage the health sector
- b. **Rights-based, Gender and Culture**: the core of the reproductive health framework. These concepts are **core values** that provide an anchor upon which reproductive health care service delivery and information is based on. These **core values** need to be clearly understood and appreciated within each individual service provider and health information facilitator so as to acquire the qualities of **respect, justice and empowerment** that is the essence of health care delivery.

Give the short explanations of these words but these will be covered in-depth as we go through the training.

- **Rights-Based**: recognizes that reproductive health is part of human rights
- **Culture**: can be both a facilitating or hindering factor to equity and equality of women and men. Some cultural activities support the oppression of women and promote the patriarchal viewpoint.
- **Gender**: has to do with differences in how men and women behave, and the ways in which their socially defined role benefits or harms them.



# MODULE 3

## **Gender Dimensions of Reproductive Health**

*SESSION 3.1* Gender and Sex

*SESSION 3.2* Gender Analysis

*SESSION 3.3* Integrating Gender and RH

# Gender Dimensions of Reproductive Health

Gender plays a central role in the provision of reproductive health care services and information. Gender should be a factor in the choice and execution of medical interventions. Therefore, an understanding of the gender dynamics that influence personal relationships, decision-making, and behavior is essential for service providers of reproductive health care. It is thus recognized that there is a need for service providers to have an understanding and appreciation of gender concepts. This training module will cover the basics of gender concepts in relation to the elements of reproductive health care.

This module will differentiate sex from gender, look into how men and women are stereotyped to play specific roles in society and how these roles contribute to the multiple burdens of women. It will also look into how women and men do not have an equal and equitable access to and control of resources. These gender concepts will then be related to how gender affects the reproductive health of both men and women.

The objectives of this training module are to:

- Explain the gender concepts and how gender affects the reproductive health of men and women; and
- Illustrate how gender concepts are applied in the delivery of reproductive health services.

## SESSION 3.1: Gender and Sex

### Introduction

This session will cover the basics of gender concepts that are relevant to reproductive health. Definitions of gender, how it is differentiated from sex, where we learned about masculinity and femininity and the stereotypes that arise from these are some of the topics that will be covered. Power dynamics as well as access to and control of resources will also be discussed to highlight the decision-making processes among individuals and couples that affect to a great extent the attainment of a high level of reproductive health.

|                           |   |
|---------------------------|---|
| <b>Session Objectives</b> | By the end of the session, participants would be able to: <ul style="list-style-type: none"><li>• Differentiate between sex and gender;</li><li>• Learn the various social constructs of gender;</li><li>• Gain insights into the various stereotyping and gender biases within Philippine Society;</li><li>• Examine stereotyping and gender biases in the provision of reproductive health care services; and</li><li>• Apply basic gender analysis tools in relation to reproductive health issues of men and women.</li></ul> |
| <b>Time</b>               | 4 hours   |
| <b>Equipment</b>          | • LCD or Overhead Projector, computer (if using LCD)  |
| <b>Materials</b>          | • Power point Presentation on Gender and Sex, meta-cards, kraft or manila paper, scissors, paste, permanent markers, masking tape   |
| <b>Handouts</b>           | • # 3.1: Gender Bingo<br>• # 3.2: Exercise: "Because I am..."<br>• # 3.3: Differentiating between Sex, Gender and Sexuality<br>• # 3.4: Sexuality Framework<br>• # 3.5: Exercise – Gender and Sex Statements<br>• # 3.6: Gender Concepts<br>• # 3.7: Gender Stereotyping<br>• # 3.8: Manifestations of Gender Biases.   |
| <b>Preparation</b>        | • Review power point presentation   |



## Activity 3.1a Differentiating SEX and GENDER

### Exercise 1: Gender Bingo [Handout # 3.1]

#### Notes for the Facilitator:

1. Facilitator tells participants that they will play a game called "Gender Bingo." The game is very much like the Bingo game in that the winner is the one who could fill out the boxes (across either diagonally, vertically or horizontally).
2. Each square has a certain characteristic or description of a situation. Participants can go around the room and find someone who fits the description given in the square.
3. A token prize for the winner may be given.
4. Processing of the exercise: Facilitator tells the participants that these characteristics are part of what they will be doing the rest of the three days in the seminar. Participants have to understand that each person holds certain beliefs or has different situations that affect her/his relationships with others and how others relate to him/her. This in essence is what will be discussed in this module of differentiating sex and gender.

### Exercise 2: Male and Female Characteristics [Handout # 3.2]

#### Notes for the Facilitator:

1. Facilitator introduces the topic. S/He tells participants that to differentiate sex and gender, they will do an exercise to first differentiate men from women. S/He then writes on a whiteboard or flipchart/manila paper two columns:

Because I am a (woman, man) I can...

If I were a (woman, man) I could...

2. Participants individually answer and fill up the boxes by completing the sentence in each of the two columns. They then share their answers and write these on the flipchart paper.
3. After participants have given their answers, the following questions are asked by the facilitator:
  - If the headings of each column were interchanged (exchange the column headings), which of these characteristics no longer apply? Ask participants to give their answers. Encircle the characteristics that are pointed out.
  - What is common to these encircled characteristics? What is common to those characteristics that are not encircled?
  - Encircled characteristics are what are described as "Sex" and the rest are what are described as "Gender".

4. **Input:** The facilitator introduces gender concepts as follows: Sex is different from gender. Sex is the biological distinction between males and females, while gender refers to socially learned behavior and expectations that distinguish masculinity from femininity.

#### **What is Sex (Biological Sex)?**

- From Latin *secare*, to divide.
- Used to refer to: sexual intercourse; what makes one male and female; biologically determined; refers to physical characteristics; constant across time; constant across different societies and cultures
- Sex is universal, fixed, and is a valid distinguishing variable.
- However, "Your destiny must not be based on your biology."

#### **What is Gender?**

Gender refers to the socially constructed roles ascribed to males and females. These roles, which are learned, change over time and vary widely within and between cultures. Whereas biological sex identity is determined by reference to genetic and anatomical characteristics, socially learned gender is an acquired identity. The concept of gender also includes the expectations held about the characteristics, aptitudes and likely behaviors of both women and men.

**Gender** from Latin *generare*, to beget. Originally used as a linguistic term (e.g., in many European languages, words have gender, e.g., in Spanish *el* for male, *la* for female.) Now used to refer to socially defined categories, status and roles.

Gender is NOT sexual orientation alone. It includes anatomy, body movements, clothing, language, occupations, and relationships

Gender is what makes one masculine or feminine; socially determined; culturally defined; changes across time; changes across places and cultures; learned behavior

Gender is a cultural, contrived distinguishing variable. It is concerned with differentiating people based on perceptions, roles, and social expectations.

Gender roles are NOT inborn, not biologically determined. These are LEARNED in the early stages of CHILDHOOD. Women's capacity for biological reproduction (childbirth) is EXTENDED to their social roles (social reproduction). What is biological can therefore be socially constructed to justify certain roles, responsibilities and activities (e.g., gender division of labor) and the values given to such roles (e.g., female labor is usually considered cheap, low-skilled).

Gender is a primary way of creating relationships of power in society (gender inequality) thus gender is one type of social inequality.



Others are class and ethnicity. But gender inequality is the most pervasive.

- Gender inequality is pervasive across rich and poor.
- Gender inequality is pervasive across different groups (kin, ethnic, caste) within a society.
- Gender is pervasive in all areas of social life: in households and intimate relationships, the labour market, education, state laws and policies, national and international development programs; religion and natural resource use.
- Gender inequality is learned through socialization. It influences the ways women and men are involved in different types of work, take up roles and obligations, acquire traits and behavioral patterns, are allocated opportunities and benefits and make decisions in private and public spheres.

5. Facilitator cites examples that were earlier given by the participants to bring home the point about differences between sex and gender.  
(Note: This Training Information can be a powerpoint slide)

### Exercise 3: Gender and Sex Characteristics Game

#### Notes for the Facilitator:

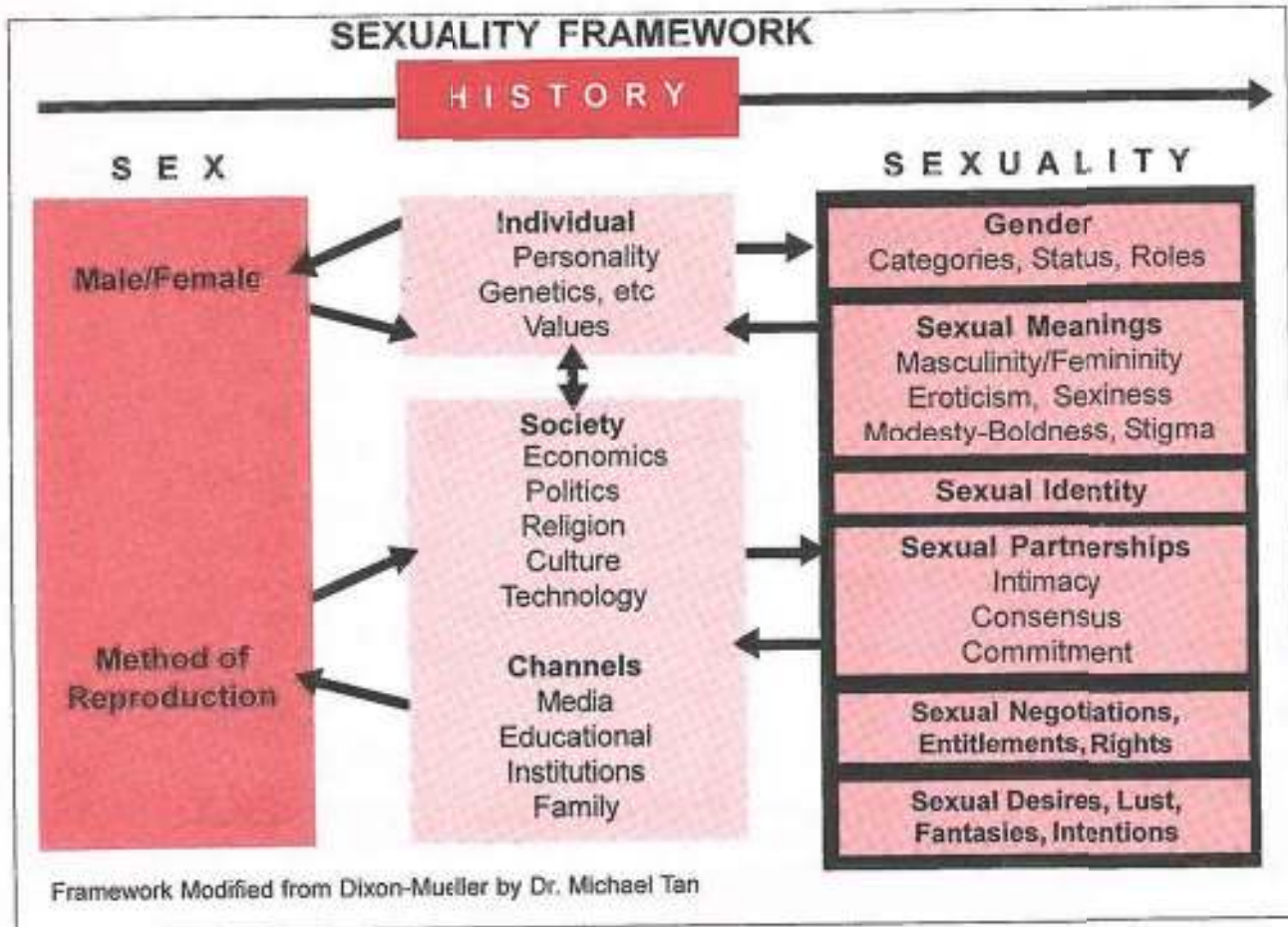
[Handout # 3.3]

#### Box 15

### TRAINING INFORMATION: Differentiating Sex, Gender and Sexuality

| SEX  | GENDER  | SEXUALITY  |
|--|---|--|
| Primarily refers to physical attributes – body characteristics, notably sex organs which are distinct in majority of individuals | Is the composite of attitudes and behavior of men and women (masculinity and femininity)  | Encompasses personal and social meanings as well as sexual behavior and biology. It includes ways the human body develop and respond sexually, includes sexual acts: kissing, touching, intercourse, includes feelings about these activities and responses. |
| Is biologically determined – by genes and hormones   | Is learned and perpetuated primarily through the family, education, religion (where dominant) and media; thus, it is an acquired identity | Also includes what we think is right and wrong, good or bad.   |
| Is relatively fixed/ constant through time and across cultures   | Because it is socialized, it may be variable through time and across cultures   | Includes life experiences that have shaped these feelings and values.  |





1. Facilitator introduces the game as a way of finding out if they understood the difference between sex and gender. S/He tells the participants that a contest will be held to apply what they have learned about sex and gender.
2. **The Game:** Facilitator divides the group into two. S/He lays down on the floor or table in front of the room a set of 15 cards per group with different characteristics of either sex or gender. (Refer to the list below.) In a form of a relay, each member of the group is instructed to get a card and post it to the respective column marked on the board as either "sex" or "gender." Note the first group to finish and the group that gets the highest number of correct answers.

### Scoring:

- The first group to finish gets 5 points.
  - One point is added for each correct answer.
  - One point is deducted for each wrong answer.
  - The team that gets the highest points will win.
3. **Processing of Sex/Gender Exercise:** The facilitator explains the basic difference between sex and gender. If the group has difficulty differentiating between sex and gender, s/he can further review the definitions.

The facilitator points out to the participants that the column of gender characteristics may be applicable to both men and women. However, the sex characteristics are unique and intrinsic to being a man or a woman. Sex characteristics are not interchangeable.

Possible list of gender and sex characteristics written down on the cards:

| Gender Characteristics | Sex Characteristics      |
|------------------------|--------------------------|
| Nagpapantalon          | Pregnant                 |
| Nag-iigib ng tubig     | Nagpapasuso ng baby      |
| Nagpapa-skinhead       | Malaki ang boses         |
| Naglalaba              | Family Planning          |
| Nagluluto              | Nag me-menstruate        |
| Nagpapa-manicure       | Ovarian Cyst             |
| Nagpapa-facial         | Balingkinitan na katawan |
| Nagba-basketball       | Broad shoulders          |
| Madaling umiyak        | Hairy chest              |
| Nanliligaw             | Bigote                   |
| Nag-aalaga ng bata     | Adam's apple             |
| Bus Driver             | Orgasm                   |
| Bra                    | Sperm                    |
| Naglalasing            | Testosterone             |
| Family Planning        | Clitoris                 |
| Nagpapahaba ng buhok   | Penis                    |

*(Source: adapted from William, S., Seed, J, Mwau, A. (1994) Oxfam Gender Training Manual. Oxford: Oxfam UK and Ireland.)*

## **Exercise 4: Gender and Sex Statements [Handout # 3.5]**

NOTE: This exercise may be incorporated into or used instead of Exercise 3.

### ***Notes for the Facilitator:***

1. Facilitator informs the participants that differentiating sex and gender does not only mean knowing the definitions of sex and gender but also means that there are deeper implications that need to be realized. The following exercise will look at these implications and discuss the realities of gender and how gender influences sex and ultimately affect the lives of women and men.
2. **Instructions:** Facilitator reads the following statements and asks the participants to write the letter "S" next to the statements that refer to sex differences and the letter "G" next to statements that refer to gender differences.
  - a. Women give birth to babies, men do not.
  - b. According to United Nations statistics, women do 67 per cent of the world's work, yet their earnings for it amount to only 10 per cent of the world's income.
  - c. In one case, when a child brought up as a girl learned that he was actually a boy, his school marks improved dramatically.
  - d. Women suffer from pre-menstrual tension, men do not.
  - e. Sex is not as important for women as it is for men.
  - f. In ancient Egypt, men stayed at home and did weaving. Women handled family business. Women inherited property and men did not.
  - g. Men's voices break at puberty, women's don't.
  - h. In a study of 224 cultures, there were 5 in which men did all the cooking and 36 in which women did all the house building.
  - i. Men are naturally prone to violent behavior.
  - j. Women are more vulnerable to STIs than men.
3. **Processing of the Exercise**

The statements that refer to gender differences offer a lot of possibilities for discussion that could lead on to the concepts for gender analysis.

  - 3.1 Facilitator calls out statements in sub-groups, starting with all those that refer to sex. These are statements a, d and g. S/He then goes over the gender statements as follows: statements b, f and h. S/He introduces the concept of the gender-based division of labor.



- 3.2 The gender-based division of labor is socially constructed; it varies across societies and cultures; it has also varied over time. Up to now, women's household and reproductive work is still not being counted in the calculation of their contribution to the economy (Statement b).
- 3.3 Statement c is about gender roles and norms. This statement is about a child brought up as a girl and then does better at school when he learns he is a boy. It leads to discussions on gender roles and norms, and social expectations about what girls and boys are supposed to do. Referring to the previous session, facilitator reiterates the powerful influence expectations have on the roles that women and men adhere to.
- 3.4 Statement e is about sexuality and sexual behavior. It introduces for the first time socially constructed norms about sexuality and sexual behavior. This statement should be used to start a discussion about the accepted norms of sexual behavior. The relationship between gender and sexuality is strong, but much current work is finding that they are not identical systems of control. Some of the examples that follow combine gender and sexuality. One way to begin to disentangle this is to note the many different ways that people in sexual relationships do not conform to dominant identities associated with gender and sexuality, such as "feminine lesbians".
- 3.5 Facilitator may ask participants to identify other such beliefs about women's and men's sexuality, for example, that men's sexual drive is strong, and that when they are aroused they cannot control their behavior. (S/He may want to challenge participants to think about how this functions in relation to gay men, or men who have sex with men, who may act in ways that otherwise wholly conform to masculine stereotypes.) Participants are encouraged to explore the idea that women have to be restrained, therefore, and not act in ways that could sexually provoke men, like being alone with a man or dressing in a certain way.
- 3.6 Statements i and j: Elements of both sex and gender. Participants may have divided responses to Statement i about violence as natural male behavior. Some may mark it as sex and others as gender. Some may argue that males are biologically prone to aggressive behavior, while others could maintain that aggressive and violent behavior is learned. While biology may have some role to play in male aggression and risk-taking, the socialization of boys and the condoning of male violence play a major role.

- 3.7 The social construction of sexuality refers to the process by which sexual thoughts, behaviors, and conditions (for instance, virginity) are interpreted and given cultural meaning. It incorporates collective and individual beliefs about the nature of the body, about what is considered erotic or offensive, and about what and with whom it is appropriate or inappropriate for men and women (according to their age and other characteristics) to do or to say about sexuality.
- 3.8 In some cultures, ideologies of sexuality stress female resistance, male aggression, and mutual antagonism in the sex act; in others, they stress reciprocity and mutual pleasure.
- 3.9 The social construction of sexuality recognizes that women's and men's bodies play a key role in their sexuality, but also looks carefully at the specific historical and cultural contexts to gain an understanding of how specific meanings and beliefs about sexuality are generated, adopted, and adapted.
- 3.10 Facilitator encourages male participants to share experiences of how they may have been taught to be aggressive. Female participants may also want to share incidents where they saw boys being encouraged to be aggressive. Statement j has both sex and gender as underlying causes.
- 3.11 Women are more vulnerable to sexually-transmitted infections not only because of their biology but also because of the social construction that condones irresponsible sexual behavior on the part of males.

*Source: Extracted from Dixon-Mueller, R. The sexuality connection in reproductive health. In: Zeidestein, S., and Moore, K., (Eds.) (1995). Learning about sexuality: a practical beginning. New York: The Population Council and International Women's Health Coalition.*

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## Activity 3.1b Socialization of Gender

**Exercise: When did you first realize you were a boy/girl?**

### **Notes for the Facilitator:**

1. Facilitator explains to the participants that since gender characteristics of women and men are based on social and cultural norms, it is formed and shaped as children grow up and are influenced within their own social circles. What are the main institutions that influence gender? How do these influences affect the way women and men behave?

The next exercise will draw out from the personal experiences of the participants on how their own gender maps were shaped and influenced.

2. **Note:** This exercise will involve sharing of life experiences that may be difficult for some. The facilitator needs to be aware of this and must be ready to process such difficult or sensitive life experiences.
3. **Instructions:** Facilitator asks the participants to make themselves comfortable in their chairs. S/He tells them that they will be taking a trip down memory lane to their earliest memories. S/He asks them to try to remember their earliest memories of being a child, and to write down their first experience of realizing that they were different from members of the opposite sex and/or expected to behave differently and treated differently from members of the opposite sex.

In one or two paragraphs they should try to record:

- how old they were
  - who was involved
  - where the incident took place
  - what the incident was about
  - how they felt about it
  - how other aspects of their identity (race, religious identity, nationality, ethnicity, caste) came into play in this incident.
4. Facilitator divides the participants into pairs. S/He tells them that they will share their memories in story form. The story that they will tell is "When did I realize that I am a boy/girl?" The life experience sharing may be allotted 15-20 minutes.
  5. In plenary facilitator asks the participants to share the story they heard. S/He then writes on a flipchart a synopsis/highlight of the story. S/He could write headings on the whiteboard to guide the story tellers:
    - Age
    - Who were involved
    - Setting
    - What Happened
    - Feelings



6. **Processing:** From the stories that were shared, the facilitator highlights the following:
  - Experiences can either be sexual or gender in origin.
  - Experiences are based on influences of certain persons; such as family members, teachers, peers, church leaders.
  - Socialization of gender roles: gender roles are learned and could be challenged, unlearned and changed.
7. The facilitator presents the following concepts to process the experiences: gender equality gender equity and gender discrimination.
8. **Additional discussion points:** (from WHO Training Curriculum, Gender and Rights in Reproductive Health)
  - **Age**  
The youngest age is usually interesting to note as it highlights how early socialization begins. The usual range is 5 to 10 years.
  - **The people involved**  
Family members, peers, teachers and people in educational and religious institutions are usually the first to introduce a child to what are considered as appropriate codes of gendered behavior.
  - **Place**  
This often corresponds with the kinds of people involved: in the home or family, at play, in school or in church for peers and teachers, and adults in general.
  - **What the incident was about**  
Usually this includes:
    - **Division of labor:** the kind of household chores that girls are expected to do compared to boys; girls work inside the home and boys outside; girls work for others in the home, for example cooking, washing dishes, cleaning the house and washing clothes; boys are sent out on errands; girls do things for boys like serving food, cleaning up after them and doing their washing; boys in some cultures are asked to escort girls in public.
    - **Dress codes:** across cultures, girls and boys are expected to be dressed differently right from the time /they are born. These differences may vary across cultures and societies.
    - **Physical segregation of boys and girls:** in many cultures, especially in Asia, starts at an early age. Common experiences often include being told not to play with members of the opposite sex, or not to get involved in any activity that will bring one into physical contact with people of the opposite sex.

- **The kinds of games girls and boys play:** girls are not encouraged to play games like football, which involve vigorous physical activity and physical contact with each other; boys are often not allowed to play with dolls or play as homemakers. Boys who do not engage in rough physical games are thought to be "sissies"
- **Emotional responses:** girls and boys are expected to respond differently to the same stimulus; while it is acceptable for girls to cry, it is seen as a weakness in boys.
- **Intellectual responses:** there is an expectation that girls are not to talk back or express their opinions. This is often mentioned in relation to school and how teachers pay more attention to boys because they expect more from boys.

#### Box 16

### **TRAINING INFORMATION: Gender Roles and Socialization [Handout # 3.6]**

#### **Gender roles are learned**

Gender roles are not natural roles: boys and girls are systematically taught to be different from each other. Socialization into gender roles begins early in life. This includes learning to be different in terms of, for example:

- appearance and dress
- activities and pastimes
- behavior
- emotions that we show
- responsibilities
- intellectual pursuits

Gender roles are learned and, therefore, can be unlearned. They are changeable.

#### **The role of the family, other social institutions and women themselves**

Gender roles are taught and reinforced by various social institutions: the family, the school, religious institutions, the workplace, society as represented by peers and neighbors, to mention a few.

#### **Society generally values women less than it values men**

Society prescribes specific roles for girls and boys, women and men, but values them differently. In almost all societies girls and women are valued less than boys and men. This unequal value is the source of discrimination and oppression for women and accounts for the inferior status given to women in society.

#### **It is difficult to put pressure on the family to change**



The family is one of the most important social institutions that upholds and reinforces gender-based inequalities. And yet, the fact that the family belongs to the private sphere (compared to public sphere institutions like the workplace, schools and state institutions) has helped to keep what happens inside the family isolated from the forces of change and policy pressure towards gender equality.

Sticking to gender roles is ensured through a spectrum of controlling behavior. This may range from simple approval/disapproval to social ostracism and socially condoned aggression and even violence (like the honor killing of women who marry against the family's wishes in some societies). Others' non-interference in what happens within a household, giving absolute power to a household's male head, is one of the most powerful tools for maintaining gender inequalities.

**Gender-based inequality is often written in laws and policies**

Gender-based inequality is systematically legitimized and institutionalized through laws and policies. This makes the task of challenging and breaking out of gender roles extremely difficult.

**Men are also constrained by the construction of masculinity**

While gender-based differences disadvantage women much more than men, men are also constrained by the construction of masculinity. There may thus be men who are also concerned with redefining gender roles and relations.

**Fighting gender inequality is about challenging an ideology**

The issue of gender inequality is far more complex than men being against women or women having to fight men. It is about challenging the ideology which rates men as superior to women (an ideology which women as well as men may help perpetuate) and vests in them greater power. And it is about challenging the institutions that uphold these values.

### **Activity 3.1c Stereotyping and Gender Biases [Handout # 3.7]**

**Notes for the Facilitator:**

1. Gender stereotypes are qualities, attitudes, and behaviors that are arbitrarily attributed to any particular sex. In line with these stereotypes, men are socialized to lead and dominate while women are socialized to follow and care for others. Socialization of gender results in stereotyping and gender bias.

Discussions should include why they have become acceptable norms in our society. Gender stereotypes lead to biases and double standards. Similarly, these gender stereotypes extend to the area of reproductive and sexual health.

#### **Exercise 1: Stereotyping RH Clients and Gender Bias among Service Providers**



### **Notes for the Facilitator:**

1. Facilitator informs participants that the previous exercise showed stereotyping and biases in gender in a general environment. Stereotyping also extends to service providers and health facilities. This next exercise will encourage participants to continue to examine the biases which they hold and what the impact on clients may be.
2. **Materials/Preparation:** scenarios written on meta-cards are posted around the room. The scenarios are as follows:
  - You are 18, in school, single and pregnant
  - You are a 24-year-old gay man with painful urination and yellowish discharge from the penis
  - You are an 18-year-old woman in prostitution with foul smelling greenish to yellowish discharge and vaginal itchiness
  - You are pregnant with your 8<sup>th</sup> child. Your 7<sup>th</sup> child was born 14 months ago
  - You are married but pregnant by another man
  - You are a woman who wants an abortion
  - You just learned you are HIV positive
  - You are a 32-year-old married woman with five children with multiple bruises on your thigh and upper arm.
3. **Procedure:** Facilitator posts 6-8 of the above scenarios around the room.
  - First round: S/He asks each of the participants to stand in front of the meta-card with the situation which s/he thinks would be the most difficult to actually be if she/he were that person. Once there, facilitator asks individuals at each situation to talk about their feelings and reasons. It is possible that everyone will group at one or two. If this happens, the facilitator can just sample several within those groups for sharing.
  - Second round: Facilitator asks each of the participants to stand at the one scenario which s/he thinks would be the most difficult for them to counsel or treat. Before sharing in the large group, those standing at each scenario will talk among themselves about their feelings and reasons for their choice of scenario. Then the facilitator can encourage several to share from each situation, involving as many as possible given the time.
  - Facilitator brings the participants back to the large group to process the activity.
4. **Processing:** Facilitator discusses the following:
  - What were some of your observations? What were the differences between your choice of scenario for the personal (first round choice) and for the professional (second round choice)?

- If you were the client, and fit into one of those descriptions:
  - What would you fear when you go to the health facility?
  - What would you want from the health worker?
  - What could the health facility do to help you the most?

5. **Summarizing Gender Bias:** Facilitator concludes this session by going through the table below. S/He explains how gender bias manifests in different ways and how being aware of these manifestations can help service providers deliver health services that are bias-free.

