

# TRAINING PACKAGE FOR HEALTHCARE PROFESSIONALS ON ENGAGING MEN IN PRENATAL CARE



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by the European Union



**TOGETHER AGAINST  
GENDER STEREOTYPES AND  
GENDER-BASED VIOLENCE**  
#eu4genderequality

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PACKAGE FOR  
HEALTHCARE  
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## ACRONYMS

<b>CSO</b>	Civil Society Organization
<b>GBV</b>	Gender-Based Violence
<b>EECA</b>	Eastern Europe and Central Asia
<b>EECARO</b>	Eastern Europe and Central Asia Regional Office
<b>EU</b>	European Union
<b>FGM</b>	Female Genital Mutilation
<b>HIV</b>	Human Immunodeficiency Virus
<b>IPV</b>	Intimate Partner Violence
<b>MNCH</b>	Maternal, Newborn, and Child Health
<b>SRH</b>	Sexual and Reproductive Health
<b>UNFPA</b>	United Nations Population Fund
<b>UN Women</b>	United Nations Entity for Gender Equality and the Empowerment of Women
<b>WHO</b>	World Health Organization





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## INTRODUCTION

The health sector is an important entry point to promote the early involvement of fathers in caregiving. However, maternal and child health providers often primarily communicate with mothers and children, and do not often engage men as supportive partners to women or as caregivers themselves. However, research<sup>1</sup> shows that the relationship between fathers and the health sector is evolving, with increasing recognition of men as significant sources of emotional support and care, and recognition of the importance of early bonding between fathers and their babies, even before birth. The World Health Organization (WHO) recommends the involvement of men during pregnancy and childbirth to support women's self-care, improve home care practices for women, improve the use of skilled care during pregnancy and childbirth, and increase the timely use of facility care for obstetric and newborn complications<sup>2</sup>.

The health sector can play a key role in the accelerated expansion of father engagement in caregiving and shared responsibility with their partner. Broadly, this requires the following:

- Tailored and context-specific guidelines and protocols on how to work with fathers and male caregivers.
- More educational campaigns and materials in the waiting room that encourage men's participation in responsible fatherhood and the couple's sexual and reproductive health.

1 Tokhi M, Comrie-Thomson L, Davis J, Portela A, Chersich M, Luchters S (2018) Involving men to improve maternal and newborn health: A systematic review of the effectiveness of interventions. PLoS ONE 13(1): e0191620.

2 WHO (2015) Recommendations on health promotion interventions for maternal and newborn health. Available at: [https://apps.who.int/iris/bitstream/handle/10665/172427/9789241508742\\_report\\_eng.pdf](https://apps.who.int/iris/bitstream/handle/10665/172427/9789241508742_report_eng.pdf)



- When men are in the consultation room, encouragement to continue their involvement. If they are not present, encouraging mothers to bring the father, provided the mothers feel safe, agree to it, and the relationship is non-violent, and as long as it is possible for the father to be involved.
- The provision of context-specific support and guidance: when the mother is single and does not communicate with the father; when the parents are separated; when they are teen parents, to ensure they are able to provide child care while remaining in school; when one or both parents live with disabilities; and in cases of couple conflict, violence against women, substance abuse, or mental health issues.
- Attention to clinic environment and policies, ensuring that the environment is welcoming to both women and men as prospective and active parents, and that services are tailored to meet the parenting needs of women, men, and non-binary caregivers.

The following training package is intended to help healthcare providers in Eastern Europe and Central Asia (EECA) better engage men during pregnancy and childbirth to improve the health and well-being of their partners and children, as well as for their own health, wellbeing, ability to bond, and feelings of connectedness. The training package is intended to be used with the Resource Package on Engaging Men During Pregnancy and Childbirth.

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## BACKGROUND

This training package has been designed in the framework of the “EU 4 Gender Equality: Together against gender stereotypes and gender-based violence” programme, funded by the European Union, implemented jointly by UN Women and UNFPA in Armenia, Azerbaijan, Belarus, Georgia, Moldova, and Ukraine. The project works towards:

1. Shifting societal perceptions around gender stereotypes and patriarchal norms which limit women’s rights
2. Increasing men’s involvement in the care-taking of their children and participation in fathers’ programmes
3. Increasing the knowledge and tools of social workers (mediators) and CSOs on how to conduct evidence-based violence prevention programmes targeting perpetrators of domestic violence.





## PROGRAM P APPROACH

Inspired by the Brazilian sociologist Paulo Freire, the approach used in this training package guides healthcare providers through a process of “conscientization,” encouraging them to reflect critically on the cultural conditions supporting and framing experiences of gender inequality in the context of prenatal healthcare provision. The approach aims to create the conditions for healthcare providers to challenge and change the restrictive gender role prescriptions that make it difficult for them to engage men in prenatal care, and to understand what might make it difficult for men themselves to engage in prenatal care.

The approach follows a socioecological model that aims to affect a broad array of influences on men - including individual perceptions and attitudes; relationships with partners, children, employers, peers, and community members; media; and local, regional and national policies - to promote a sustained change in individual attitudes and behaviors, as well as in deeply entrenched societal norms and power structures. Not only does evidence suggest that taking a multilevel approach is integral to transforming gender norms and achieving gender equality, but it also helps organizations institutionalize the change they wish to bring about in a sustainable way - changing the ways in which relevant institutions - such as healthcare providers - think about and act to promote gender equality.

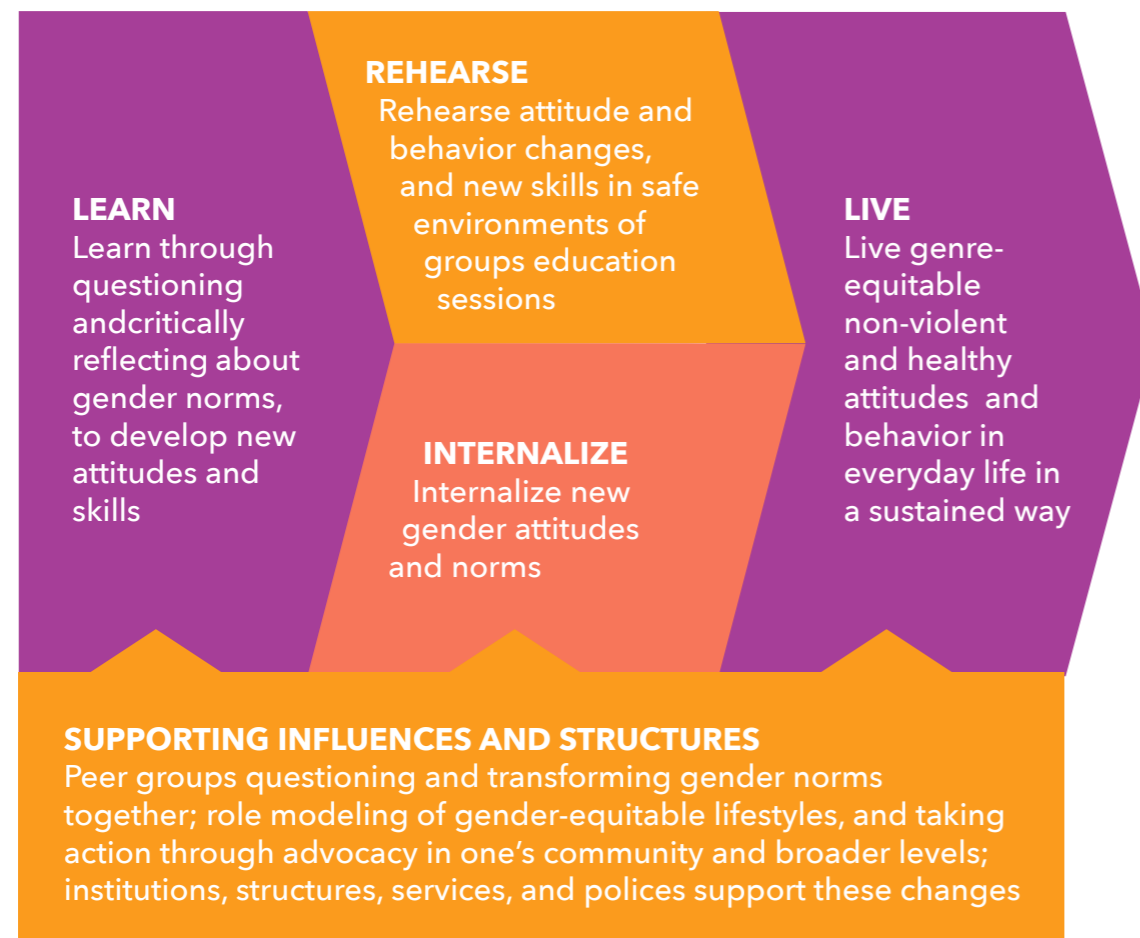


## THEORY OF CHANGE

According to the Program P model, participants:

- **Learn** through questioning and critical reflection about gender norms
- **Rehearse** equitable and non-violent attitudes and behaviors in a comfortable space
- **Internalize** these new gender attitudes and norms, applying them in their own practice

**Supporting institutions and structures**, when accompanying this integral group education process, allow individual healthcare providers and their institutions to have the tools to become agents of change for gender justice. Ultimately, this process contributes to achieving gender equity and attitude and behavior change.



## PROGRAM P OBJECTIVES

- Promote gender equality within the couple relationship, defined by the equitable division of caregiving and domestic work.
- Improve men's self-confidence and efficacy in caregiving for the child to develop and thrive.
- Promote positive parenting and healthy relationships with children through the rejection of corporal punishment of children and other forms of violence against children.
- Prevent violence against women and promote healthy and happy relationships.
- Encourage couples to teach the values of gender equality to their children and to model such equality in their relationships.

## PROGRAM P PRINCIPLES

The program promotes fathers and male caregivers that:

- Are active caregivers and nurturers: when planning to have a child, during pregnancy, during labor and delivery, and after the child is born.
- Assume equal and joint responsibility of domestic chores and in the development of a happy, healthy, and caring relationship with their partner.
- Come in many forms. They are heterosexual, gay, bisexual or transgendered; they live with their partner or separately, or with their parents; they have adopted children; they have custody of children; they are single fathers.
- Support gender equality and value the rights of women and children
- Oppose any form of violence against women and children.

## WHO IS THIS TRAINING PACKAGE FOR?

This training package was created for use by facilitators working to implement trainings for healthcare workers to engage men in prenatal care and childbirth. The training package includes a three-day curriculum to introduce healthcare workers to key gender and health concepts, review evidence and practice on engaging men in prenatal care, and complete a participatory exercise to evaluate their healthcare facility and create an action plan for institutional and policy change.

The training is designed to be institution-specific, meaning that **participants are all expected to come from the same health facility**. It is also recommended that facility leadership not be included in the training, in order to maintain a safe learning environment in which participants

feel free to speak without fear of repercussion. However, leadership can be engaged on the final day of the training to hear recommendations from their staff and commit to prioritized actions.

The training package has been designed to align with the Resource Package on Engaging Men During Pregnancy and Childbirth, drawing on the resources for exercises and learning activities. The Resource Package should be provided to all participants at the beginning of the training, as a resource that will allow them to put theory into practice with practical tools as well as dig deeper into particular themes such as gender-based violence.

## FACILITATOR SELECTION AND TRAINING<sup>3</sup>

Skilled facilitators are essential to the success of gender-transformative programs. In addition to participants learning new skills and practicing equitable behaviors, the most effective gender-transformative programs start a process of critical reflection and build solidarity among group members to mobilize change. Skilled facilitators can ignite and support this process of developing critical consciousness. The following recommendations represent lessons learned by Promundo staff working with facilitators to implement gender-transformative trainings on engaged fatherhood around the world.

**Seek out facilitators with experience in participatory methods.** Consider the background of the facilitators selected to implement your program. For instance, facilitators who have been previously trained as teachers can find it difficult to adopt a participatory style. Some facilitators may be skilled and highly trusted in the community, but due to their formal teaching background might revert to the traditional lecture style of leading sessions, which is not conducive to developing critical consciousness.

**Use role play in screening interviews for facilitators.** Successful strategies for recruitment may include casting a wide net and screening. Advertise widely in the community and highlight strong interpersonal skills as a key requirement for the facilitator position. Screening interviews that incorporate role-plays can be an efficient way to check for the necessary “soft skills” required of a facilitator.

**Advertise for specific skills and traits.** The following is an indicative list of the interpersonal skills and qualities that suitable facilitators possess:

- Authentic and sincere
- Humble
- Possesses emotional maturity
- Able to think on one’s feet
- Open to other people and new ideas

- Listens actively
- Makes others feel safe
- Guides discussions
- Invites feedback
- Responds to criticism constructively

**Seek out feminist and progressive social justice organizations as a good starting point for identifying strong facilitators.** Community organizations with progressive agendas and feminist non-governmental organizations typically already have deep experience in communities and can help identify candidates. They are also likely to already epitomize the values of gender-transformative programs, such as using a participatory approach, minimizing harm, centering experiences of women, children, and vulnerable and marginalized groups, among others.

**Sufficient time and intensity of training for facilitators are critical** – but there are differing opinions on what is ideal. One study<sup>4</sup> suggests that ten days of training is inadequate and that depending on newly recruited facilitators’ skills and experience, 25 days (including booster trainings) might be more suitable. Promundo’s facilitator trainings usually last five days (or ten days if the program is implemented over many months). “Cascade models” of training are not recommended; it is preferable that the facilitators who will lead the sessions be directly trained as much as possible.

**Discussing the theoretical underpinnings of facilitation can help clarify objectives.** Facilitators may revert to lecture-style modes of teaching if they do not fully appreciate the motivation for choosing a participatory approach. Sharing the motivation and theoretical basis for this choice can help prevent this.

**Clarify long-term goals together at the beginning.** Program goals like questioning traditional gender norms, learning skills, and building networks to organize and enact activism need to be made explicit and agreed upon with all facilitators and partners. Failing to do so can risk losing or changing focus in practice.

<sup>3</sup> Modified slightly from Promundo-US and Plan International Canada. (2020). Role of Facilitation in Gender-Transformative Programs That Engage Men and Boys. Washington, DC: Promundo.

<sup>4</sup> Bartel, D. (2018). Training and mentoring community facilitators to lead critical reflection groups for preventing violence against women. The Prevention Collaborative.





PHOTO: WAYHOME STUDIO/ SHUTTERSTOCK.COM

## KEY TERMS<sup>5</sup>

**Gender:** Gender refers to the roles, behaviors, activities, and attributes that a given society at a given time considers appropriate for men and women. In addition to the social attributes and opportunities associated with being male and female and the relationships between women and men and girls and boys, gender also refers to the relations between women and those between men. These attributes, opportunities and relationships are socially constructed and are learned through socialization processes. They are context/ time-specific and changeable. Gender determines what is expected, allowed and valued in a woman or a man in a given context. In most societies there are differences and inequalities between women and men in responsibilities assigned, activities undertaken, access to and control over resources, as well as decision-making opportunities. Gender is part of the broader socio-cultural context, as are other important criteria for socio-cultural analysis including class, race, poverty level, ethnic group, sexual orientation, age, etc.

**Gender-based Violence:** GBV is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between females and males. The nature and extent of specific types of GBV vary across cultures, countries and regions. Examples include sexual violence, including sexual exploitation/ abuse and forced prostitution; domestic violence; trafficking; forced/early marriage; harmful traditional practices such as female genital mutilation; honour killings; and widow inheritance.

**Gender Equality:** This refers to the equal rights, responsibilities and opportunities of women and men and girls and boys. Equality does not mean that women and men will become the same but that women's and men's rights, responsibilities and opportunities will not depend

<sup>5</sup> Unless specified otherwise, all terminology has been sourced from the UN Women Gender Equality Glossary (<https://trainingcentre.unwomen.org/mod/glossary/view.php?id=36>) and the UN Term Portal (<https://unterm.un.org>).



on whether they are born male or female. Gender equality implies that the interests, needs and priorities of both women and men are taken into consideration, recognizing the diversity of different groups of women and men. Gender equality is not a women's issue but should concern and fully engage men as well as women. Equality between women and men is seen both as a human rights issue and as a precondition for, and indicator of, sustainable people-centered development.

**Gender Equity:** The preferred terminology within the United Nations is gender equality, rather than gender equity. Gender equity denotes an element of interpretation of social justice, usually based on tradition, custom, religion or culture, which is most often to the detriment to women. Such use of equity in relation to the advancement of women has been determined to be unacceptable. During the Beijing conference in 1995 it was agreed that the term equality would be utilized.

This was later confirmed by the CEDAW committee in its General Recommendation 28: "States parties are called upon to use exclusively the concepts of equality of women and men or gender equality and not to use the concept of gender equity in implementing their obligations under the Convention. The latter concept is used in some jurisdictions to refer to fair treatment of women and men, according to their respective needs. This may include equal treatment, or treatment that is different but considered equivalent in terms of rights, benefits, obligations and opportunities".

**Gender Norms:** Gender norms are ideas about how men and women should be and act. We internalize and learn these "rules" early in life. This sets-up a life-cycle of gender socialization and stereotyping. Put another way, gender norms are the standards and expectations to which gender identity generally conforms, within a range that defines a particular society, culture and community at that point in time.

**Gender Relations:** Gender relations are the specific sub-set of social relations uniting men and women as social groups in a particular community, including how power and access to and control over resources are distributed between the sexes. Gender relations intersect with all other influences on social relations - age, ethnicity, race, religion - to determine the position and identity of people in a social group. Since gender relations are a social construct, they can be transformed over time to become more equitable.

