# CHECKPOINTS FOR CHOICE:
## AN ORIENTATION AND RESOURCE PACKAGE

THE respond PROJECT

USAID FROM THE AMERICAN PEOPLE

EngenderHealth for a better life

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# Preface

In September 2012, EngenderHealth's RESPOND Project, a global effort funded by the U.S. Agency for International Development (USAID), convened a high-level consultation in Bellagio, Italy, to explore the intersection of human rights and family planning (FP). With support from USAID and The Rockefeller Foundation, the consultation brought together multidisciplinary public health and human rights experts from 11 countries to identify critical challenges and priority actions to protect contraceptive choice and to seek common ground on strategies for increasing women's access to their desired method. This event was timely, as it occurred shortly after the July 2012 London Summit on Family Planning, which set the ambitious goal of giving 120 million women and girls in the world's poorest countries access to lifesaving contraceptives by 2020.

The impetus for developing this orientation and resource package emerged from the renewed focus on expanding access to and use of FP services following the London Summit. While the renewed commitment to FP was welcome, the numerical performance goals and target date set at the Summit highlight the need for assurances and safeguards to make certain that the principles of rights-based FP enshrined in the International Conference on Population and Development's Programme of Action (UNFPA, 1994) guide all global efforts to meet FP2020 goals. This orientation package builds upon materials developed for the Bellagio consultation and responds to recommendations that came out of the experts' deliberations, in particular the call for FP programs to be client-centered rather than method-driven. The package focuses on clients' full, free, and informed choice. It explains abstract concepts in concrete terms from both the program and client perspectives. It was designed to complement the Voluntary, Rights-Based FP (VRBFP) Framework (Hardee et al., 2013), which was developed by the Futures Group and EngenderHealth, with the support of the Bill & Melinda Gates Foundation, and which contributes to ongoing efforts to operationalize human rights concepts and principles in FP programs, to ensure that individuals can realize their fundamental right to access high-quality, client-centered FP information and services that help them meet their reproductive needs and desires.

# Acknowledgments

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This guide was written by Jan Kumar (Senior Advisor, EngenderHealth), Lynn Bakamjian (consultant), Shannon Harris (consultant), and Holly Connor (Senior Program Associate, EngenderHealth). The authors would like to thank several EngenderHealth colleagues for their time and expertise in the development and/or review of this guide, including Dr. Yetnayet Demissie Asfaw, Ellen Brazier, Dr. Levent Çağatay, Rouguiatou Diallo, Richard Killian, and Dr. Harriet Stanley. They also extend their gratitude to a number of external technical experts, including Carolyn Curtis, Beverly Johnston, and Erin Mielke (all of USAID) and Karen Newman (consultant), who reviewed the draft orientation and resource package. Michael Klitsch edited the final draft of this document and managed the overall publication process; Cassandra Cook designed and formatted the Orientation and Resource Package.

# Acronyms and Abbreviations

| | |
|---|---|
| CPR | contraceptive prevalence rate |
| DHS | Demographic and Health Survey |
| FP | family planning |
| HIV | human immunodeficiency virus |
| IUD | intrauterine device |
| RH | reproductive health |
| SEED | Supply–Enabling Environment–Demand |
| SRH | sexual and reproductive health |
| UN | United Nations |
| UNFPA | United Nations Population Fund |
| USAID | U.S. Agency for International Development |
| VRBFP | voluntary, rights-based family planning |
| WHO | World Health Organization |

# INTRODUCTION

*Checkpoints for Choice: An Orientation and Resource Package* helps stakeholders involved in family planning (FP) programs examine issues of full, free, and informed choice through the client's eyes. It explains key concepts related to contraceptive choice, helps participants consider characteristics of contraceptive methods that matter to women, examines the full spectrum of challenges that affect whether they get what they want from FP programs, and highlights program strengths that should be continued and expanded. It also identifies factors and warning signs that managers can track to assess whether full, free, and informed choice may be compromised and explores steps that can be taken to foster individual and program accountability for ensuring contraceptive choice within the FP program. As the global FP community works to scale up information and services to serve 120 million more women and girls by 2020, this package offers practical guidance on how to enable programs to keep the needs and preferences of clients central to their operations.

Although many tools exist for training FP counselors, for expanding and improving the quality of clinical services, and for taking a rights-based approach to sexual and reproductive health (SRH), a recent systematic review of tools that support voluntary, rights-based FP (Kumar, Bakamjian, & Connor, 2013) revealed that very few tools explicitly examine the client's experience. This document fills a gap by focusing on the client's perspective, preferences, and experience and on the many factors that affect individuals' ability to make full, free, and informed choices about FP. Taking a more client-centered approach to planning, implementing, and monitoring FP programs will not only advance the protection and fulfillment of human rights; there is reason to believe that this approach will also make FP programs more effective and sustainable.

Renewed commitment to FP is resulting in scale-up of services and efforts to increase access to a wider range of methods in many countries. Expanded access and choice support women's human rights. Yet rapid scale-up accompanied by ambitious performance goals and method-specific programs can have unintended consequences that challenge voluntarism. It is critical that stakeholders maintain a focus on the dignity of the individual, their autonomy, needs, and preferences, and their experiences with the program. Keeping the aim of full, free, and informed choice at the center of FP programs will ensure that services are voluntary, are of high quality, provide sufficient and accurate information, and remove as many barriers to access and use as is within the program's scope. The one-day orientation detailed in this document highlights many critical issues that influence this desired outcome.

## PURPOSE

This package provides all of the materials needed to lead a one-day orientation workshop to help FP stakeholders understand concepts related to full, free, and informed choice and to think critically about the extent to which contraceptive choice is protected in their programs and services. The overarching goal of this workshop is to strengthen the focus of FP programs

on clients' rights and choices, to strengthen a program's capacity to identify and address vulnerabilities, to improve overall provision of information and services, to increase people's agency, and to improve their health and well-being.

The workshop objectives are to:

1. Increase awareness and understanding of key concepts related to full, free, and informed choice
2. Increase the ability of participants to consider the client perspective when designing and providing services
3. Increase awareness and understanding of factors at the policy, service delivery, community, and individual levels that both support and obstruct full, free, and informed contraceptive choice
4. Increase awareness about program vulnerabilities and safeguards to protect full, free, and informed choice
5. Increase understanding of the importance of contraceptive choice
6. Encourage good practices that programs can sustain and build upon to ensure that clients can exercise full, free, and informed choice

## SCOPE

This package is centered on the concept of full, free, and informed choice in client-centered FP programs. It includes an orientation plan that provides an overview of the entire one-day workshop, plus individual session plans that offer detailed guidance for facilitators and all relevant support materials (PowerPoint presentations, worksheets, handouts, and facilitator guidance, by session). The orientation can be used alone or in conjunction with other training, assessment, or planning activities or tools to improve the focus on voluntarism, contraceptive choice, human rights, and accountability in FP programs. The facilitator should feel free to modify the orientation plan, selecting individual modules to fit within time constraints and to focus on areas of greatest interest to stakeholders. Reference materials and tools that are closely related to topics covered in this orientation are listed in Appendix 1.

## INTENDED USERS

This package is designed for experienced facilitators to lead a workshop with diverse participants, including donors, policymakers, program planners and managers, service providers, staff of technical assistance agencies, and rights and community advocates. It is intended for groups of 15–40 FP stakeholders who have some awareness of the policy, service delivery, and community perspectives. It works best when conducted with participants who are working within a specific country or program context. Facilitators should be well-versed in FP issues and skilled in group facilitation and discussion synthesis.

# KEY CONCEPTS AND BACKGROUND MATERIAL

This orientation is grounded in a client-centered approach to FP programming, with a focus on how clients' environment and experience of services determines their ability to make full, free, and informed choices about contraceptive use and methods. Four primary conceptual constructs create the foundation for this workshop:

1. Client-centered FP programs
2. Full, free, and informed choice
3. A holistic approach to FP programs
4. Accountability for full, free, and informed choice in FP programs

Although not the focus of the workshop, this orientation references human rights and rights-based approaches to FP programs to show that ensuring full, free, and informed choice supports the fulfillment of human rights.

## CLIENT-CENTERED FAMILY PLANNING

Client-centered FP treats clients with respect and positions clients' dignity, autonomy, needs, and preferences at the center of the program. It strives to ensure that every client is actively engaged and supported in making a full, free, and informed choice about FP. The following are elements of client-centered FP:

- Information, services, equipment, and supplies are routinely available for a wide range of FP options.
- Services are of the highest possible quality, including clinical quality; offer effective, individualized counseling; and respect dignity, privacy, and confidentiality.
- Clients have voluntary access to FP and their preferred method, without coercion or barriers.
- Providers are objective and unbiased regarding methods and client groups; they practice no discrimination against youth, the unmarried, minorities, or other vulnerable groups.
- Complete and accurate information is provided about all available options and about the method a client chooses.
- The community and the family support agency and autonomous decision making.

## FULL, FREE, AND INFORMED CHOICE

FP programs that respect an individual's ability to decide whether or not to use contraception and to choose a contraceptive method that fits with her lifestyle, beliefs, needs, preferences, and reproductive intentions contribute to fulfilling the basic human right of individuals to choose,

freely and responsibly, the number, timing, and spacing of their children (UN, 1968; UNFPA, 1994). The concept of free and informed choice is fundamental in medical ethics (Faden & Beauchamp, 1986) and is integral to quality FP programs. The elements of full, free, and informed choice can be summarized as follows:

- **Full choice**: access to the widest range of methods possible from which to choose (short-acting, long-acting, permanent, hormonal, nonhormonal, client-controlled, provider-dependent)
- **Free choice**: the decision whether or not to use FP and what method to use, made voluntarily, without barriers or coercion
- **Informed choice:** a decision based on complete, accurate, unbiased information about all FP options, including benefits, side effects and risks, and information about the correct use of the method chosen, as well as the risks of nonuse

Increasing the number of contraceptive methods available has been shown to increase use of contraceptive methods overall and aligns with longstanding principles of quality of care in FP (Ross et al., 2002; Ross & Stover, 2013; Lundgren et al., 2012; Bruce, 1990; and Jain, 1989). However, effectively providing a broad range of methods to clients remains a challenge for many FP programs. In addition, whether people are able to obtain the FP information and services they desire is affected by many factors at the policy, service delivery, community, and individual levels that either support or limit people's ability to access services. Some of these factors pose barriers and some exert pressures to use, compromising the voluntary nature of people's choice and their right to access the services, commodities, and information they want. Thus, the concept of full, free, and informed choice extends beyond the point at which services are delivered and includes factors at different levels that influence an individual's ability to make and act upon decisions about FP use. This orientation heightens awareness of the many factors at play that warrant stakeholders' attention, programmatic interventions, protective safeguards, and explicit monitoring.

Full, free, and informed choice is closely linked with voluntary FP, a longstanding principle in FP programming. The construct of full, free, and informed choice provides a way of assessing the quality of an individual's decision to use a contraceptive method.

Full, free, and informed choice is also strongly supportive of human rights. Respecting, protecting, and fulfilling the right of women and couples to choose the number, timing, and spacing of their births requires that individuals have access to information and services (UNFPA, 1994). Part of fulfilling this right is to guarantee that people are able to make choices freely, without barriers or coercion. While strongly supportive of human

**Principles of Voluntary Family Planning**

- People have the opportunity to choose voluntarily whether to use family planning or a specific family planning method.
- Individuals have access to information on a wide variety of family planning choices, including the benefits and health risks of particular methods.
- Clients are offered, either directly or through referral, a broad range of methods and services.
- The voluntary and informed consent of any clients choosing sterilization is verified by a written consent document signed by the client.

USAID, 2013

rights, ensuring full, free, and informed choice does not necessarily equate to a rights-based approach to FP. A rights-based approach entails designing programs with internationally agreed-upon rights principles, such as participation, nondiscrimination, empowerment, and accountability.

## HOLISTIC APPROACH TO FP PROGRAMS

Stakeholders are encouraged to approach FP from a holistic, client-centered, and health systems perspective, addressing factors at all levels that have the potential to uphold or to compromise human rights and the degree to which FP use results from a client's full, free, and informed choice. A holistic approach to FP programs draws on an ecological model of health, which explains health behaviors and outcomes based on a systems view of individuals situated within relationships, community, service infrastructure, and wider social norms and policy conditions. To support FP access and use, factors at different levels of the ecological model need to be considered. The ecological model views health and human rights as the outcome of interactions among many factors at four levels—the individual, relationship, community, and society. The ecological framework treats the interactions between factors at the different levels as equal in importance to the influence of factors within a single level (Krug et al., 2002). Two program frameworks that illustrate a holistic programming model are the Supply–Enabling Environment–Demand (SEED) Programming Model (EngenderHealth, 2011) and the Voluntary, Rights-Based Family Planning (VRBFP) Framework (Hardee et al., 2013).

During the workshop, participants will be asked to consider program factors at the policy, service, community, and individual levels, as described in the VRBFP Framework:

- The **policy level** includes laws, actions, or other factors influencing policies that affect equitable access and treatment; adequate resources; good governance; and management and accountability to ensure the availability, accessibility, acceptability, and quality of FP information and services.
- The **service level** is where the client interacts with the program. It includes all modalities of service delivery in all sectors, including public, private, and nongovernmental organization; clinic- and community-based; static and mobile; and social marketing, among others. The service delivery level considers those actions or factors that influence the capacity of the health system to make voluntary FP services available, accessible, acceptable, of high quality, and accountable within both facilities and communities. It includes provider competencies, attitudes and behaviors and all interactions between clients and other health care workers.
- The **community level** represents those actions and factors that empower community members to: (1) participate in the development and implementation of the policies and programs designed to serve them; (2) hold policymakers and service providers accountable; (3) adapt norms and customs; and (4) enhance community knowledge of FP and their right to make full, free, and informed FP choices and to high-quality, voluntary FP information and services.
- The **individual level** pertains to those actions and factors—including family status, educational status, economic status, religion, ethnicity, gender, and social norms—that affect

the agency and ability of individuals in a particular community to exercise their right to make full, free, and informed FP choices.

A holistic programming model guides stakeholders to think beyond a particular area of expertise, responsibility, or level within the system to consider the entire program. Ideally, this will facilitate innovative solutions and partnerships that can make a sustainable, positive impact.

## ACCOUNTABILITY FOR FULL, FREE, AND INFORMED CHOICE IN FP PROGRAMS

Accountability within FP/RH programs includes a broad spectrum of actions to track donor and government financial commitments, national-level program implementation and service provision to ensure that program processes and outcomes are guided by human rights standards and principles (such as equity, empowerment, and nondiscrimination) and contribute to the voluntary use of quality FP services.

