



USAID | **PHILIPPINES**
FROM THE AMERICAN PEOPLE

Introduction to the *Usapan* series Trainer's Guide



Introduction to the *Usapan* Series Trainer's Guide

September 2014

This document is made possible by the support of the American People through the United States Agency for International Development (USAID). The contents of this document are the sole responsibility of Chemonics International, Inc. and do not necessarily reflect the views of USAID or the United States Government.

Table of Contents

Acknowledgements	iii
Introduction	I
Training Flow	8
Session 1: Orientation on the <i>Usapan</i> (Conversations) Series.....	11
Session 2: The Role and Attributes of an Effective Facilitator.....	35
Session 3: Refreshers On FP-MCH Topics Discussed in <i>Usapan</i>	52
Session 4: Basic Skills and Techniques in Facilitating <i>Usapan</i>	94
Sessions 5 To 9: Trainer's Guide for the Sessions on Gender in FP-MCH and the 5Rs for Gender-Based Violence Victims-Survivors.....	117
Session 5: Pre-Training Test and Overview of the Training Modules on Gender in FP-MCH.....	119
Session 6: Basic Concepts of Gender and its Relevance to FP-MCH.....	121
Session 7: Nature and Causes of Gender-Based Violence (GBV)	131
Session 8: What can health providers do?.....	137
Session 9: Gender Portion of <i>Usapang Pwede Pa</i> and <i>Kuntento Na, Usapang Buntis, And Usapang Bagong Maginoo</i>	151
<i>Usapan</i> Trainer's Guide Sessions 10 to 13	170
Session 10: Demonstration of <i>Usapang Pwede Pa</i>	171
Session 11: Return Demonstrations	176
Session 12: Briefing for the Practicum.....	183
Session 13: Practicum	185
ANNEX A: Trainers' Worksheet: Topic Assignments for Basic Skills Practice Session on Sharing FP-MCH Information	186
ANNEX B: Pre/Post-Training Test Questionnaire for Training on Gender in FP-MCH and in the 5Rs for Gender-Based Violence Victims/Survivors	187
ANNEX C. Pre/Post-Test for Training on Gender in FP-MCH and in the 5Rs for Gender-Based Violence Victims/survivors.....	189
ANNEX D: A Difference in the Hypothalamic Structure between Heterosexual and Homosexual Men	191
ANNEX E: Family Planning (FP) Form #1	196
ANNEX F: PRISM2 Monthly Service Record (MSR) Form.....	199
ANNEX G: Gender Relationship Job Aid.....	201

Acronyms

BHW	Barangay Health Worker
BTL	Bilateral Tubal Ligation
CHT	Community Health Team
DOH	Department of Health
FHSIS	Family Health Services Information System
FP	Family Planning
FP-CBT	Family Planning Competency-Based Training
GBV	Gender-Based Violence
IUD	Intrauterine Device
LA/PM	Long-Acting/Permanent Method
MCH	Maternal and Child Health
MLLA	Mini-Laparotomy under Local Anesthesia
NSV	No-Scalpel Vasectomy
PPM	Private Practicing Midwives
SDM	Standard Days Method
VAWC	Violence Against Women and Children

Acknowledgements

The USAID Private Sector Mobilization for Family Health-Phase 2 (PRISM2) project is grateful to the following Manoff Group staff and consultants for preparing the content and organization of this manual:

Raul M. Caceres, PRISM2 BCC Specialist; Laurie Krieger, Senior Advisor for Health and Communication, The Manoff Group; Mary Honeylyn Joy Alipio, PRISM2 BCC Coordinator.

PRISM2 would also like to thank the many private practicing midwives (PPMs) as well as provincial and local government staff who contributed their time and ideas on FP-MCH counseling and service provision.

Introduction

Brief Background

- In 2001, the Save the Children-PESCO DEV Project developed a group counseling method called “Family Planning Action Session” (FPAS) integrating the concepts of population, health and environment (PHE).
- In 2003, a purely family planning (FP) version of FPAS was developed by the Management Sciences for Health (MSH) for the Matching Grants Project to educate reproductive-age couples on the various topics concerning FP.
- In 2005, MSH and The Manoff Group, under LEAD for Health (a USAID-supported project in the Philippines) initiated the development and pilot-testing of FPAS for permanent methods.
- In 2009, HealthPRO (a USAID-supported BCC project in the Philippines) developed a version of a health class, also based on FPAS but with a shorter duration. The project also developed the FP Action Card and other job aids for use during the class.

After a thorough assessment, PRISM2 decided to adopt the core action session approach of FPAS, but with major revisions along the following:

- Technical approach (marketing communications focusing on benefits, reliability, practicality and ease of use and less discussion on the technical/medical aspects of FP methods)
- Shorter duration of the sessions
- Minimal cost items
- Revision of and thorough integration of the “Action Card” into the sessions
- Emphasis on participation through discussion and participatory learning exercises
- To avoid confusion with the old FPAS, PRISM2 re-branded the approach as follows:
 - ✓ “*Usapan for Private Practicing Midwives (PPMs)*” Series or UPPM
 - ✓ “*Usapan for the Public Sector*” Series or UPS

The *UPS* vis-a-vis *UPPM* distinction is based on the different needs and abilities of the public and private sectors. The public sector is able to provide free contraceptives, but there may be a wait to see the provider. The private sector primarily sells commodities, but can usually provide faster private services. Furthermore, *UPPM*, unlike *UPS*, provides participants with snacks and possibly free gifts.

Usapan compared to health classes

Health classes are generally used to provide health information or raise awareness about certain health concerns. They typically use mostly top-down lectures to impart new knowledge and often are not very participatory. In many cases, the health class does not include facilitation to help participants make a choice and take action.

The *Usapan* series, on the other hand, is a carefully structured process for a facilitated group *discussion* on FP and maternal health care. The design is more conversational, as opposed to being a class/lecture type of session. It seeks to educate participants by providing only the amount of information that adults can process in one sitting (based on the adult education literature), rather than going into multiple complex details in one session. Instead, *Usapan* aims to promote FP and maternal health care by providing essential information that is emotionally appealing, so that at the end of the session, participants can link a particular method or service as possibly being responsive to their needs. At the end of an *Usapan* group session, the participant who has a method/service in mind receives a one-on-one counseling session with a trained service provider for a more thorough discussion of the method or service s/he is interested in.

WHO CAN USE THIS GUIDE

This guide is intended for trainers who will be training Private Practicing Midwives (PPMs) in facilitating *Usapan* sessions. Through *Usapan*, it is envisioned that PPMs will be able to widen their client base and thereby increase their revenues.

While the *Usapan* series may be of value to all PPMs, those with the following criteria should be prioritized:

1. Must have attended the Family Planning Competency-Based Training (FP-CBT) Level 1; preferably have also completed FP-CBT2.
2. Preferably working in or operating a PhilHealth accredited birthing facility

Moreover, while the *Usapan* series was developed for use by PPMs, many aspects of the approach are also relevant for implementation by the public health sector

Usapan has four purposes:

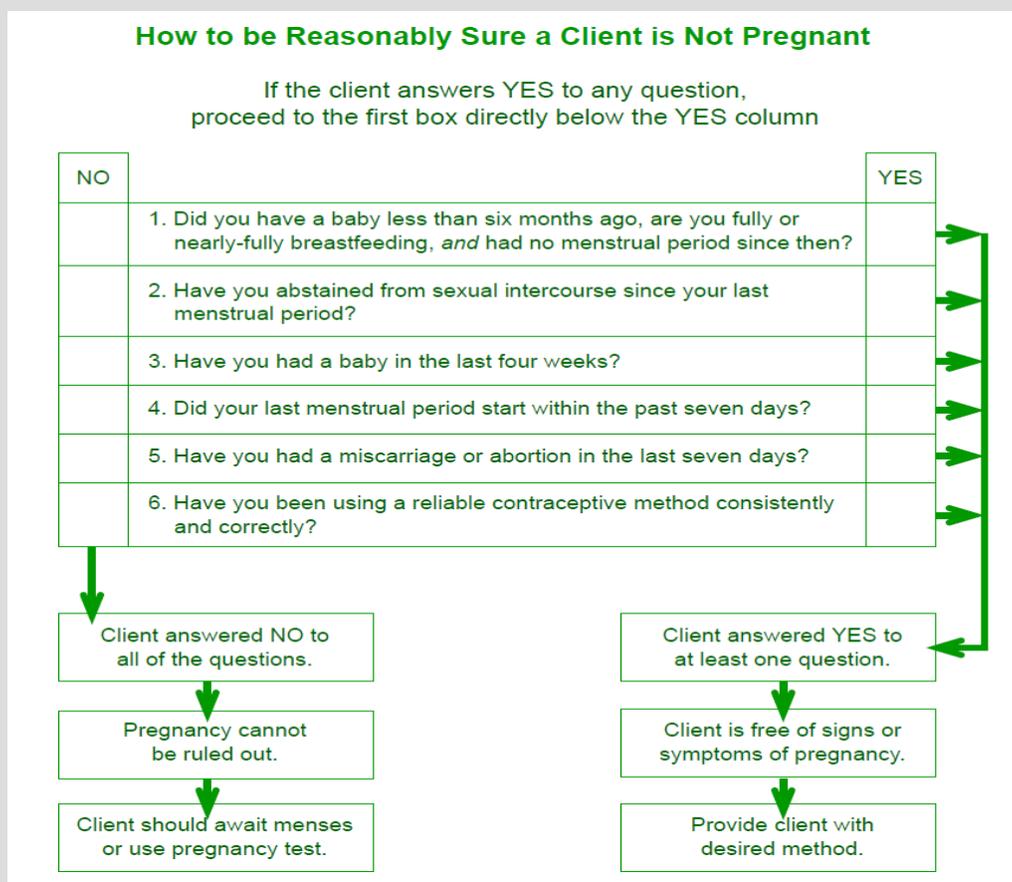
1. Create demand for FP-MCH services to increase the revenues of PPMs;
2. Meet the new demand and enhance the business practice of PPMs;
3. Help clients of PPMs to think through their hopes for their future and their family's future and to envision how FP (and/or good antenatal, delivery, and postpartum care) can help turn those hopes into reality; and
4. Introduce clients of PPMs to the role of gender in relationships and how this and gender-based violence (GBV) can interfere with accessing and using FP-MCH services and products.

Based on the *Usapan* participants' wishes and medical assessment, PPMs *provide the desired method/service on site* (e.g., pills, Standard Days Method (SDM), intrauterine device (IUD) insertion, antenatal care, etc.).

However, the *Usapan* also makes it clear to the participants that they have the option NOT to choose a method, if they are not ready for it or don't see themselves needing FP at the current time.

It is quite common among FP service providers not to provide hormonal methods or insert an IUD when the client does not have her menses. In these cases, FP providers routinely advise the client to return to the clinic when she (client) has her monthly period.

The DOH recommended practice is that if a woman is already interested to use a family planning method, FP service providers do not have to wait for that woman to have her menses before giving her the method she has chosen if it can be reasonably ascertained that the client is not pregnant. DOH (and WHO) recommends asking a set of six questions to rule out pregnancy. (Please see below).



***Usapan* should be viewed as a process that leads to immediate service provision** and not just health education. As such, conducting *Usapan* involves prior identification of clients with unmet need, segmentation according to unmet need for spacing vs. long-acting/permanent method (LA/PM), group counseling, one-on-one counseling, service provision/referral, follow-up and monitoring.

The four absolute conditions for an activity to qualify as *Usapan* are as follows:

1. No more than 15 participants (potential FP clients and/or MCH patients) per session at any given time.
2. FP-CBT 1-trained midwives or nurses must be available to provide one-on-one counseling and the chosen FP method at the actual session, and FP-CBT 2 training for those who will provide IUD insertion.
3. All temporary FP commodities must be available and ready for actual use or dispensing at the *Usapan* session venue.
4. The immediate forthcoming schedule of bilateral tubal ligation (BTL) and/or no-scalpel vasectomy (NSV) services (within the week) at a specific referral hospital or partner must be arranged and finalized prior to conducting the *Usapan* variant that promotes LA/PM.

Training Orientation

General objective: This training aims to build the capability of group counseling facilitators to conduct the four variants of the *Usapan Series* (*Usapang Pwede Pa*, *Usapang Kuntento Na*, *Usapang Buntis*, and *Usapang Bagong Maginoo*) as distinct sessions.

Learning objectives

At the end of the training, the participants will be able to:

1. Demonstrate group counseling facilitation skills that are necessary to effectively conduct the *Usapan Series*;
2. Articulate basic facts and essential information on:
 - Fertility awareness and joint fertility
 - The various FP program methods
 - Essential behaviors for pregnant women to ensure a healthy pregnancy and safe, facility-based delivery
 - Elements of male participation in FP-MCH
3. Integrate and discuss effects of gender issues and gender-based violence (GBV) in FP-MCH behaviors of clients and present actionable information so that health providers can be more responsive to victims/survivors of GBV; and
4. Demonstrate competence in facilitation of the *Usapan Series* in actual field conditions (practicum).

Training approach

In this course, the focus is on the development of *Usapan* facilitation skills because it is assumed that the trainees are active midwifery practitioners and have undergone Family Planning-Competency-based Training (FP-CBT). **Thus, the training team should avoid lengthy lectures.** To keep the training simple and straightforward, the training team may follow this approach:

1. **Describe** the skill – explain why it is important for trainees to develop it and explain when it should be applied during *Usapan*.

2. **Demonstrate** the skill – let the trainees observe the trainer perform the skill.
3. **Organize practice** sessions through return demonstrations, and supervised practicum in the field with real participants who have unmet need for FP.

Training duration

Four (4) days, including practicum on Day 4

Training team composition

Ideally, the training team should be composed of:

1. Public sector health workers (DOH-CHD or Provincial Health Office level) to help ensure that the discussion on FP-MCH topics are consistent with the DOH standards
 - a. Health Education and Promotion Officer (HEPO): trainer(s) for the facilitation/structured exercises
 - b. FP Coordinator: for FP inputs
 - c. MCH Coordinator: for MCH inputs
 - d. Gender Specialist for the gender inputs
2. A PPM with experience in conducting *Usapan* sessions. This midwife will provide the proper PPM perspective and insights during the post role-play and practicum processing/discussions.

Selection of PPMs for training as *Usapan* facilitators

The PPMs should be selected based on the following criteria:

1. Must have attended the FP-CBT 1; preferably has also completed FP-CBT 2
2. Preferably working in, or operating a PhilHealth-accredited birthing facility
3. No strong biases on FP; open to promoting all FP methods to all interested clients

Advance preparations

1. Secure agreement of co-trainer/local partner who will deliver the health information during the FP-MCH refresher session and during the demonstration of *Usapang Kuntento Na*. Find time to orient the resource person on the *Usapan* approach so that s/he also does not give excessive medical information (since this is just a refresher).
2. Secure agreement of a partner who will assist in managing/critiquing the sub-groups that will perform the return demonstrations and the practicum.
3. As early as DAY 1 of the training, get in touch personally with the person(s) who are doing the groundwork for the practicum on the last day of training. Don't rely on message relays as this is often the cause of miscommunication, e.g., invited participants to the *Usapan* practicum may actually be already FP users. Once you get in touch with those persons, determine how many practicum sites they can prepare. The ideal number is 4 or 5 trainees per practicum site. This means that if there are 20 trainees, then 4 practicum sites will do.
4. When you personally talk to the field workers who will invite participants to the practicum, clarify that:
 - a. Invited participants to the *Usapang Pwede Pa* practicum should be women with unmet need for FP, but who still may want more children. It is crucial that they are NOT current FP users.
 - b. Invited participants to the *Usapang Buntis* could be:
 - Confirmed pregnant women, especially those in their first trimester of pregnancy
 - Women who think they may be pregnant (have missed their monthly period)
 - Women who intend to get pregnant in the near future
5. When you have the number of practicum sites, then you can do the necessary sub-groupings of your trainees. Do the sub-groupings towards the end of Day 1 and post the names of group members on a wall within the venue. Give each group member her/his topic assignment so she can start preparing in the evening by reviewing the Facilitator's Guide. The assigned topic(s) per trainee should be the same for the return demonstrations and the practicum.

Training Flow

DAY I

Arrival of Participants and Trainers

Check-in and Registration of Participants and Trainers

<p>8:00 – 9:00 a.m.</p>	<ol style="list-style-type: none"> 1. Preliminaries <ul style="list-style-type: none"> • Invocation • National Anthem • Welcome Remarks 2. Icebreaker and Introductions (training staff and participants) 3. Leveling of expectations 4. Administrative matters (house rules) 5. Course Overview: Training objectives, design, and pedagogy
<p>9:00 – 11:00 a.m. (snacks served while in session)</p>	<p>SESSION 1: Orientation on the Conversations Series</p> <ol style="list-style-type: none"> 1. What is the <i>Usapan</i> Series? <ul style="list-style-type: none"> • Rationale • Technical description • Structured flow 2. Guidelines for Conducting <i>Usapan</i> Sessions
<p>11:00 a.m. – 12:00 p.m.</p>	<p>SESSION 2: The Role, Attributes of an Effective Facilitator</p> <ol style="list-style-type: none"> 1. Perception 2. Values and biases 3. Role and attributes
<p>12:00 – 1:00 p.m.</p>	<p>Lunch Break</p>
<p>1:00 – 5:30 p.m.</p>	<p>SESSION 3: Refreshers on FP-MCH Topics Discussed in <i>Usapan</i></p> <ol style="list-style-type: none"> 1. Fertility awareness 2. Modern methods for spacing pregnancies 3. LA/PM 4. Handling FAQs on FP methods 5. Essential MCH behaviors for pregnant women 6. Male Participation in FP-MCH

DAY 2	
8:00 a.m. – 12:30 p.m.	<p>SESSION 4: Basic Skills and Techniques in Facilitating <i>Usapan</i></p> <ol style="list-style-type: none"> 1. Rapport building 2. Managing structured <i>Usapan</i> exercises 3. Presenting/discussing health information 4. Generating discussion and maintaining group interest 5. Balancing the discussion during <i>Usapan</i> 6. Negotiating for behavioral commitment and closing the deal
12:30 – 1:30 p.m.	Lunch break
1:30 – 2:00 p.m.	SESSION 5: Pre-training test and Overview of the Training Modules on Gender in FP-MCH
2:00 – 3:30 p.m.	<p>SESSION 6: Basic Concepts of Gender and its Relevance to FP-MCH</p> <ol style="list-style-type: none"> 1. Differentiation of the concept of gender from sex 2. Gender issues in FP-MCH 3. Relevance of pursuit of gender equality to FP-MCH 4. Features of a gender-synchronized FP-MCH service 5. Challenges to FP-MCH service providers
3:30 – 4:30 p.m.	<p>SESSION 7: Nature of Gender-based Violence (GBV) and Recognizing a GBV Victim-Survivor</p> <ol style="list-style-type: none"> 1. What is GBV? 2. Forms of GBV 3. Factors that perpetuate GBV
4:30 – 6:00 p.m.	<p>SESSION 8: What can Health Providers Do? – 5Rs</p> <ol style="list-style-type: none"> 1. Recognize GBV victims-survivors among FP-MCH clients 2. Record the profile of GBV victims-survivors 3. Report statistical data on assisted GBV victims-survivors 4. Refer GBV victims-survivors to proper agencies for further assistance 5. Raise the awareness of FP-MCH clients through the <i>Usapan</i> modules
DAY3	
8:00 – 9:30 a.m.	SESSION 9: Gender portion of <i>Usapang Pwede Pa, Usapang Kuntento Na, Usapang Buntis, and Usapang Bagong Maginoo</i>
9:30 – 11:45 a.m.	<p>SESSION 10: Demonstration of <i>Usapang Kuntento Na</i></p> <p>(includes 15-30 minutes Q&A after the demonstration) (includes run-through of the steps in the other <i>Usapan</i> variants)</p>

11:45 a.m. – 12:00 p.m.	Assignment to breakout groups
12:00 – 01:30 p.m.	Lunch Break / practice session for return demonstration After lunch, trainees practice their assigned topics in preparation for the return demonstrations
1:30-5:30 p.m.	SESSION 11: Return Demonstrations (with processing and feedback)
5:30 – 6:30 p.m.	SESSION 12: Briefing for the Practicum (includes discussion on completing Usapan forms: Attendance Sheet, Recording Form, Snacks Reimbursement Form)
DAY 4	
8:00 a.m. – 12:00 p.m.	SESSION 13: Practicum
1:00 – 4:00 p.m.	SESSION 14: Sharing of Lessons from the Field, Action Planning and Closing Program <ol style="list-style-type: none"> 1. Impressions 2. Distribution of certificates 3. Class picture

Session 1: Orientation on the *Usapan* (Conversations) Series

SUB-TOPIC 1A: WHAT IS THE USAPAN SERIES?

Learning Objective: The participants will learn about the *Usapan* Series: Rationale, and core elements of this service marketing approach

TIME ALLOTMENT: 1 hour

CONTENTS AND METHODOLOGY

Content	Methodology	Time Allocation
What is the <i>Usapan</i> (Conversations) Series? <ul style="list-style-type: none"> • Rationale • Technical description • Types of <i>Usapan</i> • Essential Elements of the <i>Usapan</i> Approach 	Lecture-discussion	1 hour

ADVANCE PREPARATION OF MATERIALS:

1. Metacards, pentel pens and rolls of masking tape
2. PowerPoint presentation Title: **Usapan Facilitators Training.Session 01.Orientation on the Usapan Series.PPMs.pptx**
3. LCD projector and laptop (check that these are compatible and that PowerPoint display is good)
4. FP and MCH Tarpaulin Flipcharts displayed in a highly visible area in the training room

5. Handouts and reference materials for this session with one copy for each participant. It is recommended that these be included in the kit and given out to trainees upon registration. This will help save time. These materials are:

- *Usapan* Facilitator's Guide
- *Usapang Pwede Pa and Kuntento Na* Action Card
- *Usapang Buntis* Action Card
- *Usapang Bagong Maginoo* Action Card

TOPIC / CONTENTS	TEACHING – LEARNING PROCESS
 <p>SESSION 1: Orientation on the Usapan Series</p>  <p>Sub-Topic 1a. What is the Usapan Series?</p>	<ol style="list-style-type: none"> 1. Open the discussion with the focus question: “What are your views on why FP hasn’t been used by more Filipinos/Filipinas?” 2. You may ask a co-trainer to write the participants’ responses on Manila paper, whiteboard, or metacards
<p>Health Sector Challenges that PPMs Can Turn into Business Opportunities Through The <i>Usapan</i> Series</p>	<p>Use participants’ answers to segue into this introductory slide of the business opportunities for PPMs through the <i>Usapan</i> series.</p>

Challenge #1. Increasing contact between non-users & FP service providers

	2003 NDHS	2008 NDHS
Percentage (MWRA) who were visited by fieldworker	11.5	9.6
MWRA who visited a health facility and discussed FP	13.6	12.3
(MWRA) Neither discussed family planning with fieldworker nor at a health facility	80.3	82.5

DISCUSS:

Based on the National Demographic and Health Surveys (NDHS) of 2003 and 2008, there has been **very low interaction** between FP providers and Married Women of Reproductive Age (MWRA) who are non-FP users. The implication of this is that there are fewer opportunities to:

- clarify and thoroughly discuss health concerns about FP methods
- inform these women about the available safe and modern options for FP

Challenge #2. Reducing Unmet Needs for Family Planning

	FHS 2006	FHS 2011
Unmet Need	15.7%	19.3%
Spacing	8.4%	10.5%
Limiting	7.3%	8.8%

Three important factors that contribute to unmet need
Casterline, JB, Perez, AE, Biddlecom, AE (1997). Factors underlying unmet need for family planning in the Philippines

- (1) strength of women's reproductive preferences
- (2) husband's fertility preferences
- (3) perceived detrimental side effects of contraception

DISCUSS:

Again, according to the 2006 Family Planning Survey and 2011 Family Health Survey, many women said that they did not want to have any more children, and yet they were not using any method to prevent unplanned pregnancy at the time of the survey. This is referred to as Unmet Need for FP.

Discuss also the 3 factors that contribute to unmet need for FP.

Challenge #3. Bridging the gap between knowledge/ awareness of FP from demand generation and actual service provision/FP method acceptance

- Demand-generation activities are conducted; but services are not immediately available to those interested
- Commodities/Services are available at the birthing home and other commercial sources; but demand-generation activities are insufficient

DISCUSS:

1. When demand-generation activities are conducted and the services are not immediately available, it can result in “missed opportunities” on the part of the providers, and “unmet need” among prospective clients, which could lead to unplanned pregnancies. This could also result in frustration among clients because they expect that when you promote a product or service, it should be readily available.
2. Many instances have occurred where products are available but demand-generation activities that are being conducted are insufficient. This could result in the products just staying in the PPMs’ display areas or stockroom and not being dispensed to clients.

Challenge #4 Low market share of PPMs in private sector provision of commodities

Source	Female sterilization		Pill	
	2003	2008	2003	2008
Public sector	75.8	73.0	56.6	22.2
Government hospital	68.3	64.7	1.0	0.2
Rural/urban health center	7.0	8.2	19.8	6.9
Barangay health center	0.0	0.0	0.0	0.0
Private sector	0.0	0.0	43.4	77.8
Pharmacy	0.0	0.0	43.4	77.8
Private nurse/midwife	0.0	0.0	0.0	0.4
Other	0.0	0.0	0.0	0.0
Private	0.0	0.0	0.0	0.0
Pharmacy	0.0	0.0	0.0	0.0
Private nurse/midwife	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0
Private	0.0	0.0	0.0	0.0
Pharmacy	0.0	0.0	0.0	0.0
Private nurse/midwife	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0
Private	0.0	0.0	0.0	0.0
Pharmacy	0.0	0.0	0.0	0.0
Private nurse/midwife	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0

DISCUSS:

This data show that, among modern FP users who obtain **pills** from commercial outlets, their primary source is the pharmacy (71.7% in the 2008 NDHS). At the time of the survey, “private nurse/midwife” only accounted for 0.4% provision of pills.

This means that PPMs can still get a bigger slice of the market if they become alternative distribution points (ADPs) and start conducting *Usapan* to generate demand for modern FP methods. Their advantage is that they are very accessible in communities, so users no longer have to commute to get to the pharmacy. They are also knowledgeable about methods, so they can immediately answer questions and handle side effects.

<p>Challenge #5. Increasing private sector participation in addressing the four challenges earlier mentioned, through</p> <hr/> <ul style="list-style-type: none"> • Increased service marketing activities • Improved service provision 	<p>DISCUSS:</p> <p>For various reasons, there are always people who prefer private sector service providers over public health ones. Maybe they do not want to fall in line or may prefer a more private setting, especially for FP.</p>
<p>SOLUTION: The <i>Usapan</i> Series</p> <hr/> <ol style="list-style-type: none"> 1. Facilitate more FP discussions (for challenge #1) <ul style="list-style-type: none"> • Group counseling • one-on-one counseling • Follow-up IPC 2. Address factors that contribute to unmet need (for challenge #2) 3. Combine demand generation and service provision on site, whenever feasible (for challenge #3) 	<p>The intuitive solution to the challenges mentioned above are:</p> <ol style="list-style-type: none"> 1. To provide more opportunities for FP discussion between private FP providers and MWRA's who are non-FP users. 2. During group and one-on-one discussions, address the factors that contribute to unmet need by: <ol style="list-style-type: none"> a. increasing the motivation of women to use FP b. addressing gender issues (with spouse/partner c. clarifying misconceptions and discussing health concerns 3. When conducting FP discussions, ensure that services are immediately available for those who decide to use a specific FP method.

<p>For Challenge #4 & 5, <i>Usapan</i> for enhanced private sector service marketing</p> <hr/> <ol style="list-style-type: none"> 1. <i>Usapan</i> Series as a means for PPMs to promote and market their services in their communities <ul style="list-style-type: none"> - Family planning services - MCH services – pre-natal, delivery and post-natal care, NBS, etc. in the PPMs' Philhealth accredited facility - For business enhancement 2. <i>Usapan</i> sessions as venues for PPMs to sell their FP-MCH products therefore functioning as Alternative Distribution Points <ul style="list-style-type: none"> - Contraceptives; iron, folate, multivitamins - For additional revenues 	<p>DISCUSS:</p> <p>This course, as well as other trainings, is intended to capacitate PPMs to help meet the health needs of women and men in the community. In so doing, the PPMs can increase their revenues significantly as a number of midwives have already done through <i>Usapan</i>.</p>
<p>Objectives of <i>Usapan</i></p> <hr/> <ul style="list-style-type: none"> • To assist potential FP-MCH clients to attain their vision for their respective desired family size and related quality of life by providing the venue for them to <u>freely choose</u> and <u>perform</u> specific health behaviors • To provide PPMs with a convenient, easy-to-use process and guide to respond to the health needs of potential FP-MCH clients while at the same time enhancing their businesses by marketing their services and selling their products 	<p>Show slide and read the objectives as stated.</p>

<p>What is an Usapan Session?</p> <ul style="list-style-type: none">• A form of group counseling approximating the “G-A-T and part of the H” steps in GATHER counseling• Usually between 10-15 participants• A theory-based form of FP communication with specific “rules”• A venue for immediate service provision to interested participants	<p>Show slide and explain the contents. EMPHASIZE these two points:</p> <ol style="list-style-type: none">1. The GATHER approach to counseling is the DOH-approved one-on-one FP counseling methodology. The implementation of G-A-T in a group counseling setting allows a health worker to reach more people as compared to having to talk to each person. This also shortens the one-on-one counseling process because at that point, the FP counselor only has to implement the “H” and “E” parts of GATHER. This means “Help” the potential client to make an informed choice and “Explain” to her/him the details of the FP methods or recommended MCH actions/behaviors.2. The reason for setting a maximum of 15 participants is related to Bullet 1. This helps ensure that after the group session, facilitators will still have time and energy to counsel and extend services to interested participants.3. Because <i>Usapan</i> is based on behavior change communication theories, the “rules” must be followed for this approach to be effective.
--	---

<p>Technical Features</p> <ul style="list-style-type: none"> • More conversational (Usapan), participatory and practical than a class / lecture session • A series of simple, structured participatory exercises to help guide a participant's thought process from start to end of the session • The participant is presented with adequate information about the full range of family planning methods or MCH behaviors that can respond to her/his needs; but AVOIDS information overload • Issues on gender and gender-based violence are discussed because they have an impact on quality of life, access to maternal health and family planning services, and RH choice 	<p>DISCUSS:</p> <p>“More conversational” and “structured participatory exercises” – instead of just launching into a lecture on FP-MCH, <i>Usapan</i> starts with giving the participants an opportunity to reflect on their current family situation as well as formulating a 5-year vision for their family. This approach is a key feature that makes the session more meaningful to the participant as compared to a typical health class.</p>
<p>Technical Features</p> <ul style="list-style-type: none"> • Trained family planning counselors who are present during the session, proceed to individually counsel those who have a method/service in mind • If feasible after thorough assessment, provide the method/service on-site when the client asks for it (e.g. pills, injectables, SDM, IUD insertion, pre-natal consultation, etc.). • The PPMs who conduct ^{MCH} the Usapan or their network health workers (BHWs or CHTs) will follow-up for 1-on-1 counseling among participants who cannot make a decision at the time of the Usapan or for new acceptors 	<p>Show slide and discuss the contents.</p> <p>EMPHASIZE that the following sequence of events should ideally occur on the same day: (1) group counseling session → (2) one-on-one counseling → (3) service provision, <u>as feasible</u>.</p>

<p>Usapan Types for Specific Segments</p> <ul style="list-style-type: none"> • Usapang Pwede Pa (UPP) • Usapang Kuntento Na (UKN) <i>(Usapang Pwede Pa & Kuntento Na Combo)</i> • Usapang Buntis (UB) • Usapang Bagong Maginoo (UBM) 	<p>Show the slide.</p> <p>SAY: Since this is just an introductory session, we will just briefly discuss each <i>Usapan</i> type. There will be more detailed discussions of each <i>Usapan</i> type in succeeding sessions.</p> <p>EMPHASIZE this: Though BCC theory and practice dictate that each <i>Usapan</i> type is ideal for specific groups of women and men, NO ONE is prohibited from attending an <i>Usapan</i> session.</p> <p>For example, older menopausal women have attended <i>Usapan</i> sessions so that they can relay the information to their daughter or daughter-in-law. This may be allowed so that the facilitators cannot be accused of discrimination.</p> <p>Proceed to the next slide.</p>
<p>1.) Usapang Pwede Pa (Promoting Spacing Methods)</p> <p>Market segment / participant groups:</p> <ul style="list-style-type: none"> – Men/women who still want to have children but not in the immediate future) – Not a current FP user – Married or living-in; in a relationship 	<p>Show the slide and discuss the contents.</p>

<p>1.) Usapang Pwede Pa (Promoting Spacing Methods)</p> <hr/> <p>Topics</p> <ul style="list-style-type: none">• Range of FP Choices to be discussed<ul style="list-style-type: none">– LAM– Condom– Fertility awareness methods– IUD– Pills– Injectables• Gender and Gender-based Violence (Relasyong Mag-asawa) <p>Note: ICV-compliant FP Wall Chart should be displayed prominently in the venue</p>	<p>Show slide and discuss the contents.</p> <p>EMPHASIZE that ALL methods are presented, but since this is a session for women/men who still want to have children in the future, only spacing methods are discussed.</p>
<p>2.) Usapang Kuntento Na (Promoting LAPM)</p> <hr/> <p>Market segment / participant groups:</p> <ul style="list-style-type: none">• Men / women who are already contented with their family size and NO longer want to have additional children• Non FP users and current FP users	<p>Show the slide and discuss the contents.</p>

<p>2.) Usapang Kuntento Na (Promoting LAPM)</p> <hr/> <p>Topics</p> <ul style="list-style-type: none">• Range of FP Choices to be discussed<ul style="list-style-type: none">– BTL– NSV– IUD• Gender and Gender-based Violence (Relasyong Mag-asawa) <p>Note: ICV-compliant FP Wall Chart should be displayed prominently in the venue</p>	<p>Show the slide and discuss the contents.</p> <p>EMPHASIZE that ALL methods are presented, but since this is a session for women/men who NO LONGER want to have additional children (already contented with their family size), only the three long-acting/permanent methods are discussed.</p>
<p>3.) Usapang Buntis (healthy pregnancy/safe delivery)</p> <hr/> <ul style="list-style-type: none">• Market segment/participant groups:<ul style="list-style-type: none">– Confirmed pregnant women, especially those in their first trimester of pregnancy– Women who think they may be pregnant– Women who intend to get pregnant in the near future	<p>Show the slide and discuss the contents.</p> <p>SAY: This <i>Usapan</i> type is really the easiest for midwives to facilitate because the topic covers the core practice of midwifery.</p> <p>ADD: Clients of midwives also appreciate this topic because it teaches them how to ensure a healthy pregnancy and safe delivery.</p>

<p>3.) Usapang Buntis (healthy pregnancy/safe delivery)</p> <hr/> <p>Topics</p> <ul style="list-style-type: none"> • Essential behaviors to ensure a healthy pregnancy and safe delivery (Mas Ligtas Kung Handa) • Present DOH recommended 3-5 years spacing between pregnancies; • Post-partum FP methods • Gender and Gender-based Violence (Relasyong Mag-asawa) 	<p>Show the slide and discuss the contents.</p>
<p>4.) Usapang Bagong Maginoo (Male participation in FP-MCH)</p> <hr/> <ul style="list-style-type: none"> • Market segment/participant groups <ul style="list-style-type: none"> – married males and males living-in with females (common-law wife) • Topics <ul style="list-style-type: none"> – Gender and Gender-Based Violence (Relasyong Mag-asawa) – Men's role and participation in FP-MCH as: <ul style="list-style-type: none"> ✓ Client ✓ Supportive spouse/partner (essential behaviors for supporting spouse to ensure a healthy pregnancy, safe delivery and family planning) ✓ Change agent 	<p>Show slide and discuss the contents.</p> <p>EMPHASIZE: As a general rule, this <i>Usapan</i> type is best conducted by a midwife acting as resource person for the health topics, but the structured exercises are managed by a <u>male facilitator</u>.</p> <p>Nevertheless, many men are also comfortable with this session being facilitated by women. So, if there are no male facilitators, women who are comfortable with facilitating this session can do so.</p> <p>ADD: Husbands also appreciate this topic because it teaches them how to help ensure that their spouse has a healthy pregnancy and safe delivery.</p>

<p>Essentials for Conducting Usapan Sessions</p> <p>Facilitators and service providers:</p> <ul style="list-style-type: none"> • One (1) main FP-MCH resource person: Nurse or Midwife with training on FP-CBT 1; <i>must have completed this "Usapan Facilitators' Training"</i> • One (1) main facilitator for the structured exercises: <i>must have completed this "Usapan Facilitators' Training"</i> • Other Midwives to assist in providing 1-on-1 counseling and health services to interested participants 	<p>Show the slide and discuss the contents.</p>
<p>Materials for Conducting "Usapan" Sessions</p> <ol style="list-style-type: none"> 1. Job aids <ul style="list-style-type: none"> – FP tarpaulin flipchart (with matching PowerPoint) – MCH tarpaulin flipchart (with matching PowerPoint) – Standard Usapan recording form – Standard Usapan attendance sheet 2. Handout materials <ul style="list-style-type: none"> – May Plano Ako Action Cards (for the appropriate language and module) – Method-specific brochures 3. Facilitators' Activity Guides <ul style="list-style-type: none"> – mobilize, facilitate, provide, follow-up, report 	<p>Show the slide and discuss the contents.</p> <p>DO the following:</p> <ol style="list-style-type: none"> 1. Direct attention of the trainees towards the 2 tarpaulin flipcharts. (Do not open them yet) 2. Ask the trainees to take out from their kits their copy of the <i>Usapan</i> Facilitator's Activity Guide. You may give them 2-5 minutes to scan through the guide. Point out the topic divisions as indicated by the Tab Separators. 3. Show the front and back portions of the three types of Action Card. Point out the label at the back of each type of Action Card. This should match with the type of <i>Usapan</i> that they will conduct. 4. Emphasize: Facilitators should only conduct <i>Usapan</i> <u>if they are ready to provide the FP commodities or MCH services to interested participants.</u> Without these commodities and services, the session is NOT <i>Usapan</i>, but a mere health class or something else.



