SUPPLEMENTAL TRAINING MODULE

Gender Integration in Family Planning Services

TRAINER'S MANUAL

পরিবার পরিকল্পনা অধিদপ্তর

Supplemental Training Module on Gender Integration in Family Planning Services

TRAINER'S MANUAL

Accelerating Universal Access to Family Planning (AUAFP)/ Shukhi Jibon Project 2022

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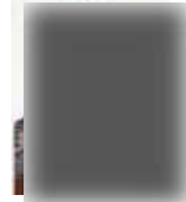

Forward

Bangladesh had made significant achievements during the last decades in reducing population [illegible] maternal and child health. In the last 50 years, Bangladesh has successfully halved infant [illegible] maternal mortality rate by 75%. Moreover, the total fertility rate has been brought down to 2.04 in 2020 from about 7 in the 1970s and this target should be brought down to 2.0 by 2022 to achieve a replacement level of fertility. To achieve this goal, the Contraceptive Prevalence Rate (CPR) should be raised to at least 75%, to achieve this we need to increase the participation of permanent and long-term methods to 20%. Reducing the maternal mortality ratio from 165 to 70 per lakh live births in Bangladesh by 2030 is an important goal of this program to achieve the Sustainable Development Goals. Various statistics have shown that gender norms, roles, behaviors, and practices affect family planning, and maternal and child health services. In this context, this Gender Integrated Family Planning Service Manual has been developed.

Almost all of us are acquainted with the word 'gender'. Gender-related knowledge identifies ongoing inequalities in personal, family, professional and social life and paves the way for equality. Gender roles and norms are deeply involved in the services of those who are especially involved in family planning, maternal and child health, and sexual & reproductive health services. Considering various indicators, it has been observed that gender norms and behaviors are closely linked with family planning and sexual & reproductive health services. In consequence, it has a huge impact on underprivileged people, especially on women's health, such as child marriage, adolescent pregnancy, infant/child mortality, and maternal mortality. Therefore, the elimination of gender inequality is essential in the development of maternal and child health.

In this context, the Directorate General of Family Planning (DGFP), Directorate General of Health Services (DGHS), National Institute of Population Research and Training (NIPORT), Shukhi Jibon Project, Pathfinder International, and USAID have jointly developed this Gender- Integrated Family Planning Service Manual. Sincere thanks and appreciation to all those who have been involved in the development of this manual for their timely assistance. This manual is a commendable initiative by the Shukhi Jibon project. The main content of the manual is designed for family planning and sexual and reproductive health care providers. Through this, service providers will get an initial idea about gender and better understand the connection of gender with family planning, and maternal and child health services. This manual can be used for basic training of family welfare visitors (FWVs). All the other manuals that are supplemented with this manual can be used in any training on family planning and maternal and child health services.

I firmly believe that the manual will contribute to developing service providers' knowledge, skills, behavior, and attitudes as well as performance. I also hope that gender will play a vital role in providing integrated family planning, and maternal and child health services.

Shahan Ara Banu, ndc
Director General (Grade 1)
Directorate General of Family Planning (DGFP)

Message

The Family Planning (FP) program of Bangladesh is a model for many countries and is appreciated all over the world. The United Nations recognized the Government of Bangladesh with an award for outstanding achievements in Maternal and Child Health Development. Extensive initiatives have been taken to ensure 24-hours safe delivery services at Union Health and Family Welfare Centers across the country. Adolescent-friendly corners are being set up in all service centers gradually. This reputation has been made possible by the multifaceted family planning programs through the last few decades. In line with the Sustainable Development Goals (SDG), Bangladesh has already made promising progress in achieving the targets of indicators related to family planning, maternal and child health. This progress and success have been made possible by the sincerity and dedication of the skilled service providers of the Directorate General of Family Planning Bangladesh (DGFP).

According to the Family Planning Program of the Government of the People's Republic of Bangladesh, bringing down the Total Fertility Rate (TFR) of eligible couple to 2.0 by June 2023 will make it possible to achieve the replacement level of fertility. Therefore, the Contraceptive Prevalence Rate (CPR) should be increased 75% and the participation of permanent and long-acting methods needs to be increased to 20%. By June 2023 we need to reduce the rate of unmet need for family planning from 12% to 10%; the adolescent pregnancy rate of 15-19-years old couples should be reduced from 30.8% to 25% and discontinuation rate should be reduced from 37% to 20%.

Proper use of family planning methods will play a helpful and necessary role in fulfilling our targeted objectives and goals. Besides, the role of family planning methods in maintaining maternal and child health is undeniable. We know that if we can ensure the use of family planning methods then it will reduce maternal and child mortality. Another significant cause of maternal mortality is repeated pregnancy, delivery, childbirth-related complications, especially ante-natal and postpartum complications that can be easily reduced through the use of family planning methods. At the same time, the desired goals of these indicators can be attained by increasing the knowledge and skills of the service providers. Considering the above and analyzing the underlying causes, it has been observed that one of the factors affecting the objective indicators is: gender-based violence caused by gender norms, customs and practices.

The Government of Bangladesh identified three issues as "Zero Tolerance": zero maternal mortality; zero unmet need of family planning and zero gender-based violence. Many issues can be solved if we work diligently on gender-based violence and sexual and reproductive health-related violence and rights. While implementing various activities, it has been observed that although the service providers have an idea about gender and gender-based violence, there is a lack in the service delivery, information sharing and gender-based knowledge to the clients. This manual has been developed with the joint efforts of the Directorate General of Family Planning (DGFP), Directorate General of Health Services (DGHS), NIPORT and 'Shukhi Jibon' Project.

I would like to express my sincere gratitude and appreciation to all those who have extended their support for the overall collaboration in the development and formulation of this Manual. Special thanks to all those involved in the USAID 'Shukhi Jibon' project for their timely cooperation. Following this manual, it is very important to provide appropriate and quality gender-sensitive services, which in my opinion, is very necessary for a quality program. I expect and believe that all service providers and managers involved in the family planning program will make the best use of it. Ultimately, the effective use of this manual will enable service providers to address violence in the provision of family planning services, maternal and child health services, adolescent health services and above all sexual and reproductive health services and finally assist in ensuring quality services through joint ventures.

Md. Niajur Rahman
Director (Finance) Line Director (Family Planning - Field Service Delivery)
Directorate General of Family Planning

Acknowledgments

The USAID Accelerating Universal Access to Family Planning Project, also known as Shukhi Jibon, is implemented by Pathfinder International, and works with the Government of Bangladesh (GOB) to build the responsiveness of the health care system and improve the health, especially of women and adolescents, by increasing the use of sexual and reproductive health (SRH) and family planning (FP) services. Shukhi Jibon provides technical support to the GOB to improve the skills of FP service providers and implement reproductive health strategies for disadvantaged people such as newlyweds, first-time parents, adolescents, and postpartum women. Gender is integrated in all the activities of the Shukhi Jibon Project.

Gender norms and related factors greatly influence reproductive health and family planning practices; however, FP service providers do not always understand how gender is associated with family planning services and health care. Considering this context, Shukhi Jibon developed a manual on gender integration in family planning services.

This manual provides an introduction to gender with a focus on how gender influences SRH/FP services and practices. The manual can be used in any training related to SRH services. Since it includes some Bangla words that have not been found in any other manual, both the Bangla and English terms have been kept for ease of reference. The Gender-Integrated Family Planning Services Manual was field-tested and vetted by a technical working group.

The manual will enable FP service providers to increase their knowledge and skills on gender and contribute to improving the quality of services. Our gratitude to the Directorate General of Family Planning (DGFP), Directorate General of Health Services (DGHS), and National Institute of Population Research and Training (NIPORT), as well as the subject matter experts and Shukhi Jibon team members who were involved in supporting the development of this manual.

Md. Mahbub Ul Alam
Project Director, USAID Shukhi Jibon and
Country Director,
Pathfinder International

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Acronyms and Abbreviations

Acronym	Meaning
AUAFP	Accelerating Universal Access to Family Planning
BOHS	Bangladesh Demographic and Health Survey
CPR	Contraceptive prevalence rate
FP	Family planning
GBV	Gender-based violence
HTSP	Healthy timing and spacing of pregnancy
IPV	Intimate partner violence
IUD	Intrauterine device
MoHFW	Ministry of Health and Family Welfare
RH	Reproductive health
SGBV	Sexual and gender-based violence
SRH	Sexual and reproductive health
USAID	United States Agency for International Development
VAW	Violence against women

Notes to the Trainer

Introduction

Bangladesh's family planning (FP) program has achieved significant success,[1] however, the latest Bangladesh Demographic and Health Survey shows that the contraceptive prevalence rate (62%) and unmet need for FP (12%) have remained stagnant over the last decade.[2] Similarly, rates of girl's marriage and adolescent fertility rates remain high.[3] Given this situation, it is urgent that people working in health programming and service delivery reflect on the gaps, barriers, and constraints that women, men, girls, and boys face when it comes to contraceptive choice and decision making.

USAID's Shukhi Jibon project has organized a range of trainings to build the capacity of health care service providers and managers, with the aim of developing competent trainers and service providers in the FP program. Gender is a cross-cutting issue in these efforts. The project's objectives related to gender are:

- Support USAID's Gender Equality and Female Empowerment Policy.
- Promote gender transformation.
- Work to reduce gender-based violence (GBV), mitigate barriers to FP and sexual and reproductive health (SRH) access, and engage men and boys in their own health and that of their families.

Goals and Objectives of the Supplemental Module

Overall Goals

This module aims to help participants to:

1. Understand key concepts related to gender norms, gender dynamics, and gender-sensitive FP service delivery.
2. Gain familiarity with the interaction between FP/RH programs and gender dynamics.
3. Acquire knowledge of the impact of gender inequality and violence against women (VAW) on FP/RH in Bangladesh.
4. Develop foundational skills in gender-sensitive FP service provision.

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[1] According to the BDHS (2017-18), the total fertility rate (TFR) decreased from 6.5 in 1975 to 2.3 in 2018.

[2] National Institute of Population Research and Training, Medical Education and Family Welfare Division Ministry of Health and Family Welfare, *Bangladesh Demographic and Health Survey (BOHS} 2017-2018.* (Rockville, MD/Dhaka: ICF/MoHFW, 2019).

[3] According to BDHS 2017-18, 59% of women ages 20-24 married before age 18 and the adolescent fertility rate is 28%.