*Checkpoints for Choice* addresses the component (or aspect) of accountability that relates to the responsibility of FP donors, managers, and service providers to ensure that the individuals served by their institution or program are able to exercise their full, free, and informed choice to use or not use contraception and to use the method of their choice. Programs should have in place (and routinely report on the results from) the following accountability mechanisms that support full, free, and informed choice:

- Routine monitoring of client characteristics, processes, and service data provides information about coverage, equity, and service quality and scale. Key questions include:
  - Are characteristics of the client population similar/not similar to the general population within the catchment area of the program? (Who is being served/not being served?)
  - What percentage of clients is being counseled? What percentage leave with their preferred method?
  - What percentage of clients discontinues for reasons other than wanting to become pregnant? Are you tracking removal services (for implants and intrauterine devices [IUDs]) in addition to insertions? What do the data tell you?
  - Is informed consent being adequately documented for all permanent method clients?
- Routine program safeguards to ensure voluntarism, such as counseling and client feedback mechanisms, are in place and are operating effectively.
- Protocols exist to investigate reports or instances of suspected problems with voluntarism, including the identification of who is responsible, and there are clearly delineated steps for assessing the alleged problem, communicating the results of the investigation, and identifying follow-up actions, if necessary. These protocols are followed routinely.
- A process is in place to manage and ensure that follow-up action takes place to remedy confirmed problems, including who is responsible for taking action, within what time frame, and reported to whom.
- Redress mechanisms are in place to compensate and support individual clients whose rights were compromised.

# ORIENTATION PLAN

**Duration:** 8 hours (including lunch)
**Participants:** 15–40 people

**Goal:** To strengthen the focus of FP programs on clients' rights and choice, so as to strengthen the overall provision of services, increase people's agency, and improve their health and well-being

## OBJECTIVES

1. Increase awareness and understanding of key concepts related to full, free, and informed choice
2. Increase ability of participants to consider the client perspective when designing and providing services
3. Increase awareness and understanding of factors at the policy, service delivery, community, and individual levels that both support and obstruct full, free, and informed contraceptive choice
4. Increase awareness about program vulnerabilities and safeguards to protect full, free, and informed choice
5. Increase understanding of the importance of contraceptive choice
6. Encourage good practices that programs can sustain and build upon to ensure that clients can exercise full, free, and informed choice

## Orientation Plan

| Session/Time/Materials | Session Objectives | Content/Methodology |
|---|---|---|
| **Session 1: Opening: Welcome and Overview**<br>30 min.<br>*Materials:*<br>• PowerPoint slide<br>• Flipchart paper<br>• Markers<br>• Handout: Oirentation Agenda | 1. Create a safe, comfortable, and open learning environment in which participants can explore issues related to contraceptive choice and rights<br>2. Clarify workshop purpose and content<br>3. Foster group cohesion and participation.<br>4. Administer pretest | • Opening remarks<br>• Introductions/icebreaker<br>• Review of meeting objectives and agenda<br>• Establishment of ground rules |
| **Session 2: Client-Centered Family Planning that Ensures Full, Free, and Informed Choice**<br>30 min.<br>*Materials:*<br>• PowerPoint<br>• Flipchart paper<br>• Markers | 1. Explain key concepts related to full, free, and informed choice, client-centered programs, and holistic programming | • PowerPoint presentation outlining key concepts and principles, clients' ability to realize full, free, and informed choice, and levels of action at which factors either support or hinder desired outcomes |
| **Session 3: Factors that Support and Factors that Hinder Full, Free, and Informed Choice and Rights**<br>1 hour, 15 min.<br>*Materials:*<br>• Flipchart paper<br>• Markers<br>• Tape<br>• Cards or sticky notes<br>• Case study handouts (one per person)<br>• Case Study Sample Grids | 1. Identify factors at the policy, service delivery, community, and individual levels in FP programs that support and that hinder full, free, and informed choice, as well as respect for, protection of, and fulfillment of rights in FP programs | • Small groups working on case studies<br>• Report-backs and plenary discussion |
| **BREAK** 15 min. | | |
| **Session 4: The Range of Challenges to Full, Free, and Informed Choice: What Warrants More Attention?**<br>45 min.<br>*Materials:*<br>• Flipchart paper<br>• Markers<br>• PowerPoint slide<br>• Colored 6" x 8" index cards<br>• Tape<br>• Facilitator sample grids | 1. Explore the full range of challenges and warning signs that indicate full, free, and informed choice may be at risk or compromised<br>2. Identify what challenges warrant more attention and action | • Small groups<br>• Report-back and plenary discussion |

## Orientation Plan

| Session/Time/Materials | Session Objectives | Content/Methodology |
|---|---|---|
| **LUNCH** 45 min. | | |
| **Session 5: Contraceptive Method Choice: What It Is and Why It Matters**<br>1 hour<br>*Materials:*<br>• PowerPoint<br>• Prepared charts<br>• Handout 5.1: Method Attributes Considered by Clients<br>• Flipchart paper<br>• Markers<br>• Facilitator discussion guide | 1. Identify what method attributes are important and what range of methods should be offered, from a client's perspective<br>2. Explain the concept of contraceptive method choice and examine the range of methods that should be offered to meet clients' reproductive intentions and preferences<br>3. Present the current local method mix and discuss whose needs are and are not being met | • Plenary discussion<br>• PowerPoint presentation<br>• Discussion |
| **BREAK** 15 min. | | |
| **Session 6: Accountability for Full, Free, and Informed Choice in FP Programs**<br>1 hour, 45 min.<br>*Materials:*<br>• PowerPoint<br>• Handouts: Program Vignettes<br>• Flipchart paper<br>• Markers | 1. Increase awareness of situations that result in vulnerabilities that could compromise full, free, and informed choice, even in well-intentioned programs<br>2. Identify actions that individual FP program stakeholders (service providers, program managers, policymakers, donors) can take and include in a plan to monitor and fulfill their responsibilities and be accountable for ensuring full, free, and informed choice with their programs | • PowerPoint presentation<br>• Small-group activity: Program vignettes<br>• Individual reflection<br>• Facilitated plenary discussion |
| **Session 7: Wrap-Up and Reflections**<br>1 hour<br>*Materials:*<br>• Flipchart paper<br>• Markers<br>• Handout 7.1: Commitment Statement<br>• Handout 7.2: Workshop Evaluation | 1. Highlight and reinforce key concepts and messages<br>2. Have participants identify concrete actions that they can take to share their learning and to ensure full, free, and informed choice in the FP programs they support or work in<br>3. Complete the workshop evaluation | • Small-group discussion, with report-back<br>• Complete actions handout<br>• Workshop posttest and evaluation |

# SESSION PLANS AND MATERIALS

## 1. Opening: Welcome and Overview

Session Plan | Facilitator Guidance | Agenda

## 2. Client Centered Family Planning that Ensures Full, Free, and Informed Choice

Session Plan | Facilitator Guidance | PowerPoint presentation

## 3. Factors that Support and Factors that Hinder Full, Free, and Informed Choice and Rights

Session Plan | Facilitator Guidance | PowerPoint presentation | Handouts

## 4. The Range of Challenges to Full, Free, and Informed Choice: What Warrants More Attention?

Session Plan | Facilitator Guidance | PowerPoint presentation | Handouts

## 5. Contraceptive Method Choice: What It Is and Why It Matters

Session Plan | Facilitator Guidance | PowerPoint presentation | Handouts

## 6. Accountability for Full, Free, and Informed Choice in FP Programs

Session Plan | Facilitator Guidance | PowerPoint presentation | Handouts

## 7. Wrap-Up and Reflections

Session Plan | Facilitator Guidance | Handouts

# SESSION 1 — 30 MINUTES

# OPENING: WELCOME AND OVERVIEW

## OBJECTIVES

1. Create a safe, comfortable, and open learning environment in which participants can explore issues related to contraceptive choice and rights
2. Clarify workshop purpose and content
3. Foster group cohesion and participation
4. Administer pretest

## NOTE TO FACILITATORS

Before initiating this workshop, review the orientation plan, which provides an overview of the entire one-day workshop, and the individual session plans, which provide detailed guidance for facilitators and identify all relevant support materials that will be needed (PowerPoint presentations, worksheets, handouts, and facilitator guidance, by session). Most of these materials should be prepared in advance of the actual workshop.

As part of this orientation, important information is provided by means of a PowerPoint presentation. Please be sure that a computer and projector are available at the workshop site. If they are not, plan to present the material on the PowerPoint slides as flipcharts.

### *Advance Preparation*

1. Make enough copies of Handout 1.1: Orientation Agenda to distribute to all participants.
2. Identify a speaker who knows the audience and can speak to the importance of the topics to be covered in the workshop.

| Time | Content/Methodology | |
|---|---|---|
| **5 min.** | **Welcome**<br>1. Welcome the participants to the workshop. Explain that it will consist of five interactive sessions highlighting key issues related to contraceptive choice and human rights.<br>2. Review the workshop objectives and hand out the agenda for the workshop.<br>3. Take care of all "housekeeping" items (locations of bathrooms, internet passwords, etc.). | MATERIALS:<br>Workshop objectives, posted either on a PowerPoint slide (Slide 3) or written on flipchart paper<br>Handout 1.1: Orientation Agenda |
| **10 min.** | **Introductions**<br>1. Ask each person to state his/her name and title/position. | |
| **5 min.** | **Establish Ground Rules for the Day**<br>1. Reiterate that the workshop will be interactive. Ask the participants to suggest ground rules that will help make the workshop a place where everyone feels comfortable contributing and participating.<br>2. Record their suggestions on a sheet of flipchart paper and post it on a wall where the participants can see it. | MATERIALS:<br>Flipchart paper<br>Markers |
| **10 min.** | **Opening Remarks**<br>1. Welcome the invited speaker and introduce him/her to the participants.<br>2. Have the speaker open the session with a talk of no more than 10 minutes about the reason for hosting the workshop and how the workshop topics contribute to the work of the program. | |

# SESSION 1
# SUPPLEMENTAL MATERIALS

## HANDOUT

1.1: Orientation Agenda

# SESSION 1
# HANDOUT 1.1:

## ORIENTATION AGENDA

| Time | Session |
|---|---|
| 30 min. | Session 1: Opening: Welcome and Overview |
| 30 min. | Session 2: Client-Centered Family Planning that Ensures Full, Free, and Informed Choice |
| 1 hour, 15 min. | Session 3: Factors that Support and Factors that Hinder Full, Free, and Informed Choice and Rights |
| | BREAK |
| 45 min. | Session 4: The Range of Challenges to Full, Free, and Informed Choice: What Warrants More Attention? |
| | LUNCH |
| 1 hour | Session 5: Contraceptive Method Choice: What It Is, and Why It Matters |
| 1 hour, 45 min. | Session 6: Accountability for Full, Free, and Informed Choice in FP Programs |
| 1 hour | Session 7: Wrap-Up and Reflections |

# SESSION 2

30 MINUTES

# CLIENT-CENTERED FAMILY PLANNING THAT ENSURES FULL, FREE, AND INFORMED CHOICE

## OBJECTIVES

1. Explain key concepts related to full, free, and informed choice, client-centered programs, and holistic programming

## NOTE TO FACILITATORS

During this session, the facilitator will use a PowerPoint presentation to introduce and explain key concepts related to full, free, and informed choice.

### *Advance Preparation*

1. Write on a sheet of flipchart paper the objectives of this session.

| Time | Content/Methodology |
|---|---|
| **5 min.** | 1. Begin the session by reviewing the objectives written on the prepared flipchart. |
| **25 min.** | 1. Using the PowerPoint slides and speaking notes:<br>a. Explain the meaning and importance of client-centered, rights-based FP.<br>b. Explain the terms full, free, and informed choice.<br>c. Explain the concepts of holistic programming/programmatic levels/ecological models.<br><br>*Note*: The presentation should be finished within 15 minutes, to allow 10 minutes for a question-and-answer discussion. |

MATERIALS:

PowerPoint presentation (slides 4–12): Key concepts/ constructs

PowerPoint slides with space to write notes

# SESSION 3

**1 HOUR, 15 MIN.**

# FACTORS THAT SUPPORT AND FACTORS THAT HINDER FULL, FREE, AND INFORMED CHOICE AND RIGHTS

## OBJECTIVES

1. Identify factors at the policy, service delivery, community, and individual levels in FP programs that support and that hinder full, free, and informed choice, as well as respect for, protection of, and fulfillment of rights in FP programs

## NOTE TO FACILITATORS

This session allows participants to apply the concepts discussed in the opening session to case studies highlighting many of the favorable conditions and good practices that support—as well as challenges that hinder—full, free, and informed contraceptive choice and rights in FP programs. Hindering factors include those that pressure, or coerce, people to accept something they do not want, as well as factors that prevent people from getting what they do want (i.e., access barriers).

Each case study focuses on one woman and the circumstances under which she seeks FP services. Participants will consider the supporting and challenging factors related to full, free, and informed contraceptive choice and rights at the policy, service delivery, community, and individual levels. The facilitator should be familiar with each case study and the different issues that each brings to light, using the Case Study Sample Grids as guidance (see Facilitator Guidance 3-1).

### *Advance Preparation*

1. In advance of the session, the facilitator should draw the template below on several pieces of flipchart paper.

| Level | Factors that support full, free, and informed choice and human rights | Coercive factors | Factors that create access barriers |
|---|---|---|---|
| Policy | | | |
| Service Delivery | | | |
| Community | | | |
| Individual | | | |

2. Make enough copies of the four case studies so they can be distributed to each participant.

| Time | Content/Methodology |
|---|---|

**5 min.**

**Introduction to Group Activity**

1. Post the prepared flipchart sheets at the front of the room at the start of this session.
2. Divide the participants into 3–6 small groups (up to eight people per group), depending on the overall number of workshop participants. Request that each group identify a timekeeper and a rapporteur to post the results of the group work and report back in plenary.
3. Hand out all four case studies to each participant, but assign one case study per group for the activity itself; more than one group can address the same case study if there are more than four groups. In addition, pass out cards and tape or sticky notes and markers to all of the groups.
4. Ask each small group to read its assigned case study and discuss what factors *supported* and what factors *challenged* each woman's ability to make a free, full, and informed choice and to exercise her human rights. Instruct the groups to write one factor per card or sticky note and determine the level of the health care system at which it exists. Tell the participants that for the enabling factors identified, they should consider what can be reinforced and built upon; for challenges, they should identify those that create coercive pressure to accept something the person does not want, and those that create access barriers that prevent people from getting what they do want. Again, they should use one card or sticky note for each suggested intervention or change.