Thank you!

END of slides for Sub-Topic 1a

Closing slide.

1. Summarize your discussion of this topic.
2. Ask trainees if they have questions. Answer 2-3 questions, if any. If there are more unrelated questions, park them by asking the questioner to write the question on a metacard and submit it to you. **Parking means:**
 - a. Acknowledging the question and . . .
 - b. . . . saying: "We will go back to these questions as we proceed with the training."
 - c. Post the metacard with the questions on a Manila paper or easel sheet and make sure that you actually do go back to all of them at the appropriate points in training.

Sub-Topic 1a: Guidelines for Conducting Usapan Sessions

This sub-topic is intended to provide clear guidelines to the trainees when they are back to their stations and are preparing to conduct *Usapan* sessions.

Learning Objectives: The participants will learn about specific guidelines for conducting *Usapan* that will give them a higher chance of success in their activity.

TIME ALLOTMENT: 1 hour

METHODOLOGY: Lecture - discussion

ADVANCE PREPARATION OF MATERIALS:

1. PowerPoint presentation Title: **Usapan Facilitators Training.Session 01.Orientation on the Usapan Series.PPMs.pptx**
2. LCD projector and laptop (check that these are compatible and that PowerPoint display is good)

TOPIC / CONTENTS	TEACHING – LEARNING PROCESS
 <div data-bbox="191 1182 797 1522" style="border: 1px solid black; padding: 10px;"> <p>SESSION 1: Orientation on the Usapan Series</p>  <p style="text-align: center;">Sub-Topic 1b: Guidelines for Conducting Usapan Sessions</p> </div>	<p>Title Slide</p>

This is marketing communication; not a lecture session

- Do not discuss detailed mechanism of action and use of FP methods; that would be reserved for 1-on-1 counselling
- Focus on and prominently promote the positive aspects of Family Planning and modern FP methods
- Clarify health concerns and so-called "misconceptions"
- Don't promote a method /service if you can't provide it or at least help the client get it through referral
- Remember to mention services that are covered by PhilHealth

DISCUSS:

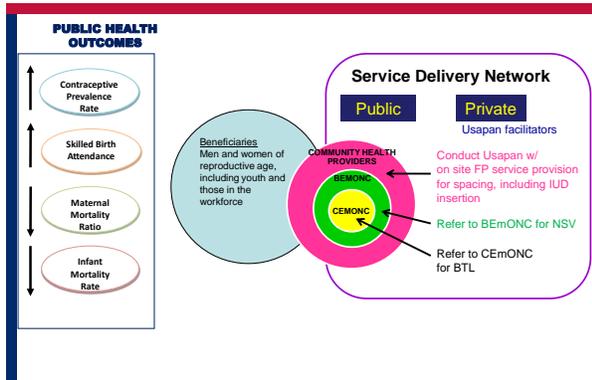
"Do not discuss detailed mechanisms of action and use of FP methods" – **emphasize that this is one of the major differences between *Usapan* and health classes.** Explain that during the group session participants cannot possibly absorb the detailed information about each of the more than 10 FP methods presented. It's simply a case of overloading the brains of the participants with so much information. **Therefore, detailed information is a waste of time** of both the speaker and the *Usapan* participants.

Discuss the other bullets in the slide and proceed to next slide.

Establish "business partnerships" with

- Volunteer health workers in your area
- NSV and BTL private sector service providers/facilities
- Cooperatives
- Workforce niches

Link-up with the MNCHN-SDN in your area



Overview

According to the **MNCHN Manual of Operations** which was released by the Department of Health in 2011, “No single facility or unit can provide the entire MNCHN Core Package of Services. It is important that different health care providers within the locality are organized into a well-coordinated MNCHN **service delivery network** to meet the varying needs of populations and ensure the continuum of care.”

This slide shows a simplified MNCHN SDN diagram that depicts how private service providers (especially midwives) can link-in as *Usapan* facilitators. The linkage corresponds to the three levels of care in the SDN:

1. Community level
2. BEmONC
3. CEmONC

Steps in organizing your Usapan session

1. Decide what variant of Usapan you will conduct and remember the correct target segment (for that variant)
2. Select and setup your venue, preferably your own clinic; You may also conduct outreach Usapan
 - If you are going to use a public facility, make sure to obtain permission first before making definite plans and preparations
3. Link up with BHWs and members of the Community Health Team in your barangay to get information on women / men who belong to your target segment and can be invited
4. Prepare the supplies and materials
5. Prepare yourself and your co-facilitators

DISCUSS this slide together with the Introduction section of the *Usapan Facilitator's Guide*.

Template for low-cost flyer to invite for Usapan



These are templates for discussion and consideration by the trainee-PPMs.

Template tarpaulin streamer



These are templates for discussion and consideration by the trainee-PPMs.

<p>Template for billboard installed in PPM's clinic</p> 	<p>These are templates for discussion and consideration by the trainee-PPMs.</p>
<p>How to invite the right participants to your Usapan session</p> <ul style="list-style-type: none"> • Link up with BHWs and members of the Community Health Team in your barangay to get information on: <ul style="list-style-type: none"> – Women with unmet need for family planning – Pregnant women • Decide what variant of Usapan you will conduct and remember the correct target segment <ul style="list-style-type: none"> – Pwede Pa: for those who are NOT current modern FP users or users of traditional FP methods – Kuntento Na: for those who are already satisfied with their current family size and want a long-acting or permanent FP method – Buntis: for pregnant women – Bagong Maginoo: males 	<p>DISCUSS:</p> <p>PPMs can request data on women with unmet need for FP from their friends who are in public health, e.g., Public Health Nurse, Rural Health Midwife, or even from the BHW/Community Health Team member. These health workers may have access to information from past surveys which then allows them to identify women who are not yet FP users but might be interested to use modern FP methods.</p> <p>Examples of these local sources of information are:</p> <ol style="list-style-type: none"> 1. Target Clients List 2. Community Health Team (CHT) survey 3. FHSIS 4. Community-based Management Information System

<p>What to do / say when inviting people for Usapan</p> <hr/> <ul style="list-style-type: none"> • Give information on the time, date, place and what to bring, if any (example: bring money in case you want services). • Consult the intended participants about the most convenient schedule that will not disrupt them from doing important personal activities • Inform the intended participants individually, if possible, at least a week before the scheduled activity. • End the interaction on a positive note, by telling the those you invite <u>how they will benefit if they attend the Usapan session</u> 	<p>Show the slide and discuss the contents.</p>
<p>1-on-1 counseling & service provision</p> <hr/> <ul style="list-style-type: none"> • Since the person is just coming off an Usapan group session, 1-on-1 counseling is shorter and only entails: <ul style="list-style-type: none"> – Explaining the details of the desired method; conducting medical eligibility assessment; asking the client if she thinks she can stand possible side-effect of a method – Providing information on signs of complications and what to do – If feasible, providing the desired method on site – If not feasible to provide the desired method on site, setting a schedule or making a referral 	<p>Show the slide and discuss the contents.</p>

<p>How to follow-up participants after your Usapan session</p> <ul style="list-style-type: none">• Text messages• Phone calls• Home visits, by<ul style="list-style-type: none">– You– Other health workers in your network	<p>Show slide and discuss the contents.</p> <p>The options are listed according to convenience. The first option is the most convenient for most, but not necessarily the most effective.</p> <p>Home visits are probably the most effective form of follow-up but PPMs might not have time for this. They can ask a friend who is a BHW or a fellow midwife to do the follow-up for them. The PPM will have to orient the BHW/fellow midwife about <i>Usapan</i>. Some midwives have established business relations with BHWs who will bring the clients and follow up from <i>Usapan</i>.</p>
<p>Post-Usapan IPC follow-up visits / discussion</p> <ol style="list-style-type: none">1. Greet and re-establish rapport (makipag-kumustahan)2. Remind the person about the Usapan session s/he attended and the purpose of the current follow-up visit or follow-up discussion3. Ask the person if s/he can give some time (about 10-15 minutes only) to discuss	<p>Show the slide and discuss the contents.</p>

<p>Post-Usapan IPC follow-up visits / discussion, <i>continued...</i></p> <hr/> <ol style="list-style-type: none"> 4. Use the Action Card that the person filled-in during the Usapan that s/he attended as take-off point for a short discussion 5. Ask if s/he had made a decision to use an FP method or MCH service <ul style="list-style-type: none"> ▪ If the person is still undecided, probing for possible barriers to action; ask how you might be of help ▪ If the person has decided to use an FP method, set a schedule for her/him to get her/his desired service 6. Summarize the discussion or agreement (if any). 7. End the visit/discussion by thanking the person for spending his/her time (with you) 	<p>Show the slide and discuss the contents.</p>
<p>Four Absolute Requirements for <i>Usapan</i></p> <hr/> <ol style="list-style-type: none"> 1. No more than 15 participants (potential FP clients and/or MCH patients) per session at any given time 2. FP-CBT level 1-trained midwives or nurses <u>must</u> be available to provide one-on-one counseling and to provide the chosen FP method at the actual session 3. All temporary FP commodities <u>must</u> be available and ready for actual use or dispensing at the <i>Usapan</i> session venue 4. The immediate forthcoming schedule of BTL and/or NSV services (within the week) at a specific referral hospital or partner <u>must</u> be arranged and finalized <u>prior</u> to conducting <i>Usapan Kuntento Na</i> 	<p>Show the slide and discuss the contents.</p> <p>EMPHASIZE: These “absolute requirements” are intended to give the PPMs higher chances of success when they conduct <i>Usapan</i>. Success of <i>Usapan</i> translates to more new and satisfied clients and, therefore, increased revenues for the PPMs.</p>



USAID | PHILIPPINES

Thank you!
END of slides for Session 1

Closing slide.

Ask the trainees if they need clarifications or have questions arising from the topic discussed.

Session 2: The Role and Attributes of an Effective Facilitator

Learning Objectives: The trainees shall:

- Be able to explain why there are no correct or incorrect ways of perceiving — everyone sees the world differently — and that our perception of others affects the way we communicate and relate to them;
- Be able to identify their attitudes, feelings, and values, and their significance in interpersonal communication, particularly their impact on discussing FP with clients;
- Understand the roles and attributes of an effective *Usapan* facilitator; and
- Explain the importance of confidentiality and ethics among *Usapan* facilitators.

Total time allotment: 1 hour

CONTENTS AND METHODOLOGY

Content	Methodology	Time Allocation
Perception and values	Structured learning exercise	20 minutes
Role of <i>Usapan</i> facilitators	Structured learning exercise Lecture-discussion	20 minutes
Attributes of effective <i>Usapan</i> facilitators; ethical considerations	Structured learning exercise Lecture-discussion	20 minutes

ADVANCE PREPARATION OF MATERIALS

- Image for the Perception Exercise
- Prepared statements for the Agree/Disagree Exercise
- Take two pieces of bond paper. In big letters, write the word “AGREE” on one paper and write the word “DISAGREE” on the other paper
- PowerPoint presentation: **Usapan Facilitators Training.Session 02.Role and Attributes of a Facilitator.PPMs.pptx**

TOPIC / CONTENTS	TEACHING – LEARNING PROCESS
 <div style="border: 1px solid red; padding: 10px;"> <p>SESSION 2:</p> <p>The Role, Attributes of an Effective Usapan Facilitator</p>  <p>Three (3) Topics in this session</p> </div>	<p>Opening slide</p>
TOPIC 1. Perception and Values	
 <div style="border: 1px solid red; padding: 10px;"> <p>Topic 1. Perception and Values</p> </div>	<p>Understanding our own perceptions, values and biases is essential to sensitive interpersonal communication. By understanding his/her own perceptions and values, the <i>Usapan</i> facilitator is better able to appreciate and respect the various experiences that shape the perceptions and values of clients.</p> <p>After each exercise, the trainer should ask for learning insights from the trainees. Sample learning insights are provided in the PowerPoint.</p>

1. For new trainers, you may use the answers provided in the PowerPoint presentation.
2. For experienced trainers, use the same exercise, but HIDE answers on the PowerPoint—use only participants' responses to draw lessons.

Share what you see...

Have a look at these pictures and say the first word that comes to your mind when you see the image.



Show PowerPoint of the Perception Exercise images. Ask if anyone has seen these images before and participated in this exercise. If anyone has, ask him/her to remain silent so that those who have not seen the exercise before can learn from it. Tell the group that you would like them to examine the pictures very closely.

1. Ask participants to describe aloud what they see.
2. EXPLAIN THAT
 - Everyone's observation is right – people see and hear things in different ways. People look at other people, other objects differently.
 - Even when we are all presented with a single stimulus, we have individual differences about which aspect of that stimulus attracts our attention.
 - This is analogous with how FP has different meanings to many people – each meaning is each person's own right to have, and is based on which aspect of FP attracts their attention.
 - We do not have to disagree with other people's perceptions because they will



Images: Points to ponder

- Understanding perception is the foundation of understanding communication and relationships
- Everyone's observation is right
- Even when we are all presented with a single stimulus, we have individual differences about which aspect of that stimulus attracts our attention
- This is analogous with how FP has different meanings to many people— each meaning is based on which aspect of FP is salient to the person

often insist on it. What we should do as facilitators is to acknowledge that IT IS THEIR perception and we respect it.

SUMMARY

1. *Usapan* facilitators need to internalize respect of clients even if their perceptions, especially about FP, are directly opposed to what health workers believe FP to be, based on their training.
2. As facilitators, we have to synthesize the perceptions of others on FP as well as what the DOH program says about FP. In this way, the *Usapan* participants will come out of the session having been enriched by the sharing.

Values and Biases

Our values are often so ingrained that we are unaware of them until we are confronted with a situation that challenges them.

	<ol style="list-style-type: none"> 1. Ask a co-facilitator to post on opposite sides of the wall in the training room the previously prepared “AGREE” and “DISAGREE” signs. 2. Ask participants to get up and stretch, but not to sit down again. Tell participants that you are going to read them a series of statements. If they agree with the statement, they should go stand under the “Agree” sign. If they disagree with the statement, they should go stand under the “Disagree” sign. Tell them that the answers are a matter of opinion rather than fact. 3. There will often be a group of people who can't decide which side they're on. You can call them the Fence Sitters or The Undecided and let them be their own group – but without a sign.
<p>There are seven (7) AGREE and DISAGREE statements in the PowerPoint.</p> <ol style="list-style-type: none"> 1. <i>Maaaring gumamit ng mga FP methods ang mga kababaihang wala pang asawa.</i> <div style="border: 1px solid blue; padding: 10px; margin-top: 10px;"> <p style="background-color: red; color: white; text-align: center; padding: 2px;">Agree ka ba o disagree?</p> <p style="text-align: center;">Maaaring gumamit ng mga family planning methods ang mga kababaihang wala pang asawa.</p> </div>	<ol style="list-style-type: none"> 1. Read the first statement and give everyone enough time to get to the side they want. 2. Ask one or two participants from each side to explain briefly why they agree or disagree with the statement. Then read the next statement. Repeat the procedure for all statements. Emphasize that there are no wrong answers for this exercise. 3. DO NOT ALLOW participants to recruit others to their side.

2. *Ang mga Katoliko ay dapat gumamit lamang ng natural family planning (NFP) methods.*

Agree ka ba o disagree?

Ang mga Katoliko ay dapat gumamit lamang ng natural family planning (NFP) methods.

3. *Dapat ibigay ng midwife sa isang babae ang FP method na gusto nito, kahit na hindi sumasang-ayon ang asawa ng naturang babae.*

Agree ka ba o disagree?

Dapat ibigay ng midwife sa isang babae ang family planning method na gusto nito, kahit na hindi sumasang-ayon ang asawa ng naturang babae.

VARIATIONS:

OPTION 1: Tell them that you don't want any discussion about whether the statements are true or false; you just want them to move to the sign that best reflects their views.

OPTION 2: Allow discussion of the question – this will take longer but some trainers have tried this.

4. **PROCESS THE EXERCISE:** Ask participants the following questions:
 - a. What have you learned from the exercise?
 - b. How can you apply what you learned in this exercise to your role as a health worker and *Usapan* facilitator?

4. *Okay lang sa isang lalaking may asawa na magkaroon ng relasyon sa iba...*

...Basta't ang lahat ng pangangailangan ng kanyang pamilya ay nasusustentuhan at hindi niya napapabayaan.

Agree ka ba o disagree?

Okay lang sa isang lalaking may asawa na magkaroon ng relasyon sa iba...

...Basta't ang lahat ng pangangailangan ng kanyang pamilya ay nasusustentuhan at hindi niya napapabayaan.

5. *Okay lang sa isang single na makipag-sex sa kanyang partner kahit hindi pa sila kasal.*

Agree ka ba o disagree?

Okay lang sa isang single na makipag-sex sa kanyang partner kahit hindi pa sila kasal.

6. *Kapag binigyan mo ng contraceptives ang isang tao, parang binigyan mo na rin siya ng lisensiya na makipag-sex sa kung kani-kanino.*

Agree ka ba o disagree?

Kapag binigyan mo ng contraceptives ang isang tao, parang binigyan mo na rin siya ng lisensiya na makipag-sex sa kung kani-kanino.

7. *Upang bumaba ang bilang ng “teenage pregnancies,” dapat ituro na ang mga contraceptive methods sa mga teenagers.*

Agree ka ba o disagree?

Upang bumaba ang bilang ng “teenage pregnancies”, dapat ituro na ang mga contraceptive methods sa mga teenagers.

Values: Points to Ponder

- Our responses to the “agree” or “disagree” exercise reflect our personal values
- Values are “culturally defined standards held by human individuals or groups about what is desirable, proper, beautiful, good or bad that serve as broad guidelines for social life”*
- Values can be influenced by religion, education, or culture, and by other personal experiences
- Values guide us in our thinking, attitudes, and behavior

Values: Points to Ponder

- Our values sometimes differ from the values of other people
- When discussing FP with others, it is important to keep these differences in mind
- Being conscious of our differences allows us to present FP in ways that are acceptable to the people we relate with

DISCUSS the “**AGREE**” and “**DISAGREE**” **EXERCISE** using the contents of the “Points to Ponder” slides

5. **CONCLUDE** the topic with summary statements:

- a. Our values can also manifest as biases when we do our work.
- b. We cannot totally disregard our biases, especially when we feel strongly about them.
- c. But we cannot impose this on people whom we are supposed to serve. We have to be cognizant of our biases and choose any of the following courses of action when at work:
 - i. Do not withhold service or information to clients who need them, especially if they ask for it.
 - ii. If you're a staff member in a lying-in clinic and you feel very strongly against providing a particular service that you ought to provide as a health worker, negotiate with the clinic manager not to assign you to perform it.

SYNTHESIS for Topics 1 and 2

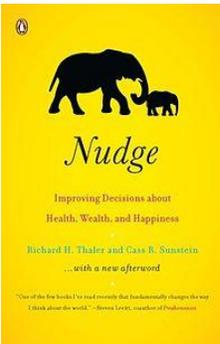
Ask participants for their insights on the Perception and Values exercises. After some responses, share the following:

- I. Everyone sees the world differently. How we perceive others affects the way we communicate and relate to them.

2. No two people have the same values and attitudes. Understanding our own values can help us better understand and respect the values of the co-worker.
3. When we only use our own values to provide information and counsel others, people either do not really hear us or they do not understand or believe us.

TOPIC 2. The Role of an *Usapan* Facilitator

Overview



In developing *Usapan*, the word, “Nudge” (as well as some concepts discussed in this training), is taken from the book *Nudge: Improving Decisions about Health, Wealth, and Happiness*, by Richard H. Thaler and Cass R. Sunstein.



USAID | PHILIPPINES
FROM THE AMERICAN PEOPLE

Topic 2. The Role of an *Usapan* Facilitator

Topic 2. Opening slide.

<p>What is the role of a Usapan facilitator?</p> <ul style="list-style-type: none"> • Write your responses on a meta-card • One idea per meta-card • Write BIG • 5-7 words only per card 	<ol style="list-style-type: none"> 1. Begin the discussion on this topic by asking the participants about their ideas on the role of a “facilitator.” Ask: “What is the role of a <i>Usapan</i> facilitator?” 2. Give out metacards for trainees to write their responses on. Let them post their metacards on your designated spot as a form of exercise/stretching. 3. Synthesize their responses into “roles,” say: “What I’m hearing from you is that a facilitator essentially performs the roles of a…” (state examples below) <ol style="list-style-type: none"> a. leader b. guide c. teacher
<p>Role of Usapan facilitators</p> <ul style="list-style-type: none"> • Sets the tone for openness among participants (establishing rapport) • Creates the environment (container) where participants’s thoughts, meanings, and aspirations are channeled to address any unmet FP needs • Serves as an enabler/guide who “NUDGES” clients from informed choice to concrete action 	<p>NOTE: Trainers should synthesize these slides with trainees’ responses through the metacards.</p> <p><u>KEY DISCUSSION POINTS:</u></p> <ol style="list-style-type: none"> 1. Sets the tone for openness – this is often achieved by the facilitator starting with a personal disclosure. For example: <p><i>Usapan</i> Facilitator: “I also feared the side effects of pills. But after having a discussion with my friend who is a midwife, my fears were gone.”</p>

2. **Creates the environment** (container)

When facilitating a group session, it is UNAVOIDABLE that participants will get distracted. The distractions can be internal (their thoughts, plans, problems, etc.) or external (noise from the outside, heat in the room, their babies or small children, etc.) To be EFFECTIVE FACILITATORS, you must create a mental environment or container that the participants can focus on or channel their thoughts to. The structured activities in *Usapan* allow you, the facilitator, to achieve this.

3. What is a **NUDGE**? Sometimes, when you are trying very hard to persuade people to accept an idea or perform a behavior, you will get a sense that they are resisting. They may do so because they get the feeling that you are “pushing” them into accepting something, even when they are not yet fully convinced that such may benefit or harm them. **A NUDGE prevents this kind of feeling among your participants. In fact, they will hardly notice that you are actually making a deliberate and conscious effort to move them in directions that will make their lives better, according to their own goals.**

But to count as a nudge, participants must be given the freedom to disagree or say NO to whatever you are presenting. For example, if participants are not given the option to say NO to FP, that is already equivalent to a push. An example of this push is when you say, “you cannot receive other benefits from us if you do not first use FP.” This kind of statement is NOT ALLOWED and is illegal.

	<p>PRACTICAL EXAMPLE OF A NUDGE: When you ride a passenger jeepney that is almost full, it is difficult to squeeze in between two other passengers. If you push hard, the passengers will resist your action and you will have a hard time staying on your small sitting space. However, if you just gently NUDGE to the left and then right, you will find that you can actually fit in comfortably. You have nudged the other passengers into giving you more space without any resistance.</p> <p>This is the practical idea behind the nudge points implemented in <i>Usapan</i>. And this is why <i>Usapan</i> is so effective.</p>
<p>Role of Usapan facilitators</p> <ul style="list-style-type: none"> • Provides medically-correct, updated FP information • Choice Architect – Guides clients to plan actions that can address their expressed needs; • Provides FP-MCH services immediately after 1-on-1 counseling, if feasible • <u>Refers</u> participants for: <ul style="list-style-type: none"> – 1-on-1 counseling and service provision (<i>if not feasible immediately after the group session</i>) 	<p>KEY DISCUSSION POINTS:</p> <p>Most of the ideas in this slide are self-explanatory, except for the term, “Choice Architect.”</p> <p>You need to discuss “Choice Architect” as follows.</p> <p>Choice Architect – has the responsibility for organizing the context in which people make decisions. When health workers give a woman 10 FP options without a clear explanation, that woman will have a hard time making a decision. However, if the health worker first determines the FP need of the client—whether she still wants to have a child or she is already satisfied with her current family size—then the options can be organized within the context of the need for “spacing” methods or “permanent” methods. This is called Choice Architecture. As an <i>Usapan</i> facilitator, you are a Choice Architect.</p>

TOPIC 3. Attributes of Effective *Usapan* Facilitators

OVERVIEW: Combining Passions and Abilities

The phrase, “Combining Passions and Abilities,” (as well as some concepts discussed in this training) is taken from *Combining Passions and Abilities: Toward Dialogic Virtuosity*¹, by W. Barnett Pearce and Kimberly A. Pearce.

In this topic, **emphasize** the importance of combining PASSION and ABILITIES.

1. **Passion** - (a) a strong liking or desire for or devotion to some activity, object, or concept; (b) intense, driving, or overmastering feeling or conviction. ([Merriam-Webster Online Dictionary](#))
 - When a worker is passionate about his/her work, s/he is willing to work hard and may even be willing to sacrifice more time and personal resources to overcome barriers to success.
 - Without passion, even a very talented person will not be very successful.
 - *Usapan* facilitators are expected to be passionate about helping others.
2. **Abilities** - the quality or state of being able; *especially*: physical, mental, or legal power to perform. ([Merriam-Webster Online Dictionary](#))
 - Even if a worker is passionate, s/he will not succeed much if s/he does not possess the necessary abilities. In fact, a passionate health worker who does not possess the necessary abilities can be dangerous to others.

SAY: in this session, we will discuss the **passion** side of the equation. **We will discuss the abilities side in another session.**

¹ Pearce, W. B. & Pearce, K. A. 2000. “Combining Passions And Abilities: Toward Dialogic Virtuosity.” *Southern Communication Journal*, 65: 161-175.



Topic 3. Attributes of Effective "Usapan" Facilitators

"Combining Passions & Abilities"

Focus question: If these are the roles (point to the outputs of clustered metacards from Topic 2) of the *Usapan* facilitator, then (next slide) "**What are the attributes (or qualities) of an effective Usapan facilitator?**"

What are the attributes of effective Usapan facilitators?

- Write your responses on a meta-card
- One idea per meta-card
- Write BIG
- 5-7 words only per card

1. Again, give out metacards for participants to write their responses on and let them post their metacards on your designated spot.
2. Ask trainees to post each metacard on the board for everyone to see.
3. Together with the trainees, cluster responses that fall under the same theme. Sum up the themes that emerged from the responses.

<p>Attributes of Effective Usapan Facilitators</p> <p>Passionate about...</p> <ul style="list-style-type: none"> • Assisting others get on their way towards defining their aspirations and addressing their needs • Guiding people; <u>Not</u> commanding them • Being Knowledgeable – Possesses up-to-date information about FP-MCH 	<p>NOTE: Trainers should synthesize these slides with trainees' responses through the metacards.</p> <p><u>KEY DISCUSSION POINTS:</u></p> <ol style="list-style-type: none"> 1. Assisting others to get on their way – This means that there are other ways that clients may wish to pursue. Realizing this, <i>Usapan</i> facilitators should WORK HARD, but NOT FEEL BAD when <i>Usapan</i> participants do not decide to use an FP method or access an MCH service. 2. Facilitators are guides. They do not give commands.
<p>Attributes of Effective Usapan Facilitators</p> <ul style="list-style-type: none"> • Respectful – Does not impose personal beliefs and opinions on the participants • Enthusiastic – loves the role • Non-judgmental - being non-critical and behaving neutrally to the content of what a person says • Tactful –Mindful not to hurt, insult nor make fun of participants' statements, reactions, views/opinions 	<p>Experienced trainers may forego the use of this slide and rely totally on the participants' responses through the metacards.</p>

Ethical Considerations

- Always provide correct information—if you don't know the answer, say so honestly.
- Do not impose; just offer options
- If you are not trained to perform a medical procedure (example: IUD insertion), refer clients to a health facility where a trained doctor, nurse, or midwife can provide the service whether that is in the private or public sector
- Be gender & culturally sensitive (words used, choices provided, discussing spousal relationship)

End the session by presenting and discussing the slide on “Ethical Considerations.”

Synthesis

Ask the Trainees:

1. “What did you learn in this session that will be important in your work as an *Usapan* facilitator?”
2. What part of ethics will be hardest for everyone to carry out?

You may end the session by asking participants to ask themselves (reflection): “Assessing ourselves, are we up to the challenge of being *Usapan* facilitators?”

Session 3: Refreshers On FP-MCH Topics Discussed in *Usapan*

NOTE: In developing this session, the assumption was that the participants in this *Usapan* Facilitator's training have undergone the course on FP-CBT I. Thus, the discussion in Session 3 is no longer expected to be in-depth. This underlying assumption is also the reason why there is no pre-test/post-test as is customary for sessions that discuss technical/medical content.

Learning Objectives: The trainees shall:

- Be exposed to the full range of FP-MCH topics that should be discussed in the four variants of the *Usapan* Series as presented in two primary job aids:
 - ✓ FP tarpaulin flipchart
 - ✓ Safe Motherhood: *Mas Ligtas Kung Handa* tarpaulin flipchart
- Be familiar with the essential health behaviors that are recommended by the Department of Health to help ensure healthy families, healthy pregnancies, and safe deliveries
- Be able to deliver dynamic presentations on FP-MCH topics to *Usapan* participants

TOTAL TIME ALLOTMENT: 4 hours and 30 minutes

CONTENTS AND METHODOLOGY

Contents	Methodology	Time Allocation
1. Definition and benefits of FP 2. Fertility Awareness and Joint Fertility 3. Modern Methods for Spacing Pregnancies 4. LA/PM 5. Handling FAQs on FP methods 6. Essential MCH Behaviors for Pregnant Women 7. Male Participation in FP-MCH	Lecture-discussion	4 hours and 30 minutes

ADVANCE PREPARATION OF MATERIALS

- Mount the 2 tarpaulin flipcharts for easy reference during this session
 - ✓ FP
 - ✓ Safe Motherhood: *Mas Ligtas Kung Handa*
- Demonstration products of FP commodities
- PowerPoint presentation: **Usapan Facilitators Training.Session 03.Refreshers on FP-MCH.PPMs.pptx**

SLIDE 1	
 <p>Session 03. Refresher on FP-MCH</p> <p>Four (4) Topics</p>	<p>TITLE SLIDE</p> <p>Present and discuss the session objectives and the flow of topics for this session (see above).</p>
SLIDE 2	
 <p>Topic 01.</p> <p>FP Topics in Usapang Pwede Pa</p>	<p><i>Usapang Pwede Pa</i> relates to a person's fertility intentions, in response to the question, "Would you still like to have another child and, if you do, can you still afford to support all your family needs and pursue your aspirations in life (<i>mga pangarap sa buhay</i>) as well?"</p> <p>There are two typical answers to this question.</p> <p>One is: "Oo, pwede pa." (Yes, we still can.) This is an indication that the person still wants to have one or more children. Unless the person indicates that she is actively trying to become pregnant, this is an opening for promoting FP spacing methods. Thus, the title "<i>Usapang Pwede Pa</i>" refers to discussions on how</p>

participants can attain their desired number of children and still have healthy outcomes through 3-5 years spacing of pregnancies using modern FP spacing methods.

The other is: "*Hindi na. Kuntento Na.*" This will be discussed later in this session.

IMPORTANT TO DO: At this point, direct the trainees' attention to the FP tarpaulin flipchart. Say that your discussion on FP will follow the flow of information as presented in the flipchart.

A co-trainer should be synchronizing the pages of the flipchart with the slides being presented by the resource speaker for this session.

SLIDE 3

Ano ang family planning?

- Pagkakaroon ng ninanais na bilang ng mga anak
- Pag-aagwat ng tama (3 hanggang 5 taon ang hustong pagitan)
- Paggamit ng mga ligtas, epektibo, at modernong pamamaraan



This is the standard DOH definition of FP.

Discuss only the contents of the slide, then go to the next slide.

SLIDE 4**Mga dulot na kabutihan ng family planning****Sa ina:**

- Pagbalik ng lakas at pagbuti ng kalusugan
- Sapat na panahon para sa pamilya- anak, asawa at sarili
- Maayos na pag-aalaga at pagpapalaki ng mga anak

Sa ama:

- Ginhawa sa kabuhayan
- Sapat na panahon para sa pamilya – anak, asawa at sarili
- Pagkakataong makapag-ipon
- Mas magaan na responsibilidad



Discuss only the contents of the slide, then go to the next slide.

SLIDE 5**Mga dulot na kabutihan ng family planning****Sa sanggol at mga anak:**

- Mas mabuting pag-aalaga
- Pagkakataong mabigyan ng edukasyon at matugunan ang iba pang pangangailangan

Sa buong pamilya:

- Ginhawa sa kabuhayan
- Sapat na panahon para sa isa't-isa
- Pagtugon sa pangangailangang pang-kalusugan, pang-edukasyon at iba pa



Discuss the contents of the slide.

CLARIFYING MISCONCEPTIONS AND/OR HEALTH CONCERNS ABOUT FAMILY PLANNING, IN GENERAL

1. At this point, begin a discussion with the trainees by asking them what health concerns about FP in general (not about FP methods) have their clients told them in their past interactions. You may ask the trainees to write these health concerns on metacards and have them posted on a wall or whiteboard.
2. Ask the trainees to share with co-trainees what they did or what they said to clarify and remove those health concerns among their clients. Note: make sure that the responses are appropriate. Tactfully discuss responses that are not so helpful without making a participant feel discouraged.
3. Get consensus among the other trainees as to how to enhance the shared “techniques” so that the whole group can use them as well in their interactions with their respective FP clients.

CONTINUATION...

SUB-TOPIC: FERTILITY AWARENESS AND JOINT FERTILITY

OVERVIEW

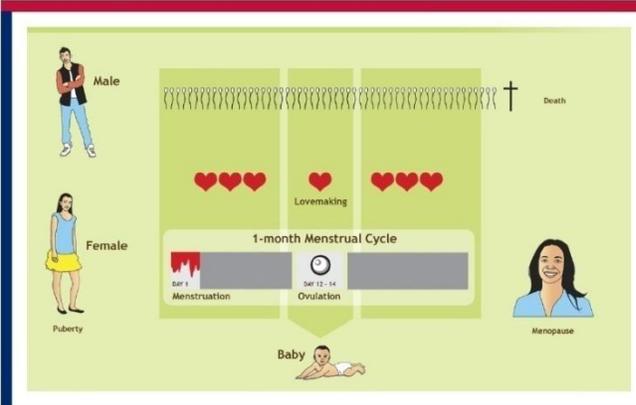
Having a child or several children is a central theme in Filipino families. Consequently, use or non-use of contraceptives or FP is closely linked to the number of children that couples already have or do not have. This is supported by data from the 2008 National Demographic and Health Survey (NDHS):

1. Twenty-two percent (22%) of women began using contraception after the birth of their first child, whereas, only 5 percent of women first used contraception before having any children.
2. Among married women respondents who were not using FP at the time of the survey, 15 percent cited “wants as many children as possible.”

Another important point – according to the 2008 NDHS – only about one in three women (35 percent) correctly identified **the fertile period in a woman’s menstrual cycle as falling halfway between two menstrual periods**. As such, it is important for Filipino men and women to have fundamentally correct knowledge and understanding of core physiological processes that lead to pregnancy.

OBJECTIVES:

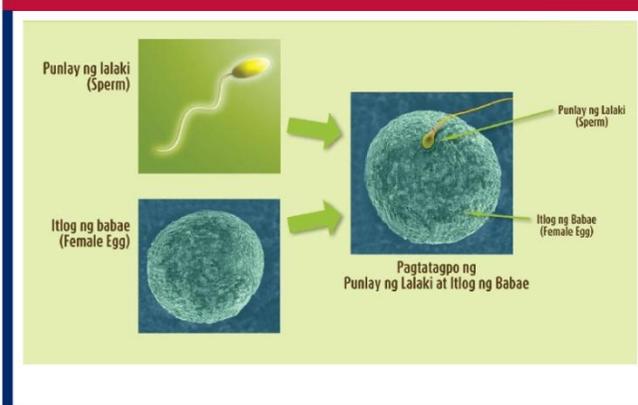
1. To provide simple and practical information on five important concepts/events related to the menstrual cycle and human reproduction (ovulation, fertile period, menstruation, fertilization, and implantation)
2. To help the participants understand (in a visual manner) how human reproduction begins with the union of the ovum and sperm (fertilization)
3. To help participants realize that without fertilization, there can be no pregnancy. Without pregnancy in the first place, there can be no abortion. FP prevents fertilization. Therefore, FP is NOT abortion.

SLIDE 6**Fertility Awareness: Joint Fertility****Discuss:**

1. Joint fertility involves the united and equal contribution of the male and female in the decision and ability to have a child.
2. Fertility in males starts during puberty (11-14) and continues on for the rest of their lives. Males who have reached puberty have the ability to make a woman pregnant at any time. At the onset of puberty, increase in the hormone testosterone causes deepening of the voice, growth of facial and body hair, growth of the penis, rapid spurts of increase in height, broadening of the chest and shoulders. Sperm production also begins. Semen (containing sperm) is the male contribution to conception.
3. In females, fertility begins at the onset of menses or *menarche* (12-16) and ends with menopause, usually between ages 45-55. Females have menstrual cycles and are fertile only for a few days in a month. During puberty, the increase in the hormone estrogen causes growth of body hair, breast enlargement and contouring of the hips. The eggs in the ovary also begin to mature and menstruation begins. The eggs plus the nurturing environment of the uterus where the fetus implants and grows to maturity are the female contribution to conception.

