An integrated holistic approach to women's sexual and reproductive health

AIDOS experience in the Middle East and its methodological tools

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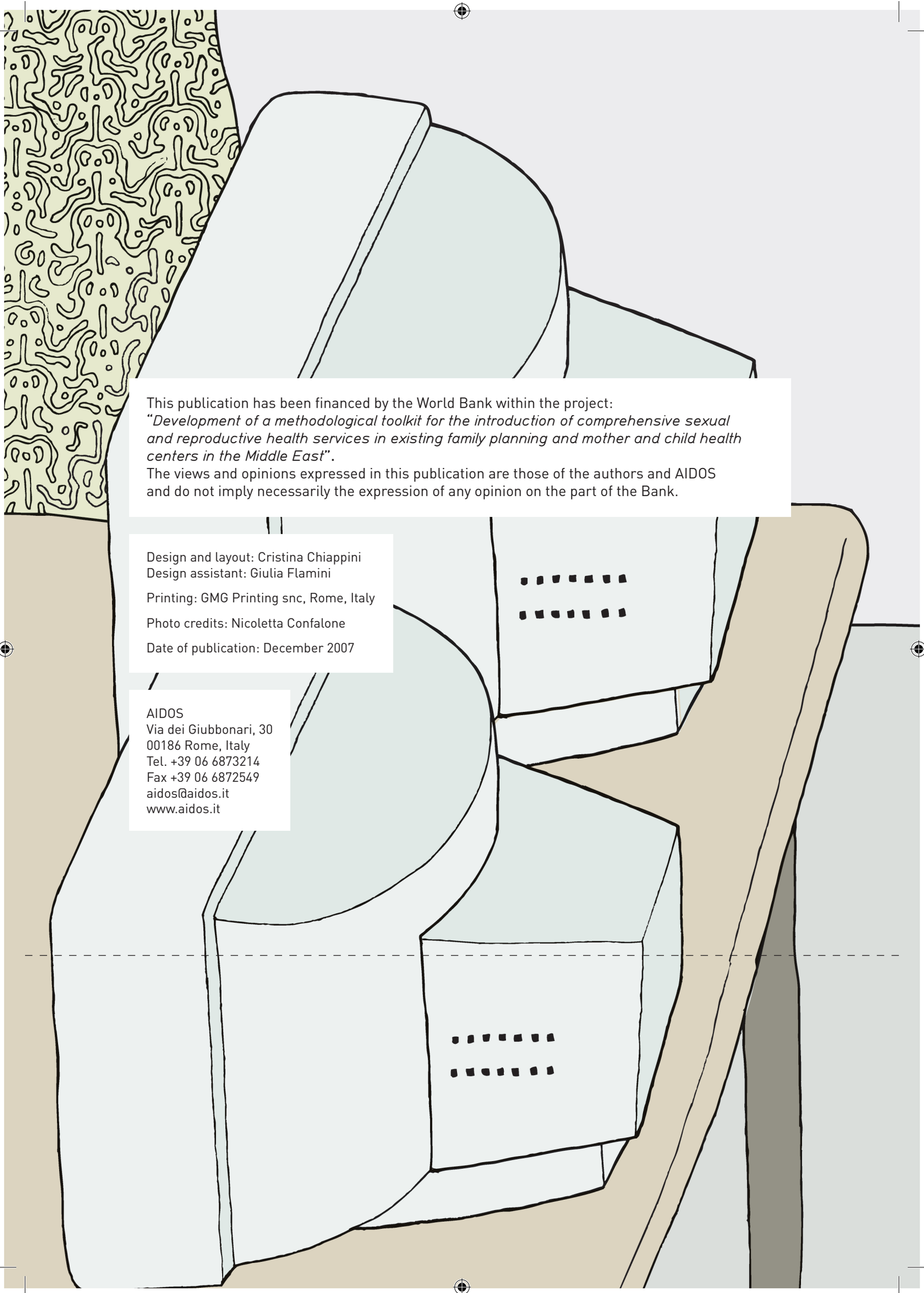

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Introduction

Most development projects in the health sector deal with women's reproductive health only in terms of maternity and/or family planning. However, women's reproductive health care plays a pivotal role in development not only in relation to children but also as a basic requirement for ensuring women's full and active participation in the process of social change.
The methodology adopted by AIDOS in reproductive health projects focuses on a holistic approach. This approach not only takes into account actual health care but also prevention and education. The basic assumption underlying this approach is that a person's well-being comes from the harmony of its being: on a physical, psychological and spiritual level. In this case, a woman is not only considered in her "reproductive" role, as a wife and a mother, but rather as a human being whose state of health goes through her entire life cycle from adolescence until after menopause and whose well-being depends upon many factors. Certainly, among the factors which influence a person's well-being, particularly that of a woman, is to be able to freely choose how many children to have and when to have them.
AIDOS activities in the field of sexual and reproductive health and rights SRHR have focused on four fundamental approaches:
a) the creation of women's health centers;
b) the technical and organizational support for national campaigns on female genital mutilations / cutting (FGM/C);
c) information on population and reproductive health issues to media, political and government institutions; d) advocacy. AIDOS conducts intense advocacy actions on sexual and reproductive health and rights (SRHR) at national, European and international levels both as an individual organization and as partner of networks in order to promote specific political and funding commitments and mainstreaming SRHR in global health. These activities address a wide range of decision and policy makers and health experts at the relevant Ministries (Ministry of Foreign Affairs, Economy and Finance, Health), MPs at national and European level as well as other stakeholders, including representatives of the private sector.
From 1994 to 2007 AIDOS has established eight women's health centers in seven different countries, such as Argentina, Palestine, Nepal, Venezuela, Jordan, Burkina Faso and Syria. The project in Jordan, in the Sweileh area of Amman, has consisted in the upgrading of a Mother and Child Health Care Center, while the one in Venezuela, in Barquisimeto, has consisted in the upgrading of a family planning structure as well as the one in Syria.
In the health structures created by AIDOS together with its local partners, the medical service is complementary to a gamut of social services. Besides medical staff, in the Centers there are also a psychologist, a social worker, a lawyer, a men counsellor and field workers. To meet the needs of the local population,

especially those expressed by women, the Centers created by AIDOS offer a variety of services ranging from medical specialties like gynecology, obstetrics and family planning to psychological and legal counselling in cases of domestic violence, to health education seminars on nutrition, hygiene, adolescence and sexuality, prevention of sexually transmitted diseases, HIV/AIDS and more.
AIDOS extensive know how in setting up women's health centers is rooted in the practical experience of Italian women's movement during the 70s when women activists first conceived of health structures that specifically catered to women's needs and finally succeeded in having a national law on reproductive health counselling centers approved. This approach recognizes the importance of concentrating social health services related to contraception, procreation and maternity into one single structure, envisioning a global approach to women's health, both physical and psychological, at the individual and collective level. One of the innovative aspects of these structures is also the introduction of specialized legal assistance for dealing with the violation of women's rights.
The other major contribution to AIDOS work in the field of reproductive health was given by the 1994 International Conference on Population and Development draft Program, which states that "to realize their full potential, women must be guaranteed the exercise of their reproductive rights and must be able to manage their reproductive roles". Reproductive health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes." Reproductive health implies that people are able to have a satisfying and safe sex life and that they will have the capability to reproduce and the freedom to decide if, when and how often to do so. Women and men must be provided with the necessary information and services to exercise this right, according to the draft Program.
All AIDOS reproductive health projects are strongly anchored and adapted to the social and cultural characteristics of the population of the country, also drawing on the local partners' experience and strengthening their know-how. On such grounds, AIDOS projects are innovative, as they utilize and implement a holistic approach to women's health integrating the medical components with the psychological and the social ones.
On the basis of the UNFPA guidelines, all the centers have implemented a gender-based violence (GBV) component aiming to raise awareness and the links between gender and violence; to prevent the most common forms of violence against women (childhood sexual abuse, rape and domestic violence); to screen all women Users of the center; to provide diagnose and treatment all those who disclose that they have been victims.
The promotion of men's comprehension of and involvement in women's reproductive

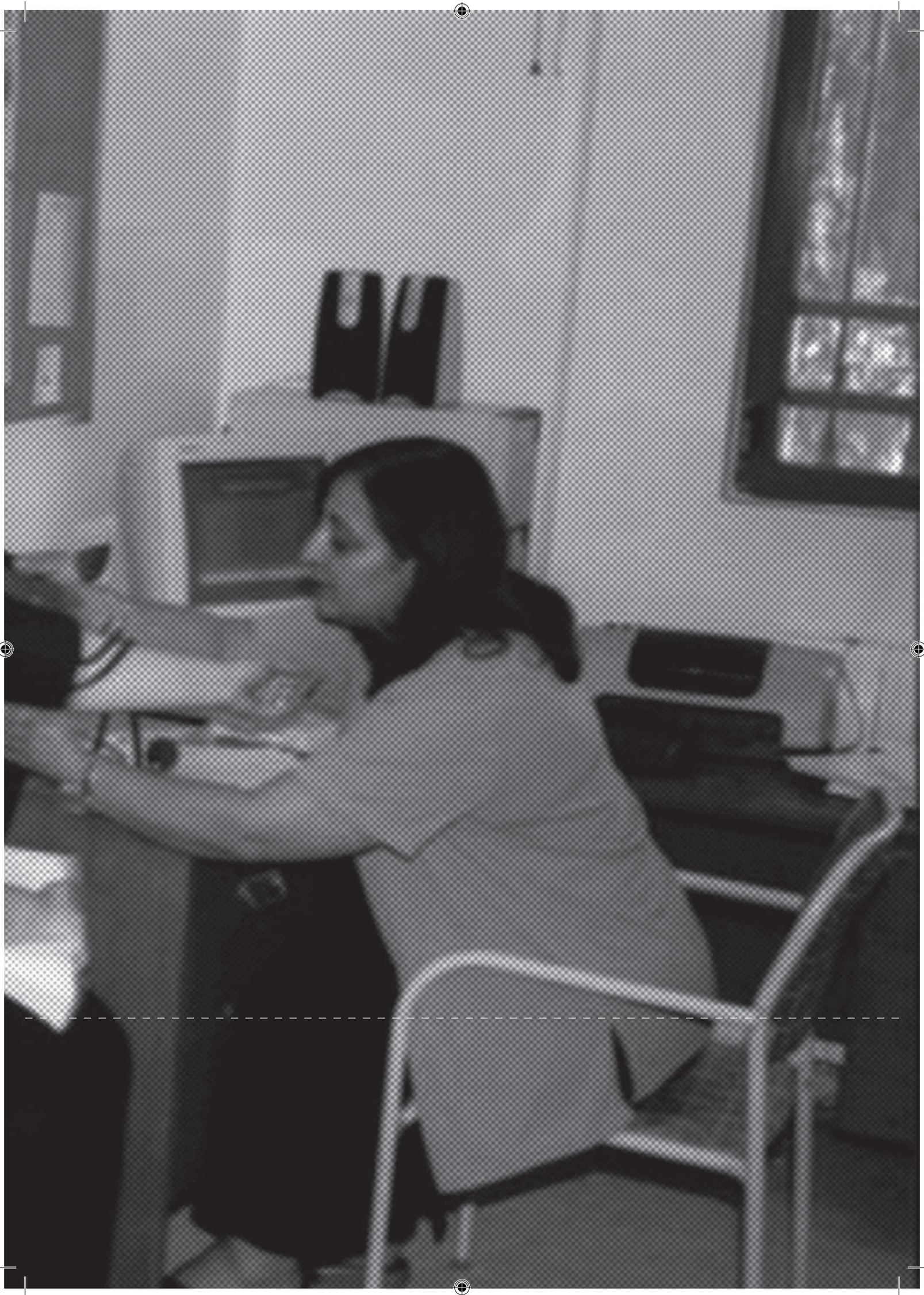
health issues are very innovative and relevant components of AIDOS projects, which are based on a gender perspective of sexual and reproductive health considering both the contributions as essential. Thus the centers involve men as essential partners in decision-making concerning reproductive health choices and promote men's support to women's empowerment in order to create a better family environment.
Moreover, given the high rates of early pregnancies and adolescents' low awareness of gender and reproductive health issues, all AIDOS projects favor sensitization practices addressed to adolescents, by offering individual counselling as well as workshops and group sessions, which include also bodily activities such as yoga, relaxation, reflexology, gymnastic. Moreover, awareness-raising activities are implemented, especially by involving school students or adolescents' family members in order to sensitize them on the problems related to that age.
For all these reasons, the involvement of the community is key to an effective implementation of the projects, as this facilitates the relation and reciprocal understanding between the center's staff and the surrounding community, the knowledge of their needs and concerns and the center's ability to respond to them.
This is generally achieved through education and participatory activities, such as workshops and seminars, often organized outside the center within the community itself.

In all projects, AIDOS has been the executing agency responsible for providing technical and professional assistance to the implementing agency, through missions of international experts/trainers who carry out either on the job training or structured training activities for the local staff according to the identified needs. The aim is to strengthen the local counterpart so as to enhance its ability to autonomously manage and sustain the project in the long run.
In the various countries the local partners have the responsibility for implementing all activities, including the conception and detailed planning of services, work for strengthening the linkages with the Government Institutions and local NGOs and collaborate with AIDOS in monitoring the progress and preparing reports.
The Centers established by AIDOS with local partners continue to operate after the end of donors' funding. A sustainability plan is an essential component of the projects and the various facilities have reached different levels of financial sustainability, depending on the social conditions of the population they serve. In case full financial sustainability is not reached, AIDOS keeps supporting the operational costs of the Centers with private funds.
AIDOS positive experience of reproductive health centers in the Middle East, Latin America, Asia and Africa and the particular successful implementation of projects for the upgrading of existing FP and MCH structures (Jordan, Syria and Venezuela) into reproductive health centers with an integrated/holistic approach have

stimulated the idea of sharing this experience with other actors in the area of sexual and reproductive health in the Middle East.
The methodology adopted by AIDOS has proved to be flexible and adaptable to different cultural contexts and this methodological tool promotes the applicability of the methodology of integrated and holistic approach to reproductive health to existing health public and private structures resulting in a strong value added and in the adoption of a common and effective approach to sexual and reproductive health.
The experience of the Institute for Family Health (IFH) in Jordan has been particularly successful and is the basis for the development of this innovative skills sharing and capacity building methodological tool kit.
The Institute for Family Health (IFH), formerly known as the Institute for Child Health and Development, was established in 1986 as a national center for disabled and underprivileged children. The Institute was Jordan's first and only facility to monitor and assess child growth and development.
The Institute included a model mother and child health clinic that offered primary healthcare services and a Child Development Unit (CDU) that assessed and supervised treatment of child disabilities.
Almost twenty years into its history, IFH evolved into a complex organization, providing a variety of services ranging from family health care, to women well-being and family planning.
It has done so thanks to the financial support and technical assistance from various donors, sponsors and partners. Technical assistance was mainly provided by AIDOS' experts in the specialist fields relevant to the upgrading of the ICHD/IFH into a Health and Counselling Centre (HCC), a 53-month process that started in February 2002 and contributed towards the technical and methodological sustainability of IFH-HCC.
With co-financing from the European Union, the United Nations Population Fund (UNFPA), the Italian Region of Sardinia, the Noor al Hussein Foundation and the co-financing and technical expertise from AIDOS, the Institute expanded its scope to serve as the first women's Health Counselling Center in Jordan. The HCC responds to women's health needs throughout their life cycle and provides clinical services; antenatal care; postnatal care; family planning services; psychological, social and legal counselling; socio psychological counselling for men; health education activities groups; counselling, reflexology, yoga and gym services and nutrition.
In addition, IFH implements an outreach program through site visits to Sweileh, Salhoub, Marsa, Abu Nuseir and Shafa Badran areas.
The Institute experience has been highly recognized in Jordan. UNFPA regional office selected the IFH as a model institution to carry out training of health workers on several SRH subjects including GBV. On the occasion of a visit to the Institute in November 2004, the Jordanian *Minister of Health* has expressed his appreciation for the Institute work and recommended the

replication of such experience within other Jordanian health structures.
This publication intends to present AIDOS experience and methodology with the aim of strengthening the capacities of governmental institutions and NGOs working in the reproductive health sector to plan, design and implement reproductive health activities with an integrated and holistic approach and upgrade existing family planning and mother and child health centers, through an innovative skills sharing and capacity building methodological tool kit.
In particular, this methodological tool intends to contribute to strengthen the capacity of Middle East public and private health structures to:

- adopt an integrated/holistic approach to SRH and apply the quality and continuity of care concept;
- improve the physical well-being and reproductive health of women and adolescents and increase access to the entire range of reproductive health services;
- increase fertility regulation by choice and responsible procreation among women and men; decrease teenage pregnancy rates;
- decrease maternal and child mortality and improve delivery conditions and infant health.
- improve psychological well-being of women, increase awareness of gender based violence and reduce its incidence;
- increase active participation of women in decision making process and increase awareness of their legal rights;
- increase men's support to women's empowerment and improve family environment;
- decrease percentage of early marriages and promote a more responsible sexual behavior among adolescents;
- enhance community awareness of all aspects of reproductive health and gender relations; reduce spread of STDs and HIV/AIDS;
- increase attention and care of the government bodies to the RH, continuity of care and GBV in their policy.