MATERIALS:
- Flipchart paper
- Markers
- Tape
- Cards or sticky notes
- Case study handouts (one per person)
- Case Study Sample Grids

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**45 min.**

**Small-Group Activity**

1. Give the groups 45 minutes to conduct the activity. Project PowerPoint Slide 15 during the small group work.

MATERIALS:
- PowerPoint Slide 15

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**25 min.**

**Activity Synthesis and Facilitated Discussion**

1. Select a group to start the report-back. Ask them to identify their case study. Give everyone two minutes to read it. Invite that group's rapporteur to share the results of its work by posting its cards or sticky notes on the blank flipchart grid in the front of the room, each in their appropriate category. If more than one group analyzed the same case study, the rapporteurs from the groups that shared the case study can report back together and alternate sharing *unique* responses, to avoid duplication.
2. Follow the same process to cover all case studies and groups. The results from one case study can be posted on top of the previous group's results, if the grid gets crowded. Alternatively, the facilitator can remove the cards or sticky notes after each case study is presented. DO NOT DISCARD THEM. They will be needed for the next session.
3. Refer to Facilitator Guidance 3-1: Case Study Sample Grid, as needed, to ensure that all of the suggested points are covered.
4. Solicit participant observations in plenary using the following discussion prompts:
   a. Did you find these case studies realistic? Do similar issues arise in your own program?
   b. Did anything surprise you? If so, what, and why?

✺ **Take-home messages to highlight:**

- Factors at all four levels can support and can hinder full, free, and informed choice; it is important to take a holistic approach that involves interventions at all levels, not just within service delivery.
- Acknowledge the supporting factors that should be valued, strengthened, and built upon.

# SESSION 3
# SUPPLEMENTAL MATERIALS

## HANDOUT

3.1: Four Case Studies

## FACILITATOR GUIDANCE

3-1: Case Study Sample Grids

# SESSION 3
# HANDOUT 3.1:

## FOUR CASE STUDIES

### Case Study 1—Florence

The government of Andoria has made family planning (FP) a national priority to address the high fertility rate in the country. Promoting adolescent reproductive health and improving the health-seeking behavior of this population group are top development priorities. However, these policies are not reflected in district- and local-level health priorities, and there is resistance in the traditional society, particularly from religious leaders, to sexual activity and the use of FP among unmarried youth. Though the expansion of youth-friendly services is part of the national sexual and reproductive health strategy, resources for community education, staff training, and supervision are inadequate at the district and local levels. Monitoring and reporting of youth-related services is weak. Client age is meant to be routinely collected and reported, but this is often not done, and there are no qualitative indicators related to youth in the health management information system.

Florence is a 16-year-old textile worker who left school in the fifth grade to work and contribute to her family's income. She lives with her widowed mother and four younger siblings. Her boyfriend, James, is pressuring her to have sex. He is six years older than Florence, and she knows that he has had several other girlfriends, but he has been very good to her; he has provided extra money and food for her family. She is afraid that he will leave her if she does not relent. Florence is conflicted, because she knows that her mother strongly disapproves of sex before marriage, and she is afraid of getting pregnant; however, she likes James very much, and he has been very good to her.

Florence's friend has told her about a local clinic where she can get FP. One day, after a fight with James over denying him sex, Florence goes to the clinic on her lunch break. She is afraid that she will meet someone who knows her mother. She is nervous about what the doctor will do to her. And because there are so many people in the waiting room, she is worried that she will not get back to work before her supervisor discovers her absence.

The clinic receptionist asks Florence's name and tells her to take a seat. Florence wants to ask her how long she will have to wait, but the woman looks busy and shifts her attention to her paperwork, so Florence sits down quietly. She notices posters on the wall. One is about "Clients' Rights," and another warns about getting a disease from having sex. Another has pictures of FP methods and a lot of small print that she cannot read. There are leaflets on the counter, but Florence is too shy to get up to take any.

During her 45-minute wait, Florence grows increasingly anxious. She is just about to give up and leave when she hears her name called by the nurse. She follows the woman into a room where

several people are sitting and talking. The nurse is business-like and does not smile. She pulls out a form and asks Florence questions that she is too embarrassed to answer. Florence fidgets. The nurse repeats the questions, and Florence whispers her answers. Irritated, the nurse asks her to speak up. Florence tries, but she does not want to be overheard by the other people in the room. She looks down at the floor silently for a moment. The nurse chides her that she is too young to be having sex. Florence says that she has changed her mind, gets up, and leaves the clinic, embarrassed and angry. On the way back to the factory, she decides to have sex with her boyfriend that night without any protection.

### *Small-group instructions:*

1. In your small group, discuss what factors *supported* or *challenged* Florence's full, free, and informed choice and human rights in this case study. Write each individual factor on a card or sticky note and determine the level of the health care system at which it exists. Separate the challenging factors into those that pushed her to accept something she did not want (coercive factors) and those that prevented her from getting what she did want (factors that create access barriers).
2. Select someone in your group to post and explain your cards during the report-back.

| Level | Factors that support full, free, and informed choice and human rights | Coercive factors | Factors that create access barriers |
|---|---|---|---|
| Policy | | | |
| Service Delivery | | | |
| Community | | | |
| Individual | | | |

## Case Study 2—Altine

Andoria is an oil-rich nation, but health is not a high development priority. The government spends a large percentage of its resources on military expenses to contain an insurgent threat at its southern border and has been investing in roads, bridges, and other infrastructure. Social services are suffering. The status of women is low, and the prevalence of gender-based violence is high. The government supports family planning (FP) to attain its demographically driven population stabilization goal, but it has no explicit policies to promote sexual and reproductive health or gender equality. It assigns each district a contraceptive prevalence rate (CPR) target to contribute to attainment of the national Millennium Development Goal (MDG).

Health care infrastructure is inadequate, particularly in the rural areas and the high, mountainous region, where roads are poor. The country has a serious shortage of health personnel. The country's four medical schools do not produce enough graduates to meet the population's needs. Security problems make it hard to attract nursing students. Staff do not want to work in remote areas or in the unstable south. Brain drain depletes the pool of competent service providers; those who remain are demoralized, are poorly paid, and lack supplies and equipment and supportive supervision.

Altine is a 32-year-old mother of four daughters. Her husband is a day laborer who struggles to provide for his family. They lost their only son to malaria, and now that their youngest girl is starting to walk, her husband wants Altine to get pregnant again to try for another boy. Altine does not want another child. She has been using an intrauterine device (IUD) for 16 months and has been happy with it. She goes to the clinic to get it removed. She arrives to find a large crowd waiting. The benches are overflowing. The floors and walls in the waiting area are dirty. There are some signs posted on the wall in English, a language not spoken by many people in the area, including Altine.

After waiting for more than an hour, Altine grows restless. She has her youngest daughter with her, but she needs to get back to relieve her neighbor, who is watching her other children. She is finally called by a nurse, who takes her into a room with two tables, a few chairs, and eight other women. The nurse does not smile and seems hurried. She asks Altine why she has come. Altine tells her she wants to have her IUD removed. The nurse asks how long she has had it. When Altine tells her, she says that it is too soon to take the IUD out: It is a 10-year method. Altine says she knows, but she now wants to get pregnant again. The nurse is unmoved and tells her that the IUD is expensive and that she should not be wasting it or the doctor's time. She asks Altine how many children she has. Altine tells her, and the nurse responds that four children are plenty. She says that she can see that Altine is poor and tells her that she should do her best to provide for the children she has and not be looking for more.

Altine feels powerless. She leaves the clinic not knowing what to do.

*Small-group instructions:*

1. In your small group, discuss what factors *supported* or *challenged* Altine's full, free, and informed choice and human rights in this case study. Write each individual factor on a card or sticky note and determine the level of the health care system at which it exists. Separate the challenging factors into those that pushed her to accept something she did not want (coercive factors) and those that prevented her from getting what she did want (factors that create access barriers).
2. Select someone in your group to post and explain your cards during the report-back.

| Level | Factors that support full, free, and informed choice and human rights | Coercive factors | Factors that create access barriers |
|---|---|---|---|
| Policy | | | |
| Service Delivery | | | |
| Community | | | |
| Individual | | | |

## Case Study 3—Dorothy

The Government of Andoria's development strategy prioritizes improving health to expand human capital. It includes specific initiatives to contain HIV and AIDS, prevent malaria, and reduce maternal and infant mortality. Family planning (FP) is promoted both to slow population growth and as a preventive health measure. However, access to basic health care services is a challenge, particularly in the rural and mountainous areas. The government has a multipronged program to strengthen the health care system and increase service capacity, including upgrading hospitals, building health posts, strengthening the logistics system, and training providers (primarily midwives and primary health care workers). But it will take several years for the system to be able to adequately meet the health care needs of the population. At least for now, the FP program relies heavily on mobile services and large-scale camps to provide the intrauterine device (IUD) and implant. Oral contraceptives and injectables are the most widely used FP methods. Female sterilization is offered only at tertiary hospitals with gynecologists on staff; vasectomy is not effectively available. There is a robust civil society, and a number of women's rights groups are active, mainly in the urban areas.

Dorothy is a 38-year-old mother of five who lives in a town in a remote district. Her last two deliveries were by cesarean section, and she has diabetes. She is certain that she does not want to get pregnant again. She has been using oral contraceptives, but with the exhaustion of caring for her home and her five children, she sometimes forgets to take them, which makes her very nervous about an unwanted pregnancy. Now that her youngest son is ready to start school, she has reached a decision, in consultation with her husband, not to have any more children. She has heard that there is an operation that can permanently end childbearing. Dorothy wants to have the procedure done so that she does not have to remember to take a pill every day and no longer has to worry when she forgets.

One day she goes to the FP clinic, which is clean but crowded. A kind nurse eventually calls her into a private room that has HIV and FP posters on the wall. One poster shows six different FP methods. Dorothy is surprised to see so many options. The nurse offers her a seat and asks why she has come. Dorothy tells her that she has taken the pill for four years but does not always remember. She knows that she does not want any more children, and her husband agrees. She now wants the operation that ends pregnancy. The nurse tells her that the clinic cannot do the procedure. It is only done at the big hospital in the city, nearly 100 miles away.

The nurse has just had implant training. She wants to get more practice with insertions. She tells Dorothy that the implant would be a good method for her. Dorothy will not have to remember to take a pill daily; she will have effective protection for three years, after which she can get another implant or go for a sterilization. Dorothy would prefer not to stay on hormones. The nurse repeats that it is a great method; she thinks it would be perfect for Dorothy. Dorothy is not convinced. She knows women who use the method and she does not want anything put into her arm. She asks about the injectable she saw on the poster. The nurse says, yes, she could use that, too. She explains that it is also hormonal and that she will have to come back every three months for another injection, unlike with the implant. Dorothy reluctantly takes a hormonal injection. Over the next few weeks, she experiences irregular bleeding, which concerns her. When she returns to the clinic three months later, she is told that injectables are out of stock. The nurse

once again tries to talk her into accepting an implant. Dorothy does not want it. She goes home without protection to think about how to get to the big hospital for the method she really wants.

### *Small-group instructions*

1. In your small group, discuss what factors *supported* or *challenged* Dorothy's full, free, and informed choice and human rights in this case study. Write each individual factor on a card or sticky note and determine the level of the health care system at which it exists. Separate the challenging factors into those that pushed her to accept something she did not want (coercive factors) and those that prevented her from getting what she did want (factors that create access barriers) .
2. Select someone in your group to post and explain your cards during the report-back.

| Level | Factors that support full, free, and informed choice and human rights | Coercive factors | Factors that create access barriers |
|---|---|---|---|
| Policy | | | |
| Service Delivery | | | |
| Community | | | |
| Individual | | | |

## Case Study 4—Mercy

Andoria is a postconflict nation with dismal health indicators and a weak economy. The new president recognizes that to stimulate economic growth, the government needs to invest in health care. She has prioritized maternal and child health and the prevention and treatment of HIV and of malaria. A key strategy in the national plan is to expand access to and use of family planning (FP). The government health system currently provides oral contraceptives and injectables. The Minister of Health has undertaken an initiative to add long-acting reversible methods of contraception to the range of options, to reach more women and to provide more effective protection against unwanted pregnancy. The government has launched a public education campaign to promote these new methods and has forged a public-private partnership with a nongovernmental organization with an extensive network of static clinics and mobile units to provide services and to train public-sector providers. The aim is to make these methods readily available throughout the country at both public and private service delivery points over the next two years and to increase the contraceptive prevalence rate from its current level of 27% to 50% by 2020.

Mercy lives in a village with her husband, who runs a sundries shop, and their two daughters, aged 2 and 3. They would like to have a son, but not for another couple of years. They rely on withdrawal. Mercy has already had two illegal abortions due to method failure. The first was uncomplicated, but the second resulted in sepsis, which required her to be hospitalized for a week. The experience has made Mercy afraid and reluctant to have relations with her husband. He has grown impatient with her, and on several occasions he has violently forced himself upon her. She is desperate for a solution that will relieve her of the fear of pregnancy and of being attacked by her husband.

One day, she hears a message on the radio about FP methods that provide worry-free protection. The message urges people to talk to their village health workers to get more details. Mercy seeks out Patience, the trusted community health worker, who tells her that the new methods would be good for her. She says that a mobile team from the private network will be providing services the following week in a town 20 km away. Mercy says that she wants to go if she can get her husband's approval and money for services.

Mercy's husband readily agrees and gives her an allowance to cover her expenses. The next week, Mercy and Patience walk several km to the nearest bus stop and then travel to the town where services are being offered. They follow signs announcing the services and telling them where to go, and they arrive at a crowd gathered around a van parked near the town market. Under the shade of a tree, a nurse is explaining different types of FP to a group of women. Mercy joins them in time to hear about the intrauterine device (IUD) and the hormonal implant. She is nervous about having something put into her body and left there for a long time. She also hears about an operation to permanently end fertility, but she is not interested in that. After the group talk, the nurse asks each woman to sit with her individually to talk about what she needs and wants. Mercy is called after about an hour. The nurse is friendly and does her best to put Mercy at ease. She asks what methods Mercy knows and what she wants. Mercy is hesitant. She asks, "Won't it hurt to have something put in your uterus and left there? Won't my husband feel it during sex? Can it move around in my body or make me sick? And what about the implant? How can

sticks in my arm block my husband's sperm?" The nurse answers her questions patiently. Mercy decides to try the IUD. The nurse asks Mercy when she last menstruated. Mercy tells her when they planted their yams (about two weeks ago). The nurse tells her she cannot have the IUD put in today; she needs to be menstruating for it to be inserted. The nurse instructs Mercy to use condoms with her husband until her next period and then to talk to her community health worker about when and where mobile services will be available. Mercy leaves, disappointed. She knows that her husband will not agree to use condoms. And there is no way to be sure that services will be available when she is menstruating.

