



# **Reflective Dialogues for Health Workers: Family Planning Counseling and Adolescent and Youth Friendly Services**

**IMAGINE:** Inspiring Married Adolescent  
Girls to Imagine New Empowered Futures





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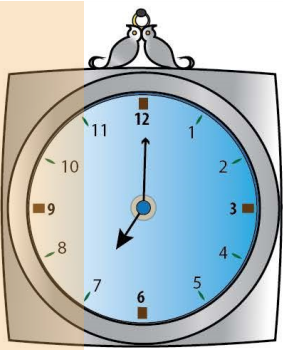
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## Introduction to the Manual

### **Inspiring Married Adolescent Girls to Imagine New Empowered Futures (IMAGINE)**

90% of adolescent pregnancies in the developing world occur among married girls, yet few programs exist for this population.<sup>1</sup> The Inspiring Married Adolescent Girls to Imagine New Empowered Futures (IMAGINE) Project aims to begin to address the needs of this population by supporting girls and their families in Niger and Bangladesh to delay their first birth and envision, value and pursue alternative life trajectories. The intervention aims to strengthen:

- Individual assets and agency among married and unmarried adolescent girls
- Relations and community support
- Health systems and alternative futures opportunity structures

### **Reflective Dialogues for Health Workers: Family Planning Counseling and Adolescent and Youth Friendly Services**

In order to support married adolescents' access to family planning services, it is imperative that health providers are able and willing to offer non-judgmental, rights-based sexual and reproductive healthcare to adolescents. Drawing on CARE's Social Analysis and Action (SAA) approach and other reflective dialogue practices, this manual contains activities to guide health workers through a process of critical self-reflection around social and gender norms and professional responsibilities grounded in the principles of rights-based care. It further provides a structure for individual goal setting and health-facility action planning to transform provider

attitudes and biases and overcome facility-level barriers experienced by nulliparous married adolescent girls when seeking reproductive healthcare. Finally, in addition to providing opportunities for self-reflection, this manual also contains exercises to strengthen providers' knowledge in family planning counseling, adolescent and youth friendly services (AYFS), and long-acting reversible contraception (LARC) provision to adolescent clients.

Sessions were originally designed for trained project field staff to facilitate with facility based and frontline health workers. Prior to rolling out the sessions, the facilitators were trained in reflective dialogue facilitation, key communication and conflict resolution skills, and the content of the manual. During the IMAGINE project, healthcare workers in Niger and Bangladesh were assembled in small groups of between 10-20 participants in order to allow for interactive, hands-on training and build broad-based provider support for AYFS and rights-based family planning for adolescent clients. The current manual presumes health workers have received an initial technical training in family planning and should be used to supplement, rather than supplant, skill-based training in the provision of family planning methods and counseling skills.

## How to Use this Manual

This manual provides a ten-session, participatory curriculum that blends reflective dialogues for examining, challenging and shifting social norms with skill-building in family planning counseling and adolescent and youth friendly services. Sessions are intended to last between one and three hours, with most sessions lasting 1.5 hours. The activities are designed to be highly participatory, enabling participants to, firstly, share, analyze and enhance their knowledge of their lives and social environment, and, secondly, to plan, act, monitor, evaluate and reflect.

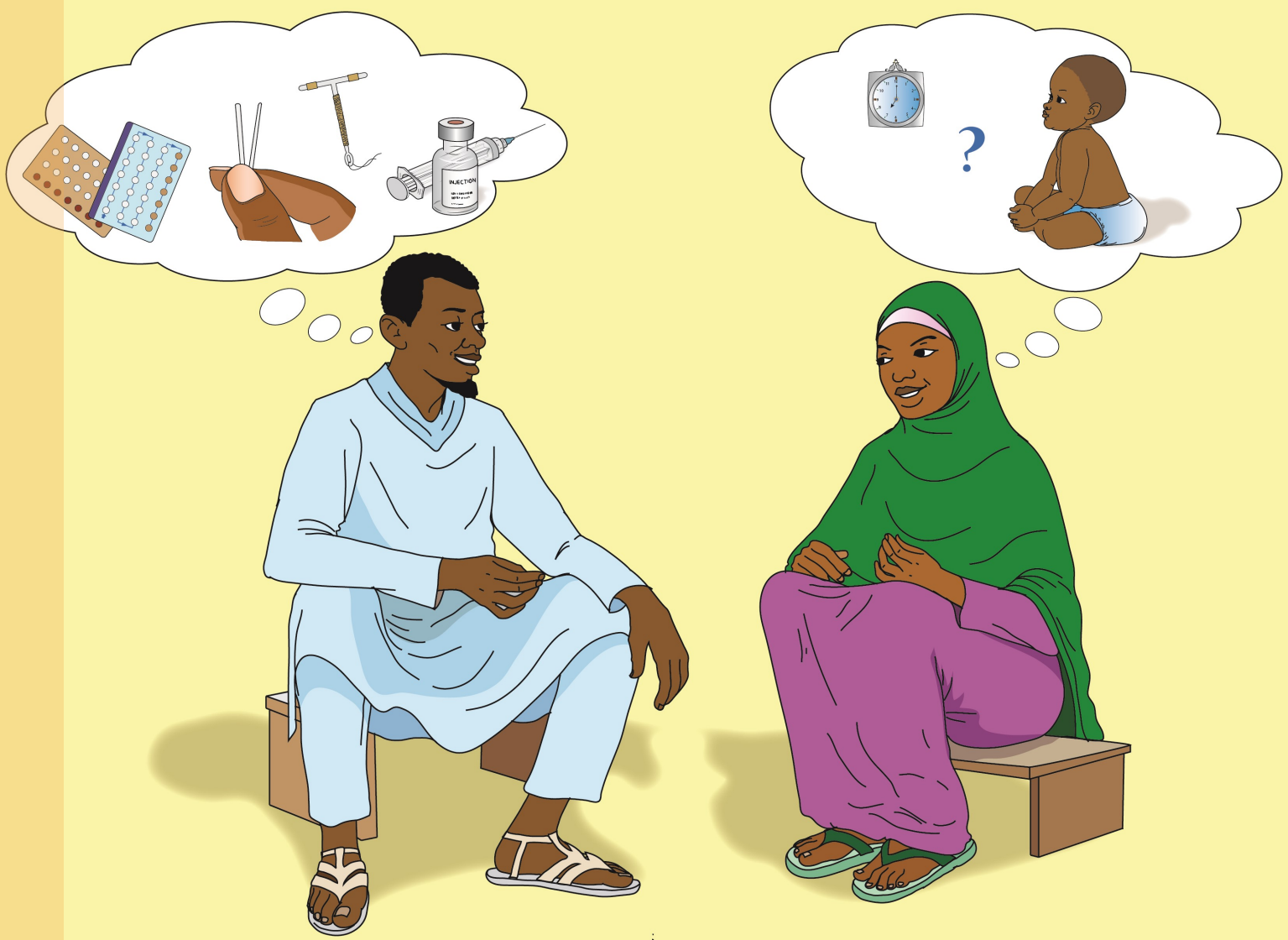
The curriculum presents information for each activity in a standardized fashion, with each session including some, if not all, of the following:

- **Objectives:** The objectives outline key learning goals or concepts for each session.
- **Materials:** The facilitator should collect and/or prepare all of the items listed *before* the start of the session. Generally, only basic materials are required. If the materials cannot be accessed easily, facilitators are encouraged to improvise. For example, flipchart and markers can be substituted with chalkboard and chalk.
- **Preparation:** These are the activities or prep work that need to be done before the start of the session.
- **Time:** This indicates how long the activity should take based on past experience. However, length of time can vary depending on the number of participants, the level of engagement of participants and other factors.

The manual further provides step-by-step instructions for facilitating the participatory learning activities that make up a given session. Most sessions contain directions for implementing an activity as well as reflective questions to orient facilitators toward their role in leading critical reflection among participants. Before beginning the training, facilitators should read through the entirety of the manual in order to understand the progression of messaging and information conveyed throughout the training and make any necessary adaptations. This will not only deepen their understanding of the topics they are exploring with participants, but it will also help them address any concerns about what the training covers.

<sup>1</sup> UNICEF. Ending child marriage: Progress and prospects. New York: UNICEF, 2013.





## Session 1

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

- Explain key concepts related to voluntary, rights-based family planning services
- Articulate personal values related to family planning and how they shape our work
- Describe health providers' responsibilities and actions to support voluntary, rights-based family planning services

**Materials:**

- Flip chart paper; Markers; *Handout: The Rights-Based Approach*; *Facilitator Reference Sheet: The Rights-Based Approach*

**Advance Preparation:**

- *Values Clarification*
  - Make two signs; one that says 'AGREE' and the other 'DISAGREE'. Place the signs at opposite ends of the training room.
- *Introduction to the Rights-Based Approach*
  - Prepare copies of *Handout: 'The Rights-Based Approach'*

**Time:**

- 1 hour 35 minutes

## Introduction (15 minutes)

1. Welcome participants to the training. Introduce yourself.
2. Invite participants to introduce themselves by giving their names, job title and favorite food.
3. Explain the purpose of the training:
  - “I am here as part of the ‘Inspiring Married Adolescent Girls to Imagine New Empowered Futures (IMAGINE) Project’. In our communities, the majority of girls are married before they turn 18, and yet few programs exist to support their needs. Often, these girls get pregnant very soon after getting married, which can have negative consequences on their health and wellbeing. I imagine that, as employees of a health care facility, you are very familiar with these negative health outcomes. Can you name a few?
    - *Facilitator notes: responses may include an increased risk of death and injury during childbirth, including eclampsia, anaemia, postpartum haemorrhage and obstetric fistula. The children of adolescents also face substantial risk of being born too soon, too small or with a low birth weight all of which shed light on why these infants are more likely to die before their first birthday than are the infants of older mothers.*<sup>2,3,4</sup>
  - “However, when married girls do not immediately become mothers, they have more opportunities to continue their education, learn skills and participate in income-generating activities that will help their families earn more money and thrive.
  - “The IMAGINE project aims to address the needs of married girls by supporting them to delay their first birth and envision, value and pursue life trajectories beyond early motherhood.
  - “In this training, we will focus on the role of health facilities in supporting adolescent girls – both married and unmarried – to lead healthy lives. We will:
    - Develop skills and strategies for delivering family planning services to adolescent girls in a manner that respects, protects and fulfills their human rights;
    - Reflect on how our personal beliefs about providing family planning services to adolescent girls can impact our professional responsibilities;
    - Learn how beliefs about acceptable roles, responsibilities and behaviors for men and women impact the reproductive health of adolescent girls;
    - Practice skills for communicating with adolescent clients in a manner that suspends judgment and supports their choice, autonomy and dignity.”
4. Ask the participants if these topics interest them. Invite questions about the topics of the training.

## Values Clarification (30 minutes)

1. Introduce the activity:
  - “The choices we make, the actions we take and opinions we hold are all influenced by our values – our judgments about what is important in life. For example, if we value our health, we might choose to spend more money on healthy food than someone who does not value their health. If we value education, we might choose to read lots

of books and stay in school. In short, values are ideas, principles or beliefs that are important to us because they help define who we are and how we behave.

- “Our values often operate in our subconscious. This means that we are rarely aware of how they are influencing us.
- “This first activity will allow us to identify and reflect on some values we hold related to the provision of family planning services.”

2. Draw participants’ attention to the ‘AGREE’ and ‘DISAGREE’ signs you have posted at opposite ends of the room.
3. Using the list of statements below, read the first statement aloud.

### Values Clarification Statements

- A woman should not get contraception without the consent of her husband
- Only the provider knows what contraceptive method is best for the client.
- Women with low literacy are better off using an IUD or implant because there is nothing to remember.
- A woman is not a real woman until she has given birth to a child.
- Married adolescents should have a child within the first year of marriage.
- Adolescents have a right to both short-acting and long-acting reversible contraceptives.

4. Ask participants to stand near the sign that best reflects their opinion. If they are not sure how they feel, they can stand in the middle.
5. Once participants line up, ask for one or two volunteers to share their opinions with the group. Allow for some diverse opinion, but do not let the activity turn into a debate. *Remember this exercise is not about coming up with an agreed-upon answer, but to show that we all have opinions that underpin how we see and interact with the world.*
6. Move on to the next statement and repeat steps 4 and 5.
7. Continue in the same manner for the remaining statements.
8. Use the following questions to facilitate a discussion:
  - How did you feel during the exercise?
  - Which statements, if any, were challenging for you? Why?
  - What did it feel like to be in the majority? The minority?
  - How can you explain the differences among the group?
  - What did you learn about your own and others’ opinions?
  - Based on the opinions you have seen expressed, in what ways might our values affect

the way we deliver family planning services at our facility?

- *Note: Encourage participants to think about how their values might support and/or obstruct adolescent access to family planning and other sexual and reproductive health services.*

9. Conclude the activity by explaining:

- It is normal to have strong feelings about the topics we have just discussed. Our opinions on these topics are informed by our values and our values are very important to us.
- Identifying our values can help us reflect on how our values affect our behavior towards our clients, the quality of care we provide them with and the impact our actions have on the ability of our clients to access, accept and use health care services.
- In this training, we will work to clarify our values; reflect on their origins and impacts; and clarify our professional responsibilities.

### **Introduction to The Rights-Based Approach (40 minutes)**

1. Introduce the activity: “Across the world, health systems have been designed according to something called the public health framework. As health professionals, I’m sure you are familiar with this. It is a framework that aims to seek the greatest good for the greatest number of people. Today we are going to learn about a new approach that complements the public health framework: the rights-based approach. Instead of looking at populations, it focuses on individuals by trying to protect and promote their wellbeing, while respecting their dignity.”
2. Explain to participants that you are going to ask a series of questions about how they spend their time at work. If they do spend part of their average workday doing the stated activity, instruct them to raise a hand.
3. Read the following questions out loud:
  - “During your workday, do you...”
    - Provide high-quality services?
    - Provide services targeted towards adolescents?
    - Counsel clients?
    - Procure or manage family planning commodities?
    - Update client records?
    - Educate clients about their health and wellbeing?
    - **Protect clients’ human rights?**
4. Explain to the group that if they raised a hand for any of the first six statements, they should have also raised their hand for the final statement about protecting human rights. Without realizing it, much of the work that health workers already do supports human rights.
5. Explain that the purpose of this activity is to explore the ways in which participants can use human rights principles to improve health care, specifically the provision of family planning services to adolescents. Even though this might require certain things to be done differently,

it should not mean adding extra work but rather building on what they, as service providers, are already doing.

6. Distribute copies of *Handout: The Rights-Based Approach*. Use the Facilitator Reference Sheet to guide your discussion.
7. Ask for volunteers to read out loud the answer to **Question 1** (What are Human Rights?).
8. For **Questions 2, 3, 4**, (What are reproductive rights? What is a Rights-Based Approach? What do Rights-Based Services Look Like?) Invite volunteers to read out the answers and, using the Facilitator Reference Sheet, support the group to answer any questions on the worksheet.
9. For **Question 5 and 6** (What can service providers and facility staff do to ensure that the family planning services at their facility respect, protect and fulfill human rights? What is unique about family planning that makes human rights so important?), facilitate a discussion, drawing on the information contained in the *Facilitator Reference Sheet*.
  - *Note: For all questions, encourage participants to come up with answers on their own before sharing the information on the reference sheet with them.*

### **Conclusion, Session Evaluation and Dismissal (10 minutes)**

1. Read out the following core messages for this session:
  - Our values can affect our behavior towards our clients, the quality of care we provide them with and the impact our actions have on the ability of our clients to access, accept and use health care services.
  - A rights-based approach aims to protect and promote the wellbeing of individuals, and respect their dignity. Among other considerations, this means that family planning services must be of high quality and acceptable, available and accessible to adolescents.
  - Adolescent girls must also have free, full and informed choice when it comes to decisions around contraception. This means that they should have the final decision around which contraceptive method, if any, best satisfies their personal, reproductive and health needs, based on a thorough understanding of their contraceptive options.
2. Ask participants to write down a commitment to applying one thing that they have learned in today's session to their professional lives. Invite a few volunteers to share their commitments.
3. If there is time, ask the following discussion questions:
  - Would anyone like to share with the group one thing they found interesting or exciting about today's session?
  - Were there any ideas or activities that challenged you? If yes, how so?
  - Does anyone have any questions or additional thoughts?
4. Inform participants of the date, time, location and topics for the next session.
5. Remind participants that personal stories and experiences shared during the dialogue should

be kept within the group, but that they are encouraged to share what they have learned with family, friends and colleagues who were not present if they feel comfortable doing so.

6. Thank participants for their active participation.
7. Dismiss the group.
8. After the session is complete and participants have left, record your answers in the session evaluation form (Annex 1).

<sup>2</sup> de Vienne, C.M., Creveuil, C. and Dreyfus, M., 2009. *Does young maternal age increase the risk of adverse obstetric, fetal and neonatal outcomes: a cohort study.* European Journal of Obstetrics & Gynecology and Reproductive Biology, 147(2), pp.151-156.

<sup>3</sup> Haldre, K., Rahu, K., Karro, H. and Rahu, M., 2007. *Is a poor pregnancy outcome related to young maternal age? A study of teenagers in Estonia during the period of major socio-economic changes (from 1992 to 2002).* European Journal of Obstetrics & Gynecology and Reproductive Biology, 131(1), pp.45-51.

<sup>4</sup> Verguet, S., Nandi, A., Filippi, V. and Bundy, D.A., 2016. *Maternal-related deaths and impoverishment among adolescent girls in India and Niger: findings from a modelling study.* British Medical Journal, 6(9), p.e011586.

## Handout: The Rights-Based Approach

### What are Human Rights?

- Human rights are fundamental entitlements and protections that all people, everywhere, possess as a human being. They are universal because everyone, everywhere has them.
- They are agreed upon by societies and governments and promoted in international declarations, conventions, protocols and treaties as well as national laws.
- Human rights are spelled out in international and domestic law. They give citizens a tool with which they can hold their governments accountable.
- Human rights hold human dignity at their core.

### What are reproductive rights?

Reproductive rights are the entitlements and freedoms related to reproduction and reproductive health. For example:

- All couples and individuals have the right to decide freely and responsibly the number, spacing, and timing of their children, and to have the information and means to do so. (International Conference on Population and Development, 1994)
- The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. (Beijing Women's Conference, 1995)

### What is a rights-Based Approach?

A rights-based approach aims to ensure that a given program RESPECTS, PROTECTS and FULFILLS the rights of individuals it is intended to serve based on how it is designed, implemented, monitored and evaluated.

### What do rights-based services look like?

Rights-based services are based on the following principles. Give an example of what each item means:

**Acceptability:** \_\_\_\_\_

**Accessibility:** \_\_\_\_\_

**Availability:** \_\_\_\_\_

**Quality:** \_\_\_\_\_

**Participation:** \_\_\_\_\_

**Non-Discrimination:** \_\_\_\_\_

**Free, Full and Informed Choice:** \_\_\_\_\_

<b>Is a service rights-based if...</b>	<b>YES</b>	<b>NO</b>
...adolescents can't afford it?		
...married adolescent girls must get consent from their husbands before receiving contraception?		
...services are denied to unmarried adolescents?		
...contraception is denied to married adolescents without children?		
...adolescents are told which method to take by the service provider?		
...adolescents are told about the pill but are not told about any of the other methods (e.g. the IUD, injectables, condoms, the implant, etc.)?		

**What can service providers and facility staff do to ensure that the family planning services at their facility respect, protect and fulfill human rights?**

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**What is unique about family planning that makes human rights especially important?**

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# Facilitator Reference Sheet: The Rights-Based Approach

## What are Human Rights?

- Human rights are fundamental entitlements and protections that all people, everywhere, possess as a human being. They are universal because everyone, everywhere has them.
- They are agreed upon by societies and governments and promoted in international declarations, conventions, protocols and treaties as well as national laws
- Human rights are spelled out in international law and the laws of your country. They give citizens a tool with which they can hold their governments accountable.
- Human rights hold human dignity at their core.

## What are Reproductive Rights?

Reproductive rights are the entitlements and freedoms related to reproduction and reproductive health. For example:

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- The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. (Beijing Women's Conference, 1995)

## What is a Rights-Based Approach?

- A rights-based approach aims to ensure that a given program RESPECTS, PROTECTS and FULFILLS the rights of individuals it is intended to serve based on how it is designed, implemented, monitored and evaluated.
- When a provider respects human rights, he or she will not interfere with or deny an individual's right to information, choice, health, safety, etc. When a provider protects human rights, he or she will take measures to guard against any abuse of human rights, such as reproductive coercion. Reproductive coercion is when a client is forced to accept something they do not want. For example, they may be forced to accept a method they do not want.
- Finally, the provider should fulfill human rights by taking action to support the fulfillment of rights by advocating for and empowering all clients, regardless of age, marital status, religious, etc. to make informed decisions around their sexual and reproductive health, such as accessing family planning or deciding when or if to have children.

## What do rights-based services look like?

- **Acceptability:** They are acceptable to clients, culturally appropriate and sensitive to vulnerable groups.
- **Accessibility:** Services are accessible to everyone in terms of physical access, affordability, access to information and non-discrimination.
- **Availability:** Services must be available in sufficient quantities.
- **Quality:** Services comply with relevant quality standards.

- **Participation:** Clients and communities have the opportunity to participate in and give input into decisions related to the design, delivery and evaluation of services.
- **Non-Discrimination:** Services and information are not restricted on the basis of race, sex, marital status, age, language, religion, political affiliation, national origin, economic status, place of residence, disability status, sexual orientation or gender identity.
- **Free, Full and Informed Choice:** Clients – not service providers – select the contraceptive method that best satisfies their personal, reproductive and health needs, based on a thorough understanding of their contraceptive options and without any controlling influences.

Is a service rights-based if...	YES	NO
<p><b>...adolescents can't afford it?</b></p> <p><i>Answer: If adolescents can't afford services, then they can't access them. According to the rights-based approach, adolescents must be able to access services.</i></p>		X
<p><b>...married adolescent girls must get consent from their husbands before receiving contraception?</b></p> <p><i>Answer: All individuals must be able to make decisions autonomously – meaning, for and by themselves, without being controlled by anyone else. If someone else's consent is required, the adolescent client is being denied free, full and informed choice.</i></p>		X
<p><b>...services are denied to unmarried adolescents?</b></p> <p><i>Answer: If a group is denied services, this is a form of discrimination. Services cannot be restricted on the basis of age or marital status.</i></p>		X
<p><b>...contraception is denied to married adolescents without children?</b></p> <p><i>Answer: Again, to deny services to a specific group is to discriminate.</i></p>		X
<p><b>...adolescents are told which method to take by the service provider?</b></p> <p><i>Answer: By telling the adolescent which method to take, adolescents are being denied to chance to make a free, full and informed choice.</i></p>		X
<p><b>...adolescents are told about the pill but are not told about any of the other methods (e.g. the IUD, injectables, condoms, the implant, etc.)?</b></p> <p><i>Answer: Adolescents are being denied a free, full and informed choice because they are not being provided with information about all of their options.</i></p>		X

## What can service providers and facility staff do to ensure that the family planning services at their facility respect, protect and fulfill human rights?