SLIDE 7

Pagsasanib ng itlog ng babae at punlay ng lalake

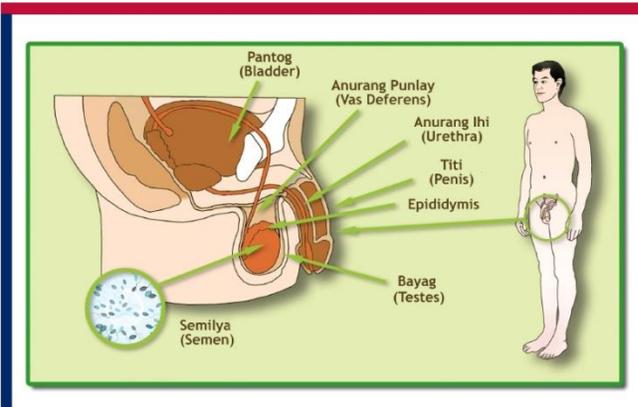


Discuss:

- 1. The fertilization process.** Fertilization occurs when there is union between a sperm cell and an egg cell. With the aid of the cervical mucus, millions of sperm swim through the uterus to the fallopian tube, but usually only one sperm needs to fertilize the egg. The fertilized egg is called the embryo.
- 2. Implantation.** After fertilization, the embryo journeys for around 6 days towards the uterus where it implants in the endometrium (or uterine lining) so that it can get its nutrients from the mother's body—soon the placenta develops that will enable the fetus to get nourishment. From here, the embryo will develop into a full-grown fetus until its birth.

SLIDE 8

Bahagi ng Reproductive System ng lalake



Discuss:

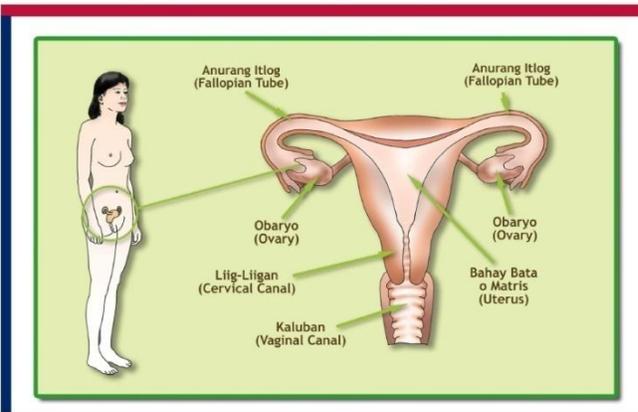
1. Parts of the male reproductive system and their role

Parts	Role
Testes	Produce sperm cells and the male hormone testosterone
Epididymis	Where the maturing sperm cells develop
Vas Deferens	Acts as the ducts for the sperm coming from the testes passing to the urethra and to the penis
Penis	Male organ for copulation, primary part of the male reproductive system

- 2. **Ejaculation.** Secretion of seminal fluid with sperm. The sperm quality and quantity are factors in being able to fertilize the female ovum.
- 3. Sperm cells from the male have a lifespan of 5 days in the fertile environment of the woman's body.

SLIDE 9

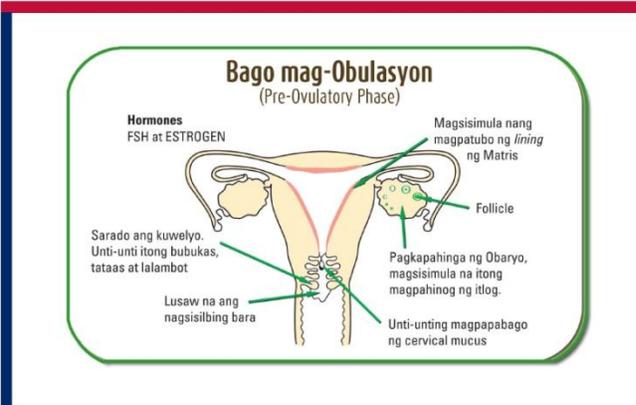
Bahagi ng Reproductive System ng babae



Discuss:

I. Parts and of the female reproductive system and their role

Parts	Role
Ovaries	Produce the eggs (ova) and the female hormones estrogen and progesterone
Fallopian Tube	Transports the ovum (egg cell) released from the ovary to inside of the uterus. If there are sperm cells in the fallopian tube during this period, the egg may be fertilized. A mature egg or "ovum" from the female lives only for one day.
Uterus	Receives the fertilized ovum. It expands as the fetus (baby) grows inside; the lining is shed as menstrual bleeding.
Cervical Canal	The passage to the uterus.

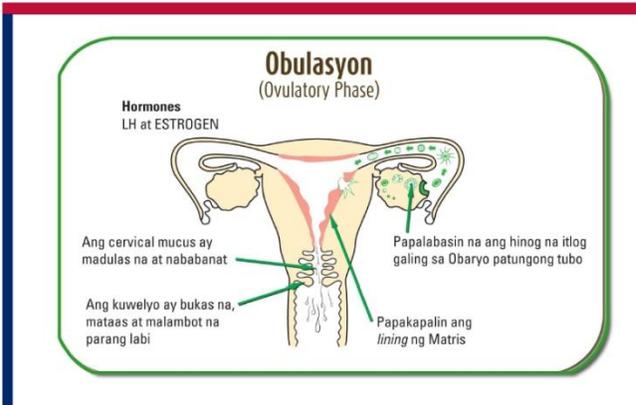
SLIDE 10**Ang siklo ng pagreregla**

Discuss:

The first menstruation is the onset for females of the capacity to become pregnant.

Before Ovulation

During each monthly menstrual cycle, the ovary releases hormones (estrogen and progesterone) that cause the thickening of the womb lining and increase the supply of blood. The thickening of the womb lining may be seen as preparation for the coming of a fertilized egg.

SLIDE 11**Ang siklo ng pagreregla**

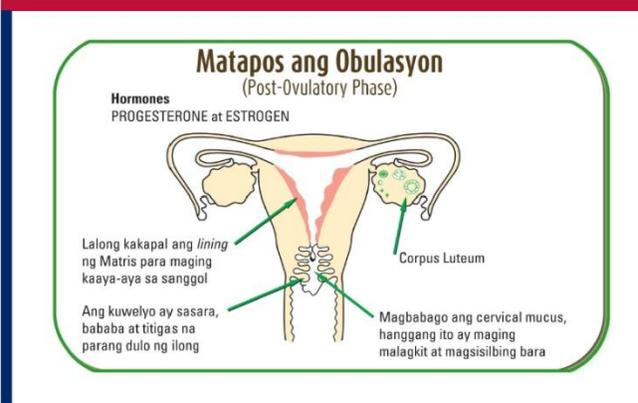
Discuss:

Ovulation

Ovulation is the release of a ripe or mature egg from an ovary into its corresponding fallopian tube. This occurs from 12-16 days after the first day of menstruation. Ovulation normally occurs only once during the 26-32 day menstrual cycle. The egg cell survives for about 24 hours in the fallopian tube.

SLIDE 12

Ang siklo ng pagrereglá



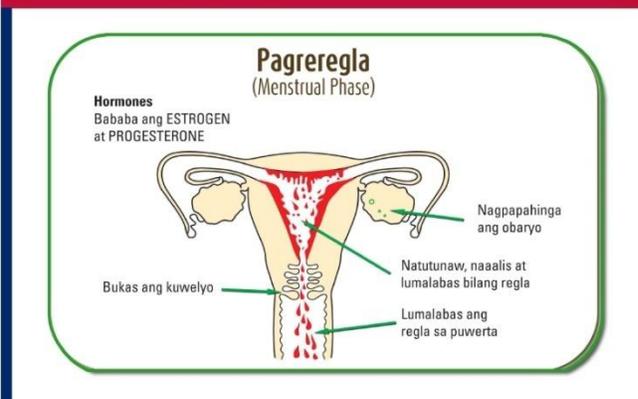
Discuss:

After Ovulation

The womb lining continues to thicken and produces nutrients in preparation for pregnancy. If the egg is not fertilized it will be dissolved and reabsorbed in the body and in about **10-16 days**, the uterine lining is shed as normal menstrual bleeding.

SLIDE 13

Ang siklo ng pagrereglá



Discuss:

Menstruation

Because there was no meeting of egg and sperm, the unused womb lining will be shed as menstrual bleeding and a new menstrual cycle will start.

The first day of menstruation is the start of the new cycle.

SLIDE 14**Modernong paraan ng family planning**

Family Planning Method	% Effectiveness	Kasama sa Benepisyo ng PhilHealth?
NSV	99.9	OO
BTL	99.5	OO
Injectables: CIC	99.9	Hindi
POI (DMPA)	99.7	Hindi
Pills : Low Dose COC	99.7	Hindi
POP	99.5	Hindi
IUD	99.4	OO
LAM	99.5	Hindi
Condom	98	Hindi
Fertility Awareness-based Methods		
• Basal Body Temperature (BBT)	99	Hindi
• Sympto-thermal Method	98	Hindi
• Billings Ovulation Method (BOM)	97	Hindi
• Standard Days Method (SDM)	95	Hindi

Discuss the 3 FP methods that are covered by PhilHealth: NSV, BTL, IUD insertion.

SLIDE 15**Mga modernong pamamaraan sa pag-aagwat ng panganganak**

DAPAT TANDAAN: Maliban sa condom ang mga pamamaraang pag-uusapan natin ay hindi magbibigay ng proteksyon sa mga sakit na nakukuha sa pagtatalik (STI, HIV at AIDS)

OBJECTIVE: To discuss briefly the spacing methods that PPMs can promote and supply to their clients

SLIDE 16**FERTILITY AWARENESS-BASED METHODS**

- Iniiwasan ang pagtatalik sa panahong "fertile" ang babae
- Epektibo kung tama at hindi pumapalya sa paggamit
- Walang pisikal na "side effects"
- Hindi kailangan ng reseta ng doktor
- Hindi magastos; walang gamot na kailangan

Discuss only the contents of the slide, and then go to next slide.

SLIDE 17**FERTILITY AWARENESS-BASED METHODS****STANDARD DAYS METHOD**

- 95% epektibo kung tama ang pagsasagawa
- Ginagamit ang "cycle beads" upang matukoy ang panahong fertile ang babae



Discuss only the contents of the slide, and then go to the next slide.

SLIDE 18**FERTILITY AWARENESS-BASED METHODS****BILLINGS OVULATION****o CERVICAL MUCUS**

- 97% epektibo kung tama ang pagsasagawa
- Binabantayan ang uri ng mucus na lumalabas sa pwerta ng babae

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
Mucus																												
Intercourse																												
Ovulation																												

Discuss only the contents of the slide, and then go to next slide.

SLIDE 19**FERTILITY AWARENESS-BASED METHODS****SYMPTO-THERMAL METHOD**

- 98% epektibo kung tama ang pagsasagawa
- Binabantayan ang:
 - ✓ Temperatura
 - ✓ Mucus
 - ✓ Pagkirot ng puso ng babae



Discuss only the contents of the slide, and then go to the next slide.

SLIDE 20**FERTILITY AWARENESS-BASED METHODS****BASAL BODY TEMPERATURE**

- 99% epektibo kung tama ang pagsasagawa
- Kinukuha ang temperatura ng babae pagkatapos ng hindi bababa sa 3 oras na tuloy-tuloy na tulog



Discuss only the contents of the slide, and then go to the next slide.

SLIDE 21**LACTATIONAL AMENORRHEA METHOD (LAM)**

- 99.5% epektibo kung wasto ang pagsasagawa
- Upang maging mabisa, dapat mayroon lahat nitong sumusunod na mga kondisyon:
 1. Tanging gatas ng ina ang ipinapasuso (ekslusibong pagpapasuso)
 2. Hindi pa muling bumabalik ang regla ng ina
 3. Wala pang anim na buwan ang sanggol



Pamamaraan upang pansamantalang pigilan ang pagbubuntis sa pamamagitan ng ekslusibong pagpapasuso sa sanggol

Discuss only the contents of the slide, and then go to the next slide.

SLIDE 22**CONDOM**

- 98% epektibo kung tama ang paggamit
- Manipis na supot na yari sa goma na isinusuot sa matigas na ari ng lalake bago magtalik
- Mabibili sa maraming botika, grocery, tindahan at private clinics (kumpanya, kumadrona o doktor)
- Proteksyon laban sa sakit na maaaring makuha sa pakikipagtalik (STI, HIV at AIDS)



Discuss only the contents of the slide, and then go to the next slide.

SLIDE 23**PILLS**

- Mabisa at ligtas na pamamaraan kung tama ang paggamit
- Pinipigilan ang obulasyon (o ang paglabas ng hinog na itlog mula sa obaryo ng babae)
- Pwedeng itigil anumang oras na gusto muling magka-anak



Discuss only the contents of the slide, and then go to the next slide.

SLIDE 24**Dalawang uri ng PILLS****Combined Oral Contraceptives (COCs)**

- 99.7 mabisa
- Iniinom ng babae araw-araw
- Hindi angkop sa nagpapasuso

**Progestin Only Pills (POPs)**

- 99.5 mabisa
- Iniinom ng babae araw-araw sa parehong oras
- Angkop sa nagpapasuso dahil hindi nababawasan ang daloy at dami ng gatas ng ina

Discuss only the contents of the slide, and then go to the next slide.

In preparing for this session (while you are still at home or in your office), think about how you will explain hormones, estrogen, and progestin in a manner that clients will understand. Note: it often helps to explain that these are the same hormones that a woman makes when she is pregnant. Therefore, the pills just make a woman's reproductive organs assume that she is already pregnant.

SUMMARIZE your discussion on pills with these important facts:

- Over **200 million** women around the world have used the pill for the past 50 years
- Up to **70 million** women around the world take the pill daily
- More than **2 million** women take the pill everyday here in the Philippines

Tell the trainees that they should remember to tell their clients the following statement: If you decide to use the pill, remember that every time you take it, **YOU ARE NOT ALONE** because millions of other women around the world and in the Philippines are also taking the pill on that day.

SLIDE 25**INJECTABLES****Combined Injectable Contraceptives**

- 99.95% mabisa at ligtas na pamamaraan kung tama ang paggamit
- Isang ineksyon lang kada buwan
- Nagiging regular ang pagdating ng regla
- Pwedeng itigil anumang oras na gusto muling magka-anak



Discuss only the contents of the slide, and then go to the next slide.

SLIDE 26**INJECTABLES****Progestin Only Injectables (DMPA)**

- 99.7% mabisa at ligtas na pamamaraan kung tama ang paggamit
- Isang ineksyon lang kada 3 buwan
- Walang epekto sa pagpapasuso at pakikipagtalik



Discuss only the contents of the slide, and then go to the next slide.

SUMMARIZE your discussion of **INJECTABLES** with these important facts:

- Injectables have been used by over 90 million women around the world; and
- Up to 363,000 women here in the Philippines are using injectable contraceptives

SLIDE 27**Pamamaraan sa pag-aagwat sa mahabang panahon****Intra-Uterine Device (IUD)****INTRODUCTORY STATEMENT:**

For women who want to space their pregnancies for up to 3-5 years, the ideal product is the IUD.

SLIDE 28**Intra-Uterine Device (IUD)****Ano ito?**

Inilalagay sa matris ng babae ang maliit at malambot na plastik



- 99.4% mabisa at ligtas na pamamaraan kung tama ang paggamit
- Hanggang 12 taon ang bisa (Copper -TCu 380A)
- Hindi maapektuhan ang dami at kalidad ng gatas ng nagpapasusong ina
- Madaling ilagay, at madali ring ipatanggal kung nais nang magbuntis

Discuss only the contents of the slide, and then go to the next slide.

Make sure you tell participants that it is not uncommon for women to think that the entire IUD package is inserted into the uterus, so it will be important for *Usapan* facilitators to emphasize and show women that only the small IUD is inserted into the uterus.

CLARIFYING MISCONCEPTIONS AND/OR HEALTH CONCERNS ABOUT FAMILY PLANNING METHODS

1. Again, initiate a discussion with the trainees by asking them what health concerns about **specific FP methods** their clients told them in their past interactions. You may ask the trainees to write these health concerns on metacards and have them posted on a wall or whiteboard.
2. Ask the trainees to share with co-trainees what they did or what they said to clarify and remove those health concerns among their clients. **Note:** make sure that the responses are appropriate. Tactfully discuss responses that are not so helpful, without making a participant feel discouraged.
3. Get consensus among the other trainees as to how to enhance the shared “techniques” so that the whole group can use them as well in their interactions with their respective FP clients.

SLIDE 29



Topic 02.

FP Topics in Usapang Kuntento Na

In Usapang Kuntento Na, only three (3) FP methods are discussed: IUD, BTL, and NSV. The IUD was already presented earlier. This section will only present BTL and NSV.

Recall the previous discussion on the question, “Would you still like to have another child and, if you do, can you still afford to support all your family’s needs and pursue your aspirations in life (*mga pangarap sa buhay*) as well?”

The two typical answers to this question are:

“*Oo, pwede pa.*” (Yes, we still can.) This was discussed earlier.

The other typical answer is: “*Hindi na. Kuntento Na.*” This response is an indication that the person is no longer considering having another child because she/he is already satisfied with the number of children that she/he has.

This is an opening for promoting the IUD, BTL and NSV. Thus, the title “*Usapang Kuntento Na*” refers to discussions on how participants can resort to the 3 LA/PM.

FP discussions in *Usapang Kuntento Na* follows the same sequence as that in *Usapang Pwede Pa*.

1. What is FP?
2. Benefits of FP
3. Fertility awareness and joint fertility
4. Parts of the female/male reproductive system
5. The menstrual cycle

For these topics, the *Usapan* facilitator will use the same slides or pages in the tarpaulin flipchart that is used in *Usapang Pwede Pa*.

In *Usapang Kuntento Na*, only three (3) FP methods are discussed: IUD, BTL, and NSV.

The IUD was already presented earlier. This section will only present BTL and NSV.

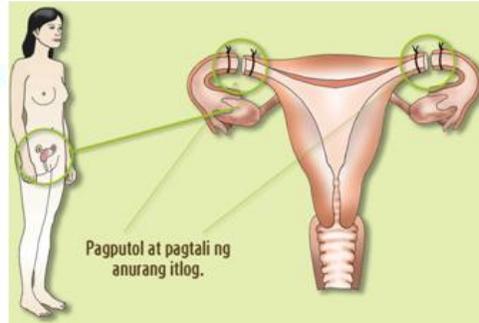
SLIDE 30

Para sa mga mag-asawa na wala nang planong madagdagan ang mga anak

- Pinaka epektibo, moderno, at permanenteng pamamaraan ng family planning
 - Bilateral Tubal Ligation (BTL)
 - No-Scalpel Vasectomy (NSV)

SLIDE 31**Bilateral Tubal Ligation (BTL)**Ano ito?

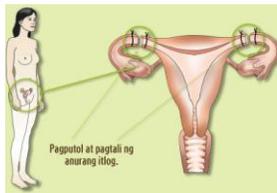
Tinatalian at pinuputol ang dalawang anurang-itlog (fallopian tubes) ng babae



Discuss only the contents of the slide, and then go to the next slide.

SLIDE 32**Bilateral Tubal Ligation (BTL)**

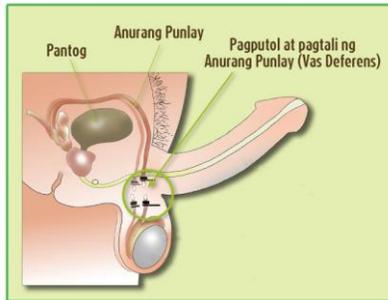
- 99.5% mabisa at ligtas na pamamaraan kung tama ang paggamit
- Permanenteng pamamaraan
- Madaling isagawa (mga 15 hanggang sa 30 minutos lamang)
- Hindi nakakaapekto sa pakikipagtalik kay mister, mas enjoy dahil nawawala ang pangambang mabuntis ng wala sa plano



Discuss only the contents of the slide, and then go to the next slide.

SLIDE 33**No-Scalpel Vasectomy (NSV)**Ano ito?

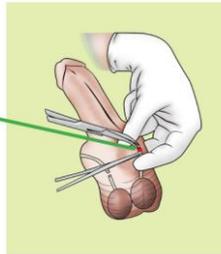
Tinatalian at pinuputol ang anurang-punlay (vas deferens) na dinadaan ng punlay (sperm) ng lalaki



Discuss only the contents of the slide, and then go to the next slide.

SLIDE 34**No-Scalpel Vasectomy (NSV)**

- 99.9% mabisa at ligtas na pamamaraan kung tama ang paggamit
- Madaling isagawa (isang maliit na butas lamang ginagawa, hindi na kailangang tahiin)
- Hindi nakakaapekto sa pakikipagtalik kay misis at sa pagkikalalaki ni mister



Discuss only the contents of the slide, and then go to the next slide.

SLIDE 35



Topic 03.

FP-MCH Topics in Usapang Buntis

MATERNAL AND CHILD HEALTH BEHAVIORS

The section presents essential behaviors to ensure a healthy pregnancy and safe delivery (*Mas Ligtas Kung Handa*). The technical contents in this section were lifted from a flipchart developed by HealthPRO/USAID and the DOH-National Center for Health Promotion.

At this point, direct the trainees' attention to the Safe Motherhood (*Mas Ligtas Kung Handa*) tarpaulin flipchart. Say that your discussion on maternal and child health will follow the flow of information as presented in the flipchart.

A co-trainer should be synchronizing the pages of the flipchart with the slides being presented by the resource speaker for this session.

SLIDE 36



Note to trainer: Remember that *Usapang Buntis* is intended to promote prenatal consultations with private practice midwives and delivery in private birthing homes.

Thus, in discussing this section, you (trainer) have to emphasize to the trainees that they should always use themselves and their clinic as their point of reference.

Examples:

CORRECT: *Magpa-prenatal check-up dito sa amin.*

WRONG: *Magpa-prenatal check-up sa clinic o RHU.*

SLIDE 37

Maging handa para mas ligtas

Para sa mas malusog na pagbubuntis at mas ligtas na panganganak:

- Magpa-prenatal check-up nang hindi bababa sa apat na beses
- Mag-birth plan
 - ✓ Pumunta agad sa ospital, kung may emergency signs
 - ✓ Manganak, sa tulong ng midwife, nars o doktor, sa health center, ospital o lying-in clinic



This slide emphasizes the importance of having **4** prenatal check-ups and having a birth and emergency plan for danger signs of pregnancy.

SLIDE 38

Magpa-prenatal nang hindi bababa sa apat na beses

Bilang ng check-up	Buwan ng pagbubuntis
Una	Mula pagtigil ng regla hanggang 3 buwan
Pangalawa	Mula 4 hanggang 6 na buwan
Pangatlo at Pang-apat	Dalawang beses mula 7 hanggang 9 na buwan

Emphasize the importance of **at least 4** prenatal visits, starting on the first trimester or the point when a woman suspects she is experiencing early signs of pregnancy, especially a missed period.

SLIDE 39

Pahalagahan ang prenatal check-up

Para masuri, malaman at malunasan ang mga kondisyon na posibleng magdulot ng panganib sa iyo o kay baby, gagawin ng midwife, nars o doktor ang mga sumusunod:



- Kukunin ang iyong health history at susuriin ang iyong katawan



- Kukunin ang iyong blood pressure (BP) at timbang



- Gagawan ka ng mga laboratory tests tulad ng pagsusuri ng dugo o ihi

Trainees should emphasize the importance of regular client's prenatal visits to their clinic.

Examples:

Instead of “*gagawin ng midwife, nars o doctor ang mga sumusunod*”

CORRECT point of reference: “**Gagawin namin ang mga sumusunod**”

Kukunin namin ang iyong:

- Health history
- Blood pressure at *timbang*

SLIDE 40

Pahalagahan ang prenatal check-up

Para mapanatiling malusog kayo ni baby, gagawin ng midwife, nars o doktor ang sumusunod:

- Bibigyan ka ng iron na may folic acid
- Babakunahan ka laban sa tetano
- Papayuhan ka tungkol sa malusog na pamumuhay, paggawa ng birth plan, pagpapasuso at pagpapalano ng pamilya pagkapanganak



Discuss only the contents of the slide, and then go to the next slide.

SLIDE 41**Gumawa kayong mag-asawa ng birth plan**

- Siguraduhing naka-enroll sa Philhealth
- Alamin ang mga pasilidad na accredited ng Philhealth
- Alamin kung saan manganganak, kailan at paano pupunta doon at kung sino ang makakasama mo
- Maghanda ng mga gamit na kakailanganin ninyo ni baby
- Magsimulang mag-ipon
- Alamin ang emergency signs, emergency contact numbers, mga dapat gawin, at kumilos agad



Emphasize the importance of planning ahead on how she will get to the facility when she is in labor (e.g., tricycle? taxi? private car? – who will drive? If by tricycle or taxi, how will she pay for the fare? How will she and her partner ensure that there is an available vehicle nearby?)

SLIDE 42**Bantayan ang emergency signs**

Pumunta agad sa ospital, kung mangyari ang alinman sa mga sumusunod na emergency signs:



- Pagdurugo sa pwerta
- Kombulsyon o pagkawala ng malay
- Matinding pananakit ng ulo na may kasamang panlalabo ng paningin
- Mataas na lagnat at panghihina
- Matinding pagsakit ng tiyan
- Mabilis o mahirap na paghinga
- Maagang pagputok ng panubigan

Discuss only the contents of the slide, and then go to the next slide.

SLIDE 43**Manatiling malusog habang buntis**

Mahalaga para sa iyo at iyong baby na manatili kang malusog habang ikaw ay buntis:

- Kumain ng sapat at masustansyang pagkain
- Uminom nang mula 8 hanggang 10 basong tubig araw-araw
- Iwasan ang kumain ng maaalat
- Mag-ehersisyo nang angkop sa buntis at maglakad-lakad
- Maging malinis sa pangangatawan at ngipin
- Huwag uminom ng alak o manigarilyo
- Huwag uminom ng gamot na hindi kumukonsulta sa midwife, nars o doktor



Discuss only the contents of the slide, and then go to the next slide.

SLIDE 44**Manganak lang sa health center, ospital o lying-in clinic**

Mas ligtas doon dahil mayroong:



- Mga dalubhasang midwife, nars o doktor na tutulong sa iyong panganganak
- Kumpleto at malinis (sterile) na mga gamit at supplies
- Wasto at agarang lunas, at referral sakaling magkaroon ng emergency
- Bakuna laban sa Hepatitis B at BCG para kay baby, na ibinibigay sa loob ng 24 oras pagkapanganak

Discuss only the contents of the slide, and then go to the next slide.

SLIDE 45**Alamin ang gagawin kapag ikaw ay manganganak****Bago manganak:**

- Pumili at sabihan ang gusto mong makasama para masuportahan ka habang nagle-labor at nanganganak
- Uminom, maglakad-lakad at maupo o tumayo sa posisyon na gusto mo habang nagle-labor

Discuss only the contents of the slide, and then go to the next slide.

SLIDE 46**Alamin ang gagawin kapag ikaw ay manganganak**

[Manood Tayo: Unang Yakap](#)

Pagkatapos manganak:

- Hilingin na ilagay agad nang padapa si baby sa iyong tiyan, balat-sa-balat (skin-to-skin), at kumutan para di ginawin
- Sa loob ng isang (1) oras pagkapanganak, hayaang kusang sumuso si baby at kusa ring tumigil
- Hilingin na laging nasa tabi mo si baby at huwag kayong paghiwalayin

Discussion points:

1. Discuss the slide contents.
2. Show the video, “*Unang Yakap.*”
3. Move to the next slide.

SLIDE 47**Gatas mo lang ang ipasuso kay baby**

- Gatas mo lang ang ipasuso kay baby mula pagkapanganak hanggang anim na buwan para siya ay maging mas malusog at matalino
- Ang eksklusibong pagpapasuso ay pagbibigay kay baby ng tanging gatas mo lamang at:
 - ✓ Walang tubig, juice o katas
 - ✓ Walang vitamins na hindi inireseta ng doktor
 - ✓ Walang gatas sa bote

Discuss only the contents of the slide, and then go to the next slide.

SLIDE 48**Gatas mo lang ang ipasuso kay baby**

Kung ikaw ay nagpapasuso, maaari ding maantala ang iyong pagbubuntis kung:

- Eksklusibo ang pagpapasuso nang anim (6) na buwan
- Ang iyong baby ay wala pang anim (6) na buwan
- Hindi pa bumabalik ang iyong regla

Discuss the slide contents, which presents the three conditions for Lactational Amenorrhea Method (LAM) to be effective.

SLIDE 49

Magpacheck-up pagkatapos manganak



- Magpacheck-up kung sa loob ng 48 oras ay makaranas ka ng emergency signs gaya ng matinding pagdurugo, lagnat, o iba pa
- Magkaroon ng check-up sa loob ng isang linggo pagkatapos manganak kahit walang kakaibang nararamdaman

TELL THE TRAINEES:

Encourage mothers to have their baby undergo **newborn screening**. (*Para malaman kung may “congenital metabolic disorder” na maaring maging sanhi ng mental retardation. Kapag maagang nakita ito ay maagapan o malulunasan kaagad.*)

SLIDE 50

Magpacheck-up pagkatapos manganak

Ito ang mga gagawin ng midwife, nars o doktor:



- Susuriin ang katawan mo at ni baby, lalo na ang kanyang pusod
- Babakunahan si baby, kung kailangan
- Bibigyan ka ng iron na may folic acid at bitamina A para sa mabilisang panunumbalik ng lakas
- Papayuhan ka tungkol sa:
 - ✓ emergency signs
 - ✓ pag-alaga ng sanggol
 - ✓ pagpapasuso
 - ✓ malusog na pamumuhay, at
 - ✓ family planning

Discuss only the contents of the slide, and then go to the next slide.

SLIDE 51**Planuhin ang pamilya, planuhin ang kinabukasan****Mag-agwat nang 3-5 taon sa pagitan ng pagbubuntis:**

- Makatutulong ito para manumbalik ang iyong lakas at kalusugan pagkapanganak
- Makatutulong din ito upang maibigay ang pangangailangan para sa tamang kalusugan, nutrisyon at edukasyon ng inyong mga anak



Discuss only the contents of the slide, and then go to the next slide.

SLIDE 52**Planuhin ang pamilya, planuhin ang kinabukasan****Mag-agwat nang 3-5 taon sa pagitan ng pagbubuntis:**

- Kausapin ang midwife, nars o doktor kung sapat na ang laki ng inyong pamilya
- May mga pansamantala't permanenteng paraan ng family planning para sa iyong pangangailangan
- Maliban sa LAM, may apat (4) pa na mga pamamaraan para sa mga babaeng bagong nanganak (post-partum)
- Ligtas, mabisa at maaasahan ang mga pamamaraang ito



Discuss only the contents of the slide, and then go to the next slide.

After the discussion on “*Planuhin ang pamilya, planuhin ang kinabukasan,*” the *Usapan* facilitator will briefly **discuss postpartum FP methods:**

1. Progestin-only Pills
2. DMPA injectable contraceptive
3. IUD
4. BTL

In discussing these postpartum FP methods, the *Usapan* facilitator will use the same slides or pages in the tarpaulin flipchart that is used in *Usapang Pwede Pa/Kuntento Na*.

SLIDE 53**Topic 04.****FP-MCH Topics in
Usapang Bagong
Maginoo**

The MCH topics in this section are exactly the same as those in *Usapang Buntis*. Only the point of reference will change, that is, the trainees will shift from saying “*Misis*” or “*Mommy*” to “*Mga Tatay, alagaan si Misis!*”

The slides reflect this change in perspective, but the flipchart is still the same as that used in *Usapang Buntis*. It is important that the trainees carefully compare and study the slides vs. the flipchart.

SLIDE 54

Alagaan si Misis at ang inyong anak na nasa kanyang sinapupunan



Discuss only the contents of the slide, and then go to the next slide.

SLIDE 55

Maging handa para mas ligtas

Para sa mas malusog na pagbubuntis at mas ligtas na panganganak ni Misis:

- Dapat magpa-prenatal check-up siya nang hindi bababa sa apat na beses
- Mag-birth plan kayo
 - ✓ Dalhin agad sa ospital kung may emergency signs si Misis
 - ✓ Dapat manganak si Misis, sa tulong ng midwife, nars o doktor, sa health center, ospital o lying-in clinic



Discuss only the contents of the slide, and then go to the next slide.

SLIDE 56

Samahan si Misis na magpa-prenatal nang hindi bababa sa apat (4) na beses



Bilang ng check-up	Buwan ng pagbubuntis
Una	Mula pagtigil ng regla hanggang 3 buwan
Pangalawa	Mula 4 hanggang 6 na buwan
Pangatlo at Pang-apat	Dalawang beses mula 7 hanggang 9 na buwan

Discuss only the contents of the slide, and then go to the next slide.

SLIDE 57

Pahalagahan ang prenatal check-up ni Misis

Para masuri, malaman at malunasan ang mga kondisyon na posibleng magdulot ng panganib sa Kanya o kay baby, gagawin ng midwife, nars o doktor ang mga sumusunod:



- Kukunin ang kanyang health history at susuriin ang kanyang katawan



- Kukunin ang kanyang blood pressure (BP) at timbang



- Gagawan siya ng mga laboratory tests tulad ng pagsusuri ng dugo o ihi

Discuss only the contents of the slide, and then go to the next slide.

SLIDE 58**Pahalagahan ang prenatal check-up ni Misis**

Para mapanatiling malusog sila ni baby, gagawin ng midwife, nars o doktor ang sumusunod:

- Bibigyan siya ng iron na may folic acid
- Babakunahan siya laban sa tetano
- Papayuhan siya tungkol sa malusog na pamumuhay, paggawa ng birth plan, pagpapasuso at pagpapalano ng pamilya pagkapanganak



Discuss only the contents of the slide, and then go to the next slide.

SLIDE 59**Gumawa kayong mag-asawa ng birth plan**

- Siguraduhing naka-enroll sa Philhealth
- Alamin ang mga pasilidad na accredited ng Philhealth
- Alamin kung saan siya manganganak, kailan, at paano pupunta doon at kung sino ang makakasama niya
- Maghanda ng mga gamit na kakailanganin nila ni baby
- Magsimulang mag-apon
- Alamin ang emergency signs, emergency contact numbers at mga dapat gawin



Discuss only the contents of the slide, and then go to the next slide.

SLIDE 60**Bantayan ang emergency signs**

Dalhin agad sa ospital si Misis, kung mangyari sa kanya ang alinman sa mga sumusunod na emergency signs:



- Pagdurugo sa pwerta
- Kombulsyon o pagkawala ng malay
- Matinding pananakit ng ulo na may kasamang panlalabo ng paningin
- Mataas na lagnat at panghihina
- Matinding pagsakit ng tiyan
- Mabilis o mahirap na paghinga
- Maagang pagputok ng panubigan

Here, tell the trainees that they should emphasize to the *Usapang Bagong Maginoo* participants to be more observant of their wives. Many times, the pregnant woman dismisses these signs and will say they just need rest. **Knowing these signs, the men can take the initiative to bring their wives to the clinic for checkup.**

Go to the next slide.

SLIDE 61**Suportahan si Misis upang manatili siyang malusog habang buntis**

Mahalaga para sa kay Misis at sa inyong baby na manatili siyang malusog habang siya ay buntis. Mga dapat gawin:

- Kumakain siya ng sapat at masustansyang pagkain
- Uminom nang mula 8 hanggang 10 basong tubig araw-araw
- Iniiwasan ang kumain ng ma-aalat
- Nag-ehersisyo nang angkop sa buntis at naglalakad-lakad
- Malinis sa pangangatawan at ngipin
- Hindi uminom ng alak o manigarilyo
- Hindi uminom ng gamot na hindi kumukonsulta sa midwife, nars o doktor



Discuss only the contents of the slide, and then go to the next slide.

SLIDE 62**Hikayating manganak lang sa health center, ospital o lying-in clinic**

Mas ligtas doon dahil mayroong:



- Mga dalubhasang midwife, nars o doktor na tutulong sa kanyang panganganak
- Kumpleto at malinis (sterile) na mga gamit at supplies
- Wasto at agarang lunas, at referral sakaling magkaroon ng emergency
- Bakuna laban sa Hepatitis B at BCG para kay baby, na ibinibigay sa kanya sa loob ng 24 oras matapos sya ipanganak

Discuss only the contents of the slide, and then go to the next slide.

SLIDE 63**Alamin ang gagawin kapag si Misis ay manganganak na**

Bago manganak si misis:



- Pumili at sabihan ang gusto mong makasama para masuportahan ka habang nagle-labor at nanganganak
- Uminom, maglakad-lakad at maupo o tumayo sa posisyon na gusto mo habang nagle-labor

Discuss only the contents of the slide, and then go to the next slide.

SLIDE 64**Alamin ang gagawin kapag si Misis ay manganganak na**

Pagkatapos niya manganak:



[Manood Tayo:
Unang Yakap](#)

- Hilingin na ilagay agad nang padapa si baby sa tiyan ni Misis, balat-sa-balat (skin-to-skin), at kumutan para di ginawin
- Sa loob ng isang (1) oras pagkapanganak, hayaang kusang sumuso si baby at kusa ring tumigil
- Hilingin na laging nasa tabi ni Misis si baby at huwag silang paghiwalayin

Discussion points:

1. Discuss the slide contents.
2. Show the video, “*Unang Yakap.*”
3. Move to the next slide.

SLIDE 65**Suportahan si Misis sa eksklusibong pagpapasuso kay Baby**

- Pinakamainam kung gatas lang ni Misis ang ipapasuso kay baby mula pagkapanganak hanggang anim na buwan para siya ay maging mas malusog at matalino
- Ang eksklusibong pagpapasuso ay pagbibigay kay baby ng tanging gatas ng ina lamang at:
 - ✓ Walang tubig, juice o katas
 - ✓ Walang vitamins na hindi inireseta ng doktor
 - ✓ Walang gatas sa bote

Discuss only the contents of the slide, and then go to the next slide.

SLIDE 66**Suportahan si Misis sa eksklusibong pagpapasuso kay Baby**

Kung si Misis ay nagpapasuso kay baby, maaari ding maantala ang kanyang pagbubuntis kung:

- Eksklusibo ang pagpapasuso nang anim (6) na buwan
- Ang inyong baby ay wala pang anim (6) na buwan
- Hindi pa bumabalik ang kanyang regla

Discuss only the contents of the slide, and then go to the next slide.