### *Small-group instructions*

1. In your small group, discuss what factors *supported* or *challenged* Mercy's full, free, and informed choice and human rights in this case study. Write each individual factor on a card or sticky note and determine the level of the health care system at which it exists. Separate the challenging factors into those that pushed her to accept something she did not want (coercive factors) and those that prevented her from getting what she did want (factors that create access barriers).
2. Select someone in your group to post and explain your cards during the report-back.

| Level | Factors that support full, free, and informed choice and human rights | Coercive factors | Factors that create access barriers |
|---|---|---|---|
| Policy | | | |
| Service Delivery | | | |
| Community | | | |
| Individual | | | |

# SESSION 3
# FACILITATOR GUIDANCE 3-1:

## CASE STUDY SAMPLE GRIDS

### Florence—Case Study 1

Note: This *Case Study Sample Grid* is intended to provide examples of possible supporting and challenging factors at each level as they relate to Case Study 1. This list is not exhaustive.

| Level | Factors that support full, free, and informed choice and human rights | Coercive factors | Factors that create access barriers |
|---|---|---|---|
| Policy | • FP is a government priority.<br>• Adolescent reproductive health (RH) and health-seeking behavior are a government development priority.<br>• The expansion of youth-friendly FP/RH services is part of the national sexual and reproductive health strategy. | | • Supportive FP policies are not reflected in district/local health care priorities.<br>• Resources for community education, staff training, and supervision are inadequate at district/local level. |
| Service Delivery | • There is access to a nearby clinic.<br>• A clients' rights poster and an STI poster were visible.<br>• FP information leaflets were available and accessible. | | • Collection, monitoring, and reporting of data on youth services are weak.<br>• Clinic hours are not youth-friendly.<br>• The waiting room was overcrowded, waiting times were long, and clients lacked privacy.<br>• Clinic staff were inattentive/ irritated.<br>• The FP poster text was too small to read.<br>• Provider was biased against sexually active, unmarried adolescents. |
| Community | • Community member/friend was knowledgeable about where to access FP. | | • There is sociocultural resistance to FP use (especially use by unmarried youth). |
| Individual | • Client feels that her boyfriend treats her well.<br>• Client desires to use FP. | • Florence feels pressure to have sex, despite not being ready and facing her mother's disapproval. | |

## Altine—Case Study 2

Note: This *Case Study Sample Grid* is intended to provide examples of possible supporting and challenging factors at each level as they relate to Case Study 2. This list is not exhaustive.

| Level | Factors that support full, free, and informed choice and human rights | Coercive factors | Factors that create access barriers |
|---|---|---|---|
| Policy | • Government provides some support for FP.<br>• Government seeks to meet national Millennium Development Goal (MDG). | • Government support for FP is demographically driven.<br>• There are contraceptive prevalence rate targets assigned to each district | • Health is not a development priority.<br>• There are no national policies in support of sexual and reproductive health or gender equality.<br>• Government expenditures on health are low.<br>• Brain drain is occurring. |
| Service Delivery | • There is access to an FP/ reproductive health (RH) clinic.<br>• FP posters are visible to clients.<br>• Facilities are equipped, stocked, and organized to provide the intrauterine device (IUD). | • The provider is biased against poor people having large families. | • Health infrastructure is inadequate (especially in rural, mountainous areas).<br>• There are too few medical schools, contributing to a shortage of health care personnel.<br>• There are long waiting times and overcrowding.<br>• Clients lack privacy during counseling.<br>• The facility is unhygienic.<br>• Health care personnel are demoralized, poorly paid, and unsupported; they therefore exhibit poor attitudes and unfriendly behavior toward clients.<br>• Supplies/equipment are inadequate.<br>• FP posters are not in the local language. |
| Community | | | • Status of women is low.<br>• Gender-based violence is high. |
| Individual | • There is support for and use of FP. | | • The husband drives FP decision making; he wants a son.<br>• There is an imbalance in power between the provider and the client. |

## Dorothy—Case Study 3

Note: This *Case Study Sample Grid* is intended to provide examples of possible supporting and challenging factors at each level as they relate to Case Study 3. This list is not exhaustive.

| Level | Factors that support full, free, and informed choice and human rights | Coercive factors | Factors that create access barriers |
|---|---|---|---|
| Policy | • Government development strategy prioritizes health (specifically HIV and AIDS, malaria, and maternal/infant mortality).<br>• FP is promoted to slow population growth and as a preventive health measure.<br>• There is a national program to strengthen the health care system and increase service capacity (e.g., by upgrading hospitals, building health posts, strengthening the logistics system, and training providers).<br>• A wide range of short-acting methods and long-acting reversible contraceptives is available. | • The FP program relies heavily on mobile services and large-scale camps to provide the intrauterine device (IUD) and implant. | • People in rural and mountainous areas have limited access to basic health care services.<br>• Government support for FP is not explicitly rights-based.<br>• The weak health care system is unable to meet the needs of a growing population.<br>• Female sterilization is offered only at tertiary hospitals with gynecologists on staff; vasectomy is not available. |
| Service Delivery | • The facility was clean.<br>• The nurse was kind.<br>• Privacy was respected.<br>• There were HIV and FP posters on the wall (showing multiple method options). | • Provider was biased toward implants. | • The waiting room was overcrowded.<br>• The method of the client's choice was not offered at the facility; no service referral was offered.<br>• The nurse did not assess what method attributes mattered to the client.<br>• Rural access to FP services was limited.<br>• Stock-outs occurred at the facility. |
| Community | • Civil society (including women's groups) is robust. | | • Women's groups are not active in rural areas. |
| Individual | • There is knowledge of/interest in FP.<br>• Husband was supportive. | | • Geographic access is limited.<br>• The client forgets to take pill |

## Mercy—Case Study 4

Note: This *Case Study Sample Grid* is intended to provide examples of possible supporting and challenging factors at each level as they relate to Case Study 4. This list is not exhaustive.

| Level | Factors that support full, free, and informed choice and human rights | Coercive factors | Factors that create access barriers |
|---|---|---|---|
| Policy | • Government support for FP is strong.<br>• Government is expanding method choice.<br>• Government supports a public education campaign.<br>• Government has forged a public-private partnership with a strong nongovernmental organization. | | • The public health system is fragile. |
| Service Delivery | • Mobile services are serving rural areas.<br>• A range of methods is offered.<br>• The nurse provides information and individual counseling. | | • The health infrastructure and service capacity are inadequate (especially in rural areas)<br>• Mobile services are not always available.<br>• No one discussed oral contraceptives with Mercy. |
| Community | • There is a trusted community health worker. | | • Women's status is low.<br>• Gender-based violence may be acceptable. |
| Individual | • Her husband supports her use of FP.<br>• They can pay for private services. | | • Husband is unlikely to wear condoms, is sexually violent.<br>• There is an imbalance in power between the husband and wife. |

# SESSION 4

45 MINUTES

# THE RANGE OF CHALLENGES TO FULL, FREE, AND INFORMED CHOICE: WHAT WARRANTS MORE ATTENTION?

## OBJECTIVES

1. Explore the full range of challenges and warning signs that indicate full, free, and informed choice may be at risk or compromised
2. Identify what challenges warrant more attention and action

## NOTE TO FACILITATORS

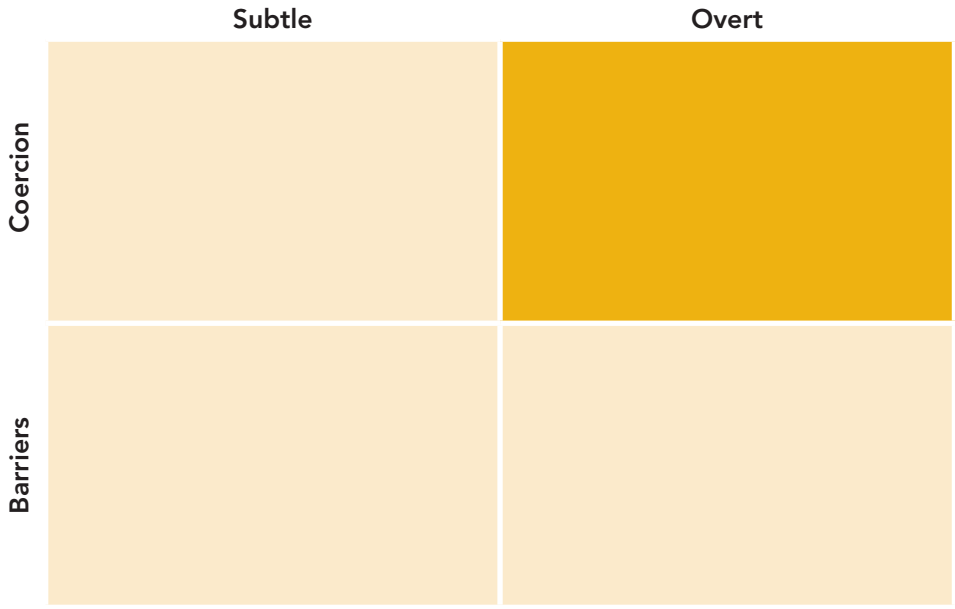
The facilitator will guide participants to carry over the outputs from their case study analysis, focusing on factors that challenge full, free, and informed choice, both coercive factors and factors that create access barriers. They will then categorize them as either overt (i.e., blatant, obvious, intentional, or direct) or subtle (i.e., more nuanced, indirect, or inadvertent). The activity will guide participants to think holistically about all of the challenges to full, free, and informed choice, many of which they may tend to overlook.

The activity will lead to a key **take-home message:** that programs typically believe that if they do not have a problem with blatant coercion, they do not have a problem with voluntarism or human rights. That is not true. Any condition or practice that exerts coercive pressure or creates an access barrier is a human rights problem that needs to be addressed. And more people are affected by access barriers and subtle coercion than by overt coercion. Participants should consider all areas that warrant increased attention and action by policymakers or program managers to ensure full, free, and informed choice.

*Note*: The grid is not intended to be a rigid tool for sorting challenges; not all participants may agree on whether a challenge is a barrier or coercion or if it is subtle or overt. The exercise is also not intended to generate an exhaustive list of all possible challenges. Rather, it is meant to generate a broader range of challenges to choice than obvious examples of coercion and to make the points that subtle coercion and access barriers are also rights violations and affect the most people.

### *Advance Preparation*

1. Create a four-celled grid using four sheets of flipchart paper and post it on the wall (see diagram below). Horizontal cells should be labeled as Barriers/Coercion, vertical cells as Subtle/Overt.




2. Post all of the outputs from the previous session on the wall, grouping all of the coercive factors and all of the factors that pose access barrier in a way that everyone can see them.
3. Write the session objectives on a sheet of flipchart paper.

| Time | Content/Methodology |
|---|---|
| **5 min.** | 1. Post the prepared flipchart and review the session objectives.<br><br>**Materials:**<br>Flipchart paper and markers to list session objectives |
| **30 min.** | **Activity: Categorize the Challenges to Contraceptive Choice and Rights**<br>1. Ask participants to quickly scan all of the outputs posted on the wall, both the coercive factors and the access barriers. For each factor, ask them to consider whether the challenge is overt (i.e., blatant, obvious, intentional, or direct) or if it is subtle (i.e., more nuanced, indirect, or inadvertent). Aim to reach a consensus for each one, noting that this is not always easy, and that some factors could serve as either a coercive pressure or a barrier (e.g., provider bias).<br>2. As each factor is categorized, post each card on the 2x2 grid that you have posted on the wall, arraying the challenges along the two axes: 1) coercion/barrier, and 2) overt/subtle.<br>3. Then ask each group to think beyond their case study and what is already posted to identify additional factors to add to the grid. Instruct them to write these ideas on cards, as before. (Allow 10 minutes.)<br>4. Once the cards are completed, invite one group to share one or two additional factors that they identified as subtle coercion. Post them on the grid on the wall. Then invite the next group to add up to two factors, followed by the third group, and so on until all groups have reported. Then invite another group to share one or two factors they identified as overt coercion. Post these and go through the same process, collecting input for this quadrant from all groups. Follow the same process for the third and fourth quadrants. Allow 10 minutes for this report-back.<br>5. Refer to Facilitator Guidance 4-1: Sample Grid Showing Illustrative Examples during the exercise, to ensure that all of the concepts are covered in this session.<br><br>**Materials:**<br>Flipchart paper and markers, to post the questions for participants<br>Tape<br>Colored 6" x 8" index cards and markers<br>PowerPoint slide with the grid and an example for each quadrant (Slide 19)<br>Facilitator prompts: Completed grid with illustrative answers |
| **5 min.** | **Activity: Reflection**<br>1. Ask the participants to review the grid and reflect on the following questions:<br>• In your opinion, which quadrant receives the most attention from rights activists, donors, policymakers, the international community, etc.?<br>• What situations (in what quadrants) affect the largest numbers of individual clients?<br>2. Record their suggestions on a sheet of flipchart paper and post it on a wall where the participants can see it.<br><br>✺ **Take-home messages to highlight:**<br>• All of these factors compromise choice and human rights, and they all warrant attention, safeguards, and corrective action.<br>• Access barriers affect many more individuals than coercion. Greater efforts are needed to understand and remove access barriers and to ensure equitable access for all. |
| **5 min.** | **Reflection and Wrap-Up**<br>1. Close the session by asking for the participants' reactions or comments regarding the exercise. |

# SESSION 4
# SUPPLEMENTAL MATERIALS

## FACILITATOR GUIDANCE

4-1: Sample Grid Showing Illustrative Examples

# SESSION 4
# FACILITATOR GUIDANCE 4-1:

## SAMPLE GRID SHOWING ILLUSTRATIVE EXAMPLES

**Activity**: Brainstorming the challenges and warning signs to full, free, and informed choice. The following are ***illustrative*** responses to use in completing the grid exercise in this session:

| | Subtle | Overt |
|---|---|---|
| **Coercion** | • Provider bias for specific methods<br>• Incentives to providers or clients that impact individual autonomy, agency, or decision making<br>• Targets and quotas<br>• Community/family pressure<br>• Lack of capacity of the health system to ensure the availability of commodities or to provide range of methods at all levels of the health care system | • Involuntary sterilization of ethnic minorities, the poor, and HIV-positive persons<br>• Provision of substantial or material incentives to providers<br>• Postpartum IUD insertion or sterilization without consent<br>• Withholding of benefits for nonacceptance<br>• Refusal to remove IUD and/or implants |
| **Barriers** | • Provider bias against specific methods<br>• Misinterpretation of eligibility criteria<br>• Lack of :<br>  ▸ Accurate information<br>  ▸ Community or spousal support for FP or specific methods<br>  ▸ Access to new/innovative contraceptive technologies<br>• Poor quality of services<br>• Gender norms and status of women (e.g., spousal consent regulations)<br>• Negative attitudes toward marginalized populations | • Limited choice of methods available (e.g., specific methods not offered, stock-outs)<br>• Lack of equitable distribution of FP outlets<br>• Lack of trained providers<br>• Costly, unaffordable services<br>• Denial of FP to unmarried youth |

**Definition of coercion**: Coercion in FP consists of actions or factors that compromise individual autonomy, agency, or liberty in relation to contraceptive use or reproductive decision making through force, intimidation, or manipulation.