Specific Learning Objectives:

By the end of this module, participants will:

- Recognize and define key gender concepts.
- Describe how gender impacts family planning and reproductive health (FP/RH).
- Identify elements of FP service provision that influence or are influenced by gender dynamics.
- Explain the continuum of gender as it relates to integrating gendered approaches into family planning service provision.
- Describe the 4 approaches to gender integration in programs and services.
- Describe the core competencies of a gender-sensitive FP service provider.
- Explain elements of client interaction in relation to the relevant gender competencies.
- Demonstrate gender-sensitive counseling.
- Explain ways of facilitating positive couple's communication and decision making.
- Describe the "do no harm" principle surrounding FP service provision and the risk of violence against women.
- Demonstrate how to respond to disclosures of SGBV with appropriate first-line information

Suggestions for Use

Timing

This module is designed to take 3 hours.

The guide contains an optional 30-minute session (Session 2: Continuum of Gender-Aware Service Delivery). If only 3 hours are available for training, this session may be omitted. However, it is strongly recommended that facilitators make time for this session. A clear understanding of the gender continuum helps participants understand how to situate their work and goals in relation to broader gender equity goals.

Audience

The guide is available in English and Bangla languages and can be incorporated into trainings for family planning health care workers of any cadre. The module was designed with health care providers in mind, but it can also be used as supplementary reference material for gender training and self-directed learning by a wide range of professionals in the health system, both at institutional and facility levels.

Use

The module is designed to be added into any training or workshop, or to be delivered alone. If it is not part of a larger training, facilitators should begin with introductions and an ice breaker activity to allow participants to get to know one another. Facilitators may draw on other Shukhi Jibon training curricula (such as the *Mentorship and Supportive Supervision: Training Manual)* for guidance on initiating a training, making introductions, and setting group norms for the training. If this module is not being delivered as part of a larger training, facilitators should also consult the Facilitation Module of Shukhi Jibon's *Counseling Adolescents on Sexual and Reproductive Health: Trainer's Manual* for guidance on adult learning theory and best practices in facilitation.

Guide to Symbols

Symbols are used throughout the unit to help guide and instruct trainers. These symbols include:

TOTAL SESSION TIME

Estimated time needed for each session. All times listed are suggested and subject to change depending on participant learning needs.

LEARNING OBJECTIVES

What the participants are expected to learn from each session; what they are expected to be able to do as a result of the session.

METHODOLOGIES

Training methods used in the module (for example, discussion or roleplay).

MATERIALS NEEDED

Materials needed to teach the session (for example, flipchart and markers).

ADVANCE PREPARATION

Planning and preparation for a session or exercise that should be undertaken in advance.

RESOURCES

A list of guidelines, books, journals, websites, and other documents that may be useful to trainers/facilitators or participants who want more information on topics or issues related to a specific session's content.

FACILITATOR NOTES

Notes on how a particular issue or session should be dealt with.

Materials Needed

- Trainer's Manual
- PowerPoint (PPT) slides to accompany each module
- Participant handouts (located in Annex 1)
- Laptop computer, projector, and screen to show PPT
- Flipchart paper, easel, and markers

Overview of the Supplemental Module

Session	Time
Session 1: Understanding Gender and its Role in Family Planning and Reproductive Health	30 min.
Session 2: Continuum of Gender-Aware Service Delivery [Optional]	30 min.
Session 3: Gender Competent Service Provision	45 min.
Session 4: Skills Development - Gender-Sensitive Counseling	45 min.
Session 5: Skills Development - Responding to Gender-Based Violence	45 min.
Concluding the Module	15 min.
Total Module Time	**3 hours***

Does not include breaks or optional Session 2

Guidance on Facilitating Discussion of Gender Issues

To facilitate open and nonjudgmental discussions, trainers should take time to:

- Consider their own assumptions and biases. Take time to consider your opinions about gender and why you hold them.
- Practice using neutral language (this includes gender-neutral language) and avoid making judgments about "right" or "wrong" behavior.

The role of the trainer in a participatory session is one of guidance, not authority. Training should be a learning journey that participants and trainers take together, not a one-off delivery of information from expert to audience. While there are content presentations included in the manual, the trainer should always strive to achieve a dialogue with participants.

Setting Ground Rules for Gender Discussions

Before starting the training, work with participants to agree to set of "ground rules." Because of the sensitive nature of discussions on gender, the ground rules should emphasize:

- Privacy and confidentiality for participants
- Using nonjudgmental language in the training space
- Allowing space for reaction and emotion
- Admitting when you do not know something
- Treating each other with respect
- Creating space for each person to speak

It is good practice to post the list of ground rules in the room where participants can see them, and periodically revisit them during the training.

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Understanding Gender and its Role in Family Planning and Reproductive Health

TOTAL SESSION TIME

30 minutes

LEARNING OBJECTIVES

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

- Recognize and define key gender concepts.
- Describe how gender impacts family planning and reproductive health (FP/RH).
- Identify elements of FP service provision that influence or are influenced by gender dynamics.

METHODOLOGIES

- Presentation
- Discussion
- Group activity

ADVANCE PREPARATION

- Review slides and training content
- Make copies of Handout 1A for all participants.

MATERIALS NEEDED

- Flipcharts
- Markers
- Training slides 1-11
- Handout 1A

FACILITATOR NOTE

Ensure that you are comfortable with module content and can present the module without displaying any prejudices in your verbal and non-verbal communication during the session. If you are being supported by co-facilitator, ensure that they do the same values self-review and preparation for the session.

Activity 1: Presentation (5 minutes)

Module and Session Objectives

STEP 1

Begin by presenting the supplemental module training objectives **(Slides 1-2).**

1. Understand key concepts related to gender norms, gender dynamics, and gender-sensitive FP service delivery.
2. Gain familiarity with the interaction between FP/RH programs and gender dynamics.
3. Acquire knowledge of the impact of gender inequality and violence against women (VAW) on FP/RH in Bangladesh.
4. Develop foundational skills in gender-sensitive FP service provision.

STEP 2

Explain the following:

- For many service providers, few subjects can feel more difficult, confusing, or complicated than gender concepts, including sexual orientation and gender identity and expression. Sometimes, our personal, cultural, or religious values and experiences put us into conflict with our desire to help clients who may be experiencing barriers related to their gender, sexual orientation, and age.
- Through this training we will start by understanding key gender concepts to allow us to understand better how gender interacts with health and health-seeking behavior, and specifically family planning, to allow us to better serve our clients and communities through gender-sensitive FP service provision.

STEP 3

Present the Session 1 learning objectives **(Slides 3-4).**

STEP4

Ask if there are any clarification questions.

Activity 2: Group Activity and Presentation (15 minutes)

Gender and Biological Sex

STEP 1

Project **Slide 5.**

Tell participants that we will now review some basic concepts related to gender and health care and will encourage some reflection around their meaning in our lives as women and men. If possible, ask participants to arrange chairs in a semi-circle.

STEP 2

Ask participants:

- *What does gender mean to you?*

STEP 3

After acknowledging several responses, on a blank sheet of flipchart paper, create 2 columns. Title one column "Man" and the second column "Woman."

Ask participants to think of the first words that come to mind when they hear the word "Woman," as well as the first words that come to mind when they hear the word "Man."

As participants call out ideas, write them on the flipchart paper in the relevant column. Make sure that each list includes words describing biological traits (e.g., "penis" for men, "breasts" for women). If the following biological traits are not mentioned, be sure include them on the lists:

MAN	WOMAN
• Penis	• Vulva, vaginal opening
• Testicles	• Uterus
• Hair on chest, face	• Can give birth
• Broad shoulders	• Breasts
• Larger "Adam's Apple" (aka laryngeal prominence)	• Can breastfeed
	• Wider hips

STEP4

Once the lists are complete, ask the group to point out those words in the "Man" column that can only apply to men. As participants call out the words, circle them on the flipchart. If participants call out traits that are non-biological, push them to reflect a bit further by asking them whether those traits might apply to both women and men (e.g., Can bravery also apply to women?).

STEP 5

Move to the "Woman" column and ask the group to point out those words that can only apply to women. As participants call out the words, circle them on the flipchart. If participants call out traits that are non-biological, push them to reflect a bit further by asking them whether those traits might apply to both women and men (e.g., can men also be caring?).

STEP 6

Explain that the remaining characteristics that are not circled help to define a person's *gender.* Gender is the set of expectations about what women and men should do and how they should act. However, we are not born with these characteristics, they are not fixed, and they are not "natural." These expectations are created and communicated to us by the society we live in.

STEP 7

Invite questions and discussion on the exercise and the difference between biological sex and gender. If needed, use the following questions as prompts to get the discussion going:

- Looking at both lists, do the differences between women and men tend to be mostly biological or mostly societal?
- Do you think women can also be "strong," "brave," and "head of a household"? Why or why not?
- Do you think men can also be "caring" and "kind" and can "take care of the children"? Why or why not?

STEPS

Present **Slides 6-8** and explain the following:

- Because sex is defined by physiological and biological determinants, it most often will require consideration of physical distinctions in FP service provision (e.g., appropriately providing a male vs. a female condom).
- Because gender is socially constructed and influences complex familial and power relationships, it requires consideration through all aspects of FP programming and service provision (e.g., counseling, barriers to continuation, method selection, desire to space pregnancies).
- We will discuss how gender impacts family planning programming and service provision in more detail in later sessions, as well as how we can better support our clients and communities by being gender-sensitive family planning service providers.

STEP 9

Ask if there are any questions regarding the difference between gender and biological sex.

Emphasize that understanding key gender concepts is the foundation for the remaining sessions and ensuring they are gender-sensitive family planning providers.

STEP 10

Distribute **Handout lA:** Gender Related Terms and Definitions.

Activity 3: Presentation and Discussion {10 minutes)

Gender Equality and Gender Equity

STEP 1

Project **Slide 9** and explain that you would like to introduce two more important terms related to the word gender.

Ask the group if they have ever heard the term "gender equality." Ask them what they think it means.

STEP 2

After acknowledging some answers, provide the following definition:

- **Gender equality** is the absence of discrimination based on a person's sex or gender. It means providing the same opportunity to each person, including access to and control of social, economic, and political resources, including protection under the law (such as health services, education, and voting rights).

Ask the group if this definition makes sense to them and invite their questions.

STEP 3

Ask the group to discuss whether gender equality actually exists in Bangladesh. As the group discusses this, write on a sheet of flipchart paper any showing that women *do not* share equal status with men in all spheres of society. Be sure to include some of the following points if they are not mentioned by the group:

- Women are more likely than men to experience sexual and domestic violence.

- Men are paid more than women for the same work (in most cases).
- Men are in more positions of power within the medical field.

STEP4

Ask the group if they have ever heard the term "gender equity."

Ask what they think it means and how it is different from gender equality.