1.1 AIDOS concept of "Health care"

AIDOS work in Sexual and Reproductive Health Centers (SRHC) and Health Counselling Centers (HCC) established in various countries (including: Argentina, Palestine, Jordan, Nepal, Venezuela, Burkina Faso, Syria) was grounded on the belief that health care, and more specifically women's overall psychological/ physical well-being, should be based on an *equal* service provider-User level and not on an unequal operator-client relationship.
In effect it should take into account a range of material, organization and emotional factors and situations.
These closely linked elements can or should "bring out the meaning and value of health care work, in the same way they contribute to underlining and streamlining operations and consistent actions, as well as enhancing the development of professional awareness for the service providers [...]."
(G. Colombo, Active Birth expert, Head of Montessori Birth Center Rome 1995)
The main aim of this holistic health care approach is to encourage those women who attend AIDOS Centers to consider themselves "active" counterparts – worthy of consideration in a totally balanced system of relating (where both service provider and User are considered equal, although with different skills) and never in an "uneven" relationship (where the service provider is considered superior and consequently the relationship is un-equal). Only when this kind of health care process follows such equal models can a health activating process occur. At the same time this can reveal unrealized skills and resources which had been previously unexplored.
The second aim of this health care strategy is to develop an "active offer" process: by enabling women to becoming aware of their right to knowing and all the implications of their choices affecting their reproductive and sexual health.
Professionally skilled service providers are the basis of this health care strategy and consequently the training, which prepares and accompanies their work, is fundamental.
This extremely delicate process often requires months of preparation to attain a profound understanding of the objectives. In effect nowadays we can see the birth of a new generation of service providers who, on the one hand, have identified personalized strategies for applying new health care principles and, on the other hand, also *"restructure"* the traditional hierarchy they had finally achieved in their respective professions (as gynecologists, psychologists, nurses, social workers or health center directors) by changing their relationship within it. For them, being aware of also being potential Users, often with the same needs, nearly always contributes to them overcoming the more traditional "unequal" approach.
Women have started developing the will to listen to others with the right kind of empathy, and adopting an "active" approach; offering both information and a specific kind of attentive ear: extremely personal and customized, for that specific woman within that particular family context and in that specific community.
This kind of health care is also much more than just "therapeutically efficient" as it has enabled AIDOS on the one hand, to identify

and highlight ways to convey the concept of the *Right To Health* throughout women's sexual and reproductive life and, on the other hand, to work at detaching women from a subordinate "aid" or being assisted mode which too often reigns in developing countries for historical reasons.
AIDOS profoundly believes that capacity building is really an instrument for both development and long-term peace. In effect, empowerment – that is developing and supporting all women's capacities and resources, promoting skills, awareness and self-esteem - is the foundation for constructing "peace"; it contributes to this by developing and respecting all the different stages of sexual and reproductive health: from the decision to have a baby, to a 'non-violent' birth which fully respects the rhythms and desires of both mother and baby.
Robin Lim, a midwife from Bali, Indonesia, has always worked with under-privileged women and declares that 'peace is built one baby at a time", by helping mothers and their babies to be born in healthy and respectful conditions.
In developing countries AIDOS has also learnt from women and their experiences: if the underprivileged and poor women are guaranteed the right to health care, kindness and to become actively creative with their bodies, AIDOS facilitates their becoming bringers of peace and conveying this to future boys and girls, by providing them with the necessary idiom to continue in its construction.
These are the various starting points that also enable to firmly ground the programme against Gender Based Violence (GBV). This programme in fact follows UNFPA guidelines and evolves from initially introducing the concept to a more in-depth study and runs parallel to promoting the principles of sexual and reproductive health.

1.2 Cross-cultural exchanges: turning "Differences" into "Values"

Cross-cultural exchange is one of the mainstays of this methodology; an indispensable instrument for verifying how much comparing and confronting different health care approaches, because they are generated by different cultures, contributes to building up knowledge of each party to encourage change.
Exchanging Know-How also contributes to establishing equal relationships.
Over the years AIDOS has managed to identify *"cultural decentralization"* as that "physiological" change in women from host countries when they wholeheartedly make this integrated holistic approach their very own. Symmetrically, when AIDOS as trainer finally becomes steeped in those different cultures, religions and social types of organizations, AIDOS experiences it too. During this often long and complicated phase, different cultures face each other to explore and re-draw the boundaries between the de-legitimisation of women and their roles developed by different cultures and religions, and women's right to exist and express themselves as active parts of their live. So, despite different cultural backgrounds, women together can really envisage different strategies for change after skimming off all the conditioning highlighted from that challenging comparison.

80% of Palestinian women can become pregnant even ten times, in intervals of more or less a year at a time. Pregnant Palestinian women in AIDOS projects have helped AIDOS to understand the range of forces at work within the refugee camps (El Bureij and Jabalia) and above all they helped AIDOS understand the two fold value of cross cultural exchange. Pregnancy in Gaza has a two-fold importance. It is both an act of survival and politics. The main objectives are occupying as much land as possible (the territories) and generating the highest number of children to help defend themselves from others and not being left by alone. Pregnancy therefore is both a family and social event and also a unique expression of female potential.

So through exchanges AIDOS discovered that just as conviviality between women fosters the concept of *"maternage"* (belonging to a kind of motherhood) to be experienced to the full, at the same time women are not free to choose when to have children and experience them in their own time and maybe even next to a loving partner. This is how the idea of women's groups of different ages (adolescent, fertile or menopausal) came about. They are information sharing and mutual support groups. These interactive encounters are opportunities for suffering and conflicts to be shared, and talents and qualities to be discovered. Creativity and becoming aware of one's body also originates through play, relaxation practices, breathing exercises, yoga, massage, reflexology all contribute to understanding the body and taking care of it. These groups also give women the opportunity to relive experiences of aggression and also release pent-up feelings through play, role-playing, farcical and cultural enactments of typical stereotypes.

Originally AIDOS programs were ultimately instruments to foster and increase self-esteem. Over the years these groups have evolved and refined their approach in promoting Health Care (with their way of relating and *self-awareness*) and also become 'key' to entering any host community.

The experience of the Gaza groups represent an example of cross-cultural exchange as an instrument for health care: especially when Palestinian women discovered that Western women used belly dancing to prepare for childbirth; a function which had in fact been "concealed" from them (belly dancing stereotype limited it to merely an instrument of seduction). Now these ancestral movements can contribute to a more mindful approach to delivery by controlling labor pains and how the fetus passes through the birthing channel in those same labor rooms where normally free movement was hampered by heavy clothing worn to avoid the shame of showing one's body.

A symbiotic exchange and a univocal integration had taken place between those who had culturally owned these techniques and their meanings, and those who had adopted and re-elaborated them to manage a type of suffering. This is how AIDOS introduces talking about the body, how it moves and functions.

1.3 Prevention

Any talk about prevention in areas where even emergency management overwhelmingly pervades aid programs (not just health assistance) casts its long shadow reducing the possibility of prevention programs where they should be promoted most, for poorer women. However, although AIDOS normally works in non-emergency situations, its methodology has also been successfully implemented in emergency situations too (as in for instance the experience in the Gaza Strip).
AIDOS program is in two parts, often parallel.

- **The first phase** consists in sensitizing the public health system and institutions of the host country to activate those means and resources required for specific programs (for example, post pap-test cytological diagnosis of cervical cancer test slides). Very often this process is difficult and time-consuming and consequently ensuring a high level of health care (in this case a proper cytological diagnosis) and keeping costs down can become very problematic. AIDOS has found that to off-set these problems, its approach of setting up a network of integrated services across the territory based on low-cost referral and exchange programs is often a reliable solution to this problem. Consequently Users can be referred to other organizations or hospital institutions for services that the Center does not provide and those same institutions can in exchange, send their Users for instance to follow ante-natal courses.
- **The second phase** aims at developing prevention campaigns on different subjects often linked to SRH programs. Such prevention campaigns promote solutions to a range of health problems that affect women throughout their life cycle (e.g. for cervical and/or endometrial tumors, breast and menopausal syndromes, osteoporosis). Whenever possible these campaigns are organized in conjunction with sections of the public health sector. These are also organized with an interactive user-friendly approach; so that information is transmitted, yet any anxieties linked to "ignorance" are at the same time minimized.

AIDOS methodology has established that a good prevention program is an essential key towards empowerment; prevention means being informed and as a result, promoting one's own health based on an informed choice. It also means being responsible for one's own body and embarking on a *Therapeutic Pact*, having consciously chosen both service provider and type of treatment.
All these stages are aimed at making women responsible for their own bodies, thus contributing to their empowerment and becoming "active" subjects.
In the long term this holistic approach which aims at developing an effective prevention approach may also result in the containment of costs for individual Users but also society and consequent with obvious advantages for the community as a whole.

1.4 The Principles of this Methodology

Over the years AIDOS approach to women's health has evolved by emphasizing the importance of improving relations within the couple and household, through education to health within the framework of a gender approach.
Consequently AIDOS has established this methodology with a comprehensive approach for Sexual and Reproductive Health, which requires a set of definitive conditions called "best practices".
The list below concerns those for establishing and upgrading Sexual and Reproductive Health Centers/Health Counselling Centers.

1.4.1 Quality of Care

It has been widely shown that high quality care also increases demand for Sexual Reproductive Health Services (SRHS), especially among the most marginalized women with less specific needs.
Good quality care implies:

- **customized assistance**. This is not just about a diversified approach based on different ages and/or sex, but about how different instruments and quality relations are used depending on the different social, cultural and religious backgrounds of those seeking assistance.
- **non-standard timetables**. Sufficient time must be given for counselling: in AIDOS Centers counselling never lasts less than an hour on whatever subject: be it contraception, ante-natal counselling, psychological or legal support etc.
- **service provider technical skills**. This is fundamental and always combined with motivation and involvement.
- **building up inter-personal relations between service providers and Users**. AIDOS likes to define this relationship a "Therapeutic pact". However the way it evolves depends on how it is managed, how resources are allocated and the User/service provider ratio. This is why clearly defining separate roles for each service provider is always important as soon as program implementation starts. This fulfils one of the main aims of AIDOS approach as overlapping roles and skills can only create confusion and inhibitions as the User must be able to clearly identify the service provider with whom they embark on their health care process.
- **planning strategies to promote continuity of health care**. The Outreach Program consists of work in the community, home visits, getting community leader support and is fundamental for establishing initial requests and part of the re-assessment/ clinic audits and/or baseline survey.
- **a variety of services**. As befits a holistic approach and above all to address AIDOS definition of Sexual Reproductive Health which promotes the rights of women as people, their right to sexual self-determination and which also considers the interaction between the physiological, social, religious and psychological

aspects of each woman. The active offer of a variety of services, from the strictly medical to those required in addressing gender based violence or promoting a playful approach to bodily awareness like physical exercise or yoga, is fundamental in making this "Therapeutic pact" endure over time.

- **activating skills**. For AIDOS this is the most important aspect of any empowerment process. Any good health care always activates skills and never dependence, paradoxically any successful evaluation of this health care process is linked to "number reduction": if more women return asking for the same information or counselling, the more questions are raised on how AIDOS support can be improved and achieve real "empowerment". Quality health care and upgrading have only been veritably achieved when established in the interests of Users and not just because our narcissism as "service providers who produce good health" needs to be satisfied.

1.4.2 Service Integration

Integrating services both inside or outside the HCC is effective for all the Centers activities, both medical and non. Such integration rests on an efficient referral system and internal communication between the various services (horizontal) and between the different public levels of assistance (vertical). When the User arrives at the Center for medical, psychological and/or social services, the next immediate level of health care should be activated/alerted (superior and/or inferior) through the referral network. Not all SRH "applications" can be dealt within *primary assistance* HCC, some Users therefore require referral to second or third level health care structures, including obstetric emergencies. This cycle thus generates a *continuum* that is health care continuity.

1.4.3 Continuity of Care

Different types of integrated services at different stages of the "Therapeutic pact" are available to Users ensuring health care continuity, a model for connected responses. It is up to the service providers to determine the most different types of needs and possibly refer them to other levels where the initial access point cannot satisfy those primary health care requirements.
The continuity of health care is built up through a series of support services and over time.
In this way, when pregnant women request ante-natal assistance, a competent service provider looks into their family and social environment and evaluates the possibility of gender based violence or other critical situations and requirements.
Lastly, all different service requests and counselling from the first visit to the last are also registered and described in content and duration to enable all service providers to access and consult any part of the whole health counselling process. This enables service providers to evaluate any collateral effects

of oral contraceptives, follow-up period for sexually transmitted diseases and potential signs of repeated violence.
On a national level this archive can also contribute to surveys and other data collection for potential institutional level initiatives or research. Health care continuity is clearly much more than simply integrating programs (for instance family planning programs with those concerning responsible and risk-free maternity). For this reason SRH service provider skills and above all AIDOS training support systems should be continually re-defined and re-evaluated based on these "clinical audits". These are in fact characterized by discussions about the clinical/ medical cases in plenary meetings, with the aim of finding efficient therapy solutions while contextualizing specific problems within the SRH context.

1.4.4 Service providers

A predominantly female staff of service providers (apart from the driver and male counsellor) is not only determined by the delicate and varied themes addressed by SRH, but also by the fact that "taking care" rather than "therapeutic health care" is often a female prerogative.
Therefore the staff should consist of:

- Director or manager
- Gynecologist
- Midwife
- Practical Nurse
- Gym trainer / physiotherapist
- Psychologist
- Social worker
- Lawyer
- Male counsellor
- Field workers (2)
- Secretary
- Accountant
- Cleaner
- Driver

The first stage of training provides an opportunity to assess Staff baseline levels and understanding of reproductive health with regard to its physiological, psychological, social and legal aspects. This methodology and its implications are discussed both at implementation level within the HCC context and in the host countries. Each country's cultural, religious and social specificities are also considered in a group discussion where the HCC Staff can express their own views, ideas and concerns.
All the staff (including both cleaner and often the driver) meets to begin the first stage of training - in five phases:
Presentation of HCC methodology

- Working approach
- Identification of suitable resources to define a referral system
- Analyzing characteristics and/or identification of target areas for the Outreach Program
- Listing Active Offer strategies

1.5 Key points of sexual reproductive health

A set of **key points on sexual reproductive health** – typical of AIDOS approach and which will characterize the HCC practical approach have been identified.
These include:
Definition of primary goals. Women's empowerment, self-determination and decision-making powers with regard to reproductive life. There is more to it than medical care and family planning. The concept of health is considered in the perspective of women's general well-being. Women should therefore take an active role at decision-making levels and deserve continuity of care throughout their life. The issue of women's health should be considered in the perspective of human rights. In this sense, SRH counseling is just an initial entry point into women's world and which accompanies them throughout their life. HCC staff should focus on relationship care to build a rapport of trust with Users.

Every User has the right to:

- Information: to learn about the benefits and availability of reproductive health services.
- Access: to obtain services regardless of sex, creed, colour, marital status, ethnicity or age.
- Choice: to decide freely whether to control fertility and which method to use.
- Safety: to be able to practice safe and effective contraception.
- Privacy: to have a private environment during counselling or services.
- Confidentiality: to be assured that any personal information will not be communicated to third parties without their consent.
- Dignity: to be treated with courtesy, consideration, attentiveness and respect.
- Comfort: to feel comfortable when receiving services.
- Continuity: to receive SRH and supplies for as long as needed.
- Opinion: to freely express views on the services they receive.

(based on IPPF Rights of the Client, source: IPPF 2004)

Pregnancy is a natural event which in itself is the first stage of preparing for childbirth and this period, in both the lives of women and of a couple, represents an opportunity for learning and maturing which can then be expressed by how they take care of their child. Today it is still surprising how many women, even from the so-called Western hemisphere, are unaware of the personal changes in their own physical and mental potential during pregnancy and how these affect the way they adapt to the phenomenon and likewise they are uninformed about the development and nourishment of a fetus (physically but also emotionally) and their very own capacity for assisting the child's birth. The number of women who need to understand

the physiological and psychological changes that occur during pregnancy is increasing.

Definition of common approach to all HCC services: best practices. Concepts of *quality of care, continuity of care, customized assistance, service integration* and *prevention*. AIDOS approach is based on a symmetric relationship in which the User and the service provider interact on the same level, generating a favorable environment for dialogue and mutual exchange.

Focusing on women requires men's participation. When planning an appropriate support program, men should be in fact involved and decide if they want to change and adopt fairer systems of being involved with aspects of SRH. To set up *male involvement program*s AIDOS has identified the following recommendations:

- Male *involvement programs* should always be included in broader SRH strategies;
- Any gender-equality program is based on understanding gender inequalities and the negative consequences of power inequality between men and women;
- Broadening programs to address aspects of male living conditions that could have negative influences on SRH (e.g.: unemployment, alcohol and drug abuse);
- Selecting appropriate, skilled, motivated *male counsellors* capable of sensitizing others;
- Reaching men in places where they meet (e.g.: bars, work places, schools, meetings places, internet points);
- Identifying religious or community leaders who can disseminate and discuss SRH principles;
- Broadening program to identify critical areas (for instance: gender based violence or female genital mutilation and cutting) and not limit it to the more classic subjects (birth control, ante-natal health and sexually transmitted diseases);
- Extending the program to include encouragement strategies for men to share their experiences of masculinity;
- Constant program strategy monitoring and revision;
- Sensitization of institutions to support and publicize programs.

HCC approach must be accepted by the community.

The role of the community is fundamental for any SRH program implementation. Once the active offer is validated and structured, the community can modify the priorities with specific suggestions and potentially re-defining its cultural context. AIDOS can therefore affirm that involving the community is fundamental for improving and monitoring health care quality. This is why the Outreach Programs, home visits and interactive workshops in important parts of the community like schools, nurseries and health districts, also take on a significant role in developing SRH programs.

Home visits represent an important instrument for accessing the community. They are carried out by some of the field and social workers who, day after day, introduce SRH information throughout the targeted population, reaching even into homes. Together with women they

determine other possible contact places (schools, nurseries, districts) as yet unexplored or particularly isolated. The first visits always aim at establishing contact with women and high-risk families and determine initial priorities (medical, psychological and/or social). Only later will those home visits become more customized. Feedback and brainstorming meetings, either plenary or about teamwork, will then determine which type of actions are needed, **who** by (doctor, psychologist, social worker, lawyer), **when** (any program can last months, because of the subjects addressed) and **how** to proceed (for example, part of the process can take place in the SRH Centers and another part in other structures).