**[Handout # 3.8]**

| Types of Gender Bias      | Manifestations   |
|---------------------------|--|
| Marginalization           | <ul style="list-style-type: none"> <li>• Undervaluation or non-valuation/non-recognition of women's work</li> <li>• Unequal pay for work of equal value</li> <li>• Last to be hired, first to be fired</li> <li>• Limited opportunities</li> <li>• Exacting sexual favors</li> </ul> |
| Subordination (political) | <ul style="list-style-type: none"> <li>• Position</li> <li>• Status</li> <li>• Decision-making</li> <li>• Process of socialization</li> </ul>  |
| Multiple Burden           | <ul style="list-style-type: none"> <li>• Shared parenting, shared housework are not being practice</li> </ul>  |
| Gender Stereotyping       | <ul style="list-style-type: none"> <li>• Child-rearing</li> <li>• Religion</li> <li>• Occupations</li> <li>• Education, language</li> <li>• Behavior</li> <li>• Government Programs</li> <li>• Media</li> <li>• Popular Culture</li> </ul>   |
| Violence Against Women    | <ul style="list-style-type: none"> <li>• Verbal, psychological, physical, economic</li> <li>• Forms of violence: jokes, wolf-whistles, "tsansing" or making sexual passes, sexual harassment, domestic violence, incest, rape, prostitution, sex trafficking</li> </ul>              |

**References**

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## SESSION 3.2: Gender Analysis

### Introduction

This session will look at the different ways gender impacts to the work that is done, how much time is spent doing it and how much money is gained from it. It will explore the various roles of women and men in society, and the concept of power dynamics between them. As a result of gender stereotyping, the sexual division of work is shown and the session will look at what is "women's work" as against "men's work" and its implications to health-seeking behavior.

|                    |  |
|--------------------|--|
| <b>Objectives</b>  | By the end of the session, participants would be able to: <ul style="list-style-type: none"><li>• Know the multiple roles and burdens of women;</li><li>• Learn the basics of gender analysis (access and control); and</li><li>• Know the power dynamics between/among men and women and the concepts of equity and equality.</li></ul> |
| <b>Time</b>        | 4 hours  |
| <b>Equipment</b>   | LCD or Overhead Projector, computer (if using LCD)   |
| <b>Materials</b>   | Powerpoint Presentation on Gender and Sex, meta-cards, kraft or manila paper, scissors, paste, permanent markers, masking tape   |
| <b>Handouts</b>    | Handout # 3.9: Exercise: 24-Hour Day<br>Handout #3.10: Gender Roles<br>Handout #3.11: Access and Control<br>Handout #3.12: Exercise: Access and Control<br>Handout #3.13: Power Dynamics<br>Handout #3.14: Practical/Strategic Gender Needs  |
| <b>Preparation</b> | <ul style="list-style-type: none"><li>• Review powerpoint presentation</li></ul>   |

### Activity 3.2a Women's Multiple Roles and Burdens

#### Notes for the Facilitator:

1. Facilitator informs the participants that part of gender analysis is knowing the various roles that men and women play in society. Most of the time there is a division of labor and the roles are played according to this expected and socially dictated division of labor. The next exercise will look at what women and men do within a period of 24 hours and subsequent analysis will be done based on what the results are.



## **Exercise: The 24-Hour Day: [Handout # 3.9]**

### **Notes for the Facilitator:**

1. Facilitator divides the participants into four groups. S/He distributes the time sheets that the groups can use as a template and informs the participants that they will make a hypothetical day for a man and woman in the following situations:

Group 1: Doming is a farmer; Juana takes care of the house and sells vegetables in the market during market days (every Tuesday and Friday). They have three children and Juana is pregnant with the fourth. Do a 24-hour day for a Friday.

Group 2: Tinio is a carpenter and comes home only on weekends while Celia stays at home with their five children, ages 1, 3, 4, 6 and 8. Celia has a small sari-sari store to augment their income and Tinio's mother stays with them and helps out in the child care.

Group 3: Ramon works as manager of a store selling hardware. His wife, Lydia, works as a schoolteacher in a public elementary school. They have one househelp, Soling, who does the cleaning, laundry and cooking. They have four children ages 4, 7, 9 and 13

Group 4: Rosing is a Barangay Health Worker. Her husband works as a seaman in the Norwegian Shipping Lines. He comes home every two years. Other than being a Barangay Health Worker, Rosing takes care of her four children, two are in high school and two in elementary school. Rosing goes to the Health Center everyday to assist in the Center. She also does home visits.

2. The groups are given 30 minutes to work on their time sheets. They are then asked to give their presentations in plenary.
3. **Processing of the Exercise:** Facilitator asks the participants what general conclusions they could draw from the exercise. S/He elicits responses that will show the imbalance of activities and multiplicity of roles that women and men do throughout the day.

The facilitator could point out the following:

- It does not matter what the economic status of women are, the roles they play are the same. It is even possible that the woman who has to work the whole day carries a heavier burden because of the multiple roles she plays.

- Show the general concept that men's work is usually for pay and woman's work is an obligation. Women are often confined to home management. Even if she is working outside, it is doubtful whether her voice matters in the crucial decisions pertaining to home and family.

4. **Input: Gender Roles [Handout # 3.10]** Facilitator shares the following roles of women and men:

- **Productive:** Comprises the work done by both women and men for payment in cash or in kind.
- **Reproductive:** Comprises the childbearing/childrearing responsibilities and domestic tasks required to guarantee the maintenance and well-being of household members. It includes not only biological reproduction but also the care and maintenance of the persons who comprise the household.
- **Community Management Role:** Comprises activities undertaken at the community level to contribute to the development or political organization of the community. It is usually voluntary, unpaid work. Women do community work that is maintenance in nature while men usually make policies.

5. Participants go back to their time charts to identify who does most of each role.

6. The facilitator shows graph (powerpoint/transparency presentation) comparing housework done by men and women. Facilitator explains what this graph shows in terms of the roles of women and men in society.



Source: UNDP Hanoi, 2002

7. Facilitator asks participants that upon knowing these roles, what would be their implications on a health care facility and the way services are given to women clients. Possible answers:
- time spent in health facilities adds to the burden of women who already have a very full day
  - volunteer work in the community (as BHW) may add to the burden of women (if she solely does the housework)
  - having different clinic days for MCH, immunization, well-baby adds to the heavy load women already have in normal daily schedule
  - need to evaluate clinic hours, when services are provided, client flow (to identify where delays happen)
  - incorporate programs that include men in the giving of health information, in the caring for the health of the families

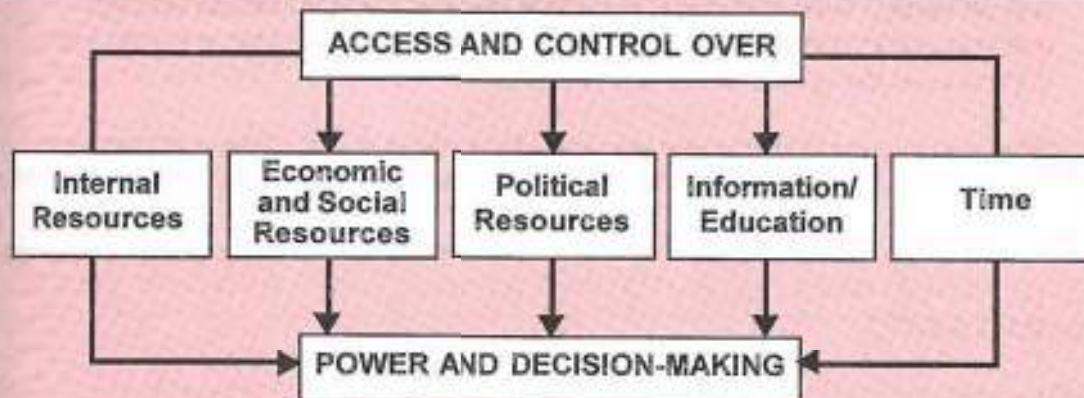
### **Activity 3.2b Gender Analysis: Access and Control of Resources**

#### ***Notes for the Facilitator:***

1. Another way of analyzing gender interrelationships is to look at who has access to and who has control of resources. Oftentimes, health services are delivered with presumptions that the clients have both access and control of various kinds of resources that support their decision making and subsequent health-seeking behavior. Knowing and analyzing access to and control of resources will help us understand and gain a broader insight on how our clients can be helped in their reproductive health needs.
2. In gender analysis, the following are accepted definitions of access and control:
  - Access - the ability to use a resource
  - Control - the ability to define and make decisions about the use of a resource
3. Facilitator shows the diagram below in a powerpoint presentation. (Handouts of the diagram can also be distributed at this point) The diagram shows that there are many types of resources. The definition of each resource and the implications of this resource in the lives of men and women is then discussed.



**Access and Control Diagram** (from *WHO Training Curriculum, Gender and Rights in Reproductive Health*) [**Handout # 3.11**]



**Definitions:**

**Internal resources** - self esteem, self confidence, ability to express one's own interests

**Economic resources** – work, food, credit, money, social security, health insurance, child care facilities, housing, facilities to carry out domestic tasks, transport, equipment, health services technology and scientific developments

**Political resources** - positions of leadership and access to decision-makers; opportunities for communication, negotiation and consensus building; resources that help vindicate rights, such as legal resources

**Social resources** - community resources, social networks, membership in social organizations

**Information/education** - inputs to be able to make decisions to modify or change a situation, formal education, non-formal education, opportunities to exchange information and opinions.

**Time** - hours of the day available to use as they choose, flexible paid work hours

**Power and decision-making** - Having greater access to and control over resources usually makes men more powerful than women in any social group. This may be the power of physical force, of knowledge and skills, of wealth and income, or the power to make decisions because they are in a position of authority. Men often have greater decision-making power over reproduction and sexuality. Male power and control over resources and decisions is institutionalized through the laws and policies of the State, and through the rules and regulations of formal social institutions. Laws in many countries of the world give men greater control over wealth and greater rights in marriage and over children.

4. **Exercise:** Facilitator tells the participants: "Let us go to back to the situations that were presented in the exercise on stereotyping and gender bias." S/He divides the participants into four groups and assigns two situations to each group. A more detailed scenario is given to each group as written below. S/He tells the groups that they will have to discuss among themselves the question of who has access to health services and who has control over the resources to access health services.
5. The groups may put their answer in the form of the matrix shown on next page. They are also asked to summarize the situation assigned to them.

**[Handout # 3.12]**

**Group 1:**

- You are 18, in school, single and pregnant. Your parents are rich, conservative and active members of Couples for Christ.
- You are a 24-year-old gay man with painful urination and yellowish discharge from the penis. You have a mid-level management position in one of the biggest investment houses in Makati.

**Group 2:**

- You are pregnant with your 8th child. Your 7th child was born 14 months ago. Your husband is a farmer working in a land owned by the mayor of the town. You have only finished second year high school.
- You just learned you are HIV positive. You are an OFW, a bartender, in a cruise liner. You learned about your status in a routine medical exam before the renewal of your contract.

**Group 3:**

- You are married but four months pregnant by another man. Your husband is a seafarer and is scheduled to come back in three months.
- You are an 18-year-old woman in prostitution with foul smelling greenish to yellowish discharge and vaginal itchiness. You come from a family of eight children and you are the eldest. You regularly send money to your parents in the province to help send your younger siblings to school.

**Group 4:**

- You are a 32-year-old married woman with multiple bruises on your thigh and upper arm. You have five children. Your husband is a tricycle driver.
- You are a woman who wants an abortion. You are a TV personality and your career is just taking off.



## ANSWER FORM

Situation: \_\_\_\_\_

Instructions: Given the situation, write down the extent this person described in the situation has access to and control over the different types of resources. Briefly describe your answer.

After the group has analyzed the situation, briefly give the implication of this situation to service providers and health facilities.

| Elements of Access/Control | Access (Yes/No, Why?) | Control (Yes/No, Why?) |
|----------------------------|-----------------------|------------------------|
| Internal Resources         |                       |                        |
| Economic Resources         |                       |                        |
| Political Resources        |                       |                        |
| Social Resources           |                       |                        |
| Information/Education      |                       |                        |
| Time                       |                       |                        |

### Effect on Service Providers and Health Facilities:

|   |  |
|---|--|
| <p>Conclusion: Degree of power and decision-making in matters relating to reproductive health; Implications to clinic staff</p> |  |
|---|--|

6. **Processing of Exercise:** Facilitator may use the training information below to summarize this activity on access to and control of resources.

**(Include here that inequitable access to and control over resources hinders development - within families and in communities. Mention that the United Nation (UN) has described the face of poverty as a woman's face. This is because society still controls how women can access the different kinds of resources.)**

Facilitators points out to the participants that knowing who has access and who has control over resources and the benefits of those resources gives rise to concepts of gender equality and equity. S/He explains the difference between



equality and equity and gender discrimination and shows how oftentimes, health services are provided as "equal" [meaning same health services for everyone] when what is needed is the "equitability" [meaning appropriate health services for women and men] of services.

### Box 17

#### TRAINING INFORMATION

**Gender equality** means equal treatment of women and men in laws and policies, and equal access to resources and services within families, communities and society at large.

**Gender equity** means fairness and justice in the distribution of benefits and responsibilities between women and men. It often requires women-specific programs and policies to end existing inequalities.

**Gender discrimination** refers to any distinction, exclusion or restriction made on the basis of socially constructed gender roles and norms which prevents a person from enjoying full human rights.

*Source: WHO Training Curriculum, Gender and Rights in Reproductive Health*

#### TRAINING INFORMATION: Interaction Between Gender and Access/Control

**Gender Implications for Women's Health:** We tend to hear that women use health services much more than men. But that utilization can be hindered at different times by a lack of access to and control of the different resources:

- In order for a woman to recognize that she has, for example, a gynecological problem, she needs to have access to the information/education that allows her to identify the symptoms of a health problem. Access to information is a crucial element so that the woman can make the decision to go to the health services.
- Even when a woman recognizes that she has a gynecological problem, she may be too embarrassed or timid to mention it to the physician. In this case, the degree of development of internal resources would give her the self-esteem necessary to take action.
- A woman may need to obtain medical care. However, the decision to go to the doctor might not be made by her, because she depends on the approval of her husband, mother-in-law, parents, etc. At this point, the woman must have control of economic resources. In this respect, the woman must be able to cover the cost of her visit and the type of health insurance that she has could be important. The woman may not have money to pay for transportation in order to get to the health service. Or she may not have someone with whom she can leave her children or her elderly and/or sick family members.

- The health care service hours, the waiting time and the travel time can constitute other obstacles due to her lack of control over her time owing to her reproductive responsibilities and roles.

#### **Implications for Men's Health:**

- Men may not have, for example, access to information on prostate cancer detection programs. In addition, they may be informed, but may decide not to have themselves checked, due to fear or embarrassment.
- A man may have control over sexual relations, but he may lack or have incorrect knowledge about sexuality and reproduction because he does not have access to adequate information. The lack of access to information can lead to sexual practices that expose both men and women to the risk of contracting sexually transmitted infections and the consequent complications of these infections.

### **Activity 3.2c Power Dynamics [Handout # 3.13]**

#### **Notes for the Facilitator:**

1. The access and control diagram shows **that whoever has the greater access and control, has more power to make decisions**. Knowing the various power dynamics in gender relations is important if the health interventions are going to be successful.
2. Pinpointing who has the power in the family and who makes decisions in any relationship provides information on what considerations to take when recommending treatment, doing counseling or motivating clients in health facilities.
3. Facilitator introduces the concept of power dynamics and tells participants that recognizing the different kinds of power dynamics, and acting to ensure the empowerment of women and men, is one step to having a gender equitable society.
4. Different kinds of Power Dynamics: Facilitator describes to the participants the various kinds of power dynamics. S/He asks the participants to add examples in any of these "power" elements.

#### **Power over? (diminishes the power of another)**

- Service providers, by the nature of their work, immediately exhibit power over the clients
- Men in the household setting have power over the women and the children
- Bosses of workers have power over the employees



**Power to?** (productive, creates action without domination)

- When service providers give appropriate information and open opportunities for clients to make decisions on their own
- When young people are provided with information on sexuality and life choices

**Power with?** (working together to achieve goals)

- Partnerships with LGUs, NGOs and Peoples' Organizations (Pos) to promote reproductive health
- Partnerships with clients to achieve reproductive health

**Power from within?** (harness the individual's inner strength and resources)

- Women deciding to leave a violent relationship/violent situation
- Informed choice

## Exercise: Role Play

1. The group is divided into four and each group is assigned one type of power dynamics. Each will think of a situation that will illustrate the assigned power dynamics and tells them they have 10 minutes to prepare and three minutes to do their presentation. Each presentation must be short, and must clearly depict the power dynamics in the situation presented.
2. **Alternative Activity:** Variation of the "Picture Me" Game. Facilitator asks all the participants to stand up and clear the space for a group game.

**Instructions:**

- Facilitator tells the group that s/he will call out a number and a specific power dynamics situation.
- When the facilitator calls out the number (example: "4") and a power dynamic situation (example: "power from within") the participants group themselves into fours and then think of a situation that will depict "power from within."
- The group is given a few seconds to think about what they want to do then the facilitator calls "Freeze!" At this command, all of the groups will have to present their situation in a tableau with no one moving. The groups that clearly depict the situation remain in the game. The ones that don't are eliminated.
- Eliminated groups could then participate as judges.



## Activity 3.2d: Programmatic Interventions: Meeting Practical or Strategic Needs?

### Notes for the Facilitator:

1. Facilitator tells the participants that knowing the division of labor and who has access and control brings the group to a point where they need to think about what possible interventions can be provided for individuals and communities. Interventions could either be meeting the practical needs or the strategic needs of individuals, families and communities.
2. Meeting the practical needs mean addressing the immediate needs of individuals. Meeting the strategic needs mean addressing and correcting the power imbalance that exists within society.
3. **Exercise:** Using the situations given in the "Access and Control" session, facilitator asks the participants to give possible practical and strategic interventions for the situations. [*Handout # 3.14*]

### Box 18

#### TRAINING INFORMATION: Practical and Strategic Gender Needs

Practical Gender Need (PGN): the need identified by women and men which arise out of the customary gender division of labor. PGNs are a response to immediate perceived necessity, identified within a specific context. They are often concerned with inadequacies in living conditions such as water provisions, health care, employment.

Strategic Gender Need (SGN): reflects a challenge to the customary gender relations and imply change in relationships of power and control between women and men. SGNs that women identify arise from women's recognition and challenge to their subordinate position in relation to men in their society, for example, equal access to employment, equal pay, and equal legal rights. SGNs which men identify arise from men's recognition of and challenge to their exclusion from domains which customary male roles impose and which contribute to the perpetuation of women's subordination, for example, sharing child care. SGNs are context-specific.

| Practical Gender Needs   | Strategic Gender Needs   |
|--|--|
| <ul style="list-style-type: none"> <li>• tend to be immediate; short term</li> <li>• unique to particular women</li> </ul>   | <ul style="list-style-type: none"> <li>• tend to be long term</li> <li>• common to almost all women</li> </ul>   |
| <ul style="list-style-type: none"> <li>• relate to daily needs: food, housing, household efficiency, income, healthy children</li> <li>• easily identifiable by women</li> </ul> | <ul style="list-style-type: none"> <li>• relate to disadvantaged position: subordination, lack of resources, vulnerability to poverty and violence</li> <li>• basis of disadvantage and potential for change not always identified by women</li> </ul> |
| <ul style="list-style-type: none"> <li>• can be addressed by the provision of specific inputs, e.g. food, water pumps, clinics, traditional IGPs, etc</li> </ul>                 | <ul style="list-style-type: none"> <li>• can be addressed by consciousness-raising, increased self confidence, education, strengthening women's organizations, political mobilization, etc.</li> </ul>   |
| <ul style="list-style-type: none"> <li>• <b>Addressing PGNs</b></li> </ul>   | <ul style="list-style-type: none"> <li>• <b>Addressing SGNs</b></li> </ul>   |
| <ul style="list-style-type: none"> <li>• tend to involve women as beneficiaries and perhaps as participants</li> </ul>   | <ul style="list-style-type: none"> <li>• involves women as agents or enables women to become agents</li> </ul>   |

**ANSWER SHEET Format:**

**GROUP #** \_\_\_\_\_

| Situation | RH Problem | PGN Intervention | SGN Intervention |
|-----------|------------|------------------|------------------|
|           |            |                  |                  |
|           |            |                  |                  |

**CLOSING STATEMENTS**

This section of the module has covered the basic understanding of terms and the framework under which the Department of Health provides reproductive health services. The framework clearly identifies gender and rights as core concepts that guide the provision of services. The rest of the training will show in greater detail what these concepts are and how they could be applied in health facilities.



## SESSION 3.3: Integrating Gender and RH

### Introduction

Women and men differ in relation to the physical spaces they occupy, the tasks and activities they perform and the people they interact with. In almost all cultures and settings around the world, and across social groups, women have less access to and control over resources than most men, and are denied equal access to facilities and opportunities like education and training.

|                    |  |
|--------------------|--|
| <b>Objectives</b>  | By the end of the session, participants would be able to: <ul style="list-style-type: none"><li>• Demonstrate knowledge on how gender affects the reproductive health of clients; and</li><li>• Show what interventions could be done by service providers on gender integration at the health facility level.</li></ul> |
| <b>Time</b>        | 2 hours  |
| <b>Equipment</b>   | LCD or Overhead Projector, computer (if using LCD)   |
| <b>Materials</b>   | Powerpoint Presentation on Gender and Sex, meta-cards, kraft or manila paper, scissors, paste, permanent markers, masking tape   |
| <b>Handouts</b>    | Handout #3.15: Philippine RH Situation<br>Handout #3.18: Exercise on Gender and RH Integration   |
| <b>Preparation</b> | <ul style="list-style-type: none"><li>• Review power point presentation</li></ul>  |

### Activity 3.3a The Philippine RH Situation [Handout #3.15]

#### Notes for the Facilitator:

1. Facilitator tells participants that now that they know (and agree) on the definitions of key words and the gender issues related to reproductive health, it is also equally important to know what the RH situation on the ground is in relation to these words. What do these words really mean in terms of the health situation of Filipino women and men?

Facilitator explains to the participants that based on the numerous health surveys as well as on the personal experiences of the service providers in the field, a snapshot of the overall health of Filipino men and women can be gleaned. Although national data may not totally reflect the local situation, one can derive a picture of the health status of Filipinos. This



picture includes the reproductive health situation in the Philippines and which will be examined.

2. Handout #3.15: "Philippine RH Situationer" is distributed as the facilitator explains that the objective of the exercise is for the participants to come up with a picture of the RH situation in the Philippines.

**NOTE: Facilitators can update this Philippine RH Situationer depending on the most recent data available.**

3. The handout has data from various sources. To come up with a clear picture of the RH situation, the participants will be divided into groups and specific RH elements will be assigned to them. Each group will then select the relevant information that will provide a picture of that specific RH element in the country. The facilitator tells the participants that it will be up to the group to select the manner of presentation of their data to highlight the situation of the assigned RH element/s.
4. The participants are divided into equal grouping of not more than five people per group. Facilitator assigns RH elements among each group making sure that the RH elements with the least data are grouped with RH elements with the most data (e.g., FP and Infertility).

Groupings:     1 – Family Planning & Infertility  
                  2 – Adolescent Reproductive Health & Reproductive Cancers  
                  3 – Maternal and Child Health & Male Involvement  
                  4 – STI, HIV and AIDS & Sexuality  
                  5 – Violence Against Women and Children & PMAC

5. Groups are given 20 minutes to work and to prepare their presentation.
6. After 20 minutes, groups are gathered together for their presentations in plenary.
7. After the presentations, participants summarize the RH profile of the Philippines based on the data presented.

### Exercise 3: Integrating Sex/Gender and Reproductive Health [Handout #3.16]

#### Notes for the Facilitator:

1. Facilitator tells participants that reproductive health has a strong relationship to sex and gender. The next exercise will try to deepen the understanding of sex and gender by analyzing the data presented in the previous exercise in terms of its gender implications and issues.
2. **Group Work:** Participants are divided into groups of five or six. Participants are asked to answer how the Philippine RH data which provides a picture of RH issues and situations are related to sex and gender.

Participants assess the data given to them in the previous exercise and then come up with explanations using the following gender concepts:

- Gender stereotyping and gender bias
- Multiple roles and burdens
- Access and control of resources

Format of report: (Participants may show this report in a creative way — using charts, drawings, etc.)

| Reproductive Health Data<br>(use specific data from previous exercise) | Explanation of the Data<br>Using Gender Concepts |
|--|--|
|  |  |
|  |  |
|  |  |
|  |  |

**3. Facilitator: Following are suggestions on how to process the results of the above statements:**

- a. Gender views of women's reproductive role; women are supposed to take care of family planning and health matters; men are not involved.
- b. Women who get infected with HIV are usually those who do not have the power to demand or negotiate safer sex; higher vulnerability.
- c. Men's roles in family planning are not seen as vital; although they don't want to have any more children or want to space the births of their children they do not access any contraceptive nor take the initiative for family planning.
- d. Rape cases display the disparity of power dynamics between men and women. Usually, rape is done by an older male to a younger or more vulnerable female.
- e. Young people experiment with sex without considering responsibility for their actions; even during adolescence, young boys are shaped by society to have sex without commitments; sex is seen as a "manly" thing to do, while childbearing is seen as a "womanly" thing to do.
- f. Double standards for men and women are evident here; men have different values than women and men are expected to act differently than women - even condone the actions of men and condemn the same actions if done by women.

### **Closing Statements**

Gender and the issues surrounding gender need to be clearly understood, internalized and in the course of a service provider's daily interaction with clients, applied. Learning about gender does not stop after this module. Looking at the world through gender lens means being constantly aware of the inequalities and inequities existing in all aspects of living, and addressing these in ways to change the existing injustices.

### **References**

- DAC Guidelines for Gender Equality and Women's Empowerment in Development Cooperation.* (1998). Paris: OECD.
- CIDA. (1996). A Project-Level Handbook: The Why and How of Gender-Impact Indicators.* Ottawa: CIDA.
- WHO Training Curriculum, Gender and Rights in Reproductive Health)*
- Oxfam-U.K. and Ireland. (1994). Gender Training Manual.*



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MODULE **3**

# Gender Dimensions of Reproductive Health

The overall objectives of the training are:

- Explain gender concepts as they relate to reproductive health of women and men
- Demonstrate how to apply gender concepts in work situations

## Session 3.1: Gender and Sex

### Objectives

By the end of the session, participants would be able:

- Differentiate between sex and gender
- Explain the various social constructs of gender
- Identify the various stereotyping and gender biases within Philippine Society
- Examine stereotyping and gender biases in the provision of reproductive health care services

## Session 3.2: Gender Analysis

### Objectives

By the end of the session, participants would be able:

- Explain the multiple roles and burdens that women have
- Apply the basic tools of gender analysis (access and control) in their own situations
- Describe the power dynamics between/among men and women and the concepts of equity and equality

## Session 3.3: Integrating Gender and RH

### Objectives

By the end of the session, participants would be able:

- Demonstrate how gender affects the reproductive health of clients
- Provide interventions that could be done by service providers on gender integration at the health facility level

## Handout 3.1-A

### Sex and Gender Bingo

|   |   |  |  |  |
|---|---|--|--|--|
| Woman who knows how to fix cars   | Man who likes to cook.                              | Likes to wear perfume.   | Has a husband who stays at home, takes care of the household | Knows the meaning of gender                                  |
| Knows the meaning of reproductive health                                  | Woman who played with guns and cars as a child      | Believes that final decisions in the home must be made by the man. | Thinks women should take care of child-rearing               | Woman who likes to watch boxing.                             |
| Breastfed all her children.   | Has a male first-born child.                        | <b>FREE SPACE</b>  | Exercises regularly.   | Is a metrosexual   |
| Was present in the delivery room during the birth of his child.           | Thinks that men are physically stronger than women. | Thinks that gays and lesbians can change their sexual orientation. | Knows of someone who takes viagra or a similar medicine.     | Man who knows how to cross-stitch                            |
| Bought pink stuff for their girl child or blue stuff for their boy child. | Voted for Loren Legarda.                            | Like to watch wrestling on TV.                                     | Woman who prefers women doctors to take care of her.         | Has a wife who stays at home and takes care of the household |



## Handout 3.1-B

### Sex and Gender Bingo

|   |   |  |   |   |
|---|---|--|---|---|
| Had a difficult birthing experience.                                      | Man who likes to do housework.                                  | Has a family history of reproductive cancers.                      | Knows someone who is homophobic                               | Knows the meaning of gender                     |
| Knows the meaning of reproductive health                                  | Woman who played with guns and cars as a child                  | Has taken care of a pregnant teenager.                             | Thinks women should take care of child-rearing                | Woman who likes to watch boxing.                |
| Breastfed all her children.   | Knows of someone who has experienced complications in abortion. | <b>FREE SPACE</b>  | Knows a male health service provider who is gender sensitive. | Has done activities to involve men in RH.       |
| As a service provider, knows how to handle VAW cases.                     | Thinks that men are physically stronger than women.             | Thinks that gays and lesbians can change their sexual orientation. | Knows of someone who takes viagra or a similar medicine.      | Man who knows how to cross-stitch               |
| Bought pink stuff for their girl child or blue stuff for their boy child. | Believes that the ultimate purpose of womanhood is motherhood.  | Was present in the delivery room during the birth of his child.    | Woman who prefers women doctors to take care of her.          | Enjoys making love in at least three positions! |

## Handout 3.1-C

### Sex and Gender Bingo

|   |  |   |  |   |
|---|--|---|--|---|
| Had a difficult birthing experience.                  | Knows of an elderly woman who is a victim of VAW.                      | Has a family history of reproductive cancers.                   | Knows someone who is homophobic  | Jointly has access to family resources.                                     |
| Knows of a woman who have not experienced orgasm.     | Woman who played with guns and cars as a child                         | Has taken care of a pregnant teenager.                          | Believes that adolescents should be provided with contraceptive methods. | Woman who likes to watch boxing.  |
| Woman who prefers women doctors to take care of her.  | Thinks that women usually are as much to blame if they experience VAW. | <b>FREE SPACE</b>   | Thinks that women who had an abortion should not receive compassion      | Bought pink things for their girl child or blue things for their boy child. |
| As a service provider, knows how to handle VAW cases. | Thinks that men are physically stronger than women.                    | Does regular breast self-exams.                                 | Knows and is aware of her own fertility.                                 | Man who knows how to cross-stitch.  |
| Enjoys making love in at least three positions!       | Believes that the ultimate purpose of womanhood is motherhood.         | Was present in the delivery room during the birth of his child. | Will buy a toy doll for a son.   | Thinks its ok for an older person to have a partner 15 years younger.       |

Handout 3.2

“Because I am...” Exercise

Because I am a \_\_\_\_\_, I can....