**Gender Roles:** Gender roles refer to social and behavioral norms that, within a specific culture, are widely considered to be socially appropriate for individuals of a specific sex. These often determine the traditional responsibilities and tasks assigned to men, women, boys and girls (see gender division of labor). Gender-specific roles are often conditioned by household structure, access to resources, specific impacts of the global economy, occurrence of conflict or disaster, and other locally relevant factors such as ecological conditions. Like gender itself, gender roles can evolve over time, in particular through the empowerment of women and transformation of masculinities.

**Non-binary:** A person identifying as either having a gender which is in-between or beyond the two categories 'man' and 'woman', as fluctuating between 'man' and 'woman', or as having no gender, either permanently or some of the time.

**Sex<sup>6</sup>:** A medical term designating a certain combination of gonads, chromosomes, external sex organs, secondary sex characteristics and hormonal balances that are used to classify an individual as female, male, or intersex.

**Sexism:** The assumption that one sex is superior to the other and the resultant discrimination practiced against members of the supposedly inferior sex, especially by men against women. Also, conformity with the traditional stereotyping of social roles on the basis of sex.



PHOTO: WAYHOME STUDIO / SHUTTERSTOCK.COM

6 Williams Institute on Sexual Orientation and Gender Identity Law and Public Policy. <https://lgbt.williams.edu/resources/terms/>





PHOTO: PROSTOCK-STUDIO/ SHUTTERSTOCK.COM

# FACILITATION GUIDANCE

## TRAINING FOR CHANGE

The following three-day training is designed to guide participants through a process of conscientization, followed by action planning and prioritization. It is also intended to create lines of accountability for change between the facility's staff and leadership, by involving leaders at the end of the training to listen to proposals made by their staff and commit to prioritized actions.

It is important to secure the participation of the facility's leadership and management before the training begins, and to let participants know up front that they will get a chance to present their recommendations to leadership. This will give participants an incentive to engage actively with the knowledge that their insights will be taken seriously and are more likely to lead to change. It will also put in place a line of accountability between staff and leadership that is hoped to remain after the training has ended.

## CREATING A SAFE LEARNING ENVIRONMENT<sup>7</sup>

Gender-transformative programs tackle complex and nuanced topics. Facilitators may find it difficult to translate complicated concepts into simpler terms for participants or may feel uncomfortable talking about certain topics. Some facilitators might want to show progress and unintentionally push participants towards “correct” answers rather than focus on critical reflection and dialogue. Facilitators may also find it difficult to lead discussions and manage group dynamics for various reasons, such as the presence of challenging participants who dominate the group and act as “gatekeepers” by stifling discussion or the presence of participants who are reticent to share personal experiences. The following guidance is intended to help facilitators navigate the complexities of gender transformative programming, understanding that norms change is a slow process, requiring patience and flexibility.

### ASK QUESTIONS THAT PROMOTE DIALOGUE

See your group as a process. Ask “process questions” - question that cause participants to reflect more, that cannot be answered with a “yes” or “no”, and that are unbiased.

- Ask “When?” “Where?” “What?” “How?” “Who?” “Why?” For example: “What were you thinking when that happened? Why do you think that is?”
- Exclude your own feelings and values from the questions and instead guide participants in identifying problems and solutions.

### DO NOT JUDGE

Remember, you are here to facilitate discussion and reflection. Your role is not to teach or punish anyone. Be friendly and create rapport with your participants. Be aware of your own position of power - avoid judgmental and authoritarian attitudes. Never impose your feelings or opinions on the group.

### PROMOTE INCLUSION

Ensure that all participants have the opportunity to speak. Be careful not to let one person dominate the conversation or make other people feel that they cannot share their opinions. Encourage people to share their experiences, and learn to identify when people want to speak but may be too shy to say something unless called on. If a participant begins to take over a group by spending too much time with a story, find an opening and kindly say, “It sounds like you have a lot of valuable experiences to share with the group. That’s great! Do others have similar or different stories they would also like to share?”

<sup>7</sup> Modified slightly from Promundo-US and University of Pittsburgh Medical Center (2018). *Manhood 2.0: A Curriculum Promoting a Gender-Equitable Future of Manhood*. Washington, DC and Pittsburgh: Promundo and University of Pittsburgh. and Promundo, CulturaSalud, and REDMAS (2013). *Program P - A Manual for Engaging Men in Father- hood, Caregiving, Maternal and Child Health*. Promundo: Rio de Janeiro, Brazil and Washington, D.C. USA.

### ADDRESS PARTICIPANTS’ CONCERNS

As a facilitator, it is important that you validate people’s concerns, but you can also engage the larger group in helping to propose solutions. Ask the group, “How do you think this problem could be solved?” or, “Has anyone faced a similar situation? What did you do?”

### MANAGE CONFLICTS RESPECTFULLY

If a conflict arises among the group, or if a participant shares a discriminatory view, remind the participants of the group agreement. Encourage other members to help mediate the situation. Ask the group what they think about the question raised or how they would suggest handling the problem. When necessary, you can offer brief responses to questions and clarify misinformation.

### APPRECIATE HONESTY AND OPENNESS

Encourage participants to be honest and open. They should not be afraid to discuss sensitive issues for fear of ridicule from their peers. Thank participants for sharing their personal stories. Never force anyone to participate in the activities. Instead, try to create an environment in which the participants feel comfortable.

### PROMOTE MOVEMENT AND INTERACTION

Include as much physical movement as possible so that participants remain active, alert, and interested. You are encouraged to use short energizer activities in between activities in order to keep the participants engaged in the topics you are discussing. You can find some examples of energizers at the end of the curriculum.

### ASK FOR FEEDBACK

Use a “check-out” to receive regular feedback from participants. What do they like and dislike about the sessions? What is working or not working? Use their input to improve the sessions. Do not divert from the planned activities but use feedback to improve the running of the sessions (for example, by including more energizers).

### BE RESPECTFUL IN YOUR PRESENCE AND APPEARANCE

Try to be as respectful as possible in your appearance and nonverbal and verbal presentation. This includes the way you dress (avoiding clothes that distract) and address participants (work on remembering their names - a simple name game can help with that).

### EMPHASIZE CONFIDENTIALITY

If someone shares some personal information, it needs to remain in the group unless a safety issue is reported and follow up may be necessary. Before beginning facilitation, make sure that you understand and can explain confidentiality and what the exceptions to it will be.

### SHARING IS A CHOICE

Participants do not have to share a difficult or personal situation if they choose not to. Although all discussions are confidential, not all experiences need to be shared, especially if it causes the participants difficulty.



## MAINTAIN NON-NEGOTIABLE GROUP VALUES

Though there will be plenty of topics that participants will disagree on, many of which will have no right or wrong answer, there are some issues and values that are “non-negotiable” and not up for debate. The following views on masculinity will be promoted throughout the training:

- Men must be active caregivers and nurturers at all times: when planning to have a child, during pregnancy, during labor and delivery and after the child is born.
- Men should assume equal and joint responsibility of domestic chores.
- Men come in many forms. They are heterosexual, gay or lesbian, bisexual or transgendered; they live with their partner or separately, or with their parents; they have adopted children; they have custody of children, and so on.
- Men support gender equality and value the rights of women and children.
- Men oppose any form of violence against women and children.

## GUIDELINES FOR IMPLEMENTING THE TRAINING ONLINE

Conducting a training during the COVID-19 pandemic may mean delivering sessions in an online format, to protect the health and safety of participants and facilitators. Should this be the case, the following guidelines can help you modify sessions to better engage your participants.

**Send materials in advance.** Send participants copies of the slides and handouts for the session in advance, so they can read along without having to look at the screen and complete activities on paper if they should choose. This is also helpful for individuals with low bandwidth who may experience technical difficulties during the session.

**Check in (icebreakers).** It’s difficult to get a sense of where participants are emotionally, without being able to read body language. Are they tired, engaged, distracted, anxious? Using check-ins at the beginning of each day is a good way to find out how participants are doing and to let them share their emotions. Acknowledging emotions and situations up front will also make it easier for participants to concentrate during the rest of the session. The following are examples of simple check-in exercises, which can also be used as icebreakers:

- Use two words to describe how you’re currently doing. (ex: “tired and anxious” or “nervous and excited”)
- If you could pick a color to describe your day, what would it be? (ex: “bright yellow” or “dark blue”)
- What percentage of you is available today? (ex: “Had insomnia last night, so I’m about 60% available” The goal is not to get participants to 100%, but to acknowledge their current state.

Participants will likely go beyond just answering the question to give you more information on their current situation. This is perfectly fine; let them speak.

**Take breaks.** Because the modules are designed for all-day sessions, make sure to take a 15-minute break every 45-60 minutes to allow participants to turn off their screens, rest their eyes, and stretch their legs.

**Use breakout rooms.** Breakout rooms can be used for exercises that may have been conducted as small groups for in-person sessions. These allow participants to get to know each other better and interact in a more intimate format. Most videoconference applications allow you to place participants in either random or intentional groupings – make sure you have practiced doing this beforehand.

**Use polls.** Polls are a good tool to engage participants and get a sense of group experience and opinions. Some videoconference applications have built in polling features. If this is not available to you, a good free resource is Poll Everywhere, but it requires you to create your poll in advance and make sure participants have access to the link by posting it in the chat box.

**Use a whiteboard.** Whiteboards allow participants to interact together and in real time by typing in answers or adding images or drawings onto a blank page or a document. Some videoconference applications have a built in whiteboard feature. If this is not available to you, a good free resource is Jamboard, which allows you to create an exercise ahead of time for participants to engage with. As with PollEverywhere, you will need to provide the link to your Jamboard exercise to participants by posting it in the chat box.

**Use the chat box.** Encourage participants to share their thoughts, ideas, and questions through the chat feature, if they do not feel as comfortable raising their hand and speaking. Make sure you or another facilitator is monitoring the chat box so that you can engage equally with both verbal and written contributions.

## OVERVIEW AND STRUCTURE: HOW TO USE THIS TRAINING PACKAGE

Each session in this manual includes the following information:

**Title:** Indicates the main theme of the meeting or session. In a phrase or sentence, the title summarizes the scope of the session, and the main topics to be addressed.

**Objectives:** Describe specific information, ideas and skills to be addressed; these outline the learning goals for each session. Unless the session’s instructions say otherwise, the facilitator should share the objectives with the participants at the beginning of each meeting.

**Recommended Time:** Suggested time interval for conducting each session. Depending on the number of participants and other factors, the recommended duration for each session may vary. It is important to adapt the length of each session to the work rate of the participants.

**Materials Needed:** Materials required for carrying out the activity or activities. If not otherwise specified, basic materials, such as paper and marker pens, should be made available. In cases where the materials listed may not be easily acquired, the facilitator has the freedom to improvise. For example, a flip chart can be replaced by cardboard, newspaper or a chalkboard.

**Preparation:** Instructions for additional preparation before the session begins.

**Key Ideas:** A summary of key educational messages that should be conveyed during a session and reiterated at the close. These help the facilitator to be clear on the primary messaging points for each meeting.

**Session Structure:** The stages or steps for performing the activity or activities during a session. In general, the activities are designed to be easily adaptable to groups with different proficiency levels in reading and writing, and the facilitator must carefully assess whether or not the steps are feasible and appropriate for participants. The structure is broken down further into "Activity 1, Activity 2" and so on, for easy reading.

**Closing Remarks:** Additional guidance for closing the session.

**Session Handouts:** Additional information and tools that complement the activities are offered in some sessions.



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## MODULE 1: GENDER AND HEALTH<sup>8</sup>

<sup>8</sup> Module 1 is based on the 2011 World Health Organization's Gender Mainstreaming for Health Managers: a practical approach. Facilitators' Guide.

# SESSION 1: DOES GENDER MATTER IN HEALTH?

## OBJECTIVE:

Facilitate a reflexive process on the importance of gender and sex in prenatal healthcare provision.

## RECOMMENDED TIME: 60 MINUTES

Materials needed:

- Index cards
- Flipchart and markers
- Presentation slides
- Flashcard Questions and Answers (see handout on page 63)

## PREPARATION:

- Review presentation, key ideas, and facilitator notes.
- Before class, use the “Flashcard Questions and Answers” handout to write all questions and answers separately on index cards. Fold each card so that the writing is hidden. Participants will each be given a question or answer card and be asked to find their corresponding pair.



### KEY IDEAS

Gender - or the cultural meaning given to individuals based on their sex - impacts roles, responsibilities, access to resources, communication, and other aspects that can influence the health behaviors of men, women, and non-binary people as well as the healthcare professionals that serve them.

## WELCOME

During the first session, start by introducing yourself, and explain the purpose of the training. Provide an overview of the day's objectives.

## INTRODUCTIONS

Allow participants to introduce themselves. Ask them to provide the following information, intended as an icebreaker:

- What is your name?
- What is your role at the healthcare facility?

- If you were not in your current job, what would your dream job be? (You can give them some examples of what this might be: author of children's books, travel writer, ballroom dancer, chocolatier, etc.)

## CREATE GROUND RULES

- Take time to collectively build group guidelines that will apply during the three days of training. Important group agreements relate to listening to and showing respect for others (e.g., not talking when others are speaking, not making rude comments, or not talking on the phone), confidentiality, and participation.  
Distribute “Questions” and “Answers” randomly to participants, either individually or in groups of two.
- Ask participants to read their card and try to find the question or answer associated with it by getting up, moving around the room, and asking others about their cards.
- Once all individuals or groups have found their match, ask participants to find a place to sit together and discuss the following questions:
  - Were they aware of the fact? Were they surprised by the fact?
  - How can they explain the fact?
  - What can be done in the health sector to address the fact and the problem it poses?
- Ask the groups to remain together and present their flash card fact and answer to the group, providing a brief summary of their discussion. Depending on the size of the group, you may want to ask participants to limit their comments to just one or two interesting points they would like to share with the group.

## ACTIVITY 1: PRESENTATION

After the group discussion, highlight the following points using **Slide 5**:

- Biological differences between men and women are not enough to explain differences in disease patterns.
- The flash card facts show some but not all of the ways in which life conditions, chances and norms can affect health outcomes for both women and men. As healthcare providers, we need to pay attention to them.
- Non-reproductive health conditions can affect women and men differently. In other words, health differences exist beyond sexual and reproductive health.
- Several of the differences in health outcomes presented on the flash card facts can be either mitigated or prevented altogether. The workshop seeks to address both the causes of these differences and what health workers can do about them in the context of prenatal health.



- The flash card facts bring us to an important conclusion: biological and social factors are important in prenatal health – in other words, sex and gender matter for the health of men, women, and babies.

#### TRANSITION TO THE NEXT SESSION

- Ask participants to keep in mind the facts they've learned as they go through the training.
- The facts we've discussed have helped to reveal the role that gender plays in health and why it is important to work on gender in prenatal health.
- We have also learned that both sex and gender matter in health. But what do these terms mean?



#### FACILITATOR NOTES

This warm up exercise is meant to immediately engage participants on the subject, and especially those who are skeptical about the relevance of gender to health. The aim of this activity is not to discuss technical health issues for each condition. Make sure you steer participants away from this line of discussion:

Healthcare professionals may want to immediately dive into a debate on the flash card facts. Record discussion points on a flip chart so you can move on but refer to them throughout the training.

Encourage participants to remember their points and raise them in later discussions.

Remind participants that the modules are designed to build skills at identifying the gender dimensions of health - and in particular prenatal health - so they can improve health outcomes.

## SESSION 2: SEX AND GENDER

#### OBJECTIVES

- Introduce healthcare professionals to key gender terminology, highlighting the difference between gender and sex.
- Understand why the distinction between sex and gender is important in health care.

**RECOMMENDED TIME:** 15 MINUTES

#### MATERIALS NEEDED:

- Flipchart and markers
- Presentation slides

#### PREPARATION

- Review presentation, key ideas, and facilitator notes.



#### KEY IDEAS

Sex and gender are not the same, but one cannot be discussed without the other. In other words, you cannot talk about gender without talking about sex. For example, the fact that women can bear children refers to sex. But the fact that most women spend more time than men caring for children refers to gender.

#### ACTIVITY 1: PRESENTATION

- Based on the flash card facts, ask participants to distinguish sex from gender. After calling on a few participants, show Slide 7 and ask participants for one or two examples of the difference to make sure the group has understood.
- Ask participants how they have seen the word gender used (and confused) with sex. **Show Slide 3** and add additional examples on a flip chart as needed.
- In the form of a group call-out, ask participants to indicate which statements on Slide 3 should be "sex" and which should be "gender".
- Emphasize that the term "gender" is often used as a politically correct way of saying sex and the two are sometimes used interchangeably. However, in the health sector, the distinction must be clear, as we cannot ignore biology any more than we can ignore the sociocultural factors that influence health.

- Make the following points:
- Sex refers to the things that most people agree are the result of biological difference, such as hormones and internal and external sex organs. It is usually difficult to change your sex, unless through surgical intervention.
- Gender refers to culturally determined beliefs about women, men, and non-binary people. It changes from society to society, depending on community notions of masculine and feminine norms. It has also changed over time, even within the same societies, and is often challenged by young generations.
- Both sex and gender have implications for health and prenatal health outcomes.

#### HEALTH BREAK (15 MINUTES)

- When we come back, we will discuss how individuals and communities learn the “rules” of gender”. We will unpack the concept of gender to understand how we learn to behave like men or women.

## SESSION 3: UNPACKING GENDER CONCEPTS

#### OBJECTIVES:

- Understand social processes that shape and construct gender norms, roles, and relations
- Make initial connections between gender norms, roles and relations, and prenatal health.

#### RECOMMENDED TIME: 100 MINUTES

#### MATERIALS NEEDED:

- Flipchart and markers
- Sticky note pads (or index cards and tape)
- Presentation slides

#### PREPARATION

- Review presentation, key ideas, and facilitator notes.



#### KEY IDEAS

Nurturing roles are not “natural” as both women and men can have nurturing and affectionate qualities through processes of socialization. In other words, women do not have a biological predisposition towards caring just as men have just as much capacity as women for caring and nurturing behavior.