Answer<sup>5</sup>:

- ***Inform and counsel all clients to ensure*** accurate, unbiased, and comprehensible information and protect clients' dignity, confidentiality, and privacy. Refer clients to other SRH services as needed
- Ensure high-quality care through ***effective training and supervision*** and performance improvement and recognize providers for respecting clients and their rights
- Ensure ***equitable service access for all***, including disadvantaged, marginalized hard to reach populations through various service models and effective referral
- Routinely ***provide a wide choice of methods*** and ensure proper ***removal services*** for implants and IUDs
- Establish and maintain ***effective monitoring and accountability systems, with community input***, and strengthen Health Management Information Systems and quality assurance and improvement processes

## What is unique about Family Planning that makes Human Rights especially important?

Answer:

- *There are factors that set family planning apart from other health care services:*
  - *It is an elective, largely preventative health care service;*
  - *It is related to sexuality and fertility, which have religious and cultural sensitivities, as well as links to gender and power dynamics;*
- *Because it has population implications, governments often set targets around family planning use and some governments or countries have a history of coercive family planning policies and programs*
- *Because of these characteristics, family planning services are particularly vulnerable to rights violations, namely coercion, access barriers (factors that prevent people from getting the family planning method they want) and low- quality services (substandard clinical care, lack of privacy or confidentiality, poor counseling, etc...). **Coercive measures (provider bias, targets, family pressure, etc.) push people to accept family planning or a specific method they DO NOT want, while access barriers, including socio-cultural barriers, prevent people, particularly adolescents, from getting information or services they do want.***

<sup>5</sup>Hardee, K., et al. 2013. *Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights: A Conceptual Framework*. Washington, DC: Futures Group.



## Session 2

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

- Explain the factors that support or obstruct the delivery of voluntary, rights-based family planning;
- Articulate strategies for upholding professional obligations in instances where they appear to conflict with personal beliefs.

**Materials:**

- Flip chart; Markers; Case Studies; Handout: Personal Beliefs and Professional Responsibilities

**Advance Preparation:**

- Prepare copies of the document *Case Studies: Barriers and Enablers to Rights-Based Family Planning*, ideally one per person
- Prepare copies of *Handout: Personal Beliefs and Professional Responsibilities*, for distribution to all the participants.

**Time:**

- 1 hour 45 minutes

## Welcome (10 minutes)

1. Welcome participants back to the training and thank them for their continued commitment.
2. Ask for a volunteer to remind the group what was discussed in the previous session. If necessary, read out the following core messages:
  - Our values can affect our behavior towards our clients, the quality of care we provide them with and the impact our actions have on the ability of our clients to access, accept and use health care services.
  - A rights-based approach protects and promotes the wellbeing of individuals and respects their dignity. Among other considerations, this means that family planning services must be high quality and acceptable, available and accessible to adolescents.
  - Adolescent girls must also have free, full and informed choice when it comes to decisions around contraception. This means that they should have the final decision around which contraceptive method, if any, best satisfies their personal, reproductive and health needs, based on a thorough understanding of their contraceptive options.
3. Invite questions or comments about the previous week's session.
4. Remind participants that they committed to applying something they had learned in last week's session to their professional lives. Invite participants to reflect on those commitments. Were they able to apply what they had learned? Why or why not?

## Barriers and Enablers in Support of a Rights-Based Approach to Family Planning Services (45 minutes)

1. Introduce the activity:
  - “In our last session, we learned that family planning services are particularly vulnerable to rights violations. Who can share an example of a rights violation related to family planning?
    - *Facilitator's note: Family planning rights violations include coercion, where clients are forced or intimidated into accepting what they don't want; access barriers that prevent people from getting the contraception they do want; and poor quality, including substandard medical care, lack of confidentiality, lack of respect for a client's dignity, lack of privacy and confidentiality, etc.*
  - Rights violations prevent women and girls from exercising full, free and informed choice around family planning. Who can remind me what free, full, and informed choice means?
    - *Facilitator's note: Clients – not service providers – select the contraceptive method that best satisfies their personal, reproductive and health needs, based on a thorough understanding of their contraceptive options and without any controlling influences.*
  - “We will now take a deeper look at the role health facilities play in guarding against these rights violations and supporting adolescents' ability to access contraception. In small groups, we are going to explore the factors that support or challenge young women's full, free and informed choice and human rights.”
2. Divide participants into teams of 3-4 people and give each team copies of the case studies

you printed off before the session. Multiple groups can look at the same case study.

3. Instruct participants to read their case study to themselves and to then answer the associated questions as a group.
4. Give groups approximately 15-20 minutes to complete the exercise, and then bring the large group back together.
5. Invite a representative from each group to provide a quick summary of their case study as well as their responses.
6. At the end of each presentation, invite additional suggestions about what the health care worker could have done to PROMOTE access to family planning services, per the rights-based approach.
7. After all groups have presented, ask the following discussion questions, recording the answers on a flip chart:
  - What possible benefits could a rights-based approach to family planning bring to clients, health care workers and health facilities?
  - What are the possible consequences of failing to adopt a rights-based approach to family planning on clients, health care workers and health facilities?
  - How can you use the idea of human rights in your position?
8. Summarize the key points of the activity:
  - RESPECTING, PROTECTING and FULFILING the human rights of our clients requires staff at this facility to...
    - Inform and counsel all clients in high-quality interactions that ensure accurate, unbiased, and comprehensible information
    - Protect clients' dignity, confidentiality, and privacy and refer clients to other sexual and reproductive health services, when necessary
    - Ensure high-quality care through effective training and supervision and performance improvement and recognize providers for respecting clients and their rights
    - Ensure equitable service access for all, including disadvantaged and marginalized, discriminated against, and hard to reach populations through various service models and effective referral
    - Routinely provide a wide choice of methods and ensure proper removal services for implants and IUDs
    - Establish and maintain effective monitoring and accountability systems, with community input<sup>6</sup>

### **Personal Beliefs and Professional Responsibilities (40 minutes)**

1. Give participants a copy of the handout, *Personal Beliefs and Professional Responsibilities*.
2. Explain that you would like them to work by themselves to complete the handout. Give participants 10 minutes to complete their answers. Bring the group back together.

3. Ask participants to describe the professional responsibilities they listed related to the provision of family planning services to adolescents. Write all responses down on a flipchart and keep this flipchart for future sessions. Answers may include:
  - Engage communities and individuals, including adolescents, in planning and monitoring programs
  - Inform and counsel all clients, including adolescents, in high-quality interactions that ensure accurate, unbiased, and comprehensible information and protect clients' dignity, confidentiality, and privacy and refer to other SRH services
  - Ensure high-quality care through effective training and supervision and performance improvement
  - Ensure equitable service access for all, including for adolescents, through various service models and effective referral systems
  - Routinely provide a wide choice of methods and ensure proper removal services for implants and IUDs
  - Establish and maintain effective monitoring and accountability systems, with input from adolescents and the community, and strengthen monitoring and evaluation and quality assurance mechanisms.
  - Incorporate rights indicators into performance expectations and routine monitoring
  - Strengthen accountability and redress mechanisms
4. Ask participants how the list of items generated in response to question 1 influences their role as a provider. Add any additional responsibilities to the flipchart.
5. Ask participants to describe their facility's responsibilities related to the provision of family planning services to adolescents. Add any additional responsibilities to the flipchart.
6. Ask participants to describe any situations when their personal beliefs conflicted with their professional responsibilities. Ask about their decision-making process. Would they do anything different in the future?
7. Ask participants what consequences adolescents face when a health facility's staff do not follow a rights-based approach to family planning service delivery. Answers include, but are not limited to:
  - Adolescents might be coerced into accepting an outcome they do not want. This includes being denied contraception or being forced to accept a method they do not want.
  - Adolescents might face barriers that prevent them from accessing the facility or accessing the services they want once at the facility.
  - Adolescents might receive poor quality services that compromise the effectiveness of their contraception. Poor quality services can relate to the clinic itself (i.e. poorly trained staff, insufficient commodities, unhygienic care, etc.) as well as provider-level factors like a lack of privacy, confidentiality and/or respect for client dignity.
  - The above factors might prevent adolescents from accessing family planning and information around their sexual and reproductive health. As a result, they *might experience an unexpected, early pregnancy or other health issues.*

8. Ask participants what are some ways we can maintain our personal beliefs about family planning, while adhering to our professional responsibilities? Answers may include:
  - Separating individual feelings from medical facts, legal responsibilities, and ethical, rights-based obligations medical providers have.
  - Continue to learn about topics that may make us feel conflicted or uncomfortable. This may include seeking advice from supervisors or other trusted colleagues.
  - Reflect on our personal beliefs. Question where your belief comes from and whether it helps or hurt your ability to provide high-quality, rights-based services.
9. Summarize the key points:
  - We must ensure that we treat and/or interact with adolescents in a professional, respectful manner, regardless of their reasons for seeking our services – even if their reasons may challenge our personal beliefs.
  - We have a professional responsibility to ensure all people, including adolescents, have access to voluntary, rights-based family planning services.

### **Conclusion, Session Evaluation and Dismissal (10 minutes)**

1. Read out the following core messages for this session:
  - Health facilities and service providers play a critical role in guarding against rights violations and in supporting adolescents to access family planning services.
  - Irrespective of our personal beliefs, we have a responsibility to deliver services in a manner that respects, protects and fulfills the human rights of our clients.
2. Ask participants to write down a commitment to applying one thing that they have learned in today's session to their professional lives. Invite a few volunteers to share.
3. If there is time, ask the following discussion questions:
  - Would anyone like to share with the group one thing they found interesting or exciting about today's session?
  - Were there any ideas or activities that challenged you? If yes, how so?
  - Does anyone have any questions or additional thoughts?
4. Inform participants of the date, time, location and topics for the next session.
5. Remind participants that personal stories and experiences shared during the dialogue should be kept within the group, but that they are encouraged to share what they have learned with family, friends and colleagues who were not present if they feel comfortable doing so.
6. Thank participants for their active participation.
7. Dismiss the group.
8. After the session is complete and participants have left, record your answers in the session evaluation form (Annex 1).

<sup>6</sup>Hardee, K., et al. 2013. *Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights: A Conceptual Framework*. Washington, DC: Futures Group.



## Case Studies: Barriers and Enablers to Rights-Based Family Planning

### Case Study 1—Florence<sup>7</sup>

Florence is a 16-year-old girl who recently married a man ten years older than her. Before getting married, she knew very little about sex and pregnancy. She finds sex painful and scary, and is quite anxious that she will get pregnant – something she does not yet feel ready for. She wants to know her husband much better before welcoming a baby into their lives. Plus, a friend of hers died in childbirth earlier in the year and she is scared that, given her age, the same will happen to her. She has heard that there are medicines she can take to help her prevent pregnancy, but she doesn't know anything about them. A friend has suggested she visit the local clinic to see if they can help her.

One day, Florence sneaks out of her marital home when everyone is out and goes to the clinic. It is very busy, and she starts worrying that she will meet someone who knows her husband or in-laws. The clinic receptionist asks Florence's name and tells her to take a seat. Florence wants to ask her how long she will have to wait, but the woman looks busy, so Florence sits down quietly. She notices posters with information on sexual health and clients' rights on the wall, but they are difficult to read because of the small text. There are also leaflets on the counter, but Florence is too shy to take any.

During her 45-minute wait, Florence grows increasingly anxious. She is just about to give up and leave when she hears her name called by the nurse. She follows the woman into a room where several people are sitting and talking. The nurse is business-like and does not smile. She pulls out a form and asks Florence questions that she is too embarrassed to answer, especially in front of the other people in the room. The nurse repeats the questions louder, and Florence whispers her answers. Irritated, the nurse asks her to speak up. Florence tries, but she does not want to be overheard by the other people in the room. The nurse scolds her, saying that she only gives her services to 'real women' who have already had children. Florence says that she has changed her mind, gets up, and leaves the clinic, embarrassed and angry.

#### Small-group instructions:

1. In your small group, discuss what factors supported or challenged Florence's desire to learn more about, and potentially use, family planning methods.
2. What factors prevented Florence from accessing family planning?
3. Were Florence's rights respected in this scenario? Why or why not?
4. What could the health provider or health facility have done differently to ensure Florence's rights were respected?
5. Select someone in your group to report back to the larger group.

<sup>7</sup> Adapted from Engender Health (2014). *Checkpoints for Choice: An Orientation and Resource Package*. Engender Health.

## Case Study 2 – Altine<sup>8</sup>

Altine is a 17-year-old married girl. Her husband is a day laborer who, despite working long hours, has a very small salary. Altine has already had a child, a boy, but he died shortly after birth. This experience was very hard on Altine, especially because her pregnancy and delivery were difficult. She decided to start using an intrauterine device (IUD) to delay pregnancy because she didn't feel emotionally ready to try for another child. Her husband wants to try for another boy, though.

She arrives to find a large crowd waiting. The benches are overflowing. The floors and walls in the waiting area are dirty. There are some signs posted on the wall in English, a language few people in the area speak, including Altine.

After waiting for over an hour, Altine grows restless. She is finally called by a nurse, who takes her into a room where eight other women are waiting. The nurse does not smile and seems hurried. She asks Altine why she has come. Altine tells her she wants to have her IUD removed. The nurse asks how long she has had it. When Altine tells her, she says that it is too soon to take the IUD out; it is a 10-year method. Altine says she knows, but she now wants to get pregnant again. The nurse is unmoved and tells her that the IUD is expensive and that she should not be wasting it or the doctor's time. She says that she can see that Altine is poor and that a child would only make her life harder than it already is. Altine feels overwhelmed. She leaves the clinic not knowing what to do.

### Small-group instructions:

1. In your small group, discuss what factors supported or challenged Altine's desire to learn more about, and potentially use, family planning methods.
2. What factors prevented Altine from having her IUD removed?
3. Were Altine's rights respected in this scenario? Why or why not?
4. What could the health provider or health facility have done differently to ensure Altine's rights were respected?
5. Select someone in your group to report back to the larger group.

<sup>8</sup> Adapted from Engender Health (2014). *Checkpoints for Choice: An Orientation and Resource Package*. Engender Health.

## Case Study 3—Dorothy<sup>9</sup>

Dorothy is a 15-year-old married girl who lives in a town in a remote district. She is certain that she does not want to get pregnant yet. She and her husband have been using condoms. Sometimes, they run out of condoms and they have sex without any protection, or the condom breaks and they continue having sex anyway. When this happens, Dorothy gets very nervous that she will get pregnant. She has heard from her sister-in-law that there are other options. She decides she wants to learn more about them.

One day she goes to the family planning clinic, which is clean but crowded. A kind nurse eventually calls her into a private room. The nurse offers her a seat and asks why she has come. Dorothy tells her that she and her husband use condoms, but she wonders if there is a more reliable method she could try. She knows that she does not want any children for another few years, and her husband agrees.

The nurse has just had implant training. She wants to get more practice with insertions. She tells Dorothy that the implant would be a good method for her. She will have effective protection for three years, after which she can get another implant or get pregnant. After hearing about the method Dorothy shares that she would prefer to avoid hormones and so is interested in something else. The nurse repeats that implants are a great method; she thinks it would be perfect for Dorothy. Dorothy is not convinced. She thinks to herself about what she has heard from her sister-in-law about this method – that it can cause deformities in babies and lead to infertility. She doesn't share any of this with the nurse, though, and the nurse doesn't ask.

She asks about the injectable. The nurse says she could use that, too. She explains that it is also hormonal and that she will have to come back every three months for another injection, unlike with the implant. The nurse then tells her that time is running out; she must make a decision. Dorothy reluctantly takes a hormonal injection. Over the next few weeks, she experiences irregular bleeding and doesn't know why. When she returns to the clinic three months later, she is told that injectables are out of stock. The nurse once again tries to talk her into accepting an implant. Dorothy does not want it and leaves with no method.

### Small-group instructions :

1. In your small group, discuss what factors supported or challenged Dorothy's desire to learn more about, and potentially use, family planning methods.
2. In the end Dorothy leaves the clinic without a family planning method despite the fact that she does not want to get pregnant. What factors influenced Dorothy's ultimate decision to not use family planning?
3. Were Dorothy's rights respected in this scenario? Why or why not?
4. What could the health provider or health facility have done differently?
5. Select someone in your group to report back to the larger group.

<sup>9</sup> Adapted from Engender Health (2014). *Checkpoints for Choice: An Orientation and Resource Package*. Engender Health.

## Handout: Personal Beliefs and Professional Responsibilities

1. Describe your professional responsibilities related to the provision of family planning services to adolescents.
2. Describe your facility's responsibilities related to the provision of family planning services to adolescents.
3. Have there been any situations in which your personal beliefs conflicted with your professional responsibilities? How did you react?
4. What consequences do adolescents face when your facility's staff does not follow a rights-based approach to family planning service delivery?
5. What are some ways we can fulfill our professional responsibilities even if our personal values may sometimes conflict?



## Session 3

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

- Identify the root causes and consequences of low contraceptive uptake among adolescent girls;
- Articulate the role they can play as health professionals in helping adolescent girls overcome these barriers in order to fulfill their reproductive intentions and desires;
- Identify characteristics of facilities, services and service providers that support the human rights of adolescents.

### Materials:

- Flip chart; Markers; Handout: Characteristics of Youth-Friendly Services

### Advance Preparation:

- Problem Tree
  - Draw the outline of a tree on flip chart paper, with the roots and leaves clearly visible. On the trunk, write “Low use of contraception among married girls.”
- Introduction to Youth-Friendly Services
  - Write the following titles and questions on a flip chart:
    - **Service Characteristics:** What types of services would be offered? How would the services be designed?
    - **Service Provider Characteristics:** What would the staff be like? How

- would they treat adolescent clients?
- **Health Facility Characteristics:** What would the facility look like? Where would it be located?
- Prepare copies of the handout, *Characteristics of Youth-Friendly Services*

### Time:

- 1 hour 40 minutes

### Facilitator Background Reading

Norms around the timing and spacing of pregnancy and childbirth are often closely linked to social factors. In some parts of the world, these norms support women to delay pregnancy until they are at least 18 years old and also to wait two years after giving birth before getting pregnant again. However, in other parts of the world, especially in countries with high rates of child marriage, an array of structural, community and individual level factors encourage early and frequent childbearing. Early childbearing among married girls is of particular concern given the health risks associated with adolescent pregnancy and birth. For example:

- Early pregnancy puts mothers at risk:
  - When couples have a child before the wife is 18, there is a greater chance that her body is not physically mature, even if she is menstruating. Girls under 18 have a higher risk of high blood pressure, anemia (iron deficiency) and prolonged or complicated labor because their bodies are not yet fully grown.
  - The small size and physical weakness of many young pregnant girls makes it extremely difficult for them to give birth to a child. Delivery can therefore be prolonged and lead to obstetric fistula, which is caused by several days of obstructed labor, without timely medical intervention or cesarean section. 65% of fistula cases occur among adolescent girls.<sup>10,11</sup>
  - Adolescents 15 through 19 are twice as likely to die during pregnancy or childbirth as those over 20; girls under 15 are five times more likely to die.<sup>12,13</sup>
- Early pregnancy puts children at risk:
  - Infants face health risks if their mother is not physically mature – which adolescent girls are not. Their bodies, especially their pelvises, are still growing and developing.
  - Newborns are at risk of being born too soon, too small or with a low birth weight.<sup>14,15</sup>
  - The infants of adolescent mothers are more likely to die before their first birthday than are the infants of older mothers.<sup>16</sup>

### Welcome (10 minutes)

1. Welcome participants back to the training and thank them for their continued commitment.
2. Ask for a volunteer to remind the group what was discussed in the previous session. If necessary, read out the following core messages:
  - Health facilities and service providers play a critical role in guarding against rights violations and in supporting adolescents to access family planning services.
  - Regardless of our personal beliefs, service providers have a responsibility to

deliver services in a manner that respects, protects and fulfills the human rights of our clients.

3. Invite questions or comments about the previous week's session.
4. Remind participants that they committed to applying something they had learned in last week's session to their personal and professional lives. Invite participants to reflect on those commitments.

### **Problem Tree (40 minutes)**

1. Welcome participants. Explain that this activity will help identify the root causes and consequences of a problem facing their community.
2. Display the drawing of the tree you prepared before the session. Read out the problem statement written on the trunk of the tree: Low use of contraception among married girls.
3. Ask participants to identify all the main causes of the problem. Draw or write these along large roots of the tree, indicating that they are "root" causes.
4. Select one of the main causes. Ask, "Why do you think this happens?" This question will help us to identify the secondary or underlying causes. Write the secondary causes as smaller roots coming off the larger root of the tree.
5. Repeat the process for each of the other main causes.
6. Ask participants to identify the main consequences/effects of the problem. Write each as large branches of the tree.
7. Select one of the main consequences/effects. To identify the secondary effects, ask, "What else does this lead to?" Write the secondary effects as small branches coming off the larger branch of the tree.
8. Repeat the process for the other main effects.
9. Highlight the beliefs and norms related specifically to gender that are identified as causes and effects. To do this, the facilitator can use probing questions as follows:
  - Is this effect something that happens more to men or to women?
  - Is this cause related to something that only men or women are allowed to do?
  - Are both men and women affected by this consequence?
  - How many of the causes and/or consequences are related to gender, social and power norms?
  - Who suffers most due to these effects? Who benefits? Why?
10. End the discussion with the following reflection questions:
  - Looking at the root causes we have identified, which ones can you, as health workers, address in whole or in part?

- *Facilitator’s Note: Circle the root causes identified by participants.*
- How would you address these root causes? What steps would you take? What changes would you make?
- What steps could your facility take to address these root causes? What changes could your facility make?
- If you were to address these root causes by implementing all the changes you have proposed, how would things change for adolescents?

11. Conclude the activity:

- “As we have seen in this activity, low uptake of contraception among married girls contributes to high rates of early pregnancy. We know that pregnant adolescents face increased risk of mortality and morbidity. The negative health consequences extend to their children too, as they face substantial risk of preterm birth, low birth weight and neonatal and infant death.
- “The negative consequences of early pregnancy extend past the health of the mother and child, and can affect her and her family’s economic and social wellbeing. She may have to stop her education, or her work earlier than she planned
- “As health service providers, you can plan a central role in protecting and promoting the health of adolescents by sharing information with them about family planning and supporting them to access a contraceptive method if they choose to use one.

### **Introduction to Youth-Friendly Services (40 minutes)**

1. Explain that the purpose of this activity is to further reflect on the role health facilities can play in supporting the healthy timing and spacing of pregnancy for adolescents.
2. Say: “Today we are going to think about how we can apply a rights-based approach to your facility’s family planning services for adolescents. Adopting a rights framework requires us to be PROACTIVE in ensuring that all aspects of this facility resonate with and respond to the needs of adolescents.”
3. Tell the participants to think about the number of adolescents, both married and unmarried, they serve at the facility. Ask them if they think enough adolescents access their facility, and why or why not. Ask them if they think marital status might impact the likelihood of an adolescent accessing services and why or why not. Take a few responses.
4. Invite participants to reflect on the case studies they read last week and on the root causes of low FP use among adolescents that they identified during the Problem Tree exercise. Are there any characteristics of the clinic, the counseling interaction or the service provider that make it difficult for adolescents to get the services they needed? Take a few responses.
5. Explain to the participants that during this activity they will have an opportunity to think about what type of facility or provider would attract adolescents. What would the site look like? What services would be available? Who would provide the services?
6. Divide the participants into three groups. Instruct each group to go to a different part of the room. Distribute a sheet of flip chart paper and markers to each group.