SLIDE 67**Samahan si Misis na magpacheck-up pagkatapos manganak**

- Samahan siyang magpacheck-up kung sa loob ng 48 oras ay makaranas siya ng emergency signs gaya ng matinding pagdurugo, lagnat, o iba pa
- Samahan siyang magpacheck-up sa loob ng isang linggo pagkatapos niyang manganak kahit walang kakaibang nararamdaman

Discuss only the contents of the slide, and then go to the next slide.

SLIDE 68**Samahan si Misis na magpacheck-up pagkatapos manganak**

Ito ang mga gagawin ng midwife, nars o doktor:



- Susuriin ang katawan niya at ng inyong baby, lalo na ang kanyang pusod
- Babakunahan si baby, kung kailangan
- Bibigyan si Misis ng **Iron** na may Folic Acid at **Bitamina A** para sa mabilisang panunumbalik ng kanyang lakas
- Papayuhan kayo tungkol sa:
 - ✓ emergency signs
 - ✓ pag-aalaga ng sanggol
 - ✓ pagpapasuso
 - ✓ malusog na pamumuhay, at
 - ✓ family planning

Discuss only the contents of the slide, and then go to the next slide.

SLIDE 69**Planuhin ang pamilya, planuhin ang kinabukasan**

Mag-agwat nang **3-5 taon** sa pagitan ng pagbubuntis:

- Makatutulong ito para manumbalik ang lakas ni Misis pagkapanganak
- Makatutulong din ito upang maibigay ang pangangailangan para sa tamang kalusugan, nutrisyon at edukasyon ng inyong mga anak



Discuss only the contents of the slide, and then go to the next slide.

SLIDE 70**Planuhin ang pamilya, planuhin ang kinabukasan****Mag-agwat nang 3-5 taon sa pagitan ng pagbubuntis:**

- Kausapin ang midwife, nars o doktor kung sapat na ang laki ng inyong pamilya
- May mga pansamantala't permanenteng paraan ng family planning para sa iyong pangangailangan
- Ligtas, mabisa at maaasahan ang mga paraang ito



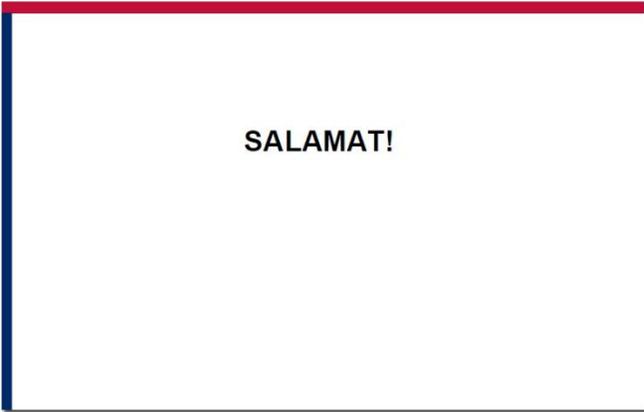
Discuss only the contents of the slide, and then go to the next slide.

After the discussion on “*Planuhin ang pamilya, planuhin and kinabukasan*,” the *Usapan* facilitator will present the FP methods through the slide in the left column or through the FP Wall Chart. This is just a cursory presentation.

The facilitator will then say something like, “These are the full range of modern FP methods that are available for both men and women. But since you are all men, we will **FOCUS** on the two male-specific FP methods:

1. Condoms
2. NSV

In discussing these male-specific FP methods, the *Usapan* facilitator will use the same slides or pages in the tarpaulin flipchart that are used in *Usapang Pwede Pa/Kuntento Na*.



SALAMAT!

The preceding discussions complete the refresher on FP-MCH topics that are going to be discussed during *Usapan* sessions.

Ask trainees if they have questions. Answer the questions.

At this point, the trainees need to familiarize themselves with using the 2 flipcharts. This is a good time to distribute those materials to the trainees and ask one to open flipcharts and become familiar with the layout and contents.

Session 4: Basic Skills and Techniques in Facilitating *Usapan*

This session focuses on the most important skills that are needed for facilitating *Usapan*.

Learning Objectives: The participants shall be able to

- Describe and demonstrate the skills and techniques that are necessary for successful facilitation of an *Usapan* session.
- Perform competently the prescribed sequence of steps in the structured flow of *Usapan*.

CONTENTS AND METHODOLOGY

Content	Methodology
Overview: Combining Passions and Abilities*	Lecturette/discussion
1. Establishing rapport	Demonstration (by the trainer) Discussion
2. Managing structured <i>Usapan</i> exercises	Lecture-discussion Demonstration (by the trainer) Practice session (in sub-groups)
3. Presenting /discussing health information	Lecturette/discussion Demonstration (by the trainer)
4. Generating discussion and maintaining group interest	Plenary Practice
5. Balancing the discussion during <i>Usapan</i>	
6. Doing a recap/synthesis	Lecturette/discussion Demonstration (by the trainer)
7. Closing the deal and negotiating behavioral commitment	Lecturette/discussion Demonstration (by the trainer)

TIME ALLOTMENT: Total of 4 hours and 30 minutes

ADVANCE PREPARATION VENUE AND MATERIALS

1. Aside from the main training venue, there should be pre-identified breakout areas where trainees can practice with minimum distractions from the other trainees.
2. PowerPoint presentation file name: **Usapan Facilitators Training.Session 04.Basic Skills for Usapan Facilitators.PPMs.pptx**
3. LCD projector and laptop (check that these are compatible and that PowerPoint display is good)
4. Tarpaulin flipcharts (FP version and MCH version)

Other Supplies

1 copy each of the 3 types of Visioning/Action Card (*Usapang Pwede Pa/Kuntento Na, Usapang Buntis, Usapang Bagong Maginoo*)

- Ballpens or pencils
- Metacards
- Masking tape
- Pentel pens
- Board or wall to post the metacards on

OVERVIEW

Being a good *Usapan* facilitator is beneficial in two ways. From the standpoint of the facilitator, the application of the relevant facilitation skills will result in a highly successful and fruitful session which would then contribute to increasing the number of your clients as well as helping more people to realize their fertility goals. On the other hand, the *Usapan* participants will leave the session feeling satisfied because their FP-MCH needs have been addressed. Therefore, the trainees should be encouraged to internalize and practice these skills to become effective facilitators.

In this session, the *Usapan* Trainer will present and discuss the basic facilitating skills in the context of their application in the various steps of conducting an *Usapan* session, as shown below. Notice, in the table below, that the discussion of the relevant skills is parallel to the sequence of activities in an *Usapan* session.

Basic Skills in Facilitating <i>Usapan</i>	Steps in the <i>Usapan</i> Session where the Facilitating Skills need to be Applied
1. Establishing rapport	<i>Magkakilanlan tayo</i> (Let us get to know each other)
2. Managing structured <i>Usapan</i> exercises	Steps 1 to 5 (Standard in all <i>Usapan</i>) <ol style="list-style-type: none"> 1. Structured exercise to establish the family “baseline” 2. Structured exercise to formulate a vision for the family (moving forward from the baseline) 3. Brief individual reflection 4. Structured exercise to visualize the family size 5 years hence, in relation to the participant’s vision for the family 5. Structured exercise to formulate steps (action plan)
3. Presenting/discussing health information	<ol style="list-style-type: none"> 1. <i>Usapang Pwede Pa</i> <ol style="list-style-type: none"> a. Fertility Awareness/Joint Fertility
4. Generating discussion and maintaining group interest	<ol style="list-style-type: none"> a. FP Presentation/Discussion: Spacing Methods c. Clarifying method-specific health concerns and fear of side-effects
5. Balancing the discussion during <i>Usapan</i>	<ol style="list-style-type: none"> d. Discussion of GBV: <i>Relasyong Mag-asawa</i> e. Testimony of satisfied FP users (current user of pills, injectables or IUD or NSV/BTL client) 2. <i>Usapang Kuntento Na</i> <ol style="list-style-type: none"> a. Fertility Awareness / Joint Fertility b. FP Presentation/ Discussion: LA/PM c. Clarifying method-specific health concerns and fear of side-effects d. Discussion on Gender and GBV: <i>Relasyong Mag-asawa</i> e. Testimony of satisfied FP users (current users)

Basic Skills in Facilitating <i>Usapan</i>	Steps in the <i>Usapan</i> Session where the Facilitating Skills need to be Applied
	<p>3. <i>Usapang Buntis</i></p> <ol style="list-style-type: none"> a. Discussion on essential behaviors for ensuring healthy pregnancy, safe delivery and FP b. Discussion of Gender and GBV: <i>Relasyong Mag-asawa</i> c. Testimony of satisfied mother <p>4. <i>Usapang Bagong Maginoo</i></p> <ol style="list-style-type: none"> a. Discussion of Gender and Gender-Based Violence: <i>Relasyong Mag-asawa</i> b. Discussion of men's role and participation in FP-MCH as: <ul style="list-style-type: none"> • Client • Supportive spouse/partner (essential behaviors for ensuring healthy pregnancy, safe delivery and FP) • Responsible father c. Testimony of satisfied <i>bagong maginoo</i>
6. Doing a recap/synthesis	Recap/summary of what had transpired so far in the <i>Usapan</i> session
7. Closing the deal/negotiating for behavioral commitment	<p>Presentation of the options for the participants to choose from (structured exercise to select a method/service using the back of the Action Card)</p> <ol style="list-style-type: none"> 1. <i>Usapang Pwede Pa/Kuntento Na</i> Kung ikaw ang papipiliin, anong pamamaraan ang iyong gagamitin? (If you were asked to choose, what method would you use?) 2. <i>Usapang Buntis</i> Ano ang mga hakbang na gagawin mo, Misis? (What steps would you take, Misis?)

Basic Skills in Facilitating <i>Usapan</i>	Steps in the <i>Usapan</i> Session where the Facilitating Skills need to be Applied
	<p>3. <i>Usapang Bagong Maginoo</i></p> <p>Ano ang mga hakbang na gagawin mo, Mister? (<i>What steps would you take, Mister?</i>)</p> <p>After the participants have indicated their intended actions on their respective Action Cards:</p> <p><i>Usapang Pwede Pa/Kuntento Na</i></p> <p>Presentation of FP clients' rights (What to expect when you consult a health provider about FP-MCH?)</p> <p><i>Usapang Buntis</i></p> <p>Note: The <i>Buntis</i> has a different ending.</p> <p><i>Usapang Bagong Maginoo</i></p> <p>Note: <i>Bagong Maginoo</i> has a different ending.</p> <p>Ending the session and obtaining commitment to action from participants.</p>

TOPIC / CONTENTS	TEACHING – LEARNING PROCESS
 <div style="border: 1px solid red; padding: 10px; margin-top: 10px;"> <h2 style="margin: 0;">Basic Skills in Facilitating Usapan</h2> <div style="display: flex; justify-content: space-around; align-items: center; margin-top: 20px;"> <div style="text-align: center;"> <p>Combining Passions & Abilities</p> </div>  </div> </div>	<p>Title Slide</p> <p>The phrase, “Combining Passions and Abilities” (as well as some concepts discussed in this training) is taken from Combining Passions and Abilities: Toward Dialogic Virtuosity, by W. Barnett Pearce and Kimberly A. Pearce.</p> <p>Citation: Pearce, W. B. & Pearce, K. A. 2000. “Combining passions and Abilities: Toward Dialogic Virtuosity. <i>Southern Communication Journal</i>. 65: 161-175</p>
<p style="text-align: center;">“Transformative Communication & Virtuosity”</p> <div style="border: 1px solid red; padding: 10px; margin-top: 10px;"> <ul style="list-style-type: none"> • "Virtuoso: A person who excels in the technique of doing something, especially singing or playing music" - <i>Oxford American Dictionary (1980)</i> • "Virtuosity" is what results when people follow their passions to know something well and to perform skillfully </div>	<p>TOTAL TIME ALLOCATION: 30 Minutes</p> <p>10 minutes (for overview and intro)</p> <p>Overview</p> <p>In Topic 3 of Session 2, we introduced the concept of “Combining Passions and Abilities” and discussed the importance of being passionate about one’s work as a key to success.</p> <p>In this session we will discuss the <u>“abilities”</u> side of the equation, i.e., “Combining Passions and Abilities.”</p> <p>Ability - a: the quality or state of being able; especially: physical, mental, or legal power to perform. (Merriam-Webster Online Dictionary)</p>

In the context of the *Usapan* facilitator's training, "abilities" refer to the application of the relevant facilitation skills while conducting the *Usapan* session.

IMPORTANT: At this point, *Usapan* trainers need to deliver a "motivational talk" to the trainees so that they are primed to be more receptive to the succeeding exercises.

INTRODUCTION:

ASK a participant: "Who is your favorite singer or musician?" Follow-up question: "What qualities of this singer or musician do you like?" (e.g., great voice, sings with feelings, excellent guitar player, etc.)

SAY something like: I am pretty sure that your favorite singer/musician reached this level of success and popularity because she/he has achieved a level of "virtuosity." She/he combined his/her passion and talent to be able to sing or play a musical instrument at a high level of quality. But I am also sure that your favorite singer/musician did not achieve success overnight. It is very likely that she/he spent COUNTLESS hours of practice and actual live performances to be able to reach this level of virtuosity, where WE ARE EVEN WILLING TO **BUY** A MUSIC CD or A CONCERT TICKET so that we can hear this singer/musician perform live.

EMPHASIZE: Well, our vision is for you to become virtuoso *Usapan* Facilitators. **We envision you becoming very good facilitators so that your clients love to listen to you and they actively participate in the structured exercises during *Usapan* sessions.** Isn't that exciting?

Structured Flow of Usapan: 12 NUDGE Points

1. Structured exercise to establish the family “baseline”
2. Structured exercise to formulate a vision for the family (moving forward from the baseline)
3. Brief individual reflection
4. Structured exercise to visualize the family size 5 years hence, in relation to the participant’s vision for the family
5. Structured exercise to formulate steps (action plan)
6. BRANCH POINT for the specific Usapan Modules (*each will run through separate Steps 7 to 10*)
 - ✓ Usapang Pwede Pa
 - ✓ Usapang Kuntento Na
 - ✓ Usapang Buntis Na
 - ✓ Usapang Bagong Maginoo

LOOP BACK 

11. Briefly present Clients Rights (base on Rights of FP Clients) for Pwede Pa and Kuntento Na
12. Ending the Session and obtaining behavioral commitment from participants

20 minutes to discuss structured flow

To the left are the steps in conducting *Usapan*. At this point, you will briefly discuss the structured flow by using the Facilitator’s Guide as reference. Ask the participants to take out their facilitator’s guide and go to the Section, **“Introduction to the Usapan Series Facilitator’s Guide.”**

With the participants using their copies of the facilitator’s guide as reference, walk through the structured flow of *Usapan* (Steps 1 to 12).

Allow participants to ask questions and respond as appropriate.

Basic Skills vis-à-vis 12 Nudge Points

Seven (7) Basic Skills in Facilitating Usapan	Steps in the Usapan Session where the Skill needs to be Applied
1. Establishing rapport	“Getting to know you” (<i>Magkakilanlan Tayo</i>)
2. Managing structured Usapan exercises	STEPS 1 to 5 (<i>using the Action Card</i>)
3. Presenting / discussing health information	STEPS 6 to 10 <i>(using the tarpaulin flipchart or PowerPoint)</i>
4. Generating discussion and maintaining group interest	
5. Balancing the discussion during Usapan	
6. Doing a recap/synthesis	STEPS 11 – 12 (<i>Back of Action Card</i>)
7. Closing the deal / negotiating for behavioral commitment	

SAY: Here are the skills that will help you get to the level of being virtuoso *Usapan* facilitators. We will discuss each one in the succeeding slides.

1. Establishing Rapport

- Be friendly, warm, cheerful
- Prepare a very short “Getting-to-know you” game or Icebreaker
- Master some energizers

TIME ALLOCATION: 20 minutes

SAY: Because you have been invited to attend this *Usapan* facilitator’s training, we assume that you already possess the skill of “establishing rapport.” In *Tagalog*, this is “*pakikipagpalagayang-loob*.” But let me share with you my favorite way of doing it:

1. Tell trainees your most effective way of doing it.
2. Then, ask 2-3 participants how they usually establish rapport.
3. Ask for additional inputs from other participants.

NOTES:

Many facilitators interchangeably use the terms “icebreakers” and “energizers” but they are not exactly the same. The difference is in their function.

- Icebreakers are used at the start of an activity to establish rapport among participants and between participants and facilitators.
- Energizers are typically used in the middle of an activity as the participants tend to get distracted by other thoughts and concerns, get bored, or are simply sleepy.

For non-*Tagalog* trainees, you may ask: Do you have your own term for “establishing rapport” or “*pakikipagpalagayang-loob*”?

Tone of Voice

How we say something is almost as important as what we say. Our tone of voice can be used to project feelings and thoughts that can be picked up by the persons we are talking to in either a negative or positive way.

Throughout the session, *Usapan* facilitators should be conscious about their tone of voice: use a friendly, natural tone of voice to build rapport or establish a comfortable environment for the participants to speak and share their thoughts.

Sample: Establishing Rapport “Getting-to-know you” game

Kaloka-like

- Sabihin ang iyong pangalan at kung sino ang artista na kamukha mo.
- Sabihin sa grupo kung bakit siya ang iyong napili.

SAY: In *Usapan*, we have included an example of an Icebreaker that facilitates establishing rapport between facilitators and participants as well as among participants.

DEMONSTRATE how to facilitate the exercise by starting with yourself. Try to make a funny comparison with an actor/actress. Then ask 2-3 participants to do the same.

SAY: This is just an example. You may replace this with your own favorite and effective Icebreaker. **As we proceed to the training, we will ASK TRAINEES to demonstrate his/her favorite and effective Icebreaker for the benefit of the group.**

2. Managing the structured Usapan exercises

- Follow the prescribed sequence from Step 1 to 12 Do not re-arrange the sequence
 - *Internalize (memorize and understand the flow of activities)*
 - *practice, practice, practice!*
- Always do linking from step-to-step, so that participants can follow the train of thought
 - *Linking guides participants' thought process from the previous topic to the next*

TIME ALLOCATION: 1 hour (including familiarization and practice session)

INTRODUCTION: *Usapan* is based on practical application of theories and concepts of Behavior Change Communication. These concepts are implemented through the structured exercises and other activities which we refer to as nudge points.

In the *Usapan* Facilitator's Guide, we also make the analogy of these exercises as being **Stepping Stones**.

They are all designed to produce an effect in the minds of the participants. These desired effects are described in the *Usapan* Facilitator's Guide. Imagine that you are guiding a person from Point A to Point B by providing stones along the way so that the participant can step on them and move forward. Without these stepping stones, it would be difficult for them to move forward. Therefore, it is important that each structured exercise be performed the right way and in the right sequence so that it produces the desired effect. Do not skip, do not rush, and do not prompt the participants for their responses.

Structured Flow of Usapan: Steps 1 - 5

1. Structured exercise to establish the family "baseline"
2. Structured exercise to formulate a vision for the family (moving forward from the baseline)
3. Brief individual reflection
4. Structured exercise to visualize the family size 5 years hence, in relation to the participant's vision for the family
5. Structured exercise to formulate steps (action plan)

SAY: Here is the structured flow of *Usapan*, from Steps 1 to 5. We will now walk you through each step and allow you to practice the necessary skills to effectively facilitate this part of the *Usapan* session.

ASK participants to take out their copy of the *Usapan* Facilitator's Guide and open the module for ***Usapang Pwede Pa***.

With the trainees occasionally referencing/ looking at their guide and a copy of an Action Card, discuss Steps 1 to 5.

EMPHASIZE each step to the related section of the Action Card.



DEMONSTRATE Steps 1 to 5, using only the job aid version of the front side of the *Usapan* Action Card.

TO THE TRAINER: It is important that you demonstrate this part with confidence and great competence. There should be no mistakes and unnecessary comments, as the trainees might think that what you are saying is also part of what they have to say during the actual *Usapan*. **PRACTICE! PRACTICE! PRACTICE!** Until you can do this part from memory. As they say, you should be able to “perform this even with your eyes closed.”

DEMONSTRATION STEPS:

1. Introduce the Action Card and show which one is the front side and which is the back side.

2. SAY: For this demonstration, the Action Card has numbers indicating the steps and the corresponding part in the card. The actual *Usapan* Action Cards do not have these numbers. *(Ask trainees to take out and inspect their copies of the real action cards)*
3. Perform the demonstration. You, the trainer, should **demonstrate “linking” from one structured exercise to the next.**
4. Emphasize that facilitators should **speak slowly and clearly** to ensure that *Usapan* participants understand what they are being asked to do.
5. Ask trainees if they have questions or clarifications. Answer the relevant questions put forward.

PRACTICE SESSION:
Usapan Steps 1 to 5

SAY: After my demonstration, it is now time for you to practice facilitating Steps 1 to 5.

Divide the trainees into smaller groups of five members each. Before you allow them to move to their sub-groupings and breakout areas, give out the instructions first and make sure the trainees understand what they are expected to do.

INSTRUCTIONS:

1. Each sub-group will select a discussion facilitator.
2. The selected group facilitator will manage the role-play practice and ensuing discussions.

3. Each group will conduct a round-robin exercise where each trainee facilitates Steps 1 to 5 and the others will act as Usapan participants.
4. Trainees should just **SKIP the establishing rapport step.**
5. For this practice session, the trainees may (at their option) use the Job Aid version of the Action Card. **BUT It would be best if they can already use their copy of a real Action Card.**
6. For every round, there will be a designated observer who will note down the following:
 - a. Name of acting facilitator
 - b. What she/he did well?
 - c. What steps she/he omitted?
 - d. What needs improvement?
7. The designated observer will hand his/her notes to the trainee that she/he observed.
8. The group proceeds with each member until the round robin is completed.
9. Once the round-robin is completed, the selected group facilitator asks for sharing among the group members about the following (allot **10 minutes** to do this):
 - a. What step(s) were easy to perform?
 - b. What step was the most difficult to perform?

TO TRAINERS:

1. This is a full-return demonstration by the trainees (complete with the metacards, pentel pens and action cards). You have to insist that trainees perform Steps 1 to 5 as if they're already facilitating a real *Usapan*.
2. While trainees are role playing, the training team should go around to each group and see how they are doing. Make sure that the note taker is writing down helpful, rather than critical information.
3. **RECONVENE THE TRAINEES** once they've completed their round-robin and discussion.
4. Ask the trainees how they felt about Steps 1 to 5, both as facilitator and as *Usapan* participant. Ask for a volunteer to write the group's responses on a flipchart and add any from the trainer's notes if the group has not mentioned it.

CONCLUDE BY EMPHASIZING to the trainees that Steps 1 to 5 are very important because they prime the *Usapan* participants:

1. To really think about their vision for themselves and their families;
 2. Plan their course of action to attain their vision;
 3. **THEREFORE, *Usapan* facilitators need to PRACTICE! PRACTICE! PRACTICE!** in order to master facilitating these steps.
-

3. Presenting / discussing health information

- Whether using the standard PowerPoint or tarpaulin flipcharts, stick to the discussion points (to ensure you do not take too much time)
- Share or present FP methods / MCH services as if you're presenting a product:
 - *Highlight the main benefits of the method*
 - *Do not lecture so much on the technical aspects*
 - *Use terminology that the participants will understand; avoid using jargon*
- Use demonstration products/commodities (*so that your participants know exactly what you are talking about*)

TOTAL TIME ALLOCATION: 2 hours

Ask the trainees, “What makes an effective and dynamic presentation of health information?”

Solicit 2-3 responses and use these as your link to discuss the contents of this slide.

Discuss the bullet points in the slide (see copy of the slide to the left).

At this point, you can distribute the tarpaulin flipcharts to the trainees. Tell them to be familiar with the contents of the pages in the FP and Safe Motherhood flipcharts.

EMPHASIZE that during the session, the *Usapan* facilitators should strive to focus the discussion on the contents of the flipchart. **This doesn't mean that they will just read the contents—they can use their own words or translate the meaning to the local language.**

DEMONSTRATE presenting information on pills and injectables. Use the standard PowerPoint or the tarpaulin flipchart as reference, and provide sample pills and injectables.

<p>4. Generating discussion and maintaining group interest</p> <hr/> <ul style="list-style-type: none"> • Keep your discussion anchored to the issues that are salient in the minds of participants <ul style="list-style-type: none"> – <i>Relate to their vision / aspirations for their family</i> – <i>Thoroughly discuss/ assuage fear of side-effects & clarify health concerns</i> • Talk about how your participants will benefit if they perform the recommended FP-MCH behaviors • Talk to one person at any given moment; don't talk to the wall, ceiling, or floor 	<p>Discuss the bullet points in the slide (see copy of the slide to the left).</p> <p>TELL the trainees: You will be able to maintain group interest if you add pizzazz to your delivery:</p> <ol style="list-style-type: none"> 1. Demonstrate enthusiasm and energy 2. Modulate vocal delivery to build up the excitement 3. Vary the speed at which you speak and by raising and lowering your voice at the appropriate times 4. Pause after stating a key point to allow participants to digest the information <p>Pizzazz – the quality of being exciting, having an energetic style of delivery. Opposite of boring.</p>
<p>5. Balancing the discussion during Usapan</p> <hr/> <p>Be conscious of and watchful for:</p> <ul style="list-style-type: none"> • Time constraints <ul style="list-style-type: none"> – <i>Some participants still have to cook, or have to fetch their kids at school, etc.</i> • Level of detail <ul style="list-style-type: none"> – <i>is the discussion heading into too much detail that cannot be settled during the session?</i> – <i>as a general rule, respond to 3 questions per FP method</i> • Control the level of participation among participants <ul style="list-style-type: none"> – <i>Don't let a few participants dominate the Usapan</i> – <i>Encourage some participants who seem withdrawn / quiet to share their insights or thoughts without embarrassing them</i> 	<p>Discuss the bullet points in the slide (see copy of the slide to the left).</p>

PRACTICE SESSION:
**Using the standard tarpaulin
flipcharts (FP and Safe Motherhood)
in providing FP-MCH information**

For facilitating this part, use the Trainers' Worksheet: Topic Assignments for Basic Skills Practice Session on Sharing FP-MCH Information. **See next page for easy reference.** The worksheet is intended to make it easy for trainers to assign topics to individual trainees. Trainers can just randomly assign trainees to the clusters of topics by writing their names on the spaces allocated in the worksheet.

The trainees will use the tarpaulin flipcharts to practice presenting FP-MCH information in plenary. This practice session is also a good way for them to be familiar with these flipcharts which are the primary *Usapan* job aids.

If there are more than 12 trainees, just cycle back to the top of the list of topics and assign another trainee to the same cluster of topics.

This exercise should take about 5 minutes per trainee to **deliver in plenary**.

Trainers don't have to critique each trainee because this is just a familiarization and initial practice session. Just let them finish, acknowledge the effort and call the next trainee.

After everyone has delivered their assigned cluster of topics, you can process the exercise by asking the trainees to reflect on their experience. Here are some guide questions:

1. What are your insights on providing information using a flipchart, but not reading from it the whole time? Easy? Difficult?

	2. What tips can you give to fellow trainees so that they can deliver a dynamic presentation and not just read from the flipchart?
--	--

Trainers' Worksheet: Topic Assignments for Basic Skills Practice Session on Sharing FP-MCH Information

Name of Trainee	Assigned Topic	Job Aid	Page No
1.	<ol style="list-style-type: none"> 1. Brief Introduction (ad lib) 2. Ano ang FP? 3. <i>Mga Kabutihang Dulot ng FP</i> 	FP Tarpaulin flipchart	1-3
2.	<ol style="list-style-type: none"> 1. Fertility Awareness: Joint Fertility 2. <i>Pagsasanib ng itlog ng babae at punlay ng lalake</i> 3. <i>Mga Bahagi ng Reproductive System ng Lalake at babae</i> 4. <i>Ang Siklo ng Pagrereglá</i> 	FP Tarpaulin flipchart	4-7
3.	<ol style="list-style-type: none"> 1. <i>Mga Modernong Paraan ng FP: Fertility-Awareness Based Methods</i> 2. Standard Days Method (SDM) 3. Billing Ovulation Method 4. Sympto-thermal Method (STM) 5. Basal Body Temperature Method 6. Lactational Amenorrhea method (LAM) 	FP Tarpaulin flipchart	8-10
4.	<ol style="list-style-type: none"> 1. Condom 2. Pills 3. Injectables 	FP Tarpaulin flipchart	11-13
5.	<ol style="list-style-type: none"> 1. IUD 2. BTL 3. NSV 	FP Tarpaulin flipchart	14-16
6.	<ol style="list-style-type: none"> 1. <i>Mga Katotohanan Tungkol sa FP</i> 2. <i>“Buti nalang Pwedeng Magtanong” (Alamin ang inyong mga karapatan.)</i> 	FP Tarpaulin flipchart	17-18
7.	<ol style="list-style-type: none"> 1. <i>Mas Ligtas kung Handa (ad lib brief Intro)</i> 2. <i>Maging handa para mas ligtas</i> 3. <i>Magpa-prenatal ng hindi bababa sa 4 na beses</i> 	SM Tarpaulin flipchart	1-3
8.	<i>Pahalagahan ang prenatal check-up</i>	SM Tarpaulin flipchart	4-5

9.	1. <i>Gumawa kayong mag-asawa ng birth plan</i> 2. <i>Bantayan ang emergency signs</i>	SM Tarpaulin flipchart	6-7
10.	1. <i>Manatiling malasog habang buntis</i> 2. <i>Manganak lang sa health center, ospital o lying-in clinic</i>	SM Tarpaulin flipchart	8-9
11.	1. <i>Alamin ang gagawin kapag ikaw ay manganak na</i> 2. <i>Gatas mo lang ang ipasuso kay baby</i>	SM Tarpaulin flipchart	10-11
12.	1. <i>Magpa-check up pagkatapos manganak</i> 2. <i>Planuhin ang pamilya; planuhin ang kinabukasan</i>	SM Tarpaulin flipchart	12-13

6. Doing a recap/synthesis

- "Refresh" the short-term memory of participants about highlights of what just transpired
- Clarify issues, summarize facts, and re-state them in simple terms
- Summarize similarities and differences, and finding a unifying thread

Time allocation: 15 minutes

Discuss the bullet points in the slide (see copy of the slide to the left).

SYNTHESIS EXAMPLE FROM SEN. MIRIAM SANTIAGO:

No matter how heated the debate in the Senate is, you are supposed to be above it all and at heart remain as legislators united in our love of country regardless of our different views on how to express that love of country, that patriotism."

You (the trainer) should **demonstrate** how to do a recap / synthesis. One way to do this is to recap what has been discussed in this session so far. That is, the discussion of skills from:

1. Establishing rapport
2. Managing structured *Usapan* exercises
3. Presenting/discussing health information
4. Generating discussion and maintaining group interest
5. Balancing the discussion during *Usapan*
6. Doing a recap/synthesis

Then, you can say: “Now that we have finished discussing the 6 skills, we will now move on to the 7th skill that *Usapan* facilitators need to master.”

EXAMPLE SYNTHESIS of two opposing opinions on FP:

We, Filipinos, have different views on FP. Some who like FP only support the so-called natural FP methods, while most of the medical community believe that all modern methods are safe and effective. Nonetheless, both sides are united in the thought that FP is important to ensure a better quality of life for our families. For us, that unity is the most important. In the end, whatever method a person ultimately uses, we all have to respect that person's choice.

<p>7. Closing the deal / negotiating for behavioral commitment</p> <ul style="list-style-type: none"> • Close the deal (using the back side of the Action Card) <ul style="list-style-type: none"> – Review the options that participants can choose from the range of services you are offering as a service provider – Ask, (while pointing to the list at the backside of the Action Card) <ul style="list-style-type: none"> • “If you were to <u>choose</u> now, which among the methods listed here would you be interested to use?” • “If you were to <u>act</u> now, which among the steps listed here are you be ready to undertake?” • Secure a commitment to action <ul style="list-style-type: none"> – Say, “Those of you who are interested in the services that we have just discussed, please stay after the group session. We will have 1-on-1 discussions so that we can provide to you <u>NOW</u> the method / service that you want” 	<p>Time allocation: 15 minutes</p> <p>Discuss the bullet points in the slide (see copy of the slide to the left).</p> <p>Ask the trainees to take out their copies of the 3 types of Action Cards. Remind them to take note that the list of options on the back side is different for each type. Give the trainees at least 1-2 minutes to get familiar with the list of options on each Action Card.</p>
---	--

1. **Ask** trainees to take out their Facilitator’s Guide and go to Module 1: *Usapang Pwede Pa*, Slide 52. (See below.) Discuss with the trainees the contents of the page.
2. **Demonstrate** how to perform this part.

<p>Ngayon, ano ang nasa isip mo?</p> <p>Kung ikaw ang papipiliin, anong pamamaraan ang iyong gagamitin?</p>	<table border="1"> <thead> <tr> <th>INTERESADO AKO SA...</th> <th>PANO TSKAN (✓)</th> </tr> </thead> <tbody> <tr><td>No. Scapal/Waterlily (NSW)</td><td></td></tr> <tr><td>Bikang luto/bugtan (BLI)</td><td></td></tr> <tr><td>Brno. Blano Device (BD)</td><td></td></tr> <tr><td>Imposible (IMP)</td><td></td></tr> <tr><td>Ngayon! Camalagap/otako Carboxylate (CG)</td><td></td></tr> <tr><td>FB: One Day Combined Oral Contraceptive (COC)</td><td></td></tr> <tr><td>FB: Progestin Only (PO)</td><td></td></tr> <tr><td>Cocoon</td><td></td></tr> <tr><td>LACKING: APOGONIC METHOD (AM)</td><td></td></tr> <tr><td>NOVUS: EYES METHOD (NM)</td><td></td></tr> <tr><td>Real Body, separation (RB)</td><td></td></tr> <tr><td>Sungat: Natural method (SM)</td><td></td></tr> <tr><td>Bilaga: Christian Method (BM)</td><td></td></tr> </tbody> </table> <table border="1"> <thead> <tr> <th>INTERESADO AKO PERO...</th> <th>PANO TSKAN (✓)</th> </tr> </thead> <tbody> <tr><td>... hindi pa napiliin agyayak kung nroing panatimanan ang gagamitin</td><td></td></tr> <tr><td>... hindi nroing nagayak agyayak</td><td></td></tr> <tr><td>... ayaw pagmamayag ng akawo ko</td><td></td></tr> </tbody> </table> <table border="1"> <thead> <tr> <th>HINDI INTERESADO...</th> <th>PANO TSKAN (✓)</th> </tr> </thead> <tbody> <tr><td>Walang kaisa, panatimanan ng panatimanan sa Paggamit ng Pwede Pa</td><td></td></tr> </tbody> </table> <p>Pangalan: _____ Address: _____ Cell/number/text: _____</p>	INTERESADO AKO SA...	PANO TSKAN (✓)	No. Scapal/Waterlily (NSW)		Bikang luto/bugtan (BLI)		Brno. Blano Device (BD)		Imposible (IMP)		Ngayon! Camalagap/otako Carboxylate (CG)		FB: One Day Combined Oral Contraceptive (COC)		FB: Progestin Only (PO)		Cocoon		LACKING: APOGONIC METHOD (AM)		NOVUS: EYES METHOD (NM)		Real Body, separation (RB)		Sungat: Natural method (SM)		Bilaga: Christian Method (BM)		INTERESADO AKO PERO...	PANO TSKAN (✓)	... hindi pa napiliin agyayak kung nroing panatimanan ang gagamitin		... hindi nroing nagayak agyayak		... ayaw pagmamayag ng akawo ko		HINDI INTERESADO...	PANO TSKAN (✓)	Walang kaisa, panatimanan ng panatimanan sa Paggamit ng Pwede Pa	
INTERESADO AKO SA...	PANO TSKAN (✓)																																								
No. Scapal/Waterlily (NSW)																																									
Bikang luto/bugtan (BLI)																																									
Brno. Blano Device (BD)																																									
Imposible (IMP)																																									
Ngayon! Camalagap/otako Carboxylate (CG)																																									
FB: One Day Combined Oral Contraceptive (COC)																																									
FB: Progestin Only (PO)																																									
Cocoon																																									
LACKING: APOGONIC METHOD (AM)																																									
NOVUS: EYES METHOD (NM)																																									
Real Body, separation (RB)																																									
Sungat: Natural method (SM)																																									
Bilaga: Christian Method (BM)																																									
INTERESADO AKO PERO...	PANO TSKAN (✓)																																								
... hindi pa napiliin agyayak kung nroing panatimanan ang gagamitin																																									
... hindi nroing nagayak agyayak																																									
... ayaw pagmamayag ng akawo ko																																									
HINDI INTERESADO...	PANO TSKAN (✓)																																								
Walang kaisa, panatimanan ng panatimanan sa Paggamit ng Pwede Pa																																									

OBJECTIVE: To NUDGE participants into making a mental choice of the FP method that can meet their need as reflected in their plan.

Have you noticed how sales persons often attempt to close the deal by asking you, “What time would you like me to deliver the product?” or “Should I pack this item already?” or “Should I prepare the contract now?” That is part of what is called “closing the deal”.

In this step, we are facilitating the clients’ decision-making process through this gentle nudge question.



Thank you!

Time allocation: 10 minutes

Recap to conclude this session:

1. **In Session 1** – you introduced the trainees to the *Usapan* Series
2. **In Session 2** – you discussed who will implement *Usapan* – that is, the trainees who will become *Usapan* facilitators
3. **Session 3** – you have just finished discussing what *Usapan* facilitators will do during the session as well as the skills needed to be effective facilitators.

ASK trainees:

1. How was your experience in learning and applying the skills for *Usapan*? (What was easy? Difficult?)
2. How confident do you feel about conducting *Usapan* at this point?

CONCLUDING STATEMENT: It might be a bit difficult now, but you should maintain your passion and practice your abilities in order to become very good *Usapan* facilitators. If you continue to combine your passion and abilities, you will eventually become virtuoso *Usapan* facilitators.