People of indeterminate sex at birth also function under gender norms, roles, and relations, although these are more complex than those of other people.

#### ACTIVITY 1: PRESENTATION (20 MIN)

- Show **Slide 11** and explain that the concept of gender has five basic elements. Gender is:
  - **Relational.** Is about women and men.
    - *Gender is constructed in the way we relate to one another. For example, women help reinforce gender norms about women’s domestic role when they mock men’s cooking and cleaning skills; while men reinforce gender norms about male breadwinning when they get angry if their female partner makes a higher salary than they do.*



- **Hierarchical.** Often privileges male power or characteristics, or those of a particular group of males in society.
  - For example, masculine norms may privilege male dominance and control, making other forms of masculinity and norms associated with femininity- such as collaboration and power sharing - less attractive.
- **Historical.** Is based on historical traditions and practices that evolve and change across space and time.
  - For example, in many societies men's role as a parent has focused on their income-earning and provider role. This is changing as young generations are exposed to western norms in media and movies that promote a more engaged and egalitarian caregiving relationship.
- **Contextually specific.** Is not only about women, men, and non-binary people, but about the multiple identities they have (age, ethnicity, sexual orientation) and different in all contexts due to cultural traditions and practices.
  - For example, a father who is an ethnic minority and disabled will have different gendered experiences and needs than a father who is able-bodied and a part of the ethnic majority.
- **Institutionally structured.** Is an influential factor in society and can perpetuate gender-related beliefs through infrastructure such as laws, religion, policies, procedures, including in institutions such as healthcare facilities.
  - For example, laws and policies that provide men with 2 days of parental leave and women with 3 months reinforce gender norms that do not see men as active caregivers and parents of infants.
  - Show **Slide 12** and explain that the concept of gender is socially constructed. It draws its meaning from the broader sociocultural, economic, and political context.
- **Socialization process:** the things we learn from our environments (social, physical, and otherwise) from a very young age are an important source of gender learning. In other words, boys and girls learn about acceptable and unacceptable gender norms, roles, and relations through the socialization process.
  - Explain that the following slides will address each of these terms. The figure shows the overall process of unpacking gender, by demonstrating that socialization is a key trigger for the learning and establishment of gender norms, roles, and relations, all of which are closely linked, influencing each other. These can be understood as **components of gender** and can lead to stereotypes and result in social patterns such as the gender-based division of labor.
  - Remind participants that these processes are not linear and changes in the gender-based division of labor can provoke changes in gender roles. For example, the changing role of women in the paid workforce has contributed to changes in norms and domestic roles for women and men in many contexts.

- Show **Slides 13 and 14**, and explain that **laws or regulations** do not always explicitly prescribe gender norms by stating how men and women should act, or beliefs about women and men. But gender norms can be upheld by rules or laws. For example, laws that provide men with zero to a few days of parental leave after a baby is born are based on the norm of men's role as provider rather than caregiver and assumes women's role as primary caregiver.
- Gender norms are passed from generation to generation through the process of **socialization**. They are also challenged in different ways by different generations.
- **Gender norms:** change over time and look different in different cultures and populations due to development, globalization, legislation, and other sociocultural, economic, and political structures.
  - Religious or cultural traditions often contribute to defining expected behavior of men and women.
  - Many women and men consider these traditions - and the gender norms based on them - to be the "natural order of things".
  - Resistance to addressing gender may occur if these factors are not considered and the right actors involved appropriately. Addressing gender requires cultural sensitivity and a diversity of approaches to counter traditional beliefs or practices that may be harmful to health. This is why any modification to these norms may be contested if not addressed properly, and requires short, medium, and long-term strategies.

## ACTIVITY 2: BRAINSTORMING GENDER NORMS, ROLES, AND RELATIONS (60 MIN)

- Using the sticky notes and markers on their tables, ask participants to write down examples of **gender norms** they see either in their interaction with patients or in the way the healthcare facility may treat men and women differently. Ask them to get up and place their notes under the heading "Gender norms" on the wall.
- Read out one or two examples and refer back to how these reflect the definition of a gender norm and how it may relate to traditions or something perceived to be natural by or for women, men, or non-binary people.
- Explain to the group that these gender norms will remain on the wall for the rest of the workshop and will be revisited the next day to dig deeper into how they might influence prenatal health outcomes. Ask them to begin thinking about how gender norms can influence prenatal health, to contribute to discussions the following day.
- Conclude the section by showing **Slide 15**, reminding participants that the point of the discussion is not to pass judgement on existing gender norms, or the cultures and traditions from which they may come. Instead, the exercise is to prompt reflection on the way norms may affect the way men and women seek out prenatal healthcare and the ways in which healthcare providers treat women and men during pregnancy and delivery.

- Recall that gender norms are not all harmful, but it's important to identify those that lead to the mistreatment of one group or sex over another, or a difference of power and opportunities, because these can lead to inequality.
- Inequality influences prenatal health outcomes.
- Put up **Slide 16** and emphasize the following:
  - Gender roles are closely related to gender norms.
  - The distinction is that gender roles refer to what women and men can and should do, and what they feel responsible for in households, communities, and the workplace.
  - Like gender norms, gender roles are also shaped by broader sociocultural, economic, and political factors, which can change from place to place and over time.
  - Refer to one of the norms from the Gender Norms brainstorming, making a connection with how gender norms can lead to expected gender roles for women and men.
- As with the Gender Norms brainstorming, ask participants to write down examples of **gender roles** from their work at the healthcare facility, either in the context of work with their patients or in the way the healthcare facility treats women and men differently - staff and patients. Ask them to get up and place their notes under the heading "Gender roles" on the wall.
- Show **Slide 17** and introduce the concept of **gender relations**. Emphasize the following:
  - Gender norms and roles contribute to the establishment of gender relations.
  - Gender relations are about the social relations between and among women, men, and non-binary people. In other words, they set out the rules for how women, men, and non-binary people should interact with each other and amongst themselves.
  - They can determine hierarchies between groups of women, men, and non-binary people based on gender norms and roles. For example, in many households men are often those with final decision-making authority. In consultation sessions with heterosexual couples, you may see women deferring to men when a decision is to be made during pregnancy, even when this decision has a significant impact on the woman's own body and health.
  - Sometimes, gender relations - or the unwritten rules about how women and men interact - can contribute to unequal power relations.
  - As with the Gender Norms and Gender Roles brainstorming, ask participants to write down examples of **gender relations** from their work at the healthcare facility, either in the context of work with their patients or in the way the healthcare facility treats women and men differently - staff and patients. Ask them to get up and place their notes under the heading "Gender relations" on the wall.
- Show **Slide 18** and conclude by emphasizing the following:

- Gender norms, roles, and relations affect everyone - women, men, and non-binary people - regardless of the level of education or the culture they live in. But they affect groups of women, men, and non-binary people differently.
- It is important to look at all three components of gender to better understand sociocultural patterns that can influence women and men's lives.
- Gender norms, roles, and relations can increase exposure to risk factors or vulnerability to certain health outcomes through stereotypes, discrimination, and the gender-based division of labor.

### ACTIVITY 3: PRESENTATION (20 MIN)

- Show **Slide 19**, highlighting the following:
  - Different roles do not cause inequality; it is the value, stemming from norms or beliefs, placed on these roles that leads to inequality.
  - Most societies ascribe a higher value to masculine norms and roles. This has led to inequalities disadvantaging women and girls and can lead to **gender stereotypes**.
  - Gender norms, roles, and stereotypes affect groups of women and men differently. Refer to the examples on the slide.
- Using **Slide 15**, briefly discuss the gender-based division of labor, making the following points:
  - Concretely, this term means that gender norms, roles, relations, and sometimes stereotypes, help to determine the field in which women and men work, and the work roles they take on.
  - "Gender-based division of labor" refers to formal market and informal labor activities. This means it refers to jobs outside the home as well as tasks men, women, and non-binary people perform in their households and communities. It includes both paid and unpaid work.
- Ask participants to call out examples of the **gender-based division of labor** in their healthcare facility and in the type of health concerns they see in their patients. Note how these examples refer back to the norms, roles, relations, and stereotypes discussed in the previous activities - adding that the health effects can be either at an outcome level or in terms of exposure to risk factors. For example:
  - Men tend to work on construction sites more often than women due to the heavy physical demands. This may make them more susceptible to work-related injuries.
  - At the same time, women are increasingly entering into traditionally male-dominated working environments with high levels of machine-related accidents and unhealthy working conditions, notably in export-processing zones. These are often high-stress, low-paying jobs that might lead to cardiovascular disease, mental disorders or



repetitive stress injuries. Women may be increasingly at risk for miscarriage and other pregnancy-related problems in such settings.

- Conclude the discussion on gender being socially constructed with the following points:
  - People are born female, male, or intersex but are taught what appropriate behavior and roles are expected of them, including how they should relate to other people.
  - Due to the different values ascribed to these norms and roles, women, men, and non-binary people may be treated unequally.
  - Inequality leads to discriminatory practices that can affect health, including prenatal health.
  - Societies uphold and protect gender norms, roles, and associated behavior, considering them to be the “natural order of things”. Women, men, and non-binary people may uphold these beliefs.
  - Unlike sex (outside of surgical intervention), gender norms, roles, and relations can change.



#### FACILITATOR NOTES

Facilitators should make sure that each table has a stack of sticky notes and markers. In preparation, ensure space on a wall in the room, marked with three headings: 1. Gender norms; 2. Gender roles; and 3. Gender relations. Participants-filled sticky notes will be put up under each heading during the exercise to help stimulate discussion. If time is a concern, the brainstorming activity can be done as a group call out with facilitators recording examples on a flip chart for discussion.

There may be confusion about, or even opposition to, saying that gender norms can be changed. It is important to unpack such statements by emphasizing that integrating gender into prenatal healthcare programs and policies is not about changing cultural traditions for arbitrary reasons, nor is it about changing women, men, or non-binary people. Rather, it is about encouraging behavior and practices that promotes health. Counter skeptical attitudes with open dialogue and by soliciting concrete examples from participants.

#### LUNCH BREAK (60 MINUTES)

- This morning we have seen that gender matters in health, and particularly in prenatal health. And now we have discussed exactly what gender means and how it is different from sex.
- When you return, we will examine the international frameworks to which we should be responsive as healthcare workers.

## SESSION 4: IDENTITY AND POWER

#### OBJECTIVES:

- Understand the interactions of gender with other determinants of health.
- Identify key health stakeholders and patterns of health inequalities.

#### RECOMMENDED TIME: 60 MINUTES

#### MATERIALS NEEDED:

- Index cards
- Presentation slides
- [Power Walk Roles and Statements \(see handout on page 67\)](#)

#### PREPARATION:

- Review presentation, key ideas, and facilitator notes.
- Before class, use the “Power Walk Roles and Statements” handout to write each power walk role on a separate index card. Fold each card so that the writing is hidden. Participants will each be given a role and be asked to respond to statements based on that role.



#### KEY IDEAS

Sex, age, ethnicity, sexual orientation, and place of residence are all important determinants of access to and quality of healthcare. When they interact with gender they often compound inequalities and reduce the ability of certain characters - women, men, and non-binary people - to safeguard their own health.

Certain life conditions may mean that you have less social support for coping with health issues or less power to make decisions about your own body. These life conditions become apparent when we pay attention to gender.

### ACTIVITY 1: THE POWER WALK (30 MIN)

- The Power Walk exercise is based on a human-rights approach; it allows participants to experience the ways that gender and other determinants of health interact. Participants take one step forwards or stay put, similar to what happens in a board game or a race. At the end of the role play, the position of each “player” is analyzed to unearth the interactions of gender and other health determinants.
- The exercise is preferably carried out in an open and fairly large space to allow for movement and can take a fair amount of time to finish. It can also serve as an energizer after lunch, to get participants moving around.
- Distribute the roles. Randomly assign roles to participants. Ideally, at least eight assorted characters are needed to depict a range of vulnerabilities and privileges. A maximum of 12-15 is recommended, and some characters can be duplicated if necessary for differences in experience to be revealed, depending on the time available. Remind participants not to share their “identities” with others.
- Assemble participants as if they are about to begin a race: in a horizontal line facing forward. Explain the rules of the Power Walk:
  - Read out the statements from the list provided (or adapted) one at a time
  - Participants must silently think about whether they can answer yes or no to the given statement in their assumed identity. “Yes” indicates that they can take a step forward. “No” indicates that they remain in the same place. An uncertain answer should be taken as a “No.” Participants who feel that their “characters” could partly answer yes to the given statement should take a small step forward. Each statement is equivalent to one step.
- After the last statement, participants should remain in their places and reveal their identity to the group.
- Participants should stay in their formation until the facilitator ends the power walk.

### ACTIVITY 2: DEBRIEFING DISCUSSION (15 MIN)

- Lead a discussion on the outcomes of the Power Walk exercise and its connections to health interventions.
- Select a couple of characters from the front of the line to describe their experience and what it felt like to be in those positions. After the group in the front row has spoken, tell them that these characters often have the most decision-making power and access to resources. Discuss how women, men, and non-binary people are represented in this group.
- Follow a similar process of discussion with characters from the middle of the line. Discuss how women, men, and non-binary people are represented in this group. Ask participants what strategies could help to move this group towards the front of the line.

- Use the same process for characters from the back of the line. Discuss how women, men, and non-binary people are represented in this group. Ask how they felt as they watched others moving forward. Ask why they are at the back.
- Ask participants to now look at how women, men, and non-binary people are distributed throughout the Power Walk outcome. Are all the women at the back? All the men at the front? What does this mean in terms of gender? When no sex was specified for a character, ask participants which sex they assumed their characters were and make necessary linkages with gender stereotypes, norms, and roles as appropriate.
- Point out that the Power Walk confirms that gender norms, roles, and relations can affect women, men, and non-binary people in different ways. It also shows that gender interacts with other determinants of health. Use examples within the Power Walk to demonstrate how education, profession, income, age, sex, and gender can influence the ability of Power Walk characters to move forward or not.
- Note that for optimal health outcomes, health equity, and promotion of gender equality, there’s a need to work with key characters that are represented in all three sections. The back clusters must be consulted for their needs to be understood and incorporated into plans, programs, and policies.

### ACTIVITY 3: PRESENTATION (15 MIN)

- If you are outside, bring the group back into the classroom and let everyone get settled.
- Project **Slide 24** and transition into a brief discussion of empowerment, asking why some characters at the back may not have been able to take a step forward.
- Introduce the definition of empowerment, emphasizing the following:
- The characters in the back cluster often have lower levels of empowerment, which sometimes explains why they have difficulty moving forward.
  - Make the links between empowerment, reducing unequal power relations, addressing unequal gender norms, roles, and relations, and ultimately gender mainstreaming. In other words, gender mainstreaming cannot be achieved without attention to empowerment.
  - Ask participants whether they felt empowerment was an obstacle to moving forward. Time permitting, record these on a flip chart.
- Ask what the outcome of the Power Walk says about how prenatal health programs and policies should be developed. Ask what capacity the various people need to participate effectively or to listen to others in the process of prenatal health programming or policy making. Agree on the different groups to consult and involve when developing prenatal health programs or policies.

## HEALTH BREAK (15 MINUTES)

- As the Power Walk demonstrated, not all characters have equal chances to protect their health and maintain good health status.
- When we return from our break, we will look in more detail at the concepts of equality and equity to understand how to address these imbalances.



### FACILITATOR NOTES

It is essential to review the list of “characters” and “statements” of the Power Walk exercise to make sure they are relevant to participants. Use your local context and realities to add local population groups; and modify, add, or delete statements to highlight those most relevant to your context.

The front and middle clusters in the Power Walk exercise often represent characters that have more decision-making power in the community and in the health system than those in the back. Characters represented in the front and middle are often gatekeepers while those in the back are from marginalized groups.

## SESSION 5: EQUALITY AND EQUITY

### OBJECTIVES:

- Understand the distinction between gender equality and gender equity.
- Define and apply concepts of health equity.
- Brainstorm ways the healthcare facility can modify existing programs to address gender and health inequities, by applying the concepts learned throughout Module 1.

**RECOMMENDED TIME:** 75 MINUTES

### MATERIALS NEEDED:

- Flipchart and markers
- Presentation slides

### PREPARATION:

- Review presentation, key ideas, and facilitator notes.



### KEY IDEAS

Avoidable health differences can only be reduced when both equality of opportunity and needs recognition among groups of women, men, and non-binary people are addressed.

Achieving gender equality, gender equity, and health equity is not a one-off goal. They must be constantly promoted and actively sustained..