# SESSION 5 — 1 HOUR

# CONTRACEPTIVE METHOD CHOICE: WHAT IT IS AND WHY IT MATTERS

## OBJECTIVES

1. Identify what method attributes are important and what range of methods should be offered, from a client's perspective
2. Explain the concept of contraceptive method choice and examine the range of methods that should be offered to meet clients' reproductive intentions and preferences
3. Present the current local method mix and discuss whose needs are and are not being met

## NOTE TO FACILITATORS

During this session, the participants will be introduced to the concept of contraceptive method choice. Throughout the session, the participants will be encouraged to reflect critically about how the contraceptive method mix in a country does or does not meet the needs of individuals. The additional readings and resources at the end of this section are strongly recommended as background reading for the facilitator.

### *Advance Preparation*

1. In preparation for this session, the facilitator will need to access data from the most recent Demographic and Health Survey (DHS) of the country in which the orientation is taking place and customize pie charts for the local method mix in the session's PowerPoint, using the contraceptive prevalence data by method (see Facilitator Guidance 5-1: Gathering DHS Data and Preparing Graphs in PowerPoint, page 47, for instructions). The facilitator should also become familiar with the two example pie charts and their accompanying analyses for the related discussion.
2. Prior to the session, choose five of the client profiles from Facilitator Guidance 5-2: "Looking through a Client Lens" Client Profiles and copy them onto note cards.
3. Write the session objectives on a sheet of flipchart paper.
4. Make enough copies of Handout 5.1: Method Attributes Considered by Clients to distribute to all participants.

| Time | Content/Methodology |
|---|---|
| **5 min.** | 1. Post the prepared flipchart and review the session objectives.<br><br>**Materials:**<br>PowerPoint Slide 21 |
| **15 min.** | **Activity: Looking through a Client Lens**<br>1. Select five participants to read each of the prepared client profiles, and after each one, ask the following questions:<br>• What attributes might this client be looking for in a contraceptive method?<br>• Based on your knowledge and experience of the services and supplies that are available where you work, would this client be able to choose a method that meets her reproductive intentions and desires?<br>2. Engage in a group discussion, using the suggestions in Facilitator Guidance 5-3: "Looking through a Client Lens" Discussion Guide.<br>3. After all of the client profiles have been read and discussed, pass out Handout 5.1: Method Attributes Considered by Clients. Explain that this provides a list of a number of different method attributes that are important to clients, and that many of these were mentioned in the previous discussion. Note that decisions about which contraceptives programs will offer are generally based on donor or program priorities, instead of client needs and preferences. Then explain that when we look through a client lens, we see that clients consider a number of method attributes when deciding whether to use contraceptives and what method to use.<br>4. Then ask the following:<br>• Are there any other factors or variables that should be considered in determining the range of methods offered, to ensure that contraceptive method choice is a reality for all clients?<br>5. Explain that the extent to which clients have a choice of methods in programs can be assessed in a few ways and that the remainder of the session will be dedicated to discussing method choice in FP programs.<br><br>**Materials:**<br>PowerPoint slides 22–23<br>Slips of paper or note cards with client descriptions<br>Flipchart paper and markers<br>Handout 5.1: Method Attributes Considered by Clients |
| **5 min.** | **Introduction of Method Choice Concepts**<br>1. Introduce the concept of contraceptive method choice as outlined in the PowerPoint slides. On Slide 27, introduce the concept of skewed method mix and describe the two example pie charts:<br>• Country 1's method mix is dominated by permanent methods (63%), with 26% of women using short-acting methods and only 4% using long-acting reversible methods.<br>• Country 2's method mix is dominated by short-acting methods (69%), while 22% of women use permanent methods and only 4% use long-acting reversible methods.<br><br>**Materials:**<br>Presentation from PowerPoint slides 24–27 |

| Time | Content/Methodology |
|---|---|

**15 min.** **Analysis of Method Mix Using Examples**

MATERIALS:
Plenary discussion (Slide 28)

1. Referring to Country 1, ask the participants:
   - What questions about contraceptive choice are raised by these data?
   - What factors might contribute to this situation?
2. Repeat the analysis for Country 2.
3. Use the following probing questions, if needed:
   - For Country 1, what factors might contribute to the high level of permanent method use? Why might long-acting reversible methods be limited in use?
   - For Country 2, what factors might contribute to the high level of short-acting method use? Why might long-acting reversible methods be limited in use?
4. Be prepared to offer examples of factors that drive current method mix: limited ability to provide certain methods (skills, supplies); provider bias; regulations that limit task shifting; client preferences; affordability of certain methods; etc.

---

**20 min.** **Analysis of Local Method Mix**

MATERIALS:
Prepared pie chart of country's method mix, using template included in Powerpoint on Slide 29
Slides 29–30
Flipchart paper

1. Describe the data in the pie chart for the participants, noting the different methods that are used and those that are more prevalent (as you did for the example pie charts).
2. Ask the participants to consider the data on the pie chart and ask them:
   - What questions about contraceptive choice are raised by these data?
   - What factors might be driving the current method mix? *Examples*: differential provision by the public, private, and nongovernmental sectors; limited ability to provide certain methods (skills, supplies); provider bias; regulations that limit task shifting; client preference; affordability of certain methods; etc.)
   - To what degree does the method mix meet current or emerging needs among different groups (e.g., youth, men, postpartum women, HIV-positive clients, underserved geographic groups, or clients with different reproductive intentions to delay, space, or limit future births)?
3. Record the participants' responses about these factors on a sheet of flipchart paper.
4. If you need to pose additional questions to prompt discussion, consider using the following suggestions:
   - Are certain methods offered to different client cohorts (e.g., by age, sex, reproductive intention, lactation status, health profile, minority or income group status)?
   - Are there acceptable method choices for women and men who wish to space births and those who wish to limit future births, or for those who prefer hormonal contraception and those who do not?

   *Note*: Unlike the example pie charts, this discussion should focus more on the participants' knowledge of the local FP program.
5. Next, ask the participants to think about the people whose needs might not be met with the current method mix.
   - Who do you think they are (e.g., adolescents, people living with HIV, women in rural areas)?
   - What may be influencing their decision to use or not to use contraceptives?
   - Why might they not use their chosen method correctly or consistently?
   - What factors at each level might contribute to access barriers?

*Continued on next page*

| Time | Content/Methodology |
|---|---|
| | 6. Finally, ask:<br>• What issues or constraints stand in the way of expanding contraceptive method choice? How might these be addressed?<br>7. Wrap up the discussion by describing the many method attributes that clients consider when making choices about contraceptive use but that may not be considered by program funders and implementers. |
| **5 min.** | **Wrap-Up**<br>1. Ask the participants: What key messages are you taking away from the session?<br><br>MATERIALS:<br>PowerPoint Slide 31<br><br>**Take-home message:**<br>• Governments and programs have a duty to make available and accessible to all clients the widest possible range of methods to meet their changing needs and preferences throughout their lives. |

# SESSION 5
# SUPPLEMENTAL MATERIALS

## HANDOUT

5.1: Method Attributes Considered by Clients

## FACILITATOR GUIDANCE

5-1: Gathering DHS Data and Preparing Graphs in PowerPoint
5-2: "Looking through a Client Lens" Client Profiles
5-3: "Looking through a Client Lens" Discussion Guide

# SESSION 5
# HANDOUT 5.1:

## METHOD ATTRIBUTES CONSIDERED BY CLIENTS

**Ease and comfort of use**
- Does/does not require a pelvic exam
- Frequency of use/of clinic visits
- Does/does not require touching one's genitals
- Is linked or not linked to sexual encounter
- Has/has no impact on pleasure
- Side effects
- Nonsurgical or surgical
- Risks
- Discreetness

**Mode of action**
- Hormonal
- Nonhormonal
- Barrier

**Duration of effectiveness**
- Short-acting
- Long-acting reversible
- Permanent

**Ease of access**
- Public sector
- Private sector
- Kiosk
- Clinic or hospital
- Home distributor

**Control of method**
- Client
- Partner
- Provider

**Ease of discontinuation**

**Cultural acceptability**

**Affordability**

**Others:**

_____

_____

_____

_____

_____

# SESSION 5
# FACILITATOR GUIDANCE 5-1:

## GATHERING DHS DATA AND PREPARING GRAPHS IN POWERPOINT

If an electronic version of the Orientation PowerPoint is not available, the graphs needed for this session can be made in a new PowerPoint slide, using the following instructions. Data and reports for many countries can be accessed from http://www.dhsprogram.com/publications/index.cfm. Alternatively, StatCompiler (http://www.statcompiler.com) can be used to select contraceptive prevalence rate (CPR) datahttp://www.statcompiler.com. To access these data in StatCompiler:

- Click on "Data Table" (at the right of the page).
- Select the country of interest, then click "Next."
- Click on the "Complete List" tab.
- Select "Family Planning."
- Select "Current use of contraceptives."
- Select "Current use of contraceptives" again.
- Select all contraceptives of interest, and click OK.

A table will be generated with current data, which can be then used to make a pie chart in PowerPoint.

In PowerPoint:

- On a new slide, click on the "Graph" icon in the center of the slide. If there is no content on the slide, click the "Insert" tab and then click on "Chart".
- Choose "Pie chart" from the list of charts.
- A generic pie chart will be generated and a spreadsheet will pop up.

For the method mix slide:

- In Row 1 of Column B, enter the title of the chart, or specify the data that are being reported in the pie chart. In Column A of the spreadsheet, list the names of all of the contraceptive methods reported in the DHS, starting in Row 2. In the remaining rows of Column B, enter the percentage of women who use that method, as reported in the DHS. For the graph to turn out correctly, you will need to divide the number of women using a particular method by the total CPR.

| Contraceptive method | Method mix among married women of reproductive age |
|---|---|
| Female sterilization | x.x% |
| Male sterilization | x.x% |
| Intrauterine device (IUD) | x.x% |
| Implants | x.x% |
| Injectables | x.x% |
| Pill | x.x% |
| Condoms | x.x% |
| Lactational amenorrhea | x.x% |
| Traditional | x.x% |
| Other | x.x% |

# SESSION 5
# FACILITATOR GUIDANCE 5-2:

## "LOOKING THROUGH A CLIENT LENS" CLIENT PROFILES

*Directions*: In advance of the session, copy client profiles onto note cards (change the names to fit the local context) and ask different participants to read each one aloud. After each client description, ask: "What attributes might this client be looking for in a contraceptive method?" Ask the participants to call out different attributes. Write their responses on a sheet of flipchart paper. Then ask: "Based on your knowledge of the services and contraceptives available, would the client be able to get a method that meets his or her needs?"

### *Client Profile A*

Louise is 17 years old and has a 6-month-old baby. She is just starting a new relationship and might want another baby in a year or two. She lives in a culture where condoms are used mainly to prevent HIV. While some men are willing to use them for pregnancy prevention, most are not. She has never used a contraceptive method before and has limited access to public-sector services. She knows that oral contraceptives and condoms are sold in her town.

### *Client Profile B*

Geraldine is a 32-year-old mother of four children living in a predominantly conservative community. She is happy with the size of her family and does not want any more children. She and her husband currently use the withdrawal method to prevent pregnancy, but she worries about getting pregnant anyway. She does not have time for regular visits to the family planning clinic. She knows that mobile clinics come through the village on occasion.

### *Client Profile C*

Mary is a 25-year-old mother of two children. She got pregnant with her second child sooner than she wanted because she did not take the pill consistently. She would like to wait before having another child in a couple of years, but she does not like the side effects of the pill.

### *Client Profile D*

Josephine is 23 years old and has two children. She is illiterate, and her family disapproves of family planning. She works hard on their farm and does not want to have any more children at this time, but she is afraid of disobeying her husband.

### *Client Profile E*

Sarah is 30 years old, has two children, and is pregnant with her third child. Her husband travels for months at a time for work, and so they have infrequent sex. She is unsure if they will want more children; she wants to wait at least two years before having another. The community health worker has visited and talked about family planning and about Sarah's having her baby in the hospital.

### *Client Profile F*

Carlos is the father of three children. He and his wife are happy with this family size, and they do not want more children. His wife has used injectables to prevent pregnancy for the last three and one-half years, but the repeated visits to the clinic are inconvenient and costly.

### *Client Profile G*

Elaine is 15 years old. She wants to pursue her education. She has a boyfriend and has not had sex yet, but she knows that she will probably have sex before she gets married. She wants to avoid pregnancy until she has finished her education and is more established.

# SESSION 5
# FACILITATOR GUIDANCE 5-3:

## "LOOKING THROUGH A CLIENT LENS" DISCUSSION GUIDE

### *What attributes might these clients be looking for in a contraceptive method?*

Open a discussion so that the participants can brainstorm some of the characteristics that were included on Slide 23:

- *Example*: Louise may want a method that she can start and stop, depending on her relationship status—i.e., a method that she controls.
- *Example*: Geraldine may want a method that she will not have to think about for at least a couple of years after she gets it; she may consider the cultural acceptability of methods.
- *Example*: Josephine may want to use a method that she can hide from her husband, or she may want support in changing her family's attitudes about FP, so she can use it in a supportive environment.

Ask the participants to keep these clients in mind as they think about the services that are offered in their programs.

### *Based on your knowledge and experience of the services and supplies that are available where you work, would this client be able to choose a method that meets her reproductive intentions and desires?*

*Probing questions:*

- How frequently are methods out of stock?
- Do facilities have enough trained personnel to provide long-acting reversible and permanent methods?
- Do providers have the required infrastructure, including what is needed to ensure infection prevention, to provide long-acting reversible and permanent methods?
- Do health workers have time to counsel clients and provide accurate and unbiased information?
- Are public- and private-sector services available? Do they differ substantially in quality?
- What options are women offered postpartum and postabortion?