Sessions 5 To 9: Trainer's Guide for the Sessions on Gender in FP-MCH and the 5Rs for Gender-Based Violence Victims-Survivors

Introduction

This guide is intended for trainers of the gender session of the **Usapan Facilitator's Training Workshop** of PRISM2. The title of the session is **Gender in FP-MCH and the 5Rs for Gender-Based Violence (GBV) Victims-Survivors**. This session orients the intended participants, who are expected to be mostly private health care providers, on the integration of gender concerns in FP-MCH services, and trains them on the recognition, reporting, recording and referral GBV victims-survivors, and raising of awareness of FP-MCH clients on GBV (5Rs).

In conducting this training, PRISM2 seeks to integrate gender considerations in FP-MCH services. The approach to gender is gender synchronization, which focuses on both women and men, girls and boys “in an intentional and mutually reinforcing way that challenges gender norms, catalyzes gender equality, and improves health” (Greene & Levack, 2010, p. vi).

The core part of gender synchronized FP-MCH is the promotion of equitable participation and benefit to both women and men in FP-MCH and the involvement of FP-MCH service providers in addressing GBV. GBV is presented as a violation of human rights and an obstacle to seeking and using FP-MCH services and products. Therefore, addressing GBV is both a public health and social responsibility, as well as a means to help achieve FP-MCH goals. Learning objectives reflect this focus.

Learning Objectives

The general objectives of this training are a) to raise the awareness of FP-MCH service providers on the importance for the health of women and children of gender synchronizing FP-MCH, and b) to develop their capabilities to recognize or detect and respond to gender-based violence that may be experienced by their clients. Thus, after attending this training, the FP-MCH providers are expected to: (a) become sensitive to the manifestations of gender issues in FP-MCH; (b) be able to recognize, record, report, refer, and raise awareness (5Rs) of GBV victims-survivors among their clients; (c) be able to give psychological first aid to GBV victims-survivors in the form of compassionate listening and referral to the proper agencies; (d) be able to raise the awareness of their clients on gender and GBV by integrating these topics into their group conversations with their clients on FP-MCH; and, (e) be willing to be part of a GBV referral network and support group in their province or city/municipality.

More specifically, at the end of a one-day training workshop, participants will be able to:

- I. Define the concept of gender and its relevance to FP-MCH;

2. Explain how the pursuit of gender equality can contribute to the achievement of FP-MCH objectives (i.e., reduced maternal mortality ratio and infant mortality rate; increased CPR and more SBA-assisted deliveries);
3. Identify gender issues in FP-MCH, including the nature, extent and general causes of GBV or violence against women and children (VAWC);
4. Follow the 5Rs (recognition/detection, recording, reporting, referral, and raising of awareness) of GBV victims-survivors; and
5. Provide psychological first aid (through compassionate listening) before referring a GBV victim-survivor to agencies/organizations providing professional assistance.

Session 5: Pre-Training Test and Overview of the Training Modules on Gender in FP-MCH

Begin by administering the pre-test. Distribute the pre-test form (See [Annex B](#)) and explain the instructions. Emphasize the following:

- The pre-test and post-test that will be administered at the beginning and end of the gender sessions, respectively, are tools not for evaluating the knowledge of the participants on gender, but rather the effectiveness of the sessions in providing additional knowledge about gender in FP-MCH, GBV, and actions that FP-MCH providers can do to assist GBV victims-survivors. Additional knowledge resulting from the training will be measured by computing the difference in the scores of each participant between pre- and post-tests;
- Identities of participants will be kept confidential. Participants will be asked to write codes rather than their names in the pre- and post-tests;
- Both the pre-test and post-tests have four main statements. Each main statement has four sub-statements. Participants can tick more than one sub-statement for each main statement;
- Scoring is right minus wrong. Participants should be careful in selecting the correct sub-statements for every main statement.

Collect the answered pre-test forms and check the answers (after the gender sessions) using the answer key in [Annex C](#). Compile a table with the pre- and post-test scores for each numbered participant (no names or other identifiers) for your reference.

Overview of the Gender Module

Contents	Teaching-Learning Process
 <p>Gender in FP-MCH and the 5Rs of Gender-based Violence Victims-Survivors</p>	<p>While this slide is being flashed, explain the reason for this discussion of the concept of gender in the training of <i>Usapan</i> facilitators. Say that all four <i>Usapan</i> variants have a short gender section (stress that they will not use the term, 'gender,' during any of the four <i>Usapans</i> with FP-MCH clients). The effective delivery of this gender portion of each <i>Usapan</i> will depend on the facilitator's appreciation of the basic concepts of gender, its relevance to FP-MCH, and knowledge of what FP-MCH providers can do in case they encounter victims-survivors of GBV among their clients.</p>
<p>Key Questions</p> <ol style="list-style-type: none"> 1. What is gender? What is the importance of this concept of gender to MNCHN/FP-MCH? 2. What is gender-based violence (GBV)? 3. How can health providers assist GBV victims-survivors? 	<p>Say that in this session, you will be discussing the answers to three questions. Read the questions. Each question corresponds to one part of the gender session.</p> <p>After giving this overview of the gender session, proceed to Part I.</p>

Session 6: Basic Concepts of Gender and its Relevance to FP-MCH

LEARNING OBJECTIVES

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

1. Differentiate the concept of gender from the concept of sex;
2. Identify the manifestations of gender inequality in households and communities; explain how gender inequality and gender-based violence affect FP-MCH;
3. Explain the importance of and general approaches to the pursuit of gender equality in FP-MCH; and
4. Describe the behavior/practice of a gender sensitive FP-MCH service provider.

CONTENTS

1. Differentiation of the concept of gender from sex
2. Gender issues in FP-MCH
3. Relevance of pursuit of gender equality to FP-MCH
4. Features of a gender-synchronized FP-MCH service
5. Challenges to FP-MCH service providers

METHODOLOGY

1. Structured Learning Exercise using a video clip, "The Impossible Dream," as the activity/experience to reflect on and analyze
2. Lecture-discussion

TIME ALLOTMENT: 1 1/2 hours

ADVANCE PREPARATION OF MATERIALS

1. “The Impossible Dream” video clip
2. Laptop, LCD projector, and sound system
3. Visual aids to be printed as handout
4. Whiteboard and marker

Topic/Contents	Teaching-Learning Process
<div style="border: 1px solid black; padding: 10px; text-align: center;"> <p>PART 1: Basic Concepts of Gender and Its Relevance to FP-MCH</p> </div>	<p>Read the slide and state the objectives of the session. See 3.1 Learning Objectives.</p>
<p>The Concept of Gender</p> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <p>THOUGH GENDER IS RELATED TO SEX, IT IS NOT ABOUT SEX.</p> </div> <div style="border: 1px solid black; padding: 5px;"> <ul style="list-style-type: none"> • Sex refers to the biological characteristics (genital organ, reproductive system) of males and females • Sex of a person is since conception/birth • Male and female physical characteristics are universal </div>	<p>Begin by differentiating the term “gender” from the term “sex.” Read the slide. Emphasize that sex refers to the biological or natural characteristics of males and females.</p> <p>Gender does not refer to the biological or given (since conception) characteristics of individuals.</p>

Understanding the Concept of Gender

- Video clip, "Impossible Dream?"



(Impossible Dream?)

<http://videos.recettes-de-cuisine.eu/1/video/Impossible%20Dream/yt-2:JBPBjFR2Y.html>

Private Sector Mobilization for Family Health - Phase 2 (PRISM 2)

3

If gender is not sex, then what is it? Say that to facilitate a discussion of the concept of gender, you will show a video clip entitled, "Impossible Dream."

Let the participants watch the 8-minute video clip.

Guide Questions

A. Discussion on the video clip

1. What did you see in the video clip? Describe the relationship of the husband and wife, girl and boy?
2. What do you think are the effects of this kind of relationship on the health of the woman and the man?
3. What are the effects on the girl and boy?
4. In this relationship, who is/are at the disadvantaged side?

After the video clip, say that there are two sets of questions for discussion. In the first set, questions are focused on the video clip. Any discussions regarding its relation to real life or situation will be suspended as this will be the focus of the second set of questions.

Because of time limitations, let two to three participants answer each question very briefly. Then, summarize the answers.

Highlight the questions on "change." You will use the answers to questions related to change as take off point in defining gender. That is, the understanding of the man (husband) and the woman (wife), and the girl (daughter) and boy (son) on how to be a woman/girl or a man/boy is learned, not innate, and can be changed if unfair and inequitable.

Guide Questions

B. Reflection on Filipino society, own community, own family

1. Do you think this is happening in Filipino society?
2. Do you want it changed? Why?
3. Can the situation be changed? How?
4. Based on this video, what do you think is gender and what are examples of gender issues?

What is GENDER?

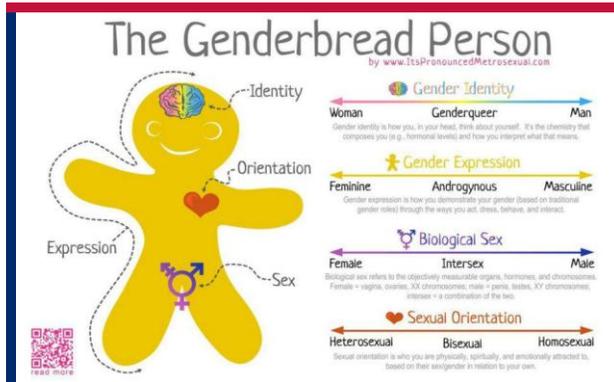
GENDER REFERS TO:

- Socially/culturally/individually constructed characteristics, roles, rights, opportunities and limitations as well as power differences of women and men
- Varies from society to society, person to person
- Can be contested and changed

Using their answers to the questions, explain the concept of gender.

You may cite countries with different attitudes toward the roles and capabilities of women in society.

What is GENDER?



Further differentiate the concept of gender from the concept of sex by presenting this slide.

This slide shows that sexual orientation (to whom one is attracted – same sex or homosexual, opposite sex or heterosexual, or both sexes or bisexual, or transgender) –may not be entirely biologically-based.

Sex: Hypothalamus^{1,2&3}

- Study of LeVay (1991) found the male INAH-3 to be more than twice larger than the female INAH-3; and also more than twice larger than the homosexual male INAH3. This finding suggests that sexual orientation is biologically based or at least biologically expressed.
- It is not clear how environmental factors, including the effects of stress in the second trimester, might influence the size of INAH-3. A number of hereditary and environmental factors may have a significant influence on the size of INAH-3 (Solms & Turnbull, 2002; Carey, 2005).

To support the view that sexual orientation is more biological than socially constructed, share the study of Levay (1991). Emphasize that sexual orientation is much more complicated than this study indicates.

See [Annex D](#) for copy of the study.

Do not show to the participants the slide on the left. You will use this in explaining why sexual orientation is considered as biological.

Gender: A Development Concept

An **ANALYTICAL LENS** which looks at:

- **WHAT** - the **norms/beliefs/practices** of a society related to the roles, rights, opportunities and limitations of men and women;
- **EFFECTS** - of norms/beliefs/practices on the health, social and economic conditions and needs of women and men, as well as their power relations in the household/family, community/workplace and society;
- **HOW TO TRANSFORM** inequitable norms/beliefs/practices to achieve holistic and sustainable development of persons (male and female), families, communities/organizations, and society.

State that gender is a development concept.

Liken a gender lens to eyeglasses. If one with defective eyesight is not wearing a pair of eyeglasses, then she/he will tend to ignore things that she/he will not see. It's the same with a gender lens: if one is not wearing this (figuratively) then she/he will tend to ignore gender issues. But if worn, this gender lens will sensitize the person to situations in the environment (e.g., the context of FP-MCH clients' lives, political and economic opportunities, role of alcohol in the culture) that affect the role, opportunities, relations of men and women.

What are norms? 'Norms' are rules that people carry around in their heads that justify and provide guidance for what people ought to do and what is acceptable for them to do. Norms lead to social expectations.

Read the slide.

Example: Transforming Gender Norms and Rewriting Gender Scripts in FP-MCH

Gender Norms/Beliefs	Effects on FP-MCH
<ul style="list-style-type: none"> • Men are the breadwinners and heads of families, while women are the house-keepers and child-minders. • Men are independent and superior, while women are dependent and inferior. 	<ul style="list-style-type: none"> • Women are the ones involved in family planning and child health care; • But men as the heads of families and income earners decide on when and how women and the couple will use FP services and methods

Show how gender stereotypes and gender norms/beliefs affect men's and women's roles or participation in FP-MCH.

Do an exercise. Before showing the second column of the table in the slide, ask the participants what the effects of these gender stereotypes are on FP-MCH behavior.

Example: Transform Gender Norms and Rewriting Gender Scripts in FP-MCH

Gender Norms/Beliefs	Effects on FP-MCH
•Women are naggers, emotional, vain, rumor monger, and fickle-minded; while men are rational, consistent and controlled in behavior.	•Violence against women is sometimes, if not oftentimes, justified.

Repeat the exercise with another gender stereotype. Show the gender stereotype/belief in the first column of the table. Ask the participants about its effects on attitudes towards violence against women.

Explain that stereotypes are not rules for behavior the way norms are, but that stereotypes can also legitimate behavior.

Example: Gender Issues in Health (FP-MCH)

- NDHS 2008: Women of reproductive age who participate less in decision making in the households have the highest unmet family planning need and are less likely to seek postnatal care.

Say that the effects of gender issues on FP-MCH have been demonstrated by studies. Read the findings of the National Demographic and Health Survey in 2008.

Read the two slides.

Example of gender issues in health (FP-MCH)

- NDHS 2008: Women who believe that wife beating is justified for 3-5 reasons have higher ideal size than women who do not say wife beating is justified (p.199)
- NDHS 2008: Married women who participate in more decisions and women who accept fewer justifications for wife beating are more likely to use contraception (p. 198)

If gender inequality affect FP-MCH, then FP-MCH providers should advocate for gender equality.

Before flashing this slide, ask the participants about the challenges to FP-MCH providers, given the relation between gender issues and FP-MCH service access. Then, read this slide to state the overall conclusion of the connection of gender issues with FP-MCH.

The Pursuit of Gender Equality IN Health

Gender equality is both a means and an end.



The aim is to pursue gender equality in health. Gender equality is both a means and an end.

As an end, gender equality is a goal to be achieved, and is something that we aspire to because it is good in itself. If a man and a woman respect each other's rights, dignity, worth and capabilities, then they will have a more harmonious and equitable relationship. FP-MCH providers can contribute to this goal by making their health services responsive to women and men, transforming gender relations between clients and their partners as well as transforming gender relations in health care provision.

Gender equality is also a means to an end. If there is a good relationship between a man and woman, then they are likely to take care of each other, and promote each other's health. Therefore, women will be more likely to use FP methods, and to visit and deliver with a trained health service provider. FP-MCH providers will thus have more clients (good business).

<p>How can we pursue gender equality in health?</p>	<p>When this slide is flashed, say:</p> <p>Gender equality is 1) good in itself; 2) will help increase the clients of private FP-MCH service providers; and 3) will help achieve MDGs 4 and 5. So, how can we pursue gender equality in health?</p>
<p>Gender Synchronization</p> <p>Focuses on both women and men, girls and boys “in an intentional and mutually reinforcing way that challenges gender norms, catalyzes gender equality, and improves health” (Greene & Levack, 2010, p. vi).</p>	<p>The answer is gender synchronization. Read the slide.</p> <p>Emphasize that gender synchronization (that is, responding to the needs of, and engaging both, women and men) should (read each term in the definition):</p> <ul style="list-style-type: none">• Be Intentional: it is part of the plan or interventions of the health service provider;• Be Mutually reinforcing: develops both women and men, and clients and service providers;• Challenge gender norms: seeks to change gender inequality in FP-MCH and other health areas;• Catalyze gender equality: facilitates gender equality in practice or initiatives (in the case of the public sector);

	<ul style="list-style-type: none"> • Improve health: the ultimate effect is the improvement of everyone's health. The family will be happier, and thus healthier. Additionally, women and their families will be able to access needed health services and will have better spaced children, leading to both improved maternal and child health.
<p>Example: Features of a Gender Synchronized FP-MCH Services</p> <ul style="list-style-type: none"> • Meets the FP needs of both men and women of reproductive age; • Raises awareness of clients/patients on the importance of making FP and child care a shared responsibility of couples (both men and women); • Proactively advocates for men's support for or constructive involvement in maternal health care; • Behavioral change communication materials on FP-MCH are meant for both men and women of reproductive age; they promote shared responsibility. 	<p>Give some features of a gender-synchronized FP-MCH service.</p> <p>Read this slide and the next slide.</p>
<p>Example: Features of a Gender Synchronized FP-MCH Services</p> <ul style="list-style-type: none"> • Ensure both women and men participate in the bodies/structures/mechanisms for health improvement; • Personnel, management and client databases should be sex-disaggregated; • Develops competency in gender sensitive Recognition, Recording, Reporting and Referring of gender-based violence cases, and Raising of awareness on GBV (5Rs). 	

How can this health provider be gender sensitive and responsive?



End this Part I of the gender session by asking the participants to analyze this slide.

Ask: If the client answers "No," what will happen if the health provider is not gender sensitive or is not wearing a gender lens? On the other hand, what will she/he do if she/he is gender sensitive or wearing a gender lens?

The expected answer is that the health provider will not ask the client further questions if the provider is not gender sensitive.

If the health provider is gender sensitive, she/he will ask questions to ascertain possible gender issues causing the client to say no, and will plan appropriate interventions.

The second slide shows possible gender issues. Read the slide. These are the perceptions of men and women on contraceptives and power relations.

Session 7: Nature and Causes of Gender-Based Violence (GBV)

LEARNING OBJECTIVES

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

1. Define GBV and its different forms;
2. Discuss the four levels of factors that perpetuate GBV;
3. Identify GBV or VAWC as never justified and as a public health concern requiring a comprehensive and multi-stakeholder response; and
4. Explain FP-MCH providers' key role in recognizing and addressing GBV.

METHODOLOGY

1. Structured Learning Exercise: Agree or disagree with statements
2. Short lecture

TIME ALLOTMENT: ONE HOUR

ADVANCE PREPARATION OF MATERIALS

1. Laptop and LCD projector
2. Visual aids (PowerPoint Presentation) to be printed as handout

Topics/Contents	Teaching-Learning Process
<p style="text-align: center;">PART 2: Nature and Causes of Gender-Based Violence</p>	<p>Say that this session is about the worst manifestation of gender inequality which is GBV. GBV poses a serious problem to maternal and child health care and is a barrier to effective FP.</p>
<p>Exercise: Agree or Disagree?</p> <ol style="list-style-type: none"> 1. Men sometimes have good reasons to use violence against their wives. 2. It is not appropriate for FP-MCH service providers to intervene in problems related to gender-based violence. <p>QUESTION: What is gender-based violence?</p>	<p>Begin with this exercise.</p> <p>Ask the participants to stand up;</p> <ol style="list-style-type: none"> 1. Flash the first statement. Tell the participants who agree with the statement to go to the left side of the session hall; and those who disagree with the statement, to the right side of the session hall. 2. Ask those who agree with the statement to explain their reasons for agreement. Ask those who disagree with the statement to explain their reasons. 3. Move to the second statement. Repeat the same process as above. 4. Say that at the end of the session, you will come back to the two statements and state the answers given by gender equality advocates. 5. Show the question <p>Ask the participants about their understanding of gender-based violence.</p>

Definition of GBV

- Violence involving men and women,
- The female is usually the victim;
- Derived from the unequal power relationships between men and women;
- Includes, but is not limited to, physical, sexual, and psychological abuse

Say that this is the international definition of gender-based violence, taken from the United Nations Population Fund (UNFPA).

Definition of Violence: RA 9262, Sec. 3

- Any act or a series of acts committed by any person against a woman who is his wife, former wife, or against a woman with whom the person has or had a sexual or dating relationship, or with whom he has a common child, or against her child whether legitimate or illegitimate, within or without the family abode, which result in or is likely to result in **PHYSICAL, SEXUAL, PSYCHOLOGICAL HARM OR SUFFERING, OR ECONOMIC** abuse including threats of such acts, battery, assault, coercion, harassment or arbitrary deprivation of liberty.

The Philippines, Republic Act 9262 or the Anti-Violence Against Women and their Children (VAWC) Act of 2004 is defined as having four forms of violence: physical, sexual, psychological and economic. Read the slide.

FORMS of GBV

PHYSICAL ABUSE: Acts that include bodily or physical harm

Slapping	Burning
Shaking	Kicking
Beating with fist or object	Strangulation
Inflicting injury through knife or other weapons	



Present the different forms and examples of gender-based violence.

FORMS of GBV

SEXUAL ABUSE

Rape	Exposure of genitalia
Unwanted touching, kissing	Exposure to pornography
Sexually suggestive statements	Forcing to do indecent acts or any sexual activity and making films about these acts
Forcing the wife/mistress/lover to live in conjugal home or sleep together in same room with the abuser	Prostituting the person

FORMS of GBV



PSYCHOLOGICAL ABUSE: Acts or omissions causing or likely to cause mental or emotional suffering		
Isolation from others	Verbal aggression	Marital infidelity
Excessive jealousy	Intimidation through destruction of property	Constant belittling
Control of his or her activities	Harassment or stalking	Humiliation
Causing or allowing a victim to witness abuse of a member of the family		

FORMS of GBV

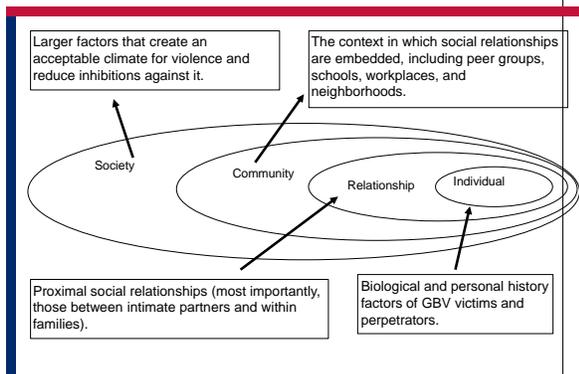


• **ECONOMIC ABUSE** : Acts that create dependency and submissiveness to the other sex.

Deprivation or threat of deprivation of financial resources and right to use and enjoy conjugal or property owned in common
Withdrawal of financial support; abandonment
Destroying household property
Use of family funds for vices
Preventing the victim from engaging in any legitimate profession, occupation, business except on valid, serious & moral grounds (Art 73 of Family Code)
Ownership of common property

If you have statistical data on GBV reported cases in the area, insert a slide here on these data.

Factors Perpetuating GBV



Present the ecological model in analyzing the factors that perpetuate GBV. Say that there are four levels of factors. All of these factors interact in perpetuating GBV.

Even if psychological treatment of perpetrators at the individual level is important, it is not enough to eradicate GBV. There must be multi-sectoral, multi-disciplinary interventions – including private health providers – in addressing the issue of GBV.

Examples: GBV Individual Risk Factors

- A history of violence in the perpetrator's or victim's family of origin (including intimate partner violence and child abuse)
- Male alcohol use
- Male personality disorders

Use the contents of the slides on the left to further explain the four level of risk factors of GBV.

Do not show these slides to the participants.

Remember that these are RISK factors. In other words, they increase the chances of experiencing GBV.

Examples: GBV Risk Factors in Relationships

- Marital conflict
- Family dysfunction
- Male dominance in the family
- Economic stress
- Marrying at an early age
- Large number of children
- Friction over women's empowerment
- Family honor considered more important than the health and safety of the victim

Examples of GBV Factors in Communities

- Poverty
- Weak community sanctions against GBV
- Traditional gender roles for women who are in transition
- Normative use of violence to settle all types of disputes
- Social norms that restrict women's public visibility
- Lack of safety in public places
- Lack of shelter or other forms of assistance/sanctuary

Examples of GBV Factors in Society

- Traditional gender norms that give men economic and decision-making power in the household
- Social norms that justify violence against women
- Lack of criminal sanctions against perpetrators of GBV (impunity)
- High levels of crime
- Armed conflict

Exercise: Agree or Disagree?

1. Men sometimes have good reasons to use violence against their wives.
2. It is not appropriate for FP-MCH service providers to intervene in problems related to gender-based violence.

QUESTION: What is gender-based violence?

End the session by returning to the questions raised at the start of the session. Give your concluding answers:

1. Violence in all of its forms against women or any person is never justified. To stop the vicious cycle of violence, one has to stop using violence as a way of resolving a problem.
2. FP-MCH service providers – both private and public – being at the front line of health services, have a big role in detecting and addressing the issue of GBV.
3. What can FP-MCH service providers do? This is our next topic.

Session 8: What can health providers do?

Recognize, Record, Report, Refer GBV Victims-Survivors and Raise Awareness of FP-MCH Clients on GBV (5Rs)

LEARNING OBJECTIVES

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

1. Perform the 5Rs of GBV victims-survivors: recognition/detection, recording of profile, reporting of statistical data; referral to proper agencies for assistance; and raising of awareness on GBV towards ending GBV and transforming unfair gender relations;
2. Provide psychological first aid to a victim-survivor through compassionate communication; and
3. State why it is important for them to be part of the GBV referral network in their area.

METHODOLOGY

1. Participants' sharing of experiences in handling GBV victims-survivors
2. Lecturette

TIME ALLOTMENT: 1 1/2 hours

ADVANCE PREPARATION OF MATERIALS

1. Laptop and LCD projector
2. Visual aids (PowerPoint Presentation) to be printed as handout

Topics/Contents	Teaching-Learning Process
<p style="text-align: center;">PART 3: What can FP-MCH providers do? = 5 Rs</p>	<p>If health providers should be included in advocacy for the elimination of GBV, then what can they do?</p> <p>Ask participants whether they have been approached by a client who is/was a victim-survivor of GBV. Let two or three participants share their experience. If not mentioned, ask: what kind of abuse was experienced? What did the health provider/participant do? What happened?</p> <p>Summarize the key points shared.</p>
<p>Key Laws Related to GBV</p> <ol style="list-style-type: none"> 1. RA 7610: Special Protection of Children Against Abuse, Exploitation and Discrimination Act of 1992 2. RA 7877: The Anti-Sexual Harassment Act of 1995 3. RA 8353: Anti-Rape Law of 1997 4. RA 8505: Rape Victim Assistance and Protection Act of 1998 5. RA 9208: Anti-Trafficking in Persons Act of 2003 6. RA 9262: Anti-violence Against Women and Their Children Act of 2004 7. RA 9710: Magna Carta of Women (MCW) of 2009 	<p>State the laws that define interventions or assistance to GBV survivors. Due to lack of time, you will not be able to discuss each of these laws.</p> <p>If possible, provide the participants with copies of these laws (e.g., in CDs).</p>
<p>5Rs</p> <ol style="list-style-type: none"> 1. RECOGNIZE GBV victims-survivors among clients 2. RECORD the profile of the victim-survivor for reference on his/her case; treat this as confidential. 3. REPORT statistical data (not personal identities) of assisted GBV victims-survivors to the proper authorities (VAWC Referral Network). 4. REFER GBV victims-survivors (with their consent) to agencies or organizations providing services to GBV victims-survivors 5. RAISE AWARENESS on GBV and its ill-effects on FP-MCH as well as on the growth and wellness of male and female family member. 	<p>Say that this training promotes the 5Rs for GBV victims-survivors.</p> <p>Give an overview of the 5Rs for GBV victims-survivors. Read the slide. Say that you will discuss each of these Rs.</p>

<div data-bbox="292 363 656 464" data-label="Section-Header"> <h2>RECOGNIZING A GBV VICTIM-SURVIVOR</h2> </div>	<p>This is the title slide of the first R.</p>
<div data-bbox="206 707 522 747" data-label="Section-Header"> <h3>Physical Signs of GBV</h3> </div> <ul data-bbox="224 793 716 961" style="list-style-type: none"> • Bruises (single or multiple) or injuries that look like they came from choking, punching, or being thrown down • Black eye, red or purple marks in the neck, or sprained wrists • Perforated eardrums 	<p>First, ask the participants what are the signs or indicators of GBV. When do they know if an individual is experiencing GBV?</p> <p>Participants usually mention the physical signs in the slide. Read these signs.</p>
<div data-bbox="206 1201 599 1239" data-label="Section-Header"> <h3>Psychological Signs of GBV</h3> </div> <ul data-bbox="214 1266 716 1549" style="list-style-type: none"> • ATTEMPTING TO HIDE BRUISES with makeup or clothing • MAKING EXCUSES FOR BRUISES like tripping or being accident-prone or clumsy. Often the seriousness of the injury does not match up with the explanation • Having FEW CLOSE FRIENDS AND BEING ISOLATED from relatives and co-workers and being kept from making friends • Having LOW SELF-ESTEEM; being extremely apologetic and meek • Having a DRUG OR ALCOHOL PROBLEM • Having SYMPTOMS OF DEPRESSION such as sadness or hopelessness, or loss of interest in daily activities • Talking about SUICIDE OR ATTEMPTING SUICIDE 	<p>Say that aside from physical signs, there are also psychological and behavioral signs. Read this slide and the next slide.</p>

Behavioral Signs of GBV

- Accompanied by a male who answers all the questions
- Gives explanations that do not account for the injury
- Avoids eye contact while explaining causes of injury
- Minimizes/trivializes injury or blames themselves for being clumsy
- Gives a quick ready-made response before being asked

RA 9262, Sec 35: Rights of a Victim-Survivor

- a) To be treated with respect and dignity
- b) To be accorded confidentiality
- c) To avail of legal assistance from the Public Attorney's Office or any public legal assistance office
- d) To be entitled to support services from the Department of Social Welfare and Development and local government units
- e) To be entitled to all legal remedies and support provided by the Family Code;
- f) To be informed of their rights and the services available to them, including their right to apply for a **protection order**.
- g) To avail up to 10 days of paid leave of absence in addition to other paid leaves (Sec 43).

Say that when a health service provider detects or suspects a client to be a GBV victim-survivor, the first thing to do, according to RA 9262, is to inform the client of her/his rights.

Read the slide.

What to do When Abuse is Recognized

- Try to elicit admission
 - *“Misis, may pasa ka, ano ang nangyari dyan?”*
 - *“Kumusta po sa bahay? Kumusta ang pagsasama po ninyo ni Mister?”*

A health provider can try to invite a victim-survivor to confide in them.

Read slide.

If a victim-survivor decides to disclose abuse:

- Let them talk at their own pace
- Be accepting of what they say – there is no right or wrong way to feel
- Be attentive, kind, caring and respectful
- Express concern and empathy through body language, tone of voice, words and actions.
- Compassionately listen; don't be judgmental; don't interrogate or sound like a reporter.

Read the slide.

Say that it is important for the health provider to give a victim-survivor psychological first aid; this can help in their healing and recovery process.

- First and foremost, assure her that she is in a safe place, and all that she shares will be treated with confidentiality.
- If the survivor is distressed, link her/him to somebody she/he trusts. Ask her/him whom she/he would like to be with at that moment. If that person can be contacted by phone, then contact her/him and ask her/him about the situation and the needs of the victim-survivor;
- Don't blame the victims for their situation. Forget about your gender bias even if you think it is the victim-survivor who provoked the violence.
- Read the slide.
- Say that you will explain the techniques for compassionate listening.

<p>Tips in Compassionate Communication</p> <ul style="list-style-type: none"> Compassionate communication skills include the use of statements that are reflective and clarifying, supportive, empowering (Brymer et al, 2006) and information seeking (WHO, 1996). 	<p>Give an overview of the elements of compassionate communication. Read the slide.</p>
<p>Reflective and clarifying statements mirror what the speaker says.</p> <p>Example 1: “It sounds to me like you are afraid of going back to your house. Is this correct?”</p> <p>Example 2: “You are saying that you are unsure about leaving your husband because your child is still young and you don’t have a job. Did I get that right?”</p>	<p>Explain the first element of compassionate communication: ‘reflective and clarifying statements,’ and give examples. Read the slide.</p> <p>Ask the participants how, in their opinion, giving reflective and clarifying statements will affect GBV victims-survivors.</p> <p>Then ask two to three participants for their own examples of reflective and clarifying statements.</p>
<p>Supportive statements convey a message of support to the victim or survivor.</p> <p>Example 1: “That’s really hard...,” or “That’s tough... I can feel your pain.”</p> <p>Example 2: “I am so sorry to hear about that...”</p>	<p>Move to the next element of compassionate communication: ‘giving of supportive statements.’ Read the slide.</p> <p>Then, ask the participants how, in their opinion, giving supportive statements will affect GBV victims-survivors.</p> <p>Ask two to three participants to give examples of reflective and clarifying statements.</p>

Empowering statements tap into victim/survivors' coping mechanisms:

Example: Your decision to come here seems to show your desire to end the abuse. You can also decide to accept or refuse any assistance that will be given to you.

Move to the next element of compassionate communication: 'giving of empowering statements.' Read the slide.

Say that the purpose of empowering statement is for the victim-survivor to reclaim the power she/he lost when she/he was abused sexually, physically and/or psychologically.

Information seeking statements are used when there is a need to get information to understand the nature of the problem and how a person can be helped.

- Ask questions in a calm and slow manner;
- Refrain from insisting that the person should answer you;
- Refrain from sounding like a reporter or interrogator; and
- Think of how your question might affect the person.

The fourth element of compassionate communication is 'information seeking statements.'

This is related to the next R (Recording). Read the slide for the general guidelines in seeking information from the victim-survivor.

Demonstrate how a reporter or an interrogator asks questions (not how a health care provider should ask these questions). Emphasize that a reporter or interrogator questioning, whose main purpose is to gather information rather than show empathy, is **not** compassionate communication. Therefore, it is **not** the model that participants should emulate in questioning a GBV victim-survivor.

What to do When Abuse is Recognized

- If you are not a trained/authorized medico-legal examiner, don't perform any genital examination/treatment on the victim, unless her/his condition is life-threatening, wherein you (if a doctor) are in the best position to provide emergency assistance.
- Do not touch the victim/survivor or invade her/his space unless she/he allows you to.
- Never ask the victim/survivor to remove their clothing to explain or demonstrate abuse.

Read the slide.

RECORDING THE PROFILE OF A GBV VICTIM-SURVIVOR

Move to the second R. Read the slide.

RECORDING GBV: Duties and Functions of Health Care Providers (RA 9262, IRR Sec 49)

Any healthcare providers from public or private hospitals, clinics or rural health units, including, but not limited to, an attending physician, nurse, clinician, barangay health worker, therapist or counselor who suspects that a female patient or her children are victim/survivors of abuse shall:

- a) Record all complaints, observations, and circumstances from the examination;
- b) Properly document all the victim's physical, emotional, and/or psychological injuries;
- c) Properly document all the victim's observation, emotional or psychological state and safeguard the record and make them available to the victim/survivor upon request at actual cost;
- d) Provide the victim/survivor immediate and adequate notice of rights and remedies provided under the Act, and the services available to them;
- e) Provide emergency care assistance to victims.

Read this slide (Sec 49 of the Implementing Rules and Regulations of RA 9262) to show that all health service providers, in public and private health facilities, are obliged by law to record or document the profile of a GBV victim-survivor.

Emphasize the part which says that recording must be properly done.

Importance of Recording GBV Cases

Recording will help in:

- Diagnosing a problem,
- Determining the service/intervention needed,
- Tracking the progress of the condition of the person at risk or victim/survivor.

Read this slide to explain the purposes of recording the profile of a GBV victim-survivor.

Guidelines in Recording

- Recording should be undertaken with utmost care and precision because a medical record can be subpoenaed for evidence
- Avoid subjective interpretation of data; just record what you saw (be objective) and heard (the survivor's own words "patient stated.....")
- **NOTE:** it is not the health service provider's responsibility to determine whether an assault occurred: that is a LEGAL DECISION; health service providers can help legal authorities by keeping thorough medical records

Section 49 of the IRR RA 9262 states that the profile of a victim-survivor must be properly documented. Present these guidelines to provide the rules for proper documentation. Read the two slides on recording guidelines.

<p>Guidelines in Recording</p> <ul style="list-style-type: none"> Confidentiality of personal data, for both the survivor/victim and the perpetrator, should be kept confidential unless subpoenaed. Ensure that the interview is done in a private place (will not be overheard by other clients, etc.) and say that their answers will be treated confidentially. 	
<p>RA 9262 (Anti- VAW and their Children Act)</p> <p>SEC. 44. Confidentiality. - All records pertaining to cases of violence against women and their children including those in the barangay shall be confidential and all public officers and employees and public or private clinics or hospitals shall respect the right to privacy of the victim. Whoever publishes or causes to be published, in any format, the name, address, telephone number, school, business address, employer, or other identifying information of a victim or an immediate family member, without the latter's consent, shall be liable to the contempt power of the court.</p> <p>Any person who violates this provision shall suffer the penalty of one (1) year imprisonment and a fine of not more than Five Hundred Thousand Pesos (P500,000.00).</p>	<p>Read this slide to stress the importance of complying with the rule of confidentiality.</p> <p>Emphasize that recording is required, but sharing information about a GBV victim-survivor with anyone else is betraying the confidentiality you promised and should never be done. Ask what might happen if a health care provider consciously or inadvertently tells a friend or colleague about the abuse suffered by a patient.</p>
<p>Recording Tool</p> <ul style="list-style-type: none"> To identify women/men experiencing GBV or at risk of becoming a victim of GBV. 	<p>To record instances of GBV, the FP-MCH providers can use FP Form #1 (Participants who have undergone FP-CBT I are familiar with this form), See Annex E.</p> <p>Show them the section of FP Form #1 on Risks for VAW. Show them where the health service provider will be able to identify whether a client is a victim-survivor or is at risk of becoming a victim of GBV.</p>

FP Form #1

Risks for Violence Against Women:

- History of domestic violence or VAW
- Unpleasant relationship with partner
- Partner does not approve of the visit to FP clinic
- Partner disagrees with using FP

This is the VAW section of FP Form #1.
Read the slide.