### ACTIVITY 1: PRESENTATION (15 MIN)

- Ask if anyone can define gender equality.
- Show the top of **Slide 26**, highlighting the following:
  - What **gender equality** is NOT about:
    - Making women, men, and non-binary people the same
    - Giving one sex more authority over others
    - Making the incidence, prevalence, morbidity, or mortality of health issues the same for women, men, and non-binary people



- What gender equality IS about:
  - Being valued equally, regardless of sex
  - Taking steps to ensure that women, men, and non-binary people have the same chances and opportunities in life: this is also known as **formal equality**, or making sure that formal structures allow for equal access and participation
- Reveal the second half of the slide and tell participants that **gender equity** is about going beyond equality of opportunity to recognize that women, men, and non-binary people have different needs, preferences, and interests. This means that different treatment is needed to ensure equality of opportunity. This is often referred to as **substantive equality** and requires that the realities of women's, men's, and non-binary people's lives be considered in setting goals around equality and equity.
- Summarize the distinction between gender equality and gender equity by emphasizing that, although the concepts are used interchangeably, they refer to different strategies - and that both strategies are needed to contribute to health equity.
- Show **Slide 27** and read the definition of **health equity**. Make the connections between gender equality, gender equity, and health equity by emphasizing the following:
  - Equality of opportunity (gender equality) is needed to ensure that women, men, and non-binary people have the same chances to access social, economic, and political resources
  - Recognizing different needs and abilities related to social, economic, and political resources (gender equity) is a fundamental aspect of addressing inequality between women, men, and non-binary people
  - Avoidable health differences can only be reduced when both equality of opportunity and needs recognition among groups of women, men, and non-binary people are addressed
- Show **Slide 28**, the cartoon test. Use this as a way of clarifying the concepts of gender equality, gender equity, and health equity as necessary. Solicit examples from the group as needed to ensure that the concepts are understood.
  - The test creates equality of opportunity for all "students" but does not actually consider their different needs so that they can actually take and pass the test. In other words, the test is not equitable.
  - Although the test is a fun way of looking at these concepts, it remind us that if we establish prenatal healthcare facilities much like this "tree test", without considering whether, how, and under what conditions all groups of women, men, and non-binary people can actually reach them, we may end up like this professor, with very few "students" that pass the test

## ACTIVITY 2: BRAINSTORMING CHANGES FOR EQUITY (45 MIN)

- Use **Slide 29** presenting the case study. After participants have read it, ask them to turn to their neighbor (buzz groups) and discuss the questions included on the slide. This can also be done in plenary.
- Facilitators may wish to go over each of the questions and highlight some of the "forgotten" gender issues:
  - Campaign information is only on written posters. This means that illiterate men, or men who do not speak the national language such as recent immigrants, cannot access the information.
  - The posters are available in the health facility. This implies that men need to actually go to the health facility to be aware that the campaign exists. Men who live far from health facilities may never see the posters. Also, are free prenatal workshops also being offered to women and couples or are they completely excluded?
  - The posters are made available in the community, but it is unclear whether these are in places in which men normally are and whether there is any attempt to ensure that men from all backgrounds are able to access them.
  - Although the campaign states that it is free of charge, it is delivered in health facilities and not in the community. This implies indirect costs such as transportation and potential time off work. All of these may be differently available to men.
  - The fact that the campaign is facility-based may also mean that rural populations will not have access.
- Wrap up the discussion by highlighting the need to contextualize such analysis of health interventions and the responses required. Remind participants that addressing the harmful ways that gender norms, roles and relations affect health requires understanding certain practices in societies. Local populations must be consulted to understand what different needs, realities and practices may exist. Remind participants of the Power Walk - and that all the characters are important stakeholders in health. This means that we must find ways to engage with them all.
- Using **Slide 30**, sum up this session with the following points:
  - Achieving gender equality, gender equity, and health equity is not a one-off goal. They must be constantly promoted and actively sustained.
  - Remind participants that there should be no gender words without gender actions!



### FACILITATOR NOTES

The differences between equality and equity are often difficult to understand for new gender learners. Minimize the use of jargon where possible.

The brainstorming activity is a short “teaser” for what is to come: that is, it is intended to get health planners and managers in the room already thinking of how work on gender applies directly to their work. Facilitators should adapt and modify the case study as needed to stimulate discussion based on local prenatal health programs and gender norms, roles, and relations.

### CLOSING REMARKS AND PROGRESS CHECK (15 MIN)

- Congratulate and thank participants for their participation in Module 1. Acknowledge that Module 1 is intense and concept-heavy but that it sets the framework for the rest of the training.
- Ask the group what stood out to them from the first day of training.
- Recap the key messages from Module 1 using **Slide 31** and tell the group that the next day will be focused on understanding the evidence around male engagement in prenatal care.
- Distribute the **daily assessment (See Annex III)** for Module 1.







## **MODULE 2: EVIDENCE AND PRACTICE FOR MALE ENGAGEMENT**



# SESSION 1: BENEFITS AND BARRIERS

## OBJECTIVE:

Understand the benefits of and barriers to male engagement in prenatal care.

**RECOMMENDED TIME:** 70 MINUTES

## MATERIALS NEEDED:

- Flipchart and markers
- Presentation slides
- [Rapid Assessment on Father Engagement in Prenatal Care \(see handout on page 69\)](#)
- [Rapid Assessment on Father Engagement in Antepartum, Labor, and Delivery Care \(see handout on page 72\)](#)
- [Individual Action Plan \(see handout on page 76\)](#)

## PREPARATION:

- Review presentation, key ideas, and facilitator notes.
- Print out enough handouts for each participant to have a copy (rapid assessments and individual action plan).



### KEY IDEAS

Men play an important role in maternal and newborn health as partners and parents, and can positively influence behaviors within their households (such as increase attendance at prenatal visits) and support the physical and emotional health of their partner.

When men receive support during pregnancy and delivery, along with their partners, such as through counseling or parental training for fathers, they report better physical and mental health and fewer problems in their relationship with their partner after birth. Research also indicates that the more a father is engaged early on, the stronger the attachment to his baby and development of paternal identity.

## WELCOME

Welcome everyone back to the training.

Revisit the previous day's learning as well as the ground rules.

Provide an overview of the day's objectives. Note in particular that today's work will be

focused on understanding the benefits of and barriers to male engagement in prenatal care, as well as determining the implications for interactions with clients and the need for policy or procedural changes.

## ACTIVITY 1: PRESENTATION ON BENEFITS AND BARRIERS (15 MIN)

- Show **Slide 35**, noting that maternal and child health programs in Europe and around the world have increasingly recognized the benefits of involving men as partners and fathers as a way of promoting egalitarian decision-making and sharing of care responsibilities, as well as equal partnership and responsibility in sexual and reproductive health. Today, there is also a much better understanding of the benefits on men themselves.
- Show **Slides 36-39** to review current evidence on the benefits of male engagement in prenatal health - for mothers, for men and male caregivers, and for the baby once born.
- While there are clear benefits for men to be engaged during pregnancy and delivery, barriers exist, many of which are tied to the restrictive gender norms, roles, and relations.
- Show **Slides 40-43** with examples of some of the barriers we know of based on recent research. Bring participants' attention to the brainstorming exercises they took part in the day before, noting the barriers they've encountered in their own work when attempting to engage men.
- Ask if anyone in the room has experience engaging men in prenatal care visits or in the delivery room. Ask what their experience was like.
  - What challenges did they face?
  - What were the outcomes they saw?
  - Are there any risks to male engagement? How do you address them?
- Record participant answers on the flipchart.

## ACTIVITY 2: VOTE WITH YOUR FEET (15 MIN)

- Ask participants to stand up and move to the middle of the room.
- Tell them that you will be showing them a series of facts about male engagement in prenatal care, and that based on what they believe is true or false, they should move to one side of the room or the other.
- Note which side of the room is "False" and which side is "True".
- Use **Slides 45-48** to show a series of study results tied to the benefits or barriers to male engagement in prenatal care.
- After each slide, ask participants to walk to the side of the room that represents their belief about the statement - either "True" or "False"

- Call on one or two participants to explain why they made their choice and then reveal the answer.

### ACTIVITY 3: INDIVIDUAL ASSESSMENT AND ACTION PLAN (45 MIN)

- Hand out the “Rapid Assessment on Father Engagement in Prenatal Care” and the “Rapid Assessment on Father Engagement in Antepartum, Labor, and Delivery Care” to participants. Each participant receives a copy of each.
- Tell participants that this is an individual reflection exercise that will allow them to assess their own practices and behaviors when it comes to engaging men and promoting male participation during pregnancy and delivery.
- Once participants have finished the assessment, hand out the “Individual Action Plan” worksheet. This is also a personal exercise, meant to help you prioritize the kinds of changes you feel would be most helpful to your own practice. Based on the work we’ve done so far and the assessment you just completed:
  - What is one thing you would like to start doing?
  - What is one thing you feel you should stop doing?
  - What is one thing you are already doing that has been successful and that you would like to continue?
- Ask if anyone would like to share their thoughts on the assessment or individual action plan and call on 2-3 participants.

### HEALTH BREAK (15 MINUTES)

- “We have reviewed the benefits of male engagement, as well as the gender-related barriers that often keep men from being involved during pregnancy and delivery. And you’ve had a chance to think about your own practice and opportunities for change.”
- “When we return from our break, we will practice common scenarios encountered in prenatal care and counseling visits.”



#### FACILITATOR NOTES

During action planning, note that participants should think both about changes that are easy to make, or “low-hanging fruit” as well as changes that might be a bit more difficult but would create a larger or more long-lasting impact. They should also think about their place, role, and decision-making power within the healthcare facility - where can they as an individual, by virtue of their role, make the most difference?

## SESSION 2: PRENATAL VISIT PRACTICE

### OBJECTIVES:

- Practice engagement with men in prenatal visits and counseling sessions with couples.
- Encourage a more personal understanding of the experiences men might have during their partner’s pregnancy and delivery.

### RECOMMENDED TIME: 90 MINUTES

### MATERIALS NEEDED:

- Flipchart and markers
- Presentation slides
- [Prenatal Visit Scenarios and Strategies \(see handout on page 77\)](#)

### PREPARATION:

- Review presentation, key ideas, and facilitator notes.
- Print out enough handouts for each participant to have a copy.



#### KEY IDEAS

Health care providers can improve their interactions with men during prenatal counseling visits by becoming aware of their own biases, values, and attitudes and working to prevent them from interfering with their ability to offer nonjudgmental services.

### ACTIVITY 1: PRENATAL VISIT ROLE PLAY (60 MINUTES)

- Divide participants into three groups. Hand each group one of three scenarios (print out multiple copies so that each member in the group gets a copy of the scenario).
- Ask each group to reflect on the scenario and come up with a short skit to demonstrate how they would respond to the situation in a way that would challenge harmful gender norms and engage male partners without reducing women’s decision-making power or autonomy.
- Give groups 15 minutes to prepare and tell them that their skit should be no longer than 5 minutes.

- Have each group present their skit. Once their skit is over, ask the following questions of the group:
  - What kinds of gender stereotypes, norms, roles, or relations did you observe?
  - What did you think of the solutions proposed by the group?
  - Would you do anything differently?
  - Did you identify any risks in the scenario? If so, how would you address them?

### ACTIVITY 2: FATHERHOOD INTERVIEWS (30 MIN)

- Ask participants to divide into groups of two.
- Tell the groups that they will be given 10 minutes each to interview each other, taking on the roles of expectant father and clinician. In the first round, the clinician will ask the father the following questions:
  - What do you enjoy most during this pregnancy?
  - What is the hardest thing for you during this pregnancy?
  - What do you think your baby will be like?
  - How do you think your life is changing and will change?
- Note that they are encouraged to use their personal experience as a parent, or as someone who has observed other parents, to answer the questions.
- After 10 minutes, ask the groups to switch roles, with the father now taking on the role of the clinician and asking the same set of questions.
- When the activity is over, ask participants to reflect on the experience. Is this a conversation they have had before? How has it impacted their view of expecting fathers?

### LUNCH (60 MINUTES)

- “Great work this morning! When we return, we will turn from individual practice to the policymaking level, and analyze policies and protocols that encourage or hinder male engagement.”



#### FACILITATOR NOTES

During action planning, note that participants should think both about changes that are easy to make, or “low-hanging fruit” as well as changes that might be a bit more difficult but would create a larger or more long-lasting impact. They should also think about their place, role, and decision-making power within the healthcare facility - where can they as an individual, by virtue of their role, make the most difference?

## SESSION 3: PRINCIPLES AND POLICIES<sup>9</sup>

### OBJECTIVES:

- Identify principles to guide work with men during pregnancy and delivery and strategies to carry them out.
- Understand the programmatic continuum used to engage men and the types of activities that can be implemented along it.

### RECOMMENDED TIME: 90 MINUTES

### MATERIALS NEEDED:

- Flipchart and markers
- Presentation slides
- [Continuum for Engaging Men \(see handout on page 81\)](#)

### PREPARATION:

- Review presentation, key ideas, and facilitator notes.
- Print out enough handouts for each participant to have a copy.



#### KEY IDEAS

Health care providers can improve their interactions with men during prenatal counseling visits by becoming aware of their own biases, values, and attitudes and working to prevent them from interfering with their ability to offer nonjudgmental services.

### ACTIVITY 1: PRINCIPLES FOR ENGAGING MEN (45 MIN)

- Divide participants into 3 or 4 groups, depending on the number of participants and the time available for group feedback.
- Show **Slide 55**. Ask groups to brainstorm a list of principles they think should guide their healthcare facility's work with men in prenatal care, and write these on a sheet of flipchart paper.
- After the group work, ask participants to present their list to the rest of the class.
- Consolidate the list of principles presented by the groups onto the flip chart, making sure to avoid duplication.

<sup>9</sup> Activities in this session are based on Sonke (2011) Gender Mainstreaming for Health Managers.



- Choose 2 or 3 of the principles and ask the group for ideas as to how these could be operationalized. Meaning, what would they do to translate the principles into the day-to-day functioning of staff at the healthcare facility?
- Conclude by presenting WHO key principles for male engagement on **Slides 56-59**. These should hopefully be similar to those identified by the participants. If anything has been missed, make a point of highlighting it. Congratulate participants on the principles they identified.

### HEALTH BREAK (15 MINUTES)

- “We have reviewed the benefits of male engagement, as well as the gender-related barriers that often keep men from being involved during pregnancy and delivery. And you’ve had a chance to think about your own practice and opportunities for change.”
- “When we return from our break, we will practice common scenarios encountered in prenatal care and counseling visits.”



### FACILITATOR NOTES

On the continuum exercise, participants may often find it difficult to determine exactly where on the continuum each of these activities should be placed because of a lack of specific information. Remind participants that there is no one “correct” approach to engaging men.

Participants may ask what the connection is between these activities and their daily work. Turn the question to them - ask about the policies and activities carry out day-to-day and how these might or might not be gender-sensitive or -responsive.

### ACTIVITY 2: CONTINUUM FOR ENGAGING MEN (45 MIN)

- Explain the following:
  - Programs have used many different ways to engage men in prenatal care.
  - It is important to understand these because they have different goals and strengths and weaknesses.
- Present **Slide 60**, which shows the continuum graphic.
- Review the participant handout that describes the continuum. Make sure all participants understand the differences between the three different approaches presented.
- Explain that the approaches are not mutually exclusive. Some programs may promote services to men as a way of recognizing that existing gender norms force women to take greater responsibility in decision-making relating to several aspects of reproductive health services and that men need to assume their share of the burden. Other programs may encourage men to be supportive partners after they ask men to examine what it means for them to be “men” and develop healthier views or masculinity.
- Select one or two case studies from **Slides 64-65** to brainstorm as a group.
- Ask a volunteer to read out loud one of the case studies.
- Ask the following questions:
  - What approaches from the continuum does this case use?
  - Some feel that it is not useful for a program to simply address the needs of men as clients if they are not also addressing the social norms that perpetuate gender inequality. Do you agree or disagree with this viewpoint? Why?
  - Can men be effective allies of women’s issues if they do not embrace the concepts of gender equality and address these issues in their own lives? Why?
- Ask another volunteer to read a second case study out loud and ask the same questions of the group as you asked for the first case study.

## SESSION 4: FEATURES OF SUCCESSFUL ENGAGEMENT<sup>10</sup>

### OBJECTIVE:

Share key features and elements of successful interventions to engage men during pregnancy and delivery.

**RECOMMENDED TIME:** 90 MINUTES

### MATERIALS NEEDED:

- Flipchart and markers
- Presentation slides
- Case studies of successful male engagement (see handout on page 82)

### PREPARATION:

- Review presentation, key ideas, and facilitator notes.
- Print out enough handouts for each participant to have a copy.



### KEY IDEAS

Gender-responsive policies and programmes are needed to address harmful gender norms, roles and relations – especially gender inequality. Gender-responsive programmes are either gender-specific or gender-transformative. Both contribute to achieving gender equality and health equity during pregnancy and delivery.

### ACTIVITY 1: SUCCESSFUL PROGRAMS (30 MIN)

- Begin by presenting **Slides 67-68** on the framework for engaging men.
- Explain that this is one way of thinking about interventions that work with men.
- Divide participants into groups to share their experiences on elements that have helped them successfully engage men in prenatal care.
- Ask them to answer the following questions during their group work:
  - What program interventions have you used in your previous work to engage men in prenatal care?

- What were some of the key elements that made these programs or activities successful?
- What were some of the challenges and how were you able to overcome or mitigate them?
- If participants have not had any experience engaging men in prenatal care, ask them to think about experiences their colleagues may have had, or that they have heard about in the media or in research, for example.
- Leave approximately 15-20 minutes for group discussion. Note key feedback points on the flipchart.
- Choose one or two key challenges that have been brought up and prompt discussion on strategies to overcome these.
- Tell the class that you will now be looking at case studies of successful policies.

### ACTIVITY 2: SUCCESSFUL POLICIES (60 MIN)

- Divide participants into five groups and give each group a case study on effective public health policy dealing with men and prenatal care. If you can, make enough copies for each participant.
- Show **Slide 71** and ask participants to spend 15 minutes discussing the following three questions after reading their case study:
  - How might the policy in the case study work in your context or country? If you already have a similar policy, discuss lessons learned from the study.
  - How could policies on this issue be further strengthened or amended to include a stronger focus on men and gender equality?
- Ask each group to appoint a note-taker and presenter as they will be asked to present a summary of their discussion and key features of their plan to the full group.
- After the group work, ask participants to reconvene. Give each group 5 minutes to present and ask that participants wait until all groups have presented before asking questions or making comments.
- After each group has presented, allow 15-20 minutes for a group discussion of key themes and challenges related to the development and implementation of policies.

### CLOSING REMARKS AND PROGRESS CHECK (15 MIN)

- Congratulate and thank participants for their participation in Module 2.
- Ask the group what stood out to them from the second day of training.
- Recap the key messages from Module 2 using **Slide 72** and tell participants that the

<sup>10</sup> Activities in this session are based on Sonke (2011) Gender Mainstreaming for Health Managers.

last day will focus on assessing and providing recommendations for ways the health facility can better engage men in prenatal care.