7. Explain to groups that you want them to imagine that they have been given funding to create a new health facility that provides reproductive health services to adolescents.
8. Ask the groups to describe what this facility would be like. Display the questions that you have written on the flip chart and point to it as you read the questions aloud:
  - Service Characteristics: What types of services would be offered? How would the services be designed?
  - Service Provider Characteristics: What would the staff be like? How would they treat adolescent clients? How would they treat adolescents?
  - Health Facility Characteristics: What would the facility look like? Where would it be located? What equipment or materials would it have?
9. Give the groups 15 minutes to discuss and write their answers on a flip chart.
10. Reconvene the groups and tell them that each group will have 5 minutes to report what they have written on their flip chart. After the first group reports, each successive group can add only what the other groups did not already mention under each category.
11. After the presentations, discuss the following questions:
  - Do you disagree with any characteristics? Why?
  - Which are the most important characteristics? Why?
  - In what ways do your facilities support the human rights of adolescent clients?
  - In what ways could they violate the rights of adolescents? What changes can be made to ensure the facility and its services do not violate clients' rights?
  - Which characteristics could you apply with minimal effort/cost to the facility in which you work?
12. Explain that health facilities across the world have taken steps to make their services more accessible, acceptable and available to young people. They are often called adolescent- and youth-friendly services (AYFS). Adolescent- and youth-friendly services share the following traits:
  - Providers are trained to communicate with adolescents in a respectful and nonjudgmental manner
  - The facility has policies of confidentiality and privacy for adolescents
  - The facility has convenient hours and location for adolescents, as well as a nonthreatening environment
  - The fees are affordable, ideally free
  - Adolescents participate in developing policies and implementing services through an advisory board, as peer educators, and in other roles
13. Distribute and review the handout, *Characteristics of Adolescent and Youth-Friendly Services*. Review the characteristics with the group.
14. Ask:
  - Would you make any changes to this best-practice list in order to make the services friendly for adolescent girls in your community? If yes, how? Why?

- Earlier, you designed health facilities targeted at adolescents. Do the characteristics of your facilities align with the recommendations made in this best-practice document? Would you make any changes to your 'imaginary facility' based on the recommendations in this best-practice document?

### Conclusion, Session Evaluation and Dismissal (10 minutes)

1. Read out the following core messages for this session:
  - Health service providers play an important role in ensuring adolescents are able to access family planning services.
  - Adopting a rights framework requires health facilities to be PROACTIVE in ensuring that all aspects of their facility and services resonate with and respond to the unique realities of adolescent. This includes providing adolescent- and youth-friendly services.
2. Ask participants to commit to applying one thing that they have learned in today's session to their professional lives. Invite a few volunteers to share their commitments.
3. If there is time, ask the following discussion questions:
  - Would anyone like to share with the group one thing they found interesting or exciting about today's session?
  - Were there any ideas or activities that challenged you? If yes, how so?
  - Does anyone have any questions or additional thoughts?
4. Inform participants of the date, time, location and topics for the next session.
5. Remind participants that personal stories and experiences shared during the dialogue should be kept within the group, but that they are encouraged to share what they have learned with family, friends and colleagues who were not present if they feel comfortable doing so.
6. Thank participants for their active participation.
7. Dismiss the group.
8. After the session is complete and participants have left, record your answers in the session evaluation form (Annex 1)

<sup>10</sup> de Vienne, C.M., Creveuil, C. and Dreyfus, M., 2009. *Does young maternal age increase the risk of adverse obstetric, fetal and neonatal outcomes: a cohort study*. European Journal of Obstetrics & Gynecology and Reproductive Biology, 147(2), pp.151-156.

<sup>11</sup> Haldre, K., Rahu, K., Karro, H. and Rahu, M., 2007. *Is a poor pregnancy outcome related to young maternal age? A study of teenagers in Estonia during the period of major socio-economic changes (from 1992 to 2002)*. European Journal of Obstetrics & Gynecology and Reproductive Biology, 131(1), pp.45-51.

<sup>12</sup> Williamson, N. 2013. *Motherhood in Childhood: Facing the Challenge of Adolescent Pregnancy*. New York: UNFPA.

<sup>13</sup> World Health Organization, UNFPA. 2006. *Pregnant Adolescents*. Geneva: WHO

<sup>14</sup> de Vienne, C.M., Creveuil, C. and Dreyfus, M., 2009. *Does young maternal age increase the risk of adverse obstetric, fetal and neonatal outcomes: a cohort study*. European Journal of Obstetrics & Gynecology and Reproductive Biology, 147(2), pp.151-156.

<sup>15</sup> Haldre, K., Rahu, K., Karro, H. and Rahu, M., 2007. *Is a poor pregnancy outcome related to young maternal age? A study of teenagers in Estonia during the period of major socio-economic changes (from 1992 to 2002)*. European Journal of Obstetrics & Gynecology and Reproductive Biology, 131(1), pp.45-51.

<sup>16</sup> World Health Organization. 2012. *Early Marriages, Adolescent and Young Pregnancies: Report by the Secretariat*. Geneva: World Health Organization.

# Handout: Characteristics of Adolescent- and Youth-Friendly Services<sup>17</sup>

## Service Characteristics:

- Youth are involved in program design.
- Both boys and girls are welcomed and served.
- All youth are welcome, including married and unmarried clients.
- Services respect the evolving capacity of young people as they grow and develop to make decisions in relation to their own sexual and reproductive health.
- Service delivery empowers adolescents to make their own decisions around their sexual and reproductive health.
- Group discussions are available.
- Parental involvement is encouraged but not required.
- Fees are affordable, ideally free.
- A wide range of services are offered or necessary referrals are available.
- An adequate supply of commodities is available.
- Drop-in clients are welcome, and appointments are arranged rapidly.
- Waiting times are short.
- Educational material is available on-site.
- Services are well promoted in areas where youth gather.
- Linkages are made with schools, youth clubs, and other youth-friendly institutions.
- Alternative ways to access information, counseling, and services are provided.

## Service Provider Characteristics:

- Service providers adopt a 'sex positive' approach, meaning that they accept young people as sexual beings and promote healthy sexual experiences.
- Staff are trained in adolescent issues.
- Respect is shown to young people by both clinical and non-clinical staff.
- Privacy and confidentiality are maintained.
- Adequate time is given for client-provider interaction.
- Peer counselors are available.

## Health Facility Characteristics:

- Convenient hours
- Convenient location
- Adequate space
- Private spaces are offered for service consultation and delivery
- Comfortable surroundings

<sup>17</sup> Adapted from PHN Center. 2000. *Assessing and Planning for Youth-Friendly Reproductive Health Services*. FOCUS on Young Adults Project.



## Session 4

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

- Articulate how gender roles affect men and women’s decision-making abilities on matters related to sexual and reproductive health and rights;
- Establish trust and build rapport with adolescent clients.

**Materials:**

- Flip chart paper; Markers; Paper; *Scenarios – Establishing Rapport and Building Trust with Adolescent Clients*

**Advance Preparation:**

- Decision-Making Pile Sort
  - Make three cards with the words “wife,” “husband” and “both”
  - Write on cards the Reproductive Health Decisions written on the following page
- *Introduction to Counseling using a Rights-Based Approach: Counseling with Awareness and Respect*
  - Prepare a flip chart with the following questions:
    1. What methods, if any, do you use to prevent STIs and HIV?

2. Have you ever used any form of contraception? Which ones?
  3. Have you ever had an STI? If yes, when?
  4. Has anyone ever been violent with you or demanded sex?
- *Copies of Establishing Rapport and Building Trust with Adolescent Clients*

<b>Reproductive Health Decisions</b>
<ul style="list-style-type: none"> <li>• When to have children</li> <li>• How many children to have</li> <li>• Birth spacing between children</li> <li>• Use of family planning</li> <li>• Choice of family planning method</li> <li>• When to go to the health clinic</li> <li>• When to have sex</li> <li>• Which type of health service provider to consult (traditional healer or facility-based)</li> <li>• How much money to spend for family planning services</li> </ul>

**Time:**

- 2 hours

**Welcome (10 minutes)**

1. Welcome participants back to the training and thank them for their continued commitment.
2. Ask for a volunteer to remind the group what was discussed in the previous session. If necessary, read out the following core messages:
  - Health service providers play an important role in ensuring adolescents are able to access family planning services.
  - Adopting a rights framework requires health facilities to be PROACTIVE in ensuring that all aspects of their facility and services resonate with and respond to the needs of adolescents.
3. Invite questions or comments about the previous week's session.
4. Remind participants that they committed to applying something they had learned in last week's session to their personal and professional lives. Invite participants to reflect on those commitments. Were they able to apply what they had learned? Why or why not?

**Decision-Making Pile Sort (45 minutes)<sup>18</sup>**

1. Introduce the exercise:
  - "In every relationship, there are many decisions that need to be made every day.

Together, we will explore these decisions, paying attention to how these decisions are made, who makes them, and why they make them.”

2. Show participants that there are three categories that will be used: pile 1 is for husbands, pile 2 is for wives, and pile 3 is for both.
3. Explain the exercise. “I am going to hold up a decision card. [*Hold up one of the reproductive health decision cards you prepared before class*]. Your task is to tell me who usually makes the final decision in households in your community, not who is able to make this decision: husbands, wives or both? If you tell me it is husbands, I will place this card in the ‘husband’ pile. If you tell me it is wives, I will place it in the ‘wife’ pile, and finally, if it is both, I will place it in the ‘both’ pile.
4. Proceed with the activity.
  - If the group decides to put a card in either the ‘husband’ or ‘wife’ pile, ask some of the following questions:
    - Why can only one group make this decision? Is the other group able to make this decision? Why or why not?
    - What would happen if both husbands and wives made this decision?
    - What is preventing both husbands and wives from doing so?
    - Are there steps we could take so that men and women share more of these decisions? If yes, what are they?
  - If a group decides to put a decision card in the ‘both’ pile, ask the following questions:
    - How are these joint decisions made? Who has the final say?
    - Do both parties have equal say in the decision-making process? If not, who has the greater say?
    - *Facilitator’s Note: If one partner has a greater say, move the card to their pile.*
5. Facilitate a discussion using the following questions:
  - Who makes more decisions? Why?
  - If one group makes more decisions, how does that affect them? How does that affect the other group?
  - Let’s think specifically about adolescents. How would you describe their decision-making power? Who influences their decisions-making process? How does this impact them?
  - How might your counseling approach change if another person is present during counseling, such as an adolescent’s mother-in-law or her husband?
  - *Facilitator Note: Remind participants that people are all experts on their own needs, situation and preferences but that neither is the expert on the other’s needs, situation, or preferences. However, they may offer guidance or insight.*
    - *If counseling a couple, during a counseling session, the service provider should encourage both the husband AND wife to participate. Also, help the couple think through plans for using family planning correctly and consistently. Encourage partnership.*
    - *If the adolescent is accompanied by a family member, the service provider*

*should invite this person's opinion but also ensure that the adolescent has the ultimate say in which method she uses.*

- *If those in the room are speaking more than the adolescent, try saying something like, 'I can see that you have lots to say on this topic, but I would also like to hear NAME's perspective on this,' or 'Thank you for sharing but now I would like to hear what NAME has to say.'*
- *If the adolescent looks uncomfortable or is not sharing their point of view, consider whether it would be appropriate to ask to speak to the adolescent privately and individually.*

6. If there is time, ask participants 2-3 of the following closing discussion questions:

- Does this exercise reflect our behavior in our own families and relationships? If not, why do we expect different things in our home than what we perceive in our communities?
- How does it feel to look at this list of decisions as a man/woman? Is it fair? Why? Why not?
- Do you wish it were different? Why?
- Do you think you can initiate a couple of things in your family/ personal life to challenge some of the expectations we have around who can make decisions?

7. Ask: Do you think your health facility could initiate any actions to better promote adolescents' ability to make empowered choices around their reproductive health?

8. Conclude the discussion, saying:

- "As this activity shows us, gender norms – or, in this case, the expectations we have about what men and women can and can't do – often restrict a woman's ability to make decisions related to her own sexual and reproductive health and rights. This is especially true when it comes to the reproductive intentions of adolescent girls. Societal norms often prioritize men's family planning preferences over women's, despite the fact that both men and women play a role in starting a pregnancy and both will be affected by a decision to have and raise a child.
- "Ideally, both men and women should play a role in preventing pregnancy. However, when it comes to decisions about when to get pregnant, it is ultimately women – not men – who bear the greater burden and all of the physical risks in pregnancy and childbirth. Therefore, it is incredibly important that women are central to decisions about taking those risks. This is as true adolescents without children as it is for older women with many children. All clients have a right to choose if, when and how frequently to reproduce."

## **Introduction to Counseling Using a Rights-Based Approach: Counseling with Awareness and Respect (25 minutes)**

1. Introduce the activity:

"In previous sessions, we learned that the actions of facility staff are really important to achieving rights-based and adolescent- and youth-friendly family planning services for adolescents. In this activity, we will reflect on our counseling skills, learning strategies to enhance respect for human rights, specifically a client's right to choose when, if and how

frequently to have children. We will learn about a technique called ‘Counseling with Awareness and Respect’. It will involve reflecting on our own areas of comfort and discomfort in matters related to sexual and reproductive health, including young people’s sexuality.”

2. Explain to participants that counseling clients on family planning and other sexual and reproductive health issues involves asking questions that may be uncomfortable because they are personal. Beginning a consultation with questions about a woman’s general health can set the scene for more sensitive questions about sexual practices, reproductive intentions, violence and sexually transmitted infections.
3. Display the flip chart you prepared before class with the list of questions that might be used when talking to a client during a family planning counseling session.
4. Ask participants to pair up. Select one person to play the role of health service provider. The other will play the role of an adolescent client. First, the health service provider will ask the even numbered questions. Once finished with all the even numbered questions switch roles, and ask and answer the odd numbered questions
  - *Facilitator Note: **The person playing the adolescent should answer the questions as if they were an adolescent, giving only a made-up answer.** This is because this activity is merely meant to help them reflect on how they feel asking or answering the questions. Instruct them to take note of the questions they feel uncomfortable asking or answering.*
5. Give them 5 minutes to complete the activity. Bring the group back together and ask for a few volunteers to share their thoughts.
6. Point out that discussing these topics can be an uncomfortable experience, even for health professionals. Ask participants to identify questions that might be particularly difficult or uncomfortable for adolescents. Ask participants if there are any questions adolescents might not understand. Why?
7. Ask participants how adolescents might feel when face-to-face with a health worker during a family planning counseling session. Invite a volunteer to record the answers on flip chart paper.
  - *Facilitator Note: possible answers may include:*
    - *Shy about being in a clinic and needing to discuss personal matters*
    - *Embarrassed that they are seeking assistance on a taboo topic*
    - *Worried that someone will see them and tell their family*
    - *Concerned about confidentiality of the health worker and other facility staff*
    - *Intimidated by the facility and/or the many “authority figures” in the facility*
    - *Unsure about how to ask for help related to their sexual and reproductive health and rights*
    - *Hopeful that clinic staff can provide them with the care they want*
8. Ask: how can we make adolescents more comfortable during family planning counseling?



Invite a different volunteer to record the answers on flip chart paper.

- *Facilitator Note: Use the below list to help facilitate the discussion on establishing rapport and building trust with adolescents.*
  - *Speak in a friendly tone and make eye contact, if appropriate, when you speak with them.*
  - *Do not use judgmental words or body language. Do not talk down to them by scolding, shouting, blaming, or getting angry.*
  - *Use words and language that adolescents can understand and that are appropriate to their age and developmental stage.*
  - *Use visual aids to explain complicated information.*
  - *If sensitive issues are being discussed, make sure that conversations are not seen or overheard by others.*
  - *Reassure adolescents that anything they say will be kept confidential. This extends to all facility staff (i.e. receptionist, security guard, facility manager, etc.) and not just the health service provider.*
  - *Health workers should stress that information entrusted with them will not be shared – even with caregivers – unless the client gives their permission.*
  - *Allow enough time for adolescents to ask questions and express concerns. Show an understanding of and empathize with the client's situation and concerns.*
  - *Reassure adolescents that their feelings and experiences are normal.*
  - *Be honest and admit when you do not know the answer to a question. If possible, seek an answer from your supervisor without giving any identifying information about the adolescent herself.*

### **Establishing Rapport and Building Trust with Adolescent Clients (25 minutes)**

1. Explain that participants will now practice establishing rapport and building trust with adolescent clients.
2. Ask participants to pair up. Hand out copies of the scenarios you prepared before class and assign one to each pair. You can assign the same scenario to multiple pairs.
3. Instruct participants to prepare a short skit using the scenario they have been assigned. One partner should play the role of the client and the other the health worker. In the skit, the health worker should use some of the strategies the group has just discussed to establish rapport and build trust with the client.
4. Give the group 10 minutes to prepare their skits.
5. Depending on the size of the group and the time that remains in the session, either invite all pairs to present their skit or choose a few groups to present.
6. After each skit, ask the group to identify the strategies the health worker used to establish rapport and build trust with the adolescent.

### **Conclusion, Session Evaluation and Dismissal (10 minutes)**

1. Read out the following core messages for this session:
  - Gender norms restrict adolescents' ability to make decisions related to their own sexual and reproductive health and rights, thereby comprising their health and wellbeing;
  - For many reasons, including the fact that women – not men – bear the greater burden and all of the physical risks in pregnancy and childbirth, it is important that women and girls are central to any decision about when, if and how frequently to reproduce;
  - Counseling with awareness and respect can support a client's right to choose when, if and how frequently to reproduce.
2. Ask participants to commit to applying one thing that they have learned in today's session to their professional lives. Invite a few volunteers to share their commitments.
3. If there is time, ask the following discussion questions:
  - Would anyone like to share with the group one thing they found interesting or exciting about today's session?
  - Were there any ideas or activities that challenged you? If yes, how so?
  - Does anyone have any questions or additional thoughts?
4. Inform participants of the date, time, location and topics for the next session.
5. Remind participants that personal stories and experiences shared during the dialogue should be kept within the group, but that they are encouraged to share what they have learned with family, friends and colleagues who were not present if they feel comfortable doing so.
6. Thank participants for their active participation.
7. Dismiss the group.
8. After the session is complete and participants have left, record your answers in the session evaluation form (Annex 1).

<sup>18</sup> Adapted from 'Pile Sorting' in Cowan, E., F. Mekuria, A. Sprinkel. 2016. Social Analysis and Action: Global implementation manual. Atlanta: CARE USA.

## Scenarios – Counseling with Awareness and Respect

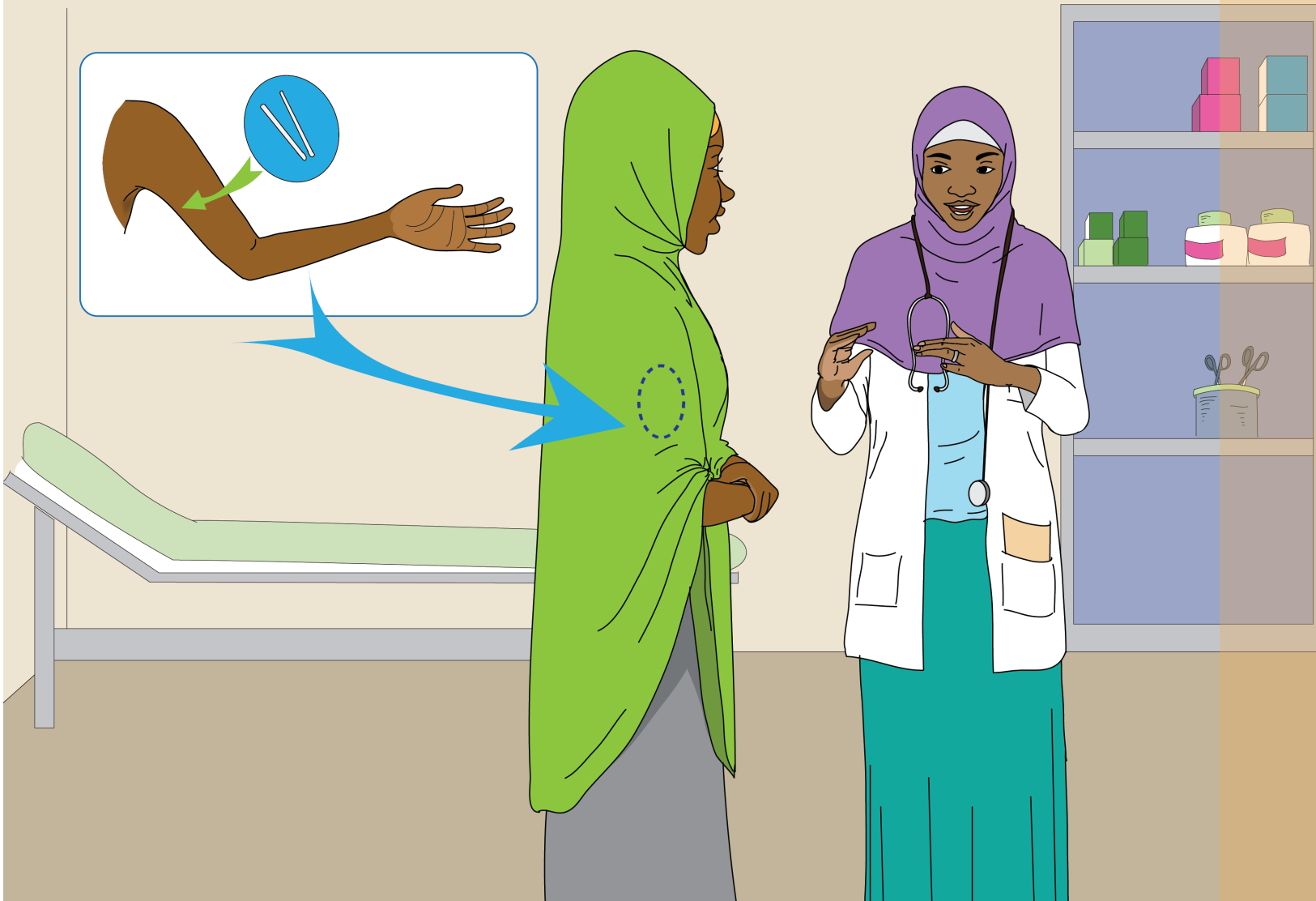
**Scenario 1:** Eden is a 17-year-old girl who was married last month. You have known her since she was born because you are friends with her mother. You are aware that she is still in school and dreams of becoming a nurse, like you. She comes to the clinic today claiming that she is having some stomach pains. You suspect that the real reason she has come is because she wants to talk about something. How do you proceed with Eden?