STEP 5

Acknowledge their responses and explain that:

- Gender equity is the process of being fair to women, men, and those with diverse gender identities.
- It recognizes that men and women have different needs, power, and access to resources, which should be identified and addressed in a manner that rectifies the imbalances.
- Addressing gender equity leads to equality.
- For example, an affirmative action policy adopted by a health facility to increase the number of women in senior leadership posts may be gender-equitable because it leads to ensuring equal rights among men and women.

When discussing the concepts of gender equity and equality, emphasize the following **key points:**

- The goal of gender equality is not for women and men, girls and boys, to become the same. The goal of gender equality is to ensure that women and men have the same chances to access and benefit from social, economic, and political resources (e.g., have the same opportunities to vote, to be educated).
- The goal of gender equity moves beyond equality to strive toward equality of outcomes. Thus, it moves beyond considering women and men as being equal under the law to ensuring that conditions will not block their equal participation in health promotion activities. It recognizes, for example, that women and men may have different needs, preferences, and interests, and that achieving equality of opportunity (e.g., gender equality) may require treating women and men differently and/or separately.
- Gender equality differs from gender equity in that gender equity is about how health services meet different population needs, whereas gender equality is about making sure that everyone is given the same opportunity to use those services.

STEP 6

Project PPT **Slide 10** and ask participants to describe how they think the cartoon illustrates the differences between gender equity and gender equality.

After participants have shared some ideas, explain that while the "test" referred to in the cartoon creates equality of opportunity for all students, it does not actually consider their different needs so that they can actually take and pass the test. In other words, the test is not equitable. Similarly, if we establish health facilities without considering whether, how, and under what conditions all groups of men, boys, women, and girls can actually reach them, we may end up like this professor, with very few students who pass the test.

STEP 7

Conclude by presenting and discussing PPT **Slide 11,** which illustrates visually the difference between equality and equity. Invite participants' comments and questions.

Continuum of Gender-Aware Service Delivery[4] [Optional]

TOTAL SESSION TIME

30 minutes

LEARNING OBJECTIVES

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

- Explain the continuum of gender as it relates to integrating gendered approaches into family planning service provision.
- Describe the 4 approaches to gender integration in programs and services.

METHODOLOGIES

- Presentation
- Discussion

ADVANCE PREPARATION

- Review slides and training content
- Make copies of Handout 2A and 2B for all participants

MATERIALS NEEDED

- Training slides 12-23
- Handouts 2A and 2B

FACILITATOR NOTE

If there are only 3 hours available for training, this session may be omitted. However, it is strongly recommended that facilitators make time for this session. A clear understanding of the gender continuum helps participants understand how to situate their work and goals in relation to broader gender equity goals.

[4] This session content is taken from: Population Reference Bureau. *The Gender Integration Continuum: Training Session User's Guide* (Washington, DC: Populational Reference Bureau, 2017). Accessed at: https://www.igwg.org/wp-content/uploads/2017/12/17-418-GenderContTraining-2017-12-12-1633_FINAL.pdf.

Activity 1: Presentation (5 minutes)

Session Objectives and FP/RH Outcomes in Bangladesh and Gender

STEP 1

Present the session learning objectives **(Slides 12-13).**

STEP 2

Present content on the FP/RH national statistics through a gender lens **(Slides 14-15).**

Emphasize the following:

- FP/RH providers deliver services and care in the context of gender inequality and discrimination.
- Women's access to and use of services are inherently influenced by their gender roles, norms, identity, and individual circumstance, such as age and exposure to gender-based violence.
- Gender inequity and inequality contribute to poor and non-optimal health outcomes.

STEP 3

Ask participants: *What other examples of gender impacting FP/RH are you aware of?*

Spend only a few minutes discussion, but ask participants to jot down examples to discuss later.

Activity 2: Presentation (15 minutes)

Overview of Gender Integration Continuum

STEP 1

Tell participants we will look at how taking gender norms and roles into consideration-or not-when designing services can impact outcomes.

STEP 2

Show the gender continuum slides **(Slides 16-20)** and present the content below

Gender Continuum:

- USAID has adopted a Gender Integration Continuum showing how gender is approached in projects, and we are going to use it to evaluate family planning services:
  - On one end, we do not address gender at all, or gender norms and roles are exploited, which is harmful and promotes gender inequity.
  - As one moves along the Continuum away from exploitative, one gradually moves toward actively trying to influence and promote equality between the genders. This is where gender-sensitive service provision and service providers aim to be.
- This Continuum is used by numerous international development organizations, donors, NGOs, and governments (ministries of health) around the world.

Gender Blind:

- Gender inequalities in the greater society impact the use of health care, including FP/RH, and this is detrimental in relation to both health experience and opportunities. In addition, health systems that are 'gender blind' - that is, where gender differentials in health services are not recognized -

may maintain and/or reinforce gender inequalities and gender inequity in wider society, both in their day-to-day operation and in their development of health policies.

- Ask if anyone can think of an example of a gender-blind project.
- Share the example of a single, uniform health program open to all girls and boys.

Gender Exploitative:

- This approach is harmful and, in the long run, can undermine project objectives, even if it achieves short-term results.
  - **Example - Campaign to Increase Male Involvement in Zimbabwe:** In an effort to increase contraceptive use and male involvement in Zimbabwe, an FP project initiated a communication campaign promoting the importance of men's participation in FP decision making. Messages relied on sports images and metaphors, such "Play the game right-once you are in control, it's easy to be a winner," and "It is your choice." The campaign increased the use of contraceptive methods. When evaluating impact, the project asked male respondents whether ideally they, their partners, or both members of the couple should be responsible for making family planning decisions. The evaluation found that: 'Whereas men were far more likely to believe that they should take an active role in family planning matters after the campaign, they did not necessarily accept the concepts of joint decision making.' Men apparently interpreted the campaign messages to mean that family planning decisions should be made by men alone.

Gender Accommodating:

- Programs and services that maintain existing gender dynamics and roles to achieve project outcomes. While this approach is not harmful, it does not seek to reduce gender inequalities or address broader systemic factors that perpetuate inequalities and maintain the status quo.
  - **Example - Community-based Delivery of Long-acting Methods:** The Ministry of Health (MOH) in Ethiopia wanted to address unmet need for contraception by expanding access to long-acting methods, including the implant (Implanon/Jadelle). To meet this need, the MOH trained community health extension workers, who already go door-to-door addressing a range of health issues (for example, water and sanitation, HIV, immunization, and FP) to offer Implanon. Community health workers were trained to provide information on Implanon (as part of their FP counseling), screen women for medical eligibility criteria, and provide Implanon (in addition to condoms and contraceptive pills).

STEP 3

Show **Slide 21** and walk participants through the example of how an FP promotion program could fit along the Continuum.

STEP4

Distribute **Handouts 2A** and **2B.**

Activity 3: Presentation and Discussion {10 minutes)

Importance of Understanding Where a Program or Services are Along the Continuum

STEP 1

Show PPT **Slide 22** and explain the following:

- To achieve the goal of the current Health Population and Nutrition Sector Program (HPNSP) to increase CPR by 75% by 2022 it is urgent that above key gender issues are addressed. Achieving these goals will require acknowledging and responding to gender norms and dynamics that influence FP/RH.
- This can be done to varying degrees along a continuum as resources and time allow.

STEP 2

Show **Slide 23** and explain that:

- The Gender Integration Continuum is used in planning how to integrate gender into FP programs and services. It can also be used to revise health services or approaches to be more gender equitable.
- This Continuum can be used as a diagnostic tool or a planning framework. In either case, it reflects a two-tiered process of analysis that begins with determining whether interventions are "gender blind" or "gender aware," and then considers whether they are exploitative, accommodating, or transformative.
- As a diagnostic tool, it can be used to assess if or how well FP programs and/or services are currently identifying, examining, and addressing gender considerations, and to determine how to move along the Continuum toward more gender transformative programming.
- As a planning framework, it can help determine how to move along the Continuum toward more gender-transformative FP programs and services.
- It is important to emphasize that programmatic interventions should always aim to be "gender aware" and to move towards "transformative gender programming."

STEP 3

Ask the group if they have any questions or comments about the four categories.

STEP4

Conclude by reminding participants that:

- The most important consideration is to ensure that the program does not adopt an exploitative approach in keeping with the fundamental principle in the development of DOING NO HARM.
- The graphic on the slide attempts to reflect this visually, using the color red and the dotted line to highlight that while some interventions maybe, or contain elements that are (intentionally or unintentionally) exploitative, the aim should always be to move them toward transformative approaches.

Gender Competent Service Provision

TOTAL SESSION TIME

45 minutes

LEARNING OBJECTIVES

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

- Describe the core competencies of a gender-sensitive FP service provider.
- Explain elements of client interaction in relation to the relevant gender competencies.

METHODOLOGIES

- Presentation
- Brainstorm
- Discussion

ADVANCE PREPARATION

- Review slides and training content.
- Make copies of Handout 3A for all participants

MATERIALS NEEDED

- Flipcharts
- Markers
- Training slides 24-34
- Handout 3A

Activity 1: Presentation (5 minutes)

Core Competencies of a Gender-Sensitive FP Service Provider

STEP 1

Present the session learning objectives **(Slides 24-25)** and the content below.

- As countries make progress in key areas of health workforce development and expand the availability of and access to FP services, providers' awareness of gender and the skills needed to appropriately incorporate gender equitable approaches are critical issues to address.
- Although descriptions of gender competency exist in general terms, it was recognized that no single definition was predominant, commonly used, or applied specifically to providers, particularly in the context of FP services.

- To address that gap, USAID (through its Human Resources for Health in 2030 program) developed a Gender Competency Framework for Family Planning Service Providers to link gender and FP service provision with specific knowledge, skills, and attitudes to reduce provider bias and improve FP services. [5]

STEP 2

Show **Slide 26** and present the definition of gender competency.

"**Gender competency** - the capacity to identify when and how different norms, social constructs, roles, expectations, power differentials, opportunities, and constraints assigned to women, men, girls, and boys are manifested in daily life, and how they might affect health and well-being, including how the provider's own attitudes and norms about gender and power affect professional interactions.

Gender competency requires the application of appropriate knowledge, skills, and attitudes in daily work and interactions to communicate and treat people equitably and produce more equal agency and decision-making for women, men, girls, and boys, regardless of age or relationship status."

Activity 2: Brainstorm (5 minutes)

What Does a Provider Need to be Gender Competent?

STEP 1

Ask participants to brainstorm what knowledge, skills, and attitudes a provider needs to be gender competent.

List responses on a flipchart and tell participants we will revisit this list at the end of the session.