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If I were a \_\_\_\_\_, I could....

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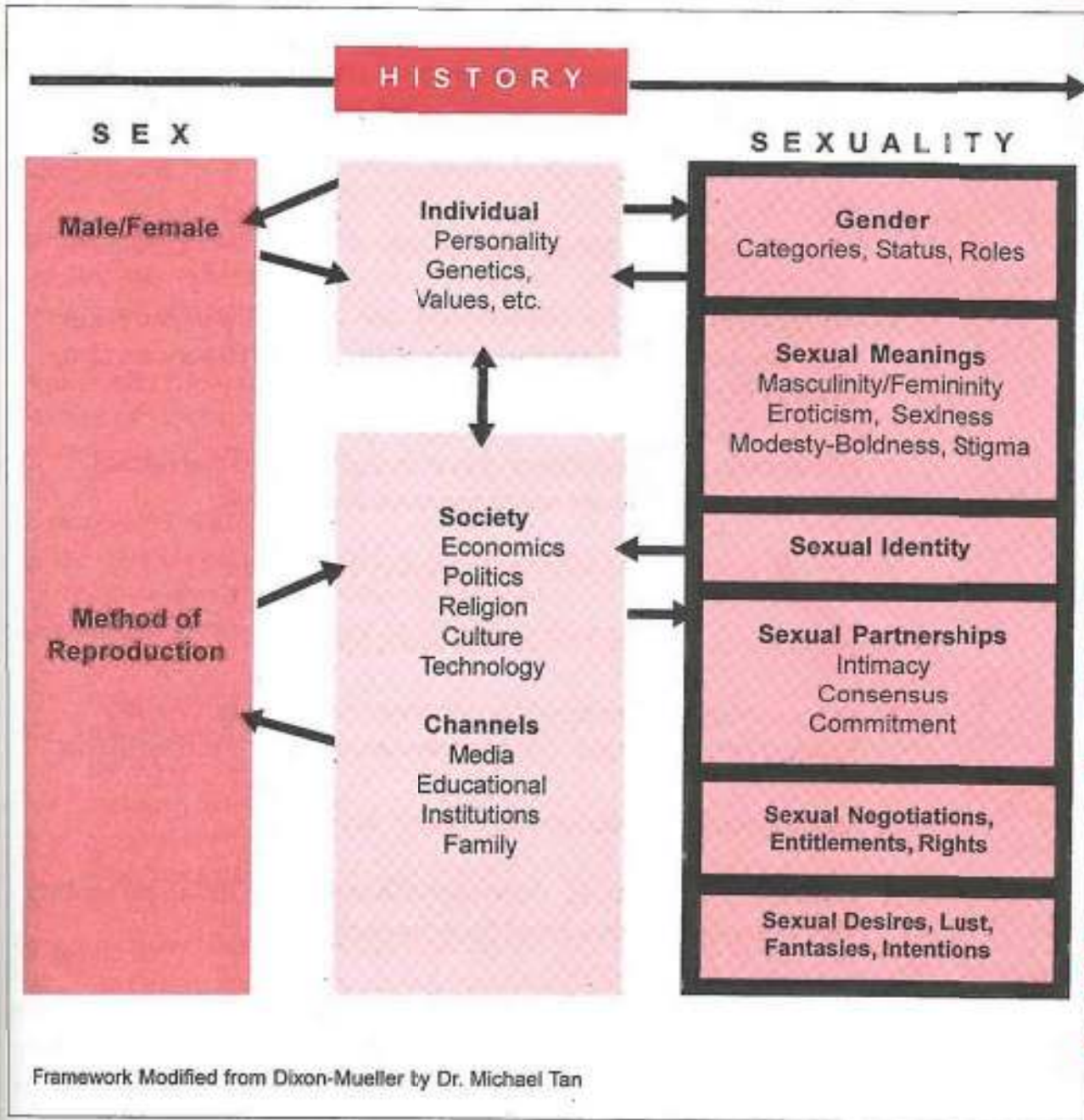


### Differentiating Between Sex and Gender

| Sex  | Gender   |
|--|--|
| Primarily refers to physical attributes—body characteristics notably sex organ which are distinct in majority of individuals | Is the composite of attitudes and behavior of men and women (masculinity and femininity)                                   |
| Is biologically determined—by genes and hormones<br>media; thus, it  | Is learned and perpetuated primarily through: the family, education, religion (where dominant) and is an acquired identity |
| Is relatively fixed/constant through time and across cultures  | Because it is socialized, it may be variable through time and across cultures  |

**Sexuality:** Encompasses personal and social meanings as well as sexual behavior and biology. It includes ways our bodies develop and respond sexually, includes sexual acts: kissing, touching, intercourse, includes feelings about these activities and responses. Also includes what we think is right and wrong, good or bad. Includes life experiences that have shaped these feelings and values.

### Sexuality Framework



### Exercise: Gender and Sex Statements

**Instructions:** Read the following statements. Write the letter "S" next to statements that refer to sex differences and the letter "G" next to statements that refer to gender differences.

- a. Women give birth to babies, men do not.
- b. According to United Nations statistics, women do 67 per cent of the world's work, yet their earnings for it amount to only 10 per cent of the world's income.
- c. In one case, when a child brought up as a girl learned that he was actually a boy, his school marks improved dramatically.
- d. Women suffer from pre-menstrual tension, men do not.
- e. Sex is not as important for women as it is for men.
- f. In ancient Egypt, men stayed at home and did weaving. Women handled family business. Women inherited property and men did not.
- g. Men's voices break at puberty, women's don't.
- h. In a study of 224 cultures, there were 5 in which men did all the cooking and 36 in which women did all the house building.
- i. Men are naturally prone to violent behaviour.
- j. Women are more vulnerable to STIs than men.



## Gender Concepts, Roles and Socialization

**Gender equality** means equal treatment of women and men in laws and policies, and equal access to resources and services within families, communities and society at large.

**Gender equity** means fairness and justice in the distribution of benefits and responsibilities between women and men. It often requires women-specific programmes and policies to end existing inequalities.

**Gender discrimination** refers to any distinction, exclusion or restriction made on the basis of socially constructed gender roles and norms which prevents a person from enjoying full human rights.

### **Gender roles are learnt**

Gender roles are not natural roles: boys and girls are systematically taught to be different from each other. Socialization into gender roles begins early in life. This includes learning to be different in terms of, for example:

- appearance and dress
- activities and pastimes
- behaviour
- emotions that we show
- responsibilities
- intellectual pursuits

Gender roles are learnt and therefore can be unlearned. They are not unchangeable.

### **The role of the family, other social institutions and women themselves**

Gender roles are taught and reinforced by various social institutions: the family, the school, religious institutions, the workplace, society as represented by peers and neighbours, to mention a few. Women play as significant a role as men in socializing girls and boys into their gender roles.

**Society generally values women less than men**

Society prescribes specific roles for girls and boys, women and men, but values them differently. In almost all societies girls and women are valued less than boys and men. This unequal value is the source of discrimination and oppression for women and accounts for the inferior status given to women in society.

**It is difficult to put pressure on the family to change**

The family is one of the most important social institutions which upholds and reinforces gender-based inequalities. And yet, the fact that the family belongs to the private sphere (compared to public sphere institutions like the workplace, schools and state institutions) has helped to keep what happens inside the family isolated from the forces of change and policy pressure towards gender equality.

Sticking to gender roles is ensured through a spectrum of controlling behaviour. This may range from simple approval/disapproval to social ostracism and socially condoned aggression and even violence (like the honour killing of women who marry against the family's wishes in some societies). Others' non-interference in what happens within a household, giving absolute power to a household's male head, is one of the most powerful tools for maintaining gender inequalities.

**Gender-based inequality is often written in laws and policies**

Gender-based inequality is systematically legitimized and institutionalized through laws and policies. This makes the task of challenging and breaking out of gender roles extremely difficult.

**Men are also constrained by the construction of masculinity**

While gender-based differences disadvantage women much more than men, men are also constrained by the construction of masculinity. There may thus be men, too, who are concerned with redefining gender roles and relations.

**Fighting gender inequality is about challenging an ideology**

The issue of gender inequality is far more complex than men being against women or women having to fight men. It is about challenging the ideology which rates men as superior to women (an ideology which women as well as men may help perpetuate) and vests in them greater power. And it is about challenging the institutions which uphold these values.

*(from WHO Training Curriculum, Gender and Rights in Reproductive Health)*

Handout 3.7

**Gender Stereotyping**

**Gender stereotypes are qualities, attitudes, and behaviors that are arbitrarily attributed to any particular sex. In line with these stereotypes, men are socialized to lead and dominate while women are socialized to follow and care for others. Socialization of gender results in stereotyping and gender biases.**



## Manifestations of Gender Biases

| Gender Biases             | Manifestations  |
|---------------------------|---|
| Marginalization           | <ul style="list-style-type: none"> <li>• Under or non-valuation/ non-recognition of women's work</li> <li>• Unequal pay for work of equal value</li> <li>• Last to be hired, first to be fired</li> <li>• Limited opportunities</li> <li>• Exacting sexual favors</li> </ul>  |
| Subordination (political) | <ul style="list-style-type: none"> <li style="width: 50%;">• Position</li> <li style="width: 50%;">• Decision-making</li> <li style="width: 50%;">• Status</li> <li style="width: 50%;">• Process of socialization</li> </ul>   |
| Multiple Burden           | <ul style="list-style-type: none"> <li>• Shared parenting, shared housework are not being practice</li> </ul>   |
| Gender Stereotyping       | <ul style="list-style-type: none"> <li style="width: 50%;">• Child-rearing</li> <li style="width: 50%;">• Behavior</li> <li style="width: 50%;">• Religion</li> <li style="width: 50%;">• Government Programs</li> <li style="width: 50%;">• Occupations</li> <li style="width: 50%;">• Media</li> <li style="width: 50%;">• Education Language</li> <li style="width: 50%;">• Popular Culture</li> </ul> |
| Violence Against Women    | <ul style="list-style-type: none"> <li>• Verbal, Psychological, physical, economic</li> </ul> <p>Forms of violence: jokes, wolf-whistles, "chancing" or making sexual passes, sexual harassment, domestic violence, incest, rape, prostitution, sex trafficking</p>   |

## Exercise: 24-Hour Day

### **Instructions:**

Based on your group's collective experiences, put together a 24-hour diary of the couple assigned to you. Divide the diary into one-hour slots and fill it up with the tasks and work that the couple will do in one day.

### **Grouping Scenarios**

- Group 1:** Doming is a farmer; Juana takes care of the house and sells vegetables in the market during market days (every Tuesdays and Friday of the week). They have three children; and Juana is pregnant with the fourth. Do a 24-hour day for a Friday.
- Group 2:** Tinio is a carpenter and comes home only on weekends while Celia stays at home with their five children, ages 1, 3, 4, 6 and 8. Celia also has a small Sari-Sari store to augment their income and Tinio's mother stays with them and helps out in the caring of the children.
- Group 3:** Ramon works as manager of a store selling hardware and his wife, Lydia, works as a schoolteacher in a public elementary school. They have one househelp, Soling, who does the cleaning, laundry and cooking. They have four children ages 4, 7, 9 and 13
- Group 4:** Rosing is a Barangay Health Worker. Her husband works as a seaman in the Norwegian Shipping Lines. He comes home every two years. Other than being a Barangay Health Worker, Rosing takes care of her four children, two who are in high school and two in elementary school. Rosing goes to the Health Center everyday to assist in the Center and also does home visits.

# H A N D O U T S

Diary Format:

| Time  | Woman | MAN |
|-------|-------|-----|
| 12 MN |       |     |
| 1 AM  |       |     |
| 2     |       |     |
| 3     |       |     |
| 4     |       |     |
| 5     |       |     |
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| 7     |       |     |
| 8     |       |     |
| 9     |       |     |
| 10    |       |     |
| 11    |       |     |



## Handout 3.10

## Gender Roles

Gender Roles are divided into three types:

- **Productive:** Comprises the work done by both women and men for payment in cash or kind.
- **Reproductive:** Comprises the childbearing/rearing responsibilities and domestic tasks required to guarantee the maintenance and well-being of household members. It includes not only biological reproduction but also the care and maintenance of the persons who comprise the household.
- **Community Management Role:** Comprises activities undertaken at the community level to contribute to the development or political organization of the community. It is usually voluntary, unpaid work. Women do community work that is maintenance in nature while men are usually policy-makers.

## Access and Control of Resources

**Internal resources** - self esteem, self confidence, ability to express one's own interests.

**Economic resources** – work, food, credit, money, social security, health insurance, child care facilities, housing, facilities to carry out domestic tasks, transport, equipment, health services technology and scientific developments.

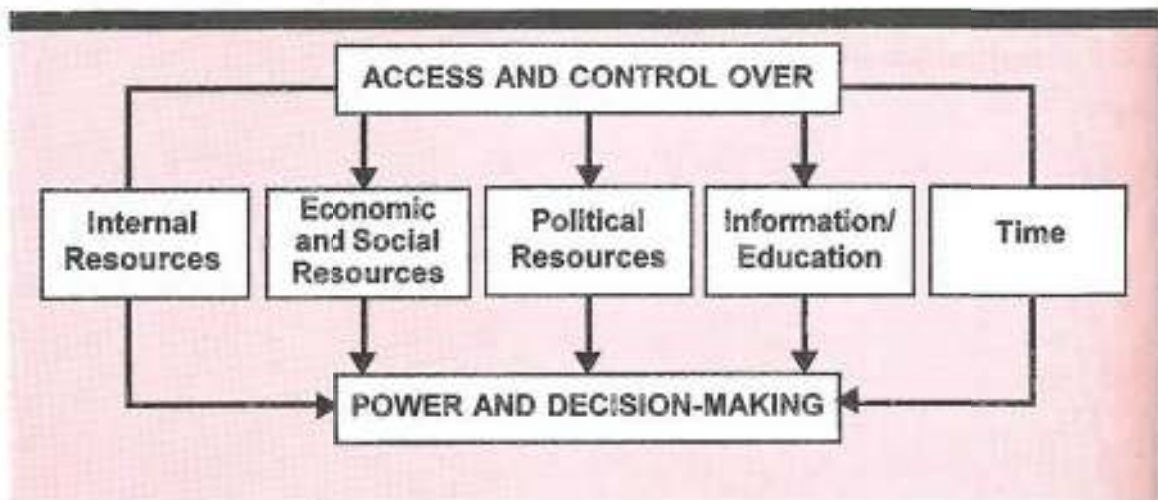
**Political resources** - positions of leadership and access to decision-makers; opportunities for communication, negotiation and consensus building; resources that help vindicate rights, such as legal resources.

**Social resources** - community resources, social networks, membership in social organizations.

**Information/education** - inputs to be able to make decisions to modify or change a situation, formal education, non-formal education, opportunities to exchange information and opinions.

**Time**- hours of the day available to use as they choose flexible paid work hours.

**Power and decision-making** - Having greater access to and control over resources usually makes men more powerful than women in any social group. This may be the power of physical force, of knowledge and skills, of wealth and income, or the power to make decisions because they are in a position of authority. Men often have greater decision-making power over reproduction and sexuality. Male power and control over resources and decisions is institutionalized through the laws and policies of the state, and through the rules and regulations of formal social institutions. Laws in many countries of the world give men greater control over wealth and greater rights in marriage and over children.



## Exercise: Access and Control of Resources

### Situation Assignments:

#### Group 1:

- You are 18, in school, single and pregnant. Your parents are rich, conservative and active members of the Couples of Christ.
- You are an 24-year old gay man with painful urination and yellowish discharge from the penis. You have a mid-level management position in one of the biggest investment houses in Makati.

#### Group 2:

- You are pregnant with your 8th child. Your 7th child was born 14 months ago. Your husband is a farmer working in a land owned by the mayor of the town. You have only finished second-year high school.
- You just learned you are HIV positive. You are an OFW, a bartender, in a cruise liner. You learned about your status in a routine medical exam before the renewal of your contract.

#### Group 3:

- You are married but four months pregnant with another man's baby. Your husband is a sea-farer and is scheduled to come back in three months.
- You are an 18 year old woman in prostitution with foul smelling greenish to yellowish discharge and itchiness. You come from a family of eight children and you are the eldest. You regularly send money to your parents in the province to help send your younger siblings to school.

#### Group 4:

- You are a 32-year old married women with five children with multiple bruises on your thigh and upper arm. Your husband is a tricycle driver.
- You are a woman who wants an abortion. You are a TV personality and your career is just taking off.

**Instructions:** Given the situation, write down the extent this person described in the situation has access and control over the different types of resources. Briefly describe your answer.



## Handout 3.13

**Power Dynamics**

- **Power over?** (diminishes the power of another)
  - Examples: service providers by the nature of their work, immediately exhibit power over the clients
  - Men in the household setting have power over the women and the children
  - Bosses of workers have power over the employees
  - (note: the facilitator can ask the participants their contributions)
- **Power to?** (productive, creates action w/out domination)
  - when service providers give appropriate information and open opportunities for clients to make decisions on their own
  - when young people are provided with information on sexuality and life choices
- **Power with?** (working together to achieve goals)
  - Partnerships with LGUs, NGOs to promote reproductive health
  - Partnerships with clients to achieve reproductive health
- **Power from within?** (harness the individuals inner strength & resources)
  - Women deciding to leave a VAW situation
  - Informed choice

## Practical and Strategic Needs

**Practical Gender Needs (PGNs):** the need identified by women and men which arise out of the customary gender division of labor. PGNs are a response to immediate perceived necessity, identified within a specific context. They are often concerned with inadequacies in living conditions such as water provisions, health care, employment

**Strategic Gender Needs (SGNs):** reflect a challenge to the customary gender relations and imply change in relationships of power and control between women and men. SGNs which women identify arise from women's recognition and challenge to their subordinate position in relation to men in their society, for example, equal access to employment, equal pay, equal legal rights. SGNs which men identify arise from men's recognition and challenge to their exclusion from domains which customary male roles impose and which contribute to the perpetuation of women's subordination, for example, sharing child care. SGNs are context-specific.

| Practical Gender Needs   | Strategic Gender Needs   |
|--|--|
| <ul style="list-style-type: none"> <li>• tend to be immediate; short term</li> </ul>   | <ul style="list-style-type: none"> <li>• tend to be long term</li> </ul>   |
| <ul style="list-style-type: none"> <li>• unique to particular women</li> </ul>   | <ul style="list-style-type: none"> <li>• common to almost all women</li> </ul>   |
| <ul style="list-style-type: none"> <li>• relate to daily needs: food, housing, household efficiency, income, healthy children</li> </ul>                                   | <ul style="list-style-type: none"> <li>• relate to disadvantaged position: subordination, lack of resources, vulnerability to poverty and violence</li> </ul>  |
| <ul style="list-style-type: none"> <li>• easily identifiable by women</li> </ul>   | <ul style="list-style-type: none"> <li>• basis of disadvantage and potential for change not always identified by women</li> </ul>  |
| <ul style="list-style-type: none"> <li>• can be addressed by the provision of specific inputs, e.g. food, water pumps, clinics, traditional IGPs projects, etc.</li> </ul> | <ul style="list-style-type: none"> <li>• can be addressed by consciousness raising, increased self confidence, education, strengthening women's organizations, political mobilization, etc.</li> </ul> |
| Addressing PGNs  | Addressing SGNs  |
| <ul style="list-style-type: none"> <li>• tend to involve women as beneficiaries and perhaps as participants</li> </ul>   | <ul style="list-style-type: none"> <li>• involves women as agents or enables women to become agents</li> </ul>   |
| <ul style="list-style-type: none"> <li>• can improve the condition of women's lives</li> </ul>   | <ul style="list-style-type: none"> <li>• can improve the position of women in society</li> </ul>   |
| <ul style="list-style-type: none"> <li>• generally does not alter the traditional roles and relationships</li> </ul>   | <ul style="list-style-type: none"> <li>• can empower women and transform relationships</li> </ul>  |

Practical and Strategic Needs Exercise  
Answer Sheet

Group # \_\_\_\_\_

| Situation | RH Problem | PGN Intervention | SGN Intervention |
|-----------|------------|------------------|------------------|
|           |            |                  |                  |
|           |            |                  |                  |



## Philippine RH Situation

**Table 2-1. Wanted Fertility Rates: Total Wanted Fertility and Total Fertility Rates for the Three Years Preceding the Survey, Philippines 1998**

| Background Characteristics | Wanted Fertility Rates |            | Total Fertility Rate |            |
|----------------------------|------------------------|------------|----------------------|------------|
|                            | 1991                   | 1996       | 1991                 | 1996       |
| <b>Residence</b>           |                        |            |                      |            |
| Urban                      | 2.6                    | 2.3        | 3.5                  | 3.0        |
| Rural                      | 3.3                    | 3.3        | 4.8                  | 4.7        |
| <b>Education</b>           |                        |            |                      |            |
| No Education               | 4.0                    | 3.9        | 4.9                  | 5.0        |
| Elementary                 | 3.7                    | 3.3        | 5.5                  | 5.0        |
| High School                | 2.9                    | 2.7        | 3.9                  | 3.6        |
| College or Higher          | 2.4                    | 2.5        | 2.8                  | 2.9        |
| <b>Total</b>               | <b>2.9</b>             | <b>2.7</b> | <b>4.1</b>           | <b>3.7</b> |

Note from source: Rates are based on births to women 15-49 in the period 1-36 months preceding the survey. Sources: NSO, DOH and Macro International, 1999; National Demographic and Health Survey, 1998 as cited in the State of the Philippine Population Report (SPPR) 2000.

**Table 2-2. Unmet Need for Family Planning Services, Philippines 1998**

| Characteristics   | Unmet Need for Family Planning (%) |              |             |
|-------------------|------------------------------------|--------------|-------------|
|                   | For Spacing                        | For Limiting | Total       |
| <u>Age</u>        |                                    |              |             |
| 15-19             | 27.4                               | 4.6          | 32.1        |
| 20-24             | 21.2                               | 8.2          | 29.4        |
| 25-29             | 13.5                               | 10.3         | 23.9        |
| 30-34             | 7.2                                | 11.9         | 19.1        |
| 35-39             | 4.6                                | 15.2         | 19.8        |
| 40-44             | 2.3                                | 13.5         | 15.8        |
| 45-49             | 0.0                                | 6.3          | 6.3         |
| <u>Residence</u>  |                                    |              |             |
| Urban             | 7.3                                | 9.0          | 16.3        |
| Rural             | 9.8                                | 13.4         | 23.3        |
| <u>Education</u>  |                                    |              |             |
| No education      | 14.0                               | 14.5         | 28.4        |
| Elementary        | 8.1                                | 15.8         | 23.9        |
| High school       | 9.1                                | 9.6          | 18.7        |
| College or higher | 8.1                                | 7.5          | 15.6        |
| <b>Total</b>      | <b>8.6</b>                         | <b>11.2</b>  | <b>19.8</b> |

Sources: NSO, DOH and MI, 1999; National Demographic and Health Survey, 1998 as cited in the SPPR 2000.

### **Prevention of Abortion and Management of its Complications**

- One estimate places the number of abortions in the Philippines at 400,000 cases annually, with teenagers accounting for 17 percent of these cases, (Perez et al., 1997).
- Based on DOH records, 12 percent of all maternal deaths in 1994 were due to complications related to abortion, making it the fourth leading cause of maternal deaths in the country.
- The most vulnerable women, whether married or unmarried, are the poor. Among the top three reasons cited for terminating pregnancies is economic difficulty (POPCCM, 2001).

### **Violence Against Women (VAW)**

- Domestic violence is now recognized as a major social concern that particularly affects women. According to the 1993 Safe Motherhood Survey (SMS), 1 woman out of 10 experiences physical abuse even while pregnant. Other common forms of VAW are rape and act of lasciviousness.
- About 3 percent of SMS survey respondents said they were physically forced to have sex with a man. Of these, more than 60 percent did not seek help, and most were women in younger age groups (POPCOM 2001a).

### **Men's reproductive health**

- The leading cause of cancer deaths in men 20-35 years old is testicular cancer. The incidence is 35 times higher among men with undescended testes (Philippine Statistics, 1990-1995).
- The second most common cancer in men is cancer of the prostate. Its incidence has been increasing from 12.5 per 100,000 male population in the period 1980-1982, to 19.6 per 100,000 male population in 1993-1995.
- Other male RH concerns are sexual dysfunctions such as impotence, premature ejaculation, and erection dysfunctions.
- In a review of 177 women's health projects in five cities, it was found that 47 percent of the projects involved men in the areas of RH, domestic violence, and STD/HIV-AIDS, although male participation in RH was peripheral (Lee, 1996).
- Other surveys show that men are beginning to share somewhat in household chores, such as caring for sick members of the family, shopping for food, and preparing household budgets (POPCOM, 2001a).

### **Prevention and treatment of infertility and sexual disorders**

- Data on infertility reveals that 10 percent to 15 percent of couples are not able to conceive after a year of unprotected, adequately-timed intercourse (WHO, 1986).
- There has been little or no service available to infertile couples in the country probably because only 2 percent of women are considered infecund (1998 NDHS and 1993 NSMS as cited in POPCOM, 2001a).
- There is no data at all for infertile men and services for infertility are provided only by a few training hospitals in the country. Infertile couples, particularly in rural areas, resort to traditional rituals and use of herbal medicines



## Adolescent Health Risk Behaviors

### Early sexual activity

- Some 2.5 million or 18 percent of the youth (1.8 million boys and 670,000 girls) already had premarital sex and around 80 percent were not using any method of protection.
- There were also indications that about 10 percent of girls with experience having sex were forced into sexual relations by their partners and that many young people engaged in premarital sex are without adequate knowledge on how to avoid pregnancy or STIs.
- Thirty-seven percent of those who admitted being sexually active are at risk for a variety of reasons, including having multiple partners, engaging in commercial sex, and using intravenous drugs.
- YAFSS II data further reveal that about 48 percent of sexually active youth (38 percent, males and 72 percent females) engage in repeated sexual intercourse with the same partner after the first time. Young males are more likely to have a repeat of sexual activity not only with the same partner but also with others. The pattern observed is that once a young person gets initiated into premarital sex, a "repeat" either with the same partner or with another, is likely.
- The "buntog" phenomenon, which is a ritual exchange of sex within a youth peer group and seen as either a result of seeking acceptance among peers or in reaction to family breakdown and stress, has led girls in cities like Davao and Cebu into exchanging sex for money, shelter, and food (Varga, 2001; Cabigon, 2002).
- Between 1960-1990, for ages 20-24, single males increased from 66 percent to 73 percent, and females from 44 percent to 56 percent (Xenos and Raymundo, 1999). In 1994, 13 percent of young Filipinas were already married by age 18; 43 percent by age 21 and 60 percent by age 24 (Balk and Raymundo, 1999), a level higher than in most other Asian countries.
- The number of teenagers who have begun childbearing is increasing, although still below 10 percent of all women of reproductive age based on the 1993 NDS and 1998 NDHS (Cabigon, 2002). Teenage childbearing is much higher among rural and low educated females. Fertility among adolescent women declined by about 8 percent in the five years before the 1998 NDHS. More women today delay childbearing past their teen years compared to a generation ago. The reverse is true among less-educated women. Young women today generally want smaller families.