### *Should any other factors or variables be considered when analyzing the range of methods offered to ensure that contraceptive method choice is a reality for all clients?*

*Examples:*

- Cultural appropriateness of methods (methods that are not culturally appropriate for some groups may be acceptable for other groups; dominant group should not take precedent)
- Task shifting/service availability
- Affordability of methods

### *What issues or constraints stand in the way of expanding contraceptive method choice? How might these be addressed?*

*Examples:*

- Inadequate service modalities for special populations, such as adolescents, postpartum women, men, people living with HIV
- Skewed service provision within one sector (e.g., lack of private-sector involvement in FP or inadequate public–private-sector collaboration to foster a total market approach)
- Limited number of trained providers
- Frequent stock-outs of contraceptives, supplies, and equipment
- Infrequent use of certain methods, making providers uncomfortable about providing them (e.g., their skills get rusty)
- Inadequate health infrastructure
- Inadequate use of the private sector or alternatives to fixed public-sector service delivery
- Protocols about who can provide which methods
- Providers and staff assuming which methods clients will find acceptable

Examples of ways to address some of the issues listed above:

- Increasing policy support and community support for youth-friendly services
- Improving training and emphasis on offering postpartum FP
- Using a total market approach to fill service gaps and reach additional client
- Promoting task shifting to increase the number of providers who can offer FP
- Finding ways to attract people to the field of FP service provision
- Improving supply chains for FP
- Providing refresher trainings for providers to practice skills for providing IUDs, implants, and tubal ligation
- Advocating for increased investment in the health infrastructure
- Advocating for policy changes to allow task shifting
- Training providers on the respectful treatment of clients and on informed and voluntary decision making

# SESSION 6

**1 HOUR, 45 MIN.**

# ACCOUNTABILITY FOR FULL, FREE, AND INFORMED CHOICE IN FP PROGRAMS

## OBJECTIVES

1. Increase awareness of situations that result in vulnerabilities that could compromise full, free, and informed choice, even in well-intentioned programs
2. Identify actions that individual FP program stakeholders (service providers, program managers, policymakers, donors) can take and include in a plan to monitor and fulfill their responsibilities and be accountable for ensuring full, free, and informed choice within their programs

## NOTE TO FACILITATORS

This session consists of two activities. In the first, participants are asked to review and discuss a few brief vignettes that illustrate how well-intentioned program interventions may result in vulnerabilities regarding full, free, and informed choice in FP programs.

Following a brief presentation, the second activity has participants explore whether these or other vulnerabilities exist within their own programs and identify actions they can take from whatever vantage point at which they "sit" within the program, to strengthen program accountability.

### *Advance Preparation*

1. Write the session objectives on a sheet of flipchart paper.
2. Make a copy of Facilitator Guidance 6-1: Program Vignettes—Vulnerabilities to Full, Free, and Informed Choice and cut the paper into strips, one for each of the vignettes.

| Time | Content/Methodology |
|---|---|
| **5 min.** | 1. Post the prepared flipchart and review the session objectives.<br><br>MATERIALS:<br>PowerPoint Slide 33 |
| **55 min.** | **Activity: Good Intentions/Unintended Consequences**<br>1. Divide the participants into small groups of five participants and provide each group with one program vignette.<br>2. Ask the participants to discuss briefly in their groups the following questions *(20 minutes)*:<br>• What did this program do to support full, free, and informed choice? (the good intention)<br>• How does this situation contribute to vulnerabilities that negatively impact clients' experience of full, free, and informed choice? (the unintended consequence)<br>• How did the good intention go wrong? (vulnerability)<br>• What safeguards could have been implemented in the beginning to reduce the vulnerability? (prevention strategy)<br>• What safeguards can be put in place now, and what actions could be taken to remedy the problem?<br>3. Ask the small groups to report back quickly to the plenary (*approximately five minutes per group, or 25 minutes in all*):<br>• Read the vignette, and summarize the group's depiction of the good intention, the unintended consequence, and what might be done about it.<br>4. Facilitate a discussion among the groups by posing the following questions (*10 minutes)*:<br>• What vulnerabilities exist in program interventions that support:<br>▸ Method-specific promotion?<br>▸ Performance-based financing?<br>▸ Programs with targets and/or incentives?<br>▸ Demographically-driven programs?<br>• What can be done by these programs to ensure full, free, and informed choice?<br><br>MATERIALS:<br>PowerPoint Slides 34–35<br>Vignettes A–E, one vignette per group<br>Flipchart paper and markers |
| **40 min.** | **Activity: What Am I Responsible for?**<br>1. Present key concepts on what can be done to strengthen accountability within the program. (*10 minutes*)<br>• Routine monitoring<br>• Implementation of routine safeguards<br>▸ Counseling<br>▸ Client feedback mechanisms<br>• Protocols for investigating problems or rumors regarding voluntarism<br>• Clear process/responsibility for addressing the problem<br>• Clear mechanism in place for providing redress to clients if/when voluntarism abuse occurs<br><br>MATERIALS:<br>PowerPoint Slide 36<br>Flipchart paper and markers to record participant responses |

*Continued next page*

| Time | Content/Methodology |
|---|---|

2. Ask participants to spend five minutes working individually to answer the following questions (see PowerPoint slide 37):
   - In your current role, how are you responsible for ensuring full, free, and informed choice?
   - Based on what you have learned in this orientation, what issues or vulnerabilities may exist within your FP program? [Or, if you are not currently working in a specific FP program, what issues or vulnerabilities have you observed within FP programs with which you are familiar?]
   - What is currently being done to monitor and safeguard full, free, and informed choice within your program?
3. Once participants have had time to consider the questions, facilitate a discussion (*15 minutes*). Begin by asking the following question:
   - How many of you have responsibility for ensuring full, free, and informed choice (ask for a show of hands)?
4. Among those who raised their hands, ask for examples of where and how full, free, and informed choice is vulnerable. Elicit examples from different types of stakeholders (service providers, community health workers, managers, policymakers, donors, etc.).
5. Ask participants to provide/describe examples of instances within their programs where vulnerabilities to full, free, and informed choice existed. For one or two examples, lead a discussion, using the following questions:
   - Have others observed this or similar things happening within their program? How common is this problem?
   - How did you know? What data informed you? Did you monitor this?
   - What follow-up actions were taken? [Prompts: Investigations? With what protocols? Who was responsible? What safeguards would prevent this from recurring? What would you do for clients whose voluntarism was compromised?]

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**5 min.** **Wrap-Up**

1. Ask the participants: What key messages are you taking away from the session?

MATERIALS:
PowerPoint Slide 38

✺ **Key take-home messages**

- Service providers (or those assigned to counsel) aren't the only ones who have responsibility for ensuring voluntarism. All actors, from donors to policymakers to community health workers, play a role in safeguarding and monitoring full, free, and informed choice.
- Vulnerabilities to full, free, and informed choice can exist—even in programs with the best of intentions. Often, good policies or program plans are undermined by poor implementation and oversight.
- For programs to be accountable for ensuring full, free, and informed choice, it is necessary to have a plan in place that clearly outlines the safeguards, how the program will be routinely monitored, and how the program will identify potential problems and then investigate, follow up, and provide redress when problems occur.

# SESSION 6
# SUPPLEMENTAL MATERIALS

## FACILITATOR GUIDANCE

6-1: Program Vignettes—Vulnerabilities to Full, Free, and Informed Choice

# SESSION 6
# FACILITATOR GUIDANCE 6-1:

## PROGRAM VIGNETTES—VULNERABILITIES TO FULL, FREE, AND INFORMED CHOICE

Program A has just instituted a new performance-based financing scheme to reward health care facilities that increase the quality and quantity of services, so that they have additional resources to motivate and retain health center staff. Dr. Joseph is the director of a busy health center that offers primary care to the surrounding subdistrict. He signed a contract with the central ministry that includes a service plan to increase the numbers of clients counseled for FP and the numbers of clients that adopt an FP method. The facility team receives 1,000 LC[1] for new injectable users and 2,500 LC for new implant or intrauterine device (IUD) users. The plan does not pay for referrals for permanent methods, nor does it subsidize return clients. Dr. Joseph used the payments to raise the salaries of the FP team, motivating them to increase their efforts. The staff found that if they played up the benefits of the IUD and played down the side effects, more women would adopt the IUD instead of opting for reinjections, resulting in continued subsidies for the FP team.

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In Program B, the Ministry of Health has contracted with a nongovernmental organization to support mobile services in remote rural areas to increase access to implants, as part of a larger strategy to broaden the method mix and increase contraceptive prevalence. The mobile team visits a specific area once every 4–6 months. Initial uptake was rapid, especially given the high unmet need in these areas and particularly among women who have never used contraception before. With this increased uptake has come an increase in the number of requests for implant removal; however, there are no providers trained in removal in these communities.

---

Program C was designed to increase postpartum IUD availability and use among women giving birth at the large maternity hospital in the capital city. Providers were oriented to two key messages: 1) the large unmet need for contraception among postpartum women and how using FP provides a "win-win" benefit to both the mother and child; and 2) the IUD is a cost-effective, long-acting method (and contributes to more couple-years of contraceptive protection than many other methods). Dedicated resources were pumped into the hospital as part of a method-specific project to support postpartum IUD adoption, creating an expectation among the providers associated with the project to increase the number of clients who receive an IUD postpartum.

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[1] LC = local currency.

Program D would like to increase the use of contraceptives and knows that in some areas using family planning is taboo. They want to help change attitudes, educate families about the benefits of family planning, and make services more available so they begin a community health worker extension program. The community health workers visit homes, develop relationships with families, and encourage FP use. They are respected women in the community. The supervisor in District X closely tracks the performance of the community health workers he oversees. He expects them to produce a certain number of new users each month; otherwise, they may lose pay or their positions.

---

In Program E, as part of an overall economic development policy, the government of the country would like to encourage couples to have only the number of children they can provide for. They have decided to launch a campaign to promote smaller families. They have created radio messages and television ads and are using community entertainment to explain that responsible parents only have the children they can afford—and that responsible citizens do their duty by having small families. In the campaign, FP is promoted as a way to ensure that children are born only when couples are ready. Hoping that their messages will be effective, they work closely with health care providers and networks of community volunteers to make sure that FP information and services are available. Community health workers and providers begin to tell women that two children are enough and that they should use FP to avoid having any more children than that. Providers also begin to treat women with three or more children rudely if they do not adopt FP.

# SESSION 7 — 1 HOUR

# WRAP-UP AND REFLECTIONS

## OBJECTIVES

1. Highlight and reinforce key concepts and messages
2. Have participants identify concrete actions that they can take to share their learning and to ensure full, free, and informed choice in the FP programs they support or work in
3. Complete the workshop evaluation

## NOTE TO FACILITATORS

This session is designed to reinforce key concepts and messages and to have each participant leave the workshop feeling positive and energized about actions they can take to apply what they have learned in their own work. It will conclude with completion of a workshop evaluation, to provide workshop organizers with feedback to inform the design and conduct of similar workshops in future.

### *Advance Preparation*

1. Make enough copies of Handout 7.1: Commitment Statement and Handout 7.2: Workshop Evaluation for each participant.

| Time | Content/Methodology |
|---|---|

**20 min.** **Recap of Key Concepts and Messages**

MATERIALS:
Flipchart paper
Marker

1. Ask the participants to work in pairs to identify the three most important concepts or take-home messages that they got from the workshop. Allow them five minutes to do so.
2. Ask one pair to call out a response, and then rapidly go around the room, asking other pairs to add new ideas to whatever has been reported. Capture these responses on a sheet of flipchart paper.
3. Repeat this process for a second round and then for a third round, until all responses have been recorded without duplication.
4. Review Facilitator Guidance 7.1: Key Messages Reference Sheet for any key points that were missed and add these at the end.

---

**10 min.** **Application of New Awareness and Learning in Your Work**

MATERIALS:
Handout 7.1: Commitment Statement

1. Hand out the Commitment Statement forms and ask the participants to fill in the blanks on the following statements:
   - Following this workshop, I will:
     - Apply what I have learned to strengthen full, free, and informed choice and human rights in the FP program(s) I support/work in by (doing what?)

       _____

     - Share what I've learned with_____, by _____
       (how?)
2. Allow the participants five minutes to complete the statements. Then invite them to share their responses, asking people to only add new ideas to those already offered. When finished, ask participants to hand the statements in to the facilitator.

---

**5 min.** **Thanks and Farewell**

1. Express thanks to the workshop hosts, any guests, those who provided logistical support, and the participants.
2. Encourage the participants to take their statements of follow-up action with them, to remind them of what they said they would do.
3. Conclude by inviting their commitment to being true champions for contraceptive choice and human rights in FP, stressing the importance of this work.

---

**15 min.** **Workshop Evaluation**

MATERIALS:
Handout 7.2: Workshop Evaluation

1. Hand out the evaluation form and allow the participants 15 minutes to complete it.

# SESSION 7
# SUPPLEMENTAL MATERIALS

## HANDOUTS

7.1: Commitment Statement
7.2: Workshop Evaluation

## FACILITATOR GUIDANCE

7-1: Key Messages Reference Sheet

# SESSION 7
# HANDOUT 7.1:

## COMMITMENT STATEMENT

Following this workshop, I will:

- Apply what I have learned to strengthen full, free, and informed choice and human rights in the FP program(s) I support/work in by (doing what?)

  _____

- Share what I've learned with_____,

  by _____
  (how?)

Signed:

Participant Name_____

Institution_____

Date:_____

# SESSION 7
# HANDOUT 7.2:

## WORKSHOP EVALUATION

| END-OF-WORKSHOP EVALUATION | | | | |
|---|---|---|---|---|
| **How do you think this workshop added value to the work you do? If it did not add value, describe why not and what could improve its value.** | | | | |
| | | | | |
| **Please read the following statements and circle your response to each.**<br>**The workshop content was:** | | | | |
| Relevant | Strongly disagree | Disagree | Agree | Strongly agree |
| Comprehensive | Strongly disagree | Disagree | Agree | Strongly agree |
| Easy to understand | Strongly disagree | Disagree | Agree | Strongly agree |
| **The workshop handouts:** | | | | |
| Supported the material presented | Strongly disagree | Disagree | Agree | Strongly agree |
| Provided useful additional information | Strongly disagree | Disagree | Agree | Strongly agree |
| Were clear and well-organized | Strongly disagree | Disagree | Agree | Strongly agree |
| **The workshop:** | | | | |
| Was well-paced | Strongly disagree | Disagree | Agree | Strongly agree |
| Had sufficient breaks | Strongly disagree | Disagree | Agree | Strongly agree |
| Was a good mix between listening and activities | Strongly disagree | Disagree | Agree | Strongly agree |
| Activities were useful learning experiences | Strongly disagree | Disagree | Agree | Strongly agree |

| What did you like *best* about this workshop? |
| --- |
| |
| **What did you like *least* about this workshop?** |
| |
| **What will you *take away* with you from this workshop?** |
| |
| **Please provide any additional comments about any aspect of the workshop (content, materials, facilitation, etc.) that you believe the facilitators would find useful.** |
| |

**Name (optional):**_____

# SESSION 7
# FACILITATOR GUIDANCE 7-1:

## KEY MESSAGES REFERENCE SHEET

Factors at the **policy, service delivery, community**, and **individual** levels can support and can hinder full, free, and informed choice; it is important to take a holistic approach that involves interventions at all levels, not just within service delivery.