Activity 3: Presentation (20 minutes)

Gender-Competent Service Provision

STEP 1

Distribute **Handout 3A.**

STEP 2

Show the 6 competencies and present their definitions **(Slides 27-33).**

Be sure to emphasize the **key points** related to several of the competencies below and share the illustrative examples.

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[5] USAID/HRH 2030, "Defining and Advancing Gender-Competent Family Planning Service Providers: A Competency Framework and Technical Brief," Second Edition (2020). Available at: https://hrh2030program.org/gender-competency-tech-brief/.

1. **Uses gender-sensitive communication**
    - Example: when an unmarried woman comes to the clinic for FP information and a contraceptive method that works for her, the nurse manager establishes a nonjudgmental rapport with the client by using respectful language and attentive body posture, providing her complete information on method options, and confirming the client's comprehension of choices and services.

2. **Promotes individual agency**
    - Example: the nurse manager asks the client about her FP needs, including efficacy, longevity, accessibility, and tolerance of side effects to ensure the client can make her own informed and voluntary choice. After time, the woman marries, the nurse manager supports the woman with her changing FP needs, whether for spacing births or preventing pregnancy.

3. **Supports legal rights and status related to family planning**
    - Bangladesh's constitution guarantees equal rights to all citizens, however, in real life, men and women enjoy these rights differently. (Mention MoHFW's 2014 Gender Strategy.)
    - It is important that FP providers are aware of relevant gender and population policies in FP that can be used to help couples and individuals to make informed and violence/coercion-free family planning choices.
    - Raise the following points to explain gender discriminatory practices against women and girls prevalent in society:
        - Men have fewer restrictions than women (less mobility for women and girls)
        - Men can exercise power over women and can make decisions on their behalf
    - Health care providers sometimes bring their own gender biases when providing contraceptive care to women, girls, men, and boys. Common gender and social norms (e.g., the assumption that newlywed women will not want a long-acting contraceptive) can be a barrier to promoting agency. Emphasize that in this way gender norms and biases hinder and influence providers' ability to achieve good FP outcomes.
    - Exercising legal rights creates an enabling environment for informed contraceptive decision making. Relevant information about legal rights needs to be promoted extensively at community level.
        - *Example:* the nurse manager knows there are no laws or policies in her country requiring the consent of a client's family or husband for her to use FP. So, the nurse does not require consent beyond the client's during their session because she acknowledges that each client has the right to make the final decision about using or not using FP.

4. **Engages men and boys as partners and users**
    - The existing FP service delivery structure is not men- and boys-friendly in most cases. To engage men and boys it is important to address all the existing gaps and barriers that men and boys face and to generate their interest in and motivation to participate in FP programming.
        - *Example:* the nurse manager respectfully asks the woman if she would like her husband to join their session and respects her decision. The nurse manager uses affirmative language to encourage non-controlling, positive male participation in method choice and use, which the nurse manager recognizes may help with her client's FP method satisfaction and continuation.

5. **Facilitates positive couple's communication and cooperative decision making**
    - In a male-controlled society, it is important to have positive couple's communication. This improves intra-spousal communication and ensures men support gender-equitable contraceptive decision-making.
    - Cooperative decision-making is when both members of the couple share in the decision-making process.
    - These are complementary and reinforce each other in ensuring partner communication in family planning.
        - *For example,* the nurse manager gives equal attention to both the woman and her husband during couple's counseling and discusses each partner's concerns and preferences with FP methods.

6. **Appropriately addresses and responds to a context of gender-based violence**
    - For example, the nurse manager recognizes that intimate partner violence is relatively common, so she regularly assesses FP clients for the common signs and symptoms of gender-based violence (GBV). The nurse manager has an established rapport with the trained GBV provider and knows how to make a warm and compassionate referral for clients when necessary. The nurse manager concludes FP counseling sessions with subtle but positive reminders about the right to be treated with respect and to feel safe in a relationship.

Activity 4: Discussion and Presentation (10 minutes)

Appropriately Addressing and Responding to Gender-Based Violence

STEP 1

Ask: *What is meant by the term "gender-based violence"?*

STEP 2

Return to PPT **Slide 33** and discuss the definition further.

STEP 3

Emphasize the importance of the Do No Harm principle and that participants will have a chance to explore what this looks like in more detail during the skill development session.

Highlight that FP/RH/MCH primary care providers are among the most likely professional to receive disclosures/notice intimate partner violence (a particularly common form of GBV).

Explain the importance of confidentiality, privacy, and responding compassionately and nonjudgmentally to disclosure of violence.

STEP4

Share the following definition:

"Sexual and gender-based violence (SGBV) refers to any act that is perpetrated against a person's will and is based on gender norms and unequal power relationships. It encompasses threats of violence and

coercion. It can be physical, emotional, psychological, or sexual in nature, and can take the form of a denial of resources or access to services. It inflicts harm on women, girls, men, and boys."[6]

STEP 5

Ask: *Does anyone have an example of SGBV that you witnessed as an FP provider?*

STEP 6

Share additional examples:

- Insulting language or physical assault on wife when husband learns she is using an IUD or Implant
- For newlywed girls and women, a constant pressure to prove her fertility, ignoring her voice and choice in contraceptive decision making
- In case of infertility, unilateral blaming and shaming of the wife (which in some case leads to divorce)

Activity 5: Presentation and Discussion {5 minutes)

Gender Competence Wrap-up

STEP 1

Present **Slide 34** and refer participants again to **Handout 3A.**

STEP 2

Return to the flipchart where you brainstormed core competencies at the beginning of the session. Lead a brief discussion about the similarities and differences between the brainstorm and the content presented.

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[6] UNHCR, "Sexual and Gender-based Violence" (webpage). Available at: https://www.unhcr.org/sexual-and-gender-based-violence.htm l.

Skills Development - Gender-Sensitive Counseling

TOTAL SESSION TIME

45 minutes

LEARNING OBJECTIVES

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

- Demonstrate gender-sensitive counseling.
- Explain ways of facilitating positive couple's communication and decision making.

METHODOLOGIES

- Presentation
- Roleplay <u>or</u> case studies
- Discussion

ADVANCE PREPARATION

- Review slides and training content.
- Decide whether you will facilitate Activity 2 <u>or</u> Activity 3.
- Make copies of Handouts 4A and 4B for all participants.

MATERIALS NEEDED

- Training slides 35-39
- Handouts 4A and 4B

FACILITATOR NOTE

The facilitator can choose to facilitate the skills building session in one of two ways. You may choose Activity 2 (Roleplay) <u>or</u> Activity 3 (Case studies).

- If you choose Activity 2 (Roleplay), ignore/skip Activity 3
- If you choose Activity 3 {Case Studies), ignore/skip Activity 2.
- The scenarios (Handout 4A) are the same for both Activity 2 and Activity 3.

Activity 1: Presentation (5 minutes)

Introduction to Gender-Sensitive Counseling

STEP 1

State that this session is focused on skill development on gender-sensitive counseling or client provider interaction.

Present the session learning objective **(Slides 35-36).**

STEP 2

Show **Slide 37** and make the connection between this content and the previous session clear.

Activity 2 [Option A]: Skills Building Roleplay (40 minutes)

Gender-Sensitive Counseling

STEP 1

Explain to participants that we are going to act out roleplays to develop skills in gender-sensitive counseling.

- Divide the participants into groups of 3-4 participants.
- Distribute **Handouts 4A** and **4B** and assign each group a different scenario for the roleplay.
- Show **Slide 38** and discuss the instructions (below).

Roleplay instructions

- Work together as a team.
- In each group, the team should select: 1 participant to play the role of the client (and 1 participant to pay the partner, if it is a couple's counseling scenario); 1 participant to roleplay the provider. (The remaining participants should be observers.)
- Review the scenario and the associated questions on **Handout 4A** together and do the roleplay.
- Review **Handout 4B** and draw on the content as you do your roleplays and conduct observation of the roleplays.
- Rotate and switch positions so that everyone has a chance to play the role of provider.
- After **15 minutes,** we will come back together to discuss the roleplays as a group.

STEP 2

After 15 minutes, spend 20 minutes discussing each roleplay by asking each group the following questions. (Begin the discussion of each roleplay by asking one of the group members to read the scenario out loud).

Ask the provider:

- How did you feel conducting the counseling?
- Can you describe 2 aspects of the counseling session that went well?
- Can you identify 2 aspects of the counseling session that you would do differently?
- Based on what we have learned in this training, was the counseling session gender sensitive? If so, how? If not, what could a provider do differently?

Ask the clients:

- How did you feel during the counseling session?
- Can you identify 2 aspects of the counseling session that were effective?
- Can you identify 2 aspects of the counseling session that could have been done differently?
- Were there issues you expected the counselor to address, but were not addressed?
- Did you feel the counseling session was gender sensitive? If so, how? If not, what could the provider do differently?

Ask the observers:

- Can you identify 2 aspects of the counseling session that were effective?
- Can you identify 2 aspects of the counseling session that could have been done differently?
- Was the counseling session gender sensitive? If so, how? If not, what could a provider do differently?
- Where there issues you expected the counselor to address, but were not addressed?

Activity 3 [Option B]: Skills Building Case Studies (40 minutes)

Gender-Sensitive Counseling

STEP 1

Explain to participants that we are going to break into groups to examine case studies in order to develop skills in gender-sensitive counseling.

- Divide the participants into 3 groups.
- Distribute **Handouts 4A** and **4B** and assign each group a different scenario.

STEP 2

Show **Slide 39** and give the instructions below:

Case study instructions:

- Work together as a team.
- Review the scenario and the associated questions on **Handout 4A** together.
- Prepare to present your thoughts on the case and questions to the larger group.
- Use **Handout 4B** to guide your discussion and inform your presentation.
- You will have **10 minutes** to prepare.
- We will discuss each case study for **5 minutes.**

STEP 3

Facilitate a discussion on each case, following each group's presentation, using the questions below:

Using gender-sensitive communication, what counseling should a provider give to:

- Promote individual agency?
- Facilitate positive couple's communication and cooperative decision making?
- Engage men as partners and users?
- Address use/non-use of contraceptive methods?
- Continue/discontinue the contraceptive methods?

Skills Development - Responding to Gender-Based Violence

TOTAL SESSION TIME

45 minutes

LEARNING OBJECTIVES

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

- Describe the DO NO HARM principles surrounding FP service provision and the risk of violence against women.
- Demonstrate how to respond to disclosures of GBV with appropriate first-line information

METHODOLOGIES

- Presentation
- Discussion
- Demonstration
- Roleplay

ADVANCE PREPARATION

- Review slides and training content.
- Decide whether you will facilitate Activity 2 or Activity 3.
- Make copies of Handouts SA,SB and SC for all participants.