After having fully examined principle SRH content, the following points concerning **active participation** should also be fully understood:

- Social factors (cultural, economic, religious) - pointing out Staff awareness with regard to these factors as benchmarks in carrying out their tasks. Discrimination against women in education, profession, families impair decision-making.
- Physiological factors: understanding the anatomy of the body and its functions as first step of empowerment process; women of different stages in reproductive life need different strategies of information and prevention.
- Psychological factors: integrating psychological support with all other services; trust-based relationship; different therapeutic strategies for different psychological statuses, age groups as key tool to create awareness, mutual and self-help dynamics.
- Differentiated integrated approach: AIDOS approach must fit not just medical but User needs. Therapy and counselling result from integration of different skills and shared knowledge; integrated approach considers different needs determined by age, social position, work, education and psychological status.
- Legal implications and counselling: women must be granted access to legal rights under all circumstances. Information on women's rights is the first step in creating self-determination; legal advice allows women to make appropriate decisions; it is also key in fighting domestic violence.
- Gender perspective: women have the right to form their own perspective on reproductive life, family planning and local family legislation. Gender perspective can be achieved through women's participation: they help the HCC adapt its services to women's community needs.
- Right to sexual self-determination: women's empowerment yields progress to the whole community. Improving sexual relationships and family dynamics is an important step towards women's empowerment; women are free to decide If, When and What method of contraception to adopt.
- Equity and justice between men and women: women's empowerment can only succeed with the involvement of men and the community as a whole. Sexual

and RH education create equity between the sexes; specific youth groups must be educated to shape future behavioral patterns and influence future sexual and reproductive health; men counselling and involvement in group activities to reach male population.

In order to verify Staff counselling techniques, simulations need to be carried out to spot any possible gaps; underlining the importance of explaining more than what Users ask for. User specific requests should be viewed as opportunities to extend the scope of counselling sessions to other relevant aspects of the User's life. For instance, whenever a User enquires about a specific topic, say HIV/AIDS, it is advisable to inform the User about other STDs and related implications.

1.6 HCC organizational structure

Job descriptions are reviewed during a participatory session involving all staff members; to define and clarify specific roles. (Please also refer to Annex 2: Job Descriptions).
To favor internal organization, and above all to encourage the practice of "Clinical Audits" (even with plenary discussions) AIDOS has experimented dividing the staff into four teams as follows:

- Medical (Midwife, Gynecologist, Practical Nurse, Gym trainer/physiotherapist)
- Psychosocial (Field Worker, Psychologist, Social Worker, Men Counsellor)
- Legal (Legal Advisor, Field Worker, Psychologist, Social Worker)
- Administrative and Support Staff (Director, Secretary, Accountant, Driver and Cleaner).

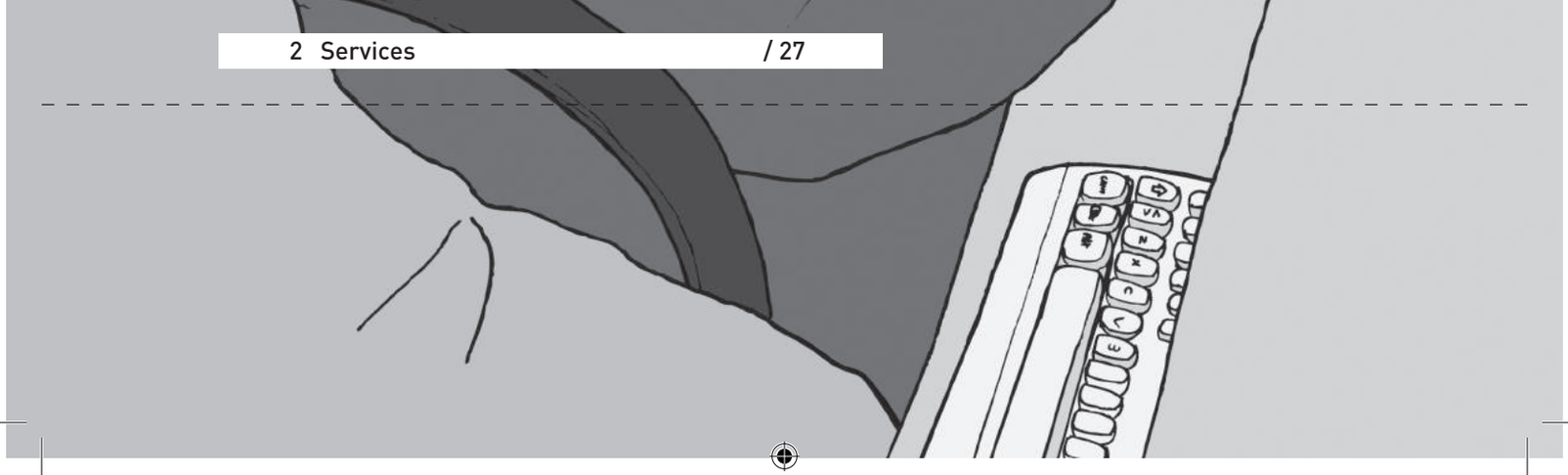
Weekly meetings of each single team and of all staff for sharing views, approaches, and strategies are fundamental.
In conclusion, on the one hand, the need to structure and incorporate clinical audits supports and reinforces an integrated service approach and on the other, discussions and sharing views on specific cases lead to an improved and more articulate way of identifying strategies.

1.7 Future Perspectives

This particular methodology has developed and evolved increasingly through AIDOS working with women. Over the years AIDOS has also been inspired and encouraged by the knowledge that its work in the SRH Centers was considered, by the relevant institutions, as both innovative and capable of potentially bringing about profound changes - even if slowly and with difficulty.
This is why AIDOS has always adopted a respectful and flexible approach whereby any difficulties encountered could be addressed in a variety of ways and over sufficient periods of time.
AIDOS decisions have always been taken together with women, learning that experience pays and that this is the only strategy to fully support sustainable development.
The main aim is still to attain that state of awareness where women are self-sufficient,

supported by knowledge and the strength this entails. For this **the following four points** represent the future aims of AIDOS already established Centers:

- To encourage local government to train and enable hospitals to deal with non-medical assistance for birth and guarantee continuity of care for Users, from the HCC to hospital structures where births take place.
- Promoting public structures to train for baby-friendly initiatives (UNICEF programs that standardize the application of Good Practices to promote and support breast-feeding) still connected to a humanized birthing culture.
- The use of *empowered* women as new resources to activate skills and lead to new ante-natal and breast feeding support groups, and SRH themed workshops.
- To test out new areas or Centers where the Users themselves have a great role and no longer require counselling, being capable of sharing their knowledge and their own SRH experiences with those other women who have not yet reached that same skilled level – undertaking in this way a peer counselling role for gender issues.



All HCCs offer reproductive clinical services, individual and group counselling services, a program for the prevention, diagnosis and treatment of gender-based violence and an outreach program.

2.1 Reproductive Clinical Services

2.1.1 Primary gynecological care

It provides detection and primary care of gynecological problems, ultrasound examinations, and testing during pregnancy. Encouraging, improving and strengthening ultrasound examination services during pregnancy for safe ante-natal diagnosis. It is advisable to envisage more focused training on ultrasound evaluation requiring two to three examinations at specific stages of pregnancy. This effort is fundamental in trying to re-align this type of medical assistance with WHO guidelines, at the same time as promoting an "active offer" to bring out potential "skills". In this case it could be to encourage Users to independently decide on a possible pregnancy scan plan following the correct information about scans, rather than potentially use them "superficially" (like monthly scans without ensuring correct diagnostic responses and/or encouraging a form of "dependence"). Similarly regular scans should be encouraged during women's sexual active life and in menopause. This practice is key to early detection of female reproductive organ diseases (like: ovarian cysts, fibroids, endometriosis) and reducing the risk of hormonal replacement therapy leading to breast and endometrial cancers.

2.1.2 Breast cancer prevention

All women Users who come to the centers for routine gynecological visits should be screened for breast cancer, in addition to determining any higher risk Users through investigating inherited maternal possibilities. Teaching women self-breast screening through individual counselling and in specific workshops about breast cancer prevention is mandatory, as well as referral through integrated service network across the territory for breast scans and/or other types of mammograms depending on specific prevention protocols and requirements.

2.1.3 Cervical cancer prevention

It implies carrying out yearly pap-tests (or every six months for women with pre-cancerous lesions) for all sexually active women and organizing prevention workshops about: Papilloma Virus (significant risk factor for cervical cancer) and other STDs (like Chlamydia, Mycoplasma, Hepatitis, AIDS) and to promote barrier contraception methods for high-risk women categories.

2.1.4 Reproductive tract infection (RTI) prevention

HCC should focus on a prevention program on Reproductive Tract Infections (RTIs), including STDs, iatrogenic infections (including post abortion and postpartum sepsis) and endogenous infections.
The first step is evaluating the scope and importance of the problem to identify priorities and develop indicators.

The second step is understanding people's perspectives on RTIs. The third step consists in strengthening primary prevention approaches based on the provision of Pap smears and vaginal swabs.
When a standard HPV vaccination is designed, further campaigns and meetings should be organized for overall STDs and cervical cancer prevention, encouraging a responsible attitude especially in adolescent girls to continue screening for other STDs which although not directly causing cervical cancer, can still entail risks for their (reproductive) health.
In addition, for appropriately extensive prevention, early detection of HPV infection has become necessary not only in female patients, through pap smear but also in male patients; in fact although women are more directly exposed to cervical cancer, men are carriers of the same infection. Consequently developing ad–hoc campaigns targeting men to promote the use of condoms is equally significant as they are in fact more likely to infect women. Because of the common practice of early marriage women are in fact less exposed than men to sexual intercourse with different partners. Consequently the HCC should encourage men to undergo a urethral test for HPV diagnosis.

2.1.5 Family planning

Women and adolescents are provided with information and counselling regarding all possible contraceptive methods: natural methods, condom, injections, pill and IUDs, in order to facilitate an optimal and responsible, free choice. Meetings and workshops on reproduction and family planning need to be organized for various target groups (including adolescents). The HCC should deal with FP and gynecological care above all as a women's issue and then also as a family issue; it is therefore necessary to practically integrate this perspective into the counselling service.
Furthermore AIDOS considers timing essential as any Good Practice reinforces and broadens opportunities to access contraception when women are more receptive to both information and services: the most significant periods could be post-abortion, post-birth, post-puberty and the beginning of sexual activities. The aim is to improve women's own reproductive health and consider future intentions of fertility.

2.1.6 Ante-natal care

It provides technically adequate and timely care throughout pregnancy, childbirth and puerperium and by using written evidence-based guidelines for pregnancy and childbirth care, as set out by WHO recommendations (*'Appropriate Technologies for Birth'*, May 1985)

Fundamental Principles of natural pregnancy and childbirth care

Specific project goals (listed below) are based on an assumption which emerged back in 1987 with the *Safe Motherhood Initiative*, i.e., that reducing maternal mortality and morbidity requires continuous care from decision of pregnancy, to childbirth and puerperium (about six weeks after birth), through to early childhood, and on evidence-based medicine on childbirth care.
Evidence shows that humanized care reduces mother and child morbidity and mortality.

- Informing women (as well as adolescents and adult men) on sexual and reproductive health and women's rights, to support them in experiencing childbirth as protagonists, in permanent consideration of their choices, desires and needs.
- Providing technically adequate and timely care throughout pregnancy, childbirth and puerperium
- Promoting natural, humanized childbirth in the broader framework of a non-medicalized childbirth culture, which grants the use of appropriate technologies without overlooking the natural pace of pregnancy and childbirth, as well as the intimate and emotional needs of parents and children.
- Using written evidence-based guidelines for pregnancy and childbirth care, in line with WHO recommendations (*'Appropriate Technologies for Birth'*, May 1985)
- Adopting a multidisciplinary and holistic approach to pregnancy and natural childbirth care
- Matching pregnancy and childbirth care to local cultural standards and ensuring women's involvement in decision-making of whatever sort.
- Promoting motherhood as an experience to share at the couple, family and community level, with particular focus on adolescents as future couples.
- Providing continuous care from pregnancy decision, to childbirth and puerperium, through to early childhood.

- Providing adequate facilities to meet women's needs from pregnancy decision through to delivery
- Following staff lifelong training and update schemes
- Setting up a database and information system
- Periodically identifying and verifying maternal and perinatal health indicators
- Drafting a long-term action plan to develop mother and child care protocols

Pregnancy monitoring and counselling services. Individual pre-natal counselling services are offered to pregnant women attending the HCCs and include counselling for early detection of abnormalities, miscarriages in early pregnancy, threatened abortion, anemia, Urinary Tract Infections (UTIs) and Reproductive Tract Infections (RTIs). Cases of missed or threatened abortion and of Intrauterine Growth Restriction (IUGR) are referred to hospitals. The service also includes ultrasound examinations for pregnancy monitoring. The medical staff registers the expected deliveries for post-natal follow up.

Pre-delivery courses. They represent a significant opportunity for women to take full advantage of developing physically and emotionally; another important step towards empowerment. The main aim of these courses is to assist women in discovering their bodies, not only the physical aspects, but with the broader potential of becoming more aware of their own rhythms and needs and consequently making decisions "knowingly" during the various different stages of their

becoming mothers, and of course, later in life. The holistic approach is based on the idea that the body and mind form a unified whole, just as individuals are connected to their immediate environment, community and culture which are all essential for their well-being. From this point of view, ante-natal courses concentrate on reinforcing positive thinking, enthusiasm, courage and the personal resources of each pregnant woman as even the weakest bodies and minds can always become strong and healthy. In this way any ante-natal course inevitably promotes the concept of well-being and self-care as women share their experiences with other women in the same condition with facilitators, like obstetricians or ante-natal service providers.

Discussions, participation, active listening are all significant elements for this veritable experiential process promoting empowerment and self-growth in all participants.

The service provider naturally explains, instructs and shares appropriate techniques (for labor/childbirth) ensuring that all participants initially know how to relax correctly within an active context of exchange within the group.

All courses should take into account the socio-economic and cultural backgrounds of women Users and avoid any authoritarian methods or excessively scholastic approaches, which could inhibit or distance participants.

Everything described earlier can be valid for all women, whatever their ethnicity, culture or religious backgrounds are, in matters of reproductive health and how to experience maternity in the most respectful manner and especially if we believe that their right to choose is fundamental for human dignity (also in line with the WHO 1996 recommendations).

However, too often this right to choose especially in countries where AIDOS works, in matters concerning pregnancy and childbirth is denied or not even contemplated, starting from the very choice of when to get pregnant.

AIDOS holistic approach is obviously re-defined in the field, when dealing with women: with no awareness of their bodies, heavily clothed, married to blood relatives that can lead to possible malformed children; with pregnancies decided by mothers-in-law and husbands, and babies delivered by health workers, sometimes in emergency situations and in undignified locations. However, each minute with these women reminds us that there are no universal recipes and how an ideal view rarely corresponds to real-life which is why AIDOS has developed a flexible overall approach, and more specifically for ante-natal courses which are based on identifying prevalent socio-cultural conditions to then promote the best possible way to encourage women to adopt more aware choices. AIDOS courses are therefore "moderate" and respectful of these backgrounds. AIDOS initial approach is to sensitize service providers to the different needs of each particular situation.

This is also used in Italy by Women's Health Centers (WHC) to then develop the most appropriate services for each specific target area; in Italy service providers are encouraged to experience a variety of different situations from Women's Health Centers, pregnancy and general gynecological clinics, both public and private to begin coming to terms with how they are organized and what kind of assistance is on offer, even if initially these are only based on visits. Study tours are organized when possible to Italy or in nearby countries to other AIDOS projects (such as in Jordan and Palestine) to experience different ante-natal courses and be

consequently inspired to develop further ways of working in other cultural contexts.
These courses cover both theory and practice.

Theory. For poorer women or those from underprivileged backgrounds, like most of AIDOS WHC Users in the Middle East, the subjects covered during the theoretical sessions have to take into account: the need for these women to improve their general knowledge of anatomy and more precisely of the reproductive organs; the importance of nutrition for mothers, the fetus and its development; introducing the idea of already being a "good" mother in pregnancy which also continues through labor and birth. Improving mothers' living conditions and style of living during pregnancy will in fact contribute to an efficient primary level of prevention, increasing psychological-physical wellbeing of the mother, and the mother-child couple, before and after birth.
Other subjects include: hygiene for mother and baby (like caring for the stump of the umbilical cord), long-term breastfeeding, responsible contraception for the couple to plan and space possible future pregnancies.
Encouraging long-term breastfeeding with no restrictions means fully benefiting from the ideal nutritional qualities of maternal milk compared to artificial milk, but also fully exploiting the contraceptive qualities of breast-feeding on request, especially during the nights of the baby's first six months. Breast-feeding represents the most natural and satisfying way of nourishing a baby in the first months of his/her life, not only from a nutritional point of view but also to encourage a psycho-emotional bonding between mother and baby. The typical, gradual changes of breast milk composition is geared to the different requirements of a growing baby, which in part also explains the results of recent studies confirming the higher IQ levels of breastfed babies compared to those fed on artificial milk[1].
By raising awareness of pregnant women they in turn can also request facilities to support another important element possibly influencing how medical structures develop: early mother-baby contact and 'rooming-in' structures in hospitals.

The UNICEF 1990 "The Innocenti Declaration on the protection, promotion and support of breastfeeding" recommended ways to give children (and their mothers) "the best possible start in life" – like the best conditions possible for each mother and child, taking into account their respective needs. The final document recommended that all women should be encouraged to breast-feed and that all new-born should only be nourished exclusively with mothers' milk from birth at least to their first six months. Following this all babies can be breast fed until at least 2 years of age and beyond, if this diet is complemented by appropriate and adequate food.

1 The Dunn Nutritional Studies Unit (Cambridge University) has shown in an IQ study of eight year old children, born prematurely, that breast fed babies had an 8 point advantage over those fed on artificial milk. (These results also apply to non-premature babies.)