- According to YAFSS II, 33 percent of young women between 20-24 years old already gave birth to their first child before reaching their 21<sup>st</sup> birthday. Of the total 1.8 million young women who already had sex, 94 percent said they were unwilling and unprepared to become parents.
- Young pregnancies account 12 percent of normal deliveries, 6 percent of spontaneous abortions, 3 out of 4 maternal deaths, 10 percent of forced first sexual relations, 30 percent of births to females in reproductive ages, 30 percent of marriages below 20 years old among those aged 15-24, and 74 percent of illegitimate births (JOICFP, 1998). Some 21 percent of these illegitimate births were among the 15-19 age group and 53 percent among the 20-24 age group.
- Young pregnancies account for 17 percent of induced abortion cases. Teenagers who have unprotected sex or unwanted pregnancies are more likely to resort to abortion. The largest proportion (28%) of women who had induced abortion complications belonged to the 20-24 age group (Raymundo et al., 2001). Restricted access to contraceptive supplies and RH services, plus social pressure of shame and guilt, influence the relatively high rates of abortion among young women (Cabigon, 2002).

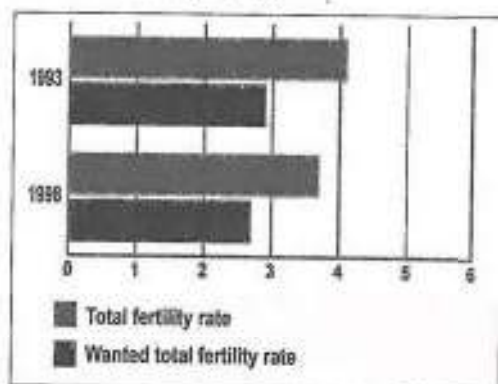
### Additional Data:

(Source: Alan Guttmacher Institute Publication, Research in Brief "Improving Reproductive Health in the Philippines", May 2003.)

The average woman in the Philippines today has four children, whereas her counterpart 40 years ago had seven.<sup>5</sup> Modernization, the changing role of women, severe poverty in some regions, the rise in the value of educating children and an increased desire to improve the quality of life all have contributed to this reduction in fertility. However, women want even smaller families than they have (**Chart A**). The wanted total fertility rate was one child lower than the total fertility rate in 1998.† Although this gap had decreased somewhat since 1993 (when it was 1.2), the level of unwanted childbearing was very high: About one-quarter of the average woman's lifetime births were unwanted (that is, they occurred after she had decided that she wanted no more children or at a time when she specifically said that they were unwanted). On average, Filipino women have one child more than they want.

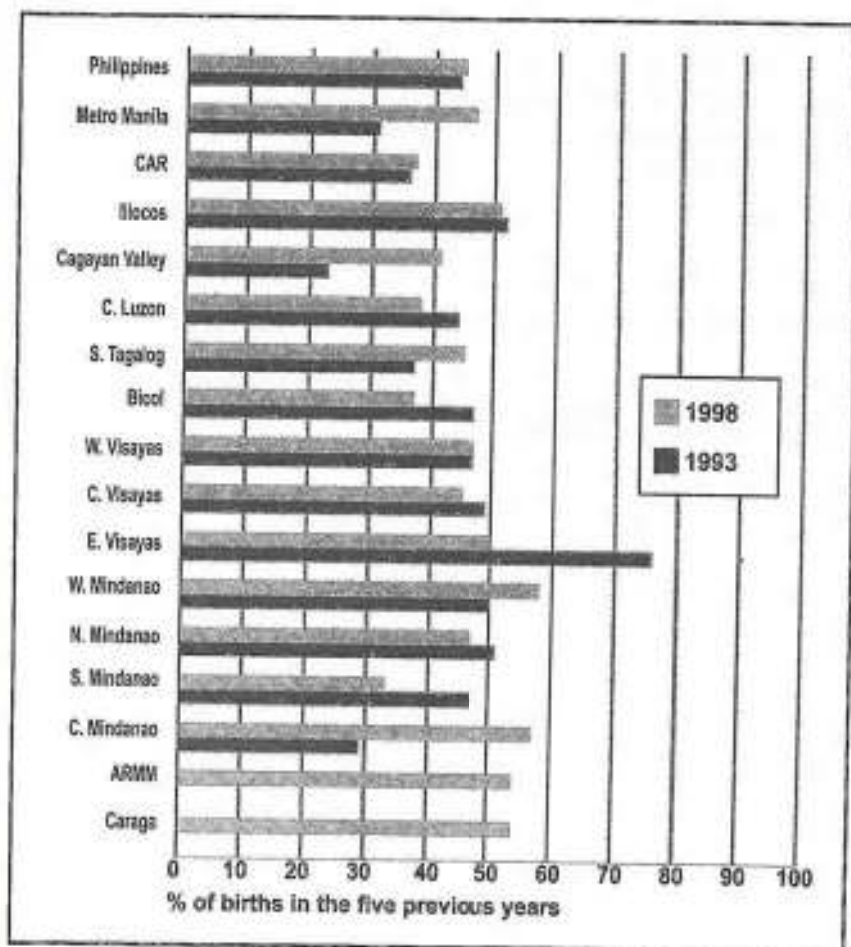
**chart a Total and Wanted Fertility**

On average, Filipino women have one child more than they want.



**chart b Unintended Births**

Significant proportions of births are unwanted or mistimed.



Induced abortion is one method that Filipino women use to meet their reproductive goals.

Nationally, the estimated annual abortion rate in the mid-1990s was 25 per 1,000 women aged 15-44; this rate corresponds to about 400,000 abortions each year. While women in every region had abortions, the rate varied considerably across regions (Chart C). Metro Manila had the highest rate — 41 per 1,000, representing an estimated 105,000 abortions. Some regions, generally those in more rural parts of the country, had rates lower than 10 abortions per 1,000 women.

chart C Abortion Rates

Abortion rates vary widely by region.



Notes: CAR=Cordillera Administrative Region.  
ARMM=Autonomous Region of Muslim Mindanao.

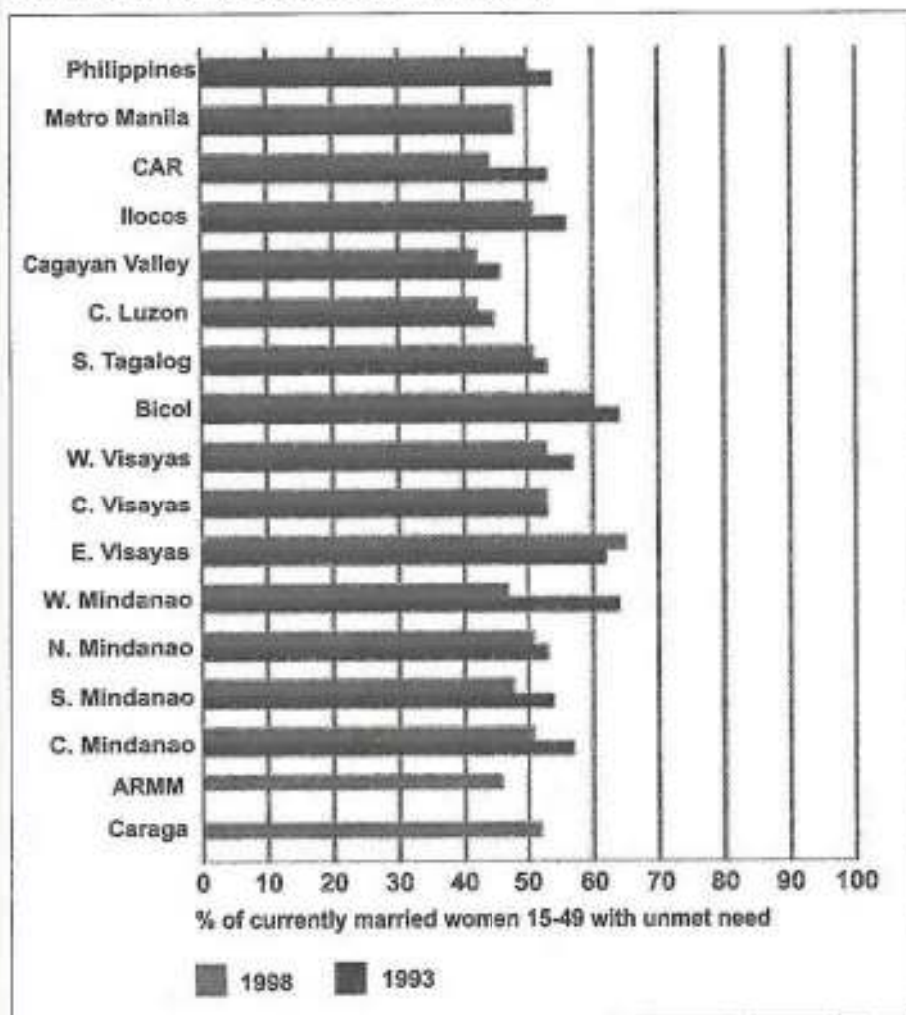


A 1994 survey in three large hospitals, each in a different region, showed that women of all social classes seek and obtain abortions. Compared with the general population, women who are in cohabiting (live-in) unions, those who are better educated and those from households with six or more children are overrepresented among women who are hospitalized for abortion complications.<sup>9</sup>

An estimated 100,000 women are hospitalized and treated each year in the Philippines for complications due to induced abortion.<sup>9</sup> A 1994 study showed that the most common medical complications are fever (accounting for 67% of hospitalizations for complications), abdominal pain (33%) and excessive bleeding (14%).<sup>10</sup>

### chart d Unmet Need

About half of currently married women in all regions have an unmet need for effective contraception.



Notes: CAR=Cordillera Administrative Region. ARMM=Autonomous Region of Muslim Mindanao.

**Table 1**

Percentage distribution of married women aged 15-49, by current contraceptive use, and percentages relying on the most commonly used methods, all according to region and residence, Philippines, 1993 and 1998

| Region and residence | Any method |      | Modern* |      | Traditional† |      | No method |      | Total |      |
|----------------------|------------|------|---------|------|--------------|------|-----------|------|-------|------|
|                      | 1993       | 1998 | 1993    | 1998 | 1993         | 1998 | 1993      | 1998 | 1993  | 1998 |
| All                  | 40         | 48   | 25      | 28   | 15           | 20   | 60        | 52   | 100   | 100  |
| Region               |            |      |         |      |              |      |           |      |       |      |
| Metro Manila         | 42         | 50   | 27      | 28   | 15           | 22   | 58        | 50   | 100   | 100  |
| CAR                  | 39         | 42   | 23      | 30   | 16           | 12   | 61        | 58   | 100   | 100  |
| Ilocos               | 39         | 44   | 22      | 29   | 17           | 15   | 61        | 56   | 100   | 100  |
| Cagayan Valley       | 41         | 48   | 32      | 39   | 9            | 10   | 59        | 52   | 100   | 100  |
| C. Luzon             | 44         | 56   | 31      | 35   | 13           | 20   | 56        | 44   | 100   | 100  |
| S. Tagalog           | 35         | 47   | 23      | 26   | 13           | 20   | 65        | 53   | 100   | 100  |
| Bicol                | 36         | 40   | 16      | 19   | 20           | 22   | 64        | 60   | 100   | 100  |
| W. Visayas           | 40         | 46   | 24      | 25   | 16           | 21   | 60        | 54   | 100   | 100  |
| C. Visayas           | 46         | 51   | 29      | 28   | 17           | 23   | 54        | 49   | 100   | 100  |
| E. Visayas           | 36         | 43   | 18      | 16   | 18           | 26   | 64        | 57   | 100   | 100  |
| W. Mindanao          | 28         | 45   | 17      | 30   | 12           | 16   | 72        | 55   | 100   | 100  |
| N. Mindanao          | 49         | 55   | 31      | 34   | 18           | 21   | 51        | 45   | 100   | 100  |
| S. Mindanao          | 46         | 55   | 27      | 36   | 19           | 20   | 54        | 45   | 100   | 100  |
| C. Mindanao          | 33         | 46   | 21      | 29   | 12           | 18   | 67        | 54   | 100   | 100  |
| ARMM                 | na         | 19   | na      | 9    | na           | 10   | na        | 81   | 100   | 100  |
| Caraga               | na         | 50   | na      | 28   | na           | 21   | na        | 50   | 100   | 100  |
| Residence            |            |      |         |      |              |      |           |      |       |      |
| Urban                | 43         | 52   | 28      | 31   | 15           | 21   | 57        | 48   | 100   | 100  |
| Rural                | 37         | 44   | 22      | 25   | 15           | 19   | 63        | 56   | 100   | 100  |



| Region and residence | Most commonly used methods |      |                      |      |                   |      |            |      |
|----------------------|----------------------------|------|----------------------|------|-------------------|------|------------|------|
|                      | Pill                       |      | Female sterilization |      | Period abstinence |      | Withdrawal |      |
|                      | 1993                       | 1998 | 1993                 | 1998 | 1993              | 1998 | 1993       | 1998 |
| All                  | 8                          | 10   | 12                   | 10   | 7                 | 9    | 7          | 9    |
| Region               |                            |      |                      |      |                   |      |            |      |
| Metro Manila         | 9                          | 11   | 15                   | 12   | 7                 | 10   | 8          | 10   |
| CAR                  | 3                          | 7    | 16                   | 15   | 7                 | 4    | 8          | 7    |
| Ilocos               | 7                          | 10   | 13                   | 13   | 6                 | 3    | 11         | 11   |
| Cagayan Valley       | 15                         | 16   | 13                   | 12   | 3                 | 3    | 6          | 6    |
| C. Luzon             | 9                          | 12   | 19                   | 19   | 3                 | 6    | 10         | 13   |
| S. Tagalog           | 6                          | 8    | 12                   | 12   | 5                 | 6    | 8          | 12   |
| Bicol                | 6                          | 8    | 7                    | 5    | 8                 | 6    | 12         | 9    |
| W. Visayas           | 10                         | 8    | 10                   | 9    | 10                | 12   | 6          | 7    |
| C. Visayas           | 10                         | 8    | 12                   | 7    | 9                 | 15   | 8          | 8    |
| E. Visayas           | 6                          | 4    | 10                   | 7    | 10                | 10   | 7          | 10   |
| W. Mindanao          | 9                          | 16   | 6                    | 4    | 7                 | 10   | 3          | 3    |
| N. Mindanao          | 12                         | 14   | 8                    | 5    | 13                | 13   | 4          | 7    |
| S. Mindanao          | 8                          | 14   | 11                   | 7    | 11                | 13   | 7          | 6    |
| C. Mindanao          | 7                          | 8    | 6                    | 9    | 8                 | 10   | 3          | 6    |
| ARMM                 | na                         | 4    | na                   | 3    | na                | 2    | na         | 1    |
| Caraga               | na                         | 9    | na                   | 8    | na                | 13   | na         | 6    |
| Residence            |                            |      |                      |      |                   |      |            |      |
| Urban                | 9                          | 11   | 14                   | 13   | 8                 | 9    | 7          | 9    |
| Rural                | 8                          | 9    | 10                   | 8    | 7                 | 8    | 7          | 8    |

\* The pill, IUD, injectable, spermicide, barrier methods, and male and female sterilization. †All forms of periodic abstinence (calendar, Billings, mucus, basal body temperature, symptothermal and lactational amenorrhea), withdrawal, breastfeeding and other, local methods. Notes: na=not applicable because the region was created after 1993. CAR=Cordillera Administrative Region. MM=Autonomous Region of Muslim Mindanao.



| INDICATOR   | National |       |       |
|---|----------|-------|-------|
|   | Total    | Urban | Rural |
| <b>Maternal Health</b>  |          |       |       |
| <i>% of women w/ a livebirth in the 5-yrs before the survey</i> |          |       |       |
| No antenatal care   | 6        | 5     | 7     |
| Received 2+ doses of tetanus toxoid                             | 37       | 37    | 38    |
| <i>% of livebirths in the 5-yrs before the survey</i>           |          |       |       |
| Delivered in a health facility                                  | 38       | 54    | 22    |
| Assisted by a doctor nurse or midwife at delivery               | 60       | 79    | 41    |

| INDICATOR                                     | National |       |       |
|---|----------|-------|-------|
|   | Total    | Urban | Rural |
| <b>Family Planning</b>                        |          |       |       |
| <i>% of currently married women age 15-49</i> |          |       |       |
| Currently using any method                    | 49       | 50    | 47    |
| Currently using any modern method             | 33       | 34    | 33    |
| Unmet need for family planning                | 17       | 15    | 20    |

| INDICATOR   | National |       |       |
|---|----------|-------|-------|
|   | Total    | Urban | Rural |
| <b>HIV/AIDS and Tuberculosis</b>  |          |       |       |
| Women who know that AIDS can be prevented by using condoms and limiting sex to one uninfected partner (%) | 45       | 46    | 43    |
| Men who know that AIDS can be prevented by using condoms and limiting sex to one uninfected partner (%)   | 56       | 57    | 55    |
| <i>Source: 2003 National Demographic and Health Survey Key Findings</i>                                   |          |       |       |

| INDICATOR  | National |       |       |
|--|----------|-------|-------|
|  | Total    | Urban | Rural |
| Total Fertility Rate                             | 3.5      | 3.0   | 4.3   |
| Mean ideal number of children per woman          | 3.0      | 2.8   | 3.2   |
| Median age at first marriage for women age 25-49 | 22       | 23    | 21    |
| Median birth intervals (months)                  | 31       | 31    | 30    |

**Maternal Mortality by Main Cause**  
**Number Rate/1000 Livebirths & Percentage Distribution**  
**Philippines, 2000**

| Cause   | Number       | Rate       | Percent      |
|---|--------------|------------|--------------|
| 1. Other Complications related to pregnancy occurring in the course of labor, delivery and puerperium | 769          | 0.4        | 45.3         |
| 2. Hypertension complicating pregnancy, childbirth and puerperium                                     | 431          | 0.2        | 25.4         |
| 3. Postpartum hemorrhage  | 345          | 0.2        | 20.3         |
| 4. Pregnancy with abortive outcome  | 152          | 0.1        | 9.0          |
| 5. Hemorrhage related to pregnancy  | 1            | 0.0        | 0.1          |
| <b>Total</b>  | <b>1,698</b> | <b>1.0</b> | <b>100.0</b> |

*Source: Philippine Health Statistics, 2000*

**Maternal Mortality Rate (2000): 1.0**  
**Maternal Deaths by Region**  
**Philippines, 2000**

| Area                          | Maternal Deaths |
|-------------------------------|-----------------|
| Philippines                   | 1,698           |
| NCR (Metro Manila)            | 164             |
| CAR (Cordillera)              | 23              |
| Region 1 (Ilocos)             | 86              |
| Region 2 (Cagayan Valley)     | 60              |
| Region 3 (Central Luzon)      | 129             |
| Region 4 (Southern Tagalog)   | 272             |
| Region 5 (Bicol)              | 192             |
| Region 6 (Western Visayas)    | 129             |
| Region 7 (Central Visayas)    | 186             |
| Region 8 (Eastern Visayas)    | 102             |
| Region 9 (Western Mindanao)   | 73              |
| Region 10 (Northern Mindanao) | 63              |
| Region 11 (Southern Mindanao) | 114             |
| Region 12 (Central Mindanao)  | 42              |
| ARMM                          | 50              |
| CARAGA                        | 12              |
| Foreign Countries             | 1               |
| Residence not stated          | -               |

*Source: Philippine Health Statistics, 2000*

**Answer Format**  
**Exercise in Integration of RH and Gender**

| Reproductive Health Data<br>(use specific data from previous<br>exercise) | Explanation of the Data Using<br>Gender Concepts |
|---|--|
|   |  |
|   |  |
|   |  |
|   |  |



# MODULE 4

## **Client-Centered and Rights-Based Integrated Reproductive Health Service Delivery**

*SESSION 4.1* Concept of Integration

*SESSION 4.2* Integration at the Clinic Level

*SESSION 4.3* Gender-Responsive and  
Rights-Based IRH for Health Facilities

*SESSION 4.4* Action Planning

# Client-Centered and Rights-Based Integrated Reproductive Health Service Delivery

## Overview

The practical application of the lessons learned from the Gender and RH module will be shown through reproductive health services that are client-centered and rights-based. This module will present an integrated approach to reproductive health care service delivery at the clinic facility level through the application of the principles of gender and rights responsiveness.

The Objectives for this Module are to:

1. Describe the operational framework for a client-centered integrated reproductive health services in health facilities; and
2. Demonstrate how gender-responsive and rights-based integrated reproductive health is implemented in a health facility.

## Session 4.1: Concept of Integration

### Introduction:

This section will provide an overview of what integration is, why there is a need for integration of RH at the clinic level and of the various integration approaches that are currently in practice.

|                   |   |
|-------------------|---|
| <b>Objectives</b> | By the end of the session, participants would be able to: <ul style="list-style-type: none"> <li>• Assess a client's reproductive health situation through a gender lens; and</li> <li>• Explain the concept of integration.</li> </ul> |
| <b>Time</b>       | 1.5 hours   |
| <b>Equipment</b>  | LCD or Overhead Projector, Computer (if using LCD)  |
| <b>Materials</b>  | PowerPoint Presentation on the Framework; pad paper, pens   |
| <b>Handouts</b>   | <ul style="list-style-type: none"> <li>• Handout #4.1: Case Studies for Gender/RH Integration</li> <li>• Handout #4.2: Layers of Integration Concepts</li> <li>• Handout #4.3: Integration Framework</li> </ul>                         |

## Activity 4.1a The Concept of Integration

### *Notes for the Facilitator:*

1. Integration is not a new concept in health service delivery. At the health facility level, integration takes place automatically when service providers treat several problems at the same time. However, a conscious effort to integrate gender principles with reproductive health services is a result of knowledge about gender and applying this knowledge to the day-to-day operations in the clinic. The next exercise will provide opportunities to look at gender and RH in a holistic manner.
2. Facilitator explains to the participants that the rest of the training will be looking at actual cases of women and men with reproductive health problems. The cases will be assigned to different groups and discussions will be done by group and then in plenary.

The exercise will be done in two steps. The first step is to make a client profile that includes not only the health care problem but also the gender situation of the client. The second step is to look at possible areas of integration at the health facility level.

3. **Step 1: Client Profile Exercise.** The first step in integrating gender and RH is to look at the clients and know their reproductive health care needs within the context of their gender backgrounds. Participants will be assigned case studies that are examples of clients that they may meet in a clinic setting.



Participants will:

- Put together a client profile based on the case studies distributed. The profile will include a gender profile and a reproductive health profile.
- Gender Profile: This may include information on gender roles, gender biases, power dynamics, access/control to resources. Sexual and reproductive health (SRH) rights violated or threatened.
- Reproductive health profile: This includes reproductive health care needs, attitudes, problems and practices.
- Use the format in the Participants' Handouts for the gender and reproductive health profile of the case study.

Facilitator distributes the case studies [**Handout #4.1**] and asks the participants to do the Client Profile Exercise.

4. **Step 2: Elements of Integration.** The second part of the exercise will identify what elements of integration can take place. The integration that they will examine will be in terms of: (1) gender integration, and (2) integration of RH elements.

5. **Questions for each group to answer:**

- **Gender Integration**

Based on the gender profile previously done by your group, what implications would this profile have on the reproductive health of your case?

What implications, if any, would this particular gender profile have on the health service providers?

- **RH Elements Integration**

Which of these RH issues can be addressed at the local health facility level (RHU)?

How will you address these RH issues knowing the existing gender conditions under which the person is living?

6. **Processing:** The term “integration” reflects that one’s sexual and reproductive life is not separable from other health concerns such as contraception, disease prevention and treatment, reproduction, and experience with intimacy and pleasure. For individuals and couples, all of these elements are woven together into sexual and social relationships, interactions, and consequences - personal, medical and social. Since these issues are integrated in the client’s life, it makes sense to provide information and services in an integrated manner. *(From EngenderHealth, Comprehensive Counseling for Reproductive Health – Trainers Manual, 2003).*

Gender sensitivity in a health facility setting and practiced by service providers contribute to the effectiveness of the overall healing process and ensure that the service are indeed “client-centered.”

The term “integration” when applied to reproductive health means different things at different levels. For instance, integration could mean programmatic or process integration (see definition of “process integration” on p. 165).

## Layers of RH Integration: [Handout #4.2]

- a. **Integration of gender and rights with reproductive health** – takes into consideration the underlying social constructs that determine how men and women relate to each other and how these affect their reproductive lives. Integrating gender and reproductive health is included in the Cairo Program of Action which was adopted during the 1994 International Conference on Population and Development (ICPD). Reproductive health recognizes that gender determinants of health-seeking behavior need to be taken into consideration if a holistic viewpoint is to be achieved.
- b. **Integration of RH elements in the delivery of health services** – recognizes that women and men who seek health care services may have underlying conditions that influence or add to their overall health. A woman, for example, seeking contraceptive services may have STIs/RTIs, may be a victim of VAW, and need information on sexuality. Integration at the clinic level of various elements of RH must be done up to whatever the technical capacity of the service provider is. There has to be, however, a conscious effort on the part of the clinic staff to approach reproductive health in a holistic manner.

### Box 19

#### Training Information

According to the ICPD Programme of Action, "Reproductive health care programs should be designed to serve the needs of women, including adolescents, and must involve women in the leadership, planning, decision-making, management, implementation, organization and evaluation of services..." Given this mandate, a successful gender-integrated RH program promotes the empowerment of women and supports gender equity/equality goals to enhance RH outcomes for all.

An equitable approach to RH/HIV/AIDS services and programs focuses on the different needs of women, men, adolescents, and communities. In order to eliminate gender disparities, women and men must actively participate in reproductive and sexual decision-making. Moreover, it is critical that adolescent boys and girls be involved and their concerns addressed if sustainable and equitable reproductive health outcomes are to be achieved.

Based on the experience of a number of programs around the world, five principles are fundamental to RH/HIV/AIDS programs that integrate gender: 1) working through community partnerships; 2) supporting diversity and respect; 3) fostering gender accountability; 4) promoting human rights, including reproductive rights; and 5) empowering women, men, youth, and communities.



- c. **Programmatic and process integration** – This aspect of integration deals with the administration and management of clinic programs and health projects that approach the delivery of services and provision of health care in an integrated fashion – client-centered, gender appropriate and responsive with a high degree of technical competence.