MATERIALS NEEDED

- Flipcharts
- Markers
- Training slides 40-44
- Handouts SA, SB and SC

Activity 1: Presentation and Discussion {15 minutes)

Do No Harm

STEP 1

Present the learning objectives **(Slides 40-41).**

STEP 2

Show **Slide 42** and lead a discussion on the content.

Emphasize the following **key points:**

- One of the key issues of gender-sensitive client provider interaction is DO NO HARM.
- If being used against a partner's wishes, in the context of intimate partner violence, use of contraception can result in escalation of that violence. These can include increased frequency and severity of beating, forced sex, or restrictions on a woman's movements or ability to socialize.
- All of these may be viewed as "normal" given that recent evidence indicates at least 1 in 4 married women in Bangladesh are currently living with intimate partner violence.
- As a health provider each of you has a duty to provide services in a way that *does no harm* and minimizes the risk of your actions increasing, escalating, or triggering violence against your clients.

STEP 3

Ask participants to share examples of the confidentiality procedures used at their facility (3-4 brief shares, or as time permits).

STEP4

Show **Slide 43** and emphasize the following **key points** on responding to disclosures of gender-based violence using LIV(ES):

- As a health provider, we tend to want to fix and treat. This may not always be possible-often it is not possible in the context of an FP visit. But, compassionate, respectful acknowledgement, especially when accompanied by provision of information or referral for other services, can be catalytic.
- In a moment, you will have a chance to roleplay the skills of listening, inquiring about, and validating a survivor's experience. The most important thing to remember is that it is *not* recommended that you try to make a woman disclose experiences of violence. It *is* recommended that you listen in an open and respectful manner that helps a woman to feel safe sharing experiences or fear of violence.
- The LIVES mnemonic/acronym was developed to help providers remember that straightforward listening techniques can have a positive impact on their patients. However, the final 2 elements of the acronym are only for use in settings where SGBV treatment and response services are actively provided. Don't worry about learning those at this time.

STEP 5

Distribute **Handout SA:** LIVES Pocket Card.

Reiterate that the last 2 components (the E and S) of LIVES should not be undertaken before a readiness assessment is done to determine whether the health facility meets minimum standards for SGBV service provision

Activity 2: Demonstration and Discussion (5 minutes)

Responding to SGBV Disclosure

STEP 1

Demonstrate a simple disclosure and the steps of L -1-V with another facilitator using the demonstration example below.

Client - I don't want to get pregnant, but I'm worried about my husband.

Provider - Okay. Before I explain the different contraceptive options, do you have any specific concerns you'd like to share with me?

Client (disclosing) - I'm afraid my husband will beat me if he finds out I'm avoiding getting pregnant.

Provider - I'm sorry you are dealing with that. You deserve to feel safe and to be able to choose when is the best time for you to become pregnant. Would you like to have your husband be a part of the decision making? I can also give you information on different family planning options that may be more private.

STEP 2

Invite several participants to share their observations or ask questions.

STEP 3

Point out the provider's open body language; open questions; non-blaming response.

Activity 3: Roleplay (10 minutes)

Responding to SGBV Disclosure

STEP 1

Divide participants into small groups of 3.

STEP 2

Distribute **Handout SB** and ask half the groups do work on Scenario 1 and half the groups to work on Scenario 2.

STEP 3

Show **Slide 44** and give the instructions below:

- Each group should identify 1 person to roleplay provider, 1 person to roleplay client, and 1 person to serve as an observer. (If there is a fourth, that person can also serve as an observer.)
- You have **10 minutes** to conduct the roleplays in their small groups. You should switch role so everyone has a chance to play the provider. ***(NOTE:*** *Facilitators will circulate during this time.)*
- After 10 minutes, come back together as a group to discuss the roleplay experience.

Activity 4: Discussion of Roleplays (15 minutes}

SGBV Disclosure Roleplays Debrief

STEP 1

Facilitate a large group discussion using the questions below as a guide.

Ask the providers:

- How did it feel to not offer a solution or a fix?
- What do you think went well?
- What aspects of the counseling session would you do differently?

Ask the clients:

- How did you feel during the counseling session?
- If you disclosed experiencing violence, did you feel comfortable doing so? Why or why not?
- If you did not disclose violence, did you feel heard and respected?
- Which aspects of the counseling session could have been done differently?

Ask the observers:

- What went well in the roleplay you observed? What did it achieve?
- What challenges did you observe during the roleplay?

STEP 3

Distribute **Handout SC** as a reference.

Concluding the Module

TOTAL SESSION TIME

15 minutes

Activity 1: Discussion and Presentation (10 minutes)

STEP 1

Ask participants to share what they think are the primary take-aways from the Supplemental Training Module on Gender Integration in FP Services.

STEP 2

Acknowledge their responses and present the primary take-aways **(Slides 45-47).**

STEP 3

Facilitate a concluding discussion around the following questions:

- What is one thing you learned today that surprised you?
- What will you do differently in your work as a result of this training?
- How will you share what you learned in this module with your colleagues?
- Are there issues related to gender and service delivery you want to learn more about?

STEP4

Invite any final questions or comments, and thank the participants for participating in this important training **(Slides 48-49).**

Annex 1: Participant Handouts

SESSION 1 HANDOUTS

HANDOUT 1A

Gender-Related Terms and Concepts

Cisgender is a term used in many countries to describe a person whose sense of personal identity and gender correspond with the sex they were assigned at birth.

Empowerment means expansion of people's capacity to make and act upon decisions affecting all aspects of their lives - including decisions related to health - by proactively addressing socioeconomic, and other power inequalities in a context where this ability was previously denied. Programmatic interventions often focus specifically on empowering women, because of the inequalities in their socioeconomic status.

Gender is about the roles, norms, and behaviors that society consider appropriate for women, men, girls, boys, and those with diverse gender identities, such as transgender. These are socially constructed and vary widely within and across cultures, religions, class and ethnicity. For example, in many societies a common gender norm is that women and girls should do most of the domestic work.

Gender-based violence, in the broadest terms, is violence that is directed at individuals based on their biological sex, gender identity, or perceived adherence to culturally-defined expectations of what it means to be a woman and man, girl and boy. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private. GBV is rooted in economic, social, and political inequalities between men and women. GBV can occur throughout the lifecycle, from infancy through childhood and adolescence, the reproductive years and into old age (Moreno 2005), and can affect women and girls, and men and boys, including transgender individuals. Specific types of GBV include (but are not limited to) early and forced marriage, child sexual abuse and exploitation; sexual coercion, harassment and abuse; neglect; domestic violence; economic deprivation.

Gender equality is the absence of discrimination based on a person's sex or gender. It means providing the same opportunity to each person including access to and control of social, economic and political resources, including protection under the law (such as health services, education and voting rights).

Gender equity is the process of being fair to women, men and those with diverse gender identities. It recognizes that men and women have different needs, power and access to resources, which should be identified and addressed in a manner that rectifies the imbalance. Addressing gender equity leads to equality.

Gender identity refers to one's internal sense of being male, female, neither or both.

Gender integration refers to strategies applied in in programs and health services to take gender considerations (as defined above, in "gender") into account and to compensate for gender-based inequalities.

Gender-related barriers are obstacles to access and use of health services that are related to deep rooted social and cultural norms about the roles of women, men, and those with diverse gender identities. For example, when caregivers, primarily women, have not been educated, lack decision-making power, are economically dependent, or are unable to move freely outside their homes, there is a greater likelihood that they will not take their children to get vaccinated.

Gender-responsive approaches are those that consider women's and men's specific needs without necessarily changing the larger contextual issues that lie at the root of the gender inequities and inequalities. For example, employing female health workers will facilitate enhanced FP service acceptance and uptake, but would not address the underlying cultural barrier that prevents female caregivers from seeking services from male health workers.

Gender-transformative approaches are those that attempt to re-define and change existing gender roles, norms, attitudes and practices. These interventions tackle the root causes of gender inequity and inequality and reshape unequal power relations. For example, promoting men's caregiving and active fatherhood encourages equitable gender roles, or providing health education to girls improves their agency builds their confidence.

Intersex: Individuals who have genital, chromosomal, or hormonal characteristics which do not correspond to the given standard for "male" or "female" categories of sexual or reproductive anatomy. It may take many forms and covers a wide range of bodily characteristics

Sexual orientation refers to one's sexual or romantic attractions, and includes sexual identity, sexual behaviors and sexual desires.

Sex is typically assigned at birth and refers to the biological characteristics that define humans as female, male or intersex.

Transgender is an umbrella term referring to individuals who do not identify with the sex category assigned to them at birth or whose identity or behavior falls outside of stereotypical gender norms. The term "transgender" encompasses a diverse array of gender identities and expressions, including identities that fit within a female/male classification and those that do not. Transgender is not the same as intersex, which refers to biological variation in sex characteristics, including chromosomes, gonads and/or genitals that do not allow an individual to be distinctly identified as female/male at birth.(The *term can include a wide range of other identities, such as members of third genders, as well as individuals who identify as more than one gender or no gender at all.*

SESSION 2 HANDOUTS

HANDOUT2A

Gender Integration Continuum

Source: Populational Reference Bureau, The Gender Integration Continuum: Training Session User's Guide. Washington, DC: Populational Reference Bureau, 2017). Available at: https://www.igwg.org/wp-content/uploads/2017/12/17-418-GenderContTraining-2017-12-12-1633_FINAL.pdf

HANDOUT2B

Gender Integration Continuum Definitions

Definitions of the Approaches on the Gender Integration Continuum[7]

The terms "gender blind" and "gender aware" relate to the degree to which gender norms, relations, and inequalities are analyzed and explicitly addressed during design, implementation, and monitoring.

Sex - classification of people as female, male, or intersex. At birth, infants are assigned a sex based on a combination of bodily characteristics including: chromosomes, hormones, internal reproductive organs and genitalia (USAID IGWG).

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[7] Populational Reference Bureau, *The Gender Integration Continuum: Training Session User's Guide.* Washington, DC: Populational Reference Bureau, 2017). Available at: https://www.igwg.org/wp-content/uploads/2017/12/17-418-GenderContTraining-2017-12-12-1633_FINAL.pdf

Gender refers to roles, norms, and behaviors society considers appropriate for women, men, girls, boys, and those with diverse gender identities, such as transgender people. These are socially constructed and vary widely within and across culture, religion, class, and ethnicity. For example, in many societies a common gender norm is that women and girls should do most of the domestic work.

Gender norms are defined by what society considers male and female behavior, and it leads to the formation of gender roles, which are the roles men and women/girls and boys are expected to take in society.