- Distribute the **daily assessment** (See Annex III) for Module 2.



#### FACILITATOR NOTES

Participants should all come from the same health facility, but may have different roles. Not everyone will be directly involved in making or changing policy, or implementing programs - however, everyone is likely impacted by policies and programs and should be able to reflect on the ways in which gender-sensitive and transformative changes could improve prenatal healthcare delivery..

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## **MODULE 3: GENDER-BASED VIOLENCE**

PHOTO: PROSTOCK-STUDIO/SHUTTERSTOCK.COM

## SESSION 1: UNDERSTANDING GBV

### OBJECTIVES:

- Understand forms and causes of gender-based violence.
- Understand the important role of health clinics and health care providers in addressing the needs of pregnant women subject to gender-based violence.

### RECOMMENDED TIME: 75 MINUTES

### MATERIALS NEEDED:

- Presentation slides
- Plastic bags - one bag per group
- [Types of GBV \(see handout on page 83\)](#)

### PREPARATION:

- Review presentation, key ideas, and facilitator notes.
- Print out as many copies of the Types of GBV handout as you will have groups for the exercise. Cut out the terms and definitions and place them in bags - one bag per group. Print and cut out one full set of terms and definitions per bag.



### KEY IDEAS

Health professionals have an important role to play in addressing gender-based violence among their pregnant clients. They are sometimes one of the only sources of support and aid available to women experiencing GBV. Pregnant women may experience a range of forms of GBV, including physical violence, psychological violence, sexual violence, or economic violence. They may be survivors of harmful traditional practices.

### WELCOME

Welcome everyone back to the training.

Revisit the previous day's learning as well as the ground rules.

Provide an overview of the day's objectives. Note that in the morning, participants will focus on an important dimension of gender and health - gender-based violence. In the afternoon, participants will examine institutional and policy change and conduct a rapid assessment of their health facility.

### ACTIVITY 1: SHORT VIDEO AND DISCUSSION (15 MIN)

- When participants are all seated, show the following video from the World Health Organization: *Violence against women: Strengthening the health system response*, that can be accessed in the following link: [https://www.youtube.com/watch?v=Qc\\_GHITvTml](https://www.youtube.com/watch?v=Qc_GHITvTml)
- Note the following:
  - One in three women worldwide experience physical and/or sexual violence in their lifetimes. This includes pregnant women.
  - The clinic and health professionals can play an important role in providing services and support for women's physical and mental health needs, as well as referrals to meet their legal, financial and other needs.
- Ask participants:
  - How does the clinic currently address the needs of pregnant women experiencing gender-based violence?
  - Where do you think service gaps might exist?
- Tell participants that you will now be looking at both the types of gender-based violence they are likely to encounter in their practice as well as the risk factors and triggers for violence.

### ACTIVITY 2: TYPES OF GBV<sup>11</sup> (30 MIN)

- Divide participants into 2 or 3 groups, depending on the size of the class.
- Explain that each group will be given a bag with terms and definitions on pieces of paper. Each group will have 10 minutes to match the terms with the definitions. The group that gets the most correct matches wins.
- After 10 minutes, pass out the Types of GBV handout to each group and let them check their answers. Ask the groups to announce how many they answered correctly.
- Ask participants:
  - Which types of GBV take place in the communities where they work?
  - What might be warning signs or tips that could indicate that GBV is occurring in the community and facilities where they work?
- Note that gender-based violence can occur at all stages of life, including during pregnancy.

<sup>11</sup> Activity from Messner, L., A. Odukoya, G. Osakue, E. Otiye-Igbuzor, D. Santillán, and S. Byrne. 2018. *Gender Integration and Gender-Based Violence Prevention and Response: Training Manual*. Arlington, VA: Strengthening High Impact Interventions for an AIDS-free Generation (AIDSFree) Project.

### ACTIVITY 3: PRESENTATION<sup>12</sup> (30 MIN)

- Tell participants that the next presentation will focus on their understanding of intimate partner violence (IPV), a common form of gender-based violence experienced by pregnant women and other women in heterosexual partnership.
- Show **Slide 74-76** and explain key terms related to causality:
  - Definition of GBV
  - Types of GBV
  - Risk factor: a characteristic of an individual, setting, or society that increases the likelihood of violence occurring.
  - Protective factor: a characteristic of an individual, setting, or society that reduces the likelihood of violence occurring.
  - Situational trigger: an immediate event or circumstance which can precipitate an incident of violence.
- Show **Slides 77-81** to introduce the socio-ecological model and explain:
- A socioecological model looks at the interaction of individual, interpersonal, community, and societal factors that increase or decrease the likelihood of violence.
  - **Individual** level: risk factors related to individual attributes, developmental histories and behaviors can increase the likelihood of men perpetrating violence and women experiencing violence.
  - **Interpersonal** level: factors in relationships that increase the risk of IPV. Depending on the setting, this may include intimate partners, family, or a peer or friendship network. In intimate partner relationships, these risk factors need to be understood alongside a set of specific situational triggers that can precipitate an incident of violence.
  - **Community** level: factors in the immediate environment that encourage, condone, or create a local enabling environment for men to perpetrate IPV.
  - **Societal** level: broader environment that either enables or inhibits IPV, including relevant policy and legislative frameworks and economic and cultural influences.
- Go to **Slide 82** to discuss risk factors for IPV at each level of the socio-ecological model. Review the risk factors on the slides.
  - All of these risk factors can be reframed as protective factors. For example, social isolation may increase the likelihood of women experiencing violence, while social support can decrease it.
  - The risk and protective factors most relevant for your communities may vary depending on the setting.

- Show **Slide 83** on the situational triggers of IPV. Explain:
  - Recent research on IPV in heterosexual relationships has identified situational triggers, or immediate events or circumstances that can precipitate an episode of violence. This could be excessive drinking, jealousy, or disagreements about household spending for example.
  - Gender is important here. Some situational triggers relate to instances where women or men fail to meet certain gendered expectations. For example, a man may beat a woman as a form of 'discipline' if she fails to care for the children or prepare meals 'properly'.
  - Conflict can arise if a man is not able to provide financially for his family, thus failing to meet gendered expectations of men as providers. Feelings of shame, inadequacy, or anger can prompt men to respond with violence, especially if they feel their masculinity or authority is under threat.

### HEALTH BREAK (15 MIN)

- Tell participants that when they return from break, they will have a chance to discuss approaches to addressing GBV with clients, and practice identification and counseling skills.

12 Material from The Prevention Collaborative (2020). Prevention Foundations Brief 2: Understanding the causes of violence against women. Written by Kamani Jinadasa and Lyndsay McLean; designed by Henrik Hilker.



## SESSION 2: RESPONDING TO CLIENTS EXPERIENCING GBV

### OBJECTIVES:

- Understand how to respond to clients experiencing GBV.
- Practice skills to meet the needs of clients experiencing GBV.

**RECOMMENDED TIME:** 90 MINUTES

### MATERIALS NEEDED:

- Presentation slides
- Scenario: Pregnant survivor of violence (see handout on page 86)
- Guiding principles (see handout on page 87)

### PREPARATION:

- Review presentation, key ideas, and facilitator notes.
- Print out two copies of the Scenario handout.
- Print out the Guiding Principles handout - one for each participant and a few extra.



### KEY IDEAS

Although universal screening for IPV is not recommended, healthcare workers should practice clinical enquiry and know when and how to ask clients about experiences of IPV. Written information on IPV should be made available in the clinic, for example through posters, pamphlets, and leaflets in women's washrooms. Do No Harm principles should be practiced at all times. These include: safety, confidentiality, respect, non-discrimination, and honesty.

### ACTIVITY 4: PRESENTATION (15 MIN)

- Show **Slides 84** to review the essential services and actions for health care providers
- Go to slides **85-93** on identification of IPV
- Show slide **94** on mandatory reporting since 14 out of 17 countries in the region have legal requirements on this issue
- Go to slide **95** on first-line support as the most important care that a health staff can provide
- Explain slide **96** on referral process
- Go to slides **97-98** on risk assessment and safety planning

- Explain slides **99-100** on other services to be provided according to identified needs of the survivor and most common barriers faced by health care providers in providing support for GBV survivors
- End the presentation with slides 101-102 on principles on working with GBV survivors.

### ACTIVITY 5: ROLE PLAY<sup>13</sup> (75 MIN)

- Ask for 2 volunteers willing to take part in a role play. One person will play the health care provider and the other person will be the client.
- Invite the volunteers to come up to the front of the room and sit in two chairs facing each other.
- Share the scenario with the client and ask her to tell her story to the health care provider, taking no more than 5 minutes. Share the Dos and Don'ts with the health care provider and ask them to respond to the client with behaviors in the "Don't" column.
- Ask participants:
  - What did you observe that was well done?
  - What did you observe that could be done better?
  - What is your opinion about this counseling session?
- Pass out the Guiding Principles handout and give participants a few minutes to read over it.
- Review the Dos and Don'ts and ask participants if they have any questions about the handout.
- Explain that you will redo the role-play. Tell them that in the last role play, the volunteer counselor was asked to reflect the "Don't" behavior. This time, the health care provider will follow the Dos.
- Ask for the client volunteer to come back up to the front of the room and ask for a new health care provider volunteer. Ask them to perform the role play with the same scenario, only this time following the recommended behaviors.
- Ask participants to compare the second role play with the first one:
  - What felt different? How were the sessions different?
  - Ask the client: what felt different the second time? How did you feel? What was different for you?
  - What can we take away from this exercise?

### LUNCH BREAK (60 MINUTES)

- Thank you for your work this morning. This afternoon, we will get a chance to do an institutional walk-through assessment and start thinking about your priorities as

<sup>13</sup> Activity adapted from Messner, L., A. Odukoya, G. Osakue, E. Otiye-Igbuzor, D. Santillán, and S. Byrne. 2018. Gender Integration and Gender-Based Violence Prevention and Response: Training Manual. Arlington, VA: Strengthening High Impact Interventions for an AIDS-free Generation (AIDSFree) Project



## **MODULE 4: POLITICAL WILL AND INSTITUTIONAL CHANGE**

PHOTO: DUSAN PETKOVIC / SHUTTERSTOCK.COM

# SESSION 1: INSTITUTIONAL ASSESSMENT

## OBJECTIVES:

- Conduct a rapid institutional assessment for male engagement.
- Build group consensus on status of the healthcare institution with regard to male engagement, with a view to formulating recommendations for leadership.

## RECOMMENDED TIME: 150 MINUTES

## MATERIALS NEEDED:

- Flipchart and markers
- Sticky notes
- Small round stickers (at least 3 x the number of participants in the class)
- Presentation slides
- [Institutional Assessment \(see handout on page 91\)](#)

## PREPARATION:

- Review presentation, key ideas, and facilitator notes.
- Module 4 requires advance coordination with the healthcare facility's leadership or management team on two points:
  - To let them know that the facility walk-through exercise will involve training participants walking through the facility in small groups. Ask them if there are any considerations they would like participants be aware of during the walkthrough, such as remaining silent or quiet in the building, or in certain parts of the building.
  - To request that leadership join the training in the afternoon for an hour to hear a presentation of assessment findings and recommendations made by participants. Ask if they would be willing to commit to taking action on the recommendations made to them, and if so, how they would like to be held accountable for these actions (or what processes are already in place for accountability to staff).



## KEY IDEAS

A rapid institutional assessment for male engagement is useful to identify behavioral, policy, and environmental barriers that could be changed to encourage men to participate in prenatal health activities. Participants will also learn to develop a prioritization matrix for changes they would like to see in their healthcare institution, creating a shared mental model within the group that can form the basis for collective action after the training is over.

## ACTIVITY 1: HEALTHCARE FACILITY WALK-THROUGH (60 MIN)

- Hand out a printed copy of the Healthcare Facility Walk-Through Questionnaire to all participants.
- Review each question one by one to address any questions participants may have. If there are questions about key terms or ideas, seek agreement as a group as to their meaning. Certain questions may also need to be skipped because they do not apply to this particular institution - identify these as relevant.
- Divide participants into 4 groups.
- Give participants the following instructions:
  - As you walk through your health facility, imagine that you are a man coming for a prenatal visit for the first time. Keeping the man's perspective in mind, assess how the facility would appear to him on the basis of the criteria in the questionnaire.
  - Please remain respectful of your colleague's working spaces and stay as quiet as possible while you are in the building.
  - In order to minimize disruption, avoid discussing your answers to the questions while you are doing the walk-through; instead, wait until you have finished the questionnaire and exited the building with your team. To make sure you capture your thoughts and impressions during the walkthrough, however, please write them down on your individual copies of the questionnaire.
  - Make sure to capture details beyond "Yes" or "No" answers - tell us why you feel a certain way. Include specific features or elements that you've noticed.
  - When you have finished your walk-through, please come back to the training room with your team to finalize your answers.
- Release the first group to start the walk-through. Wait 2-3 minutes before releasing each subsequent group.



- Once the four groups have returned to the room, give them up to 15 minutes to finalize their answers as a group.
- Ask each group to report out on one of the 4 sections of the questionnaire. Once a group has reported out, ask the rest of the room if they would like to add anything to the assessment, or if any group felt differently about any of the questions.
- Ask the group how it felt to view their facility from the viewpoint of an expectant father. Did they see things they may not have seen before?

## ACTIVITY 2: BRAINSTORMING SOLUTIONS (30 MIN)

- While participants are on break, put up four large pieces of flipchart papers onto the wall, and title them: 1. Facility approachability 2. Services provided 3. Reception area 4. Service areas and examination rooms. Place stacks of sticky notes and markers at the center of each table.
- Ask participants to return to their groups and brainstorm possible solutions to the problem areas they have identified. Ask them to list solutions on the sticky-notes - one solution per sticky-note - and place them under the appropriate title on the wall.
- Once all groups have finished, read off the solutions posted under each assessment area, noting where groups seem to have similar or original answers.

## HEALTH BREAK (15 MIN)

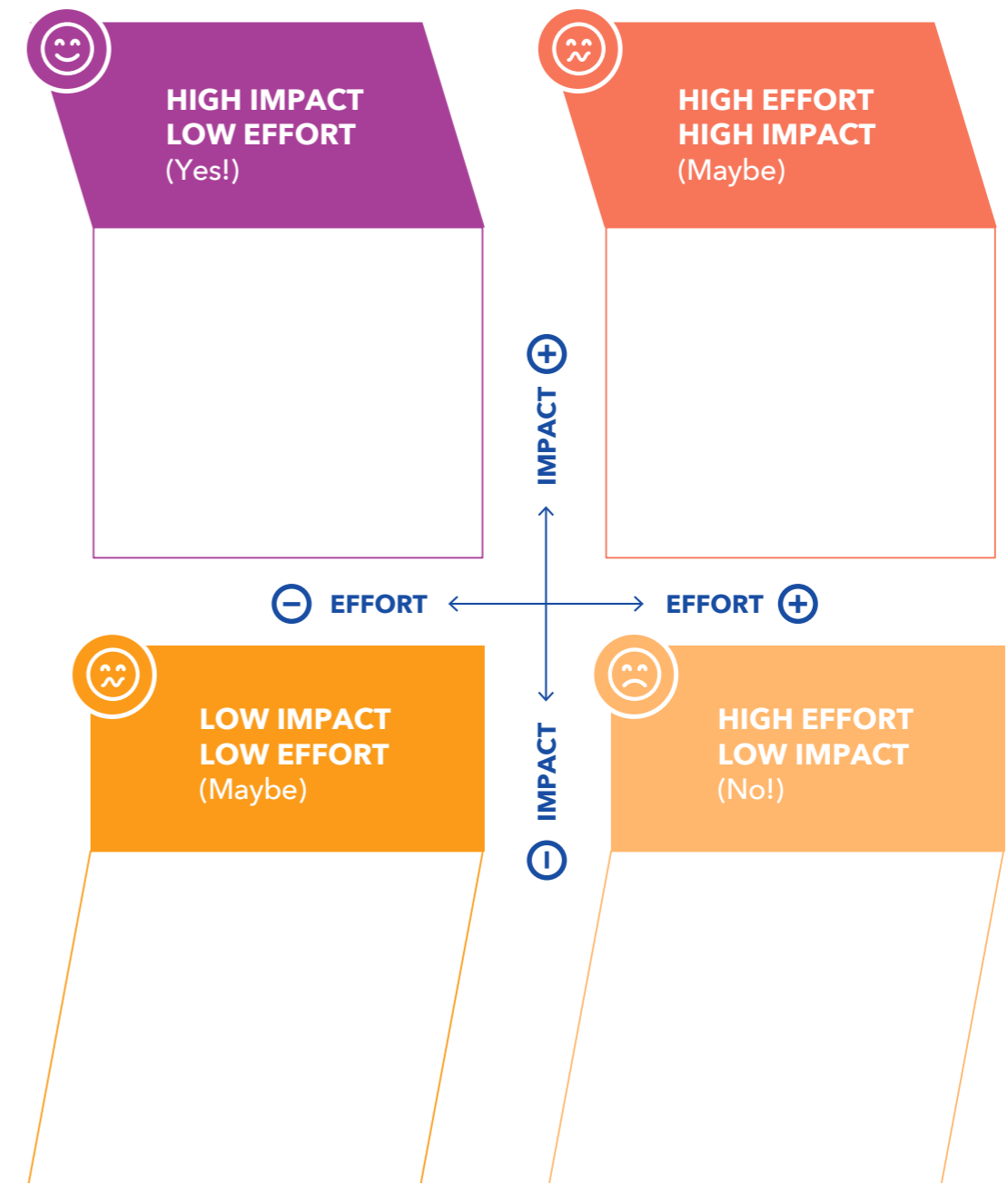
- "A rapid institutional assessment is a useful tool to identify possible physical and environmental barriers to male engagement in prenatal health. It can be used as the basis for an action plan or new/changed policies."
- "When we return from our break, we will bring together your thoughts and solutions from yesterday's work on clinic policies and protocols as well as your work this morning on the clinic environment, and prioritize the changes you would like to see made at your healthcare facility."
- While participants are on break, write out each original solution on the flipchart paper for its respective title (meaning, if a solution has been proposed multiple times, only write it out once).
- Next to the solutions for institutional change, put up the results of the previous day's solutions brainstorming on clinic policies and protocols.