**Scenario 2:** Mia is a 16-year-old married girl. She informs you that she does not want to get pregnant but faces pressure from her husband to have children as soon as possible. What she isn't saying is that her good friend died in childbirth this past year and she is afraid that the same will happen to her if she gets pregnant. She has used the opportunity when her husband and in-laws are busy in town to visit the clinic. While she wants contraception, she is very worried they will find out. How do you proceed with Mia?

**Scenario 3:** Lea is a 15-year-old girl who is engaged to be married. When you call out her name for her appointment, you notice that she keeps her head down. Once seated in the counseling room, she refuses to make eye contact with you. When you ask her a question, she mumbles under her breath. You are not sure how to counsel her because you do not know why she has come. How do you proceed with Lea?

**Scenario 4:** Odette is a 14-year-old girl who has been married for a year. When you sit down with her for her appointment, you find her to be quiet and anxious. She hesitantly explains to you that she has come to get help in getting pregnant. She says she has been having sex with her husband for over a year but still has “nothing to show for it.” You quickly realize that Odette is confused about her body, sex and pregnancy. How do you proceed with Odette?

**Scenario 5:** Mica is a 16-year-old unmarried girl. You have been told by the receptionist that she has come because she has a cough; however, when you sit down to begin the appointment, you notice that she has picked up a number of pamphlets on contraception that are available throughout the clinic. It is clear that she has been reading with interest. How do you proceed with Mica?



## Session 5

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

- Reflect on how gender norms can impact how health workers provide family planning services to adolescents;
- Develop communication skills that support client choice, autonomy and dignity.

**Materials:**

- Flip chart paper; Marker; *Communication Skills Worksheet*

**Advance Preparation:**

- Communication Skills
- Prepare copies Of *Communication Skills Worksheet*, ideally one per person
- Prepare a flip chart with information on 'ROLES' from the following page

**Time:**

- 1 hour 40 minutes

## **'ROLES'**

**R:** A RELAXED and natural attitude with clients is important. Do not move around quickly or chat nervously.

**O:** Adopt an OPEN POSTURE. Crossing your legs or arms can signal that you are critical of what the client is saying or that you are not listening. Using an open posture shows that you are open to the client and what he or she is saying

**L:** LEAN FORWARD toward the client. This communicates that you are interested in involved in the conversation.

**E:** Maintain appropriate EYE CONTACT. Never stare or glare at the client.

**S:** SIT SQUARELY, facing the client. This posture shows involvement. If this is considered threatening for any reason, sit off to the side.

### **Welcome (10 minutes)**

1. Welcome participants back to the training and thank them for their continued commitment.
2. Ask for a volunteer to remind the group what was discussed in the previous session. If necessary, read out the following core messages:
  - Gender norms restrict adolescents' ability to make decisions related to their own sexual and reproductive health and rights, comprising their health and wellbeing;
  - For many reasons, including the fact that women – not men – bear the greater burden and physical risks in pregnancy and childbirth, it is important that women and girls, are central to any decision about when, if and how frequently to reproduce;
  - Counseling with awareness and respect can support a client's right to choose when, if and how frequently to reproduce.
3. Invite questions or comments about the previous week's session.
4. Remind participants that they committed to applying something they had learned in last week's session to their professional lives. Invite participants to reflect on those commitments. Were they able to apply what they had learned? Why or why not?

### **Act Like a Man, Act Like a Woman (40 minutes)<sup>19</sup>**

1. Introduce the activity: "In this activity, we will reflect on the origins and impacts of the ideas we hold about which roles, responsibilities, behaviors and emotions are 'appropriate' for adolescent girls and boys."
2. Divide the group in two. Explain to one group that they will be exploring the ideas we hold about adolescent girls, while the other group will do the same but for adolescent boys.
3. Hand out flip chart paper and markers to each group.
4. Instruct each group to draw a large box and, in it, the outline of an adolescent boy or adolescent girl, depending on which they have been assigned.

5. Invite each group to discuss their own experience of the roles, behaviors and norms society expects of the 'typical' adolescent, and to capture these ideas by drawing symbols or writing key points inside the box.
  - *Facilitator Note: Ideas for adolescent girls may include knowing how to cook well, taking care of siblings and other small children, have completed a basic education, being married before a certain age, having many children, looking beautiful, being a virgin until marriage, not opposing their husbands. Ideas for adolescent boys may include having a job, having completed secondary education, owning property and/or valuable goods like livestock, being sexually experienced, not showing emotions such as sadness, being physically strong, participating in community events, etc.*
  
6. Next, give groups a few minutes to think specifically about the roles and behaviors society expects 'typical' adolescent boys and girls to adopt related to each of the following topics:
  - Marriage
  - Contraceptive use
  - Sex

Remind participants to note their answers on the flip chart paper.
  
7. Bring the group back together. Give each group the chance to share their answers. After the first group has presented, groups can only add ideas that have not already been raised.
  
8. Ask the group:
  - What differences do you notice between the expectations we have for adolescent girls versus adolescent boys when it comes to marriage, contraceptive use and sex?
  - When you were an adolescent, did you live up to or fulfill every one of these expectations? What similarities and/or differences do you see in how people of your gender were expected to behave and how you yourself behaved?
  - What about those around you? Did they live up to and fulfill every one of these expectations? What about adolescents today? Do they live up to and fulfill every one of these expectations?
  - Do you think these expectations are helpful? If so, who do they help and how?
  - Are any of these expectations unhelpful? If so, who do they harm and how?
    - *Facilitator Note: Draw attention to the fact that the gender norms that privilege men over women burden women but they also burden men. By addressing these norms, both women and men stand to benefit.*
  - Where do these expectations come from? Who do we learn them from? In other words, who teaches us that these are the 'right' roles, responsibilities and behaviors?
    - *Facilitator Note: Ensure that participants realize that these ideas – or social norms – are often taught to us by previous generations. In other words, social norms get passed along from generation to generation.*
  
9. Instruct participants to write the sources of expectations around the outside of their boxes and to circle each source.
  
10. Ask the group if there are any roles, behaviors and norms that society attributes to the 'non-typical' adolescent girl or boy?

- *Facilitator Note: Examples for adolescent girls may include dressing up like a man, being sexually active before marriage, having more than one sexual partner, speaking loudly, speaking in public, smoking, drinking, going out without permission, going out at night, going out alone, doing a job that is typically seen as being for men only, not having kids or delaying childbirth, waiting to get married, etc. For adolescent boys, examples may include not having an income or money, crying, being weak, speaking softly, cooking, fetching water, performing household chores, helping with child-rearing, etc.*

11. Instruct groups to write their ideas for non-typical roles and behaviors outside the box.

12. Ask the following questions:

- What are the consequences, both positive and negative, of practicing behaviors that are outside of the box? These are the behaviors that might be different from what society expects for an adolescent girl or boy.
- Do you think the expectations we have for adolescent girls and boys affect their ability to seek reproductive health services? How might these expectations help or hinder adolescents from accessing services?
- Let's think specifically about your roles as service providers. Do you think these expectations affect your ability to support clients to access services? If so, how?
- Now that we are aware of how these expectations might impact our work, what strategies can we use to ensure we are fulfilling our obligations to respect, protect and fulfill our clients' rights?

13. Conclude the activity by reminding participants that they have a professional responsibility to provide family planning services to all clients, including adolescents, in a manner that respects, protects and fulfills their rights, even if their community and social norms do not support them doing so.

### **Communication Skills (40 minutes)**

Introduce the activity: "In this next activity, we will continue to develop our counseling skills by focusing on how we communicate. Good counselors use verbal and non-verbal listening and learning skills to help clients through their process of exploration, understanding, and action. We will look at four useful skills for communicating with clients:"

- **Skill 1:** Use helpful non-verbal communication
- **Skill 2:** Ask open-ended questions
- **Skill 3:** Reflect back what the client is saying
- **Skill 4:** Avoid words that sound judgmental

#### **Skill 1: Use helpful non-verbal communication (10 minutes)**

1. Explain that the first skill, non-verbal communication, refers to all aspects of a conversation that convey information without the use of words.
2. Invite a participant up to the front of the group. Ask them to tell you what they did today, starting from the moment they woke up. As they speak, do some of the following behaviors:
  - Yawn

- Roll your eyes
  - Scowl
  - Don't make eye contact and look away from the speaker
  - Fidget
  - Laugh sarcastically
  - Mumble under your breath
  - Frown
3. After a minute or so, pause the exercise. Ask the group:
    - Based on my actions, was I interested in what NAME was saying?
    - How do you think it made them feel? Did they feel respected? Did I seem professional?
    - Do you think they wanted to continue speaking with me?
  4. Repeat the exercise with another volunteer. This time, though, when the volunteer is detailing their day's activities, do some of the following:
    - Make eye contact.
    - Smile or make other appropriate facial expressions based on the story
    - Nod
    - Encourage the speaker to continue with small verbal comments like 'yes' and 'uh huh'.
    - Lean in towards the speaker
  5. Ask the group:
    - Based on my actions this time round, was I interested in what NAME was saying?
    - How do you think it made them feel? Did she feel respected? Judged? Valued?
    - Did I seem professional?
    - Do you think she wanted to continue speaking with me?
  6. Display the flip chart (Skill 1: ROLES) you prepared before class. Explain that using 'ROLES' can help them communicate respect, interest and professionalism to their clients.
  7. Invite volunteers to help you read out the different components of 'ROLES' and encourage all participants to practice the behaviors as they read.

### **Skill 2: Ask open-ended questions (10 minutes)**

1. Explain that questions can help clarify and break down problems into smaller, more manageable parts.
  - Open-ended questions begin with words like "how," "what," "when," "where," or "why." For example, "When was the last time you used a condom?" This type of question encourages clients to talk openly and in a way that leads to further discussion. They help clients explain their feelings and concerns, and they also help service providers get the information they need to help clients make decisions.
  - Closed-ended questions, on the other hand, usually start with words like "are you?," "did he?," "has she?," or "do you?," and usually only require a "Yes" or "No" answer. For example: "Do you use condoms?" Closed-ended questions are good for gathering basic information at the start of a counseling session or on a questionnaire. However,



they are less helpful in assessing a client's worries and concerns.

2. Give participants copies of the handout you prepared before class. Instruct them to practice converting close-ended questions to open-ended questions.
3. After a few minutes, invite participants to share their answers with the rest of the group.

### Skill 3: Reflect back what the client is saying (10 minutes)

1. "Reflecting back," or paraphrasing, means repeating back what a client has said in order to encourage them to say more. For example, if a client says, "I can't tell my husband that I have an implant," the health worker could paraphrase by saying, "It sounds like talking to your partner about contraception is not something that you feel comfortable doing right now." After the client confirms that this is accurate, the health worker could then say, "Let's talk about that some more."
  - Paraphrasing shows that the health worker is actively listening, it encourages dialogue, and it helps the health worker understand the client's feelings in greater detail.
2. Refer participants to the *Communication Skills Worksheet*. Take them through the formula for paraphrasing, then given them 5 minutes or so to practice paraphrasing statements. Ask for a few volunteers to share their answers with the group.

### Skill 4: Avoid words that sound judgmental (10 minutes)

1. Explain that words like right, wrong, well, badly, good, enough, and properly can convey judgment. If a health worker uses these words when asking questions, adolescent clients may feel that they are in the wrong or that they need to respond in a certain way to avoid disappointing the health worker. Health workers should also avoid phrasing questions in a way that is judgmental, which means asking questions that lead the client to respond in a certain way because they are scared to disappoint the health worker.
2. Ask for two volunteers. Show them the 'Counseling Script: What NOT to do', found below and invite them to act it out for the group. Instruct one volunteer to play the role of the health worker and the other volunteer to play the role of the client.

#### Counseling Script: What NOT to do

**Health Care Worker:** Did you listen to me and use a condom?

**Client:** Um...yes.

**Health Care Worker:** Did you take your medicine correctly?

**Client:** I think so.

**Health Care Worker:** Didn't you understand what I told you about taking your medicine?

**Client:** I don't know, I think so.

**Health Care Worker:** Did you do the right thing and talk to your husband about using condoms?

**Client:** Well, yes, I tried to talk to him....

3. Ask the following discussion questions:
  - How do you think the client feels in this interaction?
  - Do you think the client is answering the health worker's questions honestly?
4. Refer participants to Skill 4 on the *Communication Skills Worksheet*. Ask them to convert the judgmental questions into non-judgmental questions.
5. After five minutes, bring the group back together to share their answers.

### **Conclusion, Session Evaluation and Dismissal (10 minutes)**

1. Read out the following core messages for this session:
  - The social expectations our society holds about how adolescents should behave can hinder their ability to access family planning services. In providing family planning services in line with the rights-based approach, health workers can help improve adolescents' access to services.
  - Non-verbal communication, open-ended questions, paraphrasing and the avoidance of judgmental words can help service providers encourage dialogue, better understand the needs of the clients and, ultimately, support clients' to make healthy decisions.
2. Ask participants to commit to applying one thing that they have learned in today's session to their professional lives. Invite a few volunteers to share their commitments.
3. If there is time, ask the following discussion questions:
  - Would anyone like to share with the group one thing they found interesting or exciting about today's session?
  - Were there any ideas or activities that challenged you? If yes, how so?
  - Does anyone have any questions or additional thoughts?
4. Inform participants of the date, time, location and topics for the next session.
5. Remind participants that personal stories and experiences shared during the dialogue should be kept within the group, but that they are encouraged to share what they have learned with family, friends and colleagues who were not present if they feel comfortable doing so.
6. Thank participants for their active participation.
7. Dismiss the group.
8. After the session is complete and participants have left, record your answers in the session evaluation form (Annex 1)

<sup>19</sup> Adapted from 'Gender Box' in Cowan, E., F. Mekuria, A. Sprinkel. 2016. *Social Analysis and Action: Global implementation manual*. Atlanta: CARE USA.

## Handout: Communication Skills Worksheet

### Skill 2: Open-Ended Questions

**Instructions:** Convert the close-ended questions to open-ended questions.

Close-Ended Questions	Open-Ended Questions
Do you have any concerns about the birth control pill?	<i>e.g. What concerns do you have about the birth control pill?</i>
Do you want to have children?	<i>e.g. What can you tell me about your plans for having a family?</i>
Do you know how to use condoms?	
Are you having sex?	
Does your husband know you are using contraception?	
Have you spoken to your husband about using contraception?	
Are you interested in the IUD?	
How many times have you missed your pill in the last month?	
Have you used this method as instructed?	

### Skill 3: Reflecting Back or Paraphrasing

Paraphrasing Formula
“You feel _____ because _____.”
It seems that you feel _____ when _____.
“You seem to feel that _____ because _____.”
“You think that _____ because _____.”
“So I sense that you feel _____ because _____.”
“I’m hearing that when _____ happened, you _____.”

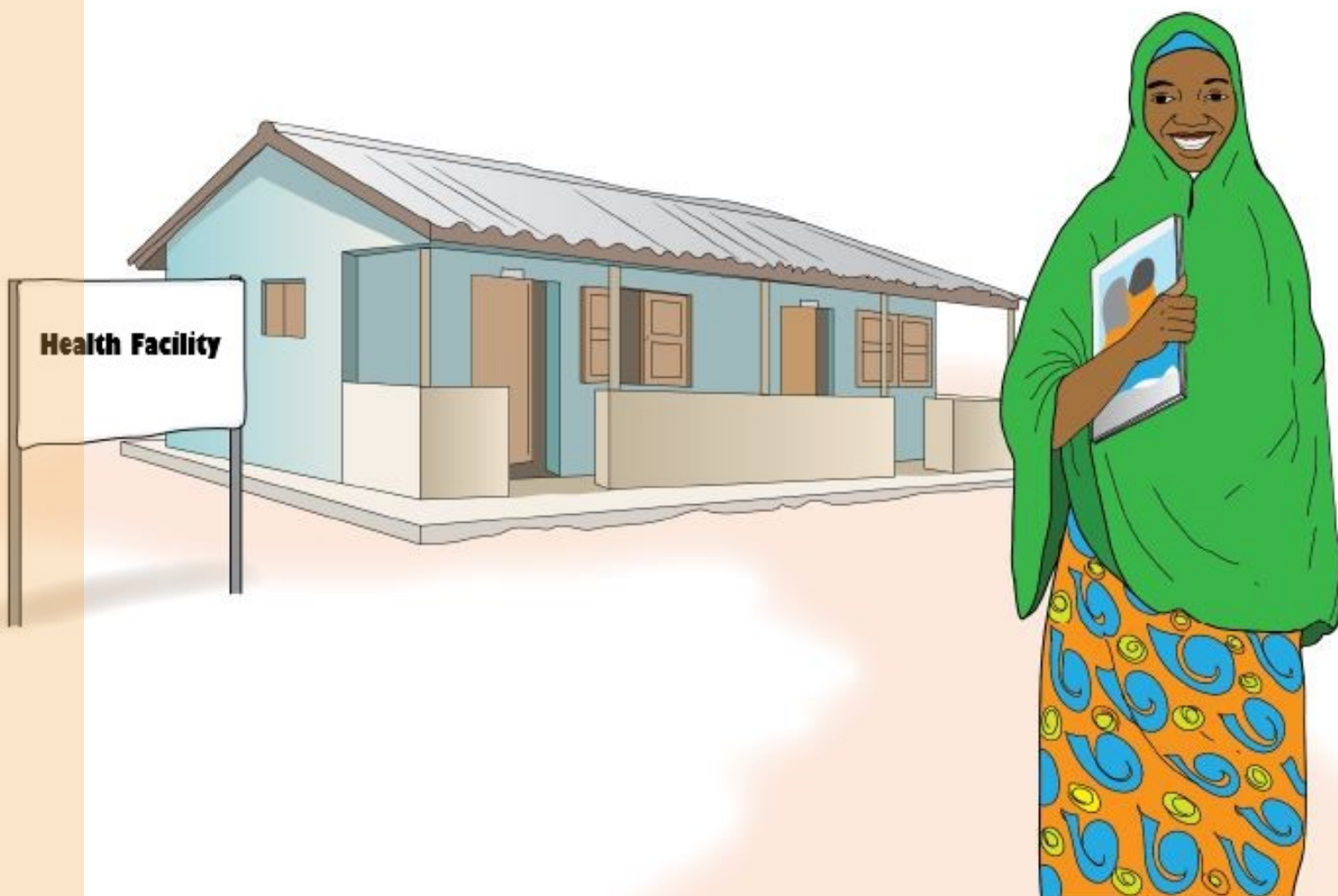
**Instructions:** Paraphrase the following statements using the ‘Paraphrasing Formula’ above.

Statement	Paraphrased Statement
I can't speak to my husband about using contraception. He will think I'm having an affair!	
If my in-laws find out I'm using contraception, they will be furious.	
I haven't yet had a child. Why on earth would I need to know about contraception?	
I know that I chose to get the injection at my last session, but all my friends tell me it can make me infertile.	
Two months ago, you prescribed me the pill. Since then, I've been experiencing a lot of spotting and weight gain, and I'm feeling anxious about continuing to use it.	
You told me that my IUD is safe but now I learn from my mother-in-law that it can lead to birth deformities in my future children. How could you do this to me?	
I know that you wanted me to talk to my husband about his desires for a family, but I just haven't found the right time.	
I think my mother-in-law has found my birth control pills. What am I going to do?	

#### Skill 4: Avoid words that sound judgmental

**Instructions:** Convert the following questions to non-judgmental questions.

Judgmental Question	Non-Judgmental Question
Did you use condoms like I told you to?	<i>e.g. What form of family planning, if any, did you use the last time you had sex?</i>
Are you taking the pill properly?	<i>e.g. Can you explain to me how and when you take the pill?</i>
Did you do what I told you and talk to your husband about your desire to get the implant?	
Are you using condoms the right way?	
Didn't you understand what I told you about coming back every three months for your injection?	



## Session 6

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

- Identify techniques for upholding a professional standard of high-quality, rights-based family planning services for adolescent girls;
- Articulate their personal beliefs and professional responsibilities in relation to the provision of rights-based family planning services to adolescents;
- Defend and respectfully explain other, sometimes conflicting, points of view regarding the provision of rights-based family planning services to adolescents;

**Materials:**

- Flip chart paper; markers
- Handouts: *Four Corners – Part A*; *Four Corners – Part B*

**Advance Preparation:**

- *Four Corners:*
  - Make copies of *Handout: Four Corners – Part A*, one per person
  - Make copies of *Handout: Four Corners – Part B*, one per person
  - Make signs reading 'Strongly Agree,' 'Agree,' 'Disagree,' and 'Strongly Disagree.'

Display the signs in four corners of the workspace.

**Time:**

- 1 hour 25 minutes

**Welcome (10 minutes)**

1. Welcome participants back to the training and thank them for their continued commitment.
2. Ask for a volunteer to remind the group what was discussed in the previous session. If necessary, read out the following core messages:
  - The social expectations our society holds about how adolescents should behave can hinder their ability to access family planning services.
  - In providing family planning services in line with the rights-based approach, health workers can help improve adolescents' access to services. Non-verbal communication, open-ended questions, paraphrasing and the avoidance of judgmental words can help service providers encourage dialogue, better understand the needs of the clients and, ultimately, support clients to make healthy decisions.
3. Invite questions or comments about the previous week's session.
4. Remind participants that they committed to applying something they had learned in last week's session to their personal and professional lives. Invite participants to reflect on those commitments. Were they able to apply what they had learned? Why or why not?

**Strategies for Counseling Using the Rights-Based Approach (20 minutes)**

1. Introduce the activity: "We will start today's session by thinking through actions we can take to improve our counseling skills in line with the rights-based approach."
2. Explain to participants that you want to share with them findings of research that looked into how family planning services are delivered to adolescents. The research found:
  - Providers often fail to discuss the client's wishes, (e.g. their reproductive intentions, their preferred methods, etc.)
  - Providers often give too much information, regardless of whether the methods being discussed suit the client's needs
  - The information provided about the method the client chooses is insufficient. Clients often leave their counseling sessions lacking important information about side effects, contraindications and instructions for use.
3. Explain that you will now think through some strategies they can apply in their counseling sessions to avoid making these 'common mistakes.'
4. Invite participants to brainstorm a list of questions they could ask adolescents to determine their wishes, including the client's reproductive intentions and preferred methods. Remind them about the communications activity from the week before. Note their ideas on a flip chart paper.
  - *Facilitator Note: Answers include:*
    - *Do you wish to have children in the future?*

- (For clients that do want children) When were you thinking of starting or continuing your family?
  - Are there any methods that you do not want to use or have not tolerated in the past?
  - Are there any methods that you are particularly interested in? What interests you about these methods?
  - Are there any concerns you have about contraception, in general, or any method specifically?
5. Invite participants to brainstorm a list of questions they could ask adolescents to determine an adolescent client's needs and unique medical and social considerations. Note their ideas on a flip chart paper.
- *Facilitator Note: Answers include:*
    - Does your partner support you in family planning?
    - Are you breastfeeding an infant less than 6 months old?
    - Do you have any medical conditions?
    - Are you taking any medications?
6. Invite participants to brainstorm strategies and techniques for providing adolescent clients with information about the contraceptive method they have chosen. What information should the provider include?
- *Facilitator Note: Possible answers include the following:*
    - Discuss the chosen method with the client, using brochures, pamphlets and/or visual aids, if available. These instructions must address side effects, contraindications and instructions for use. Determine the client's comprehension and reinforce key information:
      - General information
      - How method works
      - Important facts (about the method)
      - Method not advised if you...
      - Side effects
      - Health benefits (if applicable)
      - How to use
      - Follow-up (if applicable)
      - When to return to the health care facility
  - *Facilitator Note: If providers are interested, volunteer to share with them the **Balanced Counseling Strategy Plus**, a simplified version of which is found in Annex 3. This method provides guidance for counseling in line with the rights-based approach.*
7. Conclude the activity by reminding participants that there is no single way to deliver services in line with the rights-based approach. Overall, it is important that services are delivered in a manner that is:
- Simple and straightforward from the client's perspective
  - Aligned to the client's needs and reproductive intentions
  - Easily integrated with other sexual and reproductive health services (e.g. HIV testing and counseling, breast cancer screening, STI screening and treatment, etc.)