Questions to Ask

1. In the past, was there any instance when you experienced physical or sexual or psychological abuse or economic deprivation by your husband/wife/partner?
2. Are you still experiencing this or are you afraid that you might experience this again? Would you like to share the problem with me?
3. Does your partner know that you came here for FP consultation? Does he/she agree with your visit here?
4. Does he/she agree with your use of contraceptives or family planning method?

According to the Department of Health's FP-CBT Training Manual, to identify whether a client has a history of domestic violence or VAW, ask, "How is your relationship with your husband/partner?"

To make it easier for the client to say if she/he has a history of domestic violence, suggest converting this question into a closed question. Read the first question. Tell the client they do not have to speak, they can just gesture "yes" or "no."

If a client answers "yes" to the first two questions, then she/he is a victim-survivor of GBV. If she/he answers "no" to the last two questions, then she/he is at risk of GBV.

The second question, if answered affirmatively, is followed up by "Would you like to share the problem with me?" Because the health service provider is triggering the opening of an emotional wound, she/he must show compassion to the client.

<div data-bbox="230 333 709 457" data-label="Section-Header"> <h2>REPORTING STATISTICAL DATA ON ASSISTED GBV VICTIM-SURVIVOR</h2> </div>	<p>Move to the third R. Read the slide.</p>
<div data-bbox="204 709 693 745" data-label="Section-Header"> <h3>Reporting GBV: Key Points to Consider</h3> </div> <ul data-bbox="212 772 745 1083" style="list-style-type: none"> • Reporting will help in: <ul style="list-style-type: none"> – Monitoring the extent of GBV in an area; – Developing needed area-wide (multi-sectoral) interventions • Reports should specify the number of victims/survivors, their ages, the types of abuse, and the types of services provided. Under no circumstances should the report include the victim/survivor's name or any personal or identifying information • Only statistical data (should not contain personal information about the person at risk or victim/survivor, and the perpetrator/s) - number of female and male survivors, their ages, types of abuses, types of services provided. 	<p>Read the slide.</p> <p>Stress that the report should not contain the personal identities of the GBV victim - survivors nor that of their perpetrators.</p>
<div data-bbox="215 1199 431 1236" data-label="Section-Header"> <h3>Reporting Tool</h3> </div> <ul data-bbox="217 1281 688 1310" style="list-style-type: none"> • PRISM2 Monthly Service Record on FP-MCH 	<p>For PRISM2 partners, request them to make use of the back page of the Monthly Service Record on FP-MCH when presenting consolidated data on assisted GBV victims-survivors. By “assisted”, we mean those that you identify and help through the five Rs.</p> <p>Explain how to fill out the form. See Annex F for a copy of the Form.</p>

REFERRAL OF GBV VICTIMS/SURVIVORS TO PROPER AGENCIES FOR FURTHER ASSISTANCE

Move to the fourth R. Read the slide.

Say that it is important to refer clients who are GBV victims-survivors, given the service provider's limitations in assisting the client.

Refer To Agencies that are Legally Mandated to Provide Services for GBV Survivors

- **Barangay Council** for the issuance of barangay protection order
- **DSWD** for the provision of psychosocial services (counseling, temporary shelter, livelihood, financial support during court hearing.)
- **DOH/PHO/CHO/MHO** (WCPU) medico-legal services and issuance of medico-legal certificates;
- **NBI/PNP Women and Children's Protection Desk** for investigation of the case, and rescue and protection of the victim-survivor
- **DOJ/PAO/PROSECUTOR's Office** for legal/prosecution services.

Read the list of agencies and the services they provide that are mandated by RA 9262 (and other laws) to assist GBV victims-survivors.

(Insert here slide on available services in the local areas of the participants)

If you have information on available services and contact information of agencies/ organizations providing services to GBV victims-survivors in the local area(s) of the participants, you may insert them here.

Legal Protection of Service Providers

- **RA 9262 SEC. 34. Persons Intervening Exempt from Liability.** – In every case of violence against women and their children as herein defined, any person, private individual or police authority or barangay official who, acting in accordance with law, responds or intervenes without using violence or restraint greater than necessary to ensure the safety of the victim, shall not be liable for any criminal, civil or administrative liability resulting therefrom.
- **RA 9262 IRR Section 44. Protection of Service Providers.** – In all cases, the privacy and identity as well as the locations of service providers, including NGOs and POs shall not be disclosed by any person who has knowledge of the VAWC cases.

Read the slide on the protection of individuals and organizations assisting GBV victims-survivors.

<p style="text-align: center;">RAISE AWARENESS OF FP-MCH CLIENTS ON GBV TO HELP ELIMINATE GBV AND POSITIVELY TRANSFORM GENDER RELATIONS</p>	<p>Move to the fifth and last R. Read the slide.</p>
<p>Raise Awareness Through the USAPAN</p> <p>4 USAPAN Modules:</p> <ul style="list-style-type: none"> • The quality of the relationship between a husband and wife is important to FP-MCH • A serious problem that can affect FP-MCH is gender inequality and GBV • Actions that spouses can take to stop GBV and enhance their relationship. • Available services for women and men experiencing GBV 	<p>Read the slide for the general contents of the gender section of the four <i>Usapan</i> variants.</p> <p>Then say that this will be the topic of Part 4 of the gender session.</p>

At the end of Part 3, distribute the post-test. Collect the forms once the participants have finished answering.

Session 9: Gender Portion of *Usapang Pwede Pa* and *Kuntento Na*, *Usapang Buntis*, And *Usapang Bagong Maginoo*

(Reflection on the Effects of the Equality of Relationship of Spouses/Partners concerning FP-MCH)

LEARNING OBJECTIVES

At the end of this session, participants will be able to facilitate the portion of the four *Usapan* variants that:

1. Invites participants to reflect on the effects of the quality of their relationship with their spouses/partners on FP (for *Usapang Kuntento Na*, *Usapang Pwede Pa*, and *Usapang Bagong Maginoo*) and on safe motherhood (for *Usapang Buntis* and *Usapang Bagong Maginoo*);
2. Presents the effect of gender inequality issues, including gender-based violence, on the ability of a woman to respond to her FP needs and seek maternal health care;
3. Orients the participants about government agencies tasked to provide services to GBV victims-survivors; and
4. Urges the participants to take proactive action to achieve equitable relations with their spouses and to stop domestic violence, if any.

METHODOLOGY

1. Explanation of the overall steps of the gender portion of the four *Usapan* variants as presented in the *Usapan* facilitator's guide;
2. Demonstration

TIME ALLOTMENT: 1 1/2 hours

ADVANCE PREPARATION OF MATERIALS

1. *Usapan* Facilitator's Guide (with gender section)

SESSION GUIDE

Begin by informing the participants about the presence of two job aids: 1) a PowerPoint presentation and 2) a flip chart. The flip chart will be used if the facilitator does not have access to, or cannot use, a computer and LCD projector during the *Usapan*. The guide for using the PowerPoint is explained in the *Usapan* facilitator's guide, whereas the guide for using the flip chart is written on the back of each page of the flip chart. Presented below is the guide for the PowerPoint presentation. See [Annex G](#) for the flip charts.

Also say that the contents and procedures of *Usapang Buntis*, *Usapang Pwede Pa*, and *Usapang Kuntento* are the same except for the linking statement from the previous topic. In *Usapang Buntis*, the discussion about the relationship of spouses/partners is linked to the discussion about safe motherhood by saying that the quality of this relationship is crucial to safe motherhood. In *Usapang Pwede Pa* and *Usapang Kuntento Na*, the discussion of about the relationship of spouses/partners is presented as important to effective FP. To save time, only the contents and procedures of *Usapang Buntis* and *Usapang Bagong Maginoo* will be discussed in this session.

Finally, advise the participants not to use the words 'gender' and 'gender-based violence,' as these words might not be familiar to their FP-MCH clients. In this guide, the terms used are "relationship of woman and man or spouses/partners" and "use of violence or harm."

Usapang Buntis

Bring the participants' attention to the gender section of *Usapang Buntis*. Flash the facilitators guide and show the location of the gender section, which is presented below.

INPUTS ON GENDER AND ADDRESSING GENDER-BASED VIOLENCE

This part of the *Usapan* tackles the principles and manner of improving or transforming man-woman relations towards family health and wellness as well as the available services for those experiencing GBV, including intimate partner violence.

Step	Topic / Content	Indicative Time Allocations	Materials/Supplies Needed
Entry of the gender part	This gender part begins after the interactive lecture on safe motherhood and before action planning.		
1	Linking Statement (Introduce this gender portion by stressing the relevance and importance of the nature of husband-and-wife relationship to safe motherhood)	1 minute	<ul style="list-style-type: none"> PowerPoint presentation cover page
2	Exercise: Differences between Two Types of Husband-and-Wife Relationship (Ask participants to write on a set of metacards the characteristics of the first type of husband-wife relationship, and on another set of metacards the characteristics of the second type of husband-wife relationship)	4 minutes	<ul style="list-style-type: none"> Metacards (2 colors; 2 pieces per color per participant) Permanent markers Masking tape Manila paper (2 pieces) Board or wall
3	Sharing of Reflections on the Two Types of Husband-and-Wife Relationship (Let the participants share their comparison of the effects of the two types of husband-and-wife relationship on safe motherhood and family well-being)	10 minutes	PowerPoint presentation (slide containing the guide questions)
4	Lecture (Enrich the participants' understanding of the effects of the condition of their relationship with their spouses on safe motherhood and family well-being, and of the importance of preventing and addressing gender-based violence.)	5 minutes	<ul style="list-style-type: none"> Visual aids (PowerPoint presentation)
TOTAL TIME: 20 minutes			

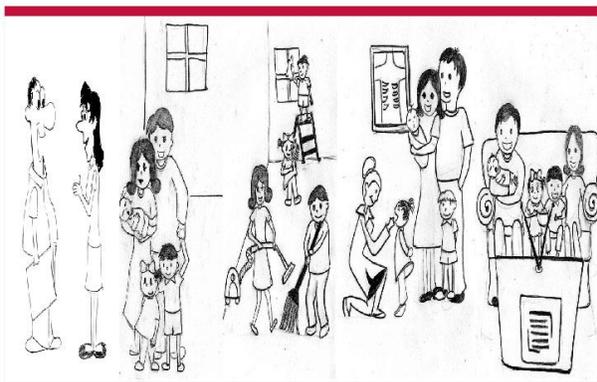
SLIDE 33	Instructions
<p data-bbox="224 296 724 325">Kumusta ang relasyon naming mag-asawa?</p> <div data-bbox="203 342 797 720" style="border: 1px solid black; padding: 10px;"> <p data-bbox="280 415 703 489" style="text-align: center;">Paano nito naapektuhan ang aking pagbubuntis?</p>  </div>	<ol style="list-style-type: none"> <li data-bbox="862 258 1422 590">1. While showing this picture, say that in this “<i>Usapan</i>,” the focus of discussion is on the relationship between the husband and wife because the quality of this relationship is important to safe pregnancy or safe motherhood. You would thus like to invite the participants to assess the condition of their relationships with their spouses. <li data-bbox="862 642 1422 785">2. Let the participants read the title: “<i>Kumusta ang relasyon naming mag-asawa? Paano nito naapektuhan ang aking pagbubuntis?</i>” <li data-bbox="862 842 1422 989">3. Say that to assess their relationships with their husbands, you will ask them to analyze two pictures representing two types of husband-and-wife relationships. <li data-bbox="862 1045 1422 1079">4. Show the first picture/image.
<p data-bbox="191 1150 321 1180">SLIDE 34</p> <p data-bbox="215 1241 639 1270">Unang larawan ng relasyon ng mag-asawa</p> <div data-bbox="203 1287 797 1665" style="border: 1px solid black; padding: 10px;">  </div>	<ol style="list-style-type: none"> <li data-bbox="862 1203 1422 1346">1. While showing this first picture/image, ask participants to closely look at the characteristics of the relationship between the husband and the wife. <li data-bbox="862 1402 1422 1625">2. Give each participant one metacard. Ask them to write on their metacards the characteristics of the relationship between the husband and the wife in the picture. Tell them to write only one characteristic in their metacard. <li data-bbox="862 1682 1422 1751">3. Ask them to post their metacards on a designated part of the wall or board. <li data-bbox="862 1808 1422 1841">4. Arrange together the metacards with the

same or similar contents.

5. Do not read yet the metacards. Move to the next part, that is, show the second picture.

SLIDE 35

Ikalawang larawan ng relasyon ng mag-asawa



1. Similar to the first image, ask them to closely look at the relationship between the husband and the wife in this second image.
2. Give each participant one metacard. Ask them to write on their metacards the characteristics of the relationship of the husband and wife in the picture. Tell them that there can be only one characteristic on one metacard.
3. Ask them to post their metacards on designated part of the wall or board.
4. Arrange together the metacards with the same or similar contents.

SLIDE 36

Paghahambing ng dalawang larawan

- Ano ang katangian ng relasyon ng mag-asawa sa unang larawan?
 - Ano ang epekto ng ganitong relasyon sa pagpapalano ng pamilya, pagbubuntis at kalusugan ng ina at sanggol?
- Ano ang katangian ng relasyon ng mag-asawa sa sa ikalawang larawan?
 - Ano ang epekto ng ganitong relasyon sa pagpapalano ng pamilya, pagbubuntis at kalusugan ng ina at sanggol?
- Ano ang gagawin ng mag-asawa upang maiwasan ang unang uri ng relasyon at maitaguyod ang pangalawang uri?

1. Read the first question on the slide. For the answer, let one participant read the contents of the metacards for the first picture/image. Then ask the sub-question, *“Ano ang epekto ng ganitong relasyon sa pagpapalano ng pamilya, pagbubuntis at kalusugan ng ina at sanggol?”*
2. Read the second question. For the answer, let another participant read the contents of the metacards for the second picture/image. Then ask the sub-question, *“Ano ang epekto ng ganitong relasyon sa pagpapalano ng pamilya, pagbubuntis at*

	<p><i>kalusugan ng ina at sanggol?”</i></p> <ol style="list-style-type: none"> 3. Focusing on both images, ask the participants: <i>“Ano ang gagawin ng mag-asawa upang maiwasan o matigil ang unang uri ng relasyon at maitaguyod ang pangalawang uri ng relasyon?”</i> 4. Summarize the answers of the participants to your questions. 5. Then say that you will deepen this discussion by sharing the results of studies on the effects of the relationship between the husband and wife on FP-MCH care. Proceed to your very brief lecture.
SLIDE 37	
<p>Epekto ng relasyong mag-asawa sa FP-MCH</p> <hr style="border: 2px solid red;"/> <p>Sang-ayon sa National Demographic and Health Survey 2008:</p> <ul style="list-style-type: none"> – Ang mga babaeng hindi gaano o hindi kasama sa pagdesisyon sa pamilya ay ang siyang: <ol style="list-style-type: none"> 1. Hindi natutugunan ang pangangailangan para sa pagpapalano ng pamilya (high unmet FP need). 2. Hindi nagpapatingin sa doktor sa tamang panahon pagkapanganak. 	<ol style="list-style-type: none"> 1. Ask a participant to read the slide. 2. Say that the results of this survey can be interpreted as saying that women who are not given a chance to participate in decision-making, or who do not want to participate in decision-making have less ability to assess, consult health providers, and act on their FP needs. They also tend not to get post-partum care. This implies that their lack of assertiveness or lack of recognition of their important role in decision-making or their inability to implement what they would like to do is an obstacle to FP and maternal health care. 3. Therefore, this survey strongly suggests the importance of the participation of women together with men in decision-making in their families. Even very poor families must make decisions about how to spend money. Why is the mother often the last to have her needs taken

	care of? (Limit discussion here to two comments and move on.)
SLIDE 38	
<p>Epekto ng relasyong mag-asawa sa FP-MCH</p> <p>Sang-ayon sa National Demographic and Health Survey 2008:</p> <ul style="list-style-type: none"> – Ang mga babaeng ipinagtanggol pa ang pananakit sa kanila ng kanilang asawa ay malamang na : <ol style="list-style-type: none"> 1. Hindi gumagamit ng contraceptive methods (modern man o traditional); at 2. Mas malaki ang pangarap na dami ng anak. <p>Ang pananakit o karahasan ay maaaring nasa anyong seksuwal, pisikal, psikolohikal (kalooban) at pangkabuhayan (economic).</p>	<ol style="list-style-type: none"> 1. Ask a participant to read the slide. 2. Say that this result of the survey shows the need to raise the awareness of women on the effects of violence, and their right to be free from all forms of violence. When free from violence, a woman will more likely effectively participate in FP and take care of health, especially during and after pregnancy. <p>IMPORTANT: Don't ask the participants if they are being abused or hurt by their husbands. This will put them on the spot, and may cause them to lose interest in the topic. Use plural third person "they/<i>sila</i>" in describing victims-survivors and perpetrators.</p>
SLIDE 39	
<p>Relasyon ng Babae at Lalaki sa Pilipinas</p> <p>Sang-ayon sa mga batas ng Pilipinas:</p> <ul style="list-style-type: none"> • Pantay ang babae at lalaki sa pamilya at sa lahat ng larangan ng lipunan. • Dapat na parehong nag-dedesisyon ang mag-asawa sa anumang usapin sa pamilya, kasama na sa pagpapalano ng pamilya. • Sa panahon ng hindi pagkakasundo, ang desisyon ng may katawan (gagamit ng FP method) ang masusunod. Kagaya ng kanyang asawa, hindi kailangan ng babae ang nakasulat na pagsang-ayon (written consent) ng asawa para sa paggamit ng anumang uri ng FP method. 	<ol style="list-style-type: none"> 1. Say that the equality of women and men is promoted and protected by Philippine laws. 2. If asked what these laws are, mention the following examples: <ul style="list-style-type: none"> • Philippine 1987 Constitution • Family Code of the Philippines • Women in Development and Nation Building Act

- Magna Carta of Women

- Responsible Parenthood and Reproductive Health Law

3. Ask another participant to read the slide.
4. Stress the importance of decision-making of husband and wife. Say that there are, however, times when conflict or disagreement between them happens. In this situation, it is important for the man to respect the decision of the woman if she is the one to use the FP method. This is her legal right. And violence should not be committed against her if her choice or decision conflicts with her husband.

To promote equality between women and men in the households/families and stop intimate partner violence, it is important to do the actions listed in the next two slides.

SLIDE 40

Ano ang maaaring gawin ng mag-asawa upang mapaunlad ang kanilang relasyon?

Mahinahon at buong pagmamahal na pag-usapan ang:

- Magkatuwang na pagdedesisyon sa pamilya;
- Pagtutulongan sa gawaing bahay at pangangalaga ng mga anak.
- Masinop na paraan ng paglutas ng alitan o problema. Hindi gagamit ng anumang uri ng karahasan. Dapat may paggalang sa dignidad at karapatan ng bawat isa.

Humingi ng payo (o family counseling) sa mga eksperto at kinauukulan kung hindi sapat ang pakikipag-usap sa asawa.

1. Let all the participants read the slide.
2. You may say that if any participant needs more information or guidance on how to enhance her relationship with her spouse, she may consult you. In addition, she may also approach government organizations, such as the Department of Social Welfare and Development or the Women's Desk (if any) of the barangay, and other organizations, such as the Church or NGOs, for counseling.

SLIDE 41**Para sa mga nakararanas ng karahasan****Humingi ng tulong sa kinaaukulan:**

- Barangay Council para sa protection order
- DSWD para sa serbisyong psycho-social (counselling, temporary shelter, livelihood, tulong pinansiyal sa panahon ng paglutas ng problema.)
- DOH/PHO/CHO/MHO o ng Women and Children Protection Unit para sa serbisyong medikal at serbisyong mediko-legal;
- NBI/PNP Women and Children Protection Desk para sa investigation, rescue at proteksiyon ng biktima;
- DOJ/Public Attorney's Office/Prosecutor's Office para sa serbisyong legal/prosecution.

1. Ask another participant to read the slide.
2. It would help if you have prior knowledge of the contact information or government agencies mentioned here, and of NGOs providing help. If you do, then you may share this information with the participants. This is in case there is a GBV survivor among participants who would like to directly contact these agencies or organizations.
3. After this, say you will proceed to the next steps of the *Usapang Buntis*.
4. When the process reaches the part where the participants are asked to fill out the back part of their Action Card, bring to their attention the part of the action card that is meant to improve their relations with their husbands.

Usapang Bagong Maginoo

Bring the participants' attention to the gender section of *Usapang Bagong Maginoo*. Flash the facilitators guide and show the location of the gender section, which is presented below. Say that in this discussion the portions of *Usapang Bagong Maginoo* that are different from *Usapang Buntis* will be presented. These are the following:

- Linking statement, which highlights the effects of the characteristics of the male partner on the quality of relationship with the female partner, and the effects of the quality of relationship of spouses on FP and safe motherhood/pregnancy;
- Exercise, where the focus is on the characteristics of the male partner in the two pictures (same pictures used in *Usapang Buntis*) rather than on the characteristics of the relationship of spouses/partners; and
- Four additional slides, which discuss the attitudes and behavior of a man as a partner of a woman, client of FP, and agent of change.

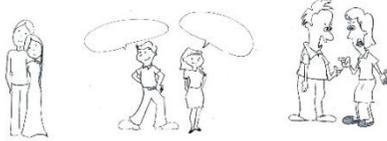
INPUTS on GENDER AND ADDRESSING GENDER-BASED VIOLENCE

This part of the *Usapan* tackles the principles and manner of improving or transforming man-woman relations towards family health and wellness, as well as the available services for those experiencing gender-based violence, including intimate partner violence.

Step	Topic / Content	Indicative Time Allocations	Materials/Supplies Needed
Entry of the gender part	The gender portion begins after Step 5 or after the participants have filled in the front portion of their “ <i>May Plano Ako</i> ” Action Card		
1	Linking Statement (Introduce this gender portion by stressing the importance of the influence of the characteristics/ attitudes of men in a husband-wife relationship on FP-MCH)	1 minute	<ul style="list-style-type: none"> • PowerPoint presentation cover page
2	Exercise: Differences between Two Types of Men in a Husband-and-Wife Relationship (Ask participants to write on a set of metacards the characteristics of the husband in the first type of husband-wife relationship, and on another set of metacards the characteristics of the husband in the second type of husband-wife relationship)	4 minutes	<ul style="list-style-type: none"> • Metacards (2 colors; 2 cards per color per participant) • Permanent markers • Masking tape • Manila paper (2 pieces) • Board or wall
3	Sharing of Reflections on the Two Types of Husband/Male Partner (Let the participants share their comparison of the effects of the two types of husband/male partner on FP-MCH)	10 minutes	PowerPoint presentation (slide containing the guide questions) or PRINTED job aid
4	Lecture (Enrich the participants’ understanding of the role of men in FP-MCH and the effects of the condition of their relationship with their spouses on family health and well-being, and of the importance of preventing and addressing gender-based violence.)	15 minutes	<ul style="list-style-type: none"> • Visual aids (PowerPoint presentation)
TOTAL TIME: 30 minutes			

SLIDE 9**Sino ang Bagong Maginoo?**

**Kumusta ang kanyang
relasyon sa kanyang
asawa at mga anak?**



1. While showing this picture, say that, at this point, the *Usapan* will move to a discussion of the characteristics of a man because these characteristics affect the quality of the husband-and-wife relationship, and that the quality of relationship affects smooth/effective decision-making on FP methods as well as safe pregnancy or safe motherhood. Because of its importance, you would like each of the participants at this point in the *Usapan* to assess the condition of his relationship with his spouse.
2. Let the participants read the title: “*Sino ang bagong maginoo? Kumusta ang kanyang relasyon sa kanyang asawa at mga anak?*”
3. Say that to discuss the characteristics of the new gentleman, you will begin by asking them to analyze two pictures depicting two types of men in a husband-and-wife relationship.
4. Show the first picture/image.

SLIDE 10**Isang larawan ng lalaki**

1. While showing this first picture/image, ask them to closely look at the characteristics of the man or husband.
2. Give each participant one metacard. Ask them to write on their metacards characteristics of the man in the picture. Tell them to write only one characteristic on their metacard.
3. Ask them to post their metacards on designated part of the wall or board.
4. Arrange together the metacards with the same contents.
5. Don't read the metacards yet. Move to the

	next slide, the second picture.
<p>SLIDE 11</p> <p>Isa pang larawan ng lalaki</p> 	<ol style="list-style-type: none"> 1. Similar to the first image, ask participants to look closely at the characteristics of the husband in this second image. 2. Give each participant one metacard. Ask them to write in their metacards the characteristics of the man in the picture. Tell them to write only one characteristic on their metacard. 3. Ask them to post their metacards on a designated part of the wall or board. 4. Put together the metacards with the same contents. Move to the next slide.
<p>SLIDE 12</p> <p>Paghambing sa dalawang lalaki</p> <ul style="list-style-type: none"> • Ano ang katangian ng lalaki sa unang larawan? <ul style="list-style-type: none"> ➢ Ano ang epekto ng ganitong katangian sa pagpapalano ng pamilya at pangangalaga ng kalusugan ng ina? • Ano ang katangian ng lalaki sa ikalawang larawan? <ul style="list-style-type: none"> ➢ Ano ang epekto ng ganitong katangian sa pagpapalano ng pamilya at pangangalaga ng kalusugan ng ina? • Sino sa dalawang lalaking ito ang bagong maginoo? Bakit? 	<ol style="list-style-type: none"> 1. Read the first question on the slide. For the answer, let the participants read the contents of the metacards for the first picture/image. Then ask them the sub-question, “<i>Ano ang epekto...?</i>” 2. Read the second question. For the answer, let the participants read the contents of the metacards for the second picture/image. Then ask them the sub-question, “<i>Ano ang epekto...?</i>” 3. Ask the participants: “<i>Sino sa dalawang lalaking ito ang bagong maginoo? Bakit?</i>” Summarize the answer of the participants to your questions. 4. Then say that you will deepen this discussion by presenting the characteristics of the new gentleman. Proceed to your lecture.

SLIDE 13	
<p>Ang bagong maginoo</p> <ul style="list-style-type: none"> • Dati, ang lalaki ay itinuturing na maginoo kung siya ay: <ul style="list-style-type: none"> – Macho – Mas mataas ang estado sa buhay kaysa sa babae – Tagapag-desisyon – Dominante (hindi raw “under the saya”) • Ngayon, ang lalaking itinuturing na bagong magino ay ang lalaking: <ul style="list-style-type: none"> – Katuwang ng babae – Kliyente ng pagpapalano ng pamilya – Tagapag-sulong ng pagbabago 	<ol style="list-style-type: none"> 1. Ask a participant to read the slide. 2. Then you may say that we hope that this ‘bagong maginoo’ will be present in all families because this kind of man is needed to ensure family health through FP and support of safe pregnancy/motherhood. 3. Say that you will discuss each of these characteristics of a ‘bagong maginoo.’ Go to the next slide.
SLIDE 14	
<p>Ang maginoong lalaki: Bilang katuwang</p> <p>Itinuturing niyang katuwang ang babae – kapantay niya sa kahalagahan, karapatan at kakayahan:</p> <ul style="list-style-type: none"> • Pinapakita niya ito sa larangan ng magkasamang pagdedesiyon at bahaginan ng gampanin sa pamilya, kasama na ang gawaing-bahay. • Mahinahon nilang nilulutas ang kanilang alitan. Hindi kailan man gumagamit ng dahas. 	<ol style="list-style-type: none"> 1. Ask a participant to read the slide. 2. Say that if there are hindering factors to becoming a partner, then it is important to remove or overcome these factors for the sake of the health and well-being of the families.
SLIDE 15	
<p>Ang maginoong lalaki: Bilang kliyente</p> <p>Itinuturing niyang kapwa responsibilidad nilang mag-asawa ang pagpapalano ng pamilya. Kaya:</p> <ul style="list-style-type: none"> • Siya din ay lumalahok sa mga konsultasyon ukol sa pagpapalano ng pamilya. • Sinusuri din niya kung ano ang angkop na FP method ang gagamitin nila. • Hindi sinasaktan ang asawa kung hindi siya sang-ayon sa FP method. 	<ol style="list-style-type: none"> 1. Ask a participant to read the slide. 2. Say that one of the resource persons of this <i>Usapan</i> or you will later discuss FP methods that men can use.

SLIDE 16	
<p>Ang maginoong lalaki: Bilang taga-pagsulong ng pagbabago</p> <p>Itinataguyod niya ang pagpapalano ng pamilya at pangangalaga ng kalusugan. Kaya, nakikilahok siya sa:</p> <ul style="list-style-type: none"> • Pagtaas ng kamulatan ng mga lalaki ukol sa pantay na halaga, dignidad, karapatan at kakayahan ng lalaki at babae, at sa kahalagahan ng magkatuwang na partisipasyon ng lalaki at babae sa pagpapalano ng pamilya. • Pagtigil sa lahat ng uri ng karahasan laban sa babae, kapwa lalaki, at mga bata. • Pagbibigay impormasyon ukol sa mga nakalaang serbisyo para sa mga biktima ng karahasan. 	<ol style="list-style-type: none"> 1. Ask a participant to read the slide. 2. Emphasize that if this kind of man is present in families and society, then we will have healthy families and communities. 3. Then, you may say the following as a linking statement to the next slide: <p>For further discussion of the importance of adopting the qualities of the new gentleman, let us discuss the results of a study on the effects of husband-and-wife relationship on FP-MCH.</p>
SLIDE 17	
<p>Epekto ng relasyong mag-asawa sa pagpapalano ng pamilya at kalusugan ng ina</p> <p>Sang-ayon sa National Demographic and Health Survey 2008:</p> <ul style="list-style-type: none"> – Ang mga babaeng hindi gaano o hindi kasama sa pagdesisyon sa pamilya ay ang siyang: <ol style="list-style-type: none"> 1. Hindi natutugunan ang pangangailangan para sa pagpapalano ng pamilya (high unmet FP need). 2. Hindi nagpapatingin sa doktor sa tamang panahon pagkapanganak. 	<ol style="list-style-type: none"> 1. Ask a participant to read the slide. 2. Say that the results of this survey can be interpreted as suggesting that women who are not given a chance to participate in decision-making, or who prefer not to participate in decision-making, have a lower ability to assess and consult health providers and act on their FP needs or they do not perceive FP needs. They also tend to ignore or be unaware of, or are not allowed to attend to their need for post-partum care. This implies that their lack of assertiveness or lack of recognition of their important role in decision-making tend to serve as obstacles to FP and maternal health care. 3. Therefore, this survey strongly suggests the importance of the participation of women together with the men in decision-making in their families.

SLIDE 18	
<p>Epekto ng relasyong mag-asawa sa pagpapalano ng pamilya at kalusugan ng ina</p> <p>Sang-ayon sa National Demographic and Health Survey 2008</p> <ul style="list-style-type: none"> – Ang mga babaeng ipinagtatanggol pa ang pananakit sa kanila ng kanilang asawa ay malamang na: <ul style="list-style-type: none"> • Hindi gumagamit ng contraceptive methods (modern man o traditional) at • Mas malaki ang pangarap na dami ng anak. <p>Ang pananakit o karahasan ay maaaring nasa anyong seksuwal (marital rape, incest), pisikal, psikolohikal (kalooban) at pangkabuhayan (economic).</p>	<ol style="list-style-type: none"> 1. Ask another participant to read this slide. 2. Say that this result of the survey strongly suggests the need to raise the awareness of men and women on the effects of violence, and on the right of women (as well as of men) to be free from all forms of violence. 3. IMPORTANT: Don't ask the participants if they are abusing or hurting their wives. This will put them on the spot, and may cause them to lose interest in the topic. Use the plural third person, "they/<i>sila</i>," in describing victims-survivors and perpetrators.
SLIDE 19	
<p>Relasyon ng babae at lalaki sa Pilipinas</p> <p>Sang-ayon sa mga batas ng Pilipinas:</p> <ul style="list-style-type: none"> • Pantay ang babae at lalaki sa pamilya at sa lahat ng larangan ng lipunan. • Dapat na parehong nagdedesisyon ang mag-asawa sa anumang usapin sa pamilya, kasama na sa pagpapalano ng pamilya. • Sa panahon ng hindi pagkakasundo, ang desisyong may katawan (gagamit ng FP method) ang masusunod. Kagaya ng kanyang asawa, hindi kailangan ng babae ang nakasulat na pagsang-ayon (written consent) ng asawa para sa paggamit ng anumang uri ng FP method. 	<ol style="list-style-type: none"> 1. Say that the equality of women and men is promoted and protected by Philippine laws. If asked on what these laws are, mention the following as examples: <ul style="list-style-type: none"> • Philippine 1987 Constitution • Family Code of the Philippines • Women in Development and Nation Building Act • Magna Carta of Women • Responsible Parenthood and Reproductive Health Law 2. Ask another participant to read the slide. 3. Emphasize the importance of joint decision-making by husband and wife. Say that there are, however, times when conflict or disagreement between them happens. In this situation, it is important for the man to

	<p>respect the decision of the woman if she is the one to use an FP method. This is her legal right. And violence should not be committed against her if her choice or decision conflicts with that of her husband's.</p> <p>To promote equality between women and men in the households/families and stop intimate partner violence, it is important to do the actions listed in the next two slides.</p>
<p>SLIDE 20</p> <p>Ano ang maaaring gawin ng mag-asawa upang maitaguyod ang kalusugan at kagalingan ng pamilya?</p> <p>Mahinahan at buong pagmamahal na pag-usapan ang:</p> <ul style="list-style-type: none"> • Magkatuwang na pagdedesisyon sa pamilya; • Pagtutulongan sa gawaing bahay at pangangalaga ng mga anak. • Masinop na paraan ng paglutas ng alitan o problema. Hindi gagamit ng anumang uri ng karahasan. Dapat may paggalang sa dignidad at karapatan ng bawat isa. <p>Humingi ng payo (o family counseling) sa mga eksperto at kinaaukulan kung hindi sapat ang pakikipag-usap sa asawa.</p>	<ol style="list-style-type: none"> 1. Let all the participants read the slide. 2. You may say that if any of the participants need more information or guidance on how to enhance his relationship with his spouse, they may consult you. In addition, they may also approach government organizations, such as the Department of Social Welfare and Development or the Women's Desk (if any) of the barangay, and other organizations, such as the Church or NGOs, for counseling.
<p>SLIDE 21</p> <p>Para sa mga nakararanas ng karahasan</p> <p>Humingi ng tulong sa kinaaukulan:</p> <ul style="list-style-type: none"> • Barangay Council para sa protection order • DSWD para sa serbisyong psycho-social (counselling, temporary shelter, livelihood, tulong pinansiyal sa panahon ng paglutas ng problema.) • DOH/PHO/CHO/MHO o ng Women and Children Protection Unit para sa serbisyong medikal at serbisyong mediko-legal; • NBI/PNP Women and Children Protection Desk para sa investigation, rescue at proteksiyon ng biktima; • DOJ/Public Attorney's Office/Prosecutor's Office para sa serbisyong legal/prosecution. 	<ol style="list-style-type: none"> 1. Ask another participant to read the slide. 2. It will help if you have prior knowledge of the contact information of government agencies mentioned here, and of NGOs providing help. If you do, share this information with the participants. This is in case they know of a GBV survivor who would like to directly contact these agencies or organizations. 3. After this, say you will proceed to the next steps of the <i>Usapang Bagong Maginoo</i>: Their roles in promoting safe pregnancy/ motherhood, and FP methods that they can use.

-
4. When the process reaches the part where the participants will be asked to fill out the back part of their Action Card, bring to their attention the part of the action card that is meant to improve their relations with their spouses.
-

Apart from the above areas of difference, all other parts of *Usapang Bagong Maginoo* are the same as in *Usapang Buntis*, *Usapang Pwede Pa* and *Usapang Kuntento Na*; and hence, will no longer be discussed in this session.

Evaluation

The effectiveness of the gender session is measured in this training in two ways:

The first is by computing the difference of the scores of a participant's pre-test and post-test results. A positive difference (post-test score minus pre-test score) means that a participant acquired new knowledge from the training.

Before the closing activity of the four-day *Usapan* facilitator's workshop, present the overall results of the tests. See table below for example. Note that 18 participants got higher scores in their post-tests than in their pre-tests; thus the difference is in positive numbers. One participant got a zero, which indicates no additional knowledge; and one participant got a higher score in the pre-test than in post-test (thus the difference is a negative number), which indicates that the session did not increase his/her knowledge, but rather confused her/him about the correct answers.

Participants #	Post-test Score	Pre-test Score	Difference
1	20	10	10
2	20	16	4
3	20	16	4
4	20	14	6
5	20	12	8
6	20	6	14
7	20	14	6
8	18	12	6
9	18	12	6
10	18	10	8
11	18	16	2
12	18	12	6
13	16	10	6

14	16	14	2
15	16	14	2
16	14	12	2
17	14	12	2
18	12	6	6
19	6	6	0
20	8	14	-6

Once you have figured the pre-post-test scores, make a similar table and record the scores. The table should be sent or given to PRISM2. It is important that no participant's name will be recorded, just assign everyone a number in the table, as this table does. Return the answered pre-tests and post-tests of participants. (Note: as the participants used codes rather than their real names, let them search for their own papers). Explain the correct answers to the participants. As you may need these tests for your report, request them to give to you their answered forms.

The second way of measuring the effectiveness of the gender session is by observing participants during the gender section of the four *Usapan* variants. Focus on the way the assigned participant: (a) states the linking statement from the previous topic; (b) explains the exercise; (c) encourages participation during the exercise, sharing of reflections and analysis after the exercise, and lecture-discussion; (d) begins the lecture smoothly from the sharing of reflections/analysis; (e) explains each of the slides in the lecture portion; (f) gives the ending statement of the gender portion; and (g) effectively uses the job aid.

Usapan Trainer's Guide Sessions 10 to 13

Overview

This cluster of sessions serves as the culmination of the *Usapan* facilitator's training. The technical inputs have already been delivered in previous sessions. At this juncture, the training will focus on the application in *Usapan* of all technical inputs that trainees received.