## ACTIVITY 3: PRIORITIZATION EXERCISE (60 MIN)

- Hand out three round stickers per participant. Tell them that the stickers are votes. Ask each participant to place their stickers next to the solutions they feel would be most important to implement - these can be related to clinic policies and protocols

or to its environment. Note that they can put all three stickers on one solution if they feel strongly about it, or spread them out across two or three solutions.

- Once all participants have finished, note the top 10 solutions with the highest number of stickers next to them. List these on a separate piece of flipchart paper (you can abbreviate or use key words to speed up the process).



- Ask participants: “Which of these do you think would have the most impact?” Place a 10 next to it. “Now which of these do you think would have the least impact?” Place a 1 next to it. Continue to assign a numerical value to each solution based on how impactful the group feels it is compared to other solutions.
- Now ask participants: “Which of these do you think will take the **most effort**?” Place a 10 next to it. “Now which of these do you think will take the **least effort**?” Place a 1 next to it. Continue to assign a numerical value to each solution based on how much effort the group feels it would take compared to other solutions.
- Based on the numerical values assigned to each solution, place them on a grid similar to the one pictured below.
- Identify the solutions with the highest impact and lower effort (top left quadrant). Tell the participants that these are the solutions they will be presenting to facility leadership in the afternoon. Ask if everyone is in agreement. If there are disagreements and there is time, allow the group to discuss. If one or more people continue to disagree, write their points on a flipchart titled “Dissent” and tell them that although the larger group will move forward to present the majority’s conclusions, their dissent will also be noted and presented.

#### CLOSING REMARKS AND EVALUATION (5 MIN)

- Thank you for the thoughtfulness and attention you’ve brought to this exercise. It’s tedious but allows you as a group to have a common understanding of the issues you feel are most important for your workplace, as well as the solutions you feel would be most helpful to engaging men in prenatal care.
- Tomorrow we will create an action plan for carrying out the solutions you’ve identified and prioritized, and you will get a chance to present your plan to your leadership.
- Distribute the **daily assessment** (See Annex III) for Module 3 and Module 4, Session 1.

## SESSION 2: ACTION PLANNING

#### OBJECTIVES:

- Finalize detailed action plans, outlining the activities, timeframe, budget, and personnel needed to accomplish priority recommendations to increase male engagement in prenatal care at the facility.

#### RECOMMENDED TIME: 60 MINUTES

#### MATERIALS NEEDED:

- Flipchart and markers
- Presentation slides
- Institutional Action Plan (see handout on page 94)

#### PREPARATION:

- Review presentation, key ideas, and facilitator notes.



#### KEY IDEAS

The key components to an action plan include activities, budget, timeframe, and responsibility. Articulating these details in the context of participants’ healthcare facility will make it more likely that they and their managers will implement recommended changes to promote male engagement..

#### WELCOME

Welcome everyone back to the training.

Revisit the previous day’s learning as well as the ground rules.

Provide an overview of the day’s objectives. Note that today will be a half day of training, focused on action planning and presentations to clinic leadership.

#### ACTIVITY 1: ACTION PLANNING (60 MIN)

- Divide the group into as many recommendations were felt to be highest priority in the prioritization exercise from the day before (usually no more than 3-4); assign each group one of the recommendations.

- Distribute the Action Planning handout and explain that each group is responsible for completing a detailed action plan for their particular recommendation. That means thinking about what it will take to complete the recommended action. Will it require funding? Will it require staffing? Who will be responsible? How long will it take to complete? How will they know when it has been done, and what would it look like to be done well?
- Once the groups have finished their action plans, ask them to report out on their work, answering the following questions:
  - What is the proposed goal?
  - How will this goal help the facility better engage men in prenatal health?
  - How do they propose to accomplish this goal?
  - Activities, timeframe, budget, responsibility
- Ask that each person in the groups have the opportunity to speak during the report out as well as the final presentation. Give each group a maximum of 5 minutes for their presentation.

#### HEALTH BREAK (15 MIN)

- Note that participants can spend any remaining time before leadership arrives to practice and refine their presentation. They should feel free to get coffee/tea and stretch their legs or continue to work on their presentation, as needed.



#### FACILITATOR NOTES

Participants should all come from the same health facility, but may have different roles. Not everyone will be directly involved in making or changing policy, or implementing programs - however, everyone is likely impacted by policies and programs and should be able to reflect on the ways in which gender-sensitive and transformative changes could improve prenatal healthcare delivery..

## SESSION 3: PRESENTATION TO LEADERSHIP

#### OBJECTIVES

- Create a line of accountability between the facility's leadership and training participants to implement actions increasing male engagement in prenatal care

**RECOMMENDED TIME:** 60 MINUTES

#### MATERIALS NEEDED

- Flipchart
- Preparation
- Review presentation, key ideas, and facilitator notes.



#### KEY IDEAS

Institutional change often requires political will and accountability. The final activity in this training package is designed to lay the groundwork for changes to promote male engagement in prenatal health, by creating group consensus around key barriers and solutions and building lines of accountability for change between staff and leadership.

#### ACTIVITY 1: PRESENTATION TO LEADERSHIP (60 MIN)

- Agree on a time for the facility's leadership to join the class. Give groups time to practice their presentations until that point.
- Welcome the leadership and briefly introduce the class and the work they have done over the past three days.
  - Note that participants learned about the importance of gender in healthcare, and how it can create barriers for men to engage in prenatal healthcare activities.
  - Tell leadership that the group conducted analyses of personal, policy, and structural factors that might be changed to encourage male engagement.
  - Note that the class has worked hard to identify a number of recommendations that they feel would have the most impact on male engagement, as well as be feasible to implement.
  - They will be presenting their recommendations as well as the actions they feel need to be taken to accomplish them.



- Ask the leadership if they would like to say a few words before the groups begin their presentations.
- Ask the first group to present, and so on, until the last group has presented. Keep track of time and alert groups when they have reached the 5 minute mark.
- Lead the room in applause and appreciation for the effort and work of training participants over the past three days.
- Ask leadership for their reaction and instructions on next steps for decision-making on proposed actions.

#### CLOSING REMARKS AND EVALUATION (15 MIN)

- Distribute the **daily assessment** (See Annex III) for Module 4 Sessions 2-3 and the **Training Evaluation Form** (see Annex IV).
- Distribute certificates to all participants, thanking them for their engagement, and wishing them the best as they seek to take what they have learned and apply it to their work.



#### FACILITATOR NOTES

Make sure to agree with facility leadership in advance both on the logistical aspects of their involvement as well as the ways in which they would like to be able to follow up on the recommendations presented by their staff. It will be important for them to convey a process for decision-making as well as accountability to staff - for example, by coming prepared to approve actions that fall under a certain budget or by setting up a process for more in-depth policy review and revision.

PHOTO: PROSTOCK-STUDIO / SHUTTERSTOCK.COM





## ANNEX 1: ICE BREAKERS AND ENERGIZERS

### ICE BREAKERS

#### THE NAME GAME

**TIME:** 15-20 minutes

**OBJECTIVE:** The purpose of this game is to share everyone's names in a fun way. This game helps to learn the names of the participants.

**DESCRIPTION:** There will be two rounds in which the group plays "catch," while everyone has a chance to say their names. In the first round, each person says his or her name before throwing the ball. So, one by one, each participant says his name and then throws the ball to someone else. The facilitator can begin, in order to better demonstrate the game. This round ends when everyone has had a chance to say their name, and has passed the ball back to the facilitator. Repeat the game for the second round, but after a participant says his name, he should put his hand on his head to signal that he has already gone. Continue the second round until everyone has had a turn.



## THE BUS OF EMOTIONS

**TIME:** 10-15 minutes

**OBJECTIVE:** This game helps the participants interpret or express different emotions, and help each other to do the same.

**DESCRIPTION:** Ask four participants to “role play” people getting on a “bus.” Each person should approach the bus while expressing a different emotion. When the driver and passengers see this emotion, they are infected by it, and begin to express it as well. Follow this pattern for each additional volunteer. At the end, to process this game, ask the participants what they observed, and then ask them how they felt during this exercise.

## THE MAIL CARRIER

**TIME:** 15-20 minutes

**OBJECTIVE:** The objective of this game is for participants to share their personal information and to get to know each other a little more in a fun way.

**DESCRIPTION:** The participants are placed sitting in their chairs in a circle. Only the facilitator stands. The facilitator explains that he/she is going to start playing the role of “the postman” and that the postman will bring a letter to various people. Those people called by the postman have to change seats. For example, if the postman says: “Bring letters to all the people who like ice cream,” all people who love the ice cream will change places. When people get up and go to change seats, the postman will take out a seat so another person will be left standing. The person left standing becomes the postman, and the game continues.

## ABOUT MY FAMILY

**TIME:** 15-20 minutes

**OBJECTIVE:** To learn about other people in the group.

**DESCRIPTION:** Ask participants to form pairs, and then turn to the person next to them and share their name, number of children, and three other facts about themselves that others might not know. Allow 3-5 minutes for this. Then, have each pair introduce each other to the group. This helps to get strangers acquainted and people to feel safe – they already know at least one other person, and did not have to share information directly in front of a big group at the beginning of the meeting.

## TWO TRUTHS AND A LIE

**TIME:** 15-20 minutes

**OBJECTIVE:** To have the group get to know one another better.

**DESCRIPTION:** In a large group, have everyone write down two true statements about themselves and one false one. Then, every person reads their statements and the whole group must guess which one is false. This helps participants get acquainted and relaxed.

## VOTE WITH YOUR FEET

**TIME:** 15-20 minutes

**OBJECTIVE:** To clarify values around fatherhood

**DESCRIPTION:** In a large group have everyone stand in one long line. They will listen to one statement. Those who “agree” with the statement will step forward from the line. Those who “disagree” with the statement will step back from the line. Have volunteers explain why they agree or disagree. Sample statements:

- Men are less emotional than women.
- Men are less able to care for children than women.
- Men are better at raising boys than raising girls.
- Spanking a child is a necessary form of discipline.
- Women are better able to carry out domestic work, such as cleaning, than men.

## ENERGIZERS

### SPAGHETTI

Groups of 5-10 people.

- The group forms a tight circle. Everyone sticks their hands into the center. With one hand, everyone grabs the hand of another person. Then, using the other hand, grab a hand of someone different.
- The object of the game is to get untangled without letting go. By climbing, crawling, and wriggling around, participants can create one large open circle or, sometimes, two unconnected ones.
- If they are totally stuck, you can tell them they can choose to undo one link, and then reconnect once that person has turned around, and see if that works.
- This energizer is fun and creates a nice physical bond between participants. It also subtly communicates ideas of working together to accomplish a task.

### SPAGHETTI

Groups of 5-8 people.

- Put a blanket or several sheets of newspaper on the floor. Ask the group to stand on it. Then explain this is an iceberg that is melting away, reducing its size by half every month. Their object is to see how long they can all stay on it.
- You ask them to get off it and fold the blanket in half or remove half the paper. Each time, reduce the area by half and see how they can find ways to support each other to allow everyone to stay on.



### THE SCREAM

Only use where others won't be disturbed.

- Ask group members to stand. Tell them to close their eyes. Breathe slowly and deeply. Ask everyone to breathe in unison. Ask them to keep breathing together while they stretch their arms as high as possible. Ask them to jump up and down together and, finally, to scream as loudly as they can.

### THE RAINSTORM

Can be used as a closing.

Ask the group to stand in a circle with their eyes closed. Say that a rainstorm is approaching.

- Ask everyone to rub their palms against their pant legs. Then ask them to lightly pat their thighs with their fingertips. Ask them to do it harder.
- Now, ask them to pat their hands against their thighs. Now start slapping your hands faster and faster against your thighs.
- After a while, go back to lighter slapping, then patting, etc., to reverse the whole order until it is quiet again and the storm has passed.
- *[At first the wind was blowing the trees, then light rain started, then heavier rain, then a downpour, and then the whole thing slackened off.]*

### EXERCISING

- More basic than all the rest. Ask someone to lead the group in some simple stretching.

### HOT PEPPER

- Gather the participants in a circle. Toss a ball (or another tossable object) gently to a participant. Participants should continue gently tossing the ball, saying "Hot" when they catch it.
- As the ball is being tossed around, randomly call out, "Pepper!" The person holding the ball when "Pepper!" is called is removed from the circle.
- Tossing the ball continues until only one person is left.

### I'M GOING TO THE STORE...

- Create a circle of chairs in the center of the room. Have enough chairs so that only one person does not have one.
- Have one person stand in the center of the circle. They should start the game by saying, "I'm going to the store, and I'm taking my friend who..." and choosing a trait that some of the people seated have. For example, "I'm going to the store, and I'm taking my friend who has a red shirt on." All of the students with a red shirt on will get up and race to another chair, including the person in the center, leaving the remaining person without a chair to stand in the middle of the circle.

- The next person in the center repeats the phrase with a new trait. The rule is that participants **MUST** get up and move to another chair if the trait applies to them. They cannot move to the chair next to them.
- Repeat several times.

### STOMP PATTERN

- Teach the participants a three-count stomp pattern and do it together. (Pattern: stomp-stomp-clap, stomp-stomp-clap.)
- Then, teach the participants a four-count stomp. (Pattern: stomp-stomp-stomp-clap, stomp-stomp-stomp-clap.)
- Divide the participants in half. Have one group do the first pattern and the second do the second pattern at the same time.
- If there is a bit more time, you can have individuals create their own patterns for the group to imitate.





## ANNEX 2: SESSION HANDOUTS

### FLASHCARD QUESTIONS AND ANSWERS

#### FLASH CARD #1

**QUESTION:** Do more men than women die from road traffic injuries

**ANSWER:** Yes. Almost three times as many men die from road traffic injuries than women. This is true especially for men younger than 25 years.

*Gender and road traffic injuries. Geneva, World Health Organization, 2002 ([http://www.who.int/gender/other\\_health/en](http://www.who.int/gender/other_health/en).)*

*Toroyan T, Peden M, eds. Youth and road safety. Geneva, World Health Organization, 2007 ([http://www.who.int/violence\\_injury\\_prevention/publications/road\\_traffic/youth\\_road\\_safety/en](http://www.who.int/violence_injury_prevention/publications/road_traffic/youth_road_safety/en))*

#### FLASH CARD #2

**QUESTION:** Do boys and girls have the same access to high-quality health care?

**ANSWER:** No, not always. For example, surveys conducted in Bangladesh, India, Indonesia, Nepal, Sri Lanka, and Thailand found that even when girls were vaccinated at comparable rates to boys they were often not taken to a health provider or care facility for illness episodes.

*Women of South-East Asia: a health profile. Delhi, WHO Regional Office for South-East Asia, 2000 ([http://www.searo.who.int/en/Section13/Section390/Section1376\\_5513.htm](http://www.searo.who.int/en/Section13/Section390/Section1376_5513.htm))*

### FLASH CARD #3

**QUESTION:** Do smoking-cessation programs have the same effects on men and women?

**ANSWER:** No. While smoking rates among men tend to be 10 times higher than among women, the rapid rise in tobacco use among younger females in low- and medium-income countries is a worrying trend. Women generally have fewer successful smoking-cessation attempts and more relapses than men, and nicotine replacement therapy may be less effective among women.

*WHO report on the global tobacco epidemic 2008: the MPOWER package. Geneva, World Health Organization, 2008 (<http://www.who.int/tobacco/mpower/en>)*

*Sifting the evidence: gender and tobacco control policy. Geneva, World Health Organization, 2007 (<http://www.who.int/tobacco/mpower/en>)*

### FLASH CARD #4

**QUESTION:** Do men and women experience violence in the same places, by the same types of perpetrators?

**ANSWER:** No. Women experience physical, sexual, and psychological violence in their homes, often from intimate partners, in conflict settings, and in communities, often by people they know. Sometimes they die from these situations; sometimes they remain in unsafe settings. Men who experience violence, in contrast, often experience violence at the hands of strangers and tend to die as a result of homicide by unknown perpetrators.

*García-Moreno C et al. WHO Multi-country Study on Women's Health and Domestic Violence against Women: initial results on prevalence, health outcomes and women's responses. Geneva, World Health Organization, 2005 ([http://www.who.int/gender/violence/who\\_multicountry\\_study/en](http://www.who.int/gender/violence/who_multicountry_study/en))*

### FLASH CARD #5

**QUESTION:** Do armed conflicts affect men and women in similar ways?

**ANSWER:** No. Although men and boys are often more likely than women to be recruited into or to join armed forces, exposing them to the possible risks this role brings, civilian women and girls also bear the brunt of conflicts today. Women and girls may be combatants or associated with fighting forces, and the impact on their well-being may differ from that of their male counterparts depending on their roles. Further, women and girls are more likely than men and boys to experience sexual violence in conflict, which has additional implications for their physical and mental health and social well-being.