#### Box 20

### Training Information

#### 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

## Framework for Integration

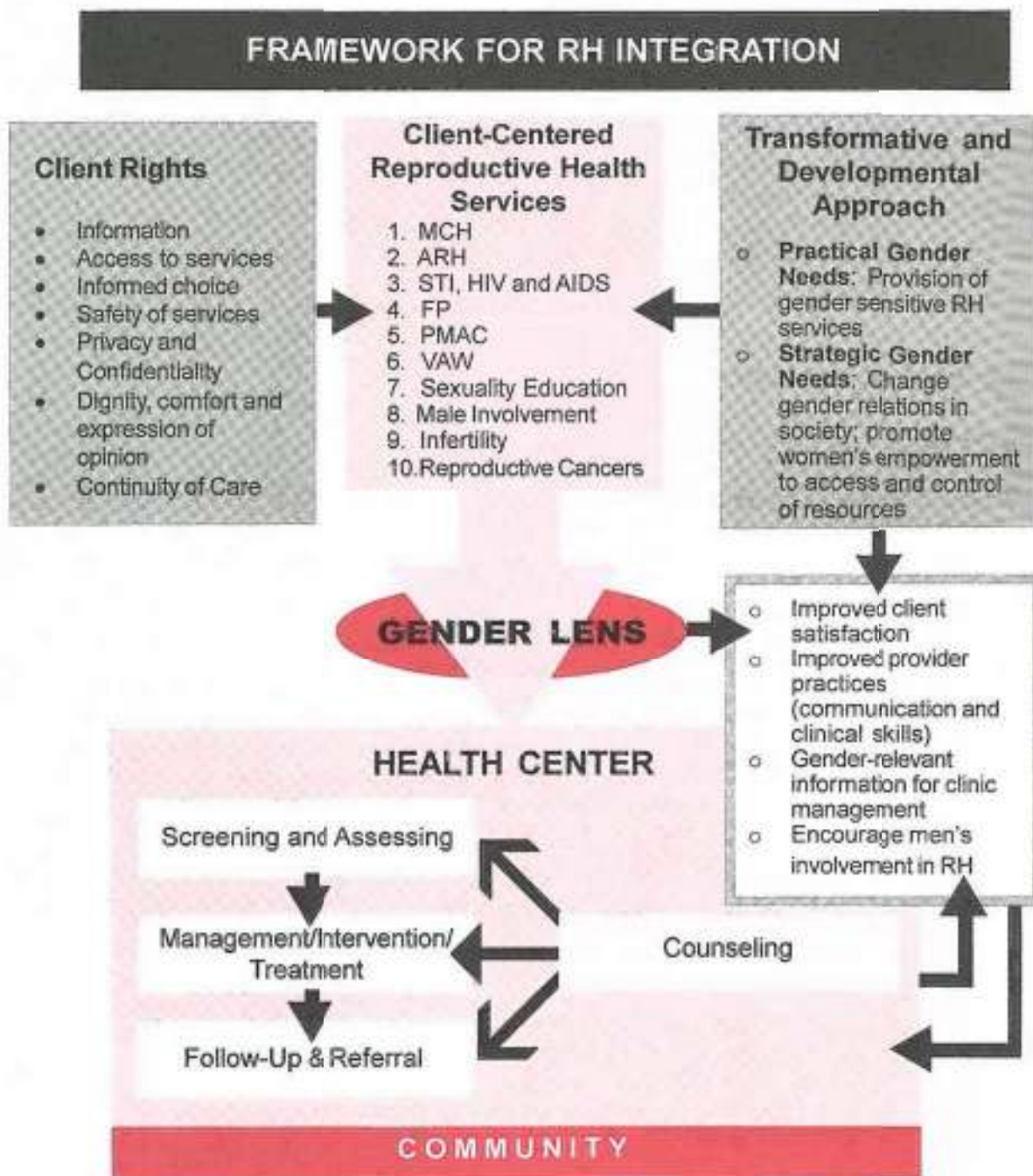
### Notes for the Facilitator:

1. Based on the client profiles, the participants will now look at the clients in terms of integrating both gender and RH concerns. The rest of the training will look at the health center specifically, at the reproductive health services being provided, with a **gender lens**.
2. A gender lens will incorporate the perspective of the client and the exercises that will be done will provide opportunities to practice gender sensitive approaches to the delivery of health services. Gender lens also means that the service provider will take into consideration the social constructs that make up the sum of experiences of the client, how these social constructs influence her/his decisions and her/his health. Having a gender lens will also allow the clinic service provider to apply gender-sensitive interventions that will allow empowerment and acknowledge the client's rights. Gender lens could be applied to achieve the following
  - a. Improving the satisfaction of both female and male clients with the way they are received and cared for at the health facilities;
  - b. Improving provider practices, including communication and clinical skills;
  - c. Using gender-relevant information to establish policies, set goals, develop strategies, and organize and evaluate operations;
  - d. Strengthening management systems that support gender-sensitive services, including human resources, logistics and information management; and



- e. Encouraging men to develop responsibility in respecting women's reproductive rights.
3. The diagram of the framework also shows that client-centered reproductive health is presented in only one box, which puts emphasis on the holistic approach to RH. Oftentimes, when clients come to the clinic, they do so because of a specific ailment or need. The gender integrated approach will expand the provision of services to encompass the whole person. Assessment, counseling, treatment and examination will include the other elements of RH that will provide a clearer picture of the client's real needs.

**Handout 4.3**



## Case Studies

### 1. Manang Pacita

Born in Kiangon, Ifugao, Manang Pacita was formerly employed as a utility worker at an inn in the nearby town. Having been accused of connivance with a politician who lost in the previous elections, she was laid-off from work. Since then, she joined her husband in tilling their farm.

At 38, Manang Pacita has five live children to rear and support. For her, family planning nowadays is necessary because life is hard, as aptly opined, "*kasapulan ta narigat ti biag*". Asked what FP methods she had been using, she just gave an impish smile and said, "*awan*" (nothing). She expressed fear for the use of any contraceptive method due to the perceived side effects. Besides, her husband, Manong Roger, prefers a bigger family, as children are regarded as security for their old age.

Nothing has changed since the time she left town for farm life. She describes her life as *narigat* (difficult), for she is constantly plagued by violence and suffering. Manong Roger is an alcoholic, and was constantly suspicious and jealous of Manang Pacita. When she still worked in town, they would quarrel over his unfounded suspicions. Now that she has gone back home and worked together with Manong Roger in the fields, he still gets jealous. She has become paranoid and would always be on her toes every time her husband would come home drunk. Her husband has violent tendencies. Oftentimes, he lashes out doors, boxes the wall, yells at her, and slaps and beats her. Manang Pacita already suffers from *nerbiyos* (nervousness). Unfortunately, this was a cause for one miscarriage, which was attended to by the *hilot*.

Manong Roger's disinclination for farm work due to hangover compelled Manang Pacita to take on the arable farm in order to catch up with the planting season. At bedtime, she cannot help but think about tomorrow. Where will the money for the children's education, kitchen needs, and farm work come from? While she believes that sex is part of marital life, and it is her husband's right and her obligation as a wife to give in to his demand, she could not even think of it anymore because her mind is too preoccupied with thoughts of obtaining salt for tomorrow.

With the thought of making both ends meet, Manang Pacita never realized the very poor health management she gave her children. She fed them any kind of food, which caused their loss of appetite. She never even bothered to clean up her children after retiring from a day's play. It was not until one child contracted UTI that she learned that the kind of food fed to her children and the lack of hygienic practices could cause UTI. She was thankful that it was cured from a decoction of medicinal herbs.

Reproductive health is always the least preoccupation of Manang Pacita. Within the vicinity lives her very old and weak mother-in-law. Manang Pacita frequents her shelter to check on her and feed her. Occasionally, when the children are home, she requests them to feed and watch over their grandmother. But the children complain and refuse to attend to their grandmother due to the stench of her vaginal discharge. Manang Pacita claims her mother-in-law began to excrete such after menopause.



Despite the daily bath and cleansing she gives her, such secretion never stopped. Asked why the medical inattention, she said her mother-in-law feels terribly embarrassed every time they attempted to visit the health center. Manang Pacita mutually shares the sentiment, and after a few visits, they stopped consultations.

Unfortunately, Manang Pacita has recently been agonizing over her putrid vaginal discharges, too. She expressed humiliation in seeing a doctor. As a palliative measure, she instead sought the assistance of a *hilot*, who gave her abdominal massages. She also uses herbal medication, an advice given by fellow women in her community.

Her main concern now is how she contracted her ailment? She hears several possible causes. Was she contaminated by her mother-in-law's disease? Could it be menopausal syndrome? Could it be cancer? Or could it also be a sexually transmitted infection?

## 2. Brenda

Brenda of Sadanga is married to Manong Pedro, a 42-year-old man who comes from Abra. She is the second wife of Manong Pedro. She never thought she would get impregnated because of talks that her husband is impotent, a perceived cause to his first marital break-up. As of the interview, Brenda is five months pregnant with her second child. Her eldest child is only one year old.

At 25, Brenda perceives that it is actually sexuality that makes a man and a woman cohabit, and it is now her personal choice why she is married to this much older man. She expressed that sex is a wife's obligation to her husband, "*ited tapnu awan iti riri*" (give in to avoid quarrels). There are times when she refuses, her husband accuses her of having another man, "*nu agmadi, kuna ti lalaki nga adda pangitedan nga sabali iti babai*" (If refused, the man says that the woman [wife] might have some other man).

In matters of family planning, Brenda shares that it is for both of them to decide upon. However, if given the choice, she feels that there is a need to limit the number of children, "*ta narigat iti biag*". She, however, fears the side effects of modern contraceptives. The seasonal job of her husband serves as a natural impediment to pregnancy. Her husband is a carpenter, who, most of the time, is deployed in other places. He comes home when construction work is over, and he then assumes farm work.

While she believes that men are the heads of their families and have to support and decide for their families, their set-up mobilizes her to work, think, and decide for her self and her child. When Brenda does not baby sit, she goes to the field. Working in the field is perceived to be a form of exercise and would facilitate child delivery. She solely does household chores and child care. But since the birth of her first child, she opened a small retail store to augment their income.

She complains of "*tannog*" (physical fatigue), moodiness and irritability. This is aggravated by the fact that she is on the family way. Culture, however, dictates that her marrying at an early age merits her ability for productive and reproductive work.



While she could become a *"nasaayat nga ina"* (good mother), what she cannot sometimes tolerate is her husband's mean treatment of her.

One concern that Brenda raised was having a drunkard husband. Even when Brenda is pregnant, she is slapped and beaten up. When Manong Pedro is not drunk, he apologizes and promises not to beat her again. He repeatedly affirms his love for his wife and child. Yet, when he gets drunk he lapses into his old habit of slapping and beating her.

Upon seeking the advice of the older womenfolk, they expressed disapproval of Brenda's answering back at her drunken husband. They say it is inappropriate and justifies this as a reason for her being battered. They advised her to be more lenient and forbearing. She should keep quiet and give in to the demands of Manong Pedro, for that is how a wife should be.

Brenda expressed her annoyance, *"makauma, kanayon metten"* (it's exasperating, he does it often). Tolerance and patience are virtues, but becomes *katangahan* (foolishness) when these virtues are abused, she reasoned out. She also averred that her husband's marital failure with his first wife is not because of impotence, but probably because she was indeed a battered wife, just like Brenda now. She is vacillating between leaving her husband and keeping her family together.

### 3. Susana

Susana is a forty-year old rural woman, married to a farmer who, like her, has almost no formal education. While living a hand-to-mouth existence, she gives pride to her husband's capability to support her and her four children, out of mere diligence and perseverance.

When asked what her concept of health was, she associated it with being *"naragsak"* (happy) and the absence of physical infirmities. A happy family, she adds, should have happy family members. Everyone stays well, as health care is perceived as expensive and unaffordable. Instead of spending money on medication, their limited income should rather be spent on food.

Sharing her thoughts on motherhood, she thinks that a mother should be accorded utmost respect for bearing and nurturing children. It is clear to her that as a mother, she should stay home and raise her children well, be responsible for the upkeep of the home, while her husband goes out to farm. She believes that the husband's primordial role is to earn a living for the family.

On family size, Susana says she did not want too many children. This is probably a reflection of her experience when she was a young girl, having come from a family of a dozen children. The lack of provisions and basic education, and medical inattention has been repercussions of a big family. Unfortunately, her husband asserts that they should not refuse what God wants to give them. As an optimist, he says they can support more children. He did not want any of the family planning methods being offered because of fear of side effects. Such outlook was influenced by stories heard in the community on the adverse effects of the different family planning methods. They have heard of a cousin who gradually lost weight for using pills and then IUD.

Another cousin suffered from infection when she had ligation. He also has his mind set against vasectomy. This is perceived to lessen men's virility. He fears that once he undergoes vasectomy, he would not be able to satisfy his wife anymore, or even weaken his body for physical work.

She never realized the essence of having her children registered, not until her fourth child. On health knowledge and skills, Susana says an itinerant traditional birth attendant, who was more accessible then, assisted her in her first deliveries. It was a normal occurrence during her first three deliveries to experience *manas*. This, however, subsided when she has already given birth. On her fourth delivery, it was a midwife that assisted her.

She expressed conflicting practices between traditional knowledge handed down to her by elders from what the Young Mother's Class taught her after the child's delivery. It was her usual practice to bathe the baby with warm water right after delivery, as instructed by her folks, but the mothers' classes taught her to bathe the newborn with oil first and then alcohol is applied for cleaning the umbilical cord.

To augment her lactation problem, she fed her babies soup, mashed sweet potatoes, bananas and rice porridge. She contends that all went well with her kids. In terms of immunizations, only her youngest have acquired complete dosages. All her other children had not been given sufficient immunizations because it (i.e., Hepatitis B immunization) was not for free.

A source of discomfort for Susana is the frequent quarrels between her three sons. She could not sometimes control her temper and her children get a lot of scolding and beatings. Unfortunately, what she perceives as discipline for children is nowadays perceived as child abuse. She averred:

"Ay samo eyak getken ay waday makmakwani as child abuse. Baken laeng gayam mang al-alpak wenna mangdangdangran si unga, wenna inayon na gayam pati nan ikkan ay kumali...Idwani maawatak san gapo no apay nga isumsumsuma nan kaarubak sak-en sin ik-ikkak sin an-ak ko. Adik oppay ammo ay child abuse et san dey da inik-ikkak ken daida."

(I did not know that there is such a thing as child abuse. I have learned that it does not only mean doing physical harm to the child, but it also includes verbal abuse. Now, I understand why my neighbors always call my attention, and advise me to deal properly with my children. All the while, I have been abusing my own children.)

Another concern that worries her and her husband is the softness they see in the character of their second son. They notice their son manifests feminine traits, which has caused frequent scolding, and at times spanking. "*Agbakla-bakla sin an-ak ko...kababain, mangirurumen, naalas*", was a description they attributed to their son. However, a friend advised her to accept the child as he is, especially if he finds happiness in being such, but it is her husband that they have to convince on this matter.



## 4. Cynthia

Cynthia is 17 years old. She came to Manila two years ago with her first cousin, Lourdes. Cynthia stopped going to school when she was 14 and the offer for a job in Manila was too good to pass by. The job offer was as a factory worker making bags in Bulacan. The job was first offered to Lourdes through a visiting friend of the owner of the only dry goods store in Sangcub, Zamboanga del Norte. The parents of Lourdes would not allow her to leave by herself so she brought Cynthia along.

When they got to the Pier in Manila, no one met them. In the waiting shed, they met a woman, Mrs. De la Paz who offered to shelter them in her house in Tondo. Mrs. De la Paz owned a carinderia for travelers and truck drivers and in return for board and lodging, Cynthia and Luz were asked to pitch in while waiting for the person who will pick them up.

In the carinderia, Cynthia and Luz were asked to wait on the customers. They worked long hours and had little time to rest. Mrs. De la Paz gave them some money to tide them over but they soon realized that they were going to be stuck in that place since no one came to pick them up. The customers were mostly male and in the late afternoons, they would start drinking. Mrs. De la Paz encouraged the two girls to be "friendly" with the customers and even told them that they could practice their singing using the karaoke in the carinderia. Cynthia had a good singing voice and enjoyed singing so she usually was asked to sing especially when customers were around. Cynthia liked this because she was freed up from waiting on tables and helping out in the kitchen. Soon, Cynthia was made a regular "entertainer" for the carinderia. She was given nice clothes to wear, taught to wear makeup and fix herself up. Mrs. De la Paz saw this as a good thing because customers stayed longer in the eating place and spent more. Lourdes encouraged this new assignment for Cynthia because they had more money to spend during their off days which was on Mondays.

Ricardo is a truck driver for the Global Shipping Company with branches in Baguio, San Fernando and Legaspi. He drives a truck that brings cargo/goods from the Manila Harbor to all of these branches. He is married with four children who are living in San Fernando. Although Ricardo earns enough to support his family, he usually spends for drinks and women while "relaxing" on his trips. While waiting for his truck to be loaded at the Manila Harbor, Ricardo chanced upon Mrs. De la Paz's carinderia. Taking his *pahinante* along with him, he went inside to have a few drinks and *pulutan*. There he saw Cynthia singing. He was immediately attracted to this young girl and tried to attract her attention. Cynthia was smitten by this older man who was treating her like a lady. Pretty soon, Ricardo was bringing her candies and little trinkets which she wore while singing. The next time Ricardo was at the Manila Harbor, he invited Cynthia to go out and watch a movie with him. Cynthia then promised to go out the following day which was Monday. Ricardo did not bring Cynthia to the movie house. Instead they spent the day in a motel.

The following day, Lourdes asked Cynthia what happened during her "date" with Ricardo. Cynthia told Lourdes that she had a most fantastic experience and that she was no longer a virgin. Cynthia was looking forward to the following week when Ricardo will be back from his trip to the Bicol region. True enough, when Ricardo came back, he took Cynthia out again for a whole day.



Ricardo was gone for a couple of weeks after that. However, he would send text messages to Cynthia professing her care and love. When Ricardo came back he spent most of his free time with Cynthia in various motels or in Cynthia's room while Lourdes was not around. When Cynthia expressed her concern about getting pregnant, Ricardo assured her that he was *baog*, and could not get anyone pregnant. This went on for a couple of months.

Two days after Ricardo's last visit, Cynthia began itching and scratching. Then she noticed a foul smelling discharge when she went to the bathroom the following morning. Not knowing what to do, she talked to Lourdes about it. Lourdes advised her to take antibiotics that she knew about. Three days after, she stopped taking the medicines because she thought she was ok already.

However, a day after she stopped taking the antibiotics, her itchiness came back and seemed to be worse than before. Lourdes also did not know what to do anymore and she said that there was a health center a tricycle ride away and maybe Cynthia could go and seek medical help.

## 5. Lando

Lando is the "siga-siga" in the neighborhood. When he is not working as a dispatcher in a warehouse in Valenzuela, Bulacan, he spends time working out in a nearby gym. He likes to wear tight-fitting shirts that show off his muscles and his physique. For a long time, he remained unmarried but had many girlfriends whom he kept stringing along with promises of marriage. This was what he did before he met Cherry.

Cherry worked as an assistant clerk at the warehouse. She was only 19 when she started working, having dropped off from college (taking up computer science) since her family could no longer afford sending her to school. As a 19-year-old girl, she felt she had the world in her hands. She could do anything and had enough left over from her earnings to buy things she wanted. She enjoyed working at the warehouse because she met a lot of men who admired her and flirted with her. She knew all about romance and love but was not too sure about the physical aspect of it. This was before she met Lando.

On Lando's 35<sup>th</sup> birthday, he decided to treat his friends from the warehouse to a karaoke bar in Caloocan. One of his friends invited Cherry to come along. Cherry decided to go since she knew a lot of those who were going and they all promised her a good time. She knew that it was someone's birthday party, so she decided to buy a little gift to give to the birthday celebrant. Lando was already at the Karaoke Bar when the group of Cherry arrived. She was promptly introduced to Lando and he was pleased that she was thoughtful enough to give him a gift even if they did not know each other.

That whole night, Lando could not keep his eyes off Cherry. Cherry also found herself looking at Lando and oftentimes their eyes would meet even when they were sitting at opposite ends of the table.

The next morning, when Cherry arrived at the Warehouse, she saw a rose bud on her table and upon seeing that it was from Lando she was excited and thrilled. Every

morning for the whole week, she received a single rose from Lando. She sought him out to thank him for the flowers and Lando asked if she would like to go out with him. In a couple of weeks, Lando's whole life was centered around Cherry and Cherry reciprocated his feelings. Common friends started teasing them and saying that Cherry was really too young to get involved with an old man like Lando. Cherry, however, loved the caring and attention that she was getting.

In a couple of months of going out and dating, Lando only went as far as kissing Cherry. When he proposed marriage to her, he went as far as kissing her on the lips. The parents of Cherry agreed to a simple wedding and this was done six months after Lando's birthday.

On their wedding night, Lando and Cherry were too exhausted partying and entertaining their friends from the warehouse that they promptly fell asleep after a couple of kisses. Cherry did not know what to expect but was happy that she was able to handle the first night without all of the fuss that her friends were hinting at. The following day, Lando and Cherry went to Tagaytay to spend a couple of days at a hotel there. Cherry was feeling scared and at the same time excited because she was looking forward to this time of intimacy with Lando.

Unknown to Cherry, Lando was beginning to feel anxious since he had a traumatic experience that began when he was 11 years old, when he was abused by his uncle for the three years that his uncle stayed with them. The reason why he could not commit to marriage before was this fear of not being able to consummate the marriage. For Lando, the sexual act was a painful reminder of his abusive experience during his pre-puberty years. He compensated with this feeling of inadequacy by looking and acting "macho."

Needless to say, their daytime in Tagaytay was fun but their evenings were spent cuddling and kissing. Lando read somewhere that he could satisfy Cherry through stimulating her so on the last night in Tagaytay, he did just this. Cherry did not know any better and enjoyed the whole experience thoroughly.

Six months after the wedding, one of Cherry's friends gave her an x-rated movie. Cherry watched it by herself one day when Lando was working overtime. There she realized that she was still a *virgin* and that she has not experienced having sexual intercourse. When Lando came home, she tried to do to Lando what she saw in the movie and, to her surprise, Lando turned away from her and became angry. Trying not to show her disappointment, Cherry turned to her side of the bed and went to sleep.

Two years later during their wedding anniversary, their common friends remarked that Lando and Cherry were an ideal couple - still very much in love but they also told them to hurry up and start a family. Cherry's parents were also asking when they will see their *apos* and that two years is more than enough time to start their family since they will not be around forever. Lando sensed that Cherry was drawing away from him and spending more time with her friends. He started to suspect that she might be seeing someone else and this made Lando more frantic.

Lando went to his best friend Mario and told him about his dilemma. Mario advised him to talk to a professional. Mario mentioned that the doctor in the Rural Health Unit is a male doctor and he knew the doctor personally. The doctor is a good one and could probably give him some advice.



## Session 4.2: Integration at the Clinic Level

### Introduction:

Each client that comes to a health facility is unique. Each client comes with a unique set of circumstances, responses, and outlook in life. As a service provider, one is called upon to look at a client in a holistic manner thus promoting healing of the whole person and not just a disease or an illness.

Part of the healing process includes upholding the personhood of clients, recognizing their rights and fulfilling these rights. The client-provider relationships at the health centers include principles that will facilitate clients in decision-making and uphold their rights as patients/clients. It also includes providing the best possible quality of health care services that is appropriate, responsive and technically sound.

|                   |   |
|-------------------|---|
| <b>Objectives</b> | <p>By the end of the session, participants would be able to:</p> <ul style="list-style-type: none"><li>• Explain what the rights of the client are;</li><li>• State the various ways these rights can be impeded;</li><li>• Identify how service providers can promote these rights;</li><li>• Examine service provider beliefs and attitudes towards various RH needs of clients;</li><li>• Provide a process to resolve differences between provider and client beliefs and attitudes;</li><li>• Describe various approaches to RH communication and counseling;</li><li>• Provide examples on how correct communication and counseling is used in a health facility setting; and</li><li>• Apply Gender-Responsive and Rights-Based approaches and interventions in the procedures at the health facility.</li></ul> |
| <b>Time</b>       | 5 hours   |
| <b>Equipment</b>  | LCD or Overhead Projector, Computer (if using LCD)  |
| <b>Materials</b>  | PowerPoint Presentation on the IRH Framework  |
| <b>Handouts</b>   | #4.4: Exercise - Client's Rights<br>#4.5: Story of Marita<br>#4.6: REDI v. GATHER<br>#4.7: Client Flow  |



## Activity 4.2a Rights of the Client [Handout #4.4]

### Notes for the Facilitator:

1. The 10 Rights of Clients was developed by the International Planned Parenthood Federation (IPPF) for family planning. These rights were modified into seven rights by EngenderHealth.
2. The following are the Seven Rights of the Client:
  - Information
  - Access to Services
  - Informed Choice
  - Safety of Services
  - Privacy and Confidentiality
  - Dignity, Comfort and Expression of Opinion
  - Continuity of Care
3. **Exercise - Group Work:** Participants are divided into groups. They will discuss the rights of the clients and state examples of how service providers can hinder or facilitate these rights. How can the staff promote these rights? How can they impede these rights? What situations can arise?

Depending on time availability and other considerations, the facilitator may introduce alternative exercises to demonstrate how service providers may promote clients' rights. For example, in lieu of or in addition to the matrix exercise, s/he may request the participants to do role play. One participant may be asked to act as the client and another as a health service provider. The group will then process their observations and learnings.

#### 4. Answer Sheet Matrix

| Rights                                     | Service Providers |        |
|--|-------------------|--------|
|  | Promote           | Hinder |
| Information                                |                   |        |
| Access to Services                         |                   |        |
| Informed Choice                            |                   |        |
| Safety of Services                         |                   |        |
| Privacy and Confidentiality                |                   |        |
| Dignity, Comfort and Expression of Opinion |                   |        |
| Continuity of Care                         |                   |        |

## Activity 4.2b The Story of Marita – A Case Study [Handout #4.5]

### *Notes for the Facilitator:*

1. Gender-based differences in access to and control over resources, in power and decision-making, and in roles and responsibilities, have implications for women's and men's health status. They result in: differential risks and vulnerabilities to infections and health conditions; different perceptions of health needs and appropriate forms of treatment; differential access to health services; different consequences or outcomes from disease; and differing social consequences as a result of ill health.
2. Gender may influence health status in the following ways:
  - exposure, risk or vulnerability
  - nature, severity and frequency of health problems
  - ways in which symptoms are perceived
  - health seeking behavior
  - access to health services
  - ability to follow advised treatment
  - long term social and health consequences.
3. **Exercise:** Facilitator introduces the exercise and distributes the case study "The Story of Marita." This exercise could be done as a role play. Participants are assigned to read out the parts of the characters.
4. **Case Study: [Handout #4.5]** Participants read out the parts aloud. After the reading, they group themselves to discuss the questions on gender integration with reproductive health found at the end of the case study.
5. Participants present their discussions in plenary. Facilitator summarizes the learning insights presented by the groups. Areas of emphasis:
  - Marita's experience in the clinic
  - Service provider's (midwife's) viewpoint: gender issues
  - Clinic set-up
  - Male involvement (decision-making)
  - Client's rights
  - Multiple roles
  - Access and control
  - Practical and Strategic Gender Needs

## The Story of Marita

(Source: EngenderHealth Training Manual)

### Scene 1:

*Isang umaga sa BHS ng San Mateo, dinatnan ng midwife si Marita na naka-skedyul magpalagay ng IUD.*

MW: O, ano Marita, handa ka na ba? Ang aga mo, a.

Marita: E, inihatid ko kasi yung mga anak ko sa eskwelahan.

MW: O, kumusta na ang inaanak ko?

Marita: Ayun, ang likot-likot pa rin.

MW: Siyempre, bata, e. Sugurado ka na bang magpa-IUD? Dadalawa pa lamang ang anak mo, a? Anong sabi ni Kumpare?

Marita: Ayaw man niya, e kailangan. Napaliwanagan ko naman, kaya hayun at inihatid pa ako hanggang sa may labasan.

*(Darating ang iba pang mga ina na a-attend ng mothers' class na inihanda ng midwife.)*

MW: O, mga misis, buti dumating kayo. Umpuo muna kayo at may aasikasuhin lang ako sandali. Wala pa naman ung ibang magma-mothers' class.

*(Pabulong kay Marita)* O, baka naman gusto mong umattend ng klase tungkol sa pagpapalano ng pamilya?

Marita: Magpapa-IUD na nga ako, ano! Papa-attend-in mo pa ba ako?

MW: O, sige na. Mahiga ka na rito.

Marita: Mare, wala yata and kurtina mo ngayon?

MW: Pinalabhan ko, e. Maitim na sa alikabok.

Marita: Nahihiya naman yat akong humiga diyan. Nasa may paanan ko yung pinto.

MW: Mare, may kanya-kanyang pekpek and mga yan kaya huwag ka nang mahiya. Kung gusto mo, doon ka na lang humarap sa may bintana.

Marita: E, wala ring kurtina.

MW: Wala naman dumadaan. Mare, napakaselan mo naman. Parang wala ka pang anak. Si Mareng Loleng nga, doon ko pa sa labas pinaanak dahil nabasa ng bagyo itong center – binaha. Sige na't andiyan na yung iba pang mga nanay!



*(Napilitang humiga si Marita. Ilan pang sandali, natapos na ang paglalagay ng IUD.)*

MW: O, mare. Okey na. Mabilis lang naman yan. Sa una'y may mararamdaman kang sakit sa puson. Pag tumindi at dumugo nang sobra o kaya'y pakiramdam mo'y lumalabas, bumalik ka sa akin.