Acknowledge the supporting factors that should be valued, strengthened, and built upon.

All of these factors compromise choice and human rights, and they all warrant attention, safeguards, and corrective action.

Access barriers affect many more individuals than coercion. Greater efforts are needed to understand and remove access barriers and to ensure equitable access for all.

Governments and programs have a duty to make available and accessible to all clients the widest possible range of methods to meet their changing needs and preferences throughout their lives.

Service providers (or those assigned to counsel) are not the only ones who have responsibility for ensuring voluntarism. All actors, from donors to policymakers to community health workers, play a role in safeguarding and monitoring full, free, and informed choice.

Vulnerabilities to full, free, and informed choice can exist—even in programs with good intentions. Often there are good policies or program plans, but poor implementation and oversight.

For programs to be accountable for ensuring full, free, and informed choice, it is necessary to have a plan in place that clearly outlines the safeguards, how the program will be routinely monitored, and how the program will identify potential problems and then investigate, follow up, and provide redress when problems occur.

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# APPENDIXES

# APPENDIX 1:

# SUGGESTED READING AND RESOURCE MATERIALS

Erdman, J. N., and Cook, R. J. 2008. Reproductive rights. in *International Encyclopedia of Public Health*. K. Heggenhougen, ed. Oxford, UK: Academic Press, pp. 532–538.

Hardee, K., Newman, K., Bakamjian, L., Kumar, J., Harris, S., Rodriguez, M., and Willson, K. 2013. *Voluntary family planning programs that respect, protect, and fulfill human rights: A conceptual framework*. Washington, DC: Futures Group.

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## Resources for Addressing Policy-Level Barriers

**Strengthening Family Planning Policies and Programs in Developing Countries: An Advocacy Toolkit**
U.S. Agency for International Development (USAID), 2006

The purpose of this toolkit is to assist advocates in the FP/RH field in their efforts to promote policy dialogue on the health, social, and economic benefits of increasing access to FP services. By tailoring the messages included in the toolkit, advocates can present culturally relevant arguments to promote FP and birth spacing in their particular settings.

**Reforming Operational Policies: A Pathway to Improving Reproductive Health Programs**
POLICY Project, 2001

This document focuses on the vast arena between national policies and the point of service delivery, which is the domain of operational policies. Operational policies are the rules, regulations, codes, guidelines, and administrative norms that governments use to translate national laws and policies into programs and

services. The document discusses the nature of operational policies, examines the important role they play in the continuum from national decrees to local services, and provides a framework for operational policy reform.

## Resources for Addressing Service Delivery–Level Barriers

**Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations**
World Health Organization (WHO), 2014

These WHO guidelines provide recommendations for programs as to how they can ensure that human rights are respected, protected, and fulfilled, while services are scaled up to reduce unmet need for contraception. Both health data and international human rights laws and treaties were incorporated into the guidance. This guidance complements existing WHO recommendations for sexual and reproductive health programs, including guidance on FP, maternal and newborn health, safe abortion, and core competencies for primary health care.

**Choices in Family Planning: Informed and Voluntary Decision Making**
EngenderHealth, 2003

This tool supports a process to understand key concepts of informed and voluntary decision making; to identify and consider factors that affect informed and voluntary decision making (IVDM) in sexual and reproductive health; to develop strategies and action plans to strengthen IVDM in sexual and reproductive health programs; and to monitor and assess program quality and progress.

**Strategic Pathway to Reproductive Health Commodity Security (SPARCHS): A Tool for Assessment, Planning and Implementation**
U.S. Agency for International Development (USAID)/Maximizing Access and Quality (MAQ) Project, 2004

This tool (also a framework/approach) helps countries develop and implement strategies to secure essential supplies for FP/RH programs. Its focus is on meeting national reproductive health objectives, assessing supply conditions, determining future needs, and assisting in the development of strategies and action plans.

**Quick Investigation of Quality (QIQ): A User's Guide for Monitoring Quality of Care in Family Planning**
MEASURE Evaluation Project, 2001

The quick investigation of quality (QIQ) is a set of 25 "short list" indicators specifically designed to collectively measure quality of care in FP programs.

**COPE® Handbook: A Process for Improving Quality in Health Services**

**COPE® for Reproductive Health Services: A Toolbook to Accompany the COPE® Handbook**
EngenderHealth, 2003

The COPE® process (which stands for client-oriented, provider-efficient) is a set of four tools developed as a means to enable staff to assess their own work, so as to identify problems at their facility and local solutions to those problems. These tools—Self-Assessment Guides, a Client-Interview Guide, Client Flow Analysis, and an Action Plan—enable supervisors and their staff to discuss the quality of their services, identify problems that interfere with the delivery of high-quality services, identify root causes of those problems, recommend ways to solve the problems, implement the recommendations, and follow up to ensure resolution of the problems. COPE® also helps staff become more aware of clients' needs and, through the international standards of care embedded in the COPE® tools, become more aware of what it will take to provide the highest possible level of care (and thereby meet those needs).

**The Balanced Counseling Strategy: A Toolkit for Family Planning Service Providers (User's Guide; Trainer's Guide; Counseling Cards; Algorithm)**
Population Council, 2008

The Balanced Counseling Strategy (BCS) is an interactive, client-friendly counseling strategy that uses three key job aids to provide comprehensive and high-quality FP counseling to clients.

**Ensuring Privacy and Confidentiality in Reproductive Health Services: A Training Module and Guide for Service Providers**
Program for Appropriate Technology in Health (PATH) Fund and the Global Health Council, 2003

The training guide is intended to provide clarity and practical guidance to empower front-line reproductive health workers and supervisors to develop and implement effective privacy and confidentiality policies and better support and protect the right of clients to privacy and confidentiality.

**A Client-Centered Approach to Reproductive Health: A Trainer's Manual**
Population Council, 2005

This curriculum presents a framework for training providers to deliver client-centered reproductive health services. The essence of the approach is to bring about behavior change in providers by making them more receptive and responsive to clients' needs. Further, providers are taught to treat clients with respect and dignity, assess their reproductive health needs holistically within the context of their individual circumstances, and negotiate solutions that clients are able to implement.

## Resources for Addressing Community/Individual-Level Barriers

**Women's Demand for Reproductive Control: Understanding and Addressing Gender Barriers**
International Center for Research on Women (ICRW), 2012

This document provides a new conceptual framework to illustrate that women's demand for control over their reproductive health comprises an interconnected continuum of three levels of demand: their desire to limit or space childbearing (Level 1); their desire to exercise reproductive control (Level 2); and their ability to effectively exercise reproductive control (Level 3). It addresses a persistent gap in the literature regarding the role that gender barriers play for women in defining and achieving their reproductive intentions. The framework proposes a research agenda and calls for program success to include measurement of reduction in gender barriers or through measures of demand that reflect a shift in gender norms.

**Engaging Men and Boys in Gender Equality and Health: A Global Toolkit for Action**
Promundo, United Nations Population Fund (UNFPA), and MenEngage, 2010

This toolkit presents conceptual and practical information on engaging men and boys in promoting gender equality and health. Despite the increasing recognition of the important role that men and boys play in FP and SRH, HIV and other sexually transmitted infections, gender-based violence, maternal health, and child care, they still are rarely engaged in health policies and programs. This toolkit aims to articulate and reinforce the benefits of working with men and boys and provides practical strategies for doing so in ways that address the underlying gender norms that most often influence their health-related attitudes and behaviors.

**Mobilising Communities on Young People's Health and Rights: An Advocacy Toolkit for Programme Managers and Mobilising Communities on Young People's Health and Rights: An Advocacy Training Guide**
Family Care International (FCI), 2008

This toolkit is designed to assist program planners and managers in designing, conducting, and evaluating advocacy campaigns to advance the implementation of existing policies, with a specific focus on young people's sexual and reproductive health and rights.

**Community COPE®: Building Partnership with the Community to Improve Health Services**
EngenderHealth, 2002

This handbook is designed to help supervisors and staff at service delivery sites: (1) learn how community members feel about the services they provide; (2) gather community members' recommendations for improving the services or enhancing service strengths and assets; and (3) determine ways in which to encourage community members to participate in and take ownership of quality improvement efforts both at the site and community levels. The Site Walk-Through Approach discussed in this tool is especially applicable to addressing choice and rights at the community level.

# APPENDIX 2: ORIENTATION POWERPOINT SLIDES


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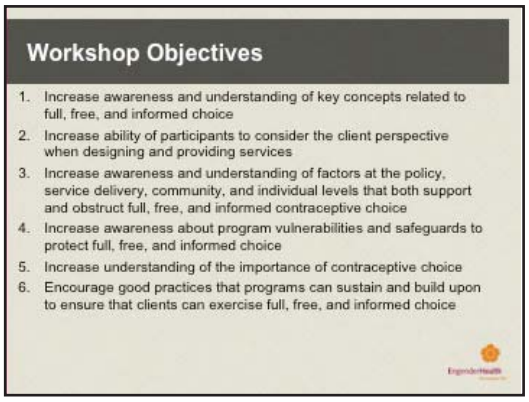
Slide 2

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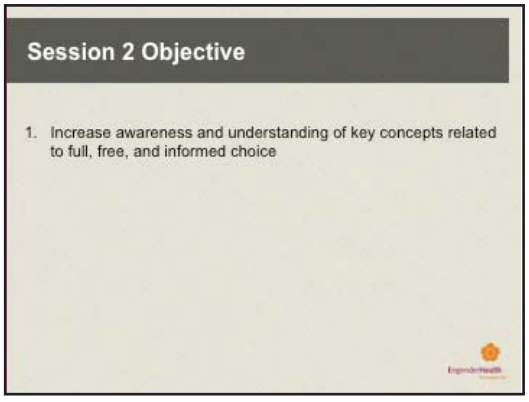


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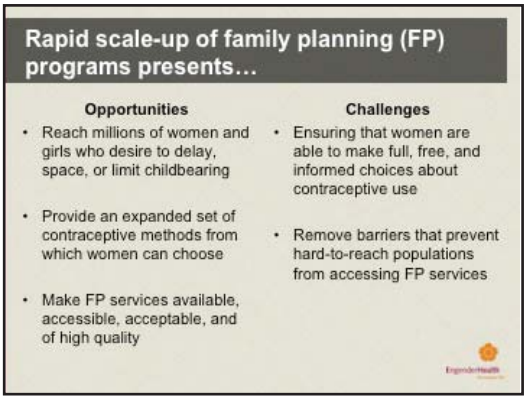


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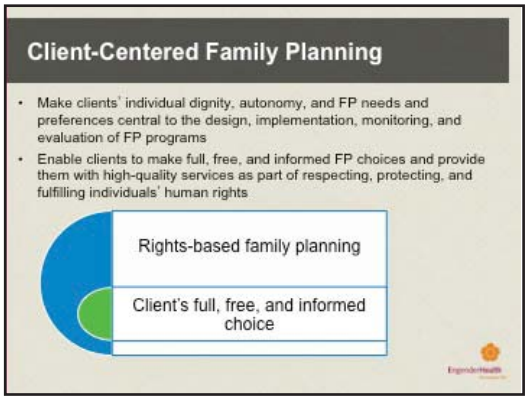


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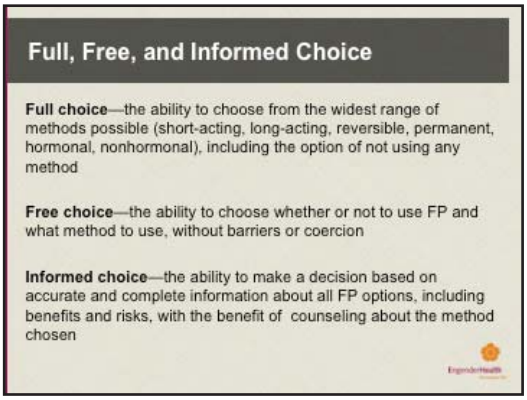


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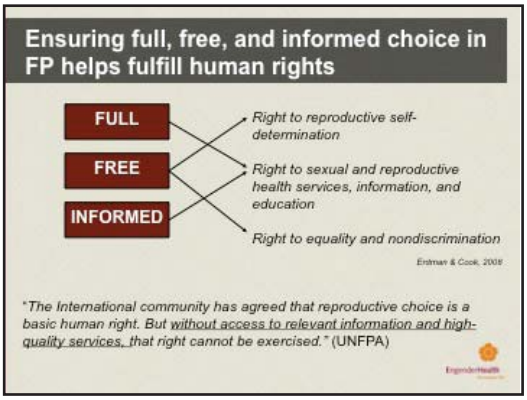


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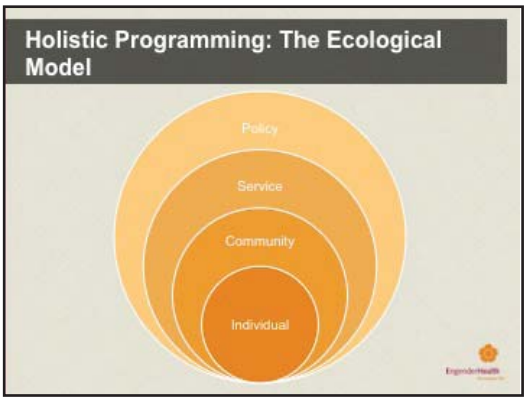