*Shoemaker J. Women and wars within states: internal conflict, women's rights and international security. Civil Wars, 2001, 4(3):1-34.*

*García Moreno C, Reis C. Overview on women's health in crises, Health in Emergencies, 2004, 20:2 ([http://www.who.int/hac/network/newsletter/Final\\_HiE\\_n20\\_%20Jan\\_2005\\_finalpdf.pdf](http://www.who.int/hac/network/newsletter/Final_HiE_n20_%20Jan_2005_finalpdf.pdf))*

### FLASH CARD #6

**QUESTION:** Do men and women differ in mortality rates related to lung cancer?

**ANSWER:** Yes. More men than women die of lung cancer. GLOBOCAN 2000 data reveal gender differences in lung cancer incidence, prevalence and mortality, with about 10 female deaths and 31 male deaths per 100 000 population being attributed to lung cancer, more than a threefold difference!

*Payne S. Gender in lung cancer and smoking research. Gender and Health Research Series. Geneva, World Health Organization, 2005 (<http://www.who.int/gender/documents/LungCancerlast2.pdf>)*

### FLASH CARD #7

**QUESTION:** Does male involvement influence maternal and child health outcomes?

**ANSWER:** Yes. Male involvement improves physical and psychosocial maternal and child health outcomes. It also leads to positive social outcomes for men themselves. Studies in Scandinavia have shown that men's involvement in maternal and child health programs can reduce maternal and child morbidity and mortality, such as: fewer low-birth-weight infants in low-income families improved cognitive outcomes for preterm and low-birth-weight babies shortened labor time and rate of epidural use obstetric emergencies may be alleviated

*Fatherhood and health outcomes in Europe. Copenhagen, WHO Regional Office for Europe, 2007 ([http://www.euro.who.int/GEM/publications/20070506\\_10](http://www.euro.who.int/GEM/publications/20070506_10))*

### FLASH CARD #8

**QUESTION:** Does blindness prevalence differ between men and women?

**ANSWER:** Yes. Trachoma infection rates are higher among girls and women, as are repeat infections that can lead to blindness. Available studies indicate that females have a significantly higher risk of being visually impaired than males in every region of the world and at all ages. Nevertheless, women often do not have equal access to surgery for eye diseases due to inability to travel to a surgical facility unaccompanied, differences in the perceived value of surgery for women, and lack of access to health information.

*Preventing chronic diseases: a vital investment. WHO global report. Geneva, World Health Organization, 2005 ([http://www.who.int/chp/chronic\\_disease\\_report/en](http://www.who.int/chp/chronic_disease_report/en))*

*Fuad D, Mousa A, Courtright P. Sociodemographic characteristics associated with blindness in a Nile Delta governorate of Egypt. British Journal of Ophthalmology, 2003, 88:614-618.*

*Khandekar R et al. The prevalence and causes of blindness in the Sultanate of Oman: the Oman Eye Study (OES). British Journal of Ophthalmology, 2002, 86:957-962.*



## FLASH CARD #9

**QUESTION:** Do smoking-cessation programs have the same effects on men and women?

**ANSWER:** No. While smoking rates among men tend to be 10 times higher than among women, the rapid rise in tobacco use among younger females in low- and medium-income countries is a worrying trend. Women generally have fewer successful smoking-cessation attempts and more relapses than men, and nicotine replacement therapy may be less effective among women.

*WHO report on the global tobacco epidemic 2008: the MPower package. Geneva, World Health Organization, 2008 (<http://www.who.int/tobacco/mpower/en>).*

## POWER WALK ROLES AND STATEMENTS

### POWER WALK ROLES

Write each of the following “characters” onto separate index cards, and fold them so that the character name remains hidden.

- Staff member at healthcare institution
- Single mother
- Single father
- Female sex worker
- Male sex worker
- Teenage girl, pregnant
- Teenage boy, having a baby
- Illiterate woman
- Illiterate man
- Woman with postnatal depression
- Man with postnatal depression
- Pharmacist
- Female survivor of rape
- Male survivor of rape
- Woman living with HIV
- Man living with HIV
- Gay couple adopting a child
- Lesbian woman, pregnant

- Transgender man, pregnant
- Transgender woman, pregnant
- Healthcare director
- Imam, male
- Pastor, female
- Male doctor
- Female doctor
- Rural woman
- Rural man

### POWER WALK STATEMENTS

- I know where to find the nearest facility for prenatal health care and delivery services
- I feel respected by my midwife, nurse, or doctor
- I have a say in health decisions in my community
- I can consult prenatal and postnatal health services when I need them
- I have access to family or household resources to pay for prenatal and postnatal health care
- I can talk openly to my midwife, nurse, or doctor about my health concerns
- I can talk openly to my family about my health concerns
- I know my rights
- I understand how to take medication given to me by my doctor (if participants feel that they would not even have access to medication they should remain in the same place)
- I am allowed to be treated by a healthcare worker of the opposite sex
- I can read and understand health information posters at the healthcare facility
- If I need medication, I know where to get it
- My opinion is important within my own ethnic group
- I eat at least two full meals a day
- I can refuse sex with my partner or spouse
- I can pay for delivery in a private hospital
- I have access to parenting training before my child is born
- I am not in danger of being sexually harassed or abused
- I do not feel judged by healthcare workers

## RAPID ASSESSMENT ON FATHER ENGAGEMENT IN PRENATAL CARE

ATTITUDES AND ACTIONS		
Questions	Y/N	If "No", action(s) to take:
When a woman comes alone to an antenatal care visit, I ask about the father/her male partner.	YES NO	
At the antenatal care visit, I am on the lookout for signs of intimate partner violence.	YES NO	
If I am sure the mother is not in a violent relationship, I encourage her to invite the father/male partner to the next antenatal care visit, if she wants him to come.	YES NO	
When the father/male partner is present, I appreciate and encourage his future participation, with the mother's consent.	YES NO	
I ask a woman if she would like her partner to be present at childbirth and emphasize the importance of a father's presence.	YES NO	
I encourage the father/male partner to be present during childbirth, with the mother's consent and if allowed in my health facility.	YES NO	
I provide guidance and information about antenatal care and post-natal care to both the mother and her partner and ask both the woman and her partner if they have any questions.	YES NO	
I provide guidance on how fathers/male partners can provide physical support to the mother during childbirth (for example, through massage, helping with breathing techniques).	YES NO	
I encourage my colleagues to actively promote fathers'/male caregivers' involvement.	YES NO	
I am aware of policies and/or protocols at the facility where I work and at the national level, related to men's involvement in antenatal care.	YES NO	
I encourage both mothers and fathers to take some type of leave following the birth of the child, where possible.	YES NO	
I feel that I have the knowledge and skills I need to effectively involve men in antenatal care.	YES NO	

CLINIC POLICIES AND PROTOCOLS		
The facility where I work...	Y/N	If "No", action(s) to take:
Uses forms that record the father's presence or absence during the first antenatal care visit.	YES NO	
Uses forms that record the father's presence or absence during all antenatal care visits.	YES NO	
Has clinical guidelines or protocols on how to involve fathers in antenatal care visits.	YES NO	
Promotes and informs fathers and mothers about parental leave (or maternity and paternity leave) if it exists.	YES NO	
CLINIC ENVIRONMENT AND MATERIALS		
The facility where I work...	Y/N	If "No", action(s) to take:
Has adequate infrastructure and space to engage fathers/male partners in antenatal care visits, for example, by having an extra chair in the consultation room.	YES NO	
Has extended hours of operation for working parents.	YES NO	
Has or provides educational materials on pregnancy and childbirth specifically for fathers, or that are designed for mothers and fathers.	YES NO	
Has posters, brochures, and/or art on the walls that include images of fathers/male caregivers.	YES NO	
Provides, or refers clients to, workshops for expectant parents, which include fathers/male caregivers.	YES NO	
Has resources, such as manuals and guides, on how to engage fathers/male partners during the antenatal period, labor, and delivery.	YES NO	
Has offered me training on gender-responsive health services.	YES NO	
Has offered me training that included information on how to engage fathers/male partners in antenatal care, labor, and delivery.	YES NO	

## RAPID ASSESSMENT ON FATHER ENGAGEMENT IN ANTEPARTUM, LABOR AND DELIVERY CARE

ATTITUDES AND ACTIONS		
Questions	Y/N	If "No", action(s) to take:
I ask a woman if she would like her partner to be present at childbirth and emphasize the importance of a father's presence, if allowed in my health facility.	YES NO	
I encourage the mother's partner to be present during the delivery, with the mother's consent and if allowed in my health facility.	YES NO	
I provide guidance on how fathers/male partners can provide physical support to the mother during childbirth, for example through massage or help with breathing techniques.	YES NO	
If the health facility does not allow a father to be in the delivery room, or if a woman does not want her partner present, I update him with information on the mother during labor and delivery.	YES NO	
I encourage and explain the importance of skin-to-skin contact between baby and mother.	YES NO	
I encourage and explain the importance of skin-to-skin contact between baby and father.	YES NO	
After birth, I encourage both mother and father to hold the infant, including handing the father the infant while explaining how to hold the infant in his arms.	YES NO	
I provide guidance and information about post-natal care to both the mother and her partner and ask both the woman and her partner if they have any questions.	YES NO	

I encourage my colleagues to actively promote the involvement of fathers/male caregivers in labor and delivery.	YES NO	
I feel that I have the knowledge and skills I need to involve men in labor and delivery.	YES NO	
I am aware of national policies and/or protocols related to men's involvement in labor and delivery, including policies that promote or prohibit men's presence at delivery.	YES NO	
I am knowledgeable about the laws on paternity establishment in my country, such as registering the father's name on the birth certificate.	YES NO	
I encourage mothers and fathers to take some type of leave following the birth of the child, where possible.	YES NO	
CLINIC POLICIES AND PROTOCOLS		
The facility where I work...	Y/N	If "No", action(s) to take:
Adheres to national laws and guidelines regarding accompaniment during delivery.	YES NO	
Uses forms that record the father's/male partner's presence during delivery.	YES NO	
Has clinical guidelines or protocols on how to involve fathers/male partners during labor and delivery.	YES NO	
Informs fathers and mothers about parental leave (or maternity and paternity leave) if it exists.		
Informs/shows mothers and fathers how to register their child in the civil or population registry, and obtain a birth certificate.	YES NO	
Has protocols describing roles and procedures related to identification and management of survivors of violence with appropriate training and continual support. The facility has staff that can offer first-line support to women survivors.	YES NO	



**CLINIC ENVIRONMENT AND MATERIALS**

The facility where I work...	Y/N	If "No", action(s) to take:
Has adequate infrastructure and space to engage fathers/male partners during labor and delivery, for example, enough space and privacy for men to be present in the delivery room, or a waiting room for fathers and family.	YES NO	
Has or provides educational materials on pregnancy and childbirth specifically for fathers, or that are designed for mothers and fathers.	YES NO	
Provides father-focused parenting education materials, or materials that are for mothers and fathers.	YES NO	
Has posters, brochures, and/or art on the walls that include images of fathers/male caregivers.	YES NO	
Has resources, such as manuals and guides, on how to engage fathers/male partners during labor or delivery.	YES NO	
Has offered me training on gender-responsive health services.	YES NO	
Has offered me training or information on how to engage fathers/male partners during labor and delivery.	YES NO	

**INDIVIDUAL ACTION PLAN**

**START**

---

**STOP**

---

**CONTINUE**

## PRENATAL VISIT SCENARIOS AND STRATEGIES

**ISSUE 1: During the prenatal visit or counseling session, the man does all or most of the talking. He interrupts his partner, always speaks first, or speaks on his partner's behalf.**

### CAUSE

- The couple may be exhibiting the culturally accepted patterns of communication and decision-making for men and women.
- The man may be consciously exerting his power in the relationship, and the woman may be ceding power to avoid conflict.
- The man may be trying to demonstrate that he is competent and knows everything about the issue or situation.

### WHAT A MALE PARTNER MIGHT SAY

- "We are here because..."
- "She does not understand the problem."

### STRATEGY

- Start with the cultural norms of the setting: acknowledge the man's interest and role.
- Explain from the beginning of the session that you will need to get information from both partners - that, in fact, this is required.
- Encourage the woman to talk by directing open-ended questions to her that cannot be answered with a "Yes" or "No"
- If possible, use any information that the woman shares to admire the man's actions. He may be afraid that when his partner talks about him, the service provider will agree with her; he will be more likely to support her talking if he gets positive reinforcement based on her comments.

### POSSIBLE RESPONSE

- "I can tell you are very interested in this information (or situation), and I would like to hear what your partner thinks."
- "I would like to hear from both partners during this meeting."

### GENDER CONSIDERATIONS

- When male service providers counsel expecting couples, it is important for them to be aware of the potential for "man-to-man" interaction. This is especially true in cultures in which men make more relationship decisions than women.

- When male service providers try to draw out a female client, they need to be careful to keep the approach clearly professional.

**ISSUE 2: The man is hesitant to share information or seems disinterested during the session, and lets his partner do all the talking.**

### CAUSE

- The man may be hesitant to appear as if he does not understand the information he is getting during the session.
- The man may be unaware of his partner's feelings, thoughts, or experiences.
- The man may perceive the visit to be "for the woman" and think that he does not have a role to play.
- The service provider may be asking questions that are hard for the man to answer, such as "How do you plan to share responsibilities for child care and household work after the baby is born?"

### WHAT A MALE PARTNER MIGHT SAY

- "I don't know."
- "Everything is fine."
- "I do not really have any problems."
- "This is really her job."

### STRATEGY

- Encourage the man to share his ideas about the situation instead of about himself. Offer him a list of choices based on the nature of the situation.
- Do not interpret the man's lack of sharing as disinterest. Do not let his partner answer for him; try to actively draw him out.
- Emphasize that the man's involvement is crucial for his partner's health and the health of the baby.
- Rephrase questions more concretely. For example, "Would you like the opportunity to cut the cord during delivery?" instead of "How would you like to be involved during delivery?"

### POSSIBLE RESPONSE

- "I appreciate that you care for your partner and show it by coming in with her today. Your support is very important for her health and the health of the baby."
- "A lot of men wonder how this all relates to them. What questions do you have about your role in...?"

- “Some other men have had these questions when they came in with their partners. [List some common questions.] Which of these questions would you like more information about?”

### GENDER CONSIDERATIONS

- When the service provider is female, a man may feel as if this is “woman’s talk” or want to avoid looking “bad” in front of two women. Also, the service provider may have a prior professional relationship with the woman; if so, the provider needs to quickly address this and direct attention to the man’s participation, ensuring he feels this concerns him, the provider is addressing him as well, and he is welcome.

### ISSUE 3: One partner reveals information during the session that is a surprise to the other partner.

#### CAUSE

- One partner is using the opportunity or safety of having a third party present to reveal the information (for example, that they do not want to/want to have another child).
- The partners may never have talked about this information before and made assumptions about their partner’s knowledge or attitudes.

#### WHAT A MALE PARTNER MIGHT SAY

- “Why did you not tell me that before?”
- “I assumed you did not want me to talk to you about that.”
- “I cannot believe you hid this from me.”

#### STRATEGY

- Focus the discussion on the reason(s) the man came in with his partner to the health care facility.
- Frame the discussion as a positive opportunity for the man to support his partner.
- Assure the man that it is common for couples not to know everything about each other, and that while it can be hard to learn some things about your partner, the information they now have can help him make better decisions for his health and better support his partner’s health and his baby’s health in the future.

#### POSSIBLE RESPONSE

- “Many couples never talk about... (i.e. sex during pregnancy, childbirth, postpartum depression), so it is not uncommon for there to be misperceptions. Now that you know this about each other, you can take better care of your health, your partner’s health, and your baby’s health.”

- “I know you want to do what is best for you, your partner, and your baby. Having this information will help you do that.”
- “I know you will want to talk more about this later, but right now we can take care of this immediate issue (i.e. prenatal care, treatment decision).”

## CONTINUUM FOR ENGAGING MEN<sup>14</sup>

Programs have used many different ways to engage men. It is important to understand these because they have different goals and strengths and weaknesses. These approaches are not mutually exclusive. Some programs may promote services to men as a way of recognizing that existing gender norms force women to take greater responsibility in reproductive health decision-making and that men need to assume their share of the burden as well. Other programs may encourage men to be supportive partners after they ask men to examine what it means for them to be “men” and develop healthier views of masculinity.



**A:** Programs focus on providing reproductive health services to men in the same way as to women. If programs choose merely to provide services for men without awareness of the specific power imbalances and gender inequalities in which women and men are embedded, they miss the central point that men’s and women’s social positions constrain their reproductive roles. This approach can potentially accept men’s dominant position in certain cultural settings as a given in a focus on their needs— rather than on gender relations – to improve reproductive health.

*Ex: prioritizing contraceptive methods that put the burden on women (rather than men, or both equally) to remember and take action.*

**B:** Reflects the view that men can improve – and impede – women’s reproductive health. These programs view men as allies and resources in efforts to improve reproductive health. Although this approach makes important contributions to reproductive health, such as the focus on men as clients, it does not always address the gender inequity that constrains health.

*Ex: a program that uses counseling sessions with men to encourage them to be more involved fathers, but doesn’t challenge them to take on equal caregiving and household duties, which would address gender inequity.*

**C:** Programs at point C acknowledge the fundamental role men play in supporting women’s reproductive health and in transforming the social roles that constrain reproductive health and rights. Many interventions offer men the opportunity to examine and question the gender

<sup>14</sup> From Sonke (2011) Gender Mainstreaming for Health Managers.



norms that harm their health and that of their sexual partners. Programmes at this stage also encourage men to take action in their own relationships, families and communities.

Ex: men's discussion groups, in which they question and challenge the gender norms they grew up with and think about how they can behave differently in their own households to promote gender equality with their partner and their children.

## CASE STUDIES OF SUCCESSFUL MALE ENGAGEMENT<sup>15</sup>

### CASE STUDY #1

In the Caribbean, several pioneering interventions have reached out to men as fathers. In one country, the government has organized 13-week courses for men on parenting topics the men themselves identify. Once these men go through the training courses, they are then encouraged to come to the clinic with their partner to learn about developing better parenting and communication skills. They are also offered counseling and services related to family planning and other reproductive health needs.