## Four Corners (45 minutes)<sup>20</sup>

1. Introduce the activity: “Throughout this training, we have worked to uncover our personal beliefs related to sex, sexuality and gender. Often, our beliefs on these topics are subconscious and we are not fully aware of them until we are faced with situations that challenge them. This activity will allow us to identify our own beliefs as well as understand the issues from other points of view. In order to get the most out of this activity, I encourage you to be as honest as possible.”
2. Hand each participant a copy of *Handout: Four Corners – Part A*. Point out that this sheet will be anonymous, so they should not write their names on their worksheet. Ask them to complete the worksheet and then turn the sheet over.
3. Hand each participant a copy of *Handout: Four Corners – Part B*. Point out that this sheet will be anonymous, so they should not write their names on their worksheet. Ask them to complete the worksheet and then turn the sheet over.
4. Ask participants to turn the handouts for Part A and Part B face up, and to place them next to each other. Tell them that Part A asks about their beliefs for adolescent girls and women in general, and Part B asks about their beliefs concerning themselves. Ask participants to take a few moments to compare their answers on Part A versus Part B.
5. Ask the following discussion questions:
  - What similarities or differences do you see in the beliefs you hold for women and adolescent girls in general versus yourself?
  - If there are differences, why do you think that is?
6. Take a few moments for a brief discussion. Point out to participants that differences between responses on Part A and Part B worksheets can sometimes indicate a double standard. For example, some people may believe that, generally speaking, adolescent girls should not be able to make family planning decisions for themselves, but that they or someone they know should be able to.
7. Gently encourage participants to consider whether they maintain a double standard for themselves versus compared to their adolescent clients and ask them to reflect on this more deeply.
8. Ask: What impact could this double standard have on adolescents’ health and wellbeing?
9. Ask participants to stand in a circle and crumple their Part A worksheets into a ball and throw them into the middle of the circle. Ask participants to select a “ball” from the middle of the circle and open it. Explain that for the remainder of this activity, they will represent the responses on the worksheet they have in their hands, even if these responses differ greatly from their own.
10. Point out the four signs you have posted around the room: ‘Strongly Agree’, ‘Agree’, ‘Disagree’ and ‘Strongly Disagree’.



11. Read the first statement out loud. Ask participants to move to the sign that corresponds to *the response circled on the worksheet they are holding*. Remind participants that they are representing the responses on their respective worksheets, even if those responses conflict with their personal beliefs.
12. Invite participants to look around the room and note the opinions held by the group. There may be different-sized groups in the four corners, and sometimes some of the corners may not be occupied. You can then ask some people to move to another group if the four corners are not evenly distributed.
13. Ask the group under each sign to discuss among themselves the strongest rationale for why people might hold that opinion. Let them know they will have two minutes to discuss and come up with reasons why they either 'Strongly Agree,' 'Agree,' 'Strongly Disagree' or 'Disagree.' Ask them to assign a spokesperson for the group.
14. Start with the spokesperson under 'Strongly Agree' and proceed in order to 'Strongly Disagree.' Remind participants that the designated spokespeople may or may not personally agree with the opinions they are presenting. Ask other groups not to comment at this time.
15. Continue this process for the remaining statements, noting the remaining time you have. If you are short on time, focus on discussing the statements you feel are the most important for this group.
16. Have participants return to their seats. Discuss some of the following questions:
  - What was it like to represent beliefs about family planning that were different from your own?
  - What was it like to hear your beliefs represented by others?
  - What rationale for certain beliefs caused you to think differently?
  - How might our beliefs affect the way we treat adolescents versus adults, or adolescents with children versus adolescents without children?
17. Solicit and discuss any outstanding questions, comments or concerns with the participants. Thank the group for their participation.
18. Summarize the key points this activity is intended to convey:
  - This activity helps us to examine what it is like to hold a perspective that is different from our own. When you argue a different point of view it can help strengthen your own point of view or help you better understand someone else's perspective.
  - Our personal beliefs and biases can impact the type of care that we provide. For example, we might treat a married adult woman more respectfully than a married or unmarried adolescent. However, all clients need our services and we should treat them with equal levels of respect and professionalism regardless of our personal beliefs about their circumstances.

## **Conclusion, Session Evaluation and Dismissal (10 minutes)**

1. Read out the following core messages for this session:

- Rights-based, family planning counseling for adolescents should be:
    - Simple and straightforward from the client's perspective
    - Aligned to the client's needs and reproductive intentions
    - Easily integrated with other sexual and reproductive health services
  - Service providers must ensure that they treat and/or interact with adolescents in a professional, respectful manner, regardless of their reasons for seeking services – even if those reasons may challenge the personal beliefs of the service providers.
2. Ask participants to commit to applying one thing that they have learned in today's session to their professional lives. Invite a few volunteers to share their commitments.
  3. If there is time, ask the following discussion questions:
    - Would anyone like to share with the group one thing they found interesting or exciting about today's session?
    - Were there any ideas or activities that challenged you? If yes, how so?
    - Does anyone have any questions or additional thoughts?
  4. Inform participants of the date, time, location and topics for the next session.
  5. Remind participants that personal stories and experiences shared during the dialogue should be kept within the group, but that they are encouraged to share what they have learned with family, friends and colleagues who were not present if they feel comfortable doing so.
  6. Thank participants for their active participation.
  7. Dismiss the group.
  8. After the session is complete and participants have left, record your answers in the session evaluation form (Annex 1)

<sup>20</sup> Activity adapted from Turner, Katherine L. and Kimberly Chapman Page. Abortion attitude transformation: A values clarification toolkit for global audiences. IPAS, 2014.

## Handout: Four Corners – Part A<sup>21</sup>

**Instructions:** Please read the following statements and put an “X” in the column that best reflects your personal beliefs. Please respond honestly and do not write your name on this sheet.

	<b>Strongly Agree</b>	<b>Agree</b>	<b>Disagree</b>	<b>Strongly Disagree</b>
Married girls should not be able to access contraception without the consent of their husbands.				
Married girls should have children as soon as possible after marriage.				
Adolescents should be able to access contraception, regardless of whether or not they have children.				
It is the woman’s responsibility to prevent pregnancy.				
Girls should wait until they are at least 18 before having a child.				
Service providers have a responsibility to provide family planning services to all clients, including adolescents.				
The provision of contraception to married adolescents encourages adultery and promiscuity.				

<sup>21</sup> Activity adapted from Turner, Katherine L. and Kimberly Chapman Page. Abortion attitude transformation: A values clarification toolkit for global audiences. IPAS, 2014.

## Handout: Four Corners – Part B<sup>22</sup>

**Instructions:** Follow the same process as in Part A. Please respond honestly and do not write your name on this sheet.

	<b>Strongly Agree</b>	<b>Agree</b>	<b>Disagree</b>	<b>Strongly Disagree</b>
I should be able to access contraception without the consent of my husband or wife.				
My partner and I should have a child as soon as possible after my marriage.				
My partner and I should be able to access contraception, regardless of whether I have children.				
It is my responsibility to prevent pregnancy.				
I should have waited until I was at least 18 before I/ my partner had a child.				
Service providers had a responsibility to provide family planning services to me when I was an adolescent.				
I am inclined to cheat on my husband or wife when I am provided with contraception.				

<sup>22</sup>Activity adapted from Turner, Katherine L. and Kimberly Chapman Page. Abortion attitude transformation: A values clarification toolkit for global audiences. IPAS, 2014.



## Session 7

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

- Identify norms in the community that influence a service provider's support for the provision of adolescent- and youth-friendly family planning services;
- Reflect on the role husbands can play in supporting married adolescents' decision-making about family planning;
- Review contraceptive methods and their appropriateness for use with adolescents;
- Correct misconceptions and address myths related to contraception.

### Materials:

- Flip chart paper; Markers; Character descriptions; *Game Show Resource Sheet*

### Advance Preparation:

- *Circles of Influence:* Print and cut out the Character Descriptions. There should be one description per participant.

### Time:

- 1 hour 40 minutes

## Welcome (10 minutes)

1. Welcome participants back to the training and thank them for their continued commitment.
2. Ask for a volunteer to remind the group what was discussed in the previous session. If necessary, read out the following core messages:
  - Rights-based, family planning counseling for adolescents should be:
    - Simple and straightforward from the client's perspective
    - Aligned to the client's needs and reproductive intentions
    - Easily integrated with other sexual and reproductive health services
  - Service providers must ensure that they treat and/or interact with adolescents in a professional, respectful manner, regardless of their reasons for seeking services – even if those reasons may challenge the personal beliefs of the service providers.
3. Invite questions or comments about the previous week's session.
4. Remind participants that they committed to applying something they had learned in last week's session to their personal and professional lives. Invite participants to reflect on those commitments. Were they able to apply what they had learned? Why or why not?

## Circles of Influence (50 minutes)<sup>23</sup>

1. Say, "Everyone is influenced by the people around them. Today, we are going to explore some of the thoughts and beliefs held by people around you. Then, we will reflect on how these thoughts and beliefs might influence how you carry out your professional duties."
2. Give each participant a character description. Give participants a few moments to read their character description.
  - *Facilitator Note: If you have a group that has fewer than 12 participants, it is not necessary to hand out all the character descriptions.*
  - Invite the character 'Augustine (service provider)' to stand beside you. Pointing to Augustine, introduce her to the group. Explain that she is a service provider at the local clinic.
  - Inform participants that they have all been assigned a character that might have some kind of influence on Augustine – especially on her willingness to provide contraceptive services to adolescents.
3. Instruct participants to arrange themselves around Augustine according to how much influence they think their character has on her willingness to provide contraception to adolescents. Characters with A LOT of influence should stand close to her. Characters with a LITTLE influence should stand far away.
4. Encourage participants to discuss among themselves where they should stand based on the reality in their community.
5. Give participants about 5-10 minutes to arrange themselves in the way that they think illustrates the circles of influence in their community.

6. Read out Augustine's character description again.
7. Ask the group whether they think Augustine sounds willing to support adolescents to access family planning services? Ask the group whether they think she would be willing to provide contraception to adolescents in a manner that aligns with the rights-based approach?
8. Turn to a participant standing close to 'Augustine'. Read out their character description.
9. Ask the group whether this character would influence Augustine to support or obstruct adolescents' access to family planning services?
10. Repeat the above steps until all participants have been given a turn.
11. Ask the following discussion questions:
  - How is this exercise like or not like your own lives?
  - What does this exercise tell you about a service provider's ability to deliver rights-based family planning services to adolescents?
  - How are service providers influenced and pressured by those people and policies around them?
12. Say, "This activity shows us that service providers may face pressure to breach their professional obligations to deliver family planning services to adolescents in a manner that respects, protects and fulfills their human rights."
13. Ask, "What support and/or resources do service providers need to enable them to feel confident in providing contraceptive services to all adolescents?"
  - *Facilitator Note: Encourage participants to answer this question in relation to their facility, district health authority, government and community structures.*
14. Conclude the activity saying: "All of us are influenced by the thoughts, attitudes and behaviours of those around us. As service providers, the influence of those around us might support or undermine our willingness to provide family planning services to adolescents. Similarly, adolescents are surrounded by people who have thoughts and opinions on if, when and how frequently they should reproduce. The influence of these people can support the health and wellbeing of adolescents, but it can also undermine it. Ultimately a service provider's foremost responsibility is to his or her clients. The best strategy for delivering services that are in the best interest of clients is to use the rights-based approach."

### **Contraception Game Show: Methods, Myths and Misconceptions (30 minutes)<sup>24</sup>**

1. Introduce the activity: "We are going to continue developing our skills in the delivery of rights-based, adolescent and youth-friendly family planning services to adolescents. Today, we will focus on two important aspects of the rights-based, youth-friendly approach:
  - Ensuring clients receive accurate information
  - Ensuring clients have choice, and that they can make choices freely and fully informed
  - To do so, we will play a game to review the contraceptive methods that are available."

2. Divide the group up into two teams. Invite each team to choose a name.
3. Ask each team to choose a representative to come to the front.
4. Explain that you will read a question out loud. The first person to raise their hand will get to answer first. If they answer correctly, their team will get a point. Participants are allowed to consult their teammates.
5. Explain that the questions are designed to test their knowledge about the contraceptive methods that are considered the most effective and appropriate for adolescents based on their ease of use and their reproductive intentions. In other words, the questions will not review permanent methods like vasectomy or tubal ligation because it is unlikely that these will be as relevant for adolescents given that they may want children in the future. The questions will also help familiarize participants with common myths and misconceptions around family planning.
6. Ask, “Why is it important for us to know the common myths and misconceptions our clients might have heard about family planning?”
7. Use the *Game Show Questions* on the *Contraception Resource Sheet* at the end of the session instructions to facilitate the activity. After each question, discuss the correct answer with the group. Ask two questions before inviting new representatives up to the front. Note the score on flip chart paper as the game progresses.
8. After the game is over, congratulate the winning team.

### **Conclusion, Session Evaluation and Dismissal (10 minutes)**

1. Read out the following core messages for this session:
  - Service providers are likely to face pressure to carry out their professional responsibilities in a certain way. Sometimes that pressure will endorse the provision of family planning services to adolescents and other times it will undermine it. Ultimately, a service provider’s foremost responsibility is to his or her clients. The best strategy for delivering services that are in the best interest of clients is to use the rights-based approach.
2. Ask participants to commit to applying one thing that they have learned in today’s session to their professional lives. Invite a few volunteers to share their commitments.
3. If there is time, ask the following discussion questions:
  - Would anyone like to share with the group one thing they found interesting or exciting about today’s session?
  - Were there any ideas or activities that challenged you? If yes, how so?
  - Does anyone have any questions or additional thoughts?
4. Inform participants of the date, time, location and topics for the next session.



5. Remind participants that personal stories and experiences shared during the dialogue should be kept within the group, but that they are encouraged to share what they have learned with family, friends and colleagues who were not present if they feel comfortable doing so.
6. Finally, ask participants to think through how to deal with some of the challenges discussed during the session.
7. Thank participants for their active participation.
8. Dismiss the group.
9. After the session is complete and participants have left, record your answers in the session evaluation form (Annex 1)

<sup>23</sup>Adapted from 'Activity 2-1: Circles of influence around young married women and their husbands/partners, and first-time parents?' in Pathfinder International. 2016. *Small Group Facilitation for Young Married Women and First-time Parents in West Africa: A Supplemental Training Module for Facilitators*. Watertown, MA: Pathfinder International.

<sup>24</sup>Adapted from 'Contraceptive True or False' in Pathfinder International. 2013. *Great Project Scalable Toolkit: I Am Great! GREAT Activity Cards for married and/or parenting adolescents*. Kampala: Pathfinder International, GREAT, USAID.

## Character Descriptions

**Augustine (Health Service Provider):** My name is Augustine and I am a nurse at the local clinic. I deliver services to many adolescents throughout my career as a nurse. I have seen with my own eyes that adolescent girls are at greater risk during pregnancy since I have been present when some of them have died during childbirth and have helped treat their injuries after delivery. I want to support adolescents to get pregnant at a healthy time but I know that would involve supporting them to use contraception. I worry what people would think of me if I gave contraception to an adolescent who is not yet married or one who is married but who has not yet had a child.

**Maria (Married Girl):** My name is Maria and I am a 16-year-old married girl. I still go to school and dream of one day becoming a teacher. I know it is expected that my husband and I have a baby as soon as possible, but I want to wait until after I have finished school and completed my teacher training. That way I can also contribute to the finances of my family. I see so many people in my community struggle to afford food for their households. That is not a future I want. Augustine, can you help me?

**Harouna (Augustine's Husband):** My name is Harouna and I am married to Augustine. Some of the men I work with are talking about the clinic where you work. They say that will not let their wives go there because the staff give contraception to young girls – even the ones that are married. They are mad that a health clinic is interfering in matters that should be between a husband and wife.

**Mother-in-Law of Maria (Married Girl):** Augustine, I am bringing my daughter to you today. She is 16 years old and married to a nice man. I would like you to teach her tricks for getting pregnant. I have already explained to her that, after her marriage, she must show respect to her new family by providing them with a child as soon as possible. This will bring great honor to her and us.

**Augustine's Father:** I am Augustine's father. Augustine, I am very proud of you and the work you do as a nurse. I am worried, though. I have heard rumors that some of your colleagues are giving married girls contraception. Don't they understand that married girls would want to use contraception is to cheat on their husbands? I hope these rumors are not true and that if they are, that you have no part in these terrible actions.

**Augustine's Mother:** I am Augustine's mother. Augustine, I am so proud of you for helping women in our community plan for the healthy timing and spacing of pregnancy. Too many women in our community give birth when their bodies aren't ready, either because they are too young or because it's too soon after their last birth. This often causes them to suffer unnecessarily. You can help these women give birth at a time that gives them, their babies and their families the best chance of thriving.

**Imam:** I am the Imam in Augustine's community. Augustine, it is not for health workers to interfere with Allah's plans for married couples.

**Augustine's Supervisor:** I am Augustine's supervisor at the clinic. Augustine, we are falling behind on our targets! Our facility is supposed to have provided long-acting contraception to 300 adolescent girls in our community and we are nowhere near achieving that goal. I expect you to encourage every eligible client you see to start on a long-acting method.

**NGO staff:** I am an NGO worker who supervises staff in Augustine's health facility. We tell people they should practice healthy timing and spacing of pregnancies and consider using contraception and explain to providers the importance of counseling on family planning to adolescents. I don't understand why it isn't easy for couples to just use contraception and delay the pregnancy. It would prevent so many health problems and save couples so much money in hospital costs that arise when things go wrong – as they so often do with adolescent pregnancies.

**District Health Official:** I am a district health official. I do not believe married girls should access family planning services until they have proven their fertility. As a result, I make no effort to make the health services in my area friendly to adolescent girls. Currently, only older women with children use the services in my district.

**Augustine's Colleague:** I am a midwife in Augustine's facility. Even though I feel conflicted about providing family planning to such young clients, I provide family planning to all adolescents, regardless of whether they are married, because I know that it is my professional responsibility as a midwife. I hope that Augustine is able to do the same.

**Health Clinic Receptionist:** I am a receptionist in Augustine's healthy facility. Sometimes, married adolescents come into our clinic asking about family planning. I am not sure why they are here, as everyone knows that they just want family planning so they can be unfaithful to their husbands with no consequences. I am not allowed to turn them away, but I do give them mean looks and make them wait extra long to see a doctor. I hope providers like Augustine do their part to make our community better by refusing to give contraception to such people!

## Resource Sheet: Game Show Questions on Contraception

<b>General Questions</b>	
<b>Question:</b>	<b>What are two benefits of family planning?</b>
<b>Answer:</b>	<p>Answers include:</p> <ul style="list-style-type: none"> <li>• Mothers and babies are healthier when risky pregnancies are avoided.</li> <li>• Smaller families mean more money, food, attention and resources for each child.</li> <li>• Parents have more time to work and to be with family.</li> <li>• Delaying first or second pregnancy lets young people stay in school and pursue economic activities.</li> </ul>
<b>Question:</b>	<b>Which contraceptive methods offer protection from sexually transmitted infections (STIs)?</b>
<b>Answer:</b>	<p>Condoms are the only contraceptive method that protect against STIs, including HIV, during sex. To be effective, they must be used each and every time a couple has sex. A condom can be used at the same time as other family planning methods, such as an implant or the pill.</p>
<b>Question:</b>	<b>How long can sperm survive inside a woman?</b>
<b>Answer:</b>	<p>Sperm can live inside a woman for a maximum of five days.</p>
<b>Question:</b>	<b>Can antibiotics reduce the effectiveness of hormonal contraceptives?</b>
<b>Answer:</b>	<p>Yes, certain antibiotics reduce the effectiveness of hormonal contraceptives. Rifampicin-like antibiotics, which are used to treat or prevent diseases such as tuberculosis and meningitis, have been proven to make hormonal contraceptives less effective. Individuals using the drugs will need to use additional contraception, (e.g. condoms), or change to a different method of contraception (e.g. condoms, copper IUD, progestin-only injectables). All other families of antibiotics have been deemed safe for use with oral contraceptives.</p>
<b>Question:</b>	<b>What are three actions a service provider can take to maintain confidentiality during a consultation with an adolescent?</b>
<b>Answer:</b>	<p>Answers include:</p> <ul style="list-style-type: none"> <li>• Carry out the consultation in a separate room</li> <li>• Make sure no one other than members of staff required for the consultation are present</li> <li>• Keep any notes regarding the consultation in a locked and secure place</li> <li>• Do not call out the client's full name or the reason for their visit in the waiting room</li> <li>• Do not discuss the consultation with anyone, including, if relevant, the client's parents, in-laws and/or husband.</li> </ul>

## The Oral Contraceptive Pill (The Pill)

<b>Question:</b>	<b>What are two possible side effects of the pill?</b>
<b>Answer:</b>	<p>Answers include:</p> <ul style="list-style-type: none"> <li>• Nausea (<i>Note: this normally goes away after a few days or weeks</i>)</li> <li>• Lighter, more regular periods</li> <li>• Reduction in premenstrual syndrome symptoms</li> <li>• Reduction of acne</li> <li>• Slight weight gain</li> <li>• Spotting between periods</li> <li>• Mood swings</li> <li>• Decreased libido (sex drive)</li> </ul>
<b>Question:</b>	<b>True or false: A woman only needs to take the pill when she has sex?</b>
<b>Answer:</b>	False. A woman must take the pill every day at the same time in order to prevent pregnancy.
<b>Question:</b>	<b>Are changes to monthly bleeding common in women who use the pill?</b>
<b>Answer:</b>	Yes. When women start on the pill, it is normal to have irregular bleeding for the first few months. Then they will start to have regular, lighter monthly bleeding later on.
<b>Question:</b>	<b>Can the pill cause deformities in children?</b>
<b>Answer:</b>	No. If a woman continues to use the pill when she is pregnant, it will not harm the baby or pregnant woman. The pill will also not harm future babies.
<b>Question:</b>	<b>Does the pill cause infertility?</b>
<b>Answer:</b>	No. Once a woman stops taking the pill, she is able to become pregnant.
<b>Question:</b>	<b>Is the pill safe for adolescents?</b>
<b>Answer:</b>	Yes. The pill has been used safely by millions of adolescent women for over 30 years and has been tested more than any other drug. In fact, studies show that the pill can protect women from some forms of cancer.