Learning objectives in this cluster of sessions: The trainees shall:

- Observe and learn more from a demonstration of an *Usapan* session
- Be able to apply their learnings through:
 - ✓ the supervised return demonstrations of selected segments of an *Usapan* session
 - ✓ in-field practicum conducting an actual *Usapan* session
- Gain additional insights on conducting an *Usapan* session through sharing of experiences from the in-field practicum

Session 10: Demonstration of *Usapang Pwede Pa*

TIME ALLOTMENT: 1 hours and 15 minutes

CONTENTS AND METHODOLOGY

Contents	Methodology	Time Allocation
<i>Usapang Pwede Pa</i>	Demonstration	1 hour & 15-30 minutes
	Plenary question and answer	15 – 30 minutes (depending on the actual time consumed during the demonstration)

ADVANCE PREPARATION OF MATERIALS

- Mount the 2 Tarpaulin flipcharts for easy reference during this session
 - ✓ FP
 - ✓ Safe Motherhood: *Mas Ligtas Kung Handa*
- Demonstration products of all available FP commodities
- Copies of *Usapang Pwede Pa* Action Cards

TOPIC / CONTENTS	TEACHING – LEARNING PROCESS
<p>Note to trainer: For this demonstration, just skip the “establishing rapport” step to save time for discussion after the demonstration.</p>	
<p>Using the metacard and Action Cards, perform Usapan Steps 1 to 5 of the structured exercises</p>	<ol style="list-style-type: none"> 1. You (trainer) will assume the role of <i>Usapan</i> facilitator. 2. Select 5-7 trainees who will assume the role of <i>Usapan</i> participants. 3. The rest of the trainees will reference their copy of the <i>Usapang Pwede Pa</i> facilitator’s guide to follow your demonstration. They will observe how you are implementing the instructions in the guide. 4. This is a full demonstration for you. Perform Steps 1 to 5 as indicated in the facilitator’s guide. 5. Do your best as <i>Usapan</i> facilitator and get the trainees who are role-playing as <i>Usapan</i> participants to actually perform the exercises by following your instructions.
<p>Deliver a dynamic presentation on FP and FP methods using the FP tarpaulin flipchart.</p>	<ol style="list-style-type: none"> 1. For this part, select another trainer, one who is really very good in presenting health information—presenting, NOT lecturing. 2. This is an abbreviated demonstration – meaning the trainer will not discuss all the FP methods in the flipchart. 3. The trainer should demonstrate discussing methods such as SDM-cycle beads and the IUD with the sample products in hand to show to <i>Usapan</i> participants.

4. Demonstrate by performing instructions in the following sections in the *Usapang Pwede Pa* Facilitator's Guide:

- a. What does FP mean to you? (*"Para sa inyo, ano ang ibig sabihin ng o kahulugan ng Family Planning?"*).

Remember to use metacards here.

- b. Discuss Page 1 of flipchart: what is Family Planning? (*"Ano ang family planning?"*)
- c. Discuss Pages 2 -3 of flipchart: Benefits of FP (*"Mga dulot na kabutihan ng FP"*)
- d. Discuss Pages 4 - 7 of flipchart: Fertility awareness and joint fertility
- e. Present Page 8 of flipchart
- f. Present Page 10 of flipchart
- g. Present Page 12 of flipchart
- h. Present Page 14 of flipchart
5. Discuss Page 17 of flipchart. Use this page as take-off point for clarifying and discussing any remaining health concerns of participants regarding FP and FP methods.

NOTE: The *Usapan* facilitator conducting this portion should remember to make this interactive—e.g., ask participants: have you ever heard of this method before? Do you know anyone who has ever used it? Does anyone have any comments? Virtually all adult learning studies show that adults learn best through experience and participation. And this isn't a "class" or a "seminar," it's an *Usapan*. This is your chance to show how this is done properly.

<p>Discuss “<i>Relasyong Mag-asawa</i>”—Inputs on gender and gender-based violence</p>	<ol style="list-style-type: none"> 1. Select a trainer who has been trained in gender/GBV issues. 2. The trainer should fully demonstrate this part by following the instructions in the <i>Usapang Pwede Pa</i> facilitator’s guide. <p>NOTE: PRISM2 has worked with a corps of gender trainers. It would be best to use one of these (names and contact information are provided in the annex of this manual).</p>
<p>NOTE: The trainer who demonstrated facilitating the structured exercises using the front of the Action Card, should come back to demonstrate from this point down to the conclusion of the session.</p>	
<p>Facilitate having a satisfied FP user giving a testimony</p>	<p>Follow the directions in the <i>Usapang Pwede Pa</i> facilitator’s guide.</p>
<p>Facilitate Structured exercise to select an FP method (flipside of Action Card)</p>	<ol style="list-style-type: none"> 1. Follow the directions in the <i>Usapang Pwede Pa</i> facilitator’s guide. 2. Trainees who are role-playing as <i>Usapan</i> participants will use the checklist at the back of the action card that they used in Steps 1-5.
<p>Present/discuss FP clients’ rights</p>	<p>Follow the directions in the <i>Usapang Pwede Pa</i> facilitator’s guide.</p>
<p>Demonstrate ending the session and obtaining behavioral commitment</p>	<p>Follow the directions in the <i>Usapang Pwede Pa</i> facilitator’s guide.</p>

The *Usapan* demonstration is now complete.

Lead trainer facilitates a discussion by asking the trainees for observations and / or comments, how they felt as participants or observers; what was different between the *Usapan* and a Health Class or other group sessions with which they are familiar; which parts of the *Usapan Pwede Pa* do they anticipate will be easy for them; any parts with which they think they might have trouble. The trainers should try to help trainees with any parts that they say might be difficult to do.

NOTE: Experienced trainers can facilitate this in their own style, taking care to surface the same information/feelings.

End of Session

Session 1 I: Return Demonstrations

TIME ALLOTMENT: 4 hours ++

1. Divide the trainees into 3 groups. Each group will deliver a plenary return demonstration of a particular variant of *Usapan*, as follows:
 - a. Group 1: *Usapang Pwede Pa/Kuntento Na Combo*
 - b. Group 2: *Usapang Buntis*
 - c. Group 3: *Usapang Bagong Maginoo*

The plenary return demonstrations will allow the trainees to observe how the other *Usapan* variants are run, aside from the one assigned to their group.

2. The return demonstrations will follow the pattern used in the *Usapang Pwede Pa* demonstration above.
3. The trainers will note down their observations and provide feedback after the group has completed their return-demonstration.
4. Trainers should strive NOT to interrupt often, as this disrupts the trainee's thought process. Allow each trainee some time to overcome their "stage fright" and to establish a rhythm.
5. The trainers may opt to interrupt the return-demonstration if a critical mistake is committed by a particular trainee. For example, the sequence of structured exercises in Steps 1-5 was interchanged, or one step was omitted, or an *Usapan* "participant" was embarrassed, or the 'facilitator' disparaged the "participant's" medically incorrect information.
6. For ease of implementation of this part of the training, use the return-demonstration topic division/assignment worksheet below.
7. Duration of delivery by a trainee for the assigned topics below may range from 5 to 10 minutes, depending on the amount of information to be shared. For best results, trainers should practice delivering each of the assigned topics in order to be familiar with the length of time needed to present the information.

Return Demonstrations Topic Division/Assignment Worksheets

Group 1: Usapang Pwede Pa/Kuntento Na Combo

Group size: 6 members

- If group size is 7 members, assign two trainees to Topic 4 (pills, injectables, IUD, NSV, BTL), that is, pills and injectables to one trainee; IUD, NSV, BTL to another trainee.
- If group size is 8 members:
 - ✓ Assign two trainees to Topic 3, that is, NFP to one trainee; LAM and condoms to another trainee.
 - ✓ Assign two trainees to Topic 4, that is, pills and injectables to one trainee; IUD, NSV, BTL to another trainee.

Job Aids:

- Action Card
 - FP tarpaulin flipchart
-

Group 2: *Usapang Buntis*

Group size: 6 members

- If group size is 7 members, assign two trainees to Topic 4.
- If group size is 8 members,
 - ✓ Assign MCH (Topics 2 and 3 below) to three trainees;
 - ✓ Assign two trainees to Topic 4.

Job Aids:

- Action Card
 - Safe Motherhood (*Mas Ligtas Kung Handa*) tarpaulin flipchart
 - FP tarpaulin flipchart
-

TOPIC	JOB AID	ASSIGNED TRAINEE
1. Intro and <i>Pakikipagpalagayang-loob</i> ; Action Card Steps 1 to 5	Action Card	Trainee A (return demo part 1)
2. MCH Part 1	Flipchart Pages 1-6	Trainee B
3. MCH Part 2	Flipchart Page 7-12	Trainee C
4. FP and postpartum methods <ul style="list-style-type: none"> • MCH • FP Condom • POP • DMPA • IUD • BTL 	MCH Flipchart page 13 FP Flipchart page 11 FP Flipchart page 12 FP Flipchart page 13 FP Flipchart page 14 FP Flipchart page 16	Trainee D
5. Gender/GBV		Trainee E
6. Closing <ul style="list-style-type: none"> • Usapan Step 9. Facilitate having a satisfied mother (one who delivered in a facility, had 4 prenatal checkups, etc) give testimony • Usapan Step 10. Structured exercise to select a health actions • Usapan Step 11. Presentation of clients' rights • Usapan Step 12. Ending the session and obtaining behavioral commitment 	Action Card (Back) Flipchart page 18	Trainee A (return demo part 2)

Group 3: Usapang Bagong Maginoo**Group size: 6 members**

- If group size is 7 members; assign MCH (Topics 3 and 4 below) to three trainees.

Job Aids:

- Action Card
 - Safe Motherhood (*Mas Ligtas Kung Handa*) tarpaulin flipchart
 - FP tarpaulin flipchart
-

TOPIC	JOB AID	ASSIGNED TRAINEE
1. Intro and <i>Pakikipagpalagayang-loob</i> ; Action Card Steps 1-5	Action Card	Trainee A (return demo part 1)
2. Gender/GBV		Trainee B
3. MCH Part 1	Flipchart pages 1-6	Trainee C
4. MCH Part 2	Flipchart page 7-12	Trainee D
5. FP for males <ul style="list-style-type: none"> • MCH • Condom • NSV 	MCH Flipchart page 13 FP Flipchart Page 11 FP Flipchart Page 15	Trainee E
6. Closing <ul style="list-style-type: none"> • Usapan Step 9. Facilitate having a satisfied mother (one who delivered in a facility, had 4 prenatal checkups, etc.) to give a testimonial • Usapan Step 10. Structured exercise to select a health actions • Usapan Step 11. Presentation of clients' rights • Usapan Step 12. Ending the session and obtaining behavioral commitment 	Action Card (Back) Flipchart Page 18	Trainee A (return demo part 2)

Session 12: Briefing for the Practicum

(Includes discussion of completing *Usapan* forms: Attendance Sheet, Recording Form)

TIME ALLOTMENT: 1 hour

ADVANCE PREPARATION OF MATERIALS

- Attendance Sheets
- *Usapan* Recording Form

TOPIC / CONTENTS	TEACHING – LEARNING PROCESS
Discuss filling-up the <i>Usapan</i> Recording Form	<p>IMPORTANT: Emphasize the importance of reporting because this is an often neglected part of the whole <i>Usapan</i> process.</p> <p>Show on screen a sample of a completed <i>Usapan</i> Recording Form</p> <p>Discuss how to fill-up an <i>Usapan</i> Recording Form based on responses in the Action Card</p> <p>Trainers may let the groups practice filling-up an <i>Usapan</i> Recording Form</p>
Show on screen group assignments and let the members of each group gather together so that they can select a team leader and begin discussing their topic assignments	<p>Once the groups are formed and the leaders are identified, trainers should phase down their involvement in the groups and become active observers. Let group dynamics take over. This means:</p> <ol style="list-style-type: none"> 1. Allowing the groups to negotiate among themselves on topic assignments.

	<ol style="list-style-type: none"> 2. Making each group responsible for ensuring that they bring the required materials to the field and that they perform all the required steps in <i>Usapan</i>. 3. Making the leader accountable for her/his team's performance during the practicum.
<p>Announce the following:</p> <p>Staging area and time of departure to the practicum area</p> <p>Vehicle assignments</p> <p>Arrangements for food and water</p>	
<p>Dismiss the groups from the session, but encourage them to continue discussing through the night:</p> <p>How to introduce themselves—who will be the lead facilitator (not necessarily the group leader)</p> <p>Transitions from one speaker to another</p> <p>Practice delivering their assigned topics</p>	

Session 13: Practicum

REMINDERS FOR TRAINERS:

1. There should be at least one trainer per group to supervise them during the practicum.
2. Trainers, at this stage, are “interested observers”. They do not get in the way as the group executes their plan according to their agreed assignments. However, trainers should bring extra supplies, in case the groups forget something.
3. Even minor mistakes in execution should be “let go”. Frequent interruptions to correct a trainee in action will not really help as it will only contribute to more anxiety and loss of confidence. Let the trainee establish a flow/rhythm for a few minutes. Soon, the trainee will lose the nervousness and be more natural in the delivery of the assigned topic.
4. Trainers should ensure, however, that the correct sequence of activities is done and that no Usapan participant is embarrassed.
5. After the group session, experience has shown that the group members already feel a sense of accomplishment and tend to relax. While the last trainee is about to close the group session, trainers should gather the other group members to remind them that they have to do the following:
 - a. Ensure that the Action Cards are completely filled-up.
 - b. Guide interested participants to the assigned one-on-one counselors.
6. After the last speaker from the group, snacks may be served to the participants. This is the right time to break up the *Usapan* session and let interested participants move on to the one-on-one session.
7. After the one-on-one sessions and service provision and all *Usapan* participants have left, the trainer should gather the trainees together and ask them to fill-up the *Usapan* Recording Form. This is to build the discipline of filling-up the reporting form immediately after the activity, otherwise, the Action Cards could be misplaced and there would be no other way to complete the form.
8. Trainers should facilitate a brief discussion about problems encountered (from trainees and also from trainers’ points of view). Ask trainees to share how they felt about the experience and what aspects they would need further help with.

ANNEX A: Trainers' Worksheet: Topic Assignments for Basic Skills Practice Session on Sharing FP-MCH Information

Name of Trainee	Assigned Topic	Job Aid	Page No.
1.	<ol style="list-style-type: none"> 1. Introduction (brief ad lib) 2. <i>Ano ang FP?</i> 3. <i>Mga Kabutihang Dulot ng FP</i> 	FP Tarpaulin flipchart	1-3
2.	<ol style="list-style-type: none"> 1. Fertility Awareness: Joint Fertility 2. <i>Pagsasanib ng itlog ng babae at punlay ng lalake</i> 3. <i>Mga Bahagi ng Reproductive System ng Lalake at babae</i> 4. <i>Ang Siklo ng Pagreregla</i> 	FP Tarpaulin flipchart	4-7
3.	<ol style="list-style-type: none"> 1. <i>Mga Modernong Paraan ng FP: Fertility-Awareness Based Methods</i> 2. Standard Days Method 3. Billing Ovulation Method 4. Sympto-thermal Method 5. Basal Body Temperature Method 6. Lactational Amenorrhea method (LAM) 	FP Tarpaulin flipchart	8-10
4.	<ol style="list-style-type: none"> 1. Condom 2. Pills 3. Injectables 	FP Tarpaulin flipchart	11-13
5.	<ol style="list-style-type: none"> 1. IUD 2. BTL 3. NSV 	FP Tarpaulin flipchart	14-16
6.	<ol style="list-style-type: none"> 1. <i>Mga Katotohanan Tungkol sa FP</i> 2. <i>"Buti nalang Pwedeng Magtanong" (Alamin ang inyong mga karapatan.)</i> 	FP Tarpaulin flipchart	17-18
7.	<ol style="list-style-type: none"> 1. <i>Mas Ligtas kung Handa</i> (ad lib brief Intro) 2. <i>Maging handa para mas ligtas</i> 3. <i>Magpa-prenatal ng hindi bababa sa 4 na beses</i> 	SM Tarpaulin flipchart	1-3
8.	Pahalagahan ang prenatal checkup	SM Tarpaulin flipchart	4-5
9.	<ol style="list-style-type: none"> 1. <i>Gumawa kayong mag-asawa ng birth plan</i> 2. <i>Bantayan ang emergency signs</i> 	SM Tarpaulin flipchart	6-7
10.	<ol style="list-style-type: none"> 1. <i>Manatiling malusog habang buntis</i> 2. <i>Manganak lang sa health center, ospital o lying-in clinic</i> 	SM Tarpaulin flipchart	8-9
11.	<ol style="list-style-type: none"> 1. <i>Alamin ang gagawin kapag ikaw ay manganganak na</i> 2. <i>Gatas mo lang ang ipasuso kay baby</i> 	SM Tarpaulin flipchart	10-11
12.	<ol style="list-style-type: none"> 1. <i>Magpa-checkup pagkatapos manganak</i> 2. <i>Planuhin ang pamilya; planuhin ang kinabukasan</i> 	SM Tarpaulin flipchart	12-13

ANNEX B: Pre/Post-Training Test Questionnaire for Training on Gender in FP-MCH and in the 5Rs for Gender-Based Violence Victims/Survivors

TRAINING ON GENDER IN FP-MCH AND IN THE 5Rs OF GENDER-BASED VIOLENCE VICTIMS/SURVIVORS

Pre/Post-Training Test

Code: _____ (Please use same code in the pre-test and post-test forms. Thanks)

Sex: Female Male

Occupation: _____

City/Province: _____

Date: _____

Instructions: Please tick the best answers for each of the following statements. You may tick more than one answer for each statement. Scoring is right minus wrong.

Statement 1:

It is important to integrate gender-related concerns in Family Planning and Maternal and Child Health (FP-MCH) care program/service because:

- 1. In a family, women (and not the men) are responsible for family planning and maternal and child health (FP-MCH) care; and FP-MCH providers should therefore help the women understand and effectively perform this responsibility
- 2. Unequal relations of men and women (such as less participation of women in decision-making in the households) can affect FP-MCH;
- 3. One way of correcting men's dominance in a family and achieving gender equality is to urge men not to be involved in FP-MCH.
- 4. Upholding gender equality is a recognition of the equal rights, worth and dignity of women and men.

Statement 2:

As part of its guiding principle and philosophy, a clinic/hospital/school/workplace resolved to integrate gender in its programs and services. This means:

- 1. Developing and implementing any program or service for women.
- 2. Developing and implementing a program/service that will address or resolve the inequitable relations of men and women.
- 3. Developing and implementing a program/service that will make men and women become sensitive and responsive to the needs of each other.
- 4. Conducting regular medical mission for women in the communities as the most important activity.

Statement 3:

Gender-based violence (GBV):

- 1. Is violence involving women and men, but in most instances the victim is a woman and the perpetrator is a man.
- 2. Is sometimes justified, such as when the victim provoked the perpetrator to commit the abuse).
- 3. Is rooted on the unequal power relations of men and women.
- 4. Can be completely resolved by treating the personality disorders (e.g., anger management, uncontrolled sexual desires) of individual perpetrators.

Statement 4:

When a service provider detects or is approached by a GBV victim/survivor, it is important for the service provider to:

- 1. Immediately make clear to the victim/survivor that the provision of service for GBV is a responsibility of the government, and that a private service provider should not in any way intervene so as not to duplicate and complicate the process.
- 2. Report to the media the incidence, including the identities of the victim/survivor and perpetrator, to protect the victim/survivor and avoid the recurrence of violence.
- 3. Attend to the victim/survivor and inform her/him of her/his rights.
- 4 Explain to the victim the different services available from government and non-government/private organizations, and then refer the victim to the organization whose service is needed and preferred by the victim/survivor.

Statement 5:

It is important to record and report the GBV case. In relation to this:

- 1. Recording is done as a part of diagnosing the problem and determining the appropriate action.
- 2. Reporting of statistical data on GBV victims/survivors and perpetrators is important so as to know the extent of problem in the area and alert government and non-government organizations on the need for comprehensive multi-stakeholder response.
- 3. A service provider is allowed to reveal the identities of the victim and perpetrator to the media and other interested individuals and groups.
- 4. A service provider can include in the records her/his own judgments about the condition.

ANNEX C. Pre/Post-Test for Training on Gender in FP-MCH and in the 5Rs for Gender-Based Violence Victims/survivors

ANSWER KEY

Name: _____ (Please write your name; rest assured, we'll keep the results confidential)

Sex: Female Male

Occupation: _____

City/Province: _____

Date: _____

Instructions: Please tick the best answers for each of the following statements. You may tick more than one answer for each statement. Scoring is right minus wrong.

Statement 1:

It is important to integrate gender-related concerns in Family Planning and Maternal and Child Health (FP-MCH) care program/service because:

- 1. In a family, women (and not the men) are responsible for family planning and maternal and child health (FP-MCH) care; and FP-MCH providers should therefore help the women understand and effectively perform this responsibility
- 2. Unequal relations of men and women (such as less participation of women in decision-making in the households) can affect FP-MCH;
- 3. One way of correcting men's dominance in a family and achieving gender equality is to urge men not to be involved in FP-MCH.
- 4. Upholding gender equality is a recognition of the equal rights, worth and dignity of women and men.

Statement 2:

As part of its guiding principle and philosophy, a clinic/hospital/school/workplace resolved to integrate gender in its programs and services. This means:

- 1. Developing and implementing any program or service for women.
- 2. Developing and implementing a program/service that will address or resolve the inequitable relations of men and women.
- 3. Developing and implementing a program/service that will make men and women become sensitive and responsive to the needs of each other.
- 4. Conducting regular medical mission for women in the communities as the most important activity.

Statement 3:

Gender-based violence (GBV):

- 1. Is violence involving women and men, but in most instances the victim is a woman and the perpetrator is a man.
- 2. Is sometimes justified, such as when the victim provoked the perpetrator to commit the abuse).
- 3. Is rooted on the unequal power relations of men and women.
- 4. Can be completely resolved by treating the personality disorders (e.g., anger management, uncontrolled sexual desires) of individual perpetrators.

Statement 4:

When a service provider detects or is approached by a GBV victim/survivor, it is important for the service provider to:

- 1. Immediately make clear to the victim/survivor that the provision of service for GBV is a responsibility of the government, and that a private service provider should not in any way intervene so as not to duplicate and complicate the process.
- 2. Report to the media the incidence, including the identities of the victim/survivor and perpetrator, to protect the victim/survivor and avoid the recurrence of violence.
- 3. Attend to the victim/survivor and inform her/him of her/his rights.
- 4 Explain to the victim the different services available from government and non-government/private organizations, and then refer the victim to the organization whose service is needed and preferred by the victim/survivor.

Statement 5:

It is important to record and report the GBV case. In relation to this:

- 1. Recording is done as a part of diagnosing the problem and determining the appropriate action.
- 2. Reporting of statistical data on GBV victims/survivors and perpetrators is important so as to know the extent of problem in the area and alert government and non-government organizations on the need for comprehensive multi-stakeholder response.
- 3. A service provider is allowed to reveal the identities of the victim and perpetrator to the media and other interested individuals and groups.
- 4. A service provider can include in the records her/his own judgments about the condition.

ANNEX D: A Difference in the Hypothalamic Structure between Heterosexual and Homosexual Men

A Difference in Hypothalamic Structure between Heterosexual and Homosexual Men



Simon LeVay

Science, New Series, Vol. 253, No. 5023 (Aug. 30, 1991), 1034-1037.

Stable URL:

<http://links.jstor.org/sici?sici=0036-8075%2819910830%293%3A253%3A5023%3C1034%3AADIHSB%3E2.0.CO%3B2-T>

Science is currently published by American Association for the Advancement of Science.

Your use of the JSTOR archive indicates your acceptance of JSTOR's Terms and Conditions of Use, available at <http://www.jstor.org/about/terms.html>. JSTOR's Terms and Conditions of Use provides, in part, that unless you have obtained prior permission, you may not download an entire issue of a journal or multiple copies of articles, and you may use content in the JSTOR archive only for your personal, non-commercial use.

Please contact the publisher regarding any further use of this work. Publisher contact information may be obtained at <http://www.jstor.org/journals/aaas.html>.

Each copy of any part of a JSTOR transmission must contain the same copyright notice that appears on the screen or printed page of such transmission.

JSTOR is an independent not-for-profit organization dedicated to creating and preserving a digital archive of scholarly journals. For more information regarding JSTOR, please contact support@jstor.org.

growth, nuclear segregation, DNA repair, and meiosis, and deletion of *HRR25* results in cell cycle defects. These phenotypes, coupled with the similarity of the *HRR25* sequence to the sequence of the Raf-c-Mos protein kinase subgroup (Fig. 3A), suggest that *HRR25* might play a similar role in *S. cerevisiae* growth and development. The defects in DNA double-strand break repair and aberrant growth properties revealed by mutations in the *HRR25* kinase extend the possible functions of protein kinases in cell growth and place *HRR25* with *CDC7* in a functional category of yeast kinase associated with DNA metabolism.

REFERENCES AND NOTES

- P. C. Hanawalt, P. K. Cooper, A. K. Ganesan, C. A. Smith, *Annu. Rev. Biochem.* **48**, 783 (1979); T. Thompson, in *Genetic Recombination*, R. Kuchelapati and G. R. Smith, Eds. (American Society for Microbiology, Washington, DC, 1989), pp. 597-631; E. C. Friedberg, *Microbiol. Rev.* **52**, 70 (1988).
- L. Hartwell and T. W. Weinert, *Science* **246**, 629 (1990); T. W. Weinert and L. Hartwell, *ibid.* **241**, 317 (1988); R. Schiestl, P. Reynolds, S. Prakash, L. Prakash, *Mol. Cell. Biol.* **9**, 1882 (1989).
- R. Haynes and B. A. Kunz, in *Molecular Biology of the Yeast Saccharomyces*, J. Strathern, E. Jones, J. Broach, Eds. (Cold Spring Harbor Laboratory, Cold Spring Harbor, NY, 1981), pp. 371-414; J. Game, in *Yeast Genetics: Fundamental and Applied Aspects*, J. F. T. Spencer, D. M. Spencer, A. R. W. Smith, Eds. (Springer-Verlag, New York, 1983), pp. 109-137.
- R. Kostriken and F. Heffron, *Cold Spring Harbor Symp. Quant. Biol.* **49**, 89 (1984); J. Nickoloff, J. D. Singer, M. F. Hockstra, F. Heffron, *J. Mol. Biol.* **207**, 527 (1989).
- R. E. Malone and R. E. Esposito, *Proc. Natl. Acad. Sci. U.S.A.* **77**, 503 (1980); B. Weiffenbach and J. Haber, *Mol. Cell. Biol.* **1**, 522 (1981).
- D. Schild *et al.*, *Curr. Genet.* **7**, 85 (1983); G. Cole *et al.*, *Mol. Cell. Biol.* **9**, 3101 (1989).
- Saccharomyces cerevisiae* strain K264-5B (26) (*MAT α ho ura3 can1⁺ tyr1 his7 lys2 ade5 met13 trp5 leu1 ade52*) was used for the mutant isolation. K264-5B was transformed with a *URA3*-based integrating plasmid that contains a *GAL1*-regulated HO endonuclease (4), and a transformant was mutagenized to approximately 50% survival with ethyl methanesulfonate. The culture was spread onto rich medium containing glycerol (to avoid formation of pellets), colonies were allowed to form at 30°C, and plates were replicated to glucose (HO-repressing) and galactose (HO-inducing) media. We identified mutants unable to grow on galactose. Approximately 200 mutants were chosen for initial characterization, and 62 mutants held the *gal*-phenotype through repeated single-colony purification. Among these, many were not complemented by various *gal* mutants. The remainder (25 mutants) were surveyed for overlapping DNA repair defects by determining sensitivity to UV irradiation and to MMS.
- M. F. Hockstra, R. M. Liskay, F. Heffron, unpublished data.
- Intragenic mitotic recombination was measured by the formation of prototrophs at heteroalleles (26), whereas intergenic recombination was measured by drug resistance at heterozygous loci (26).
- The *HRR25* gene was isolated by complementing for MMS sensitivity with a genomic library constructed in the plasmid YCp50 (27). An *hrr25-1* strain was transformed by standard methods (27), and transformants were replicated to media containing 0.01% MMS. Among 1200 transformants, a single MMS-resistant isolate was identified.
- Transposon mutagenesis with mTn10L.UK was by the methods described by O. Hoisman *et al.* [*Genetics* **116**, 191 (1987)]. Double-stranded DNA sequencing primers used to locate the end points of the mTn10 insertion in Figs. 1 and 3 were 5'-CTGCCCGGATTACAGCA-3' and 5'-GACGT-TGTAAAACGACGG-3'.
- Deletion of the *HRR25* coding sequence used a *hisG::URA3::hisG* cassette [E. Alani *et al.*, *Genetics* **116**, 541 (1987)]. The 3.1-kb *HRR25* Sal I fragment (Fig. 1) was first cloned into pBluescript (Stratagene). This plasmid was digested with Bgl II, and the two Bgl II fragments that span the entire *HRR25* gene and its flanking sequences were deleted (Fig. 1). Into this deletion was introduced the 3.8-kb Bam HI-Bgl II *hisG::URA3::hisG* fragment from pNKY51 to create the *hrr25 Δ* allele. Sal I digestion yielded a linearized fragment that deleted the entire *HRR25* locus.
- D. H. Williamson and D. J. Fennel, *Methods Cell Biol.* **12**, 335 (1975); C. Farnet *et al.*, *UCLA Symp. Mol. Biol. Cell. Biol.* **83**, 201 (1988).
- Cell populations were analyzed for DNA content distribution by flow cytometric analysis after staining with propidium iodide as described [K. J. Hunter and H. E. Eipel, *J. Gen. Microbiol.* **113**, 369 (1979)].
- S. K. Hanks, A. M. Quinn, T. Hunter, *Science* **241**, 42 (1988); S. K. Hanks and A. M. Quinn, *Methods Enzymol.* **200**, 38 (1991).
- The Lys³⁸ → Arg³⁸ mutation was introduced by site-directed mutagenesis (Bio-Rad, Cambridge, MA). The mutagenic oligonucleotide was 5'-CCTGATCGATTCCACGCTGATCGCTACTCTTCACCACT-3'.
- M. P. Kamps and B. M. Sefton, *Mol. Cell. Biol.* **6**, 751 (1986); M. J. Zoller, N. C. Nelson, S. S. Taylor, *J. Biol. Chem.* **256**, 10837 (1981); M. P. Kamps, S. S. Taylor, B. M. Sefton, *Nature* **310**, 589 (1984); M. Hannink and D. J. Donoghue, *Proc. Natl. Acad. Sci. U.S.A.* **82**, 7894 (1985).
- L. H. Johnston *et al.*, *Mol. Cell. Biol.* **10**, 1358 (1990).
- M. F. Hockstra, A. DeMaggio, N. Dhillon, unpublished data.
- A. J. Courey and R. Tijan, *Cell* **55**, 887 (1988); D. Bohmann *et al.*, *Science* **238**, 1386 (1987); I. Rousso *et al.*, *Mol. Cell Biol.* **8**, 2132 (1988); J. L. Arriza *et al.*, *Science* **237**, 268 (1987); H. Matsushima *et al.*, *Mol. Cell. Biol.* **10**, 2261 (1990).
- K. Wharton, B. Yedvobnick, V. Finnerty, S. Artavanis-Tsakonas, *Cell* **40**, 55 (1985); C. Coffman, W. Harris, C. Kintner, *Science* **249**, 1438 (1990).
- P. Silver, I. Sadler, M. A. Osbourne, *J. Cell Biol.* **109**, 983 (1989); R. B. Morceland *et al.*, *Mol. Cell Biol.* **7**, 4048 (1987).
- A. T. Lorincz and S. I. Reed, *Nature* **307**, 183 (1984); J. Hindley and G. A. Phear, *Gene* **31**, 129 (1984); P. Russell and P. Nurse, *Cell* **49**, 559 (1987); *ibid.*, p. 569.
- M. Paterson *et al.*, *Mol. Cell. Biol.* **6**, 1590 (1986); D. Schild and B. Beyers, *Chromosoma* **70**, 109 (1978); G. D. E. Njagi and B. J. Kilbey, *Mol. Gen. Genet.* **186**, 478 (1982); R. E. Hollingsworth, Jr., and R. A. Scalfani, *Proc. Natl. Acad. Sci. U.S.A.* **87**, 6272 (1990).
- N. Sagata *et al.*, *Nature* **335**, 519 (1988).
- R. E. Malone and M. F. Hockstra, *Genetics* **107**, 33 (1984); B. Montelone, M. F. Hockstra, R. E. Malone, *ibid.* **119**, 289 (1988).
- M. D. Rose *et al.*, *Gene* **60**, 237 (1987).
- An MEF14 *hrr25::LUK* heterozygous transformant was dissected onto a thin film of YPD-rich medium on a sterilized microscope slide, and segregants were allowed to germinate under a cover slip by incubation of the slide in a moist 30°C chamber. Photographs of colonies were taken after 2 days of growth.
- We thank L. Caballero, A. M. Quinn, S. Hanks, N. Dhillon, and T. Hunter for helpful comments and assistance with sequence alignments; R. Keil for help with x-irradiation screening; and S. Reed and his lab for assistance with an initial microscopic examination. M.F.H. is a Lucille P. Markey Scholar in Biomedical Sciences. Supported by grants from the Lucille P. Markey Charitable Trust and the NIH.

26 February 1991; accepted 23 May 1991

A Difference in Hypothalamic Structure Between Heterosexual and Homosexual Men

SIMON LEVAY

The anterior hypothalamus of the brain participates in the regulation of male-typical sexual behavior. The volumes of four cell groups in this region [interstitial nuclei of the anterior hypothalamus (INAH) 1, 2, 3, and 4] were measured in postmortem tissue from three subject groups: women, men who were presumed to be heterosexual, and homosexual men. No differences were found between the groups in the volumes of INAH 1, 2, or 4. As has been reported previously, INAH 3 was more than twice as large in the heterosexual men as in the women. It was also, however, more than twice as large in the heterosexual men as in the homosexual men. This finding indicates that INAH is dimorphic with sexual orientation, at least in men, and suggests that sexual orientation has a biological substrate.

SEXUAL ORIENTATION—SPECIFICALLY, the direction of sexual feelings or behavior toward members of one's own or the opposite sex—has traditionally been studied at the level of psychology, anthropology, or ethics (1). Although efforts have been made to establish the biological basis of sexual orientation, for example, by the application of cytogenetic, endocrinological, or neuroanatomical methods, these efforts

have largely failed to establish any consistent differences between homosexual and heterosexual individuals (2, 3).

A likely biological substrate for sexual orientation is the brain region involved in the regulation of sexual behavior. In nonhuman primates, the medial zone of the anterior hypothalamus has been implicated in the generation of male-typical sexual behavior (4). Lesions in this region in male monkeys impair heterosexual behavior without eliminating sexual drive (5). In a morphometric study of the comparable region of the

Salk Institute for Biological Studies, San Diego, CA 92186.

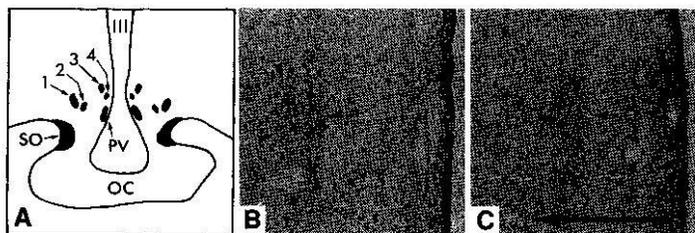


Fig. 1. (A) Semidiagrammatic coronal section through the human hypothalamus at the level of the optic chiasm (OC). The four cell groups studied (INAH 1, 2, 3, and 4) are indicated by the corresponding numerals. All four nuclei are not generally visible in the same coronal section: INAH 1 lies most anteriorly and INAH 4 most posteriorly. Supraoptic nucleus, SO; paraventricular nucleus, PV; and third ventricle, III. (B) Micrograph of INAH 3 from the left hypothalamus of a heterosexual male. The third ventricle is at the right of the figure. Arrowheads outline INAH 3. (C) Section from a homosexual male comparable to that in (B). INAH 3 is poorly recognizable as a distinct nucleus, but scattered cells similar to those constituting the nucleus in the heterosexual men were found within the area indicated by the arrowheads. The illustrated sections are near the middle of the anteroposterior extent of the nucleus in each case. The scale bar (1 mm) applies to (B) and (C).

human hypothalamus (from men and women of unknown sexual orientation), two small groups of neurons (INAH 2 and 3) were reported to be significantly larger in men than women (6). Thus, these two nuclei could be involved in the generation of male-typical sexual behavior.

I tested the idea that one or both of these nuclei exhibit a size dimorphism, not with sex, but with sexual orientation. Specifically, I hypothesized that INAH 2 or INAH 3 is large in individuals sexually oriented toward women (heterosexual men and homosexual women) and small in individuals sexually oriented toward men (heterosexual women and homosexual men). Because tissue from homosexual women could not be obtained, however, only that part of the hypothesis relating to sexual orientation in men could be tested.

Brain tissue was obtained from 41 subjects at routine autopsies of persons who died at seven metropolitan hospitals in New York and California. Nineteen subjects were homosexual men who died of complications of acquired immunodeficiency syndrome (AIDS) (one bisexual man was included in this group). Sixteen subjects were presumed (7) heterosexual men: six of these subjects died of AIDS and ten of other causes (8). Six subjects were presumed heterosexual women. One of these women died of AIDS and five of other causes (8). The mean age of the homosexual men was 38.2 years (range, 26 to 53 years), that of the heterosexual men was 42.8 years (range, 33 to 59 years), and that of the women was 41.2 years (range, 29 to 59 years). The subjects were younger and closer in age than those studied in previous investigations: tissue was not taken from elderly heterosexual men or women so that an approximate age-match would be pre-

served with the homosexual men, who were predominantly young or middle-aged adults (9).