Gender-related barriers are obstacles to access and use health services that are related to deep rooted social and cultural norms about the roles of women, men, and those with diverse gender identities. For example, when caregivers, primarily women, have not been educated, lack decision-making power, are economically dependent, or are unable to move freely outside their homes, there is a greater likelihood that they will not take their children to get vaccinated.

Gender Blind

Gender blind policies and programs are designed without a prior analysis of the culturally defined set of economic, social, and political roles, responsibilities, rights, entitlements, obligations, and power relations associated with being female and male and the dynamics between and among men and women, boys and girls. **The project/services ignore gender considerations altogether.** Gender blind services do not consider how gender norms and unequal power relations affect health care provision/outcomes, or how health care provision impact gender.

Gender Aware

The explicit recognition of local gender differences, norms, and relations and their importance to health outcomes. This begins with the analysis or assessment of gender differences, norms, and relations to address gender equity in health outcomes.

Gender Exploitative Programming

Gender exploitative policies and programs intentionally or unintentionally reinforce or take advantage of gender inequalities and stereotypes in pursuit of project outcome, or whose approach exacerbates inequalities. This approach is harmful and can undermine the objectives of the program in the long run.

Gender Accommodating Program

These are policies and programs that acknowledge but work around gender differences and inequalities to achieve project objectives. Although this approach may result in short-term benefits and realization of outcomes, it does not attempt to reduce gender inequality or address the gender systems that contribute to the differences and inequalities.

Gender Transformative Programming

Transformative policies and programs seek to transform gender relations to promote equality and achieve program objectives. This approach attempts to promote gender equality by:

- fostering critical examination of inequalities and gender roles, norms, and dynamics;
- recognizing and strengthening positive norms that support equality and an enabling environment;
- promoting the relative position of women, girls, and marginalized groups; and
- transforming the underlying social structures, policies, and broadly held social norms that perpetuate gender inequalities.

SESSION 3 HANDOUTS

HANDOUT 3A

The Gender Competent FP Service Provider[8]

[8] USAID/HRH 2030, "Defining and Advancing Gender-Competent Family Planning Service Providers: A Competency Framework and Technical Brief," Second Edition (2020). Available at: https://hrh2030program.org/gender-competency-tech-brief/.

SESSION 4 HANDOUTS

HANDOUT4A

Scenarios for Gender-Sensitive Counseling Roleplays or Case Studies

Scenario 1 (FP)

A couple, Flora and Atif, have a 2-year-old daughter. They came to the FP health facility for removal of Flora's IUD. The IUD was inserted 2 months ago following a household visit counseling session Flora had with a field worker. Atif was away for work and was not present when Flora received the family planning counseling visit and accepted IUD insertion as a contraceptive choice. However, Flora informed her husband prior to having the IUD inserted.

Atif is now saying that he doesn't like the IUD as he heard that it might cause discomfort during sex. He is forcing Flora to remove IUD even though she does not have any complaints about the IUD.

- How can the service provider counsel Flora and Atif to promote positive couple's communication and cooperative decision making?
- How can the service provider counsel and educate Atif on IUD use as a safe family planning method choice and support Flora's preference to continue with the IUD?

Scenario 2 (Adolescent pregnancy)

A young newlywed couple visits the FP health facility to receive counseling on family planning. The woman, Maimuna, was married at age 17 to a man she had never seen before their wedding. Maimuna shares that she does not want to conceive right away and wishes to delay her first pregnancy until she is older. However, her husband, Rafi, wants to conceive as early as possible to provide a grandchild to his parents and wants to force his wife to get pregnant against her wishes.

- How can the service provider counsel the couple to support positive couple's communication and cooperative decision making?
- How can the service provider support the wife's decision to delay pregnancy?

Scenario 3 (Postpartum FP)

A couple, Riad and Dina, have 2 children. Dina does not want any more children. The younger child is only 5 months old, however, Dina is now pregnant. Dina states that she became pregnant without having any menstruation after childbirth. Riad is 10 years ikder than her, and he doesn't like any family planning methods. Dina states that she sometimes uses the pill without telling her husband. She is at the FP health facility because she wants a contraceptive that will provide her longer protection or permanent protection.

- How can the service provider counsel Dina to help her prevent future pregnancies and choose a family planning method?
- Are there any risks to Dina using contraception covertly, without telling her husband?

Scenario 4 (Postpartum FP)

A woman, Joya, gives birth in a clinic. The health care workers carefully explain the importance of family planning and healthy timing and spacing of pregnancies. They schedule for her to return for another appointment to check her health, the health of her child, and for family planning. Prior to the appointment day she tells her husband, Karim, about the clinic appointment and asks him for money for transportation and service fees. Karim tells her contraception is unnecessary. He says she can go to the clinic to get the baby checked, but not for contraception. When Joya arrives, she tells the staff that her husband doesn't approve of contraception.

- How can the service provider counsel Joya on family planning?
- How can the service provider counsel the couple to support positive couple communication and cooperative decision making?

HANDOUT4B

Gender-Sensitive Counseling Job Aid

Note: this is not a comprehensive FP counseling job aid.

Do:

- Integrate gender-sensitive counseling into existing FP counseling questions.
- Give female clients information about their health directly, not to a male partner/family member.
- Allow clients of any gender and age to voluntarily choose any available and appropriate family planning method, including permanent methods (according to country policy).
- Encourage questions and listen to client to ensure client has understood.
- Use language and terminology client will understand.
- Ensure privacy during visits.

Don't:

- Do not require a client's spouse, partner, or family member (e.g. mother-in-law) to give consent for any services, including family planning.
- Do not direct information on female client's health or contraceptive choices to male spouse, partner, or family member.

Counseling introduction:

- How may I help you with family planning today?
- Would you like to have your husband/partner in this counseling session? Family planning is for both partners to discuss. Some FP methods, such as oral contraceptives and IUDs are utilized by women and some options, such as vasectomies, are used by men.
- Is there anything you'd like to tell me before asking your husband/partner to join us? The goal is to support couple communication on FP. The decision on whether and what kind of contraception to use is still yours and I will support it.

Basic history taking:

- Have you used contraception previously?
- What method(s)? Have you ever discussed your contraception preferences with your husband/partner?
- Do you have concerns about discussing contraception with your partner?
- Has your husband/partner ever shared preferences or concerns about contraception or contraception method choices?

Responding to requests for discontinuation:

- Please tell me more about why you are looking to stop using this method.

- Are you hoping to become pregnant? (Always look to the client first and encourage her to respond before her partner.)
- I can understand that some methods such as condoms and IUD can change the experience of coitus for both partners. There are ways to minimize this and we can also review other contraceptive methods available.
- After reviewing balanced counseling ask the woman first whether she'd like to continue with her current method or switch. Then, ask her partner, do you have any concerns or questions for me?

When counseling adolescents or newlywed couples

- Provide key facts on health risks of early childbearing.
- Discuss healthy timing and spacing of pregnancy (HTSP) with couple.
- Ask both partners, starting with the young woman, if they have any concerns or fears about family planning or using contraception.
- Ask the woman: What would be your ideal timing for first pregnancy?
- If needed, offer to schedule a follow-up visit or home visit by a community health worker with the mother-in-law if it would assist with dispelling myths and sharing benefits of HTSP. Emphasize that you support women and couples FP decision making.

SESSION 5 HANDOUTS

HANDOUT 5A

LIVES Pocket Card[9]

Copy or cut out this reminder card and fold for your pocket

Signs of immediate risk

- Violence getting worse
- Threatened her with a weapon
- Tried to strangle her
- Beaten her when pregnant
- Constantly jealous
- "Do you believe he could kill you?"

Asking about violence

You might say:

"Many women experience problems with their husband or partner, but this is not acceptable."

You might ask:

"Are you afraid of your husband (or partner)?"
"Has he or someone else at home threatened to hurt you? If so, when?"
"Has he threatened to kill you?"
"Does he bully you or insult you?"
"Does he try to control you - for example, not letting you have money or go out of the house?"
"Has forced you into sex when you didn't want to?"

Listen

Inquire about needs and concerns

Validate

Enhance safety

Support

- Listen closely, with empathy, not judging.
- Assess and respond to her needs and concerns - emotional, physical, social and practical.
- Show that you believe and understand her.
- Discuss how to protect her from further harm.
- Help her connect to services, social support.

[9] Source: WHO, Caring for Women Subjected to Violence: A WHO Curriculum for Training Health-care Providers (Geneva: WHO, 2019).

HANDOUT SB

SGBV Disclosure Roleplay

Scenario 1

Information for provider:
Rubina (age 22, 1 prior live birth) presents at the FP clinic requesting help delaying another pregnancy. She reports frequent headaches and tells you that she'd like a contraceptive method that won't cause headaches because they get her in trouble.

Information for client:
Your name is Rubina, age 22. You have 1 young child at home and have come to the FP clinic because you want to delay another pregnancy. You've told the provider that you get frequent headaches and hope there is a method of FP that will keep you from getting more headaches.

If asked or given an opportunity that feels safe, you will tell the provider that: Your husband sometimes hits you if you can't complete all your household chores, even when it's due to headaches or pregnancy. You are scared another pregnancy will lead to more headaches and additional physical violence from your husband. You do not know how your husband feels about contraception or the idea of spacing your children.

Scenario 2

Information for provider:
Mina (age 36) presents at the FP clinic wanting information about sterilization.

She reports having 6 children at home, and having lost 2 children when they were babies.

Mina has a bruise on her cheek, speaks quietly, and was very quick to say no when you asked if she would like her husband present for contraceptive counseling.

Information for client:
Your name is Mina, age 36. You have come to request sterilization because you have been pregnant 8 times and have 6 living children at home. Your husband frequently beats you if you try to avoid having sex or if the home is not clean enough. He has knocked out one of your teeth in the past, and once hit you so hard that you lost consciousness.

You are nervous he will find out about you coming to the clinic and getting sterilized, but you cannot have any more children or go through another pregnancy.

You will not tell the provider that your husband beats you because you are ashamed and worry what he would do if he found out you had told someone.

HANDOUT SC

LIVES Communication Skills and Pathways[10]

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[10] WHO, "Handout 6A" in Caring for women subjected to violence: A WHO curriculum for training health-care providers (2019). Available at: https://www.who.int/reproductivehealth/publications/ca ring-for-women-subject-to-violence/en/.