## The IUD

<b>Question:</b>	<b>How long can the copper IUD be left in place?</b>
<b>Answer:</b>	The copper IUD can last for up to ten years.
<b>Question:</b>	<b>What is one possible side effects of the copper IUD?</b>

<b>Answer:</b>	Answers include: <ul style="list-style-type: none"> <li>• May cause changes to menstrual bleeding including spotting and heavier bleeding</li> <li>• Stronger menstrual cramping</li> </ul>
<b>Question:</b>	<b>True or false: The IUD should only be used by women who have already had babies?</b>
<b>Answer:</b>	False. Any woman, young or old, with or without children, can safely use an IUD.
<b>Question:</b>	<b>True or false: The IUD might travel inside a young woman's body to her heart or her brain?</b>
<b>Answer:</b>	False. There is no passageway from the uterus to the other organs of the body. The IUD is placed inside the uterus and stays there until a trained health worker removes it. When it does come out, it comes out of the vagina.
<b>Question:</b>	<b>Can the IUD prick the penis during sex?</b>
<b>Answer:</b>	No. The IUD cannot be felt during sex.
<b>Question:</b>	<b>Can the IUD fall out during exercise or other physical activity?</b>
<b>Answer:</b>	No. Once the IUD is in place, it will stay there and not come out until a health worker removes it.
<b>The Implant</b>	
<b>Question:</b>	<b>Are implants safe for adolescents to use?</b>
<b>Answer:</b>	Yes. Implants are very safe for adolescents, including those who have had children and those who have NOT had children.
<b>Question:</b>	<b>Can the implant cause infertility?</b>
<b>Answer:</b>	No. After the implant is removed, a woman can become pregnant right away.
<b>Question:</b>	<b>Can the implant cause birth defects in babies?</b>
<b>Answer:</b>	No. If a woman becomes pregnant while using the implant or after using the implant, there will be no harm to the baby. Note that it is very unlikely a woman will become pregnant while using the implant.
<b>Question:</b>	<b>Can the implant move around inside a woman's body or fall out of the arm?</b>

<b>Answer:</b>	No. The implant remains where it has been inserted until a health worker removes it. The only time an implant might come out is if it was not put in properly. If this happens, the woman should see a health worker right away and use another form of contraception in the meantime.
<b>Question:</b>	<b>Can women become pregnant immediately after removing their implant?</b>
<b>Answer:</b>	Yes. After the implant is removed, a woman can become pregnant right away.
<b>Question:</b>	<b>Which method is more effective at preventing pregnancy: the implant or the pill?</b>
<b>Answer:</b>	Implants are more effective at preventing pregnancy, in large part because there is less space for human error in their use. Many people who use the pill have difficulty taking it at the same time each day, which decreases its effectiveness. With the implant, the user does not need to remember anything other than when to have it removed.
<b>The Injectable</b>	
<b>Question:</b>	<b>For injectable contraception to prevent pregnancy, a health worker gives it to a woman every ____?__ months.</b>
<b>Answer:</b>	For the most common type of injectable, Depo-Provera, a woman must see a health worker for an injection every three months. For Noristerat, it is every two months.
<b>Question:</b>	<b>What are two advantages to the injectable?</b>
<b>Answer:</b>	Possible answers include: <ul style="list-style-type: none"> <li>• It does not disrupt sexual intercourse</li> <li>• It can be used without the knowledge of others</li> <li>• The woman does not have to remember to do something every day</li> <li>• A woman can become pregnant after she stops receiving injections</li> </ul>
<b>Question:</b>	<b>True or false: A woman using the injectable won't be able to get pregnant after she stops using the injectable?</b>
<b>Answer:</b>	False. Sometimes it can take a woman 6-12 months to get pregnant after her last injection but women will NOT become permanently infertile because of the injection.
<b>Question:</b>	<b>Are injectables safe for adolescents, including adolescents that have not yet had children?</b>

<b>Answer:</b>	Yes. Injectables are very safe for adolescents, including those who haven't had children.
<b>Question:</b>	<b>Can you name two possible side effects of the injectable?</b>
<b>Answer:</b>	<p>Possible side effects include:</p> <ul style="list-style-type: none"> <li>• Changes in menstrual periods</li> <li>• No monthly bleeding. This is not harmful to the woman's body or health.</li> <li>• Headaches</li> <li>• Weight gain</li> </ul>
<b>Question:</b>	<b>Does the injectable contraception impact a woman's breast milk if she is breastfeeding?</b>
<b>Answer:</b>	No. Injectables do not decrease the amount of breast milk and they do not affect the breast milk itself or the health of the infant. Women can use the injection starting 6 weeks after childbirth.





## Session 8

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

- Explain the importance of counseling on LARC, in addition to other contraception, as part of a rights-based approach to family planning
- Gain confidence in counseling adolescent clients on LARC and work to help adolescents overcome barriers to LARC adoption
- Develop strategies for proactively providing counseling on side effects and addressing client questions at follow-up visits

**Materials:**

- Flip chart paper; Markers; Copies of *Practicing Family Planning Counselling for LARC: Person 1*; Copies of *Practicing Family Planning Counselling for LARC: Person 2*; Copies of *Contraception Reference Sheets*

**Advance Preparation:**

- Before the session, the facilitator should read the *Contraception Reference Sheets* in the annex and print copies for the class
- The facilitator should print enough copies of *Practicing Family Planning Counselling for LARC: Person 1* for half the class and *Practicing Family Planning Counselling for*

LARC: Person 2 for the other half of the class.

### Time:

- 2 hours and 35 minutes – 3 hours and 35 minutes

### Welcome (10 minutes)

1. Welcome participants back to the training and thank them for their continued commitment.
2. If necessary, read out the following core messages:
  - Service providers are likely to face pressure to carry out their professional responsibilities in a certain way. Sometimes that pressure will endorse the provision of family planning services to adolescents and other times it will undermine it. Ultimately, a service provider's foremost responsibility is to his or her clients. The best strategy for delivering services that are in the best interest of clients is to use the rights-based approach.
3. Invite questions or comments about the previous week's session.
4. Remind participants that they committed to applying something they had learned in last week's session to their personal and professional lives. Invite participants to reflect on those commitments. Were they able to apply what they had learned? Why or why not?

### Overview—Long-Acting, Reversible Contraception (15 minutes)<sup>25</sup>

1. Say, "Long-Acting, Reversible Contraception, also known as LARC, includes Intrauterine Devices (IUDs) and implants. LARC are more than 99% effective at preventing pregnancy, making them the most effective contraception available for women. They work for an extended period of time, do not require continuous action from patients in order to be effective, and are also fully reversible, meaning that once the device is removed, patients can immediately become pregnant again. In the absence of any medical contraindications, LARC are safe and effective for all clients to use, including adolescent clients who have not yet had children.

While often not technically considered LARC, injectables are also more than 99% effective at preventing pregnancy. Compared to IUDs and implants, however, the user must visit a health clinic or self-inject every 2-3 months (depending on the injection type) in order for this method to reliably prevent pregnancy. Because injectables require less user-action than a pill (used every day) or a condom (used for each sexual encounter), their ability to discreetly prevent pregnancy for up to 3 months makes them an attractive option for adolescent clients. However, ensuring that clients are visiting a clinic every three months for services or regularly self-injecting can be challenging. Today, we will talk about injectables in our broader review of LARC methods."

2. Ask, "What benefits might LARCs and injectables have for adolescent clients?"
  - *Facilitator Note:*
    - *LARC do not require any continuous action once inserted by a provider. Because adolescent girls may have less mobility and less control over their schedule compared to older women, this is ideal for clients who may be unable*

- to visit a pharmacy or health facility regularly.
  - LARC are more effective than short-acting methods at preventing pregnancy.
  - LARC are generally more cost-effective than short-term methods, particularly if used to prevent pregnancy over an extended period of time.
  - LARC are discreet—once inserted, the IUD cannot be felt or seen, except by a trained provider. The implant is also a discreet method, although it may be visible if the skin is stretched.
  - Once LARC are taken out, adolescents can immediately become pregnant again.
  - Some forms of LARC, such as hormonal IUDs, may offer other health benefits, such as lighter periods and a reduction in acne.
3. Ask, “How does providing LARCs to adolescents make you feel? Is this something you have experience with?”
  4. Ask, “Why is it important that providers counsel their clients about all the different contraceptive methods available, including LARCs?”
    - *Facilitator note: It is important to always ensure all clients, including adolescents, can exercise **informed choice**. This means explaining all the contraceptive methods your client is eligible for, including LARCs, and providing complete and accurate information to allow the client to choose which method, if any, is right for her.*
  5. Say, “Remember, providers have a professional responsibility to ensure all people, including adolescents, have access to voluntary, rights-based family planning services. We must ensure that we treat and/or interact with adolescents in a professional, respectful manner, regardless of their reasons for seeking our services – even if their reasons may challenge our personal beliefs.”

### **OPTIONAL: Reviewing LARCs and Injectables (1 hour)**

*Facilitator note: This activity is optional and should be used for groups where misunderstanding about LARC and injectables persists or a review is desired. For groups with up-to-date training on LARC and injectable methods, consider printing out the contraception reference sheets for participants instead, and skip to “Correcting Common Misconceptions around LARC.”*

1. Say, “ We are now going to spend some time reviewing IUDs, implants, and injectables. I am going to divide everyone into four groups. Using the contraception reference sheets in the annex, you should read over the information about the method and prepare a short activity to teach this information to the rest of the group. I will give you a total of 15 minutes to read your sheet and plan your activity. Then, you will have 10 minutes to complete your activity with the full group.”
2. Have participants divide into three groups. Assign each group one method: IUDs, implants, or injectables. After 15 minutes, have groups come back together to present information on their method. Ensure that each group covers all information for their method—if needed, provide additional information using the *Contraception Reference Sheets*.

## Correcting Common Misconceptions Around LARC (45 minutes)

1. Say, “There are many rumors and misconceptions about LARC methods (and family planning in general), as well as real negative experiences clients may have using a method. These can sometimes prevent clients from using certain methods of family planning. These may also impact providers’ beliefs and lead to the spread of incorrect information, especially to adolescent clients.”
2. Explain that you are now going to review some common misconceptions about LARC and injectables. You will read a statement and ask participants to determine if it is true or false.

**Statement:** *LARC is not safe for adolescents without children to use.*

**FALSE:** According to the WHO, IUD and implants are safe for all adolescents to use, regardless of whether or not they have had children.<sup>26</sup> Given that adolescents, compared to adults, have worse compliance and/or higher discontinuation rates when using short-acting methods,<sup>27</sup> LARC are an effective and safe option for adolescent clients.

**Statement:** *LARC and injectables cause infertility.*

**FALSE:** There is no data to support that LARC and injectables cause infertility. Once an IUD or implant is removed, a woman can immediately become pregnant. Once a woman stops receiving injections, her fertility will return to normal but may take between 6-12 months.

**Statement:** *Potential side effects of LARC and injectables, such as amenorrhea, spotting, and nausea, are life-threatening and only go away when a method is removed.*

**FALSE:** Most side effects associated with LARC (headache, nausea, changes in bleeding) are mild and improve over time. There is also no medical reason that a woman needs to have her period every month—changes to bleeding are normal and healthy and do not indicate that blood is “building up” in a woman’s body. Unless the client feels that these symptoms are bothersome and wishes to change methods, they are not medical reasons to discontinue use. *For a list of some side effects that do require medical attention, refer to the annex.*

**Statement:** *Legally, an adolescent needs her husband’s permission in order to receive LARCs or injectables.*

**FALSE:** There are currently no laws requiring a husband’s permission for a woman to receive LARC. Refusing to provide LARC or injectables because a husband is not present violates the rights of your client.

**Statement:** *For clients who want an IUD, implant, or injectable, it is better to spend your first meeting talking about the methods, then have the client return for a second visit to receive the method.*

**FALSE:** With adolescent clients, practitioners recommend “quick start” initiation. This means that, as long as you can reasonably rule out pregnancy either based on the patient’s history or a urine sample, all contraceptive methods, including LARC, can be started anytime, including on the day of the counseling visit.<sup>28</sup> This saves patients from having to make a follow-up visit, which costs time and money. It helps to protect patients from pregnancy as soon as possible, and in the case of the copper IUD, can act as

emergency contraception. However, if a client prefers to take some time to think about which method (if any) they would like, it is important to support her choice and assist her in scheduling a follow-up visit.

3. Say, “That’s right—all of these are misconceptions! What other rumors and misconceptions about LARCs or injectables have you heard?”
4. Write down each rumor/misconception, grouping similar rumors/misconceptions together.
5. Say, “For LARC in particular, confusion over how the methods work may lead to rumors and misconceptions. The underlying causes of rumors have to do with people’s knowledge and understanding of their bodies, health, medicine, and the world around them. They may also have to do with gender norms, or unwritten rules for how men or women should behave. These misconceptions can also be spread by health providers.”
6. Ask, “What are the consequences of provider misconceptions about LARC and other contraceptive methods for adolescents?”
  - *Facilitator Note:*
    - *Provider misconceptions can prevent adolescents from accessing the best and most effective family planning method for them, which can result in health issues, including unplanned pregnancy.*
    - *Provider misconceptions may coerce adolescent clients to obtain a contraceptive method that they do not want.*
    - *Provider misconceptions may perpetuate harmful gender norms and rumors around method use.*
    - *Provider misconceptions violate an adolescent’s right to free, full, and informed choice in methods.*
7. Ask, “As a provider, what can you do to determine whether something you know is a rumor or is supported by evidence?”
8. Ask, “How can you work with your clients to correct rumors or misinformation about family planning?”
9. Say, “Like health providers, clients may also have misinformation about family planning methods, including LARC. When talking to a client about rumors or misinformation related to family planning, listen politely, without laughing at, judging, or dismissing your client. Explain the scientific facts about the family planning method, using visual aids if possible. During counseling, always tell the truth, including clearly explaining potential side effects associated with various methods. This can help prevent rumors from starting in the future.”<sup>29</sup>
10. Ask participants to find a partner. Have each group choose one rumor or misconception. One person should play the role of the adolescent client, while another person plays the provider. The goal is for the provider to listen to the patient’s concerns and provide factual information to correct the misconception. Give groups 4-5 minutes, then have them switch roles.

## Providing LARC and Injectables to Adolescent Clients (1 hour)

1. Say, “As we mentioned earlier, providing information on LARCs and injectables is an important part of family planning counseling. Studies show that good family planning counseling, including talking about possible side effects and advantages and disadvantages of different methods, improves adolescents’ satisfaction with, and continuation of, family planning.<sup>30</sup> Counseling on LARCs and injectable is the same as counseling for any family planning method: you will want to determine a person’s fertility goals, share information on each method, determine medical eligibility, support the client to ask questions and make a decision, and refer to other services as needed (ex: cervical cancer, STIs, etc.). However, there are a few important points that you will want to make sure you emphasize in your discussion of IUDs, implants, and injectables.”
2. Ask, “Beyond the advantages/disadvantages of each method and how it works, what else would you want to make sure the client knows when considering a LARC or injectable method?”
  - *Facilitator Note:*
    - *When to return to the health facility*
      - *In addition to mentioning any reasons for follow-up visits, ensure clients understand that they may come to a clinic at any time and ask for their method to be removed or changed for any reason.*
    - *Common side effects*
      - *Remember: most side effects are mild and get better over time.*
    - *Whether a backup contraceptive method is needed during the first few days of using this method*
    - *The importance of dual protection—using both condoms (to prevent STIs) and a method to prevent pregnancy (ex: IUD, implant, injectable, etc.). Remember, LARCs and injectables are highly effective at preventing pregnancy but do NOT protect against STIs.*
3. Say, “Even though LARCs and injectables are the most effective family planning methods, they may not be a good fit for all clients, whether due to medical eligibility or individual preference. Remember—the “best” family planning method is one that a client can use consistently and correctly every time! While providing information on these methods is an important part of free, full, informed choice for clients, you should never force a client to choose a method she does not want to use.”

## Family Planning Counseling for New Users

1. Hand out *Practicing Family Planning Counselling for LARC: Person 1* to half the class and *Practicing Family Planning Counselling for LARC: Person 2* to the other half the class. Ask everyone to get into groups of 2, with one person 1 and one person 2 for each pair.
  - Explain that you are going to practice two case studies, where one person plays the provider and the other person plays an adolescent girl. For scenario one, the provider will be giving counseling to a potential new family planning user.
  - Using the *Person 1* sheet, give groups 5-8 minutes to complete a short counseling session. Explain that groups should not complete scenario 2 yet.
  - Have the “client” evaluate the “provider,” based on the questions listed on the

- worksheet. Have the client go over potential answers with the “provider.”
  - Let groups switch roles to complete scenario 1 on *Person 2’s* sheet.
2. Ask participants what they learned about providing family planning counseling to new users.

### Managing Side Effects and Counseling Clients Wishing to Change Methods

1. Say, “We have been practicing family planning counseling for new users. However, this is not the only time we offer family planning counseling to clients. Sometimes, clients come back to visit us because they are experiencing a problem, such as a side effect, or are interested in switching to another method. Side effects are the main reason that clients stop using a method,<sup>31</sup> so it is important to support adolescents to fully understand potential side effects at the time of adoption as well as provide ongoing support during future follow-up visits.”

As part of a rights-based approach, it is important to support clients’ ability to make informed decisions. This includes the decision to discontinue or to switch methods. Remember, it is a client’s right to ask for a method to be removed or to discontinue a method for any reason. While working with a client to understand her motivations for discontinuing or switching methods are important, never force a client to continue a method.

When dealing with clients returning to a clinic with problems, consider the following steps:<sup>32</sup>

- Treat all client complaints with patience, seriousness, and empathy
- Offer clients an opportunity to discuss their concerns
- Reassure the client that side effects are reversible
- Differentiate side effects from complications
- Offer clients good technical and practical information as well as how to deal with side effects
- Provide material for the client on side effects, when available
- Provide follow-up

Just like with adopting a new method, providing complete and full information, including exploring potential new options for family planning, if desired by the client, can help support your client’s availability to make an informed choice.

2. Ask everyone to get back together with their partner.
- For scenario two, the provider will be giving family planning counseling to someone visiting the clinic who is concerned about the method she is currently using.
  - Using the *Person 1* sheet, give groups 5-8 minutes to complete a short counseling session.
  - Have the “client” evaluate the “provider,” based on the questions listed on the worksheet. Have the client go over potential answers with the “provider.”
  - Let groups switch roles, using scenario 2 on *Person 2’s* sheet.
3. Ask: What did you learn about providing family planning counseling to women wishing to change methods?

### Identifying and Addressing Barriers to LARC Use by Adolescents (15 minutes)

1. Say, “Even though LARCs and injectables are highly effective and safe for all adolescents to

use in the absence of any medical contraindications, adolescent clients face a number of barriers in accessing these methods. To conclude today, we are going to think through some common barriers to adolescent clients' use of these methods and also brainstorm ways that we, as providers, can help support them to overcome these barriers."

2. Ask, "What barriers might adolescent girls face to using LARC at the individual (personal behaviors, norms, or beliefs), interpersonal (immediate social circle), and environmental (community/policy) level?"
3. Divide participants into three groups. Assign to each group one level and ask them to identify barriers girls may face at this level.
  - *Facilitator note:*<sup>33</sup>
    - *Individual level:*
      - *Because of cognitive changes during puberty, adolescents may be more likely than older adults to focus on short-term, rather than long term, goals and needs, which may make them more likely to focus on short-acting contraception.*
      - *Limited sexuality education may mean LARC methods are less familiar to adolescents, compared to short-acting methods like condoms or pills.*
      - *Adolescents, like adult women, may have misconceptions about LARC.*
    - *Interpersonal level:*
      - *Providers may refuse to offer LARC, especially to married adolescents who have not yet had children.*
      - *Parents and families may disapprove of adolescents using long-acting methods, especially if they have misconceptions about these methods.*
      - *Given gender norms, husbands or male partners may refuse to support their partner's desire to use contraception, including LARC.*
    - *Environment/policy level:*
      - *Cultural norms around decision-making, childbearing, gender, and sexuality may mean that adolescents face pressure to behave in certain ways, such as having children soon after marriage to prove fertility.*
      - *Rumors about LARC may persist in communities*
      - *Restrictive laws and policies may limit adolescents' access to contraception and other health services.*
4. Ask: "How can providers address some of these barriers/challenges?"
  - *Facilitator note: Providers can help improve adolescents' ability to access LARC and other needed health services. This may include:*
    - *Offering youth-friendly services to adolescent clients*
    - *Ensuring that their training is up-to-date on counseling for LARCs and removal/insertion of these methods*
    - *Improving knowledge and addressing misconceptions about LARCs with adolescents*
    - *Advocating for and applying policies that support adolescent access to LARCs*
    - *Offering free or low-cost LARC services*



- *Educating the community on LARC methods*

## **Conclusion, Session Evaluation and Dismissal (10 minutes)**

1. Read out the following core messages for this session:
  - Counseling on LARC and injectables methods are part of a “free, full, and informed” choice model for all clients, including adolescents.
  - LARC and injectables are safe and effective methods that all adolescents, regardless of whether they have had a child, can use.
  - Good family planning counseling, including talking about possible side effects and advantages and disadvantages of different methods, improves adolescents’ satisfaction with, and continuation of, family planning.
2. Ask participants to write down a commitment to applying one thing that they have learned in today’s session to their professional lives. Invite a few volunteers to share their commitments.
3. If there is time, ask the following discussion questions:
  - Would anyone like to share with the group one thing they found interesting or exciting about today’s session?
  - Were there any ideas or activities that challenged you? If yes, how so?
  - Does anyone have any questions or additional thoughts?
4. Inform participants of the date, time, location and topics for the next session.
5. Remind participants that personal stories and experiences shared during the dialogue should be kept within the group, but that they are encouraged to share what they have learned with family, friends and colleagues who were not present if they feel comfortable doing so.
6. Thank participants for their active participation.
7. Dismiss the group.
8. After the session is complete and participants have left, record your answers in the session evaluation form.

<sup>25</sup> Some questions and answers have been modified from Jhpeigo’s 2017 *Long-Acting Reversible Contraceptives Learning Package. Module 2: Family Planning Counseling. Facilitator Version.*

<sup>26</sup> FP 2020. *Global Consensus Statement for Expanding Contraceptive Choice for Adolescents and Youth to Include Long-Acting Reversible Contraception.* <http://www.familyplanning2020.org/sites/default/files/Global%20Consensus%20Statement%20-%20Expanding%20Contraceptive%20Choice.pdf>

<sup>27</sup> Ibid.

<sup>28</sup> ACOG. ACOG Committee Opinion. 2012. <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/Adolescents-and-Long-Acting-Reversible-Contraception>

<sup>29</sup> JHPEIGO. 2017. *Long-Acting Reversible Contraceptives Learning Package. Module 2: Family Planning Counseling. Facilitator Version.*

<sup>30</sup> FP 2020. *Global Consensus Statement for Expanding Contraceptive Choice for Adolescents and Youth to Include Long-Acting Reversible Contraception.* <http://www.familyplanning2020.org/sites/default/files/Global%20Consensus%20Statement%20-%20Expanding%20Contraceptive%20Choice.pdf>

<sup>31</sup> Pathfinder International. 2004. *Module 16: Reproductive Health Services for Adolescents.*

<sup>32</sup> Ibid.