This theoretical approach should also take into account predominantly psychological concerns like:

- the mother-father-baby relationship;
- the needs of the new-born and the family;
- maternal devotion, the mother-baby bond;
- feelings of responsibility towards the new-born;
- different states of mind and other matters like hormonal changes;
- the relationship between parents after childbirth and sexuality during these different stages and without forgetting contraception.

During the theoretical sessions the *concept* of "**Active Birth**" is introduced.
This is an innovative cultural approach to pregnancy and childbirth, which concentrates on capacity building and mainly encourages women to discover the best way for them to give birth (like initially standing up, moving about and basically feeling free to take any position which alleviates pain).
The Active Birth approach helps birthing mothers to control their own will and determination during labor/childbirth using breathing techniques, among other things and learn how to rely on their very own resources and decide how to happily bring their child into this world. Furthermore whilst fostering respect for pregnant women and the natural rhythms for labor and childbirth, this approach includes the possibility of the immediate families being present. They can also help service providers by contributing to create the best culturally sensitive conditions necessary for childbirth. Respecting these personal and natural phases of labor also allow new-born time to activate specific hormones for overcoming any birth stress.

This type of *"non-invasive"* assistance will inevitably lead to more natural and consequently less traumatic births both for mothers and their babies, which in turn contributes to reducing demand for intensive care treatment, epidural anesthetic or caesarean births which are so often suggested by doctors or presumed necessary. Lastly, women who adopt active birth techniques with the full support of the service providers consequently experience their personal potential and resourcefulness and can adapt immediately to the responsibilities of motherhood more easily.
Another approach considered is the now age-old concept of natural birth pioneered by Doctors Leboyer and Odent which considers how new-born are already capable of feeling emotions and so childbirth should take place "without violence" for instance: respecting newborns own "schedule", how they are not used to colder temperatures or the ubiquitous bright lighting of hospital delivery rooms. In conclusion but still extremely fundamental, is not separating the mother from her newborn. This is a primary need for both involved as it quickens the detachment of the placenta through uterine contractions induced by suckling the nipple, in non-medicated deliveries, and facilitates bonding. Early latching and prolonged contact also activates the release of oxytocin (the *love* hormone) and prolactin (the nursing hormone) that can intensify so-called "maternal" instinct and facilitate babies latching.

Research in 1990 on the ability of new-born to crawl across a mother's stomach towards the breasts and to latch on and correctly suckle without any help was published in THE LANCET. This led to other discoveries which revealed essentially that breastfeeding does improve a child's future capacity for

learning, (together with an improved immune system and other physical advantages) and that skin-to-skin contact in the first hour of a baby's life does save millions of babies from intestinal tract infections.

Women can be empowered and become active and responsible for their very own health and that of their children, from before their birth and as newborns, through organized ante-natal support courses. Any reproductive and sexual health education for adolescents also contributes to even earlier steps for a conscious approach to health and self-care.

Practice. Practical sessions of the pre-delivery courses use different methodologies and techniques and are delivered to groups of women and/or to couples.

Yoga techniques. Practicing Yoga is designed to stretch and relax the body, improving posture and it ultimately promotes women's self-awareness, increasing self-esteem. Improving breathing and relaxation techniques can be initially used during labor and later during breastfeeding, benefiting both parents and newborns.
The ability to concentrate in this way affects everyone deeply and is a useful tool in whatever stage of a woman's life. Stretching the body and correcting posture along those "energy meridians"[2] also stimulate immunity to those common complaints in pregnancy like nausea, high blood pressure, varicose veins, edema, hemorrhoids or badly positioned fetus, etc.
All this combined with training to master techniques for childbirth will subsequently contribute to an aware child-mother relationship.

The exercises are aimed at:

- hip/pelvic movements
- strengthening legs
- being aware of, and relaxing the perineum
- correcting posture
- abdominal breathing techniques with the diaphragm (for labor)
- movements for opening out and relaxing upper back and rib cage to improve oxygenating and awareness of capacity of positive thinking
- promoting mental calmness
- opening up an emotional space
- "listening" to the fetus

As women become more aware of their bodies and their own capacity to "internalize" all positive experiences, this contributes to both a self-induced wellbeing and empowerment. During these sessions even **Belly Dancing techniques** are adopted to improve control over the pelvic area; this primitive form of dance was also used for fertility and birthing and was traditionally considered a women's sacred dance, even during labor. It contributes to developing significant muscle control and also increases awareness of the pelvic area, abdominal and buttock muscles and the iliopsoas. Consequently gentle and slow movements and delicate actions stretch the spine in a pleasant way, unblocking the pelvic area while reinforcing the legs.

2 Energy Meridians are concepts of the Traditional Chinese Medicine. These meridians are channels through which the life force energy (Chi) flows within the body. There are 12 meridians on the arms and legs and they correspond to 12 body parts (one of which does not exist in standard medicine): Heart, Pericardium, Lung, Spleen, Liver, Kidney, Small Intestine, Triple Heater, Large Intestine, Stomach, Gall Bladder, Urinary Bladder.

These movements during labor-childbirth favors the optimum fetal position and how a baby's head moves, contributing to more efficient and less painful contractions. Together with slow and deep breathing techniques this contributes to releasing endorphins and subsequent calming effect.

Visualization techniques, **with positive thinking**, favor the mother-baby relationship according to a specific system developed for acquiring them. For thousands of years in the Far and Near East Asia the belief that the psychic health of an individual is formed during pregnancy and not after birth has been widespread. This is when the first veritable mother-child bond is created, as the fetus shares all its biological and psychological changes with the mother, which contributes to their physical development as well as their spiritual and creative growth. Future parents should come to terms with the idea of their future role as soon as possible: the father can be considered like a protective wrapping for the future mother with a supportive and protective role; in this way the child can immediately benefit from their interaction and sharing, which nurtures the kind of love which enhances birth and development.

Bio-energetic massage. An approach by Eva Reich called "Mothering the mother" is also proposed. This kind of massage was created for premature babies but can also be used for adults, including pregnant women. This Bio-energetic massage aims at activating and harmonizing all vital functions, contributing also to strengthening the immune system and a positive self-perception. During pregnancy the mother experiences a period of being very receptive, consequently any blockage resulting from past experience, in childhood, birth or even earlier, can be resolved through physical and verbal contact based on this bioenergetic approach. This massage is undertaken by social-health service providers for those pregnant women who refer to disturbances or who simply feel the need for one during a check-up or during any of the ante-natal courses.

Massage and working in couples. This part of the program encourages couples to exchange massage and work together to promote awareness of partner tensions, increase communication and being able to identify and accept the limits of one's partner. This kind of work also increases awareness for service providers, which is fundamental for this kind of work. There are exercises for couples together which also encourage them to coordinate and develop a deeper understanding of each other's needs. Contact and listening exercises help promote acceptance of each other's to enhance reciprocal help capabilities, support, empathy and trust both when in movement and when still. Positions of partner support are also taught for those who will be present during labor and childbirth. More specific exercises are included during courses for physical exercises for birth.

Who
Normally the midwife conducts these sessions, although she can be accompanied or substituted by other qualified service providers like the psychologist depending on the subject and how the HCC is organized. These sessions are essential to the concept of "health activating" groups; exchanges between pregnant women, permanent access to explanations helping regulate doubts

and fears, but also simply give pregnant women somewhere to feel truly welcome and involved, as reinforcing maternal skills through mutually beneficial exchanges also contributes to women's empowerment.

What is needed
The use of audio-visual material, diagrams and models to illustrate what is being explained is very important.

2.1.7 Post-natal care

Neo-mothers can meet up as soon as they can reach the various HCCs (this is generally one month after giving birth). This ensures that the HCC activities are then followed as part of AIDOS "continuity of care" approach, with the midwife continuing her role as provider of support and information like going over the birthing experience, answering general questions about looking after babies, how to manage breast feeding, best nutrition and personal well-being (in effect contributing to reinforcing maternal skills). Part of these meetings will be set aside for physical exercise, now aimed at recovering stomach and perineum area muscular tone, together with stretching and supporting the spine with posture exercises. Dance is encouraged specifically for pelvic floor muscle toning.
Specific massage techniques for babies will be taught, often integrating these with traditional massage techniques.

a. Individual post delivery counselling services. They are offered to women who have recently given birth; during the counselling sessions, women receive information on puerperium care, breast-feeding, family planning, and baby care.
In order to follow up women who delivered, staff directly contacts each woman for follow up.

b. Home visits. HCCs implement a home visit program for the post delivery stage.
The importance of early home visits is obvious especially for first time mothers.
In this way they can benefit from daily support from qualified service providers who can assist in the initial care of newborns and support breastfeeding, as well as keeping a vigilant eye for possible difficulties within the domestic environment.
Although AIDOS does not train hospital staff on this methodology, HCC Users (pregnant women prepared to actively participate in the birth of their children) can be supported in a different environment by the HCC service providers who know the different course subjects and how to put them into practice as well as how to protect Users from excessive medication practice (see EBM recommendations of the WHO).

c. The Doula. AIDOS concept of "continuity of care" combined with the fact that the HCCs are aimed at ante and post-natal care, also led to the idea of extending the training to other service providers potentially interested in offering either home assistance and delivery assistance to pregnant women or post-natal services to assist mothers at home with their new-born. Potential Users can be fully informed of these services as soon as they begin any ante-natal courses in the HCC. If interested they will then be encouraged to contact the midwife as quickly as possible, before or after the birth. In this way field workers or other social-health service providers can already be alerted to provide this service.
The *Doula* (a word with Greek origin) is an expert

woman who looks after other women, without necessarily being a social or health service provider; however she should be interested in supporting mothers: *during labor*, *or after at home caring for newborns*.
Her tasks can also include reinforcing maternal skills and also assisting in practical ways: for instance with other children present in the household, cooking, cleaning, helping neo-couples manage their new life on a daily basis, helping with relatives, visits, moments of doubt and fears and also simply just being another pair of reliable arms to hold the newborn, if too tired or while the mother takes a shower,
or if otherwise alone at home.
The Doula must however have some basic knowledge that enables her to dutifully carry out this role, checking the wellbeing of the child-mother couple and possibly even requesting the assistance of social or health service providers if necessary. The Doula is not a social-health service provider and consequently should not undertake any medical tasks, however she should be able to determine any changes in mother and child's condition and which service provider is the most appropriate to intervene simply through daily contact and training.

Training the *Doula* also is a two-step process, with a theoretical and practical side.
During the *theoretical sessions* the following subjects are covered:
Pregnancy

- Embryonic and Fetal Development
- Physical and psychological changes during nine-month term
- Including emotional changes in the different stages of pregnancy

During labor–childbirth

- Knowledge of active birth (free movement and different positions) and traditional labor assistance (with both the pros and cons of each), when to go to hospital and how to recognize different pathological signs
- Active birth (vertical positions and freedom of styles for bearing down) and birth assistance in classic lithotomic position (pros and cons of each)
- Hospitalized surgical birth for whom and how this can come about
- How to interact with hospital personnel
- Newborn in labor / child birth room
- Characteristics of new-born
- Physical aspects and requirements
- Bonding
- The APGAR score
- Newborn behavior
- Neonatology hospital departments
- Rooming-in
- Intensive therapy for new-born
- Pediatrics
- Different patterns and requirements of mothers and new-born during first days after birth in hospital (around 2 or 4 days depending on the couple's needs and living logistics)

Home Visits (after child-birth)

- Ability to listen and understand needs, increase confidence and support mother and her maternal skills, accompanying without overwhelming and being over protective

"Working through" birth

- Promoting mother well-being and rest,

nutrition and hydration
- Baby bathing, and caring for the stump of the umbilical cord
- Baby-massage
- Managing new-born colic /gripes
- Waking/Sleep patterns
- Breast-feeding

For the mother
- Checking (episiotomy) stitches if present
- Uterine complications
- Lochia or vaginal discharge
- Possible breast problems Mammary blockages, mastitis, how to recognize symptoms and activate any obstetric checks required
- Recognizing mothers emotional state and potential signs of depression.

The **practical sessions** concentrate on exercises like labor and childbirth support positions, bio-energetic massage and other kinds of techniques useful during labor (the partner and Doula's roles).
The Doula should initially accompany a midwife or nurse until they have acquired sufficient skills to independently carry out their tasks (normally around three months depending on how many women need assistance), under the supervision of the Center's health service providers themselves.

Duration
Training requires at least 40 hours of group work + at home background reading of texts and articles, followed by a final test.

d. Baby massage
This type of massage reinforces bonding with the mother and the energy exchange through this contact; nerve ends stimulate the brain, which elaborates it into perceptions, emotions and feelings. It has been widely accepted for years that newborns suffering from lack of contact with their mothers can consider it like an abandonment which induces them to 'block' their diaphragm, thus losing part of their innate capacity of self-regulating the bio-emotional exchange with their mothers.
This is how the vicious circle might start which can negatively influence the future health of any child on different psychosomatic levels.
Eva Reich developed the Bioenergetics method based on her hospital research anticipating the boom in modern neo-natal research by at least thirty years.
The underlying premise is that newborns' health is rooted in their emotions, which are translated into bio-energetic movements within the body. Consequently gently massaging newborns stimulate those energies contributing to their wellbeing.
Objectives of this massage are:
- Promoting a strong bonding between mother and newborn
- Stimulating health and the capacity for love
- Prevention of psychosomatic disturbances
- Prevention of birth trauma
- Curing birth traumas, among others.

In this way the newborn after the massage is:
- More tolerant of stress and is better at managing angst
- More capable of establishing relationships, loving and stimulating love in others
- Capable of improved development of the

nervous and immune system
- More vigilant.

And quantifiable physiological effects
on newborns include:
- Weight increase
- Regulating sleep patterns
- Improving breathing
- Improving digestion
- Improving circulation.

This brings us back to the holistic approach to health and healing, where no problems can be treated successfully if in isolation. Any lasting progress can only be obtained if the *whole* person changes to improve all functions on all levels.

Mothers who have been touched with care and gentleness during birth and straight after, can touch their newborn child with more capable hands. If however, their experience of contact has been cold and impersonal then women are more unsure of their relationship with their child.
The husband or partner should regularly caress the body of their pregnant partner during both the labor and immediately after. This should also become a rule of obstetric practice. I think that massaging the mother even after the second or third day after the birth would in fact prevent post-natal depression.

What is needed
A space large and comfortable for a group (possibly a maximum of 10 women). Somewhere peaceful and where privacy is guaranteed. Even a gym as long as it is clean enough for everyone to be able to sit in a circle on the floor. Mats to lie on and for exercises, either sitting or lying down; lots of cushions of different sizes to be comfortable. Where possible pleasant and relaxing music can also help and assist relaxation practices. Heating and blankets

Who
All service providers involved in this experience and possible trainees.

When
Once a week for two hours for actual activities, if possible.
Otherwise possibly separate this into two shorter meetings per week for a theory session and a practical session.

Difficulties
The main difficulty has been finding a peaceful enough environment that promotes concentration and relaxation, which are fundamental for this kind of training: a place where nobody comes knocking on the door with no coming and going, or distracting external noise. Personal difficulties include: establishing physical contact between service providers (even though most of them are women) embarrassed before and during those exercises, or vocalizing sounds and mantra. Furthermore in Muslim countries, where women wear some type of veil or covering, ensuring an undisturbed environment is very important for training as all exercises are practiced without these coverings and consequently ensuring an exclusively female environment is obligatory.
From Ashley Montague's "The Skin Language".

2.1.8 Reflexology foot massage

Foot reflexology is a non-invasive therapy based on massaging pressure points on the foot which correspond to seemingly unconnected parts of our bodies and internal organs in order to restore and/or improve their functions.
This non-conventional therapy is particularly interesting because it is adaptable, economical, easy to apply and combines prevention and therapeutic qualities. Its use has now been recognized for most physical health care treatments, is applied in many rehabilitation centers and included in physiotherapy and hospital treatments.
Foot Reflexology therapy has always been readily acknowledged by both service providers and Users as beneficial and non-invasive for overcoming, without the use of medicine or combined with natural medicine, acute and chronic, common and frequent illnesses such as: migraines, osteo-articulation difficulties, muscle strain, lumbar and sciatic pains, neuralgic and digestive problems, hemorrhoids, dysmenorrheal and other menstrual disorders, sinusitis, lymphatic disorders and other conditions which include many acute post-op and post-traumatic conditions, from palliative care and/or to encourage the full functioning of the interested organs.
For pregnant women it is also particularly useful for improving various conditions *without* the use of medicine, rectifying incorrect fetal positions, inducing labor in post-term situations, restoring and improving pelvic and perineum post-birth conditions, assisting in those common baby conditions like baby gripes and/or sleeping difficulties without of course ever being a substitute for the usual pediatric checks where necessary.
Through this therapy Users can also be sensitized to their own bodies which can ultimately contribute to a sense of empowerment and initialize their capacity for self-healing.
Foot reflexology has been widely used in various ancient civilizations from the Egyptian to the Chinese. Traditional Chinese methods have highlighted meridians and connections throughout the body, which can also be studied in conjunction with potential practical applications through yoga stretching exercises and other bodywork, which can also be applied to women's groups of all ages.

Course structure
Learning foot reflexology initially requires a theoretical approach to allow 'trainees' to map feet by themselves using different colors to represent different interconnected systems within the body. Images and other representations are used for foot mapping. This is followed by a more practical and in-depth study set out as follows:

- anatomy and anatomical connections, network representations as per Fitzgerald, 10 vertical zones, horizontal sections, basics. Practical approach.
- pressure techniques, learning rules and assistance. Foot therapy approach.
- characteristics of altered zones (warning signs to limit dosage, behavior in case of reactions during treatment)
- different handling positions
- User's history
- visual diagnosis
- User's welcoming. Therapist

responsibilities concern professional attitude, sympathy, sharing treatment with User, listening and informing the User about techniques and therapeutic positions
- pain: the different types and potential User points of view
- writing out initial treatments and establishing following treatments
- length and intervals between treatments
- reactions during intervals between treatments
- examples of treatments
- indications and What Not to Do (counter-indications)
- treating acute conditions
- self-treatment with pressure points on hands
- specific ante-natal, birth support, post-natal treatments
- treatment for new-born and children

Who
Logically frequent practice of the basic therapeutic sequences contributes to increased knowledge of foot anatomy and correct pressure point techniques. This training includes an initial introduction addressed to all staff, so that all service providers can in fact exchange treatments among themselves as practice. This can also contribute to building up the team work approach and overall capacity building.
This training is repeated several times so that, after an initial practical evaluation, those most suited and interested in a more thorough study of this technique can begin assisting the Centers' Users under the direct supervision of previously trained staff.