HANDOUT SD

Powerpoint Presentation

SUPPLEMENTAL TRAINING MODULE

Gender Integration in Family Planning Services

Module Learning Objectives

By the end of this supplemental module, participants will:

1. Understand key concepts related to gender norms, gender dynamics, and gender-sensitive FP service delivery.
2. Gain familiarity with the interaction between FP/RH programs and gender dynamics.
3. Acquire knowledge of the impact of gender inequality and violence against women (VAW) on FP/RH in Bangladesh.
4. Develop foundational skills in gender-sensitive FP service provision.

SUPPLEMENTAL TRAINING MODULE | GENDER INTEGRATION IN FAMILY PLANNING SERVICES | SESSION 1 2

SESSION 1

Understanding Gender and its role in FP/RH

Session 1 Learning Objectives

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

1. Recognize and define key gender concepts.
2. Describe how gender impacts family planning and reproductive health (FP/RH).
3. Identify elements of FP service provision that influence or are influenced by gender dynamics.

ACTIVITY: **GENDER AND BIOLOGICAL SEX**

SUPPLEMENTAL TRAINING MODULE | GENDER INTEGRATION IN FAMILY PLANNING SERVICES | SESSION 1   5

Key Gender Terms and Concepts

- **Sex** – classification of people as female, male or intersex. At birth, infants are assigned a sex based on a combination of bodily characteristics including: chromosomes, hormones, internal reproductive organs and genitalia (USAID, IGWG).

- **Gender**- refers to roles, norms, and behaviors society considers appropriate for women, men, girls, boys, and those with diverse gender identities, such as transgender people. These are socially constructed and vary widely within and across culture, religion, class, and ethnicity. For example, in many societies a common gender norm is that women and girls should do most of the domestic work.

SUPPLEMENTAL TRAINING MODULE | GENDER INTEGRATION IN FAMILY PLANNING SERVICES | SESSION 1   6

Difference Between Sex and Gender

SEX	GENDER
• Is biological	• Is socially constructed
• You are born with it	• It is learned
• Cannot be changed	• It can be changed
• It is constant	• It varies with society, culture, country and religious perspectives

Any questions regarding the understanding the difference between gender and biological sex?

Key Gender Terms and Concepts

- **Gender norms** – what society considers male and female behavior, and it leads to the formation of gender roles, which are the roles men and women/girls and boys are expected to take in society.
- **Gender-related barriers** – obstacles to access and use health services that are related to deep rooted social and cultural norms about the roles of women, men, and those with diverse gender identities. For example, when caregivers, primarily women, have not been educated, lack decision-making power, are economically dependent, or are unable to move freely outside their homes, there is a greater likelihood that they will not take their children to get vaccinated.

Gender Equality & Gender Equity

EQUALITY

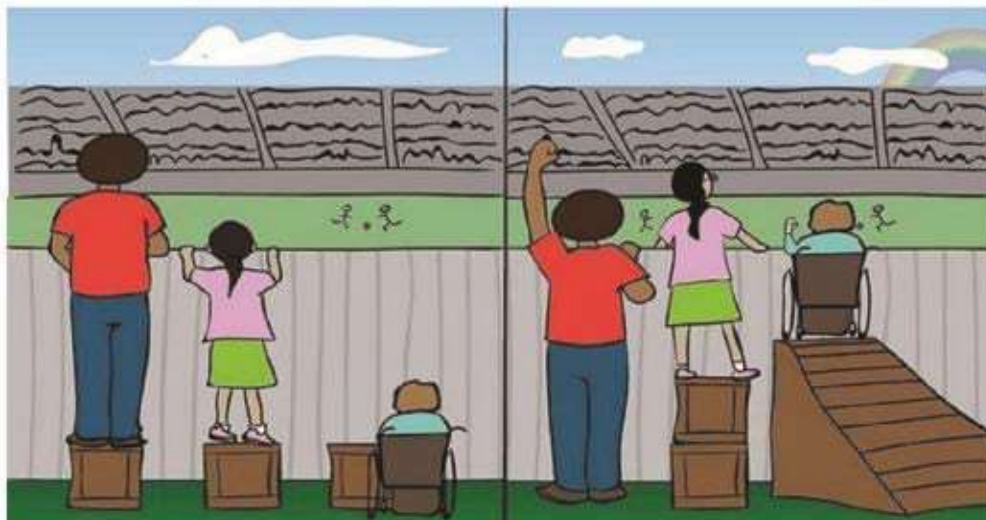
- Equality means sameness
- Giving everyone the same
- It works if everyone starts from the same place

EQUITY

- Equity means fairness
- Access to the same opportunity
- We must first ensure equity before we can enjoy equality

Everybody does not need to be the same to achieve gender equality

Equality vs. Equity



SESSION 2

The Continuum of Gender-Aware Service Delivery

Session 2 Learning Objectives

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

1. Explain the continuum of gender as it relates to integrating gendered approaches in family planning service provision.
2. Describe the 4 approaches to gender integration in programs and services.

Gender Inequity Impacts FP/RH Outcomes

FP/RH Indicators	BDHS 2014
CPR	62.4% CPR
High adolescent fertility	113/1,000 live births
Unmet need	12%
Child marriage	59%
Maternal mortality	196/100,000 live births
Violence against women (VAW)*	49.6% physical violence/intimate partner violence

* Estimates of VAW prevalence are from the 2015 national VAW survey

Gender Inequity Impacts FP/RH Outcomes

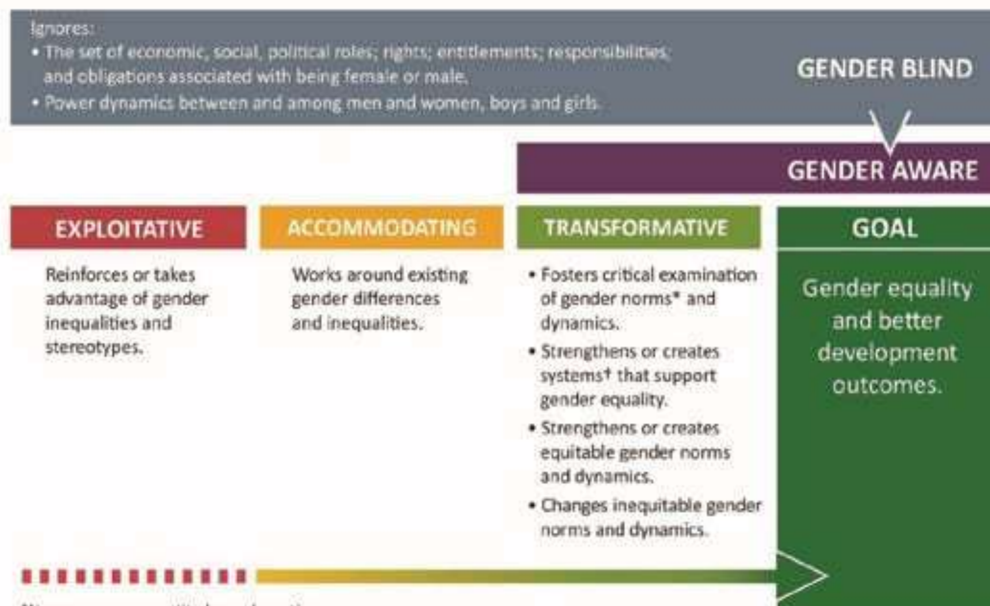
FP/RH Indicators	BDHS 2014 SVRS 2019/MICS 2019
CPR*	**CPR 63.4%**
High adolescent fertility †	**83/1000 live births**
Unmet need‡	**12%**
Child marriage†	**52%**
Maternal mortality*	**165/ 100000live births**
Violence against women (VAW) §	**49.6% physical violence/intimate partner violence**

* Sample Vital Registration System 2019
† Multiple Indicator Cluster Survey 2019
‡ Bangladesh Demographic and Health Survey 2017-2018
§ Estimates of VAW prevalence are from the 2015 national VAW survey

How Does Gender Affect FP/RH?

Topics	Examples
CPR	Male methods not popular, in many cases man are not supportive of partners desired FP method
Adolescent high Fertility	Adolescents don't get the chance to discuss their choice of birth timing/ spacing, strong pressure on married adolescents to prove fertility or produce a son
Unmet need	Restrictions on women's independent movement outside the home limits access to contraceptives
Child marriage	De-valuing of girls' education, high value placed on early proof of fertility
Maternal mortality	Lack of access to services during pregnancy and childbirth due to gendered mobility restrictions
Violence against women (VAW)	Wife beating for use or non-use of contraception, son preference

Gender Integration Continuum*



*Norms encompass attitudes and practices.
†A system consists of a set of interacting structures, practices, and relations.

* Image adapted from IGWG

Gender Blind & Gender Aware

- **Gender Blind**

  Gender blind policies and programs are designed without a prior analysis of the culturally defined set of economic, social, and political roles, responsibilities, rights, entitlements, obligations, and power relations associated with being female and male and the dynamics between and among men and women, boys and girls. Gender blind services do not consider how gender norms and unequal power relations affect health care provision/outcomes, or how health care provision impact gender.

Gender Aware

The explicit recognition of local gender differences, norms, and relations and their importance to health outcomes. This begins with the analysis or assessment of gender differences, norms, and relations to address gender equity in health outcomes.

Unpacking Gender Aware Programming

Continuum Stage	Characteristics
Gender Exploitative	Intentionally or unintentionally reinforces or takes advantage of gender inequalities and stereotypes in pursuit of project outcomes.
	Takes advantage of rigid gender norms and existing imbalances in power to achieve the health program objectives.
	This approach is harmful and can undermine program objectives in the long run.