*(Pasigaw)* Susan! Pakikuha nga ng record ni Marita at ng mailagay ko na sa record yung pag-a-IUD ko sa kanya! O, sige Mare, pahinga ka muna diyan habang nag-pe-prepare ako para sa klase ko.

*(Matapos and ilang sandali...)*

Marita: Mare, aalis na ako. Kaya ko na. Dederetso na lang ako sa bahay para tuluyang makapagpahinga.

MW: Sige, mare.

*(Pagkaalis ni Marita...)* Buti pa si Marita, dadalawa ang anak, nag-IUD na. Ang ganda pa tuloy ng pekpek niya.

Susan: Paano mo naman nasabi yan?

MW: Ikaw nga ang maglagay ng IUD sa mga nanay at kung hindi mo Makita ang kanilang mga hinaharap!

Susan: Ikaw talaga, puro kalokohan. Tayo na ngang magsimula ng mothers' class mo!

## **Scene 2:**

*(Kinahapunan, sa bahay nina Susan...)*

Susan: Hoy, Atong. Tama na yang kaka-kalabit mo at apat na ang anak natin. Baka masundan agad yang tatatlong buwan mong anak.

Atong: O, e ano naman?

Susan: Akala mo naman, ganoon kalaki ang suweldo mo. E wala naman akong suweldo sa center bilang CVHW.

Atong: Sige na. Isa lang.

Susan: Buti pa, kung talagang hindi ka mapigilan, magpa-IUD na rin ako. Si Marita nga na asawa nung kainuman mong si Ikong nagpa-IUD kanina.

Atong: Aba, dadalawa pa lang ang anak noon, a. Buti pumayag si Ikong.

Susan: E papaano po, marunong silang magplano ng pamilya. Ayun, hanggang ngayon, maganda pa rin yung ari ni Marita.

Atong: E papaano mo naman nalaman pati yoon?

Susan: Ikaw nga ang lagging kasama ng nag-a-IUD sa center.

### Scene 3:

*(Makalipas ang ilang araw, sa pondohan...)*

Atong: O, Pareng Ikong, and tagal mo nang di napapasyan ditto a. Mukhang marami kang pinagkakaabaahan.

Ikong: Napapalimit ang overtime, pare. Nag-iipon ng pampaaral, e.

Atong: Sus, ano pa naman ang pag-iipunan mo? Dadalawa ang anak mo. Balita ko pa nga, nagpalagay na ng IUD si Mare.

Ikong: Ayaw paawat, e. Pagbigyan.

Atong: Kaya siguro hanggang ngayon, maganda pa rin ang kay Misis, ano?

Ikong: Anong ibig mong sabihin?

Atong: Sabi ni misis, sabi daw nung midwife, maganda pa raw ang sa misis mo. Di ba kapapalagay pa lang ng IUD ni Marita?

Ikong: Walanghiya, nanloloko ka ba? Asawa ko ang binabastos mo a!

Atong: Aba, hindi ako! Narinig ko lang yan.

Ikong: Mapapatay ko yang midwife na yan. Saan nga ba nakatira yon?

### Questions

1. What gender issues are portrayed in this case? To what extent did these issues influence the outcome of the case? Name as many gender issues as you can find in the case study. Explain your answer.
2. If you were the service provider in this case, what changes in practical and strategic gender needs will you make in consideration of the issues involved?
3. What other practical changes can be done in a health facility to make it more gender sensitive?

## Activity 4.2c Communication/Counseling

### Notes for the Facilitator:

1. Apart from knowing their own beliefs and attitudes, participants' skills for communication and counseling are also important in providing facility-based client-centered health care services that are gender-responsive and rights-based.
2. There are different kinds of methods used to provide a guide for communication and counseling in a health facility setting. The most common ones are the "REDI" and "GATHER." (*Adapted from EngenderHealth "Comprehensive Counseling for Reproductive Health"*)
3. Review the meaning of "REDI": **[Handout #4.6]**

#### Rapport Building

- Welcome
- Introductions
- Bringing up the subject matter
- Assure Confidentiality

#### Exploration

- Explore the client's needs, risks, circumstances, social context
- Assess the client's level of knowledge and give information as needed
- Assist the client to perceive her own needs and risks

#### Decision-Making

- Identify what decisions the client needs to make
- Identify the client's options for each decision to be made
- Explore benefits, disadvantages and consequences of each decision
- Assist the client to make her/his own decision

#### Implementing the Decision

- Make a concrete and specific plan to carry out the decision
- Identify skills the client needs to carry out the decision
- Practice the skills with provider's help
- Make a plan for a follow-up

4. Review of the meaning of "GATHER"

**Greet** - Greet the client warmly and politely.

**Ask** - Ask the client about herself/himself.

**Tell** - Tell the client about the health center and the various services being provided.

**Help** - Help the client to make the decision that is best for her/him.

**Explain** - Explain to the client relevant information about the assessment, diagnosis, and treatment.

**Return** - Schedule a return visit.



5. Comparison between REDI and GATHER: Facilitator asks participants to discuss the similarities and differences between the two methods.

| Comparing REDI and GATHER     |                  |
|-------------------------------|------------------|
| R – Rapport Building          | G – Greet        |
| E – Exploration               | A – Ask/assess   |
| D – Decision Making           | T – Tell         |
| I – Implementing the Decision | H – Help         |
|                               | E – Explain      |
|                               | R – Return Visit |

6. She explains that in the next set of exercises, participants will be using these communication/counseling techniques to talk to the client.

### Activity 4.2d Screening/Assessing the Client

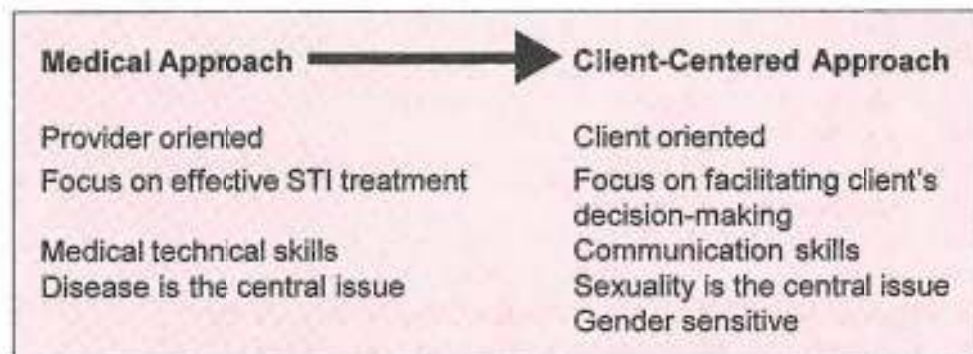
#### Notes for the Facilitator:

1. Engendering the Client Screening and Assessment
2. Asking Questions Exercise (using the case studies) (What questions will you ask to screen and assist your client?)
3. Participants are asked to use the case studies previously assigned to them. They will formulate questions at each stage of the screening/assessment procedure to surface the client's particular story.
4. Each group will appoint a person who will do a role play as client and another person to act as the client. The role play will be presented in plenary. Each group will use the REDI or GATHER Techniques.
  - History Taking
  - Taking of Vital Signs
  - Asking of Complaint
  - Assessment of Problem
  - Management of Problem
  - Endorsement of Client
5. **Processing:** In the role plays, facilitator looks at how the groups integrated gender issues with reproductive health, how the process of screening and assessing the client promotes decision-making (power dynamics), takes into consideration the multiple roles of women and promotes access and control to resources. S/He highlights and points out parts that are not taken into consideration.

## Activity 4.2e Intervention/Treatment

### Notes for the Facilitator:

1. In order to enable health workers to effectively address their client's needs, a comprehensive approach including elements other than the clinical aspects is needed. This includes understanding and respecting the client, appreciating attitudes and behaviors surrounding sexuality, understanding the linkages between sexuality, sexual behaviors and gender and how they impact on sexual and reproductive health. It also requires insights on barriers to behavior change and the skills or how to overcome these barriers.
2. By deciding to shift from a medical model to a comprehensive approach towards the clients, the interpersonal relations between the health worker and client will significantly improve. This will help the health worker to effectively assume the role of counselor. As a result, clients can explore their own situations in relation to reproductive health, consider their options, and act on their own, informed decisions.<sup>1</sup>
3. This requires shifting from a mainly medical approach which defines a successful transaction as giving a client the most effective treatment, to a comprehensive approach in which health workers and program managers see their roles in facilitating informed sexual and reproductive decision making on the part of their clients. The difficulties of making this transition and its potential benefits should not be underestimated. Sexuality is central to sexual and reproductive health programs and a vital subject to both clients and health workers. By dealing more openly with issues such as sexual pleasure and power and acknowledging the rights of individuals to make decisions concerning reproduction without discrimination, coercion and violence, health workers will better serve their clients and attract many new ones.<sup>2</sup>



<sup>1</sup> Comprehensive STI Case Management. A Joint Project of the Department of Health and European Union.

<sup>2</sup> *Ibid.*



#### 4. Application: Case Studies [Handout #4.7, Part A and B/C]

- a. Facilitator explains that these exercises test not only the participants' knowledge of the client's reproductive health problem but also their understanding of the gender situation of the client. This time they have to make clinical decisions about some patients with problems.
  - b. S/He informs participants that there are technical references on each reproductive health element that are available to participants if they need further information or need to consult on the best way to manage a certain reproductive health complaint of the clients presented in the case study.
  - c. The groups work with the same case study assigned to them in the integration section. They will be given two to three scenarios as follow-up to the case study given to them. Each scenario is in separate parts. They are instructed to answer the parts in order and should not look at the next part until they have answered the one they are on.
4. Case scenarios are then distributed to the assigned groups as follows:

### Case One: Manang Pacita

#### Part A

Manang Pacita brings her mother-in-law to the clinic. After screening and assessment, the mother-in-law is brought to you.

- What questions will you ask the mother-in-law?
- What will be your management of the mother-in-law?
- How will you communicate your course of action to the mother-in-law?

In the course of your conversations with the mother-in-law, Manang Pacita mentions that she, too, has some vaginal discharge that does not smell good. From her history, you know that she is not using any contraception.

- What questions will you ask Manang Pacita?
- What will be your course of action?

While doing a physical examination on Manang Pacita, you notice bruises on her arms, legs and back. You ask her about it but she only shrugs her shoulders. What will you do?



### **Part B**

After one week, both Manang Pacita and her mother-in-law come back to the clinic. The results of the laboratory exams show that the mother-in-law has cervical cancer.

- How will you manage her now?

The results of the laboratory exam for Manang Pacita show that she has STI. How will you share this finding with Manang Pacita? What will be your course of action?

### **Part C**

Manong Roger comes to the clinic complaining of pain and difficulty in urinating.

- What will be your course of action?
- What counseling will you do?

**Closing Question: What do you think will happen to Manang Pacita and Manong Roger after your interventions?**

## **Case Two: Brenda**

### **Part A**

Brenda comes to the health facility for pre-natal check-up. This is the first time she comes to the clinic.

- What questions will you ask her?
- What management will you do?

Upon physical examination, you notice her bruises (fresh ones and older ones) and you ask her about it. She then says that after all the things she is doing, whenever her husband comes home drunk, he beats her. She further shares her indecision on whether to stay in the relationship or leave.

- How will you counsel her?
- What other actions can you take?

### **Part B**

After three days, Brenda is back in the clinic. She is now pale and distraught. She has been bleeding since the night before after a particular heavy beating from her husband.

- How will you manage the situation?
- What immediate interventions will you do?
- What additional counseling will you give her?

**Closing Question: What do you think will happen to Brenda and Manong Pedro after your interventions?**

## Case Three: Susana

### Part A

Susana comes to the health facility because her youngest child has high fever, was vomiting and has diarrhea. The symptoms started 24 hours ago and since then the child (8 months old) has become listless and only semi-responsive.

- What questions will you ask Susana about the baby?
- What immediate interventions will you do?

Upon further questioning, you find out that Susana's way of bringing up children is far from ideal. She also shares her concern about one of her sons growing up to be gay. What counseling will you give her?

### Part B

Susana comes back to the clinic one week later than her scheduled appointment. She explained that she was unable to come earlier to the clinic because she was not feeling very well. She complains of dizziness, weakness with accompanying nausea. When you probe further about her condition, she dismissed your probing as "pagod lang at kailangan magpahinga." She said she only has time for you to examine the baby and she has to rush back home.

- How will you approach this situation?
- What possible questions will you ask Susana to surface any reproductive health problem that she might have?
- What interventions, if any, will you give?

**Closing Question:** What do you think will happen to Susana after your interventions?

## Case Four: Cynthia

### Part A

Cynthia, accompanied by Lourdes, comes to your clinic complaining of her on-and off vaginal discharges. She is visibly nervous and shy. Lourdes does most of the talking.

- How will you handle this situation?
- What will you tell Cynthia?
- What interventions/treatment will you recommend?

### Part B

Upon physical examination, you find out that Cynthia is three months pregnant.

- What will you tell Cynthia? Will you also inform Lourdes?
- What interventions will you do?

### Part C

After two weeks, Cynthia comes to your clinic by herself. She does not want to talk to anyone else in the clinic. She said that she only wants to talk to you. You bring her to the examining room and ask her to sit down. She shares with you that she has been bleeding profusely after taking 10 tablets of Cytotec. She is scared and does not know what to do.

- What questions will you ask her?
- What will you do?
- How will you counsel Cynthia?

**Closing Question: What do you think will happen to Cynthia after your interventions?**

## Case Five: Lando

### Part A

Lando goes to your clinic and asks to see Dr. Neil. Dr. Neil comes to the clinic once a week only and today is not his clinic duty day.

- What will you do?
- How will you make Lando feel comfortable in the clinic when most of the clients are women and they notice Lando's presence?

### Part B

Lando comes back to see Dr. Neil. He shares with Dr. Neil his dilemma and opens up that if he does not get any help, his wife will probably leave him. He also wants to have children but is not sure if he is capable of having children.

- If you are Dr. Neil, what questions will you ask Lando?
- What will be your course of action?
- How will you go about in your counseling sessions?
- How will you ensure that Lando will keep on coming back for follow-up sessions?
- Will you also talk to Cherry?

**Closing Question: What do you think will happen to Lando and Cherry after your interventions?**



## Activity 4.2f Follow-up/Referral

### *Notes for the Facilitator:*

1. **Engendering the follow-up and referral process:** In common practice, follow-ups and referrals are usually done, if at all, hurriedly and with the least amount of time given to the client. Facilitator explains that follow-ups and referrals are the last step in the process of integration and are as important as the screening and assessment because of the following reasons:
  - It is the time to ensure that the client has understood the instructions given in terms of medication and how to ensure that the treatment process goes well.
  - It is the time to let the client ask further questions; and sometimes, this is the way to get additional information about the client's environment and problems that may be the root cause of the problems s/he is presenting at the clinic.
  - It is a chance to explain further the condition of the client and how the client can take care of herself/himself.
2. **For the referral process,** participants are asked as to what they will do to ensure that even the referral process is engendered. The following answers should surface:
  - Take into consideration the multiple roles of the woman; that time might not be available for the woman or the client to go to another facility.
  - Consider access to and control of economic resources (how much will be spent in moving the client, how much will be spent in paying for medical bills and medicines), internal resources (not empowered to deal with other service providers, or exert what they want in front of others).
  - Service providers uphold the client's rights of privacy and confidentiality, dignity, and access to information.
3. Using one example from the Case Studies, participants are asked how they will go about doing the follow-up and referral. This exercise can be a brainstorming process where they are asked to call out the answers they could think of.
4. Facilitator then discusses the answers given and summarizes these by coming up with a process of follow-up and referral.

## Session 4.3: Gender-Responsive and Rights-Based IRH for Health Facilities

### Introduction

Gender and rights are among the most important factors in managing a health facility to fit the client's needs. Access to contraceptives, information about STI, HIV testing, prenatal services, and all other reproductive health services are all affected by how women and men interact with each other and how decisions are made within households and families.

|                           |   |
|---------------------------|---|
| <b>Objectives</b>         | By the end of the session, participants would be able to: <ul style="list-style-type: none"><li>• Identify gender issues relating to the client flow in a health facility;</li><li>• Create strategies that will uphold the rights of the client throughout the health facility;</li><li>• Examine health facility forms in terms of gender-responsiveness and integration of RH;</li><li>• Recommend revisions and changes in the client forms;</li><li>• Evaluate the physical setup in the health facility in terms of clients rights and gender-responsiveness; and</li><li>• Evaluate physical set up of the health facility in terms of integration of RH services.</li></ul> |
| <b>Time</b>               | 3 hours   |
| <b>Equipment<br/>LCD)</b> | LCD or Overhead Projector, Computer (if using   |
| <b>Materials</b>          | PowerPoint Presentation on the Framework  |
| <b>Handouts</b>           | Handout #4.8: Sample Intake Forms<br>Handout #4.9: Action Plan  |



## Activity 4.3a Integrating the Patient/Client Flow/Services

### *Notes for the Facilitator:*

1. Participants have just been through several exercises that showed the gender issues at various steps of the client-provider relationship inside a health facility. The next session will explore how the participants -- as service providers themselves -- can take the initiative on how to make their own health facility gender-sensitive, gender-responsive and rights-based and at the same time addressing the multiple RH needs of the client.
2. Participants will have an opportunity to jumpstart the planning process in their health facility. Three areas in the management of a health facility will be examined and the first will be on the client flow and integration of client services.
3. Participants are divided into small groups to prepare a specific work plan in their health center. For example, women consult for antenatal or post-natal care services. The participants may present plans and discuss on how women may be screened for infections and cancer, be scheduled for counseling, and be informed of the appropriate family planning methods. They may also include some community participation activities in their presentations.
4. Each group may select their most possible common areas of integration.
5. Participants may follow this suggested discussion flow:
  - Select one common RH ailment or condition seen in your health facility.
  - What common gender issues need to be taken into consideration in the treatment and care of these RH ailments?
  - Discuss what other possible common RH conditions may be included in the screening of the client.
  - Present suggestions on how this integration may be carried out and at the different stages of client-provider interaction (assessment, treatment, referral, and counseling).
  - What changes will have to take place before these suggestions are carried out?
6. The groups will present their output in plenary. The facilitator and the other groups will then critique.



**Activity 4.3b Forms** (review of forms used at the health center including gender perspectives like “reproductive intent” [Handout #4.8])

**Notes for the Facilitator:**

1. Clinic forms contribute to the quality of the provision of health services. In this case, clinic forms will influence how gender and rights-based client services are operationalized. Clinic forms are also important as a basis for evaluating the kind of services being given and the way the service is provided. Client Forms, therefore, should reflect gender-sensitivity and appropriateness. They should also show how RH elements are integrated and addressed.
2. Facilitator distributes sample clinic forms to the participants. S/He tells the participants that these are forms being used in women’s clinics that try to provide client-centered RH services. Participants go over the forms and see if: (1) they could see some information being asked that is not commonly found in their own client forms; and (2) they could adapt a similar approach at their health facilities.
3. Participants brainstorm on how changes in the information being gathered in their own health facility could be reformed and revised.

**Activity 4.3c Physical Set-up**

**Notes for the Facilitator:**

1. Engendering the Clinic Set-up.
2. **Exercise:** Participants are divided into groups. Each group is given a sheet of paper containing the instructions on what to do.
3. **Instructions:**
  - Make a schematic diagram of the health facility you are connected with.
  - Indicate how clients go from one place to another in the course of assessment and treatment. If you could include the average length of time the client stays in one place, the better.
  - Give a critique by pointing out the weaknesses of the schematic diagram in terms of fulfilling the rights of the client and being gender sensitive. (For example, her/his right to information: are there enough reading materials that the client could look at or learn from while waiting for her/his treatment? Or is there enough privacy provided so that her/his right to confidentiality is protected and fulfilled?)

- Review each client right. Explore how these rights are presently being violated and how the situation could be corrected by respecting, protecting and fulfilling these rights through a better physical set-up/improvement of the health facility.
4. Groups present their diagrams in plenary. Facilitator discusses and highlights some innovative ideas that are being presented.
  5. The following areas should be highlighted:
    - Information – gender sensitive IEC materials and training (i.e., mother's classes)
    - Access to services - is the health facility difficult to reach? Is it woman-friendly? Is it alienating to the men?
    - Safety of services - is the clinic safe, clean, following antiseptic practices?
    - Privacy and Confidentiality – are there spaces that provide privacy? Where are the client records being kept? Is this accessible to anyone? Can everyone hear what is going on in the examining room?
    - Dignity, comfort and expression of opinion – length of time spent at the clinic, how are the clients made to feel that they are welcome - comfortable chairs, well-lighted rooms, clean, etc.

## References

EngenderHealth. (2000). *Comprehensive Counseling for Reproductive Health: An Integrated Curriculum. The Manager, Family Planning Management Development, Management Sciences for Health. Fall/Winter 2000/01*

Interagency Gender Working Group, USAID Bureau for Global Health. (2003). *A Manual for Integrating Gender into Reproductive Health and HIV Programs: From Commitment to Action.*  
 UNFPA. (1994). *ICPD Program of Action.*

## Session 4.4: Action Planning

### Introduction

This session will provide a guide to what the participants will do after the workshop. The session will create concrete steps to be taken to ensure that the delivery of reproductive health care services is done in a gender-sensitive way and at the same time recognizes and upholds the rights of clients. Participants will be asked to make plans which will be submitted to their heads of office for discussion and implementation.

|                       |  |
|-----------------------|--|
| <b>Objectives</b>     | By the end of the session, participants would be able to: <ul style="list-style-type: none"><li>• Develop personal action plans for the provision of gender and rights-based integrated reproductive health services; and</li><li>• Provide for mechanisms for changes to take place within the health facility.</li></ul> |
| <b>Time</b>           | 2 hours  |
| <b>Equipment LCD)</b> | LCD or Overhead Projector, Computer (if using LCD)   |
| <b>Materials</b>      | PowerPoint Presentation on the Framework   |
| <b>Handouts</b>       | <ul style="list-style-type: none"><li>• Action Plan Forms (Handout #4.9)</li></ul>   |

### *Notes for the Facilitator:*

1. Since they have finished the training, participants will have a chance to respond to the challenges presented throughout these past days in a more concrete manner. Many ideas and thoughts have been happening among them and this time, they will have a chance to put these ideas in writing.  
  
These Action Plans will be shared with the respective Heads of Offices so that they can be partners in the changes that participants will propose.
2. Facilitator distributes the ACTION PLAN Forms. S/He tells the participants that they can be as detailed as they wish this to be so that they will be guided by it once they are back in the field.



## One-Year Action Plan

### Gender-Responsive and Rights-Based Integrated Reproductive Health Training

Name: \_\_\_\_\_ Position: \_\_\_\_\_

Agency: \_\_\_\_\_

Name of Immediate Supervisor: \_\_\_\_\_

Position: \_\_\_\_\_

Office Address: \_\_\_\_\_

### Goal

To improve the quality of life of women, men and adolescents through integrated reproductive health care services that is gender-responsive and rights-based.

#### 1. Integrating Gender-Responsive, Rights-Based RH in Service Delivery Protocols

| Objective | Outputs | Activities | Inputs |
|-----------|---------|------------|--------|
|           |         |            |        |
|           |         |            |        |
|           |         |            |        |
|           |         |            |        |

2. Integrating Gender-Responsive, Rights-Based RH in the Health Facility Set-Up

| Objective | Outputs | Activities | Inputs |
|-----------|---------|------------|--------|
|           |         |            |        |
|           |         |            |        |
|           |         |            |        |
|           |         |            |        |

3. Personal Action Plan

| Objective | Outputs | Activities | Inputs |
|-----------|---------|------------|--------|
|           |         |            |        |
|           |         |            |        |
|           |         |            |        |
|           |         |            |        |

MODULE **4**

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# Client-Centered and Rights-Based Integrated Reproductive Health Service Delivery

## Overview

The practical application of the lessons learned from the Gender and RH module will be shown through reproductive health services that are client-centered. This module will present an integrated approach to reproductive health care service delivery at the clinic facility level through the application of the principles of gender and rights responsiveness.

The Objectives for this Module are:

1. Describe the framework for a client-centered integrated reproductive health services in health facilities
2. Demonstrate how gender-responsive and rights-based integrated reproductive health is implemented in a health facility

## Session 4.1: Concept of Integration

### Objectives

By the end of the session, participants would be able:

- Assess a client's reproductive health situation through a gender lens
- Explain the concept of Integration

## Session 4.2: Integration at the Clinic Level

- By the end of the session, participants would be able:
- Explain what the rights of the client are
  - State the various ways these rights can be impeded
  - Identify how service providers can promote these rights
  - Examine service provider beliefs and attitudes towards various RH needs of clients
- Objectives**
- Provide a process to resolve differences between provider and client beliefs and attitudes
  - Describe various approaches to RH communication and counseling
  - Provide examples on how correct communication and counseling is used in a health facility setting
  - Apply Gender-Responsive and Rights Based approaches and interventions in the procedures at the health facility

## Session 4.3: Gender-Responsive and Rights-Based IRH for Health Facilities

- Identify gender issues relating to the client flow in a health facility
  - Create strategies that will uphold the rights of the client throughout the health facility
- Objectives**
- Examine health facility forms in terms of gender-responsiveness and integration of RH
  - Recommend revisions and changes in the clients forms
  - Evaluate the physical setup in the health facility in terms of clients rights and gender-responsiveness
  - Evaluate physical setup of the health facility in terms of integration of RH services



## Handout 4.1

# Case Studies for Gender/RH Integration

### Case Study 1: Manang Pacita

Born in Kiangan, Ifugao, Pacita was formerly employed as a utility worker at an inn in the nearby town. Having been accused of connivance with a politician who lost in the previous election, she was laid-off from work. Since then, she joined her husband in tilling their farm.

At 38, Pacita has five live children to rear and support. For her, family planning nowadays is necessary because life is hard, as aptly opined, "*kasapulan ta narigat ti biag*". Asked what FP methods she had been using, she just gave an impish smile and said, "*awan*" (nothing). She expressed fear for the use of any contraceptive method due to the perceived side effects. Besides, her husband, Manong Roger, prefers a bigger family, as children are regarded as security for their old age.

Nothing has changed since the time she left town for farm life. She describes her life as *narigat* (difficult), for she is constantly plagued by violence and suffering. Manong Roger is an alcoholic, and was constantly suspicious and jealous of Pacita. When she still worked in town, they would quarrel over his unfounded suspicions. Now that she has gone back home and worked together with Manong Roger in the fields, he still gets jealous. She has become paranoid and would always be on her toes every time her husband would come home drunk. Her husband has violent tendencies. Oftentimes, he lashes out doors, boxes the wall, yells at her, and slaps and beats her. Pacita already suffers from *nerbiyos* (nervousness). Unfortunately, this was a cause for one miscarriage, which was attended to by the *hilot*.

Manong Roger's disinclination for farm work due to hangover compelled Pacita to take on the arable farm in order to catch up with the planting season. At bedtime, she cannot help but think about tomorrow. Where will the money for tuition fee, kitchen needs, and farm work come from? While she believes that sex is part of marital life, and it is her husband's right and her obligation as a wife to give into his demand, but she could not even think of it anymore because her mind is too preoccupied with thoughts of obtaining salt for tomorrow.

With the thought of making both ends meet, Pacita never realized the very poor health management she gave her children. She fed them any kind of food, which caused their loss of appetite. She never even bothered to clean up her children after retiring from a day's play. It was not until one child contracted UTI that she learned that the kind of food fed to her children and the lack of hygienic practices could cause UTI. She was thankful that it was cured from a decoction of medicinal herbs.



Reproductive health is always the least preoccupation of Pacita. Within the vicinity lives her very old and weak mother-in-law. Pacita frequents her shelter to check on her and feed her. Occasionally, when the children are home, she requests them to feed and watch over their grandmother. But the children complain and refuse to attend to their grandmother due to the stench of her vaginal discharge. Pacita claims her mother-in-law began to excrete such after menopausal. Despite the daily bath and cleansing she gives her, such secretion never stopped. Asked why the medical inattention, she said her mother-in-law feels terribly embarrassed every time they attempted to visit the health center. Pacita mutually shares the sentiment, and after a few visits, they stopped consultations.

Unfortunately, Pacita has recently been agonizing over her putrid vaginal discharges too. She expressed humiliation in seeing a doctor. As a palliative measure, she instead sought the assistance of a *hilot*, who gave her abdominal massages. She also uses herbal medication, an advice given by fellow women in her community.