Location
A quiet room is best, with physiotherapy beds and/or many cushions to ensure that everyone is comfortable and there is sufficient knee support for both User and staff. Otherwise a space with floor matting can be used, although this can result in more uncomfortable positions for therapists.

Duration
This course lasts for 80 hours to complete three levels.

2.1.9 Physical activities

In order to help women gain self-confidence, HCC should offer exercise sessions combined with informal weight-loss advice and dietary lectures. These courses will be conducted by the physiotherapist/ gym trainer.

2.2 Counselling Services

A significant part of the Health Counselling Centers (HCC) work is providing counselling services: psychological (individual, group or for couples), legal (providing information about current legislation, and individual advice) and social (based on intensive work throughout the territory, to establish direct contact with the population through associations, community and religious leaders). Social and legal counselling are strictly linked to psychological counselling while being two distinct services offered.
One of the key concepts for AIDOS HCCs has been the holistic approach, where mind and body

form an integral whole and are consequently treated together. This essential element for well-being is extended to interconnect individuals with their surrounding environment, community and culture.
This has also marked a radical change in AIDOS approach to health care as women Users are encouraged to be responsible for their own health care process and maintain their health, instead of being considered merely passive subjects. This empowerment process contributes to self-healing in itself. The possibility of taking part in group activities significantly activates health in itself through sharing, mutual support (especially during periods of decisive changes, like adolescence, becoming a mother, menopause etc.), creativity and subsequent increase in self-esteem.

2.2.1 Psychological counselling

a. Individual counselling
Individual counselling is the most traditional form of psychological support for people with certain kinds of problems such as psychological disorders, depression and/or victims of domestic violence or sexual abuse. Sessions can be extended to couples involving both the psychologist and the male counsellor.
As part of the integrated service approach, any User can also be seen by more service providers together (for example social worker, lawyer etc.) depending on her/his problem. AIDOS approach entails strengthening the capacities that already exist in the HCC host countries and consequently utilizing the most frequently used and renowned psychological services available. In reality psychotherapy is not widespread in most Middle Eastern countries and so the initial aim is to establish basic psychological counselling where possible.
In general, notwithstanding the lack of formal training and/or specialized clinics, it was observed that selected counsellors or even social workers are capable of fulfilling this role provided they show a certain aptitude. In effect it was often found that the less qualified or least trained in this field are highly motivated, quick learners and above all, open-minded, ultimately becoming more efficient in contributing to the success of the project. AIDOS approach tries to add the more renowned approaches in this sphere (behavioral and cognitive psychology) to those lesser known locally, as they are equally efficient models, like those stemming from systems therapy, family therapy to name a few.
Privacy and confidentiality are very important elements of any type of psychological counselling. However unfortunately these are not always sufficiently guaranteed and consequently it is important to specifically work on setting up a private room, isolated acoustically, where people should knock to enter, to ensure the adequate forms of privacy required for this kind of service.
It must be also emphasized the need to dedicate sufficient time to each consultation which should last from a minimum of 45 minutes to an hour.
The most important diagnostic data should be recorded for each User, including the reason for the visit, and all such records should be kept in a reserved space only accessed by authorized service providers, maybe even protected by a specific password system. Obviously any psychological counselling can be integrated with the other services on offer, like legal, social or medical counselling – which can be undertaken either in separate sessions or with more than one service provider at a time.

b. Group counselling

In the Middle East, groups seem to be "technically" less used in routine counselling, even though they are the most widespread form of aggregation. As a result AIDOS initially encountered some resistance from service providers who believed this approach would not work. Despite this, those HCC Users who responded positively were very appreciative and especially curious about new techniques.
For example women in menopausal groups for physical exercises or yoga easily developed into problem-sharing groups. AIDOS experience has shown that group counselling is particularly suited for addressing certain types of difficulties like victims of violence and with self-help groups for women facing the same kind of life-changing situations (newly-weds or neo-mothers, mothers of adolescents, menopausal women etc.). Mutual help dynamics in the group also come into play further enforcing the Users "active" roles in a well-being process. Furthermore groups are considered important in the HCC because they reach many Users at the same time, which is crucial considering that target population is normally women from very poor sections of the community and HCCs normally operate over vast areas. Often also relaxation technique groups become very efficient in establishing a 'group' identity as its members "share" these experiences, which gradually increase the feelings of trust within the group and contribute to a group identity as they "relax". Some group exercises can also aim to raise awareness and modify certain attitudes to relationships, for example there are specific exercises that encourage trust. These are particularly useful for Users who need to recover and increase their trust towards the outside world but also their self-esteem, i.e.: trusting themselves.

General indications for groups:

- Group approach is usually good for Users who do not have "psychological sustainability" for one-to-one approach but need support.
- It is very "economic": you can see more Users at the same time.
- Groups are also "therapeutic" in themselves: sharing, communicating with others, breaks up feelings of isolation.
- Groups are generally positive for depressive, psychosomatic and anxious Users and in reducing external stress impact.
- Group sessions are to be held once per week (individual sessions are also possible).
- The setting has be carefully prepared: peacefulness, not too much light, or noise, little external stimulation.
- Group facilitates regressions so trainers/ facilitators have to be watchful.
- Two trainers are better than one.

Examples of group techniques

Relaxation. **First part**: Users report about their reactions at home then they begin relaxation exercises together; trainers give indications to the whole group, then they can approach each User individually to "correct" exercises, help, add more information (verbally and physically) if necessary.
Second part: verbal communication to work through what has happened: feelings, emotions. Trainers should listen carefully, be attentive and be aware of User's "two level" communication: body and verbal language. There are no right or wrong reactions; the important thing is determining User feelings. There are many different relaxation techniques; for instance the

Schultz Autogenic Training is widely used and is one of the most traditional and consolidated techniques.

Creative activities. Creative drawing is another technique, which is not widely used in the Middle Eastern for encouraging Users to express themselves although it is especially useful for groups of adolescents and victims of violence. Often people find talking directly about their experiences difficult; this is particularly true for people who have suffered from traumatic experience(s). One approach is to give the group a theme related to the problem and allow Users to represent it freely. For example you can also ask them to draw a scene from married life or a female person and then a male.
The Users can then show the drawing to the rest of the group who respond with feedback (not on the quality of drawing, but about what it obviously provokes in each User).
Another possibility is to let Users draw whatever they want according to their feelings at that moment. Then every one can give a "title" to her/his drawing, and try to connect it with her/his feelings. It is very important to stress that no drawing ability is required, because sometimes people are afraid of not being good enough to produce something "valid" and it is also helpful to know that the group is not interested in quality drawings!
The goal is to express feelings, so even if the person is able to draw only lines and dots the purpose can be fulfilled, even the use of different colors can express different feelings.
You need materials, like large sheets of paper (preferred to small) and colored pencils, watercolors or markers (water soluble). Be careful not to be interpretative and, moreover, not to allow other participants to be interpretative and judgmental.
The goal is to let everyone freely express themselves.

Trust activities. The objective is to provide an opportunity for group members to trust their physical and emotional safety with others by attempting a graduated series of activities, which involve taking some physical and/or emotional risks. Trust activities aim at building trust. Basic trust activities are initially chosen and can be performed repeatedly to reinforce and develop trust within a group. Remember that developing trust within the group is a gradual process. Consequently it is crucial to avoid forcing anybody and to respect people if they say "no" (especially working with GBV victims!).
The "sequential" (or specific) order to carry out these Trust Fall activities aims to gradually develop trust, thereby encouraging greater participation and deeper relationships.
Please note that the following steps are not necessary for every group, but the concept of moving gradually with the group, especially in counselling situation, is the one advocated.

1° EXERCISE: "TWO PERSON TRUST FALL"
Work in pairs, more or less of the same build. Each person takes turns to fall forward in the other's hands. One person stands, the other is behind her/him in a very stable position, one leg before, the other one behind, knees a little bit bent. It is important to add verbal communication: the faller will say: "Are you ready to catch?"; the catcher has to declare: "I am ready to catch"; the faller: "Ready to fall"; the catcher: "Fall away." It is important that the catcher is very careful. You have to be certain that no-one will fall.

(We have to build trust, not to destroy it!).
The distance between two people must be not more than one step.

2° EXERCISE: "THREE PERSONS TRUST FALL"
The same exercise can be done in 3.
In this case we will have two holders, one behind, one in front. Each person takes it in turn to fall either back or forward, as she/he is between two people.

3° EXERCISE: "YURT CIRCLE"
At least 5 or 6 people stand closely together, holding hands, in a circle with someone in the middle. The person in the middle lets him/herself fall and is held up by the "yurt circle" of people. It is important that no-one puts too much weight on those beside them and everyone's weight is equally balanced. This exercise can be used to present the concept of group cooperation.

4° EXERCISE "BLIND WALK IN TWO"
Two people take it in turns to be blindfolded; one takes responsibility for the partner and leads her/him round for a little walk, making her/him feel, touch, smell whatever they encounter during the walk. Then they exchange roles.

5° EXERCISE: "BLIND WALK IN GROUP"
One person in turn leads the group who are all blindfolded (not a big one: from 5 to 8 participants). The leader is responsible for the group. Make them keep very close, holding hands. You can guide them safely with your voice, describing what they are going to meet on the way.
Debriefing is particularly crucial after these exercises because trust activities can provoke strong feelings.

2.2.2 Social counselling

They are provided by a Social Worker and include individual counselling, couple counselling, community education and a well-organized referral system in collaboration with other organizations. The social counselling mainly concentrates on social aspects of problems. These for instance, can be linked to unemployment in which case the Social Worker can advise on any governmental institutions, NGOs, or other organizations, which address this issue or can advise on possible professional training courses, employment opportunities helping Users in this way to find a practical solution.
For example, the problems of most of the women accessing the social counselling services of the HCC (especially those counselled in relation to human rights abuses, intra-household conflicts and divorce) mostly converge towards a central theme: the lack of financial independence and of self-realization outside the household due to difficulties in finding employment or learning the skills to become self-employed. Psychological and legal counselling as well as social interaction in the women groups at HCC offer some relief, provide precious information and raise awareness even for the most vulnerable women.
However, a considerable proportion of their problems can be attributed to basic livelihood constraints, which identified the need for advice on income generating activities and on micro-credit schemes for those women interested in gaining or reinforcing

entrepreneurial skills and the setting up of a network of linkages to address this and thus contribute to women's well-being.

2.2.3 Legal counselling

It provides legal information and advice for Users about local legislation, rights and possible risks of certain situations. The User can also be referred to legal assistance organizations in case more formal legal proceedings are necessary (like going to court). This type of in-depth follow-up service is not provided by the HCC lawyers, mainly because the time-commitment is likely to be considerable and consequently too draining on the HCC resources.
However in all countries where HCC projects have been implemented, contacts are always established with free or low-cost legal aid assistance associations especially for victims of Gender Based Violence (GBV). Where possible, employing one of these professionals was considered. The lawyer and social worker, together with the field workers are given basic training to provide both social and legal counselling following the general criteria established for psychological counselling and communication skills.

2.2.4 Male counselling

Socio-psychological counselling for men is provided by an appropriately trained male socio-psychological counsellor in individual and/or group sessions. Couple counselling on social and psychological problems can also be provided in collaboration with the psychologist. This counselling partly supplements women's counselling and offers assistance when dealing with psychological disorders and family violence. The male counsellor reaches men in their meeting places and introduces the counselling activities in the HCC on the basis of men's knowledge and needs regarding reproductive health. Specific behavioral problems like promoting self-esteem can be addressed at more specific times, once Users have been screened. Also, men are advised regarding income generation activities, employment opportunities and micro-credit access.
Another very important and often challenging part of each HCC work is dedicated to men and especially male teenagers, with the aim of preventing violence and promoting community well-being. Male counsellors promote sensitization work to mainly address and encourage healthy relationships and sexual relations, and not just reproductive health. For instance many women in the HCCs in Palestine and Jordan have described how they were shocked by their wedding night experience, either because they were totally unaware of sexuality but also by how inadequate men were at creating any kind of contact with their partner. The focus is on "Healthy Relations" rather than just reproductive health; shifting the emphasis from family planning education to healthy couples, which includes promoting a healthy sex life fully respecting the differences between men and women.
The challenge is to shift the focus onto "healthy relations" between the two sexes. AIDOS has been developing a communication model, which is more complex and circular, based on understanding what is important for men in those cultures, their values and needs. This all contributes to determining their motivational levers, that is those convictions and beliefs that

can underpin any "shift" in men's convictions to bring about change and their perceptions.

These subjects and methodologies are complicated and difficult to summarize in a few words. In effect these methodologies are innovative compared to those more traditional and to purely educational models, which are generally followed working with adolescents both in schools and in the psychological sessions.

In Jordan, the first psychologist led workshops with adolescents only listed negative behaviors towards girls, their sisters or their future wives. But merely distinguishing what is "wrong" does not extinguish that behavior and consequently finding out what was behind that behavior can also encourage a shift. A participative and circular methodology is the only approach capable of really bringing about change and that expression groups are more useful than a year of traditional lessons.

2.2.5 Socio-psychological counselling for adolescents and youths

Working with adolescents is a very important element of any prevention activity. Often religious and/or socio-cultural reasons prevent this section of the population to access relevant information and services concerning sexual and reproductive health. It must not be forgotten that throughout the world relatively young girls (14/15 years old) are still being married, which in effect can lead to possible health risks and pregnancies for these teenagers who are potentially unprepared on a physical and psychological level, without considering, most significantly how this experience can limit their access to education and information in general.
HCCs provide counselling sessions at individual and group levels. The group activities are educational workshops, discussions and the conduction of physical activities such as yoga. The HCC should also organize meetings with mothers in order to sensitize them about adolescents, facilitating their participation in the center's activities, and other issues concerning their children.
These adolescents are like the reflection of a country's culture and its society, so it is very important to learn how to deal with the specific needs, which emerge from these groups and consequently develop ways to prevent gender stereotypes from taking shape as they anticipate potential violent behavior. The groups can begin by simulating episodes from daily life that are then commented together, or to draw or use whatever creative and expression techniques to portray their own life experiences and increase their own awareness.

In Jordan the first time the HCC staff asked a group of adolescents (12-17 years old) to portray a scene from their family life without any preparation, they presented a couple about to become parents, expecting a girl. At this point the atmosphere changed and everyone was obviously disappointed with the new-born (represented by a doll) who was subsequently thrown aside.
After a pause another birth was presented where a baby boy was born and this was celebrated and praised by the whole family.
In fact this 'play acting' does reflect what some women had already described about

their experiences of expecting a baby girl; some were even deliberately 'underfed' by their family, less food but also treated with less care and protection, compared to when they expected a baby boy. Other stories concerned forced pregnancies– either unwanted, or with increased health risks, or too frequent, or until baby boys were born.
In another session, the same group of adolescents was asked to draw a female and male character – some women were drawn with no heads, others in a tomb; another drawing was hidden in a folded up piece of paper. However nearly all the male characters were shown freely able to enter and exit their homes.
How can this kind of behavior and beliefs not affect the way girls begin to perceive themselves: as deprived of the right to having any rights?

2.2.6 Counselling services to menopausal women

Women during their menopause do not benefit from many services. However AIDOS HCCs offer other possible types of services which are often overlooked, like medical or psycho-social services. Women are invited to take part in weekly meetings to discuss the most common needs, possible advantages and disadvantages linked to the menopause both from the medical and psychological points of view. Each meeting is divided up into three parts: listening, discussion and physical work. They are all based on a holistic approach and can direct women to follow either the weekly yoga course offered by the HCC or physical exercise classes, and possibly other discussion sessions. These courses can be also led by the midwife or by a physiotherapist depending on the requirement. This is important as, in addition to the physical exercise courses led by the physiotherapist, the midwife can assist the women with her own approach by discussing the different problems that can arise during this new post-reproductive period. This can include the potential of *different* types of hormone replacement treatment, including natural remedies and ranging from dietary recommendations to the use of local herbs, as well as sensitizing women about regular check-ups for breast and cervical/uterine cancer. Lastly, the midwife can assist in developing, with the psychologist, thematic sessions about these further changes in women's lives, which can include recognizing signs of depression and other less obvious changes etc.
This kind of course is recommended at least once a week, although if physical activity is included two meetings a week are better.

2.3 Special program on Gender Based Violence

In the United Nations Declaration on Violence against Women of 20 December 1993, the term "violence against women" is defined as being "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life". For the most part this covers all types of domestic violence, sexual abuse and child abuse.
The WHO considers GBV as a public health issue and not merely a private problem within

the household. For UNFPA, GBV is a violation of a fundamental human right and a serious impediment to women's human rights and women's reproductive health and rights. Despite such progress however, a set of coordinated services for the victims of GBV is still missing. Although women who go to health care facilities often have symptoms related to GBV, they are generally not asked about GBV.

Based on this theoretical framework, in 2001 UNFPA has developed GBV guidelines "A practical approach to gender based violence: a program guide for health care providers and managers" which offer a step-by-step guidance on how RH facilities can begin their own GBV activities. AIDOS was the executing agency for this initiative. The UNFPA guidelines address these important gaps in services to women and provide health providers with the necessary skills to effectively tackle this issue and properly respond to victims' needs.
In particular, the guidelines focus on the three most common forms of GBV, being: childhood sexual abuse seen in adolescent girls and adult women, domestic violence and rape or sexual assault. This manual foresees three modular options (A, B & C) integrating GBV services into the health facility's organizational structure and allows for the selection of the option that best suits its infrastructure, financial and referral resources and capability.
More schematically, a guide to three programmatic options are provided as follows:

- Option A involves producing, distributing and displaying materials about GBV (including information about where to get help) in the public and private rooms of the facility and off-site, if feasible;
- Option B in addition to displaying GBV materials includes asking all Users about GBV. If Users disclose they have experienced GBV, they are then referred to outside structures that provide the necessary care and support.
- Option C includes all of activities of options A and B and also provides an in-depth assessment of each case and on-site treatment for GBV survivors.