### CASE STUDY #2

The word 'parent' is commonly heard (and used) to mean 'mother'. In the UK, when an invitation was addressed 'Dear parents' 20% of fathers attended a post-birth home visit. When the wording was changed to 'Dear mum and dad' and the hope that both would attend was made clear, 80% of the fathers came.

### CASE STUDY #3

Perceiving the fathers as 'the problem' allows a service to avoid reflecting on their own ways of working. In the US, when a prenatal course was not rated highly by fathers, it was redesigned. Afterwards, fathers gave and received more support, took on more housework, were more likely to 'reason' with their partner than enter into arguments, and reported improvements in their relationship.

### CASE STUDY #4

In the UK, a service for adolescents suffering from mental health problems has very high father/mother participation for no other reason than that the whole team believes in the importance of engaging with the dads and follows them up when they don't appear.

<sup>15</sup> From Sonke (2011) Gender Mainstreaming for Health Managers.

## TYPES OF GBV AGAINST WOMEN<sup>16</sup>

For health care professionals, it is important to keep in mind that GBV has many facets. Apart from physical and sexual violence that cause injuries and might therefore be easier to detect, women's experiences of psychological and economic violence should not be overlooked as they may also have significant negative consequences on women's health.

**Physical violence:** Physical force that results in bodily injury, pain, or impairment. The severity of the injury ranges from minimal tissue damage, broken bones to permanent injury and death. Acts of physical violence include:

- slapping, shoving, pushing, punching, beating, scratching, choking, biting, grabbing, shaking, spitting, burning, twisting of a body part, forcing the ingestion of an unwanted substance;
- restraining a woman to prevent her from seeking medical treatment or other help; and
- using household objects to hit or stab a woman, using weapons (knives, guns).

**Sexual violence:** Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality, using coercion, by any person, regardless of their relationship to the victim, in any setting, including, but not limited to home and work.

Acts of sexual violence include:

- rape, other forms of sexual assault;
- unwanted sexual advances or sexual harassment (including demands for sex in exchange for job promotion or advancement or higher school marks or grades);
- trafficking for the purpose of sexual exploitation;
- forced exposure to pornography;
- etc.

**Psychological violence (sometimes also referred to as emotional violence):** An action or set of actions that directly impair the woman's psychological integrity.

Acts of psychological violence include:

- threats of violence and harm against a woman or somebody close to her, through words or actions (e.g. through stalking or displaying weapons);
- harassment and mobbing at the work place;
- humiliating and insulting comments;

<sup>16</sup> Definitions come from the WHO, UN Women Glossary, and are in line with the Council of Europe Convention on preventing and combatting violence against women and domestic violence.

- isolation and restrictions on communication (e.g. through locking her up in the house, forcing her to quit her job or prohibiting her from seeing a doctor),
- use of children by a violent intimate partner to control or hurt the woman (e.g. through attacking a child, forcing children to watch attacks against their mother, threatening to take children away, or kidnapping the child). These acts constitute both, violence against children as well as violence against women.

**Economic violence:** Used to deny and control a woman's access to resources, including time, money, transportation, food or clothing.

Acts of economic violence include:

- prohibiting a woman from working;
- excluding her from financial decision making in the family;
- withholding money or financial information;
- refusing to pay bills or maintenance for her or the children;
- destroying jointly owned assets.

**Online or digital violence against women<sup>17</sup>:** refers to any act of violence that is committed, assisted or aggravated by the use of information and communication technology (mobile phones, the Internet, social media, computer games, text messaging, email, etc) against a woman because she is a woman.

Online violence can include the following.

- Cyberbullying involves the sending of intimidating or threatening messages.
- Non-consensual sexting involves the sending of explicit messages or photos without the recipient's consent.
- Doxing involves the public release of private or identifying information about the victim.

**Femicide<sup>18</sup>** refers to the intentional murder of women because they are women, but may be defined more broadly to include any killings of women or girls. Femicide differs from male homicide in specific ways. For example, most cases of femicide are committed by partners or ex-partners, and involve ongoing abuse in the home, threats or intimidation, sexual violence or situations where women have less power or fewer resources than their partner.

- Honor killing is the murder of a family member, usually a woman or girl, for the purported reason that the person has brought dishonor or shame upon the family. These killings often have to do with sexual purity, and supposed transgressions on the part of female family members.

Further, women and girls may experience harmful practices such as child/early marriage, forced marriages, FGM or gender-biased sex-selection that make women and girls vulnerable to GBV.

**Early/child marriage:** is a marriage in which one or both spouses are under 18 years old. Child marriage is a serious human rights violation that directly threatens lives, health, safety and education of girls and boys, limiting their future prospects.

**Gender-biased sex selection:** it is when a couple or family prefers having a son over having a daughter. It is a harmful practice and a manifestation of gender inequality. It directly impacts the sex ratio at birth (SRB) between girls and boys.

**Bride kidnapping: marriage by capture,** is a practice in which a man abducts the woman he wishes to marry by grabbing and coercing her to come with him. This is one of the forms of forced marriage and serious human rights violation against women.

**Female genital mutilation/cutting:** All procedures involving partial or total removal of the external female genitalia or other injuries to the female genital organs for cultural or non-medical reasons.

## SCENARIO: PREGNANT SURVIVOR OF VIOLENCE<sup>19</sup>

Maya is 35 years old. She has been married for 10 years. She has two children aged 7 and 4 and is pregnant with a third child. Maya works in a garment factory sewing clothes for a big foreign company. Her husband Lee works for an automobile manufacturing factory. Soon after their younger child was born, Lee started beating her and eventually forcing her to have sex. This has continued for many years and has grown worse. Lee's drinking has also grown worse over the years. One day when she had to stay late to sew clothes for a big order, the garment factory manager dropped her home. Lee saw them together and became jealous and very angry. He beat her so badly that her arm got fractured, and she had a big gash on her forehead, bruises everywhere and a swollen black eye. Her children saw this and became very scared that something would happen to their mother. Maya could not take it anymore. She was afraid for her life and for her unborn child and decided to take some action. She decided she would tell her doctor and midwife at the next prenatal appointment, which her husband was not attending.

<sup>17</sup> <https://www.unwomen.org/en/what-we-do/ending-violence-against-women/faqs/types-of-violence>

<sup>18</sup> Ibid

<sup>19</sup> Modified from <https://www.who.int/reproductivehealth/publications/exercises-resources.pdf>

## GUIDING PRINCIPLES FOR WORKING WITH GBV SURVIVORS<sup>20</sup>

### SURVIVOR-CENTERED APPROACH

Means recognizing and prioritizing the rights, needs, and wishes of the person who has experienced gender-based violence. A survivor-centered approach creates a supportive environment, ensures safety and dignity to promote a survivor's recovery, and reinforces the survivor's capacity to make decisions about possible interventions.

### SURVIVORS' FUNDAMENTAL RIGHTS

Survivors have the right to:

- Give verbal or written consent before any action, referrals, or medical exams or support is provided
- Choose and decide whether, when, and which services they need
- Seek any support, free from coercion, and change their minds at any time
- Access chosen support in a safe and discreet way that is comfortable for them, and be accompanied by a trusted person, if requested
- Have a safe space to talk
- Choose the sex of the person providing the service
- Disclose or not disclose their story

### GUIDING QUESTIONS

When a survivor is referred or comes to you, use these questions to guide your assessment of the person's immediate needs:

- Would you prefer talk to a man, woman, or non-binary staff?
- What are your immediate needs?
- Have you eaten something today or in the last 24 hours?
- When was the last time you slept or got a full night's sleep?
- Do you need any health services or a doctor's appointment?
- Have you felt in danger or unsafe in the last week or the last 30 days?
- Do you feel like anyone you live with is in danger or unsafe?

- Can you tell me who or what is making you feel unsafe?
- Can you tell me what makes you feel safe?
- How do you think I might be able to assist you?
- Would you be open to answering more questions or would you like to take a break?

### DO NO HARM PRINCIPLES

#### SAFETY

It is essential to ensure the safety of the survivor and their family at all times, including their children and people who have assisted them.

#### CONFIDENTIALITY

Respect the confidentiality of survivors (and their families) at all times by not disclosing any information, at any time, to any party without the informed consent of the person concerned. Ensure the survivor's trust and empowerment.

#### RESPECT

All actions or decisions should be guided by respect for the survivor's choices, wishes, rights, and dignity.

#### NON-DISCRIMINATION

Survivors should receive equal and fair treatment, regardless of their age, sex, race, marital status, sexual orientation, or any other characteristic.

#### HONESTY

Survivors should receive honest and complete information about possible referrals for service, be made aware of any risks or implications of sharing information about the situation and have the right to limit the types of information shared and whom it is shared with.

<sup>20</sup> Lightly modified from Messner, L., A. Odukoya, G. Osakue, E. Otiye-Igbuzor, D. Santillán, and S. Byrne. 2018. Gender Integration and Gender-Based Violence Prevention and Response: Training Manual. Arlington, VA: Strengthening High Impact Interventions for an AIDS-free Generation (AIDSFree) Project.



## HEALTHCARE WORKER RESPONSE

### DO

- Be aware of your body language. How you stand and hold your arms and head, your expression, and your tone of voice all send a clear message about how you perceive the situation.
- Explain who you are, your role and responsibilities, and that you are there to support the survivor.
- Ask what would make the survivor feel safe right now and whether they have any immediate needs they would like your help in fulfilling.
- Use a survivor-centered approach and seek permission from the survivor to ask questions about their experience. Remind the survivor that they do not have to answer a question if they choose not to. Explain why you are interested and how you will use the information to support them. Emphasize that nothing they say will be used against them, and that they can choose to participate in the conversation or not.
- Reassure the survivor. If they choose not to disclose, that is their right and they have full choice over their participation. Ask whether there is anything they would like to ask or tell you. This helps take the pressure off the survivor and empowers them to take the lead in the conversation.
- Explain that all information will remain confidential and inform the survivor about any limitations to confidentiality.
- Tell the survivor they can take a break whenever they want and can refuse to answer a question.
- Use eye contact and focus all your attention on the individual. If you must write something down, at the beginning, explain that you have to write notes from time to time, why this is important, and how written information will be used to ensure the survivor gets the best services possible. You can also remind them of this whenever you note something down.
- Show a nonjudgmental and supportive attitude and validate what the survivor is saying.
- Use an empathetic voice to reassure the survivor.
- Listen carefully to the survivor's experience and assure them their feelings are justified.
- Show the survivor you believe their story, commend them for doing what they needed to do to survive, and recognize their courage and resiliency.
- Be patient, keeping in mind that the survivor is in a state of crisis and could have contradictory feelings. The survivor also might not be able to remember some things, such as an accurate timeline of events.
- Emphasize that violence is not their fault and that the perpetrator is responsible for their own behavior.
- Use supportive statements, such as "I'm sorry this happened to you" or "You have really been through a lot" or "We're going to try and get you some help."
- Highlight that options and resources are available to the survivor. Emphasize that they can choose which services they want to receive and can change their mind at any point.
- Try to find adequate services together with the survivor. Leave an "open door" for the survivor to come back to you.
- Create a safety plan so the survivor can continue accessing services without jeopardizing their safety. If the survivor lives with the perpetrator, you might need to help the survivor think through times they can access services. Ask whether it is safe to text or call, or you should wait for them to contact you. Do not give materials to take home unless you talk through the impact. For example, if the perpetrator could get upset, it might be best to create time in the office for the survivor to read through the materials.

### DON'T DO

- Use body language that conveys a message of irritation, judgment, accusation, boredom, shock, dislike, or anger toward the survivor.
- Judge a survivor's behavior based on their age, appearance, clothing, culture, religion, type of work, or relationship to the perpetrator. There are no reasons for gender-based violence.
- Pressure the survivor to disclose.
- Make any promises you cannot keep.
- Suggest or force couples counseling or mediation between a survivor and the perpetrator. This can be traumatizing and is known to be an ineffective method.
- Ask about violence in the presence of a partner, family member, friend, or anyone else unless the survivor suggests it. The survivor's safety is the key.
- Rely on passive listening and non-commenting. This could make the survivor think you do not believe them, or that they are wrong and the perpetrator is right.
- Interrupt the survivor (for any reason) when they are talking.
- Accuse the survivor of making contradictory statements. Trauma can make it difficult to remember all the facts or timelines, and they could feel one way about the experience one day and completely differently another day. Your job is to listen and try to piece together the puzzle; you might never know all the details. Gather only as much detail as you need to provide services or support. Only ask questions that will help you assess the services and support the survivor needs and deserves.
- Blame the survivor or ask questions like "Why do you stay with your partner?" (if the partner is the perpetrator) or "Did you have an argument before it happened?" or "What were you doing out alone?" or "What were you wearing?" Instead, reinforce that gender-based violence is a violation of their rights and is never acceptable.
- Ask the same question multiple times. If you do not get an answer, keep the conversation going. You can try to rephrase later, once you have built more rapport with the survivor.

## INSTITUTIONAL ASSESSMENT

FACILITY APPROACHABILITY		
Questions	Y/N	If "No", action(s) to take:
Does the name of the facility seem welcoming to men?	YES NO	
As you approach the facility, is it obvious that it is a suitable place for men and women to seek prenatal care services?	YES NO	
Does the gatekeeper or guard know about all services that are available for men and women seeking prenatal care?	YES NO	
SERVICES PROVIDED		
Questions	Y/N	If "No", action(s) to take:
Is there a sign or poster indicating that prenatal care services welcome men?	YES NO	
Is there a sign or poster indicating that men can come with their partners for prenatal care services?	YES NO	
Does the sign or poster indicate the types of services offered for men?	YES NO	
Are brochures and handouts with information for men about prenatal care readily available?	YES NO	
Are brochures and handouts with information for men about how they can be involved as partners in SRH readily available?	YES NO	
Does the receptionist know about all services that are available for men and women seeking prenatal care?	YES NO	
RECEPTION/WAITING AREA		
Questions	Y/N	If "No", action(s) to take:
Is it a comfortable environment for men (as opposed to catering more to women or children)?	YES NO	
Are magazines, newspapers or other items that appeal to men readily available?	YES NO	

Are brochures, pamphlets, posters, or other client education materials that focus on male engagement in prenatal care readily available?	YES NO	
Is the area clean, neat, and efficient-looking?	YES NO	
Do you see any other male clients in the area?	YES NO	
Do you see any male staff members?	YES NO	
Is a men's bathroom available?	YES NO	
Is it clear where you would go if you were coming with your partner for prenatal services?	YES NO	
Does the staff appear to be polite and respectful towards men?	YES NO	
SERVICE AREAS AND EXAMINATION ROOMS		
Questions	Y/N	If "No", action(s) to take:
Is it a comfortable environment for men (as opposed to catering more to women or children)?	YES NO	
Are brochures, pamphlets, posters or other client education materials that focus on male involvement in prenatal care readily available?	YES NO	
Do you think you could speak confidentially with a service provider or counsellor here, without being seen or overheard?	YES NO	

# INSTITUTIONAL ACTION PLAN

GOAL:

ACTIVITY	TIMEFRAME	BUDGET	RESPONSIBLE

PHOTO: RIDO / SHUTTERSTOCK.COM







## **ANNEX 3: DAILY ASSESSMENTS**

PHOTO: MOTORTION FILMS/ SHUTTERSTOCK.COM



## MODULE 1

I KNOW OR UNDERSTAND...	NOT AT ALL	SOMEWHAT	WELL
Why gender matters in public health			
The difference between sex and gender			
What gender norms, roles, and relations are			
What the difference between gender equality and gender equity is			

## MODULE 2

I KNOW OR UNDERSTAND...	NOT AT ALL	SOMEWHAT	WELL
What the benefits of male engagement in prenatal care are			
What the barriers to male engagement in prenatal care are			
How to engage men during prenatal visits or counseling sessions			
How to identify where an activity falls on the Continuum for Engaging Men			

## MODULE 3

I KNOW OR UNDERSTAND...	NOT AT ALL	SOMEWHAT	WELL
How to translate the learning on benefits, barriers, and good practice in programming to my work			

PHOTO: SANDSUN / SHUTTERSTOCK.COM







## ANNEX 4: TRAINING EVALUATION FORM

Please note that your name does not need to appear anywhere on this evaluation form.

Please answer these questions truthfully, as it helps the organizers make the training better for other participants and groups in the future.

### GENERAL INFORMATION

Date:

Name of health facility:

Comments on the training



	AGREE	DISAGREE	NOT SURE
I found the training useful			
I have received new information I did not know before the training			
The training has made me think about some of my attitudes			
I think that the training would be useful to other people I know			
I will recommend to my colleagues that they attend the training			
I was informed of the dates and venue of the training well before the training			
I was told about what the training was going to cover before I attended the training			
The workshop venue was appropriate for the training			
The facilitators were well prepared for the training			
The facilitators were knowledgeable about the subject matter			
I was able to contribute to the different sessions of the training			
The training covered the issues about which I wanted to know			
The facilitators were able to answer the questions asked by participants			
The facilitators used interesting teaching techniques, such as group work, games, and role playing			
The facilitators made difficult issues easy to understand			
The training was fun			
All participants were encouraged to participate in the training			
I was able to understand the issues presented in the training			
The training has covered all the important issues			

**ADDITIONAL COMMENTS**

I found the following session(s) to be most useful:

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I found the following session(s) to be least useful:

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 -----  
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What would you suggest to improve this training?

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Other thoughts?

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 -----  
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# **ANNEX 5: PRESENTATION SLIDES**



This programme is funded  
by the European Union



**TOGETHER AGAINST  
GENDER STEREOTYPES AND  
GENDER-BASED VIOLENCE**  
#eu4genderequality