Her main concern now is how she contracted her ailment? She hears several possible causes. Was she contaminated by her mother-in-law's disease? Could it be menopausal syndrome? Could it be cancer? Or could it also be a sexually transmitted infection?

### Case Study 2: Brenda

Brenda of Sadanga is married to Manong Pedro, a 42-year-old man who comes from Abra. She is the second wife of Manong Pedro. She never thought she would get impregnated because of talks that her husband is impotent, a perceived cause to his first marital break-up. As of the interview, Brenda is five months pregnant with her second child. Her eldest child is only one-year old.

At 25, Brenda perceives that it is actually sexuality that makes a man and a woman cohabit, and it is now her personal choice why she is married to this much older man. She expressed that sex is a wife's obligation to her husband, "ited tapnu awan iti riri" (give in to avoid quarrels). There are times when she refuses, her husband accuses her of having another man, "nu agmadi, kuna ti lalaki nga adda pangitedan nga sabali iti babai" (If refused, the man says, the woman might have some other man).

In matters of family planning, Brenda shares that it is for both of them to decide upon. However, if given the choice, she feels that there is a need to limit the number of children, "ta narigat iti biag". She, however, fears the side effects of artificial contraceptives. The seasonal job of her husband serves as a natural impediment to pregnancy. Her husband is a carpenter, who, most of the time, is deployed in other places. He comes home when construction work is over, and he then assumes farm work.

While she believes that men are the heads of their families and have to support and decide for their families, their set-up mobilizes her to work, think, and decide for her and her child. When Brenda does not baby sit, she goes to the field. Working in the field is perceived to be a form of exercise and would facilitate child delivery. She solely does household chores and childcare. But since the birth of her first child, she opened a small retail store to augment their income.

She complains of "bannog" (physical fatigue), moodiness and irritability. This is aggravated by the fact that she is on the family way. Culture, however, dictates that her marrying at an early age merits her ability for productive and reproductive work. While she could become a "nasayaat nga ina" (good mother), what she cannot sometimes tolerate is her husband's mean treatment of her.

One concern that Brenda raised was having a drunkard husband. Even when Brenda is pregnant, she is slapped and beaten up. When Manong Pedro is not drunk, he apologizes and promises not to beat her again. He repeatedly affirms his love for his wife and child. Yet, when he gets drunk he lapses into his old habit of slapping and beating her.

Upon seeking the advice of the older women folks, they expressed disapproval of Brenda's answering back her drunken husband. They say it is inappropriate and justifies this as a reason for her being battered. They advised her to be more lenient and forbearing. She should keep quiet and give into the demands of Manong Pedro, for that is what a wife should be.

Brenda expressed her annoyance, *makauma, kanayon metten* (it's exasperating, he does it often). Tolerance and patience are virtues, but becomes *katangahan* (foolishness) when these virtues are abused, she reasoned out. She also averred that her husband's marital failure with his first wife is not because of impotence, but probably because she was indeed a battered wife, just like Brenda now. She is vacillating between leaving her husband and keeping her family together.

### Case Study 3: Susana

Susana is a forty-year old rural woman, married to a farmer who, like her, has almost no formal education. While living a hand-to-mouth existence, she gives pride to her husband's capability to support her and her four children, out of mere diligence and perseverance.

When asked what her concept of health was, she associated it with being "naragsak" (happy) and the absence of physical infirmities. A happy family, she adds, should have happy family members. Everyone stays well, as health care is perceived as expensive and unaffordable. Instead of spending money on medication, their limited income should rather be spent on food.



Sharing her thoughts on motherhood, she thinks that a mother should be accorded utmost respect for bearing and nurturing children. It is clear to her that as a mother, she should stay home and raise her children well, be responsible for the upkeep of the home, while her husband goes out to farm. She believes that it is the husband's primordial role is to earn a living for the family.

On family size, Susana says she did not want too many children. This is probably a reflection of her experience when she was a young girl, having come from a family of a dozen children. The lack of provisions and basic education, and medical inattention has been repercussions of a big family. Unfortunately, her husband asserts that they should not refuse what God wants to give them. As an optimist, he says they can support more children. He did not want any of the family planning methods being offered because of fear for side effects. Such outlook was influenced by stories heard in the community on the adverse effects of different family planning methods. They have heard of a cousin who gradually lost weight for using pills and then IUD. Another cousin suffered from infection when she had ligation. He also has his mind set against vasectomy. This is perceived to lessen men's virility. He fears that once he undergoes vasectomy, he would not be able to satisfy his wife anymore, or even weaken his body for physical work.

She never realized the essence of having her children registered, not until her fourth child. On health knowledge and skills, Susana says an itinerant traditional birthing attendant, who was more accessible then, assisted her in her first deliveries. It was a normal occurrence during her first three deliveries to experience "manas". This, however, subsided when she has already given birth. On her fourth delivery, it was a midwife that assisted her.

She expressed conflicting practices between traditional knowledge handed down to her by elders from what the Young Mother's Class taught her after the child's delivery. It was her usual practice to bathe the baby with warm water right after delivery, as instructed by her folks, but the mothers' classes taught her to bath the newborn with oil, first and then alcohol is applied for cleaning the umbilical cord.

To augment her lactation problem, she fed her babies soup, mashed sweet potatoes, bananas and rice porridge. She contends that all went well with her kids. In terms of immunizations, only her youngest have acquired complete dosages. All her other children had not been given sufficient immunizations because it (i.e. Hepatitis B) was not for free.

A source of discomfort for Susana is the frequent quarrels between her three sons. She couldn't sometimes control her temper and her children get a lot of scolding and beatings. Unfortunately, what she perceives as discipline for children is nowadays perceived as child abuse. She averred:



"Ay samo eyak getken ay waday makmakwani as child abuse. Baken laeng gayam mang al-alpak wenno mangdangdangran si unga, wenno inayon na gayam pati nan ikkan ay kumali...Idwani maawatak san gapo no apay nga isumsumsuma nan kaarubak sak-en sin ik-ikkak sin an-ak ko. Adik oppay ammo ay child abuse et san dey da inik-ikkak ken daida."

(I did not know that there is such a thing as child abuse. I have learned that it does not only mean doing physical harm to the child, but it also includes verbal abuse. Now, I understand why my neighbors always call my attention, and advise me to deal properly with my children. All the while, I have been abusing my own children.)

Another concern that worries her and her husband is the softness they see in the character of their second son. They notice their son manifests feminine traits, which has caused frequent scolding, and at times spanking. "Agbakia-bakia sin an-ak ko...kababain, mangirurumen, naalas", was a description they attributed to their son. However, a friend advised her to accept the child as he is, especially if he finds happiness in being such, but it is her husband that they have to convince on this matter.

#### Case Study 4: Cynthia

Cynthia is 17 years old. She came to Manila two years ago with her first cousin, Lourdes. Cynthia stopped going to school when she was 14 and the offer for a job in Manila was too good to pass by. The job offer was as a factory worker making bags in Bulacan. The job was first offered to Lourdes through a visiting friend of the owner of the only dry goods store in Sangcub, Zamboanga del Norte. The parents of Lourdes would not allow her to leave by herself so she brought Cynthia along.

When they got to the Pier in Manila, no one met them. In the waiting shed, they met a woman, Mrs. Dela Paz who offered to shelter them in her house in Tondo. Mrs. De la Paz owned a carinderia for travelers and truck drivers and in return for board and lodging, Cynthia and Luz were asked to pitch in while waiting for the person who will pick them up.

In the carenderia, Cynthia and Luz were asked to wait on the customers. They worked long hours and had little time to rest. Mrs. Dela Paz gave them some money to tide them over but they soon realized that they were going to be stuck in that place since no one came to pick them up. The customers were mostly male and in the late afternoons, they would start drinking. Mrs. Dela Paz encouraged the two girls to be "friendly" with the customers and even told them that they could practice their singing using the karaoke in the carinderia. Cynthia had a good singing voice and enjoyed singing so she usually was asked to sing specially when customers were around. Cynthia liked this because she was freed up from waiting on tables and helping out in the kitchen. Soon, Cynthia was made a regular "entertainer" for the carinderia. She

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was given nice clothes to wear, taught to wear makeup and fix herself up. Mrs. Dela Paz saw this as a good thing because customers stayed longer in the eating place and spent more. Lourdes encouraged this new assignment for Cynthia because they had more money to spend during their off days which was on Mondays.

Ricardo is a truck driver for the Global Shipping Company with branches in Baguio, San Fernando and Legaspi. He drives a truck that brings cargo/goods from the Manila Harbor to all of these branches. He is married with four children who are living in San Fernando. Although Ricardo earns enough to support his family, he usually spends for drinks and women while "relaxing" on his trips. While waiting for his truck to be loaded at the Manila Harbor, Ricardo chanced upon Mrs. Dela Paz's carinderia. Taking his *Pahinante* along with him, he went inside to have a few drinks and pulutan. There he saw Cynthia singing. He was immediately attracted to this young girl and tried to attract her attention. Cynthia was smitten by this older man who was treating her like a lady. Pretty soon, Ricardo was bringing her candies and little trinkets which she wore while singing. The next time Ricardo was at the Manila Harbor, he invited Cynthia to go out and watch a movie with him. Cynthia then promised to go out the following day which was Monday. Ricardo did not bring Cynthia to the movie house. Instead they spent the day in a motel.

The following day, Lourdes asked Cynthia what happened during her "date" with Ricardo. Cynthia told Lourdes that she had a most fantastic experience and that she was no longer a virgin. Cynthia was looking forward to the following week when Ricardo will be back from his trip to the Bicol region. True enough, when Ricardo came back, he took Cynthia out again for a whole day.

Ricardo was gone for a couple of weeks after that. However, he would send text messages to Cynthia professing her care and love. When Ricardo came back he spent most of his free time with Cynthia in various motels or in Cynthia's room while Lourdes was not around. When Cynthia expressed her concern about getting pregnant, Ricardo assured her that he was "baog" and could not get anyone pregnant. This went on for a couple of months.

Two days after Ricardo's last visit, Cynthia began itching and scratching. Then she noticed a foul smelling discharge when she went to the bathroom the following morning. Not knowing what to do, she talked to Lourdes about it. Lourdes advised her to take antibiotics that she knew about. Three days after, she stopped taking the medicines because she thought she was ok already.

However, a day after she stopped taking the antibiotics, her itchiness came back and seemed to be worse than before. Lourdes also did not know what to do anymore and she said that there was a health center a tricycle ride away and maybe Cynthia could go and seek medical help.



## Case Study 5: Lando

Lando is the "siga-siga" in the neighborhood. When he is not working as a dispatcher in a warehouse in Valenzuela, Bulacan, he spends time in working out in a nearby gym. He likes to wear tight-fitting shirts that show off his muscles and his physique. For a long time, he remain unmarried but had many girlfriends whom he kept stringing along with promises of marriage. This was what he did before he met Cherry.

Cherry worked as an assistant clerk at the warehouse. She was only 19 when she started working, having dropped off from college (taking up computer science) since her family could no longer afford sending her to school. As a 19-year old girl, she felt she had the world in her hands. She could do anything and had enough left over from her earnings to buy things she wanted. She enjoyed working at the warehouse because she met a lot of men who admired her and flirted with her. She knew all about romance and love but was not too sure about the physical aspect of it. This was before she met Lando.

On Mang Boy's 35<sup>th</sup> birthday, he decided to treat his friends from the warehouse to a karaoke bar in Caloocan. One of his friends invited Cherry to come along. Cherry decided to go since she knew a lot of those who were going and they all promised her a good time. She knew that it was someone's birthday party, so she decided to buy a little gift to give to the birthday celebrant. Lando was already at the Karaoke Bar when the group of Cherry arrived. She was promptly introduced to Lando and he was pleased that she was thoughtful enough to give him a gift even if they did not know each other.

That whole night, Lando could not keep his eyes off Cherry. Cherry also found herself looking at Lando and often times their eyes would meet even when they were sitting at opposite ends of the table.

The next morning, when Cherry arrived at the Warehouse, she saw a rose bud on her table and upon seeing that it was from Lando she was excited and thrilled. Every morning for the whole week, she received a single rose from Lando. She sought him out to thank him for the flowers and Lando asked if she would like to go out with him. In a couple of weeks, Lando's whole life was centered around Cherry and Cherry reciprocated his feelings. Common friends started teasing them and saying that Cherry was really too young to get involved with an old man like Lando. Cherry however loved the caring and attention that she was getting.

In a couple of months of going out and dating, Lando only went as far as kissing Cherry. When he proposed marriage to her, he went as far as kissing her on the lips. The parents of Cherry agreed to a simple wedding and this was done six months after Lando's birthday.

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On their wedding night, Lando and Cherry were too exhausted partying and entertaining their friends from the warehouse that they promptly fell asleep after a couple of kisses. Cherry did not know what to expect but was happy that she was able to handle the first night without all of the fuss that her friends were hinting at. The following day, Lando and Cherry went to Tagaytay to spend a couple of days at a hotel there. Cherry was feeling scared and at the same time excited because she was looking forward to this time of intimacy with Lando.

Unknown to Cherry, Lando was beginning to feel anxious since he had a traumatic experience when he was 11 years old of being abused by his uncle for the three years that his uncle was staying with them. The reason why he could not commit to marriage before was this fear of not being able to consummate the marriage. For Lando, the sexual act was a painful reminder of his abusive experience during his pre-puberty years. He compensated with this feeling of inadequacy by looking and acting "macho."

Needless to say, their daytime in Tagaytay was fun but their evenings were spent cuddling and kissing. Lando read somewhere that he could satisfy Cherry through stimulating her so on the last night in Tagaytay, he did just this. Cherry did not know any better and enjoyed the whole experience thoroughly.

Six months after the wedding, one of Cherry's friends gave her an x-rated movie. Cherry watched it by herself one day when Lando was doing overtime and there she realized that she was still a virgin and never experienced having sexual intercourse. When Lando came home, she tried to do to Lando what she saw in the movie and to her surprise, Lando turned away from her and became angry. Trying not to show her disappointment, Cherry turned to her side of the bed and went to sleep.

Two years later during their wedding anniversary, their common friends remarked that Lando and Cherry were an ideal couple—still very much in love but they also told them to hurry up and start a family. Cherry's parents were also asking when they will see their "apos" and that two years is more than enough time to start their family since they will not be around forever. Lando sensed that Cherry was drawing away from him and spending more time with her friends. He started to suspect that she might be seeing someone else and this made Lando more frantic.

Lando went to his best friend Mario and told him about his dilemma. Mario advised him to see talk to a professional. Mario mentioned that the doctor in the Rural Health Unit is a male doctor and he knew the doctor personally. The doctor is a good one and could probably give advice to him.

## Handout 4.2

### Concept of Integration

#### Layers of Integration:

1. **Integration of gender with reproductive health** – takes into consideration the underlying social constructs that determine how men and women relate to each other and how these affect their reproductive lives. Integrating gender and reproductive health was included in the Cairo Program of Action in the 1994 International Conference for Population and Development.
2. **Integration of RH elements in the delivery of health services** – recognizes that women and men who seek health care services may have underlying conditions that influence or add to their overall health. A woman, for example, seeking contraceptive services may have STIs/RTIs, be a VAW victim and need information on sexuality. Integration at the clinic level of various elements of RH must be done up to whatever the technical capacity of the service provider is. There has to be, however, a conscious effort on the part of the clinic staff to approach reproductive health in a holistic manner.

#### Participant's Additional Info

According to the ICPD Programme of Action, "Reproductive health care programs should be designed to serve the needs of women, including adolescents, and must involve women in the leadership, planning, decision-making, management, implementation, organization and evaluation of services..."<sup>16</sup> Given this mandate, a successful gender-integrated RH program promotes the empowerment of women and supports gender equity/equality goals to enhance RH outcomes for all.

An equitable approach to RH/HIV/AIDS services and programs focuses on the different needs of women, men, adolescents, and communities. In order to eliminate gender disparities women and men must actively participate in reproductive and sexual decision-making. Moreover, it is critical that adolescent boys and girls be involved and their concerns addressed if sustainable and equitable reproductive health outcomes are to be achieved.

Based on the experience of a number of programs around the world, five principles are fundamental to RH/HIV/AIDS programs that integrate gender: 1) working through community partnerships; 2) supporting diversity and respect; 3) fostering gender accountability; 4) promoting human rights, including reproductive rights; and 5) empowering women, men, youth, and communities.



3. **Programmatic and process integration** – This aspect of integration deals with the administration and management of clinic programs and health projects that approaches the delivery of services and provision of health care in an integrated fashion – client-centered, gender appropriate and responsive with a high degree of technical competence.

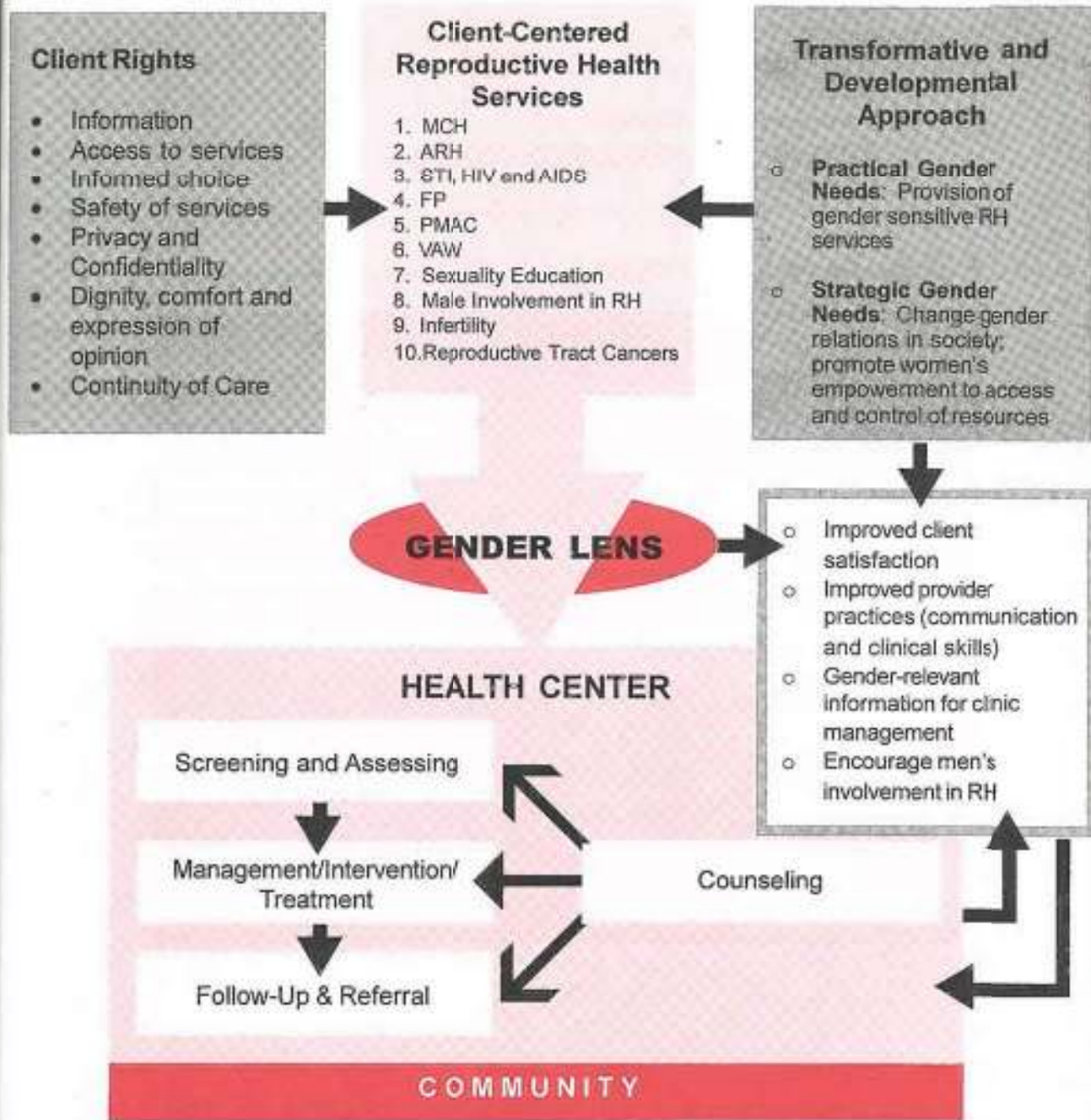
### Participant's Additional Info

#### 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



**FRAMEWORK FOR RH INTEGRATION**



## Rights of the Client Exercise

### 1. The Seven Rights of the Client:

- Information
- Access to services
- Informed choice
- Safety of services
- Privacy and Confidentiality
- Dignity, comfort and expression of opinion
- Continuity of Care

### 2 Exercise Answer Sheet Matrix

| Rights                                     | Service Providers |        |
|--|-------------------|--------|
|  | Promote           | Hinder |
| Information                                |                   |        |
| Access to Services                         |                   |        |
| Informed Choice                            |                   |        |
| Safety of Services                         |                   |        |
| Privacy and Confidentiality                |                   |        |
| Dignity, Comfort and Expression of Opinion |                   |        |
| Continuity of Care                         |                   |        |

**Handout 4.5****Case Study: The Story of Marita***(Source: EngenderHealth Training Manual)***Scene 1:**

*Isang umaga sa BHS ng San Mateo, dinatnan ng midwife si Marita na naka-skedyul magpalagay ng IUD.*

MW: O, ano Marita, handa ka na ba? Ang aga mo, a.

Marita: E, inihatid ko kasi yung mga anak ko sa eskwelahan.

MW: O, kumusta na ang inaanak ko?

Marita: Ayun, ang likot-likot pa rin.

MW: Siyempre, bata, e. Sugurado ka na bang magpa-IUD? Dadalawa pa lamang ang anak mo, a? Anong sabi ni Kumpare?

Marita: Ayaw man niya, e kailangan. Napaliwanagan ko naman, kaya hayun at inihatid pa ako hanggang sa may labasan.

*(Darating ang iba pang mga ina na a-attend ng mothers' class na inihanda ng midwife.)*

MW: O, mga misis, buti dumating kayo. Umpuo muna kayo at may aasikasuhin lang ako sandali. Wala pa naman ung ibang magma-mothers' class.

*(Pabulong kay Marita)* O, baka naman gusto mong umattend ng klase tungkol sa pagpapalano ng pamilya?

Marita: Magpapa-IUD na nga ako, ano! Papa-attend-in mo pa ba ako?

MW: O, sige na. Mahiga ka na rito.

Marita: Mare, wala yata and kurtina mo ngayon?

MW: Pinalabhan ko, e. Maitim na sa alikabok.

Marita: Nahihiya naman yat akong humiga diyan. Nasa may paanan ko yung pinto.

MW: Mare, may kanya-kanyang pekpek and mga yan kaya huwag ka nang mahiya. Kung gusto mo, doon ka na lang humarap sa may bintana.



Marita: E, wala ring kurtina.

MW: Wala naman dumadaan. Mare, napakaselan mo naman. Parang wala ka pang anak. Si Mareng Loleng nga, doon ko pa sa labas pinaanak dahil nabasa ng bagyo itong center – binaha. Sige na't andiyan na yung iba pang mga nanay!

*(Napilitang humiga si Marita. Ilan pang sandali, natapos na ang paglalagay ng IUD.)*

MW: O, mare. Okey na. Mabilis lang naman yan. Sa una'y may mararamdaman kang sakit sa puso. Pag tumindi at dumugo nang sobra o kaya'y pakiramdam mo'y lumalabas, bumalik ka sa akin.

*(Pasigaw)* Susan! Pakikuha nga ng record ni Marita at ng mailagay ko na sa record yung pag-a-IUD ko sa kanya! O, sige Mare, pahinga ka muna diyan habang nag-pe-prepare ako para sa klase ko.

*(Matapos and ilang sandali...)*

Marita: Mare, aalis na ako. Kaya ko na. Dederetso na lang ako sa bahay para tuluyang makapagpahinga.

MW: Sige, mare.

*(Pagkaalis ni Marita...)* Buti pa si Marita, dadalawa ang anak, nag-IUD na. Ang ganda pa tuloy ng pekpek niya.

Susan: Paano mo naman nasabi yan?

MW: Ikaw nga ang maglagay ng IUD sa mga nanay at kung hindi mo Makita ang kanilang mga hinaharap!

Susan: Ikaw talaga, puro kalokohan. Tayo na ngang magsimula ng mothers' class mo!

**Scene 2:**

*(Kinahapunan, sa bahay nina Susan...)*

Susan: Hoy, Atong. Tama na yang kaka-kalabit mo at apat na ang anak natin. Baka masundan agad yang tatatlong buwan mong anak.

Atong: O, e ano naman?

Susan: Akala mo naman, ganoon kalaki ang suweldo mo. E wala naman akong suweldo sa center bilang CVHW.

Atong: Sige na. Isa lang.

Susan: Buti pa, kung talagang hindi ka mapigilan, magpa-IUD na rin ako. Si Marita nga na asawa nung kainuman mong si Ikong nagpa-IUD kanina.

- Atong: Aba, dadalawa pa lang ang anak noon, a. Buti pumayag si Ikong.
- Susan: E papaano po, marunong silang magplano ng pamilya. Ayun, hanggang ngayon, maganda pa rin yung ari ni Marita.
- Atong: E papaano mo naman nalaman pati yoon?
- Susan: Ikaw nga ang lagging kasama ng nag-a-IUD sa center.

**Scene 3:**

*(Makalipas ang ilang araw, sa pondohan...)*

- Atong: O, Pareng Ikong, and tagal mo nang di napapasyan ditto a. Mukhang marami kang pinagkakaabalahan.
- Ikong: Napapalimit ang overtime, pare. Nag-iipon ng pampaaral, e.
- Atong: Sus, ano pa naman ang pag-iipunan mo? Dadalawa ang anak mo. Balita ko pa nga, nagpalagay na ng IUD si Mare.
- Ikong: Ayaw paawat, e. Pagbigyan.
- Atong: Kaya siguro hanggang ngayon, maganda pa rin ang kay Misis, ano?
- Ikong: Anong ibig mong sabihin?
- Atong: Sabi ni misis, sabi daw nung midwife, maganda pa raw ang sa misis mo. Di ba kapapalagay pa lang ng IUD ni Marita?
- Ikong: Walanghiya, nanloloko ka ba? Asawa ko ang binabastos mo a!
- Atong: Aba, hindi ako! Narinig ko lang yan.
- Ikong: Mapapatay ko yang midwife na yan. Saan nga ba nakatira yon?

**Questions**

1. What client's rights were violated in this story? What underlying gender issues contributed to the violation of these rights?
2. If you were the service provider in this case, what changes will you make in consideration of the gender issues involved?
3. What other practical changes can be done in a health facility to make it more gender sensitive?

**Counseling Techniques: “REDI” & “GATHER”**

**REDI**

**Rapport Building**

- Welcome
- Introductions,
- Bringing up the subject matter,
- Assure Confidentiality

**Exploration**

- Explore the clients needs, risks, circumstances, social context;
- Assess the client's level of knowledge and give information as needed
- Assist the client to perceive her own needs and risks

**Decision-Making**

- Identify what decisions the client needs to make
- Identify the client's options for each decision to be made
- Explore benefits, disadvantages and consequences of each decision
- Assist the client to make his/her own decision

**Implementing the Decision**

- Make a concrete and specific plan to carry out the decision
- Identify skills the client needs to carry out the decision
- Practice the skills with provider's help
- Make a plan for a follow-up

**GATHER**

**Greet** - Greet the client warmly and politely.

**Ask** - Ask the client about him/herself

**Tell** - Tell the client about the health center and the various services being provided

**Help** - Help the client to make the decision that is best for him/her.

**Explain** - Explain to the client relevant information about the assessment, diagnosis, and treatment

**Return** - Schedule a return visit.

**Comparing REDI and GATHER**

**R** - Rapport Building

**E** - Exploration

**D** - Decision Making

**I** - Implementing the Decision

**G** - Greet

**A** - Ask/assess

**T** - Tell

**H** - Help

**E** - Explain

**R** - Return Visit



**Handout 4.7****Medical Interventions: Case Studies Part II****PART A****Case One: Manang Pacita****Part A**

Manang Pacita brings her mother-in-law to the clinic. After screening and assessment, the mother-in-law is brought to you.

- What questions will you ask the mother-in-law?
- What will be your management of the mother-in-law?
- How will you communicate your course of action to the mother-in-law?