Based on the option chosen:

- in relation to option A, the staff will coordinate the elaboration, design and printing of information materials and more specifically to produce a postcard with an effective image/message and the phone number of a helpline which can be called if women need help.
- in relation to option B, after the trainers' sensitization process, screening activities should include the adaptation and finalization of the UNFPA screening form and specific training on its use. The HCC will also set up a referral system and possible network links with other specialized centers, to expand activities beyond the center.
- in relation to option C, this foresees strengthening the psychologists and health providers' expertise on GBV, its dynamics and health consequences as well as on the in-depth assessment and treatment of GBV victims.

The guidelines also help prepare the facility by progressively guiding and sensitizing the staff through the various practical steps of each option.
The focus of the training will be on the delivery of a spectrum of appropriate services to GBV victims, ranging from information and education activities to screening for all Users, from assessment to diagnosis and treatment for victims.
Whichever option is chosen, this innovative approach provides crucial care and services to victims/survivors of violence within a supportive and validating environment.
In order to do so, before any GBV related activities can be carried out, health-care managers and providers will be sensitized on the connections between reproductive and sexual health and GBV.
The cultural myths and social barriers to effectively tackle the issue will be actively discussed by all staff and explained, in this way unspoken beliefs can be shared and overcome. Helping staff to look at their own responses, beliefs and biases is key to an effective program and a supportive environment. For these reasons, an active and participatory training methodology is adopted as this facilitates staff members' personal involvement as well as experience and understanding of such innovative services.
This will include group sessions on gender issues and their cultural implications, active elaboration and presentation to other participants and, more importantly, role playing to experience providers' role and its constraints while dealing with GBV and so better understand victims' needs.
AIDOS has tested and used these guidelines in its projects in Palestine, Syria, Jordan, Venezuela, Nepal and Russia. These guidelines are also available in Arabic.

Over the years AIDOS has found that during different periods of women's sexual and reproductive life certain aspects (either unexplored or denied), like the absence of any decision-making power relating to any aspects of daily life, are transformed in later adult life as women assume certain roles of power.
For instance: mother-in-laws in Palestine become important centers of power; their agreement to and their approval of various concepts of women's sexual and reproductive roles have been key to the HCCs being able to approach men and encouraging them to support women, in addition to involving the rest of the community.
Wherever a woman's reproductive role is so central, often any type of infertility leads to immediate repudiation of some kind. Often even women are very strict about this among themselves as seemingly the only real role which is still allowed for women is a reproductive one (even in sexual education groups it has often been heard the statement that "women's only pleasure is in maternity"). Furthermore husbands repudiate their wives if they do not get pregnant even if the origin of the infertility is unknown (i.e.: could possibly be the husbands' fault) and therefore one can easily imagine what happens when this ability comes to an end.
It has been proven that many undiagnosed GBV cases are the cause of a variety of symptoms and different pathologies that as a result remain unresolved. Often GBV victims are the most difficult Users of health services as they often fail to take care of themselves and are subject

to continual relapses, unplanned pregnancies, recurring infections and more or less serious levels of mental health problems: for example rape victims are approximately 9 times more likely to attempt suicide and suffer from post-traumatic stress which can become quite acute. The term "gender" has been included to indicate how many of the victims are female and have an inferior social status to males.
This very imbalance of power is the basis of each form of GBV. In the HCCs, AIDOS works to prevent, diagnose and treat Gender Based Violence and this part of work is probably the most difficult.
As already mentioned, AIDOS approach has always respected different cultures and local traditions and consequently avoids imposing notions from other cultures, and endeavors to introduce disturbing subjects in the most culturally acceptable way. When many cases of sexual abuse and ill-treatment of women and girls by their husbands and fathers emerged, it immediately became clear why this subject was addressed with much reticence in the HCC.
This is why AIDOS focused on the "group" approach as an important component for treating this kind of case.
In some places groups addressing problems of sexual violence/GBV are not accepted and consequently the setting up of relaxation groups are recommend, for initial support or sharing experiences instead.
In this way both a welcoming and warm environment is created where experiences can be expressed and shared often for the first time.
AIDOS HCCs have always focused on creating environments which are obviously open to discussing and addressing issues concerning violent behavior, as well as communicating a sense of safety for any victim.

Staff Training is the key to any work program on GBV: consequently all staff must be aware of their own personal responses, beliefs and prejudices about GBV.

One of the main obstacles to the identification and subsequent treatment of this problem is the widespread and common prejudice, which can even be present on a subconscious level. Therefore awareness and recognizing those restricting convictions about violence should be promoted as without recognizing or identifying potential issues they cannot be addressed.
Many restricting beliefs emerge from all cultures. The most frequent being: if any abuse has taken place, the victims themselves have done something to provoke it (see for instance references to rape victim's clothing, despite statistics clearly showing how victim types are definitely more modest in appearance); not believing in violent episodes described; minimizing "culturally" violent attitudes like: "honor killings are exaggerated by the media"; denying the very existence of some forms of violence like: "child abuse does not exist here".
Specific training should focus on the service providers of the medical team (gynecologists, midwives and nurses) as they constitute the first and often only User reference point of the HCC services, and who often have never received any specific training on psychological issues.
Another unfortunately encountered significant obstacle is with staff members who have been GBV victims themselves. Their responses can be frequently defensive, whether when recognizing violence itself and/or in their approach to victims, as it has touched them personally and "hurts". They can also still have problems discussing it, or can play them down or even deny or refuse to talk about them (for example by falling asleep

during GBV sessions or avoiding any kind of participation!).
All services concerning GBV have been traditionally divided up into three sections: prevention, diagnosis and treatment.

Prevention

Involving the community is considered essential for any approach to prevention. Research and surveys are carried out to identify the best strategies for sensitization for community acceptance. Prevention normally entails raising community awareness about gender inequality and those forms of violence, which are not culturally recognized as such.
Prevention awareness activities are specifically aimed at adolescents as younger generations are always more receptive to new models of behavior; they can be carried out through schools, workshops in classes, and/or with teachers themselves.
The same subjects should also be addressed within the male community, both in the HCC male groups and outside the HCC during workshops in the community.
These prevention activities do not require explicit titles like "GBV prevention", as this can be counter-productive in some social and cultural contexts. The most effective prevention occurs when relevant information is transmitted in a culturally acceptable manner, naturally evolving from whatever situations arise. See examples in para: 4.4.1 "Sensitization concerning gender and sexual prejudices, introducing concept of gender inequalities and forms of violence".
Another key aspect of prevention concerns providing the HCC Users with accurate information about current legislation, about their rights and what is in effect legal or not.
Normally lawyers directly provide information about legislation together with another service provider from the center like the social worker or psychologist.

Diagnosis

Only service providers can correctly diagnose possible GBV in Users if trained in the basics of diagnostic criteria and how to recognize post-traumatic stress disorder (PTSD).
In practice the psychologists do not seem to ever have enough time to assess each User as it is very time consuming, although in accordance with UNFPA guidelines every User should be screened.
In fact it has already been widely accepted that all women are potential GBV victims regardless of their social, economic and cultural class.
AIDOS experience has shown that GBV victims can be found among health staff, nurses, doctors and even the lawyers.
Obviously certain socio-economic conditions contribute to an increase in GBV, like poverty, over-crowded living conditions and being in situations of permanent conflict. In the 'waiting' or 'reception area' HCCs use both GBV awareness posters and pamphlets, which can easily be seen and consulted to create an environment that can stimulate discussions on the subject of GBV and attempts to overcome taboos.
A permanent all-User screening process has been set-up in many HCCs and carried out by a service provider like a specifically trained field-worker and not necessarily the psychologist or social worker. Even a basic communication skills training enables most field workers to successfully engage in the initial listening process and welcome Users as initially required, despite their basic education. In addition to this specific screening training, the setting

is very important. It should ensure a high degree of privacy as this is fundamental for creating a relationship of trust, something which is not considered a priority in certain contexts.

Key points for diagnosis:

- How to screen
- An understanding of needs and concerns of GBV survivors
- An introduction to basic engagement techniques in working with survivors
- Differences between assessment, assumption, and diagnosis
- Service Provider Responsibilities and Community Referral
- How to refer cases and services integration
- Knowledge of the principles of record keeping and confidentiality

Treatment

The treatment is obviously the most technical and complex part. The main difficulties encountered, as already pointed out, is the lack of specialized psychotherapy training in the Middle East, consequently this often results in a lack of adequately trained human resources, as clinical psychotherapy and even psychology can be considered new. Although AIDOS basic training alone does not bridge this deficiency when encountered, some efficient treatment services can be set-up. Just the mere fact of listening and attempting to understand those needs and concerns with a listening approach and engagement levels without any prejudice is by itself a therapeutic step.

It must not be forgotten that the most common form of GBV is domestic violence which unfortunately is encountered everywhere in the world, with no geographic (North, South) or economic (rich, poor) distinctions. In some countries where AIDOS operates it is so widespread to seem practically 'normal' (regrettably encountering women who state "well, yes *of course* my husband beats me…"). In addition, legislation on this subject in many countries is in fact quite weak, consequently many crimes are not actually considered as such (the most frequent is 'marital rape' which does not legally exist in most of the countries where AIDOS works).

Consequently it immediately becomes obvious how important it is for any GBV victim to be recognized as such both by herself and by others, and above all, to face someone who is free from those forms of prejudice, avoiding for instance a listener asking what the woman might have done to deserve that beating! Nothing can justify violence. Treating these Users is very difficult, as any long protracted history of violence fractures one's own sense of personal integrity, regardless of where they come from and their immediate environment.

Women who have experienced some unrecognized forms of violence within the family or society, either because it was justified as love or considered normal within a certain social context, often suffer from a low self-esteem. AIDOS health care approach endeavors to directly address this crucial aspect, prevalently in group sessions to increase one's self-esteem and regain that hope and trust in others through games and physical exercises.

Why use 'play' in such a dramatic context? Because play is directly connected to personal imagination and the ability to fantasize.

The group thus literally becomes a no-man's-land, free and safe. A place where experiments are possible with no physical or

emotional risks. It is like a "training" area where the rules that exist can be freely adhered to or broken. This protection also enables victims to learn new risk-free behaviors, even pleasurable ones and it can offer significant space for growth leaving everyone the freedom of exploring how deep they want to feel involved but creating a warm, respectful atmosphere full of exchanges and attentive caring listening to each other.
The key points which have been developed for this treatment for both individuals or groups are:

- how to establish a trust-relationship: the importance of time
- how to respect the User's choice
- different settings
- self-help groups: for groups with similar or equally difficult problems. Relaxing techniques or/and exercises to increase self—confidence beyond simply sharing experiences on a verbal level.

AIDOS approach begins with work on gender awareness and other issues already addressed in the community. Obviously any work done specifically with those responsible for GBV is still in an experimental stage for its complexity: it is very difficult that any perpetrator accepts dealing with the service providers and/or even questions their own behavior, even if in recent years projects have been set up addressing this. Often the family of the victims themselves are considered complicit with this kind of violent behavior to avoid being associated with any disapproval shown towards the victims themselves, in accordance with that widespread prejudice whereby all victims have in some way provoked violence or "brought it on themselves". It must not be forgotten that domestic violence is often considered "normal" or is at least more acceptable socially than a "divorce".

Relaxation techniques
Relaxation techniques can be used in many situations. Relaxation is a powerful tool that can be used during group sessions in order to enhance personal well-being or to enter or "to go out" a visualization.
It is important to remember to be congruent with the message of relaxation, which wants to be transmitted. Use a calm tone of voice and find a rhythm slow enough to permit the person or the group to easily follow the indications and to contact sensations, images or whatever is required. The voice must be strong enough to be effortlessly heard by everyone, without shouting or using a high-pitched voice: it could disturb the relaxation process. No need to put on an "act" - just use a natural calm voice.
If there is time and it is appropriate for the situation, indicate which part of the body everyone can relax. In this case try and follow a "path": starting from the feet up to the head. Just say "Now relax your feet" or "Now relax your shoulders" and wait for a while before passing onto another part. Ensure that talking about parts of the body is not too embarrassing or scary even in this abbreviated manner. GBV survivors can feel disturbed about naming parts of the body.
Focusing on breathing is the most important element in reaching a state of relaxation.
It is quite impossible not to feel anxious if breathing is either/both troubled and difficult. Try to make the breathing the "internal" point of reference for everyone and if one can work on changing his/her breathing, s/he can also change his/her perceptions of reality.
Relaxation is not a "must" or a duty, so do not push people to relax, otherwise this will create a paradox: people may become tense

as they attempt to relax. In order to reassure people who find it difficult to relax, remind everyone that it is not a performance, that everything is going well and that "to have the intention" of being relaxed is already a start. Do not bring people out of the relaxation state too fast, use at least one or two minutes to permit the participants to come back to ordinary perception and to the group (in some way it is coming back to the "here and now"). If somebody is slow in returning, do not force them, just repeat the instructions again and wait. Passing from an inner focus of attention to an external one sometimes needs time.

2.4 Outreach and education program

There are different ways to work outside the HCC specifically aimed at reaching the target Users (women, adolescents, men etc.) in their own environment.

2.4.1 Community workshops

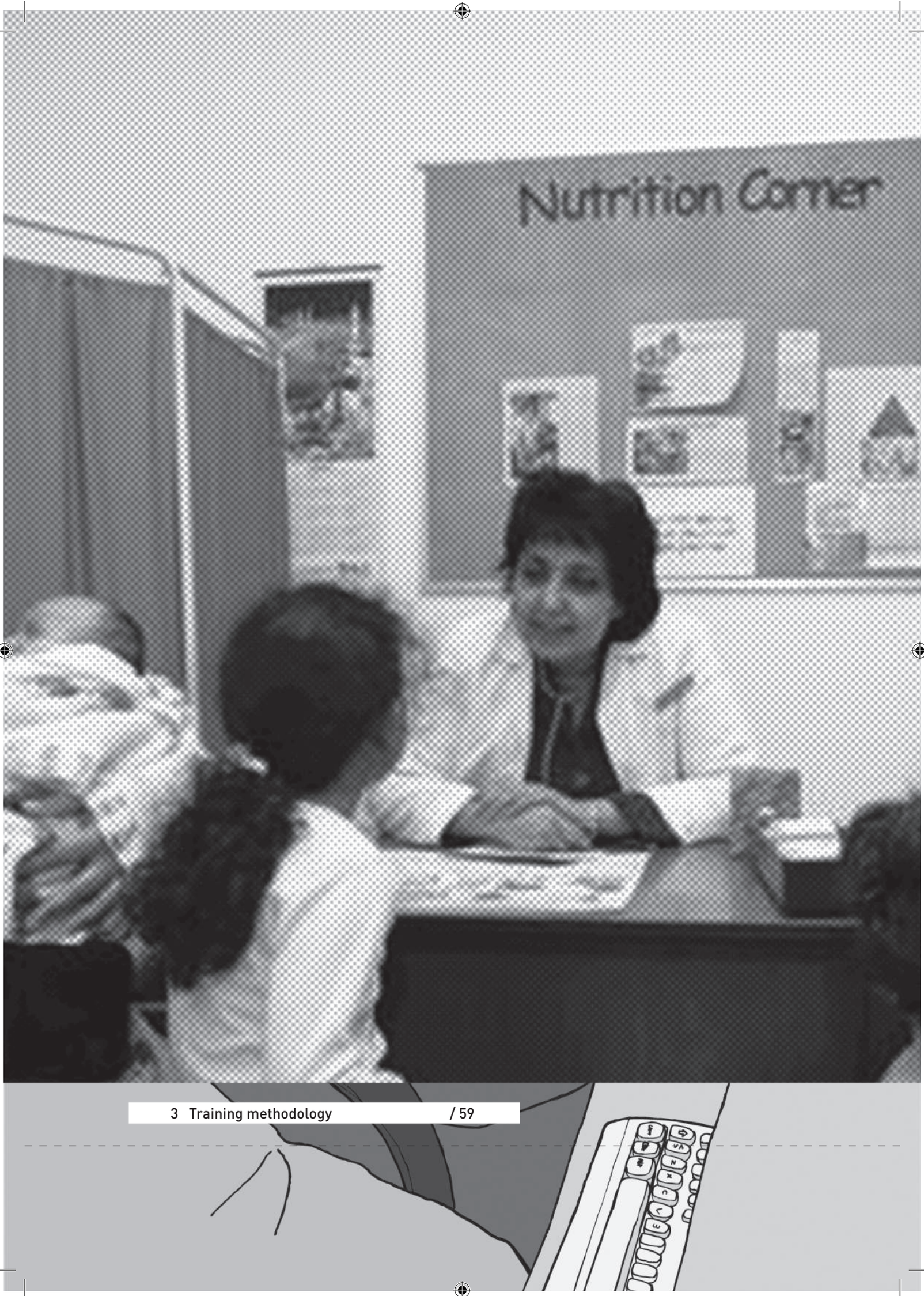
One approach is to identify the main places where people gather (village square, a local NGO, schools, gymnasiums, youth clubs etc.) and to organized *workshops* or events, which focus sensitizing the community on specific subjects regarding several aspects of reproductive health. These workshops are organized in co-operation with various organizations involved in the health/social sector and are specifically targeted to female adolescents, pregnant women, mothers, elderly women, widows, women victims of violence, but also male adolescents and adult men according to the needs.
HCC staff, at the beginning of each month, through a joint meeting, prepare the plan for the number, frequency and topics of the workshops to be held, either at the HCC premises or through public meetings. Every month each WHC organizes an average of 4-5 workshops at its premises and of 15 workshops in the community. This methodology has proven to be a successful one and has met the positive reaction of the community. The workshops concentrate on the following subjects related to: gender relation awareness, adolescence, reproductive health and family planning, breast feeding and changes in pregnancy, early marriage, sexual abuse, breast and cervical cancer prevention, sexually transmitted diseases and HIV/AIDS, safe and responsible sexual behavior, post-delivery psychological problems, menopause, water and sanitation problems, civil and Islamic law (family law, work, parenthood, property rights), domestic violence, women's credit schemes, job opportunities for women, school dropouts and family health education, men involvement.
The resources needed include human resources (HHC staff according to the topic), transportation, refreshment and information materials.
HCC Staff work in team to produce *information and training materials* for the implementation of awareness and educational activities. HCC should upgrade and develop educational and information materials (leaflets, booklets, posters, etc.) and a more specific brochure about the services offered by the HCC.