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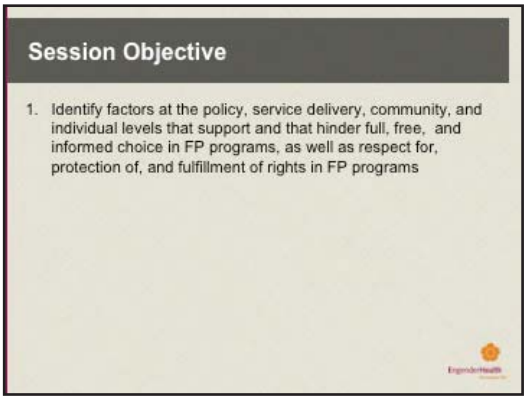


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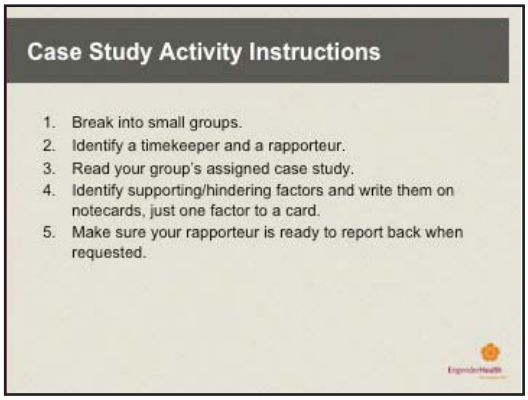


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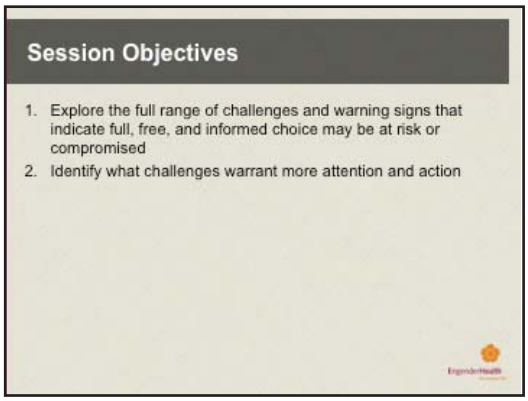


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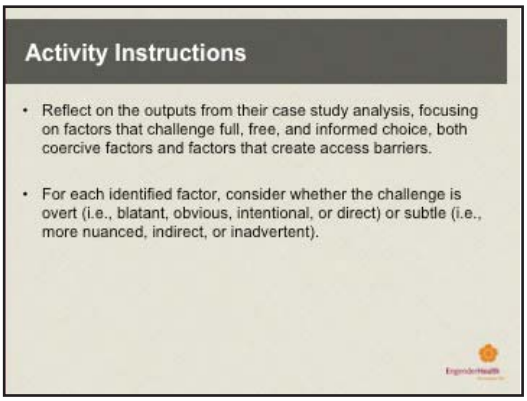


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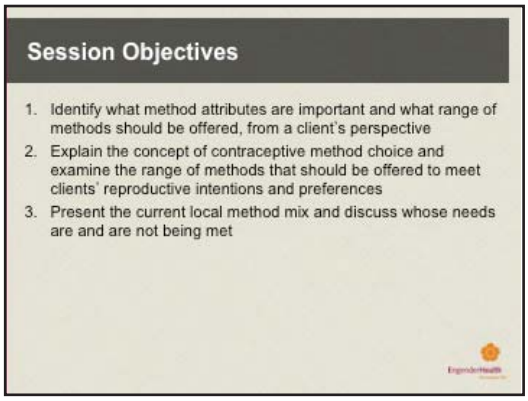


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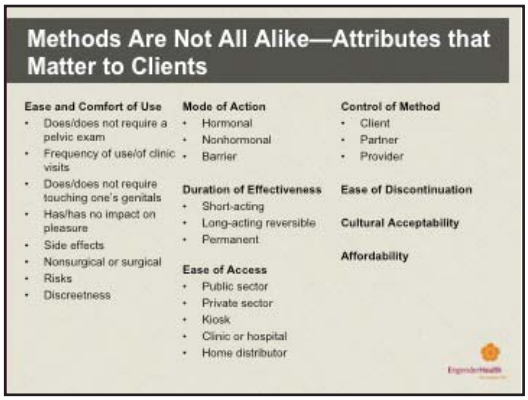


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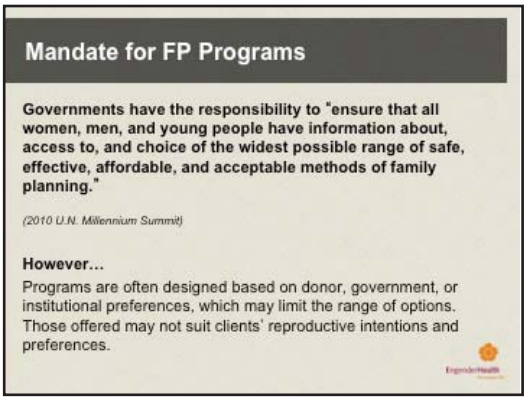


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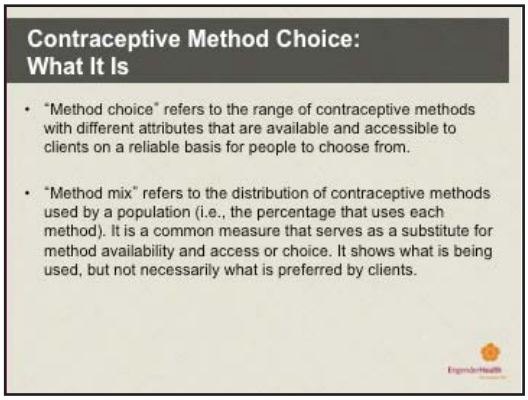


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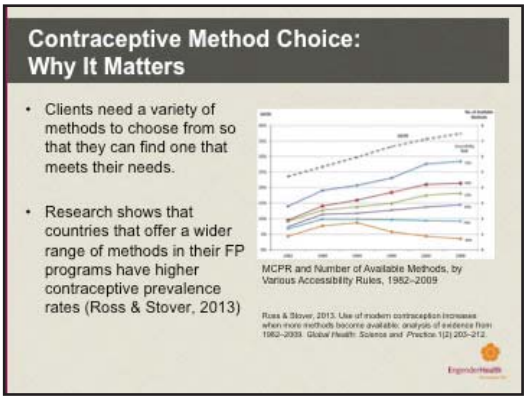


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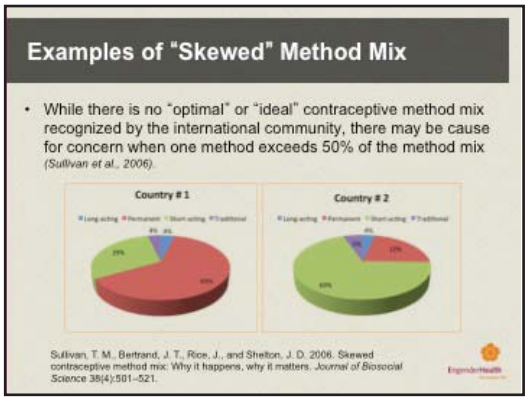


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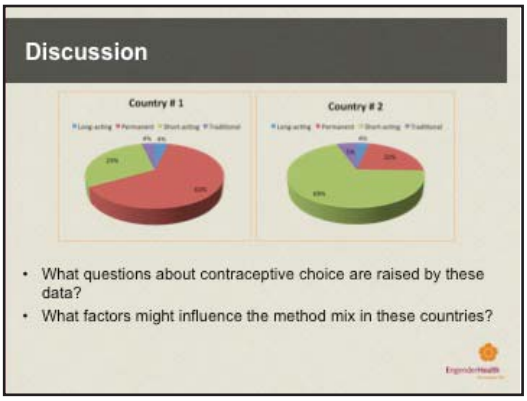


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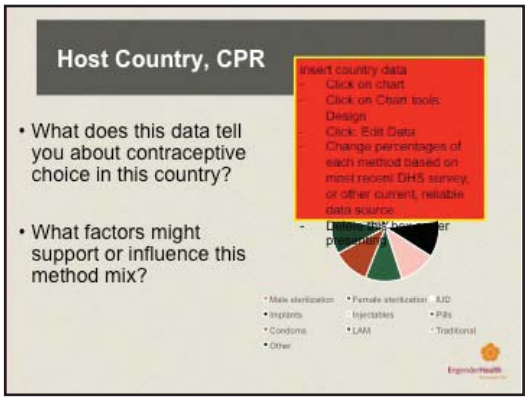


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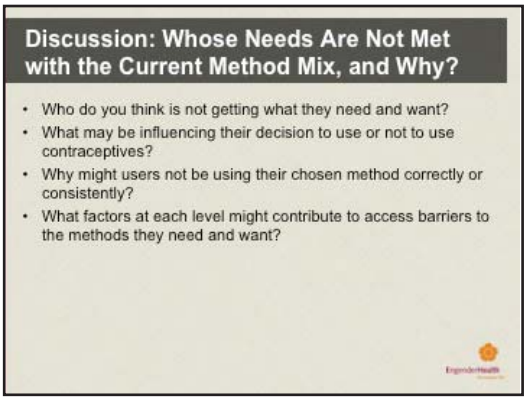


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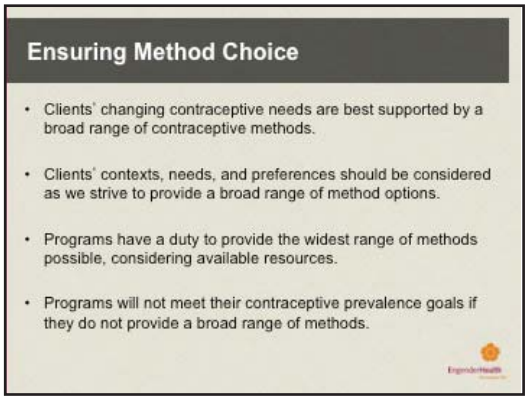


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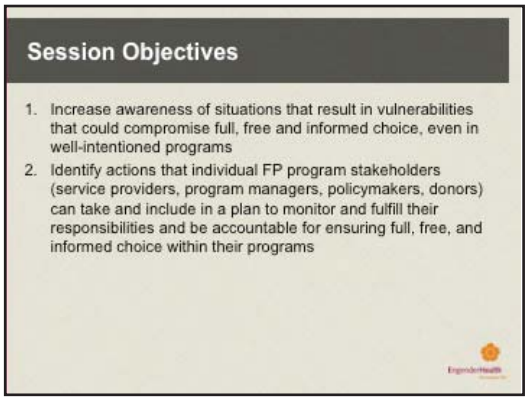


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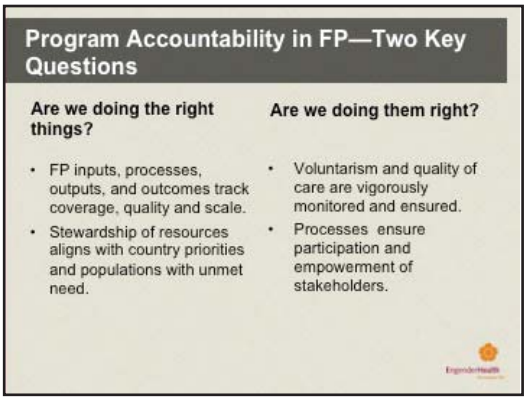


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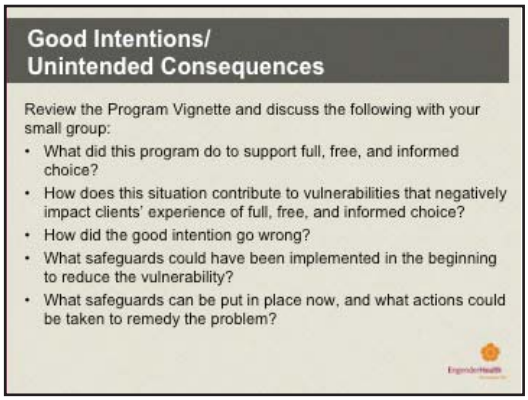


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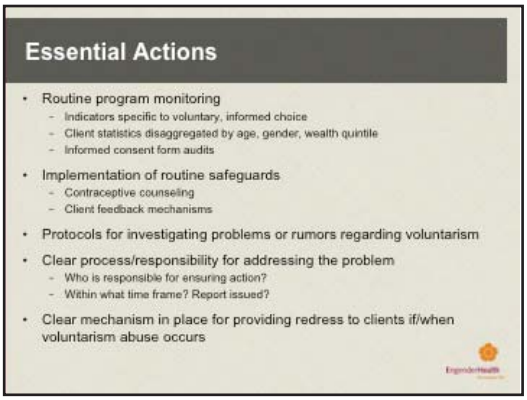


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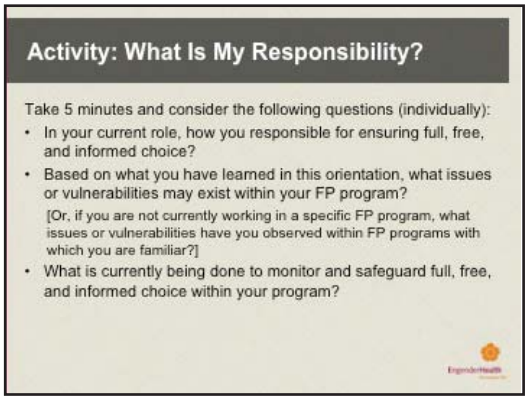


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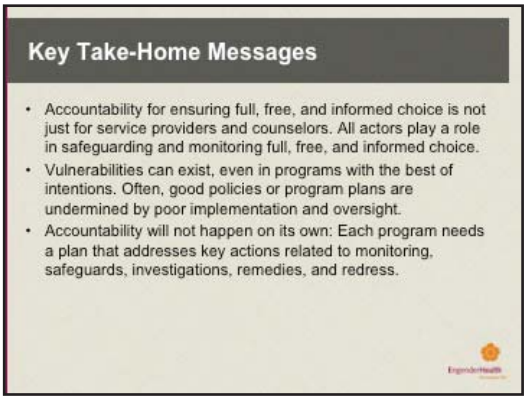


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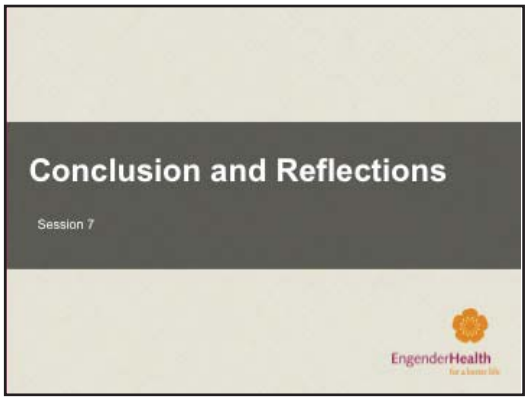


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