<sup>33</sup> Modified from Jhpeigo’s *Long-Acting Reversible Contraceptives Learning Package. Module 1: Introduction to Long-Acting Reversible Contraceptives. Facilitator Version.* 2017.

## Practicing Family Planning Counselling for LARC: Person 1

### Scenario 1:

**Client:** You are a 15-year-old, married girl who has never had children. Your husband does not support you to use family planning, so you want a method that is discreet. You would like to have children in the future. You do not have a particular method in mind.

- If probed, your last menstrual cycle ended yesterday.
- If counseled about using LARC, you are very concerned about changes to your period.
- If asked about your medical history, explain that you have a history of anemia.

### Reflection/Answer key:

Did the “provider”:

- Establish a warm, friendly rapport with you and try to understand your fertility goals?
- Share accurate information about all methods that you were eligible for and correct misconceptions?
- Support, but not force, you to make a decision?
- Encourage you to use a backup method for at least 7 days if selecting a method other than the copper IUD and also counsel you on the importance of dual protection?

*Answer: The client can use all methods except for condoms, standard days, and withdrawal, as these require partner cooperation. She also should not use the copper IUD, as this can increase monthly bleeding and exacerbate her anemia. Possible methods: Implant, levonorgestrel IUD, injectables, pills. If she is concerned with a more “discreet” method, the levonorgestrel IUD or injectables may be best.*

### Scenario 2:

**Client:** You are a returning client who is 18 years old. You have one child. Two months ago, you received the copper IUD. Since then, you have been experiencing irregular bleeding and are thinking about changing methods, as it bothers you and your husband, who supports your use of family planning. You are here to ask for advice and also potentially change methods.

- If probed, because of irregular bleeding, you are unsure when your last period ended.
- If asked about switching to an implant, explain that you are uncomfortable with the idea of something being inserted under your skin. Even after an explanation, you refuse to get the implant.
- If given adequate information and support, you are willing to consider continuing using the IUD for another few months and revisiting the facility.
- If asked about your medical history, explain that you are HIV+.

### Reflection/Answer key:

Did the “provider”:

- Treat your complaints with patience, seriousness, and empathy and offer you an opportunity to discuss your concerns?
- Acknowledge the problem you were having and help resolve it?
- Reassure you that side effects are reversible and differentiate side effects from complications?
- Offer you practical information as well as how to deal with side effects?
- Encourage you to use a backup method for at least 7 days if switching to a new method other than the copper IUD and also counsel you on the importance of dual protection?

*Answer: Your client is eligible for all methods but should not receive an implant given her discomfort with any method inserted under her skin. She could also continue using the copper IUD and revisit the clinic as needed.*

## Practicing Family Planning Counselling for LARC: Person 2

### Scenario 1:

**Client:** You are an 18-year old, married girl without children. You want to delay pregnancy for at least 2 years so you can earn money to support your family. Your husband does support you to use family planning.

- *If probed, you have no other medical conditions, and your period ended 3 days ago.*
- *If asked about your goals, explain that you are hoping to prevent pregnancy.*
- *If offered LARC methods, explain that you are afraid of LARC and injectables because you heard that they can cause infertility. However, if given a full explanation about LARC and their benefits, you will agree to get a LARC method.*

### Reflection/Answer key:

Did the “provider”:

- Establish a warm, friendly rapport with you and try to understand your fertility goals?
- Share accurate information about all methods that you were eligible for and correct misconceptions?
- Support, but not force, you to make a decision?
- Encourage you to use a backup method for at least 7 days if selecting a method other than the copper IUD and also counsel you on the importance of dual protection?

*Answer: The client is eligible for all methods. The provider should share information on all methods, including LARC.*

### Scenario 2:

**Client:** You are a 15-year-old, married girl without children. You have received and implant 7 months ago. Since then, you have gained weight, and you are also experiencing nausea and breast tenderness. You came to the clinic to get your implant removed. Your husband does support you to use contraception.

- *If probed, you are not pregnant, and you do not have any preexisting medical conditions. Your last menstrual period ended 15 days ago.*
- *If probed, you refuse to wait another few months to see if symptoms get better. You insist on getting your implant removed today.*
- *If offered another method, you refuse to use any hormonal methods.*

### Reflection/Answer key:

Did the “provider”:

- Treat your complaints with patience, seriousness, and empathy and offer you an opportunity to discuss your concerns?
- Acknowledge the problem you were having and help resolve it?
- Reassure you that side effects are reversible and differentiate side effects from complications?
- Offer you practical information as well as how to deal with side effects?
- Encourage you to use a backup method for at least 7 days if switching to a method other than the copper IUD and counsel you on the importance of dual protection?

*Answer: The client’s implant should be removed immediately because she has requested a removal. Possible methods for switching include the copper IUD. If not, condoms should be encouraged.*

# Contraception Reference Sheets

## Progestin-Only Injectables<sup>34</sup>

**What is it?** Progestin-only injectable contraceptives contain the synthetic hormone progestin, similar to the hormone progesterone in a woman's body. They are injected into muscle, which releases progestin into the blood gradually, providing contraception over a period of time. Length of pregnancy protection depends on the type of injectable:

- DMPA (depot medroxyprogesterone acetate), the most widely used progestin only injectable, is injected every 13 weeks or three months. It is also known as Depo or Depo-Provera.
- NET-EN (norethindrone enanthate, noresthisterone enanthate) is injected every eight weeks or two months.

**How does it work?** The injectable stops the egg from leaving the ovary every month. It also makes it difficult for sperm to enter the uterus. The injectable does this by thickening the mucus at the entrance of the uterus. The woman must get an injection every three months (DMPA) or every two months (NET-EN) for it to prevent pregnancy.

**How effective is it?** The injectable is over 99% effective at preventing pregnancy.

### What are the advantages to using it?

- Does not disrupt sexual intercourse and can be used without the knowledge of others
- The woman does not have to remember to do something every day
- A woman can become pregnant after she stops receiving injections
- Does not affect quality/quantity of breast milk

### What are the disadvantages to using it?

- It may take a while to get pregnant (6 to 12 months) after stopping injections.
- Causes changes in menstrual cycle, such as spotting or bleeding between periods, longer periods, or no periods
- Return visits required every three months (every two months for NET-EN)
- Does not provide protection from sexually transmitted infections

### What are the possible side effects?

*Note: These side effects are generally not signs of a health problem and may change over time.*

- Headache/dizziness
- Weight gain
- Changes in mood and sex drive or changes in menstrual periods

### Who should not use injectables?

Women who have any of the following conditions (contraindications):

- Breastfeeding while less than six weeks postpartum
- Multiple risk factors for cardiovascular disease
- Blood pressure more than 160/100 mmHg
- Acute deep venous thrombosis (unless on established anticoagulant therapy)
- Current or history of ischemic heart disease or stroke
- Unexplained vaginal bleeding (before evaluation)
- History of or current breast cancer
- Diabetes with vascular complications
- Severe cirrhosis; malignant liver tumors; or benign liver tumors, with the exception of focal

nodular hyperplasia

### **Use of injectables by HIV+ women and women with AIDS:**

- Women with HIV/AIDS who do not take antiretroviral drugs can use progestin-only injectable without restrictions. Women with AIDS on ARVs can generally use DMPA because ARVs do not interfere with effectiveness. Women with AIDS on ARVs can also generally use NET-EN.

### **Provide follow-up and counseling for:**

- Any client concerns or questions
- Common side-effects, especially irregular bleeding or spotting, or amenorrhea
- Importance of timely reinjection
- Any signs of complications; although rare, counsel the woman to come back immediately if any of the following symptoms develop:
  - Very bad headaches that start or become worse after initiation
  - Unusually heavy or prolonged bleeding
  - Severe pain in the lower abdomen (ectopic pregnancy)
  - Unusually yellow skin or eyes

### **Dispel myths regarding progestin-only injectables**

Progestin-only injectables:

- Do not cause birth defects or harm a fetus if given to a woman who is already pregnant
- Do not cause permanent infertility
- Can stop monthly bleeding, but this is not harmful. Blood is not building up inside the woman.

### **When to start?**

During the menstrual cycle

- Within 7 days of menstrual cycle, no need for a backup method; If more than 7 days, make sure she is not pregnant, and use a backup method for the first 7 days after injection

Switching from another method

- Immediately, if using the method correctly and consistently; otherwise, make sure she is not pregnant. No need for a backup method. If the woman is switching from an IUD, she can start injectable immediately.

More than 6 weeks after child birth (breastfeeding)

- If monthly bleeding has not started then can start injection any time between 6 weeks and 6 months, it is reasonably certain that she is not pregnant.
- If monthly bleeding started, then start within first 7 days of menstrual bleeding
- If it is more than 7 days after the start of monthly bleeding, can start anytime it is reasonably certain she is not pregnant. Use backup method for 7 days after injection.

Less than 4 weeks after child birth (not breastfeeding)

- Start injection at any time, no need for backup method

Post abortion/miscarriage

- Immediately, if she is starting within 7 days or days after a 1st or 2nd trimester abortion,
- If it is more than 7 days, start injection anytime it is reasonably certain she is not pregnant, use a backup method for 7 days

After emergency contraception

- After taking emergency contraceptive pills (ECP), start injection the same day or within 7 days of start of her menstrual period, after she finishes taking the ECPs. Use back up method for 7 days after the injection.

<sup>34</sup> Modified from Jhpeigo's *Long-Acting Reversible Contraceptives Learning Package. Module 1: Introduction to Long-Acting Reversible Contraceptives. Facilitator Version. 2017.*

## Implants<sup>35</sup>

**What is it?** Implants consist of matchstick-sized plastic capsules (the number varies depending on the type of implant). A trained doctor or nurse places implants under the skin of a woman's upper arm by making a very small cut. The capsules can stay in the arm for several years (again, depending on the type), but they can be taken out before if the woman wishes.

**How do they work?** Implants stop the egg from leaving the ovary. They also make it difficult for sperm to enter the uterus. They do this by thickening the mucus at the entrance of the uterus.

**How effective is it?** Implants are over 99% effective.

### **What are the advantages to using it?**

- Implants are a long acting method
- They do not disrupt sexual intercourse
- The woman does not have to remember to do something every day
- A woman can become pregnant immediately after the implant is removed
- Does not impact quality/quantity of breast milk

### **What are the disadvantages to using it?**

- Causes changes in the menstrual cycle, such as spotting or bleeding between periods, longer periods, or no periods at all
- Requires a small cut in the arm that may leave a tiny scar
- Does not provide protection from sexually transmitted infections
- The outline of the rod(s) may be visible under the skin, especially when the skin is stretched.

### **What are the possible side effects?**

- Headache/dizziness
- Weight gain
- Reduced libido
- Changes in menstrual periods

### **Who should not initiate progestin-only implants?**

Women who:

- Are pregnant (known or suspected)
- Have a history of past or current breast cancer
- Have liver tumor or severe liver disease
- Have acute venous thromboembolism
- If switching from another non-hormonal method, use back up method for 7 days.
- If she is switching from injectables, she can have implants inserted when the repeat injection would have been given. No need for a backup method.
- If switching from IUD/LNG-IUS: starting during the first 7 days of monthly bleeding, insert implant and remove the IUD. No need for a backup method.
- If switching from LNG-IUS and is amenorrheic, rule out possible pregnancy, insert implant and remove LNG-IUS. No need to wait for next monthly bleeding. No need for a backup method.
- Can be inserted during immediate postpartum period or delayed postpartum period.

### **Who should be advised to discontinue use of progestin-only implants and switch over to a non-hormonal method?**

- Women with unexplained vaginal bleeding

- Women with migraine headaches with aura

### **Use of progestin-only implants by women with HIV and AIDS**

- Women with HIV who do not take antiretroviral drugs (ARVs) can use progestin-only implants without restrictions.
- Women with AIDS who take ARVs can generally use progestin-only implants because the effectiveness of implants seems not to be significantly affected by ARVs.
- However, women on Efavirizine (EFVs) should be advised about the possible drug interactions between EFV and implants that may lead to a higher than usual contraceptive failure rate.
- Women with HIV or AIDS who have contraceptive implants should be advised to use condoms.

### **Provide follow-up and counseling for:**

- Any client concerns or questions
- Side-effects, especially irregular bleeding or spotting or amenorrhea
- Any signs of complications (although rare); counsel the woman to come back immediately if any of the following symptoms develop:
  - Infection or pus at the insertion site
  - Unusually heavy or prolonged bleeding
  - Severe pain in the lower abdomen (symptom of ectopic pregnancy)
  - Amenorrhea after having regular cycles (signs of pregnancy)
  - Expulsion of rod
- Explain to the client that implants can be removed at any time for any reason.

### **Dispelling myths regarding progestin-only implants**

Progestin-only implants do not:

- Break and move around within a woman's body **if inserted correctly**
- Cause birth defects or cause abortion if inserted during a pregnancy
- Cause cancer
- Have any contraindication for use by adolescents

### **When to start?**

Implants may be inserted at any time during the menstrual cycle when it is reasonably certain that the client is not pregnant. Post-insertion, the hormone levels in implants rise rapidly and are effective depending on timing of insertion per the woman's menstrual cycle or use of contraception.

- No need of any back up method if insertion is done within 7 days of menstrual cycle.
- If it is more than 7 days (more than 5 days for one rod implant) after the start of monthly bleeding, she can have implant inserted any time if it is reasonably certain that she is not pregnant. She will need a backup method for the first 7 days after insertion.
- If she is switching from injectables, she can have implants inserted when the repeat injection would have been given. No need for a backup method.
- If switching from IUD/LNG-IUS: starting during the first 7 days of monthly bleeding, insert implant and remove the IUD. No need for a backup method.
- If switching from LNG-IUS and is amenorrheic, rule out possible pregnancy, insert implant and remove LNG-IUS. No need to wait for next monthly bleeding. No need for a backup method.
- Can be inserted during immediate postpartum period or delayed postpartum period.

<sup>35</sup> Modified from Jhpeigo's *Long-Acting Reversible Contraceptives Learning Package. Module 1: Introduction to Long-Acting Reversible Contraceptives. Facilitator Version. 2017.*

## Levonorgestrel Intrauterine System (LNG-IUS)<sup>36</sup>

**What is it?** The Levonorgestrel intrauterine system (LNG-IUS) is a type of hormone-containing intrauterine contraceptive device that is placed in the uterus to prevent pregnancy. It is made up of a “T”-shaped plastic frame and a white cylinder-shaped hormone reservoir around the vertical arm of the frame with two nylon threads at the end for removal. The vertical stem of the system has the reservoir containing the hormone Levonorgestrel. It contains 52 mg of Levonorgestrel (LNG) and is effective for 5 years. The LNG-IUS can be replaced if continued use is desired.

**How does it work?** The IUD stops the man’s sperm from meeting the woman’s egg by thickening cervical mucus, thinning the lining of the uterus, and interfering with sperm movement.

**How effective is it?** The IUD is over 99% effective at preventing pregnancy.

### What are the advantages to using it?

- Prevents pregnancy for a long time
- A woman can get pregnant immediately after the IUD is removed
- Does not disrupt sexual intercourse
- The woman does not have to remember to do something every day or every three months.

### What are the disadvantages to using it?

- There is a higher risk for pelvic inflammatory disease when using the IUD, so youth at risk for sexually transmitted infections should consider other methods, in addition to condoms.
- Does not provide protection from sexually transmitted infections

### What are the possible side effects?

*Side effects are generally not a sign of a health problem and may diminish or change over time.*

- May cause spotting, heavy bleeding or more menstrual cramping
- Headache, nausea, breast tenderness, acne
- Mood changes

### Who should not have the LNG-IUS inserted?

Women who have the following known conditions:

- Known or suspected pregnancy
- Congenital or acquired uterine anomaly, including fibroids, that distorts the uterine cavity
- Current or recurrent PID
- Postpartum endometritis
- Post abortion sepsis
- Known or suspected uterine or cervical cancer
- Known or suspected breast cancer or other progestin-sensitive cancer, now or in the past
- Abnormal uterine bleeding
- Untreated acute cervicitis or vaginitis, including bacterial vaginosis, known chlamydial or gonococcal cervical infection, or other lower genital tract infections, until the infection is controlled
- Acute liver disease or liver tumor (benign or malignant)
- Acute venous thrombosis (Category 3) if not established on anticoagulation therapy
- A previously inserted LNG-IUS that has not been removed
- Hypersensitivity to any component of the LNG-IUS

### Use of progestin-only implants by women with HIV and AIDS

- NG-IUS is safe for use by women living with HIV



### Provide follow-up and counseling for

- Any client concerns or questions
- Potential side-effects and reassure her that they are temporary and not a sign of any disease and can be managed easily.
- A woman should return for follow up after 4 weeks of insertion **OR** at any time, if having any concerns or side-effects related to the LNG-IUS
- Any signs of complications; although rare, counsel the woman to come back immediately if any of the following **PAINS** symptoms develop:
  - **Period** related problems or pregnancy
  - **Acute** abdominal cramping during the first three to five days after insertion (perforation)
  - **Infection**: Fever and chills, unusual vaginal discharge, low abdominal pain (possible infection)
  - **Not** feeling well
  - **String**-related problems

### Timing of Insertion

- At any time, if you are reasonably sure the client is not pregnant
- During the menstrual cycle
  - Within 7 days, no need for a backup method;
  - If more than 7 days, make sure she is not pregnant, and give a backup method.
- Switching from another non-hormonal method
  - Immediately, if using the method correctly and consistently; otherwise, make sure she is not pregnant. Give a backup method for 7 days.
- Switching from another hormonal method
  - If the woman is switching from an injectable contraceptive, the LNG-IUS can be inserted prior to the next scheduled injection. No backup method is needed.
- Soon after childbirth (breastfeeding or non-breastfeeding)
  - Within 48 hours of delivery, or during a cesarean section
  - If more than 48 hours, then delay until 4 weeks
- Post abortion/miscarriage
  - Immediately or within 7 days after a 1st or 2nd trimester abortion, if no infection
  - Delay after medical (non-surgical) abortion until confirmed that the uterus is completely empty
- After taking emergency contraceptive pills (ECP), give her a backup method to start on the day she finishes taking (ECP) until the LNG-IUS is inserted
  - No monthly bleeding (amenorrhea that is not related to childbirth or breastfeeding)
  - At any time, if reasonably sure she is not pregnant; give a backup method for the first 7 days.

<sup>36</sup> Modified from Jhpeigo's *Long-Acting Reversible Contraceptives Learning Package. Module 1: Introduction to Long-Acting Reversible Contraceptives. Facilitator Version. 2017.*

## Copper Intrauterine Device (IUD)<sup>37</sup>

**What is it?** The intrauterine contraceptive device (IUD) is a small plastic device inserted into a woman's uterus to prevent pregnancy. The most commonly used IUDs are shaped like a T and have copper wires or bands on the plastic stem and arms. The Copper T 380A, or "Copper T," is the most widely used copper IUD in the world. It is effective for up to 12 years.

**How does it work?** The copper ions decrease sperm motility and function by altering the uterine and tubal fluid environment, thus preventing sperm from reaching the fallopian tubes and fertilizing the egg.

**How effective is it?** The IUD is over 99% effective at preventing pregnancy.

### What are the advantages to using it?

- Prevents pregnancy for a long time
- Effective immediately after insertion
- A woman can get pregnant immediately after the IUD is removed
- Does not disrupt sexual intercourse
- The woman does not have to remember to do something every day or every three months.
- No medical interactions.
- Safe for lactating women.

### What are the disadvantages to using it?

- There is a higher risk for pelvic inflammatory disease when using the IUD, so youth at risk for sexually transmitted infections should consider other methods, in addition to condoms.
- Does not provide protection from sexually transmitted infections
- Must be inserted/removed by a health provider.

### What are the possible side effects?

*Side effects are generally not a sign of a health problem and may diminish or change over time.*

- May cause prolonged and heavy menstrual bleeding or spotting between monthly periods
- Pain or cramping during menses

### Who should not have a copper IUD inserted

Women who have the following known conditions:

- Known or suspected pregnancy
- Sepsis following childbirth or abortion (if insertion is immediately postpartum or post abortion)
- Unexplained vaginal bleeding
- Cervical, endometrial, or ovarian cancer
- Current pelvic inflammatory disease
- Current purulent cervicitis (gonorrhea or chlamydia)
- Malignant gestational trophoblastic disease
- Known pelvic tuberculosis
- Uterine fibroid or other anatomical abnormalities resulting in distortion of the uterine cavity, which is incompatible with IUD insertion

### Provide follow-up and counseling for

- Any client concerns or questions
- Potential side-effects and reassure her that they are temporary and not a sign of any disease and can be managed easily.