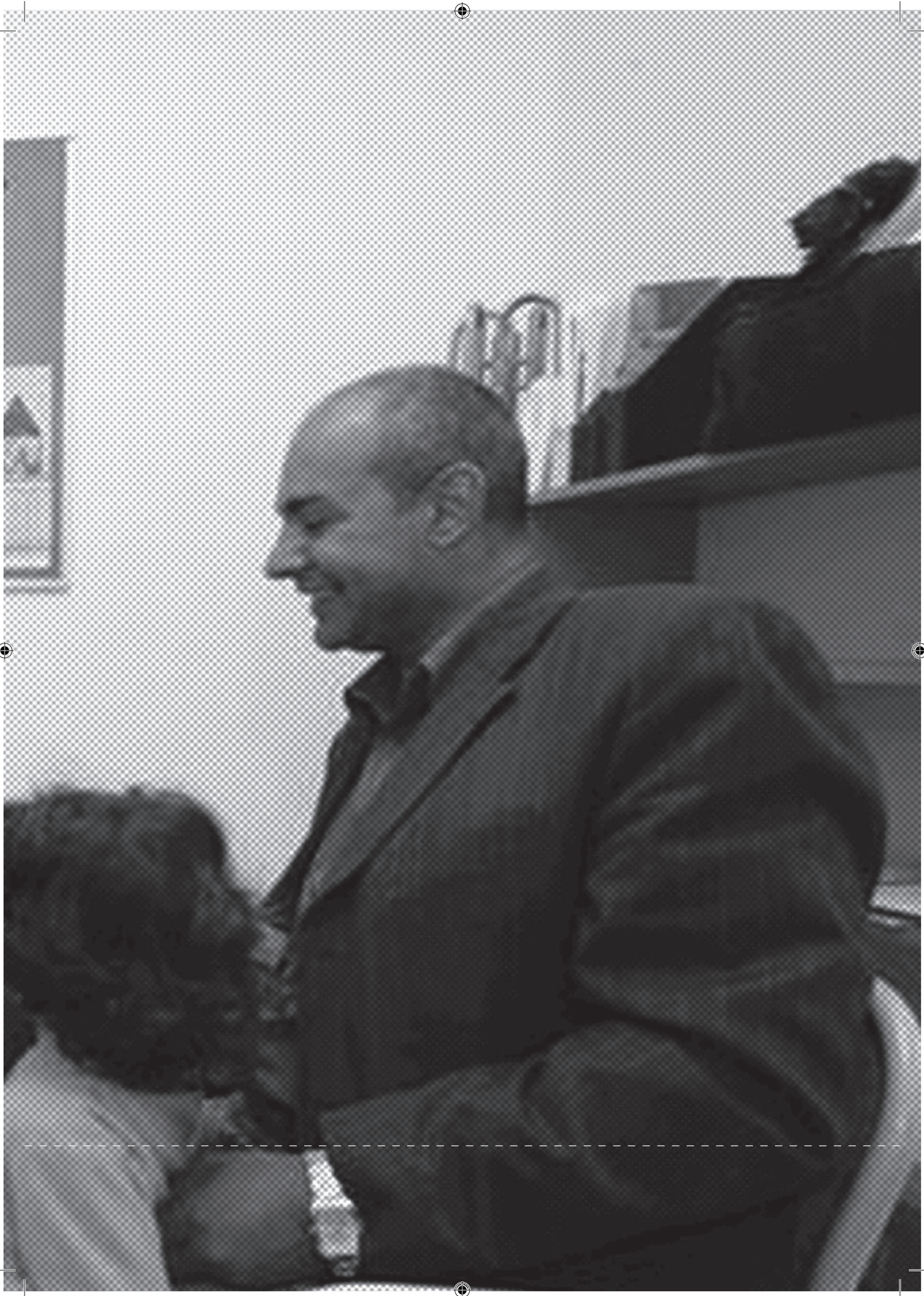
2.4.2 Preventive and sensitization campaigns

Regular campaigns can be organized in the project target area to raise community awareness on HCC activities and on specific services offered, encouraging community participation and involvement; improving the HCC visibility; promoting the concept of prevention. The campaigns will cover several RH subjects such as safe motherhood; active birth; breast and cervical cancer; family planning and STDs. The campaigns are carried out by the HCC service providers through meetings with the community in public areas and by distributing pamphlets and brochures on HCC activities also using other referral institutions like hospitals as contact points, where possible.

2.4.3 Home visits

They are another way of establishing contact with the Users in their own surroundings.
In Jordan many Users voluntarily organized workshops in their own homes and invited their neighbors to participate in that familiar and friendly atmosphere sometimes even for tea prepared by their host. This approach has proven particularly successful in encouraging the active participation of Users who would speak about their personal experiences more easily in such familiar surroundings, in what seemed more like a meeting among friends.
Another aim of these home visits is also to access those User(s) most at risk and least likely to *spontaneously* come to the HCC.
For example they can come from environments with serious financial problems and/or with cases of domestic violence. Consequently it is left to the field workers, accompanied each time by either the psychologist, or social worker or lawyer, to visit those women who, for whatever reason, find it impossible to leave their homes (for instance, often the husband has forbidden the woman to go out, or she is too ill, or in *post-partum*).


Nutrition Corner



In order to implement AIDOS methodology, HCC service providers are trained by international experts in gynecology, midwifery, psychology, communication on specific methodologies and issues.
A project model on health education in Health Counselling Centers (HCC) sets out the following general lines of intervention:

- Preventing social adversity, especially gender inequalities
- Promoting Users' self-awareness and reinforcing their identity/diversity when relating to others
- Focusing on relationship needs and improving the capacity of socializing and cooperating, keeping in mind both the cognitive and emotional spheres

Consequently service provider training should not only concentrate on the practical or "technical" aspects, although important, but also on their capacity in relating to others.
This leads to additional objectives:

- Improving team work
- Concentrating on individual and group communication skills like "active listening"
- Enhancing group observation techniques and ability to de-codify group dynamics
- Enabling service providers to be group interaction facilitators
- Facilitating self-teaching and making most use of expressive and creative potential ("Learning to learn")

Trainers are like "carriers" of appropriate instruments and methods to activate resources and do not just simply transmit information.
The Trainer is as facilitator capable of:

- Active listening
- Stimulating group participation and encouraging the participants to express themselves, without losing control of the process
- Contacting people in their own language
- Entering other people's model ("map") of the world
- Conveying messages in a simple way and ensuring others have understood, otherwise changing one's approach
- Being consistent: remember that non-verbal communication is not totally under one's control and can be more important than verbal

3.1 Principles

3.1.1 Participatory methodology

The type of training for HCC service providers is a broad and participatory one which does not follow a "linear" approach where trainers merely transmit information to service providers and who, in their turn, transmit this information to Users. This approach consists of a circular type of communication featuring listening and observation, and favoring a two-way exchange between trainers and service providers.
Consequently, service providers are encouraged to develop the same attitude with Users.
AIDOS experts begin with general training where all service providers are asked to participate, whatever their role is, consequently this includes the cleaner, driver and custodian. Initially this often causes some misunderstandings, however it does inform everyone about the aims and ways the work is carried out, promoting feelings of sharing and belonging, rather than a more "mechanical" approach to adopting their respective roles. These are "plenary sessions" consisting of meetings in the training hall over a previously agreed period of time. Methodologies are based on experience, role-playing, simulating events, listening and contact.
The goal is to train trainers in a participatory way to increase their effectiveness and efficacy by

involving them in the learning process.
Many studies show that active learning is more effective than passive: people can learn and remember better, consequently in this way skill retention increases e.g.:

- Only listening: low retention
- Listening and reading together: small increase
- Discussing: higher retention
- Role-playing: increased retention through body involvement
- Explaining or teaching the subject: it all becomes very difficult to forget, obtaining the maximum level of retention.

FIGURE 1

Learning by doing, combined with reflection, is an active process requiring the learner to be self-motivated and responsible for learning.
It is important to remember that learning is a process, not a "product". Teaching and learning based on experience (experiential-based) is very important to produce a healthy change in growth, learning and behavior in a world that is increasingly rich in information but poor in experience.
Sometimes a minimum level of anxiety is useful as more effective learning occurs when people are placed outside a position of comfort, which often entails varying degrees of acquiescence and passivity.
Important elements in participatory methodology include:

- Learners are 'participants' rather than spectators in learning or training
- Learning activities require personal motivation, to become responsible, contributing energy and becoming involved. Enjoying the specific games developed to gain new information are also useful
- Having fun is constructive because it increases motivation; boredom in contrast decreases it
- Making participants aware of the process is important for them to reflect on what happens
- Whatever is learnt must be relevant for the Users, both in the present and future.

This participatory methodology does not depend on lectures but group question sessions, involving everyone in working together through concepts (starting from gender and sex definitions) with a final discussion and redefinition with the Trainer.
Example about gender sensitization: using a free word association exercise starting from "gender" and "sex", or even asking the participants for proverbs or idiomatic phrases which remind them of these topics. A final group session analyses the main messages, which emerged, with enough time for also sharing personal experiences. The use of role-playing and simulations are included.
The group itself defines the so-called "ground rules" which govern the time and manner in which the training sessions occur and ideally how the participants themselves learn to work together (most importantly that no-one is forced to participate and/or answer questions).

3.1.2 Gender mainstreaming

The idea of "gender mainstreaming" which underlies the whole approach is developed during the plenary sessions and should become the main focus of attention as this concept is totally new in some countries.
Gender mainstreaming is one of the key guidelines of the UNFPA approach concerning sexual and reproductive health which emphasizes how any project that aims to improve women's health, well-being and self-esteem

should concentrate on the relationship between the sexes ensuring that any gender inequalities and prejudice are not reproduced in the project itself.
For instance: a contradiction "in practice" would exist if only men had managerial roles in a women's center! and likewise if during the training period the group considered any male contributions more important than the women's given their so-called "tendencies" to hold back. In some countries this occurs and this kind of interaction should be identified, understood and discussed to avoid it being repeated with Users for example during the workshops.

A fundamental point of AIDOS training program is how experiential methodology can improve service providers' self-awareness and work on any limitations they might have themselves.

This is particularly important when training staff on 'Gender-Based Violence' (GBV) as explained in the UNFPA guidelines "A practical approach to Gender-Based Violence".

3.1.3 Meta-communication

Participatory methodology in itself contains a message – emphasizing how participants themselves can be self-sufficient and not be merely passive but in fact "active" agents of their own training. A further level of communication is a 'meta-message' (from 'meta-' like in meta-physics = something related to beyond, transcending, relating to another level): fostering service providers' independence also implicitly contributes to encouraging it with Users, as those ultimately destined to receive their actions. The final aim of AIDOS training is for the service providers not to need AIDOS experts any more and for Users not to need the service providers. Consequently encouraging independence is emphasized during training, because: *"we are not suppliers of solutions but suppliers of instruments that contribute to solutions"*.
Consequently from this point of view, actions that underline this practical approach are employed especially during Training of Trainers (TOT), so they can internalize these concepts and in turn, pass them on to Users.
During training it is important to stop every now and then to explain certain methodological choices to participants like, for instance concerning group interaction, when and why we encourage a participant to talk, while another is discouraged.

After each exercise it is important to clarify when it is useful and when it is better avoided, its specific goals and meaning.

Each training course has to be adapted to the specific group. Obviously a general program is needed but the ability to modify to the specific group needs is crucial.

3.2 Methods

All instruments used depend on each specific operational situation and the trainees' requirements. More often than not the work is divided between theory and where possible practice ("**on the job**").

3.2.1 Classroom experience

This training approach does not rely on specific lectures or presenting theoretical models in line with the participatory methodological approach previously described.
Naturally some theoretic frameworks and background will be used in these sessions, integrated with other instruments that promote

direct experience such as:

- brainstorming
- small group exercises
- simulations
- role-playing
- work groups and any potentially useful tools.

To apply the "experiential" learning cycle, a debriefing session for each activity is crucial to stimulate considerations and better understand its effects. In this way we can learn from these *activities* without losing any of the opportunities they might offer.
General debriefing questions:

- How did you feel?
- What happened during the activity?
- How did the team make decisions?
- How many solutions were explored?
- How was the inter-personal communication?
- What helped the group and what did not?
- So...in general? (what general principles can we deduce?)

3.2.2 On the job

"On the job" training is the other important part of this methodology; it is more technical and specific for the psycho-social team (psychologists, social-workers etc.). This part of the training is when AIDOS consultants/ trainers accompany service providers in activities inside and outside the Centers. Follow-up meetings evaluate these "on the job" experiences and determine priority areas of work and new strategies for possible improvements.
This is useful for immediately putting into practice previously studied theoretical techniques, including the importance of team work, group supervision, exchanging feedback and integrating different skills.

3.3 Main topics

3.3.1 Team work

One of the most important training aspects is Team Work. The capacity of working together cannot be taken for granted and, despite good intentions, sometimes has to be learnt, as there is always room for improvement.

In effect team work has always achieved much better results than the sum of all the results that each individual could have achieved, so any work on this aspect improves overall group potential.

In AIDOS experience any improvements in team capacity was also perceived as a significant increase in personal work satisfaction and not just an increase in team effectiveness.
Feedback is an essential instrument for improving communication within the service providers' group (in the same way as it is for any group, like for those Users concerned with a particular topic). During training, participants will be asked to give feedback to other trainees about their role-play practice. For instance: a service provider will be role-playing a User and asked to give feedback about the "service provider" who was helping her/him, and describe what s/he found helpful and what s/he felt could have been done better. The service provider will also be asked to talk about how it felt to play a User (for example a GBV survivor).

Guidelines for "Giving Role Play Feedback":

1. Focus on the positive.
What did the service provider do to make you feel comfortable?
How did the service provider show that you were not being judged?

When did you feel that the service provider really understood your feelings?
What made you feel that way?
How did the service provider help you understand what the medical exam would be like?
Was there anything in particular that you really liked that the service provider said?
Did the service provider do anything you particularly liked?

2. Give critical feedback gently.
Everyone has a hard time being criticized and critical feedback is only useful if the recipient can learn something from it.
Think about what others have done to make their critical feedback useful to you, and do this for the service provider to whom you are giving feedback.

3. Use "I" statement.
Make "I" statements when you play the role of the survivor and give feedback to your service provider. For example: "I got really confused when you started talking about the legal process and the grand jury and used all the technical language" instead of "You really blew it when you were describing the legal process."

4. Be specific about what you felt could have been handled better.
Like: I felt that sitting on a low chair made me feel less important
Or: I would have preferred you speaking in a less complicated language

5. Give suggestions and options regarding what might have worked better.
For example: "When I asked you about my AIDS risk and you gave a long explanation about antibodies and the different tests.
I got really lost. I guess what I wanted was a shorter answer about what my risk might be."

6. Balance the negative feedback with positive feedback.
For example: although I did not like sitting so low down you were always very attentive and clear.

3.3.2 Communication Skills

A lot of emphasis is put on service providers acquiring good communication skills because of how pointless it is to develop "good content" without the capacity of transmitting it and on the fact that an efficient communication strategy for Users and between service providers is equally important.
This part of the training is based on the NLP (Neuro-Linguistic Programming) results and other data on human communication. AIDOS has chosen these models preferring a "circular" communication strategy: with the emphasis on flexibility, listening and observation and paying careful attention to the values of the other (on the "world map/model" of the other). These elements all contributed to developing this strategy combined with its efficacy and adaptability to different cultural contexts.
The NLP approach can be briefly summarized as the study of the structure of subjective human experience, therefore containing recognizable universal elements as it was verified working with different cultures.
Given that personal beliefs and values can be both individual and influenced by social groups, this strategy is the most flexible and easily adapted to "discovering the world map of the other", whether the "other" in question is a User coming from a totally different life experience to our own or when "other" means a different cultural context.

The main objectives are:

- Adopting certain communication principles: you cannot NOT communicate; the map is not the whole territory; "circular" communication.
- Increasing one's own effectiveness in communicating through observation and listening to the other.
- Recognizing one's own behavior within a relationship: from what to do, to how it is done.
- Sharpening sensory perception to determine verbal, non-verbal and para-verbal messages of whatever is being communicated.
- Learning how to give efficient and constructive feed-back, essential for group work.

(Practical exercises, simulations, role-playing will be described later in the "Exercises" section).

3.3.3 Limiting Beliefs

One's behavior is significantly determined by various belief systems: be they personal, group or social-cultural. Consequently any shift in one's beliefs will result in our behavior being equally influenced. Some beliefs can be unfortunately limiting, restricting our field of action and problem-solving capacity (a classic example of this is when service providers say to themselves "this is not for me" because they cannot specifically visualize themselves in a new role or new project). Trainer development cannot then exclude further investigating these aspects: apart from overcoming anything specific impeding HCC activities, service providers can also acquire skills which enable them to look at problems from different points of view, utilizing those personal and group resources to go beyond personal prejudices and limitations. In fact specifically sensitive subjects are mostly affected by preconceptions and bias among service providers; for example any success in working against Gender Based Violence cannot be achieved if the same prejudices are as widespread among Users as the service providers.