The brains were fixed by immersion for 1 to 2 weeks in 10 or 20% buffered formalin and then sliced by hand at a thickness of about 1 cm in, or close to the coronal plane. Tissue blocks containing the anterior hypothalamus were dissected from these slices and stored for 1 to 8 weeks in 10% buffered formalin. These blocks were then given code numbers; all subsequent processing and morphometric analysis was done without knowledge of the subject group to which each block belonged. The blocks were infiltrated with 30% sucrose and frozen-sectioned at a thickness of 52 μm in planes parallel to the original slices. The sections were mounted serially on slides, dried, defatted in xylene, stained with 1% thionin in acetate buffer (15 to 30 min), and differentiated with 5% rosin in 95% alcohol (4 to 10 min). With the aid of a compound microscope equipped with a camera lucida attachment, the outlines of four nuclei (INAH 1, 2, 3, and 4) were traced in every section at a linear magnification of $\times 83$. These four nuclei included the two nuclei reported by Allen *et al.* (6) to be sexually dimorphic and two other nuclei (INAH 1 and 4) for which no sex differences were found (6). The criteria described in (6) were followed in identifying and delineating the nuclei (Fig. 1). The outline of each nucleus was drawn as the shortest line that included every cell of the type characteristic for that nucleus, regardless of cell density. In 15 cases the nuclei in both left and right hypothalami were traced. In 12 cases only the left hypothalamus was studied, and in 14 cases only the right. The areas of the traced outlines were determined with a digitizing tab-

let, and the volume of each nucleus was calculated as the summed area of the serial outlines multiplied by the section thickness.

In the 15 cases where both left and right sides were studied, no significant interhemispheric differences were found for any of the four nuclei. Therefore, in further analysis, the mean of the two sides was used, and the cases where only one side was available were analyzed without regard to the side of origin.

One-way analysis of variance (ANOVA) was used to look for significant differences between subject groups (Fig. 2). No differences were found for INAH 1, 2, or 4. These results for INAH 1 and 4 are consistent with those of Allen *et al.* (6, 10). However, INAH 2 was reported to be about twofold larger in men than women (6). The failure to replicate that finding may have to do with the relatively young age of the subjects in the present study; as noted in (6), no sex difference was apparent when women of reproductive age were compared with men of similar ages. Thus INAH 2 is not dimorphic either with sex or with sexual orientation, at least within the age range studied.

INAH 3 did exhibit dimorphism. One-way ANOVA showed that the three sample groups (from women, heterosexual men, and homosexual men) were unlikely to have come from the same population ($P = 0.0014$). Consistent with the hypothesis outlined above, the volume of this nucleus was more than twice as large in the heterosexual men ($0.12 \pm 0.01 \text{ mm}^3$, mean \pm SEM) as in the homosexual men ($0.051 \pm 0.01 \text{ mm}^3$). Because of uncertainty about the nature of the underlying distribution, the significance of this difference was evaluated by a Monte Carlo procedure (11); this showed the difference to be highly significant ($P = 0.001$). The difference was still significant when the homosexual men were compared with only the six heterosexual men who died of complications of AIDS ($P = 0.028$). There was a similar difference between the heterosexual men and the women (mean $0.056 \pm 0.02 \text{ mm}^3$; $P = 0.019$), replicating the observations in (6). There was no significant difference in the volume of INAH 3 between the heterosexual men who died of AIDS and those who died of other causes or between the homosexual men and the women. These data support the hypothesis that INAH 3 is dimorphic not with sex but with sexual orientation, at least in men (12).

INAH 3 is situated about 1 mm lateral to the wall of the third ventricle, and about 1 to 2 mm dorsal to the anterior tip of the paraventricular nucleus. It is spherical or ellipsoidal and contains relatively large,

densely staining, polygonal neurons (Fig. 1B). The borders of the nucleus are not well demarcated; hence a blind procedure was used to reduce bias effects. In most of the homosexual men (and most of the women), the nucleus was represented only by scattered cells (Fig. 1C). Because of the difficulty in precisely defining the neurons belonging to INAH 3, however, no attempt was made to measure cell number or density.

Brain tissue from individuals known to be homosexual has only become available as a result of the AIDS epidemic. Nevertheless, the use of this tissue source raises several problems. First, it does not provide tissue from homosexual women because this group has not been affected by the epidemic to any great extent. Thus, the prediction that INAH 3 is larger in homosexual than in heterosexual women remains untested. Second, there is the possibility that the small size of INAH 3 in the homosexual men is the result of AIDS or its complications and is not related to the men's sexual orientation. This does not seem to be the case because (i) the size difference in INAH 3 was apparent even when comparing the homosexual men with heterosexual AIDS patients, (ii) there was no effect of AIDS on the volumes of the three other nuclei examined (INAH 1, 2, and 4), and (iii) in the entire sample of AIDS patients there was no correlation between the volume of INAH 3 and the length of survival from the time of diagnosis. Nevertheless, until tissue from homosexual men dying of other causes becomes available, the possibility that the small size of INAH 3 in these men reflects a disease effect that is peculiar to homosexual AIDS patients cannot be rigorously excluded.

A third problem is the possibility that AIDS patients constitute an unrepresentative subset of gay men, characterized, for example, by a tendency to engage in sexual

relations with large numbers of different partners or by a strong preference for the receptive role in anal intercourse [both of which are major risk factors for acquiring human immunodeficiency virus (HIV) infection (13)]. Sexual activity with large numbers of partners is (or was until recently) common among gay men, however, and therefore does not define an unrepresentative minority (14). In addition, the majority of homosexual men who acquired HIV infection during the Multicenter AIDS Cohort Study (15) reported that they took both the insertive and the receptive role in anal intercourse, and the same is likely to be true of the homosexual subjects in my study. Nevertheless, the use of postmortem material, with the consequent impossibility of obtaining detailed information about the sexuality of the subjects, limits the ability to make correlations between brain structure and the diversity of sexual behavior that undoubtedly exists within the homosexual and the heterosexual populations.

The existence of "exceptions" in the present sample (that is, presumed heterosexual men with small INAH 3 nuclei, and homosexual men with large ones) hints at the possibility that sexual orientation, although an important variable, may not be the sole determinant of INAH 3 size. It is also possible, however, that these exceptions are due to technical shortcomings or to misassignment of subjects to their subject groups.

The discovery that a nucleus differs in size between heterosexual and homosexual men illustrates that sexual orientation in humans is amenable to study at the biological level, and this discovery opens the door to studies of neurotransmitters or receptors that might be involved in regulating this aspect of personality. Further interpretation of the results of this study must be considered speculative. In particular, the results do not

allow one to decide if the size of INAH 3 in an individual is the cause or consequence of that individual's sexual orientation, or if the size of INAH 3 and sexual orientation covary under the influence of some third, unidentified variable. In rats, however, the sexual dimorphism of the apparently comparable hypothalamic nucleus, the sexually dimorphic nucleus of the preoptic area (SDN-POA) (16), arises as a consequence of the dependence of its constituent neurons on circulating androgen during a perinatal sensitive period (17). After this period, even extreme interventions, such as castration, have little effect on the size of the nucleus. Furthermore, even among normal male rats there is a variability in the size of SDN-POA that is strongly correlated with the amount of male-typical sexual behavior shown by the animals (18). Although the validity of the comparison between species is uncertain, it seems more likely that in humans, too, the size of INAH 3 is established early in life and later influences sexual behavior than that the reverse is true. In this connection it would be of interest to establish when the neurons composing INAH 3 are generated and when they differentiate into a dimorphic nucleus.

REFERENCES AND NOTES

- For examples of the variety of approaches to the topic, see S. Freud [*Three Essays on the Theory of Sexuality*, in *Collected Works of Freud*, J. Strachey, Ed. and Transl. (Hogarth, London, 1959), pp. 125-243], C. S. Ford and F. A. Beach [*Patterns of Sexual Behavior* (Ac, New York, 1951)], Vatican Council II [*Declaration on Certain Problems of Sexual Ethics*, in *Vatican Collection*, A. Flannery, Ed. and Transl. (Berdmans, Grand Rapids, MI, 1982), vol. 2, pp. 486-499], M. Ruse, *J. Homosex.* 6, 5 (1981), and R. C. Frickman [*Male Homosexuality: A Contemporary Psychoanalytic Perspective* (Yale Univ. Press, New Haven, CT, 1988)].
- M. Pritchard, *J. Ment. Sci.* 108, 616 (1962); H. F. L. Meyer-Bahlburg, *Prog. Brain Res.* 61, 375 (1984); G. Dörner et al., *Arch. Sex. Behav.* 4, 1 (1975); S. F. Hendricks et al., *Psychoneuroendocrinology* 14, 177 (1989); D. F. Swaab and M. A. Hofman, *Dev. Brain Res.* 44, 314 (1988).
- The suprachiasmatic nucleus (SCN) of the hypothalamus has been reported to be larger in homosexual than in heterosexual men [D. F. Swaab and M. A. Hofman, *Brain Res.* 537, 141 (1990)]. There is little evidence, however, to suggest that SCN is involved in regulation of sexual behavior aside from its circadian rhythmicity [P. Södersten, S. Hansen, B. Srebro, *J. Endocrinol.* 88, 125 (1981)].
- A. A. Perachio, L. D. Marr, M. Alexander, *Brain Res.* 177, 127 (1979); Y. Oomura, H. Yoshimatsu, *S. Aon, ibid.* 266, 340 (1983).
- J. C. Slamp et al., *ibid.* 142, 105 (1978).
- L. S. Allen, M. Hines, J. E. Shryne, R. A. Gorski, *J. Neurosci.* 9, 497 (1989).
- Two of these subjects (both AIDS patients) had denied homosexual activity. The records of the remaining 14 patients contained no information about their sexual orientation; they are assumed to have been mostly or all heterosexual on the basis of the numerical preponderance of heterosexual men in the population [A. C. Kinsey, W. B. Pomeroy, C. E. Martin, *Sexual Behavior in the Human Male* (Saunders, Philadelphia, 1948)].
- The causes of death for the ten male subjects who did not die of AIDS were lung carcinoma (two

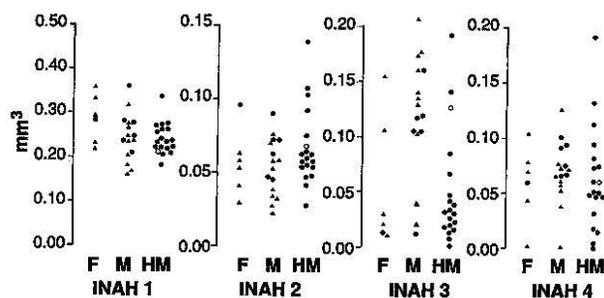


Fig. 2. Volumes of the four hypothalamic nuclei studied (INAH 1, 2, 3, and 4) for the three subject groups: females (F), presumed heterosexual males (M), and homosexual males (HM). Individuals who died of complications of AIDS, ●; individuals who died of causes other than AIDS, ▲; and an individual who was a bisexual male and died of AIDS, ○. For statistical purposes this bisexual individual was included with the homosexual men.

- cases), renal failure (two cases), coronary thrombosis, acute lymphocytic leukemia, amyotrophic lateral sclerosis, pancreatic carcinoma, pulmonary embolism, and aspiration pneumonia. For the five female subjects who did not die of AIDS, the causes of death were systemic lupus erythematosus, pancreatic carcinoma, liver failure (two cases), and abdominal sepsis secondary to renal transplantation. All six of the heterosexual male AIDS patients and three of the homosexual men had histories of intravenous drug abuse. Three of the women, two heterosexual men who did not have AIDS, and one homosexual man had histories of chronic alcohol abuse.
9. Criteria for inclusion of subjects in the study were as follows: (i) age 18 to 60, (ii) availability of medical records, (iii) in AIDS patients, statement in the records of at least one AIDS risk group to which the patient belonged (homosexual, intravenous drug abuser, or recipient of blood transfusions), (iv) no evidence of pathological changes in the hypothalamus, and (v) no damage to the INAH nuclei during removal of the brain or transection of these nuclei in the initial slicing of the brain. Fourteen specimens (over and above the 41 used in the study) were rejected for one of these reasons; in all cases the decision to reject was made before decoding.
 10. INAH 1 is the same as the nucleus named the "sexually dimorphic nucleus" and reported to be larger in men than women [D. F. Swaab and E. Floris, *Science* 228, 1112 (1985)]. My results support the contention by Allen *et al.* (6) that this nucleus is not dimorphic.
 11. The ratio of the mean INAH 3 volumes for the heterosexual and homosexual male groups was calculated. The INAH 3 volume values were then randomly reassigned to the subjects, and the ratio of means was recalculated. The procedure was repeated 1000 times, and the ordinal position of the actual ratio in the set of shuffled ratios was used as a measure of the probability that the actual difference between groups arose by chance. Only one of the shuffled ratios was larger than the actual ratio, giving a probability of 0.001.
 12. Application of ANOVA or correlation measures failed to identify any confounding effects of age, race, brain weight, hospital of origin, length of time between death and autopsy, nature of fixative (10 or 20% formalin), duration of fixation, or, in the AIDS patients, duration of survival after diagnosis, occurrence of particular complications, or the nature of the complication or complications that caused death. There were no significant positive or negative correlations between the volumes of the four individual nuclei across the entire sample, suggesting that there were no unidentified common-mode effects such as might be caused by variations in tissue shrinkage. The mean brain weight for the women (1256 ± 41 g) was smaller than that for either the heterosexual (1364 ± 46 g) or the homosexual (1392 ± 32 g) men, but normalizing the data for brain weight had no effect on the results. There was no correlation between subject age and the volume of any of the four nuclei, whether for the whole sample or for any subject group; this finding does not necessarily conflict with the report in (6) of age effects in INAH 1, and possibly INAH 2, because in (6) a much wider range of ages was examined than was used in the present study.
13. J. S. Chumley *et al.*, *Am. J. Epidemiol.* 126, 568 (1987); W. Winkenstein, Jr., *et al.*, *J. Am. Med. Assoc.* 257, 321 (1987).
 14. In the largest relevant study [A. P. Bell and M. S. Weinberg, *Homosexualities: A Study of Diversity among Men and Women* (Simon and Schuster, New York, 1978)], nearly half the homosexual male respondents reported having had over 500 sexual partners.
 15. R. Deeds *et al.*, *J. AIDS* 2, 77 (1989).
 16. R. A. Gorski, J. H. Gordon, J. E. Shyrne, A. M. Southam, *Brain Res.* 148, 333 (1978).
 17. K. D. Döhler *et al.*, *ibid.* 302, 291 (1984); R. E. Dodson, J. E. Shyrne, R. A. Gorski, *J. Comp. Neurol.* 275, 623 (1988); G. J. Bloch and R. A. Gorski, *ibid.*, p. 613; R. W. Rhee, J. E. Shyrne, R. A. Gorski, *Dev. Brain Res.* 52, 17 (1990).
 18. R. H. Anderson, D. E. Fleming, R. W. Rhee, E. Kinghorn, *Brain Res.* 370, 1 (1986).
 19. I thank the pathologists who made this study possible by providing access to autopsy tissue; P. Sawchenko, C. Rivier, S. Rivest, G. Torres, G. Carman, D. MacLeod, S. Lockery, and J. Rice for comments and suggestions; and B. Wansley for assistance with preparation of the manuscript. Supported by a PHS Biomedical Research Support Grant to the Salk Institute.

29 January 1991; accepted 24 June 1991

Technical Comments

Forensic DNA Tests and Hardy-Weinberg Equilibrium

DNA tests based on biochemical procedures are being widely used for the identification of accused individuals (1). When the DNA pattern obtained from a specimen at the scene of a crime matches that obtained from a suspect, the prosecution seeks to prove that the suspect is the only possible source of the specimen. That inference depends on knowing something about the distribution of genotypes of the entire population of other people, any one of whom might be the actual criminal. In forensic applications of DNA testing so far, that inference has been based on an assumption of Hardy-Weinberg equilibrium (H-W). H-W justifies the assumption of statistical independence implicit in formulas used to calculate the probability that the DNA patterns of a specimen and of a suspect would match by chance alone. H-W can (2, 3), and sometimes does (4, 5), fail under realistic conditions.

To evaluate H-W, Devlin *et al.* (6) developed methods "to test for an overall excess or dearth of heterozygotes" in a sample of humans and applied these methods to a database provided by Lifecodes, Inc., one of the major vendors of services for forensic DNA testing. Devlin *et al.* have provided a useful service in drawing further attention to the problem of coalescence, that is, the

appearance of a single, blurred band in autoradiographic films resulting from DNA fragments of different but similar size. However, their assertion that "the arguments so far presented against [H-W] are incorrect" is unconvincing for several reasons.

1) Devlin *et al.* reject the finding by Lander (2) of an excess of homozygosity in a Hispanic population. They use a data set drawn from a Caucasian population [reference 18 of (4)] and report no direct test of the logistic model for Hispanics, but instead use the model from the Caucasian data to interpret the Hispanic data. Their model is untested on the population from which Lander drew his data.

2) Devlin *et al.* have not used the data on apparent homozygotes. These are the data most likely to reveal an excess of homozygosity. They eliminate a subset of data that deviates from the expectations under H-W, and then test the remaining data for agreement with H-W. This predisposes them toward finding no deviation from H-W.

3) Devlin *et al.* note correctly that population subdivision must affect the overall number of heterozygotes, but they do not acknowledge that not all allelic classes need have too few heterozygotes relative to H-W. Some heterozygote classes may be in H-W,

others in excess, and still others deficient: it is only the total of all heterozygotes that is necessarily deficient when the population is subdivided (7). Because the method of Devlin *et al.* tests only a subset of the heterozygote data, they might observe no deviation from H-W in that subset and incorrectly conclude that there is no departure from H-W overall, when, in fact, there is.

4) No information is given by Devlin *et al.* about how the populations of Caucasians, blacks, and Hispanics were sampled. There is no reason to believe that these samples are random or representative samples of the corresponding self-identified cultural groups in the United States. Hence inference from the given samples to the population at large, or to the entire self-identified cultural groups, is perilous. For example, the Hispanic population around New York is primarily of Puerto Rican origin, that around Miami of Cuban origin, and that in the southwestern states of Mexican origin; there are varying mixtures of other Hispanic origins in all three regions. If the Hispanic data studied by Devlin *et al.* were drawn primarily from the New York region, the conclusions could well be invalid for the other major Hispanic subpopulations separately or for all Hispanics as a group.

5) Devlin *et al.* say that it is not appropriate to pool data from different races, yet they treat "black" and "Hispanic" as if these were biologically meaningful races. The population identified as "black" in the United States is a continuum of individuals ranging from people of primarily African origin to people of primarily European origin (and

ANNEX E: Family Planning (FP) Form #1

FP FORM-1

FAMILY PLANNING SERVICE RECORD*		SIDE A	
<p style="text-align: center;">MEDICAL HISTORY</p> <p>HEENT</p> <input type="checkbox"/> Epilepsy/Convulsion/Seizure <input type="checkbox"/> Severe headache/dizziness <input type="checkbox"/> Visual disturbance/ blurring of vision <input type="checkbox"/> Yellowish conjunctiva <input type="checkbox"/> Enlarged thyroid <p>CHEST/HEART</p> <input type="checkbox"/> Severe chest pain <input type="checkbox"/> Shortness of breath and easy fatigability <input type="checkbox"/> Breast/axillary masses <input type="checkbox"/> Nipple discharges (specify if blood or pus) <input type="checkbox"/> Systolic of 140 and above <input type="checkbox"/> Diastolic of 90 and above <input type="checkbox"/> Family history of CVA (strokes), heart attack, asthma, rheumatic heart diseases <p>ABDOMEN</p> <input type="checkbox"/> Mass in the abdomen <input type="checkbox"/> History of gall bladder disease <input type="checkbox"/> History of liver disease <p>GENITAL</p> <input type="checkbox"/> Mass in the uterus <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Intermenstrual bleeding <input type="checkbox"/> Postcoital bleeding <p>EXTREMITIES</p> <input type="checkbox"/> Severe varicosities <input type="checkbox"/> Swelling or severe pain in the legs not related to injuries <p>SKIN</p> <input type="checkbox"/> Yellowish skin <p>HISTORY OF ANY OF THE FOLLOWING</p> <input type="checkbox"/> Smoking <input type="checkbox"/> Allergies <input type="checkbox"/> Drug intake (anti-tuberculosis, anti-diabetic, anticonvulsant) <input type="checkbox"/> STI/HIV/AIDS/PIDS <input type="checkbox"/> Bleeding tendencies (nose, gums, etc.) <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <p>OBSTETRICAL HISTORY</p> <input type="checkbox"/> Number of pregnancies: _____ Full Term _____ Premature _____ Abortion _____ Living Children <input type="checkbox"/> Date of last delivery _____/_____/_____ <input type="checkbox"/> Type of last delivery _____ <input type="checkbox"/> Past menstrual period _____ <input type="checkbox"/> Last menstrual period _____ Number of days menses _____ Scanty _____ Moderate _____ Heavy _____ Painful _____ Regular <p>OBSTETRICAL HISTORY</p> <input type="checkbox"/> Hydatidiform mole (within the last 12 months) <input type="checkbox"/> Ectopic pregnancy <p>STI RISKS</p> <input type="checkbox"/> With history of multiple partners <p>For Women:</p> <input type="checkbox"/> Unusual discharge from vagina <input type="checkbox"/> Itching or sores in or around vagina <input type="checkbox"/> Pain or burning sensation <input type="checkbox"/> Treated for STIs in the past <p>For Men:</p> <input type="checkbox"/> Pain or burning sensation <input type="checkbox"/> Open sores anywhere in genital area <input type="checkbox"/> Pus coming from penis <input type="checkbox"/> Swollen testicles or penis <input type="checkbox"/> Treated for STIs in the past	<p style="text-align: center;">PHYSICAL EXAMINATION</p> <p>Blood pressure: _____ mm/Hg Weight _____ kg/lbs Pulse Rate: _____ /min</p> <p>CONJUNCTIVA</p> <input type="checkbox"/> Pale <input type="checkbox"/> Yellowish <p>NECK</p> <input type="checkbox"/> Enlarged thyroid <input type="checkbox"/> Enlarged lymph nodes <p>BREAST</p> <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <p>Right Breast</p> <input type="checkbox"/> Mass <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Skin-orange peel or dimpling <input type="checkbox"/> Enlarged axillary lymph nodes</div> <div style="text-align: center;"> <p>Left Breast</p> <input type="checkbox"/> Mass <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Skin-orange peel or dimpling <input type="checkbox"/> Enlarged axillary lymph nodes</div> </div> <p>THORAX</p> <input type="checkbox"/> Abnormal heart sounds/cardiac rate <input type="checkbox"/> Abnormal breath sounds/respiratory rate <p>ABDOMEN</p> <input type="checkbox"/> Enlarged liver <input type="checkbox"/> Mass <input type="checkbox"/> Tenderness <p>EXTREMITIES</p> <input type="checkbox"/> Edema <input type="checkbox"/> Varicosities <p style="text-align: center;">PELVIC EXAMINATION</p> <table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p>PERINEUM</p> <input type="checkbox"/> Scars <input type="checkbox"/> Warts <input type="checkbox"/> Reddish <input type="checkbox"/> Laceration <p>VAGINA</p> <input type="checkbox"/> Congested <input type="checkbox"/> Bartholin's cyst <input type="checkbox"/> Warts <input type="checkbox"/> Skene's Gland <input type="checkbox"/> Discharge <input type="checkbox"/> Rectocele <input type="checkbox"/> Cystocele <p>CERVIX</p> <input type="checkbox"/> Congested <input type="checkbox"/> Erosion <input type="checkbox"/> Discharge <input type="checkbox"/> Polyps/cysts <input type="checkbox"/> Laceration <p>Consistency</p> <input type="checkbox"/> Firm <input type="checkbox"/> Soft <p>RISKS FOR VIOLENCE AGAINST WOMEN (VAW)</p> <input type="checkbox"/> History of domestic violence or VAW <input type="checkbox"/> Unpleasant relationship with partner <input type="checkbox"/> Partner does not approve of the visit to FP clinic <input type="checkbox"/> Partner disagrees to use FP <p>Referred to: <input type="checkbox"/> DSWD <input type="checkbox"/> WCPU <input type="checkbox"/> NGOs <input type="checkbox"/> Others (specify: _____)</p> <p>ACKNOWLEDGEMENT:</p> <p>This is to certify that the Physician/Nurse/Midwife of the clinic has fully explained to me the different methods available in family planning and I freely choose the _____ method.</p> <p>_____ Client Signature</p> <p>_____ Date</p> </td> <td style="width: 50%; vertical-align: top;"> <p>UTERUS</p> <p>Position</p> <input type="checkbox"/> Mid <input type="checkbox"/> Anteфлекed <input type="checkbox"/> Retroфлекed <p>Size</p> <input type="checkbox"/> Normal <input type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Mass <p>Uterine Depth: _____ cms. (for intended IUD users)</p> <p>ADNEXA</p> <input type="checkbox"/> Mass <input type="checkbox"/> Tenderness </td> </tr> </table>	<p>PERINEUM</p> <input type="checkbox"/> Scars <input type="checkbox"/> Warts <input type="checkbox"/> Reddish <input type="checkbox"/> Laceration <p>VAGINA</p> <input type="checkbox"/> Congested <input type="checkbox"/> Bartholin's cyst <input type="checkbox"/> Warts <input type="checkbox"/> Skene's Gland <input type="checkbox"/> Discharge <input type="checkbox"/> Rectocele <input type="checkbox"/> Cystocele <p>CERVIX</p> <input type="checkbox"/> Congested <input type="checkbox"/> Erosion <input type="checkbox"/> Discharge <input type="checkbox"/> Polyps/cysts <input type="checkbox"/> Laceration <p>Consistency</p> <input type="checkbox"/> Firm <input type="checkbox"/> Soft <p>RISKS FOR VIOLENCE AGAINST WOMEN (VAW)</p> <input type="checkbox"/> History of domestic violence or VAW <input type="checkbox"/> Unpleasant relationship with partner <input type="checkbox"/> Partner does not approve of the visit to FP clinic <input type="checkbox"/> Partner disagrees to use FP <p>Referred to: <input type="checkbox"/> DSWD <input type="checkbox"/> WCPU <input type="checkbox"/> NGOs <input type="checkbox"/> Others (specify: _____)</p> <p>ACKNOWLEDGEMENT:</p> <p>This is to certify that the Physician/Nurse/Midwife of the clinic has fully explained to me the different methods available in family planning and I freely choose the _____ method.</p> <p>_____ Client Signature</p> <p>_____ Date</p>	<p>UTERUS</p> <p>Position</p> <input type="checkbox"/> Mid <input type="checkbox"/> Anteфлекed <input type="checkbox"/> Retroфлекed <p>Size</p> <input type="checkbox"/> Normal <input type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Mass <p>Uterine Depth: _____ cms. (for intended IUD users)</p> <p>ADNEXA</p> <input type="checkbox"/> Mass <input type="checkbox"/> Tenderness
<p>PERINEUM</p> <input type="checkbox"/> Scars <input type="checkbox"/> Warts <input type="checkbox"/> Reddish <input type="checkbox"/> Laceration <p>VAGINA</p> <input type="checkbox"/> Congested <input type="checkbox"/> Bartholin's cyst <input type="checkbox"/> Warts <input type="checkbox"/> Skene's Gland <input type="checkbox"/> Discharge <input type="checkbox"/> Rectocele <input type="checkbox"/> Cystocele <p>CERVIX</p> <input type="checkbox"/> Congested <input type="checkbox"/> Erosion <input type="checkbox"/> Discharge <input type="checkbox"/> Polyps/cysts <input type="checkbox"/> Laceration <p>Consistency</p> <input type="checkbox"/> Firm <input type="checkbox"/> Soft <p>RISKS FOR VIOLENCE AGAINST WOMEN (VAW)</p> <input type="checkbox"/> History of domestic violence or VAW <input type="checkbox"/> Unpleasant relationship with partner <input type="checkbox"/> Partner does not approve of the visit to FP clinic <input type="checkbox"/> Partner disagrees to use FP <p>Referred to: <input type="checkbox"/> DSWD <input type="checkbox"/> WCPU <input type="checkbox"/> NGOs <input type="checkbox"/> Others (specify: _____)</p> <p>ACKNOWLEDGEMENT:</p> <p>This is to certify that the Physician/Nurse/Midwife of the clinic has fully explained to me the different methods available in family planning and I freely choose the _____ method.</p> <p>_____ Client Signature</p> <p>_____ Date</p>	<p>UTERUS</p> <p>Position</p> <input type="checkbox"/> Mid <input type="checkbox"/> Anteфлекed <input type="checkbox"/> Retroфлекed <p>Size</p> <input type="checkbox"/> Normal <input type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Mass <p>Uterine Depth: _____ cms. (for intended IUD users)</p> <p>ADNEXA</p> <input type="checkbox"/> Mass <input type="checkbox"/> Tenderness		
<p>Reminder: Kindly refer to PHYSICIAN for any checked (✓) mark prior to provision of any method for further evaluation.</p>		<p>CLIENT NO.: _____</p> <p>NAME OF CLIENT: _____</p> <p>TYPE OF ACCEPTOR: <input type="checkbox"/> New to the Program <input type="checkbox"/> Continuing User PREVIOUSLY USED METHOD _____</p> <p>DATE/TIME _____</p> <p>NAME OF SPOUSE: _____</p> <p>NO. OF LIVING CHILDREN: _____</p> <p>METHOD ACCEPTED: <input type="checkbox"/> COC <input type="checkbox"/> Patch <input type="checkbox"/> POP <input type="checkbox"/> Inedable <input type="checkbox"/> Condom <input type="checkbox"/> IUD <input type="checkbox"/> BTL <input type="checkbox"/> VSC <input type="checkbox"/> LAM <input type="checkbox"/> SDM <input type="checkbox"/> BBT <input type="checkbox"/> Billing/Cervical Mucous/Ovulation Method <input type="checkbox"/> Symplo-thermal</p> <p>PLAN MORE CHILDREN: Yes _____ No _____</p> <p>REASON FOR PRACTICING FP: _____</p> <p>HIGHEST EDUC. OCCUPATION _____</p> <p>AVERAGE MONTHLY INCOME: _____</p> <p>NO. STREET _____ BARANGAY _____ MUNICIPALITY _____ PROVINCE _____</p>	

11.14

SIDE B		FAMILY PLANNING SERVICE RECORD				
CLIENT NUMBER _____ NAME OF CLIENT: _____ (Last Name, Given Name, MI) Province)	DATE SERVICE GIVEN	METHOD TO BE USED/ SUPPLIES GIVEN (cycles, pieces, etc.)	REMARKS • MEDICAL OBSERVATION • COMPLAINTS/ COMPLICATION • SERVICE RENDERED/ PROCEDURES/ INTERVENTIONS DONE (i.e., laboratory examination, treatment, referrals, etc.)	NAME AND SIGNATURE OF PROVIDER	NEXT SERVICE DATE	

11.15

Instructions for completing the FP Service Record or FP Form 1

Side A

1. Fill out or check the required information at the far right of the form:
 - Client number, date and time client was interviewed
 - Client name: her maiden name, family name first, date of birth, education, and occupation
 - Spouse name: family name first, date of birth, education, and occupation
 - Complete address of the client: number of the house, street, *barangay*, municipality, and province
 - Average monthly income in peso
 - Choose "yes" or "no" for the couple's plan for more children
 - Choose "new" or "continuing/current user" for type of acceptor
 - Number of living children
 - Previously used method
 - Reasons for practicing FP: completed the desired family size, economic, and others
 - Check among the list of FP method, the method accepted
2. Fill in the required information on medical, obstetrical/ gynecological history, physical examination, pelvic examination, client signature, and date.
3. Refer to a physician for any abnormal history/findings prior to provision of any method for further evaluation.

Side B

1. Fill in the required information at the far left of the form on client number and name, date of birth, education, occupation, and address.
2. On the first column, record the date when the service was delivered to the client.
3. On the second column, record the method accepted/number of supplies given.
4. On the third column, record the following:
 - Medical observations
 - Complaints
 - Services rendered, procedures/interventions done (lab, treatment)
 - Reasons for stopping or changing the methods
 - Laboratory results
5. On the fourth column, record the name of the provider with the corresponding signature.
6. On the fifth column, record the next service date or appointment date.

11.16

PRISM2 Monthly Services Record on FP-MCH Form -PMPv.3 (MSR Form)

Brand Name	Date of Delivery	DR Number	No. of Units Purchased	Brand Name	Date of Delivery	DR Number	No. of Units Purchased
INTRAUTERINE DEVICE (Unit = 1 piece)				DIAZINK (Unit = Pack of 100 tablets)			
OXYTOCIN IN UNIJECT							

Integration to Service Delivery Network

Does the facility have a signed partnership agreement with local government unit as part of SDN? Yes No

If yes, please indicate date of signing of partnership agreement with LGU _____ (attach partnership agreement) and date of community launching _____

If no, are you interested in joining the service delivery network? Yes No

At Risk of Gender-Based Violence (get data from FP Form 1, section on Violence Against Women; and from Adolescent and Youth Health Assessment Form)

Age Group	At Risk of GBV		Given Psychological First Aid		Attended Session on GBV		Referred to								
							DSWD		WCPU		NGOs		Others		
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female			
Below 15															
15-19															
20-24															
25-29															
30-34															
35-39															
40-44															
45-49															
50 & over															
Total															

Victim-Survivors of Gender-Based Violence (get data from GBV/VAWC Client Card – VAW Form 1)

Age Group	Sexual abuse		Physical (not sexual)		Psychological		Given Psychological First Aid		Referred to							
									DSWD		WCPU		PNP		Others	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female		
Below 15																
15-19																
20-24																
25-29																
30-34																
35-39																
40-44																
45-49																
50 & over																
Total																

Prepared by: Name and Signature of Health Provider

Date Prepared

ANNEX G: Gender Relationship Job Aid



Ikalawang larawan ng relasyon ng mag-asawa



Ang bagong maginoo

Dati, ang lalaki ay itinuturing na maginoo kung siya ay:

- Macho
- Mas mataas ang estado sa buhay kaysa sa babae
- Tagapag-decision
- Dominante (hindi raw “under the saya”)

Ngayon, ang lalaking itinuturing na bagong maginoo ay ang lalaking:

- Katuwang ng babae
- Kliyente ng pagpapalano ng pamilya
- Tagapag-sulong ng pagbabago

Ang bagong maginoong lalaki bilang **katuwang**

Itinuturing niyang katuwang ang babae – kapantay niya sa kahalagahan, karapatan at kakayahan:

- Pinapakita niya ito sa larangan ng magkasamang pagdedesiyon at bahaginan ng gampanin sa pamilya, kasama na ang gawaing-bahay.
- Mahinahon nilang nilulutas ang kanilang alitan. Hindi kailan man gumagamit ng dahas.

5

Ang bagong maginoong lalaki bilang **kliyente**

Itinuturing niyang kapwa responsibilidad nilang mag-asawa ang pagpapalano ng pamilya. Kaya:

- Lumalahok siya sa mga konsultasyon ukol sa pagpapalano ng pamilya.
- Gumagamit ng angkop na panglalaking FP method.
- Hindi nananakit ng asawa kung hindi siya sang-ayon sa FP method.

6

Ang bagong maginoong lalaki bilang taga-pagsulong ng pagbabago

Iinataguyod niya ang pagpaplano ng pamilya at pangangalaga ng kalusugan. Kaya, nakikilahok siya sa:

- Pagtaas ng kamulatan ng mga lalaki ukol sa pantay na halaga, dignidad, karapatan at kakayahan ng lalaki at babae, at sa kahalagahan ng magkatuwang na partisipasyon ng lalaki at babae sa pagpaplano ng pamilya.
- Pagtigil sa lahat ng uri ng karahasan laban sa babae, kapwa lalaki, at mga bata.
- Pagbibigay impormasyon ukol sa mga nakalaang serbisyo para sa mga biktima ng karahasan.

7

Relasyon ng babae at lalaki sa Pilipinas

Sang-ayon sa mga batas ng Pilipinas:

- Pantay ang babae at lalaki sa pamilya at sa lahat ng larangan ng lipunan.
- Dapat na parehong nag-dedesisyon ang mag-asawa sa anumang usapin sa pamilya, kasama na sa pagpaplano ng pamilya.
- Sa panahon ng hindi pagkakasundo, ang desisyon ng may katawan (gagamit ng FP method) ang masusunod. Kagaya ng kanyang asawa, hindi kailangan ng babae ang nakasulat na pagsang-ayon (written consent) ng asawa para sa paggamit ng anumang uri ng FP method.

8

Ano ang maaaring gawin ng mag-asawa upang mapaunlad ang kanilang relasyon?

Mahinahan at buong pagmamahal na pag-usapan ang:

- Magkatuwang na pagdedesisyon sa pamilya.
- Pagtutulungan sa gawaing bahay at pangangalaga ng mga anak.
- Masinop na paraan ng paglutas ng alitan o problema. Dapat may paggalang sa dignidad at karapatan ng bawat isa at hindi paggamit ng anumang uri ng karahasan.

Humingi ng payo (o family counseling) sa mga eksperto at kinauukulan kung hindi sapat ang pakikipag-usap sa asawa

9

Para sa mga nakararanas ng karahasan

Humingi ng tulong sa kinauukulan:

- **Barangay Council** para sa protection order.
- **DSWD** para sa serbisyong psycho-social (counselling, temporary shelter, livelihood, tulong pinansiyal sa panahon ng paglutas ng problema).
- **DOH/PHO/CHO/MHO** o ng **Women and Children Protection Unit** para sa serbisyong medikal at serbisyong mediko-legal.
- **NBI/PNP Women and Children Protection Desk** para sa investigation, rescue at proteksiyon ng biktima.
- **DOJ/Public Attorney's Office/Prosecutor's Office** para sa serbisyong legal/prosecution.

10