Unpacking Gender Aware Programming

Continuum Stage	Characteristics
Gender Accommodating	Considers gender norms, roles, and relations for women and men and how they affect access to and control over resources
	Considers women's and men's specific needs
	Intentionally targets and benefits a specific group of women or men to achieve certain policy or program goals or meet certain needs

Unpacking Gender Aware Programming

Continuum Stage	Characteristics
Gender Transformative	Considers gender norms, roles and relations for women and men and that these affect access to and control over resources
	Considers women's and men's specific needs
	Addresses the causes of gender-based health [and other] inequities
	Includes ways to transform harmful gender norms, roles and relations
	The objective is often to promote gender equality

Example: FP Promotion Program

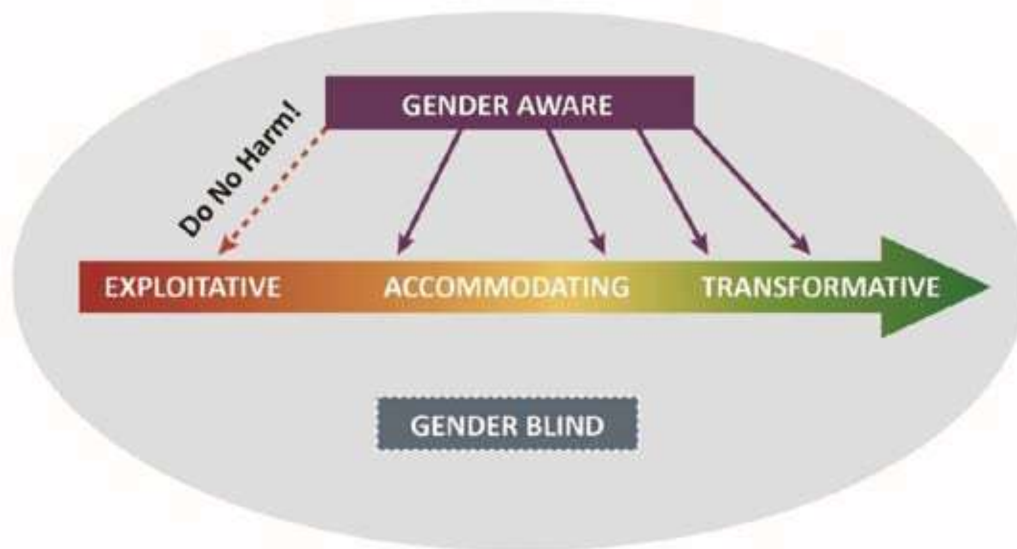
Intervention	Exploitative	Accommodating	Transformative
FP awareness raising program supported through serial cartoon strip and radio program	Characters featured in the program included an inconsiderate husband and his wife who is burdened with raising 5 children and tending to their small plot of land. Episodes that included domestic violence were featured in the serial without any discussion. From an awareness raising perspective, the program was deemed very successful as FP demand increased. However, the underlying message exacerbates gender inequalities and, as a result, domestic violence in the community remains unchanged.	An episode of domestic violence featured women caring for a woman who had been beaten by her husband. There was no discussion of men's roles in treating the problem. The program met its health objectives as more people became aware of FP services and was deemed very successful, but the underlying message maintains gender inequalities that fail to question or challenge the status quo. In this case, VAW was accepted—the symptoms were treated but the underlying causes were left unchallenged.*	An episode of domestic violence in the storyline included counseling and community involvement. In the program, groups of men and women dealt with domestic violence by exploring gender roles and roleplaying positive behavior. The program was very successful on 2 levels. FP awareness increased and communities were engaged to deal with combating domestic violence by promoting positive, healthy relations between men/boys and women/girls.

*Note: In some settings, publicly acknowledging the existence of domestic violence is revolutionary. Thus, this example could also potentially fall under the "transforming" category.

Concept into Action: Bangladesh's FP Program

- BDHS data shows that male sterilization is declining
- Limited dialogue between sexual partners around FP, use of contraception, or the pros and cons of different methods
- 2015 national survey on VAW shows high prevalence of reproductive coercion:
  - 36.1% women seek permission before accessing health services
  - 49.6% of experience physical intimate partner violence (IPV)
  - 6.4% of women report being forced to use contraception
- Standard practice for FP counseling rarely includes or provides:
  - Guidance for consideration of IPV
  - Woman's degree of independent decision making
  - How the client might perceive gender-based expectations or discrimination

Gender Continuum — Do No Harm



SESSION 3

Gender Competent FP Service Provision

Session 3 Learning Objectives

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

1. Describe the core competencies of a gender-sensitive FP service provider
2. Explain elements of client interaction in relation to the relevant gender competencies

Understanding Gender Competency

Gender Competency

The capacity to identify when and how different norms, social constructs, roles, expectations, power differentials, opportunities, and constraints assigned to women, men, girls, and boys are manifested in daily life, and how they might affect health and well-being, including how the provider's own attitudes and norms about gender and power affect professional interactions.

Gender competency requires the application of appropriate knowledge, skills, and attitudes in daily work and interactions to communicate and treat people equitably and produce more equal agency and decision-making for women, men, girls, and boys, regardless of age or relationship status.

The Gender Competent FP Service Provider

SUPPLEMENTAL TRAINING MODULE | GENDER INTEGRATION IN FAMILY PLANNING SERVICES | SESSION 3 27

1. Using Gender-Sensitive Communication

Refers to provider's ability to transmit information through verbal and non-verbal communication in a way that recognizes unequal power structures and promotes equality for all clients.

- Aware of the power differentials that may exist because of gender, culture, education, or other differences and that impact access to information and services.
- Provides information to clients to obtain FP services, regardless of barriers created by the client's gender, including literacy, access to media and technology, and ability to attend counseling.
- Maintains relaxed, friendly, and attentive body postures and eye contact, as appropriate, to show respect for the client, regardless of gender.
- Recognizes the effects of his/her own gender and power as a provider and the potential for bias to interfere with the provision of FP services.

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2. Promotes Individual Agency

Refers to the provider's capacity to support an individual client's voluntary and informed decisions about whether, when, and how often to reproduce, without pressure to conform to gender and cultural norms.

- Agency is defined as the capacity of individuals to act independently and to make their own free choices.
- Always make time for informed choice.
- Provide information and ask questions in a neutral fashion that creates an environment for clients to express their own needs and desires.
- Provide counseling information with minimal technical terms to enable all clients to understand their options.

3. Engages Men and Boys as Partners and Users

Refers to the provider's recognition of men and boys as supportive partners to women and as potential users of FP.

- Providers encourage shared FP responsibility.
- Involve male partners in FP decision making, while protecting women's rights and agency.
- A gender-competent provider promotes positive and healthy masculinities to contribute to shifting community norms and behavior change.
- A provider can most effectively achieve this competency after mastering the previous domains.

4. Supporting Legal Rights and Status Related to FP

Refers to the provider's ability to provide information and services to clients in accordance with rights and local laws and without interference of personal bias.

- Providers must know local laws and policies and have the capacity to respond to the particular needs of a client to help them make voluntary and informed decisions about FP, as well as be able to dispel any common misconceptions about rights related to FP.
- Apply accurate knowledge in client-centered service provision, free from interpretation based on the provider's own perception of gender norms, roles, and expectations.
- Post wall charts and other visual materials that remind women and men, girls and boys, of their legal right to voluntary family planning.

5. Facilitate Positive Couple's Communication and Cooperative Decision Making

Refers to the provider's capacity to help clients articulate, discuss, and negotiate reproductive intentions and to make joint reproductive decisions as a couple.

- Offer to include male partners in counseling sessions.
- Never insist on including partners or parents in counseling sessions.
- Create space for each person to ask their own questions and give their own responses.
- Facilitate opportunities for the girl or woman to respond and share preferences first.
- Upon method selection, provide information on how the partner can support correct and consistent use.

6. Addressing Gender-Based Violence

Refers to the provider's ability to respond to GBV through brief empathetic counseling, safety planning, and appropriate referrals.

- Global evidence strongly demonstrates that pushing for disclosures of violence can cause harm.
- Confidentiality and privacy can protect women living with violence from escalation related to their FP care and use.
- Include clear, but objective questions that create space for disclosure of violence.
- Provide information for each contraceptive method on degree of discreetness, regardless of whether IPV is disclosed.
- Provide nonjudgmental, compassionate response if a client does disclose being a survivor of GBV of any form.

The Gender Competent FP Service Provider

SESSION 4

Skills Development: Gender-Sensitive Counseling

Session 4 Learning Objectives

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

1. Demonstrate gender-sensitive counseling.
2. Explain ways of facilitating positive couple's communication and decision making.

Gender-Sensitive Counseling

Key points to remember:

- Gender norms and power dynamics affect your client's ability to make rights-based, personal choices.
- FP/contraception impacts men and women, and can be used by both men and women.
- Gender norms likely reduce women's comfort and ability to express different opinions from their male partners – when counseling couples, seek the women's response first.

GROUP ACTIVITY

Roleplay Instructions

Roleplay Time	15 minutes
• Review your assigned scenario	
• Assign each person a role (client, provider, partner, observer)	
• Rotate so each person can play the role of provider	
• Review Handout 4B and use it as a guide	
Group Discussion	20 minutes

GROUP ACTIVITY

Case Study Instructions

Preparation Time	5 minutes
• Review the scenario and the questions together.	
• Review Handout 4B and refer to it as you discuss.	
• Prepare to present your thoughts on the case and the questions to the group.	
Presentation	5 minutes
Discussion	5 minutes

SESSION 5

Skills Development: Responding to GBV

Session 5 Learning Objectives

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

1. Describe the DO NO HARM principles surrounding FP service provision and the risk of violence against women.
2. Demonstrate how to respond to disclosures of SGBV with appropriate first-line information

FP in the Context of GBV

First, DO NO HARM

- At least 1 in 4 married women in Bangladesh are currently living with intimate partner violence.
- Confidentiality and privacy are essential to protect women from escalation or further violence.
- Include discreetness pros and cons when providing counseling for each method to all clients.
- Discuss implications for effectiveness and safety pragmatically and without judgement if a client has disclosed IPV or fear of VAW from other perpetrators.

FP in the Context of GBV

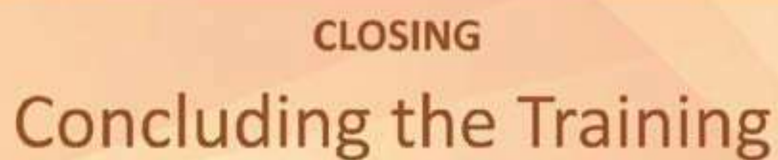
LIV(ES)

- Always allow the woman to lead. If she does not want to discuss or disclose that is okay.
- As her reproductive health provider, you may be one of her few contacts outside of her home. Every FP provider should be able to:
- LISTEN to what a woman is saying, and not saying
- INQUIRE with respect and through simple open-ended questions
- VALIDATE the woman's feelings and experience, reflecting that she deserves to be safe and receive care.

Health system response to gender-based violence is complex. Additional trainings are available should you or your facility be interested.

SMALL GROUP ACTIVITY

Practice: Responding to SGBV during an FP Service Visit



SUPPLEMENTAL TRAINING MODULE | GENDER INTEGRATION IN FAMILY PLANNING SERVICES | CLOSING 45

Gender is a socially constructed set of norms, behaviors, and expectations that influence behavior, agency, and power for girls and boys, women and men.

Gender Inequity and some traditional gender norms contribute to harmful FP/RH behaviors, including barriers to uptake and proper use of contraception.

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Primary Take-Aways Continued

- FP providers can play an important role in mitigating the negative impact of gender inequality on reproductive health.
- Gender inequity contributes to high incidence of violence against women.
- FP providers have an important role to play in mitigating the risks of and from VAW as they relate to FP/RH.

Questions?

Shukhijibon

PATHFINDER