In the course of your conversations with the mother-in-law, Manang Pacita mentions that she, too, has some vaginal discharge that does not smell good. From her history, you know that she is not using any contraception.

- What questions will you ask Manang Pacita?
- What will be your course of action?

While doing a physical examination on Manang Pacita, you notice bruises on her arms, legs and back. You ask her about it but she only shrugs her shoulders. What will you do?

**Closing Question: What do you think will happen to Manang Pacita and Manong Roger after your interventions?**

**Case Two: Brenda****Part A**

Brenda comes to the health facility for pre-natal check-up. This is the first time she comes to the clinic.

- What questions will you ask her?
- What management will you do?

Upon physical examination, you notice her bruises (fresh ones and older ones) and you ask her about it. She then says that after all the things she is doing, whenever her husband comes home drunk, he beats her. She further shares her indecision on whether to stay in the relationship or leave.

- What questions will you ask her?
- What management will you do?

Closing Question? What do you think will happen to Brenda and Manong Pedro after your interventions?

### Case Three: Susana

#### Part A

Susana comes to the health facility because her youngest child has high fever, vomiting and diarrhea. The symptoms started 24 hours ago and since then the child (8 months old) has become listless and only semi-responsive.

- What questions will you ask Susana about the baby?
- What immediate interventions will you do?

Upon further questioning, you find out that Susana's way of bringing up children is far from ideal. She also shares her concern about one of her sons growing up to be gay. What counseling will you give her?

### Case Four: Cynthia

#### Part A

Cynthia comes into your clinic with Lourdes complaining of her on-and-off again discharges. She is visibly nervous and shy. Lourdes does most of the talking.

- How will you handle this situation?
- What will you tell Cynthia?
- What interventions/treatment will you recommend?

### Case Five: Lando

#### Part A

Lando goes to your clinic and asks to see Dr. Neil. Dr. Neil comes to the clinic once a week only and today is not his clinic duty day.

- What will you do?
- How will you make Lando feel comfortable in the clinic when most of the clients are women and they notice Lando's presence?

## PART B/C

### Case One: Pacita

#### Part B

After one week, both Pacita and her mother-in-law come back to the clinic. The results of the laboratory exams show that the mother-in-law has cervical cancer.

- How will you manage her now?

The results of the laboratory exam for Pacita showed that she has STI. How will you share this findings with Pacita? What will be your course of action?

#### Part C

Manong Roger comes into the clinic complaining of pain and difficulty in urinating.

- What will be your course of action?
- What counseling will you do?

**Closing Question: What do you think will happen to Pacita and Roger after your interventions?**

### Case Two: Brenda

#### Part B

After three days, Brenda is back in the clinic. She is now pale and distraught. She has been bleeding since the night before after a particular heavy beating from her husband.

- How will you manage the situation?
- What immediate interventions will you do?
- What additional counseling will you give her?

**Closing Question: What do you think will happen to Brenda and Pedro after your interventions?**



**Case Three: Susana****Part B**

Susana comes back to the clinic one week later than her scheduled appointment. She explained that she was unable to come earlier to the clinic because she was not feeling very well—dizziness, weakness with accompanying nausea. When you probe further about her condition, she dismissed your probing as “pagod lang at kailangan magpahinga.” She said she only has time for you to examine the baby and she has to rush back home.

- How will you approach this situation?
- What possible questions will you ask Susana to surface any reproductive health problem that she might have?
- What interventions, if any, will you give?

**Closing Question:** What do you think will happen to Susana after your interventions?

**Case Four: Cynthia****Part B**

Upon physical examination, you find out that she is three months pregnant.

- What will you tell Cynthia? Will you also inform Lourdes?
- What interventions will you do?
- How will you counsel Cynthia?

**Closing Question:** What do you think will happen to Cynthia after your interventions?

**Case Five: Lando****Part B**

Lando comes back to see Dr. Neil. He shares with Dr. Neil his dilemma and opens up that if he does not get any help, his wife will probably leave him. He also wants to have children but is not sure if he is capable to have children.

- If you are Dr. Neil, what questions will you ask Lando?
- What will be your course of action?
- How will you go about in your counseling sessions?
- How will you ensure the Lando will keep on coming back for follow-ups?
- Will you also talk to Cherry?

**Closing Question:** What do you think will happen to Lando and Cherry after your interventions?

## Handout 4.8 Sample Intake Forms



### WOMEN'S HEALTH CARE FOUNDATION

Client No: \_\_\_\_\_

Date: \_\_\_\_\_

#### WOMEN'S DATA SHEET

Type of Patient:  New  Old  Continuing

##### PERSONAL DATA

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Civil Status: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Religion: \_\_\_\_\_ Ethic Origin: \_\_\_\_\_

Educational Attainment: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Office Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name of Spouse/Partner: \_\_\_\_\_

Occupation: \_\_\_\_\_ Office Address: \_\_\_\_\_

Source of Information/Referred by: \_\_\_\_\_

Coalition: Date of Membership \_\_\_\_\_  New  Renewed

Patient's Signature: \_\_\_\_\_

##### CHIEF COMPLAINT

- discharge  itching  fertility  
 bleeding  menstrual problems  prenatal/postnatal  
 others/specify: \_\_\_\_\_

##### HISTORY OF PRESENT ILLNESS

When it started: \_\_\_\_\_

Character (pain/discharge): \_\_\_\_\_

Accompanying S/S: \_\_\_\_\_

Medication taken and Source: \_\_\_\_\_

Result of Medication: \_\_\_\_\_

##### MENSTRUAL HISTORY

Date of menarche: \_\_\_\_\_ Average Cycle: \_\_\_\_\_ Average Duration: \_\_\_\_\_

Problems: \_\_\_\_\_

(MED FORM 1)

H  
A  
N  
D  
O  
U  
T  
S

### OBSTETRICAL HISTORY

OB Score: G \_\_\_\_\_ P \_\_\_\_\_  
 LMP = \_\_\_\_\_ EDC = \_\_\_\_\_  
 PMP = \_\_\_\_\_ AOG = \_\_\_\_\_

| Pregnancy | Outcome | Date | Place | Attended by | Complication |
|-----------|---------|------|-------|-------------|--------------|
| 1         |         |      |       |             |              |
| 2         |         |      |       |             |              |
| 3         |         |      |       |             |              |
| 4         |         |      |       |             |              |
| 5         |         |      |       |             |              |
| 6         |         |      |       |             |              |

### REPRODUCTIVE INTENT

No. of Children = \_\_\_\_\_ Spacing = \_\_\_\_\_

### FAMILY PLANNING HISTORY

| Method Use | Year | Reason for Choice | Duration | Reason for Change |
|------------|------|-------------------|----------|-------------------|
|            |      |                   |          |                   |
|            |      |                   |          |                   |
|            |      |                   |          |                   |
|            |      |                   |          |                   |
|            |      |                   |          |                   |

### PAST PERSONAL AND FAMILY HISTORY

Significant Findings Only: O = Normal

Past diseases/Childhood diseases: \_\_\_\_\_

Past operation/Hospitalization: \_\_\_\_\_

Allergies: Food: \_\_\_\_\_ Medicines: \_\_\_\_\_

Family diseases: Father side: \_\_\_\_\_

Mother side: \_\_\_\_\_

Others specify: \_\_\_\_\_

GT/VA: \_\_\_\_\_

### PERTINENT PHYSICAL EXAMINATION

Significant Findings Only: O = Normal

General Status: BP: \_\_\_\_\_ Wt: \_\_\_\_\_ Temp: \_\_\_\_\_

Skin: \_\_\_\_\_

HEENT: \_\_\_\_\_

Breasts: \_\_\_\_\_



Chest and Lungs: I = \_\_\_\_\_  
P = \_\_\_\_\_  
P. = \_\_\_\_\_  
A = \_\_\_\_\_

Cardiovascular System: \_\_\_\_\_  
\_\_\_\_\_

Abdomen: I = \_\_\_\_\_  
P = \_\_\_\_\_  
P = \_\_\_\_\_  
A = \_\_\_\_\_

Extremities: \_\_\_\_\_  
\_\_\_\_\_

**PELVIC EXAMINATION**

External Genitalia: \_\_\_\_\_  
\_\_\_\_\_

Speculum Examination: \_\_\_\_\_  
\_\_\_\_\_

Vaginal Wall: \_\_\_\_\_  
\_\_\_\_\_

Cervix:

- soft       open       mass       blood/discharge on examining finger  
 firm       closed       tenderness

Uterus: \_\_\_\_\_  
\_\_\_\_\_

Adnexae: \_\_\_\_\_  
\_\_\_\_\_

**IMPRESSION**

\_\_\_\_\_  
\_\_\_\_\_

**LABORATORY EXAMINATIONS**

\_\_\_\_\_  
\_\_\_\_\_

**MANAGEMENT**

- A. Medicine/s \_\_\_\_\_  
B. Procedure/s/Treatment \_\_\_\_\_  
C. Advise/Instructions Given \_\_\_\_\_  
D. Referred to \_\_\_\_\_

**REMARKS**

\_\_\_\_\_  
\_\_\_\_\_

Next Appointment \_\_\_\_\_

Attended by:

\_\_\_\_\_ MD      \_\_\_\_\_ PS/PA      \_\_\_\_\_ MT

Handout 4.9

**One-Year Action Plan  
Gender-Responsive and Rights-Based Integrated  
Reproductive Health Training**

Name: \_\_\_\_\_ Position: \_\_\_\_\_  
Agency: \_\_\_\_\_

Name of Immediate Supervisor: \_\_\_\_\_  
Position: \_\_\_\_\_  
Office Address: \_\_\_\_\_

**GOAL**

To improve the quality of life of women, men and adolescents through integrated reproductive health care services that is gender-responsive and rights based.

**1. Integrating Gender-Responsive, Rights Based RH  
in Service Delivery Protocols**

| Objective | Outputs | Activities | Inputs |
|-----------|---------|------------|--------|
|           |         |            |        |
|           |         |            |        |
|           |         |            |        |
|           |         |            |        |

**2. Integrating Gender-Responsive, Rights Based RH  
in the Health Facility Set-Up**

| Objective | Outputs | Activities | Inputs |
|-----------|---------|------------|--------|
|           |         |            |        |
|           |         |            |        |
|           |         |            |        |
|           |         |            |        |

**3. Personal Action Plan**

| Objective | Outputs | Activities | Inputs |
|-----------|---------|------------|--------|
|           |         |            |        |
|           |         |            |        |
|           |         |            |        |
|           |         |            |        |

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## Some Indicators of Women's Reproductive Health

### Maternal mortality and professional attendance at birth

Maternal mortality rate was estimated in 1998 at 172/100,000 live births, a high rate by universal standards. The target of the Millennium Development Goals (MDGs) is to reduce this to three quarters of its present level by 2015, or to bring down the number of women dying of maternal-related deaths to 43/100,000 in nine years. The National Statistics Office (NSO)<sup>1</sup> estimated the MMR at 108.1/100,000 in 2002. Despite this lower estimate, meeting the MDG target could be hampered by scarce resources available for health programs.

Related to the issue of maternal death is the attendance at birth of a health professional to help stave off danger to the woman's and the infant's health. In 2005, traditional birth attendants (TBAs) or "hilots" assisted in more than one third of birth<sup>2</sup> deliveries. Women lack awareness of the risks they face; they have little resources to pay for hospital bills and professionals and in many cases are remote from health facilities. In comparison, TBAs charge smaller fees; they are more accessible and regular in their visits and are better in establishing rapport with their clients.

**Table 1.** % of births attended by health professionals

| <i>Attendance at birth</i> | <b>2004 FPS*</b> | <b>2005 FPS*</b> |
|----------------------------|------------------|------------------|
| Doctors                    | 36.3             | 36.5             |
| Nurses                     | 1.6              | 1.4              |
| Midwives                   | 25.1             | 25.8             |
| Hilots                     | 35.7             | 34.9             |
| Others                     | 1.2              | .8               |

\*Source: NSO

Another consideration of maternal health is where birthing takes place. A health facility offers a more secure and safe place for health delivery due to the availability of health personnel, equipment and medicines in case of need. The same survey reveals that more than half of births were delivered at home.

**Table 2.** Place of delivery

| <i>Place of birth delivery</i> | <b>2005 FPS*</b> |
|--------------------------------|------------------|
| At home                        | 57.4             |
| Public facility                | 27.1             |
| Private facility               | 14.4             |
| Others                         | 1.1              |

Source: NSO

<sup>1</sup> National Demographic and Health Survey 2003, National Statistics Office

<sup>2</sup> Family Planning Survey 2005, National Statistics Office



## Mortality risks

Data also point out that more than two thirds of pregnancies in the last two surveys were at risk of mortality, both for single and multiple risks. Single risks are recognized for women who are less than 18 or more than 34 years old, the birth interval is less than 24 months and birth order is higher than 3. Multiple risks are a combination of single risks, i.e., age is less than 18 and birth interval is less than 24 months; or age is more than 34, birth interval is more than 3 and interval is less than 24 months, etc. Risk was highest (one in four) for mothers who were more than 34 years old when they conceived and who have had more than three children at the time of pregnancy.

**Table 3.** Mortality risks of pregnant women

| <b>% of women who are at risk of mortality</b> | <b>2004 FPS*</b> | <b>2005 FPS*</b> |
|--|------------------|------------------|
| Not in any risk                                | 32.3             | 34.5             |
| In any risk                                    | 64.7             | 65.3             |
| <i>Single risk</i>                             | 27.9             | 29.9             |
| Mother's age <18                               | .3               | .4               |
| Mother's age >34                               | 10.9             | 10.3             |
| Birth interval <24 mos                         | 9.3              | 8.8              |
| Birth order >3                                 | 7.3              | 10.4             |
| <i>Multiple risk</i>                           | 36.8             | 35.4             |
| Age<18 & BI <24 mos                            | .1               | .2               |
| Age>34 & BI<24mos                              | .5               | .4               |
| Age >34 and BO >3                              | 25.8             | 24.9             |
| Age >34, BO >3&BI<24mos                        | 3.7              | 3.1              |
| BI<24mos & BO >3                               | 6.6              | 6.8              |

\*Source: NSO

## Contraceptive use

The benefits of fertility regulation or family planning on the health of women and that of their children are widely recognized. Family planning allows the woman's body to recover fully from the emotional, physical and oftentimes financial rigors of childbirth and enables the mother to care for her children and give them more time and attention. An interval of less than 24 months is one of the mortality risks faced by women, more so if they are less than 18 or more than 34 years old and have had more than 3 children.

The International Conference on Population and Development or ICPD (1994) recognized the need to broaden family planning programs through the reproductive health approach, calling for universal access to a full range of safe and reliable family planning methods and the provision of related reproductive and sexual health services. Present contraceptive methods and technologies are mostly women-oriented. Considering that women are oftentimes powerless to decide on when to get pregnant or are not fully informed of available contraceptive methods, the burden of fertility regulation falls heavily on them.

Contraceptive prevalence rate (CPR) measures the extent that couples of reproductive age use any of the available methods to regulate their fertility. Based on the FPS of 2004 and 2005, below is the rate of contraceptive use by currently married women of reproductive age by all methods. From 2004 to 2005, the CPR remained at less than half (49.3%) of the targeted population. The use of pills increased while the use of condom, also critical in the prevention of sexually-transmitted infections, slightly declined.

**Table 4.** Contraceptive prevalence rate

| <i>Contraceptive prevalence rate</i> | <i>2004 FPS*</i> | <i>2005 FPS*</i> |
|--------------------------------------|------------------|------------------|
| <b>Total</b>                         | <b>49.3</b>      | <b>49.3</b>      |
| <i>Modern</i>                        | <i>35.1</i>      | <i>36</i>        |
| Ligation/female sterilization        | 9.4              | 9.1              |
| Vasectomy/male sterilization         | .1               | .1               |
| Pill                                 | 15.6             | 17.1             |
| IUD                                  | 3.9              | 3.9              |
| Injectables                          | 3.6              | 3.2              |
| Male condom                          | 2.1              | 1.9              |
| Mucus/billings/ovulation             | .1               | 0                |
| Standard days                        | .1               | 0                |
| Lactational amenorrhea (LAM)         | .3               | .3               |
| <i>Traditional</i>                   | <i>14.2</i>      | <i>13.2</i>      |
| Calendar/rhythm/periodic abstinence  | 6.9              | 6.5              |
| Withdrawal                           | 6.8              | 6.3              |
| Other traditional methods            | .5               | .4               |
| <i>No method</i>                     | <i>50.7</i>      | <i>50.7</i>      |

\*Source: NSO

The surveys also point to a high percentage of unmet need for family planning. This refers to couples who do not want additional children or want to postpone pregnancy but are not using any method of family planning.

**Table 5.** Unmet need for family planning

| <i>Unmet need for FP</i> | <i>2004 FPS*</i> | <i>2005 FPS*</i> |
|--------------------------|------------------|------------------|
| Total                    | 20.6             | 20.1             |
| Limiting                 | 9.7              | 9.2              |
| Spacing                  | 10.8             | 10.9             |

\*Source: NSO

## Abortion

A study by Perez et al. in 1997 revealed that 400,000 cases of abortion occur annually. According to the Department of Health, 12 percent of maternal deaths in 1994 were due to complications related to abortion, making it at that time the fourth leading cause of maternal death. The most vulnerable women are the poorest ones. Abortion is closely linked to unwanted pregnancies, particularly for teenage pregnancies, women's experience of violence, lack of access to family planning services and economic difficulties.

## Adolescent reproductive health<sup>1</sup>

The report on the 2002 Young and Adult Fertility and Sexuality Study (YAFSS3) provides substantial information on the sexual and reproductive health situation of young adults. The report states that a sizable percentage (23%) of young people had premarital sex experiences. The incidence among boys (31.1%) was double that of girls (15.4%). These figures registered marked increases from the 1994 survey: 18% incidence for both sexes- 25% for boys and 11% for girls.

The report also reveals increasing high risk behaviors among the young. Among sexually active boys, 20% reportedly have paid for sex and 12% have accepted payment for sex. The comparative figure for girls was 1%. More girls tended to engage in unprotected sex during their first sex episodes (62.3% vs. 28.2%) and last sex episodes (74.7% vs. 67.5%). And while there seemed to be widespread information about HIV/AIDS (94% have heard of it), 23% thought that it is curable and 60% believed that there is no chance for them to contract the infection.

These young women and men, estimated to number 18.8 million in 2002 will shape the country's future development. They need information and services to reduce their risks and exposure to reproductive health problems and behaviors, such as teenage pregnancies, abortion, sexually-transmitted infections, smoking, drug addiction and alcoholism, to enable them to become healthy and productive leaders and citizens.

## STI/HIV/AIDS<sup>2</sup>

There is a rising incidence of sexually-transmitted infections (STIs) including HIV infections in the country. Among women 15-44 years of age, the morbidity and mortality due to STIs - excluding HIV - are second only to maternal causes. Complications are more common in women because they are less likely to be aware of symptoms at the early stage of infection. STIs can lead to stigmatization, conflicts and even abuse among sexual partners.

STIs have been known to increase up to ten times the risk of acquiring HIV. They are transmitted mainly through heterosexual contact (83% of cases). The Philippine HIV Health registry reports that from January 1984 to August 2005, there were 2,333 cases of HIV Ab seropositives (including asymptomatic and symptomatic AIDS, living or dead), 697 of whom had AIDS. There were 273 deaths due to AIDS at the time of the report. The Department of Health estimates that HIV cases would reach more than 10,000 by the end of 2005.

High risk behaviors such as practice of multiple sexual partners and low condom use are widespread especially among groups whose potential for STI/HIV is highest. With the majority of the population believing that they are far from being at risk to HIV/AIDS, there is need for increased information dissemination about predisposing socio-cultural, economic, psychological and behavioral factors that might increase their probability of exposure and infection.

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<sup>1</sup> From the paper prepared by Dr. Corazon M. Raymundo, Project Coordinator of the 2002 Young Adult Fertility and Sexuality Study (YAFSS3) for the first presentation of study results held at Galleria Suites, Pasig City on December 11, 2002.

<sup>2</sup> Gender Responsive and Rights-Based Integrated Reproductive Health: A Training Manual, reference volume on HIV/AIDS, NCRFW-DOH, 2005.



## **Violence against women**

The UN Declaration on the Elimination of All Forms of Violence against Women defines violence against women as “any act of gender based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or private life.” Violence against women (VAW) is the most concrete manifestation of unequal power relations in a family or in an intimate relationship. VAW is also closely tied to the issue of women’s reproductive health and rights: HIV/AIDS, STIs, family planning (Beijing Platform for Action).

Worldwide, it has been noted that the health burden of gender-based violence is comparable to other diseases like HIV/AIDS, TB, cancer and cardiovascular diseases. Rape and violence are major causes of disability and death among women. VAW has also been noted to account for one out of every five healthy days lost to women.

The Philippines has passed several laws to address VAW, such as the Anti-Violence Against Women and their Children Act (RA 9262), Anti-Trafficking Law (RA 9208) and Anti-Rape Law (RA 8353). The Women and Children Protection Units (WCPUs) established by DOH in government hospitals are expected to assist women victims. However, due to scarce resources, not all of these WCPUs have adequate facilities and other resources to enable them to responsively serve them.

# Background Information on the Training Manual

The 5<sup>th</sup> and 6<sup>th</sup> Country Programs Supported by UNFPA

Under the 5<sup>th</sup> country program, the Department of Health (DOH), with financial assistance from the UN Population Fund (UNFPA) developed three training guides on the ten elements of reproductive health (RH). One training guide was developed for doctors, nurses and midwives, each guide consisting of four parts: Part I presents an overview of reproductive health; Part II discusses the development of a training program and Part III is a training strategy for field health workers in reproductive health. Part IV is a facilitator's guide, divided into 13 units representing the elements in reproductive health.<sup>1</sup> Each unit includes an introduction, a list of competencies expected of a health worker, an instructional plan, reference or reading materials, procedures and evaluation. Each module was designed for a 15-day training. The training modules were pre-tested in selected areas in Bulacan, and eventually used in a 15-day Training of Trainers.<sup>2</sup>

Under the 6<sup>th</sup> Country Programme, the annual work plans of the National Commission on the Role of Filipino Women (NCRFW), the Department of Health (DOH) and pilot local government units (LGUs) include common activities related to these training modules. NCRFW was tasked to review and make the modules more gender responsive, the DOH was expected to use the gender responsive modules to train two batches of trainers of DOH and LGU service providers on gender responsive integrated reproductive health while the trained LGUs were to conduct roll-out training in their respective areas.

In the initial discussions with DOH, primarily with officials from the National Center for Disease Prevention and Control (NCDPC), NCRFW was informed that the training modules could not be officially used for training because they were still not approved and adopted by DOH. They also believed that these were more suitable as references rather than as training modules. Thus, after several meetings, NCRFW and DOH agreed to jointly undertake their review and enhancement. They engaged a team of consultants from Health and Development Initiatives Institute (HDII)<sup>3</sup>, who, under the guidance of and in consultation with both agencies would lead the enhancement of the modules.

The series of agency meetings arrived at the following agreements:

1. To make it more user-friendly, the three training modules would be repackaged into one training manual to serve doctors, nurses and midwives (It was observed that the three modules had almost identical contents). The manual would have two parts: A Facilitator's Guide and a Reference Manual. The Reference Manual would contain the updated information and protocols on the ten elements of reproductive health (RH). To the extent possible, the materials in the original training modules would be updated and used;

<sup>1</sup> The training guide for midwives has only 12 units. It does not include Unit 13 (Strategic Leadership, Management and Quality Care) present in both the doctors' and nurses' modules.

<sup>2</sup> Preface, Volume I of the Guide for Training Nurses on Reproductive Health, UNFPA-DOH, n.d.

<sup>3</sup> HDII consultants are Ms. Gladys Malayang, a health and management trainer and currently Executive Director of HDII and Erlinda Palaganas, PhD, a registered nurse, trainer and a university professor based at the University of the Philippines in Baguio.

2. DOH and NCRFW would agree on a harmonized framework that integrates gender, rights, FOURmula One and RH. The training manual would be developed based on this harmonized framework;
3. NCRFW, through HDII would develop the facilitator's guide; DOH would update the protocols and ensure the technical accuracy of the reference manual on the ten RH elements;
4. Two joint peer reviews would be conducted to chart the progress of the drafting of the guide and the review of the reference manual.
5. The pre-test of the manual (by NCRFW) would also serve as the first trainers' training (by DOH). Feedback from the first pre-test/TOT would be used to further enrich the manual. NCRFW would assist DOH in the conduct of the second TOT.
6. The two agencies also agreed on schedules, sharing of expenses and delineation of work in the peer review and in the pre-test/TOT. The pre-test/TOT would be held in November 2005. DOH would identify and invite the participants while NCRFW would make the arrangements and shoulder the expenses. The consultants would facilitate the training with the help of DOH trainers.

## **Manual Development Process**

The development of the Facilitator's Guide and the updating of the Reference Manual on RH followed the agreements between DOH and NCRFW. The framework that harmonized gender, rights, culture and the Fourmula One strategy became the basis in drafting the Facilitator's Guide. (The harmonized framework was approved by DOH in the meeting of the Executive Committee on February 8, 2006. Please see p.78 for the framework). The list of DOH designated program managers who lead the review and updating of the ten RH elements contained in the reference manual is found under the Acknowledgment page of this Manual.

The two peer review sessions were held on October 18 and November 11-12, 2005. The pre-test/first TOT was conducted for five days, from November 27-December 2, 2005 at Fontana Leisure Park in Clark Field, Pampanga with 27 participants from DOH central office and pilot areas in Luzon, Visayas and Mindanao. Participants were program managers, provincial and city health officers, trainers from the DOH Center for Health and Development (CHD), RH area coordinators and some municipal health officers. The second TOT was conducted by DOH in February 2006 in Manila, with assistance from NCRFW and HDII.

## **The two training sessions on gender and RH**

The pre-test and TOT surfaced the need to deepen the understanding of the trained trainers on the basic concepts on gender and its links to RH. This is important in the conduct of the roll out training for the manual, where they are expected to process the exercises on gender and RH and adequately explain the importance of a gender, rights and culture sensitive approach to service provision. To respond to this need, DOH and NCRFW agreed that those who went through TOT would undergo a deepening session on gender and RH. Thus, NCRFW (with HDII) conducted two batches of training- one for each of the two sets of participants of the TOT- during the first quarter of 2006 before the start of the roll out training.



The deepening sessions included more intensive exercises using tools on gender analysis. The results of the Community Needs Assessment conducted by UNPPA in Mt. Province, particularly the municipality of Paracelis and its four pilot barangays (Anonat, Bantay, Bunot and Buringal) were used as case studies. DOH included a trainer from the Health Human Resource Development Bureau (HHRDB) in the second batch. The advocacy is towards engendering the other DOH programs, particularly those that are foreign-assisted.

## **Finalization and Approval of the Training Manual**

The pre-test and TOTs yielded additional inputs in the revision of the training manual. As well, the module in the deepening sessions also enriched the final version of the Facilitator's Guide. The DOH program managers conducted a final review of the reference manual as to technical accuracy and to make sure that it is updated according to current protocols in service delivery.

On 26 January 2006, the manual was presented by NCDPC and NCRFW with the consultants to Undersecretary Ethelyn Nieto and to NCDPC Director Yolanda Oliveros. The result was an agreement for NCDPC to present the manual to the Executive Committee (ExeCom) of DOH, chaired by Secretary Francisco Duque III, for approval. The ExeCom meeting on February 8, 2006 approved the manual and the harmonized framework. (Please see *Annex 2* for a copy of the resolution approving the manual). A *Department Circular* mandating concerned DOH officers at national and sub-national level to use the manual in their training on reproductive health was issued on August 9, 2006.



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**Department of Health Executive Committee**  
**RESOLUTION NO. 30 – 09**  
**Series 2006**

"RESOLVED, that the Executive Committee of the Department of Health (DOH) approve, as it hereby approves, the proposed Integrated Reproductive Health Framework and Modules of the Gender-Responsive & Rights-Based Integrated Reproductive Health Training."

Approved at the regular Executive Committee Meeting of DOH on February 8, 2006, at OSEC Conference Room, Building 1, 2<sup>nd</sup> floor, San Lazaro Compound, Sta. Cruz, Manila.

**APPROVED BY:**

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Undersecretary of Health

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Undersecretary of Health

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Secretary of Health

**ATTESTED BY:**

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The National Commission on the Role of Filipino Women



Department of Health



United Nations Population Fund