- A woman should return for follow up after her first menses (3-6 weeks following insertion) OR at any time, if having any concerns or side-effects related to the IUD
- Any signs of complications; although rare, counsel the woman to come back immediately if any of the following PAINS symptoms develop:
  - **P**eriod related problems or pregnancy
  - **A**cute abdominal cramping during the first three to five days after insertion (perforation)
  - **I**nfection: Fever and chills, unusual vaginal discharge, low abdominal pain (possible infection)
  - **N**ot feeling well
  - **S**tring-related problems

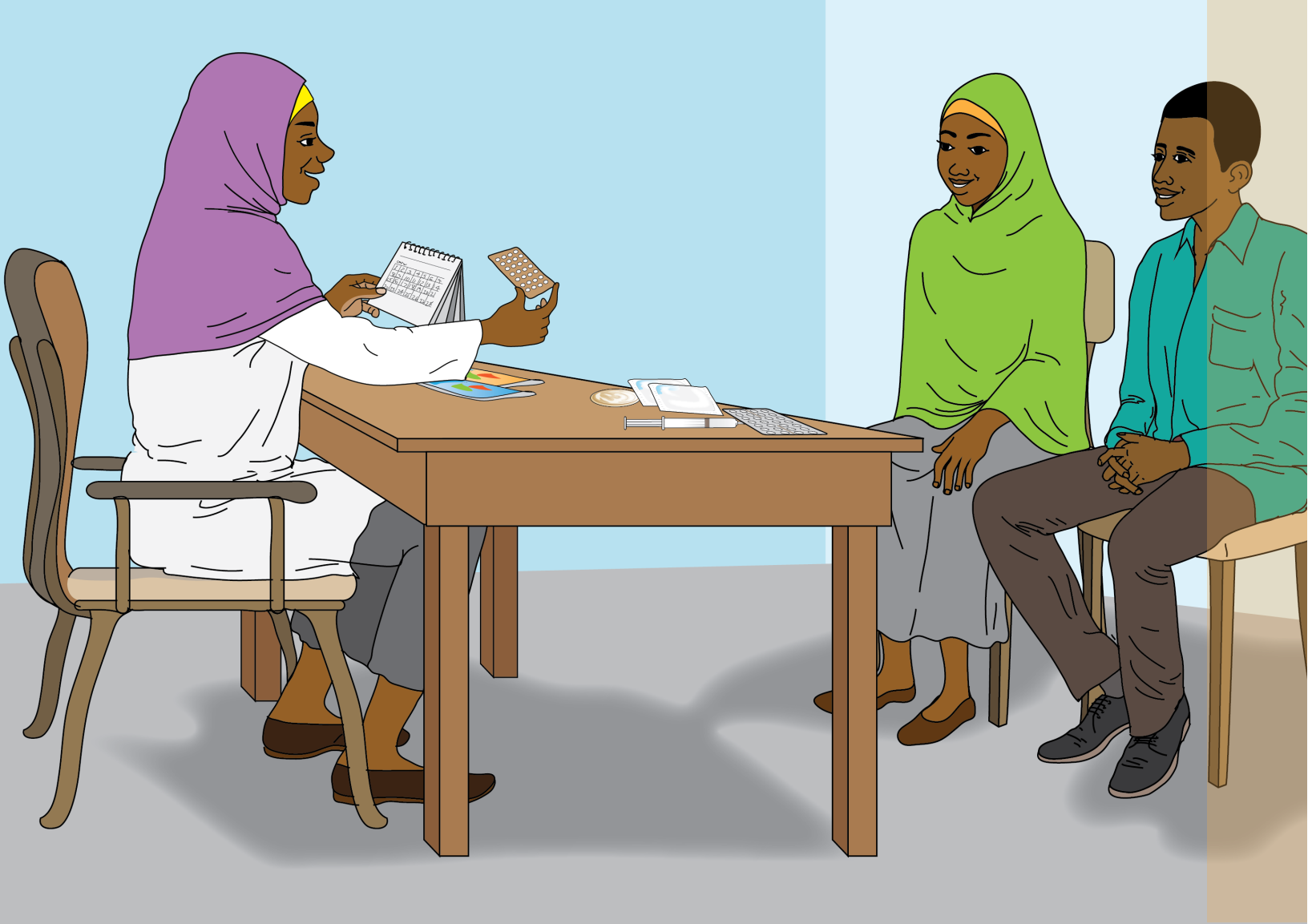
### **Use of IUDs by women with HIV and AIDS**

- An IUD can be provided to a woman with HIV if she has no symptoms of AIDS.
- An IUD generally should not be initiated in a woman with AIDS who is not taking antiretroviral drugs (ARVs).
- A woman who develops AIDS while using an IUD can continue to use the device.
- A woman with AIDS who is doing clinically well on ARV therapy can both initiate and continue IUD use, but follow-up may be required.

### **Timing of Insertion**

- The copper IUD can generally be inserted at any time, if you are reasonably sure the client is not pregnant.
- During the menstrual cycle
  - Within 12 days, no need for a backup method;
  - If more than 12 days, make sure she is not pregnant, and no need for a backup method.
- Switching from another method
  - Immediately, if using the method correctly and consistently; otherwise, make sure she is not pregnant. No need for a backup method.
  - If the woman is switching from an injectable contraceptive, the Copper T 380A can be inserted prior to the next scheduled injection. No backup method is needed.
- Soon after childbirth (breastfeeding or non-breastfeeding)
  - Within 48 hours of delivery, or during a cesarean section
  - If more than 48 hours, then delay until 4 weeks
- Post abortion/miscarriage
  - Immediately or days after a 1st or 2nd trimester abortion, if no infection
  - Delay after medical (non-surgical) abortion until confirmed that the uterus is completely empty
- For emergency contraception
  - Within 5 days after unprotected sex.
  - After taking emergency contraceptive pills (ECP) the Copper T 380A can be inserted on the same day. No need for back up method.

<sup>37</sup> Modified from Jhpeigo's *Long-Acting Reversible Contraceptives Learning Package. Module 1: Introduction to Long-Acting Reversible Contraceptives. Facilitator Version. 2017.*



## Session 9

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

- Articulate their current knowledge, feelings, values and intentions on the provision of family planning services to adolescents and how they were impacted by the workshop;
- Identify areas where they feel their values, beliefs and/or behaviors still conflict with their professional responsibilities;
- Commit to one action item as a result of the reflective dialogue process

**Materials:**

- Index cards of 3 different colors; Markers ; *Handout: Participant Worksheet – Closing Reflections*

**Advance Preparation:**

- Make copies of *Handout: Participant Worksheet – Closing Reflections*, one per person

**Time:**

- 1 hour 35 minutes

## Welcome (10 minutes)

1. Welcome participants back to the training and thank them for their continued commitment.
2. Ask for a volunteer to remind the group what was discussed in the previous session. If necessary, read out the following key messages from the previous session:
  - Counseling on LARC and injectables methods are part of a “free, full, and informed” choice model for all clients, including adolescents.
  - LARC and injectables are safe and effective methods that all adolescents, regardless of whether they have had a child, can use.
  - Good family planning counseling, including talking about possible side effects and advantages and disadvantages of different methods, improves adolescents’ satisfaction with, and continuation of, family planning.
3. Invite questions or comments about the previous week’s session.
4. Remind participants that they committed to applying something they had learned in last week’s session to their personal and professional lives. Invite participants to reflect on those commitments. Were they able to apply what they had learned? Why or why not?

## The Story of Atieno (50 minutes)<sup>38</sup>

1. Introduce the activity: “In this activity, we will use storytelling to review the factors that support or hinder the provision of rights-based family planning services. We will also reflect on steps that individuals, communities and the health sector can take to ensure all people in our community are able to realize their reproductive rights. Some of the steps we identify might seem challenging and/or impossible to implement at this point in time or ever. That is fine. Change is a complex, complicated process that often takes time. That should not dissuade us. This activity will help us reflect on the actions we can and are willing to implement. In this activity, we are going to examine the life of “Atieno.”
2. State the situation: *Atieno is a young woman aged 16. She recently got married. She would like to postpone pregnancy.*
3. Ask participants to continue the story: “What happens to Atieno?” Going around the circle, encourage participants to create a story with positive actions that Atieno can take (enabling actions) and any challenges she may encounter (obstacles). Write each aspect of Atieno’s story on index cards and place them along a timeline of Atieno’s life. Every enabling action should be written on cards of one color, every obstacle on cards of another color.
4. Encourage participants to be creative. When participants are identifying interventions to support Atieno, encourage them to identify both technical and social interventions. For example, technical interventions may include training service providers or providing services. Social interventions may include holding dialogues with women and men in Atieno’s community or facilitating couple communication.
  - *Facilitator note: Possible responses could include the following:*
    - *Atieno talks to a friend about her desire to postpone pregnancy (enabling action)*

- *Her friend advises Atieno to use family planning secretly (enabling action)*
  - *Her friend suggests a family planning method (enabling action)*
  - *Atieno sees a provider, but the provider is rude; the provider does not understand why a woman who does not yet have a child would want to use family planning and tells her a woman should not seek family planning without her husband anyway (barrier)*
  - *Atieno uses a particular method but does not like the side effects (barrier)*
  - *Atieno speaks to her husband about postponing pregnancy (enabling action)*
  - *Her husband is upset – he does not think women should talk about these things (barrier)*
  - *Her husband speaks to his mother (enabling action)*
  - *Atieno’s husband beats her (barrier)*
  - *Atieno’s mother-in-law becomes involved and pressures her (barrier)*
  - *Atieno’s husband agrees to family planning (enabling action)*
  - *When they arrive at the health facility there is no couples counseling offered (barrier)*
  - *Her husband is ridiculed at the health facility for accompanying Atieno (barrier)*
5. Ask participants to explore what can be done to help Atieno, or what interventions could be delivered to support Atieno. Write these interventions on a different color of index cards to place on the timeline.
- *Facilitator note: Examples include:*
    - *Lead community dialogue on family planning myths and misconceptions which Atieno attends*
    - *Facilitate dialogues with health care providers to identify and challenge their own biases and beliefs (including about the right of women to seek family planning)*
    - *Train health providers in family planning couples counseling*
    - *Establish youth-friendly and male-friendly services*
    - *Create discussion groups between mothers-in-laws and newly married women*
    - *Encourage men to discuss family planning with their partners*
    - *Advertise publicly details of places/persons who can provide contraception*
6. Ask participants to look at the list of interventions they have come up with and to identify any interventions that service providers specifically could implement. Mark these interventions with a star.
7. Use the following reflection questions to facilitate a dialogue:
- Do adolescents in your community face a similar situation to the ones Atieno experiences?
  - What happens to adolescents in this community when they face similar situations as Atieno?
  - What steps do adolescents in this community take to overcome the obstacles they are faced with? Are these steps effective?
  - Would service providers in this community be willing to implement the interventions we have marked with a star? Why or why not?

8. Close the dialogue by responding to any unanswered questions and correcting misinformation. Explain that change involves learning, critical thinking, reflection and community validation of the new action or behavior.
9. Thank participants for creating such a rich story and sharing their experiences.

### **Closing Reflections (25 minutes)**

1. Explain the purpose of the activity: “In this activity, we will have the chance to reflect on our experiences during these monthly meetings; identify how our knowledge, attitudes, opinions and intentions have or have not changed; express any outstanding issues, reservations or concerns; and commit to making one long-term change as a result of this workshop.”
2. Give each participant a copy of the worksheet.
3. Invite participants to spend a few minutes completing Part 1. Remind them that their responses reflect their personal views and experiences; there are no wrong answers.
4. Also ask participants to reflect on and complete Part 2.
5. When participants have finished writing, ask each participant to read one of their completed statements out loud. Participants may decline if they do not feel comfortable sharing any of their completed statements with the group.
6. Ask one or two participants to share their observations about people’s completed statements.
7. Debrief the completed statements and participants’ observations. Some possible debriefing questions are:
  - What are some similarities among our group’s feelings and intentions?
  - Where are the greatest differences in the group?
  - For anyone who identified a continued conflict between their values and/or behaviors related to the provision of family planning services to adolescents, what suggestions do we have for resolving these?
  - What is your sense about the impact of our monthly meetings on the services that we offer adolescents?
8. Solicit and discuss any outstanding questions, comments or concerns with the participants.
9. Ask each participant to briefly share with the large group the one thing they plan to do after the workshop that they wrote in Part 2.

### **Conclusion, Session Evaluation and Dismissal (10 minutes)**

1. Read out the following core messages for this session:
  - In our community, families and workplace we can take steps to begin changing norms around adolescents’ uptake of contraception. Change is difficult and rarely linear, but it is possible.

- Adolescents have the right to decide freely and responsibly the number, spacing, and timing of their children, and to have the information and means to do so.
  - Service providers are entitled to have personal beliefs that are not in support of adolescents' reproductive rights; however, their beliefs cannot interfere with their professional responsibilities to provide adolescents with family planning services in line with the rights-based approach.
2. If there is time, ask the following discussion questions:
    - Would anyone like to share with the group one thing they found interesting or exciting about this workshop?
    - Were there any ideas or activities that challenged you? If yes, how so?
    - Does anyone have any questions or additional thoughts?
  3. Remind participants that personal stories and experiences shared during the dialogue should be kept within the group, but that they are encouraged to share what they have learned with family, friends and colleagues who were not present if they feel comfortable doing so.
  4. Thank participants for their active participation. Confirm the date and time of the next session.
  5. Dismiss the group.
  6. After the session is complete and participants have left, record your answers in the session evaluation form (Annex 1)

<sup>38</sup> Adapted from "Auntie Stella: teenagers talk about sex, life and relationships on page 19 of Young People We Care training guide, John Snow International



## Handout: Participant Worksheet – Closing Reflections

### Part 1: Personal Reflection

Please complete the following statements according to how you feel now.

- My personal feelings about the provision of family planning services to adolescents are

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- My professional responsibilities regarding the provision of family planning services to adolescents are \_\_\_\_\_

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- I may not agree with \_\_\_\_\_,  
but I can respect \_\_\_\_\_

---

- My ideas about \_\_\_\_\_ have changed because

---

---

- When I think about providing family planning to adolescents, I still feel conflicted about

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- One way I plan to resolve the conflict I feel about the provision of family planning services to adolescents is to \_\_\_\_\_

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- Reflective dialogue meetings have helped me to \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Part 2: Planning for the Future**

Think about and write down one thing you plan to do after in the future to support the provision of rights-based family planning services for adolescents.



## Session 10: Health Facility Action Plan

### Objectives:

- By the end of this activity, participants will be able to:
  - Apply the information learned about adolescent and youth friendly services and family planning counseling to improve health facility services for adolescents in their communities

### Materials:

- Flip chart paper; Markers; *Handout: Health Facility Action Planning Template*

### Advance Preparation:

- Make copies of *Handout: Health Facility Action Plan*, one per person

### Time:

- 1 hour 20 minutes

## The Four Steps of Action Planning (10 minutes)

1. Welcome participants back to the training and thank them for their continued commitment.
2. Ask if participants have any questions on the materials covered last session.
3. Say, “Last session, we reflected on our roles and responsibilities providing rights-based family planning to adolescents. We also created a long-term professional goal to help improve our ability to provide high-quality services to young people.

Our individual commitments to improving services for adolescents is important. But how can we also take action collectively to ensure that our colleagues and the health facilities in which we work also support our efforts to ensure access to family planning for adolescent clients?

One way is by creating an action plan of changes we would like to make. Broadly speaking, planning for action involves answering the following four questions:

- a) What norm or practice do we want to change?
- b) Why does it need to change?
- c) How can we change it?
- d) What risks could we encounter and how should we deal with them?”

## Health Facility Action Planning Template (1 hour)

1. Distribute the Handout *Health Facility Action Planning Template*
2. Ask, “Who can remind me of some norms or practices in our health facilities that prevent adolescents from accessing family planning? And who can remind me of some examples of adolescent and youth friendly service characteristics?” [*Write participant responses on a flipchart. Tell participants to refer to the handout “Characteristics of Adolescent- and Youth-Friendly Services” from session 3 if they need more information.*]
3. Say, “These are all examples of ways we can make our services and facilities adapted to meet the needs of young people and overcome common barriers. Today, we are going to focus on specific ways that we can improve services in our community by creating an action plan.”
4. Distribute the *Health Facility Action Planning Template*.
5. Say, “This sheet will help us to express the changes we would like to see in our health facilities. In order to come up our action steps, we will need to identify a:
  - **Problem statement:** What is the challenge that you would like to address
  - **Goal:** What change do you want to see? When? Remember that a good goal should be SMART—Specific, Measurable, Achievable, Relevant and Time-bound.
  - **Description of Activity:** Provide a detailed description of the action. What will you do? How? Are any resources needed to implement the activity?
  - **Start date and end date:** Indicate when the activity will take place.
  - **Steps:** list the specific steps you will need to take to complete your goal. If you run

out of space, use the back of your sheet.

- **Challenges:** Think through problems you might face when working to achieve your goal. What steps you can take to reduce the likelihood of experiencing these problems?

First, each of us will fill out this sheet individually with one key action we think would improve adolescents' ability to access rights-based family planning in our facility/community. Then, we will share our responses. As a team, we will then select the top 2 goals we would like to create in our facilities."

6. Ask, "Does this action plan make sense to you? What questions do you have?"
7. Give participants 15 minutes to create an action step for their health facility.
8. In plenary, ask participants to share their health facility action plan with the rest of the room.
9. Ask the full group to select no more than 2 goals to move forward with as a team. Build out / agree upon the steps to achieve these goals and assign roles/responsibilities for each step. Give participants no more than 45 minutes to complete this exercise. Note the answers on a flip chart. *Make sure to save this flipchart and document and also report these goals to the CARE IMAGINE team!*

### **Conclusion, Session Evaluation and Dismissal (10 minutes)**

1. Say, "Today, we developed collective action plans to help transform the health facilities in which we work into spaces where adolescents can seek high-quality, rights-based family planning. When we work together as a community of providers to ensure that all clients, including adolescents, have access to the reproductive health services they need, we help make our communities healthier, happier places for everyone.

I urge you to share the goals you've created today with your supervisions and colleagues as a first step to achieving some of the changes we've identified today. Thank you for your commitment to improving the health and wellbeing of your community. We look forward to seeing some of the incredible changes you've identified today in the future."

2. If there is time, ask the following discussion questions:
  - How do the goals you set for your health facility relate to the personal goal you identified in the last session?
  - How can we work together to support our ability to achieve these goals?
  - Does anyone have any questions or additional thoughts?
3. Thank participants for their active participation. Confirm the date and time of the next session.
4. Dismiss the group. After the session is complete and participants have left, record your answers in the session evaluation form (Annex 1)

## Handout: Health Facility Action Planning Template

Use this sheet to create an action plan related to adolescent and youth friendly services for your health facility.

Example:

<b>Problem Statement</b>	Most staff in my health facility do not have training on the best way to communicate with adolescents and young people.
<b>Goal</b>	By August, 2019, my health facility will train all staff members, including non-clinical staff, on how to effectively communicate with adolescent clients.
<b>Description of Activity</b> <i>(What will take place? With whom can you collaborate? What resources are needed? Where and how can you obtain those resources?)</i>	I will work with the head of my health facility to arrange a 2-hour training, which will take place in July for all staff in my facility. I will co-organize the training with Fatma, my colleague, and we will work with the SAA+FPC facilitators to create training material. We will need resources for printing, so I will ask my supervisor if she can support this cost from our health facility budget.
<b>Who is responsible?</b>	Hassane Mahamadou
<b>Start date?</b>	June, 2019
<b>End date?</b>	August, 2019

### **The steps needed to achieve this goal are:**

1. I will talk to the head of my health facility to explain why it is important that we have a 2-hour training on communication with adolescent clients and receive their approval. I will also ask if the health clinic budget can support this training.
2. I will work with Fatma, the SAA+FPC trained facilitator at my clinic, to look at which materials we could use for the training. We will also decide who will facilitate the training.
3. I will work with our receptionist to schedule a training date and ensure that my colleagues are aware of what the training will cover. I will reserve a room for the training.
4. In August, we will hold the training for all health facility staff.

**Challenges:** It may be difficult to find a time when all health facility staff are available for the training. Partnering closely with both the facility receptionist and manager will ensure the selection of an appropriate time for the training.

**Action Plan:**

<b>Problem Statement</b>	
<b>Goal</b>	
<b>Description of Activity</b> ( <i>What will take place? With whom can you collaborate? What resources are needed? Where and how can you obtain those resources?</i> )	
<b>Who is responsible?</b>	
<b>Start date?</b>	
<b>End date?</b>	

**The steps needed to achieve this goal are:**

- 1.
- 2.
- 3.
- 4.

**Challenges:**

## Annex 1 – Session Evaluation

Session Title and Date: \_\_\_\_\_

Facilitator Number:

Facilitator Name: \_\_\_\_\_

Total Number of Participants: \_\_\_\_\_

1. What activities/concepts were most difficult for participants to understand, if any?

2. What topics need to be revisited or discussed in more depth?

3. What would you change about this session for next time, if anything?

Additional comments:



## Annex 2 – A Guide for Contraceptive Counseling Using the Right-Based Approach<sup>39</sup>

### The Pre-Choice Stage

1. Establish and maintain a warm, cordial relationship.
2. Inform client (and partner, if present) that there will be opportunities to address both health needs and family planning needs during this consultation.
3. Ask client about current family size and current contraceptive practices. Counsel the client on the healthy timing and spacing of pregnancy. Use visual resources if available.
  - If client is currently using a family planning method or delaying pregnancy, ask about her/his satisfaction with it and interest in continuing or changing the method.
4. Rule out pregnancy.
5. Inform the client of all the methods available, ideally using visuals. Ask client if she/he wants a particular method.
6. Ask all of the following questions. Eliminate methods based on the client's responses.
  - Do you wish to have children in the future?
    - If "Yes," eliminate vasectomy and tubal ligation. Explain Why.
    - If "No," continue.
  - Have you given birth in the last 48 hours?
    - If "Yes," eliminate the pill and injectables. Explain why.
    - If "No," continue with the next question.
  - Are you breastfeeding an infant less than 6 months old?
    - If "Yes," eliminate the Pill and injectables. Explain why. If "No," or she has begun her monthly bleeding again, eliminate LAM. Explain why.
  - Does your partner support you in family planning?
    - If "Yes," continue with the next question
    - If "No," eliminate condom, Standard Days and withdrawal. Explain why.
  - Do you have any medical conditions? Are you taking any medications?
    - If "Yes," ask further about which conditions or medications. Refer to WHO Medical Eligibility Criteria Wheel or current national guidelines and eliminate all contraindicated methods. Explain why. If "No," continue.
  - Are there any methods that you do not want to use or have not tolerated in the past?
    - If "Yes," eliminate the client does not want.

### Method Choice Stage

1. Briefly review the methods that have not been eliminated and indicate their effectiveness.
  - Briefly review the key features of each method. Emphasize effectiveness, ease of use and appropriateness for adolescent clients.
2. Ask the client to choose the method that is most convenient for her/him.

- Check whether the client has any condition for which the method is not advised.
3. If the method is not advisable, ask the client to select another method. Repeat the process from Step 8.

### **Post-Choice Stage**

1. Discuss the chosen method with the client, using brochures, pamphlets and/or visual aids, if available. Determine the client's comprehension and reinforce key information:
  - General information
  - How method works
  - Important facts (about the method)
  - Method not advised if you...
  - Side effects
  - Health benefits (if applicable)
  - How to use
  - Follow-up (if applicable)
  - When to return to the health care facility
2. Ensure the client has made a definitive decision. Give the client the method, a referral and backup method, depending on method chosen.
3. Encourage the client to involve partner(s) in decisions about/practice of contraception through discussion or a visit to the clinic.

### **Systematic Screening for Other Services Stage**

1. Using information collected previously, determine client's need for postpartum, newborn, infant care, well-child services or post abortion care.
2. Ask client when she had her last screening for cervical cancer (VIA/VILI or pap smear) or breast cancer.
  - a) If her last Cervical Cancer screening was more than 3 years ago (\*6-12 months if she is HIV positive) or she doesn't know, ask if she would like to have a screening today. Provide or refer for services.
  - b) If her last Cervical Cancer screening was less than 3 years ago continue with next question.
  - c) Review information on breast cancer and breast cancer screening.
3. Discuss STI/HIV Transmission & Prevention and dual protection with client. Offer condoms and instructions on correct and consistent use.
4. Conduct STI and HIV risk assessment. If symptoms are identified, treat her/him syndromically.
5. Ask client whether s/he knows her/his HIV status.
  - a) If client knows s/he is living with HIV:
    - Refer client to center for wellness care and treatment.
  - b) If client knows s/he is HIV negative:

- Discuss a time frame for repeat testing.
- c) If client does not know her/his status,
- Discuss HIV Counseling and Testing (HCT) with client, using counseling card.
  - Offer or initiate testing with client, according to national protocols.
  - Counsel client on test results, as per national protocols.
6. Give follow-up instructions, a condom brochure, and the brochure for the method chosen, if available. Set a date for next visit.
7. Thank her/him for the visit. Complete the counseling session.

<sup>39</sup> Adapted from Population Council. 2015. *Balanced Counseling Strategy Plus Trainer's Guide Third Edition*, part of *The Balanced Counseling Strategy Plus: A Toolkit for Family Planning Service Providers Working in High STI/HIV Prevalence Settings*, Third Edition, Washington, D.C.



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