3.3.4 Supporting the Service Provider: the Burn Out Risk in dealing with GBV cases

In the training of HCC service providers AIDOS has decided to include a section dedicated to the risk of service provider "burn out", especially when dealing with cases of violence. In general any profession dealing closely with human suffering is subject to accumulating stress; any contact with suffering in turn generates suffering and for this reason can be very risky, if not identified, worked through and contained. In addition to this, victims of violence are particularly difficult users; decision-making for them becomes as difficult as accepting any counselling, be it psychological and/or legal. It is all in fact practically impossible without building up a relationship of trust, which often takes a very long time. This is why service providers often find this kind of users also frustrating. This frustration accumulates and is worsened by a feeling of impotence when also faced with the lack of legal frameworks that protect victims. Unfortunately most HCC treating this kind of suffering simply overlook the significant risk that service providers run through these vicarious experiences. Although all psychotherapy analyst training includes one or more types of personal therapy, most service providers have not necessarily followed those comprehensive therapies which include learning ways to cope with stressful situations, like here, dealing with

vicarious violence, consequently their risk of burn out increases. To address this possible exposure/risk, supervisory groups or simply spaces for them to share their emotions and experiences should be provided.
The "Service Providers Health" factor should always be the object of a thorough institutional analysis, although it often merely remains an unproven tenet. Accumulated stress and anguish are some of the negative effects of burn out which can lead to both Users and Service Providers ultimately suffering, which in turn is negatively reflected in the quality of services provided.
The service providers that "burn-out" feel drained, emptied, incapable of investing further professional and above all personal resources in their work.

This is why AIDOS conducts specific activities to tackle this subject within the HCC organization framework.

The main aims of dealing with burn-out are:

- An understanding of vicarious trauma, its causes, and ways of managing and preventing it
- Knowledge and practice of self-care techniques;
- An introduction to supervision, including the roles and responsibilities of the supervisor and supervisee.

3.3.5 Gender Based Violence

In recent years HCCs have increasingly confronted GBV not only along the UNFPA guidelines, but also organizing specific services to deal with these widespread situations. AIDOS has therefore established a training program for service providers that can be condensed into 5 full days, with possible in-depth additional course follow-ups later.
Much of the work is concentrated on communication skills besides the more technical aspects of any GBV training.
AIDOS has developed a specific manual "Working with Gender-based Violence Survivors-A Five-day Training Course" which sets out the main subjects of this course.
Guidelines for approaching this subject can be found in Annex 4: Gender Based Violence training curricula.

3.4 Possible exercises and workshops

3.4.1 Sensitization concerning gender and sexual prejudices, introducing concept of gender inequalities and forms of violence

Gender sensitization exercises have been developed, along UNFPA guidelines, for service providers to identify gender inequalities and adopt technical skills to work with GBV victims. Service providers (directors, gynecologists, midwives, nurses, social workers, lawyers, male counsellors, psychologists, field workers) should all initially experience these exercises themselves.
The material for these exercises is the result of the work of trainers on Gender Based Violence from all over the world. These exercises can help service providers assess their own feelings, assumptions and beliefs on GBV and become more capable of supporting GBV victims as recommended by UNFPA guidelines.
Service providers should be prepared to deal with any emotions that may arise when participants think about personal experiences related to "sensitive" and "taboo" subjects. This is particularly true when participants may have

experienced some GBV situations themselves. Another purpose of the exercises is to provide technical skills in participatory adult learning methodology and to develop service providers' critical analysis on the subject.
This is meant to be a guide for service providers and is consequently *not rigid*, as AIDOS believes that all training courses should be adapted to the specific characteristics of the training group itself, taking into consideration their cultural and social environment.
The subjects covered by the gender sensitization include:

- The roots of GBV with exercises for raising awareness about gender inequality (sex/gender; proverbs; prejudices and beliefs)
- Recognizing the GBV victim, how to approach her/him
- Assessment
- How to refer cases and integrate other services
- How to establish a trust-relationship with the victim/User
- How to respect the right of User's choice.

Exercises:

- Providing examples of GBV in your community and around the world
- GBV in Your Community: Causes, Contributing Factors, Consequences.

Small group activity:
collect proverbs regarding GBV

- Definition of Sex vs. Gender (exercise: free word association starting with words like "woman", "man" and then to define the meanings of "sex" and "gender" from what has been said)
- Cycle of Violence
- Types of GBV
- Definition of Gender-based Violence
- Barriers to talking about sexual assault with Users

Definitions of Sex and Gender
Sex refers to physiological/biological attributes that identify a person as male or female like:

- Type of chromosomes (XX or XY)
- Type of genital organs (not just penis or vagina but also uterus, ovaries, prostrate, testicles, breasts etc.)
- Types of predominant hormones

Gender refers to those social features and common ideas about being men or women in any culture, including ideas like: what are typically female or male characteristics, commonly accepted abilities and expectations of men and women and how they react in various situations. These ideas and expectations are learnt/acquired through family, friends, cultural institutions, places of worship, schools, media, advertising etc. They all reflect and influence roles, social and economic status and lastly the political power of men and women in any given society.

Examples of Workshops for adolescents or adults about gender issues.
The aim is to distinguish the differences between "sex" and "gender" (roles forged by the society and culture one belongs to):

- To stimulate considerations about social expectations and stereotypes depending on gender;
- To encourage sharing personal experiences;
- To help participants understand how being female or male can affect one's own reproductive and sexual health;
- To realize how gender has influenced personal experiences and ways of thinking;
- To focus on main prejudices and limiting or misleading beliefs concerning sex and gender;
- Eventually introducing the concept

of GBV and begin considering what actually constitutes violence (physical, sexual or emotional) and how certain forms of violence are deeply rooted in one's own culture, to the point that they are no longer recognized as such.

These Workshops and themes can be adapted to either adolescents or male adults to help them recognize and personally work on gender prejudice and consequently prevent potential GBV.
In the training of service providers, personal experience and work are crucial to become more aware and sensitive, hence working on those barriers, limiting beliefs and deep-seated emotions that both cultural and personal prejudices can bring out on this subject.

3.4.2 Communication Skills Exercises

These courses should all be specifically adapted to the service providers and situations where they will be working.
General guidelines which can be easily adapted to the specific needs of any group:

a. Introduction: knowing expectations
Aims: introducing participatory approach also useful for determining and verifying aims together
Example question: "What do you expect from this training?"
Write out answers on flip-chart (to keep and consult at the end of training).

b. Working in couples/pairs
Aims: acquiring observation and listening skills; introducing difference between verbal, non and para-verbal languages and to experiment with two principles of communication (you cannot NOT communicate, the non-verbal defines the verbal)
Example exercise: the participants, in pairs, tell each other something about themselves (personal; or describe a specific episode in their life) for 3 or 4 minutes.
Then each person introduces him/herself to the group pretending to be the other person.
Set aside time for assessing feedback responses.
Questions for the group: Did you recognize yourself in the description your partner made? Were there any misrepresentations? If so, which? (example: a fundamental detail which makes the difference for one partner might not have been perceived as so fundamental for the other as it was not that important in their own 'world map'). Have we discovered something new about the other? Or something new about yourself that you want to share with the group?

c. Active listening.
Session I - Barriers to Active Listening
Aims: to determine the characteristics of a good listener; knowing the advantages and traps of listening.
Questions about active listening: What are the characteristics of a good listener? What are the advantages of a good listener? What are the traps of not listening? (list on flip-chart)
Example exercise: in groups of four: two talk about a subject, while the other two listen. This situation is then reversed and the conclusions about this experience are discussed in plenary.
Questions to the group: What have you discovered about the others? Were the others in "Rapport" (that is: did they relate efficiently with each other)? Were they listening to each other? What kind of questions did they ask: open or closed? The two observers: did they only watch the person speaking or also the person listening? Gather feedback about how it feels to be described by someone else.
This exercise helps to emphasize the importance of perceiving non-verbal messages from others

and to decipher their own map/code not our own! Be careful not to interpret somebody else's experiences only through your own eyes. Focusing attention on what is based on senses, i.e.: that which the participants have really seen and/or really perceived through the senses, to train listeners not to overlay perceptions with precocious interpretations (so-called "mind-reading").

d. The Map is not a territory; it creates it – an experiential exercise

Aims: to show how we all have our own different representation of reality (a "model" or "map of the world" in general); recognizing differences to communicate more efficiently.

Example exercise: everyone should draw a map of the room where the training takes place. Everyone's different maps are compared, without any aesthetic or logical judgments: there is no "correct map" and this underlines how anyone and everyone can perceive reality simply differently to someone else.

e. Perceiving differences and using sensory channels

Aims: to strengthen perceptions about how different and individual non-verbal messages are; recognizing aspects of interior representations of an experience.

Example exercise: calibrating (that is how differences are perceived) a pleasant or unpleasant experience (someone volunteers to declare what the experience is in front of everyone). Then the volunteer acts out one of these experiences without saying which kind it is. Others have to guess what this experience is based on what they see and not what they can interpret.The premise is that a person's state of mind is reflected by his/her actions, which translates into individual para-verbal signals (through his/her voice) or non-verbal (body signals), which are not the same for everyone.

Example exercise: the use of specific words to describe any experience reflect which sensorial channels we use mostly (visual, aural or coenaesthetic) in our own "inner" representations of these experiences and how we attribute meaning to these. In groups of three or four, each participant shares an experience with the others of the group, who observe and so determine which sensorial channel prevails; describe the experience again using different words/predicates that refer to another sensorial channel. Underline the differences when different words/predicates are used.

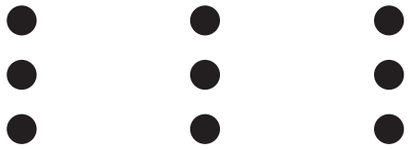
Questions to the group: What differences have they discovered? How did you feel? Was your "inner" state different when using a different channel?

f. Flexibility and filters of perception

Aims: to experiment how filters of perception can deform reality and contribute to creating limiting beliefs that restrict problem solving. Flexibility as a personal resource.

Example exercise: "Nine points". The aim of this exercise is to directly experience how our limiting beliefs shape our thinking processes, our vision of a problem and our possibility of finding a solution, even if elements to find a solution are available.

Draw 9 points on the board as shown below:



Ask participants to copy them on their own paper. The task is to draw a line of 4 segments without interruption that unify all the points.

Let participants try for a while (it is better to ask them initially to *pretend* to draw, only going through the movements with the pencil,

so as not to be "trapped" by their first attempt). Do not give them the solution immediately; it is important they try and experience a little frustration.
After 3 - 5 minutes of attempts, ask the participants: "*Are you using everything you have*?" and "*What do you really have*?"
Collect the answers and underline that they have only 9 points (not a square!) and a SPACE! Normally they do not use the whole space, but only the space between the points, like in an imaginary square.
This is exactly the limiting belief in this case: we see a square that is only in our mind and we usually do not think about the space **outside the square**.
Let the participants try for a while and then show them the solution. At this point do not wait too long as you are not really interested in possible geometrical solutions. The important thing is to go beyond the imaginary square and the maximum effect of this insight is obtained if you do not spend too much time searching for a geometrical solution.
This is an excellent metaphor to show us how we become trapped in our prejudices and beliefs.
Important: before starting the game ask if anyone already knows the solution.
If so, ask them to be silent and not to interfere with the game.

g. Shifting focus from content to relating (from "what" to "how")
Aims: to focus attention on relational aspects of communicative process.
Example exercise: role-playing in groups of four, one speaking about something s/he considers particularly important to two listeners, while the fourth observes. The two listeners have been given different instructions unknown to the speaker: one expresses agreement verbally and disagreement non-verbally (posture, breathing, facial expressions etc.), the other the opposite set of behavior. Then compare the experiences of all participants, especially ask the first participant to say who s/he felt more connected with.

h. Communicating with the knowledge of the other's values
Aims: to get to know the importance of each individual's sets of values affecting how they see the world. Learning how to recognize the values of others and using this knowledge for efficient communication.
Example exercise: "Searching for Values". Ask participants to work in pairs. In turn, one of the two chooses a topic to discuss. The topic must be related to what the participant feels important in her/his life. The other, without discussing with the partner, has to use active listening with questions and find out 3 or more values relevant to the speaker and write them down. Each value must be expressed, summarized in a single word, not in a sentence (like love, friendship, work, success, family, adventure, etc.). Questions must be kept short to encourage the person to talk about their selected topic. After 5-6 minutes the participants exchange roles, so the listener becomes the speaker and vice versa. When both have finished, they can compare notes. After this short discussion in pairs ask each pair to share what they discovered in plenary meeting. For this exercise it is obviously important for each participant to check if the values identified by their listener mean something for them, if they recognize themselves in these words or if they want to add anything. After this short practical experience with the group you can discuss what values mean and how to become more sensitive to other people's values.
Example exercise: "The Magic Shop". This exercise is about selling. In some way, service providers are also sellers of new ideas, new perspectives, new points of view. Consequently recognizing which values are essential for the

User ("client" for this exercise) is very important.
This exercise follows the "active listening" and "searching for values" exercises.
Divide the group into 3 smaller groups.
This is a role-playing exercise: where each group chooses someone to be the "seller" and another to be the "client". All groups take part.
In turn, each "seller" and "client" from every group will have played their respective roles with their counterparts from the other groups.
Each group has the task of selling one magic or strange thing (for example, a flying carpet, walking suitcases, self reading books etc...).
Even if the situation is "unreal", the "client" has to behave according to what s/he feels during the interaction with the seller: if s/he feels interested or motivated to buy s/he has to show it, otherwise not.
The "seller" can invent any characteristic about the product (magical, technological etc.) and may have a time-out for consultation with her/his group in order to decide on the most successful strategy.
After the first round you can underline elements of the client-seller interaction. For example, it is very common for a "seller" to talk much more than a "client". The stereotype about being a "good seller" is to be a talkative person, but in reality listening is the most important. A "good seller" is able to make short and appropriate questions and understands the "client's" needs and values on the basis of the answers that s/he *listens* to.
A second round can be played now: the "sellers" are required to use the *listening* attitude and ask more appropriate questions.
Moreover, you can underline the 3 or 4 values of the "client" (which emerged from the "searching for values" exercise), asking the "seller" to match them.
Do not worry about reality, it is a game!
The practical outcome of this exercise is to increase flexibility and listening, not to have a real sale!
You can call for a time-out at any moment and discuss what is happening.

i. Responsible communication: about being responsible for what you say

Aims: to realise the responsibility of one's own communication to increase efficiency and lessen short circuits.
Distinguishing and experimenting with some basic rules:

- The meaning of communication is in the answer it obtains
- Taking responsibility for one's own statements using "I" statements instead of "People say that ..." or "everyone..." etc.
- Clearly underlying intentions in the act of communication: *What do I really want to communicate*?
- Having a clear objective: *What do I want to achieve/ What am I getting at*?

l. Closure: exchanging gifts

Aims: Delineate the part of the training experience, which has had the most impact for each participant and finish off in a positive fashion, by letting the group acknowledge its own importance.
Let participants exchange written positive feedback about what they most appreciated: *What struck me most favorably about the people we met*?


2008

This chapter presents a summary of the sustainability analysis and strategy planning that was done by AIDOS for the HCC in Sweileh (Amman), part of the Institute for Family Health (IFH), managed by the Noor Al Hussein Foundation (NHF).

4.1 Integrated approach to 'sustainability'

> Sustainability of a development project/ intervention is the ability of its positive outcomes to persist over time, maintain relevance and raise/generate resources.

Once HCC Project stakeholders agreed that the sustainability analysis and strategy would adopt an integrated approach, any development and eventual self-reliance of the IFH (and particularly of its role as HCC) were regarded from a broader perspective on financial resources and to include the following analytical dimensions:

- **financial and economic** sustainability (e.g.: looking at the financial and other economic resources, their source, generation and utilization)
- **technical and methodological** sustainability (e.g.: concerning the stock of know-how and methods, their upgrading and valorization)
- **managerial and organizational** sustainability (e.g.: analyzing the internal organizational structure and management style/processes, their rationalization and improvement)
- **institutional** sustainability (e.g.: considering the institutional identity and role of the HCC within its stakeholder environment, including issues of liaison, coordination and partnership)
- **socio-cultural** sustainability (e.g.: evaluating the interaction of the HCC work on key social and cultural factors of its target community)
- **developmental and policy-related** sustainability[1] (e.g.: valorizing the impact of the HCC in terms of local development as well as its potential as a 'model' or body of 'best practices' and 'lessons learnt' that may inform strategy and policy at sectoral and national levels).

The Sustainability Study therefore adopted a markedly inter-disciplinary approach (using frameworks from social sciences like economics, sociology, private law, institutional theory, management, marketing, etc.). However, the overall analysis focused on economic and managerial issues – mainly due to the key role of *cost-recovery* in the sustainability strategies of HCC. For instance, aspects of managerial / organizational and institutional sustainability are a necessary condition of sustainable income for IFH to continue pursuing its mandate of social development (beyond the life of the HCC as an international aid project).
The main focus of the Sustainability analysis was on HCC Project implementation and its implications for the IFH. However, other activities and projects carried out by the Institute like initiatives supported by UNFPA and UNICEF had to also be considered in the sustainability strategy, consequently this focused *on the HCC Project* while also *looking at the Institute as an overall organization* and functional internal linkages. The holistic approach of the HCC does in fact support a vision of an institution providing integrated services for the benefit of the local community, which makes each activity/project of the Institute virtually inseparable. The diagram in FIGURE 2 depicts IFH's different projects for health and counselling services. The operational units composition is described and visualized through organizational charts (under 'Managerial and Organizational Sustainability').

1 See in FIGURE 1

When working on SRH project sustainability ensure that its cohabitation or integration with/across other activities of the same health center is taken into account and clearly visualized. This helps with organizational and resource management issues, and to focus on strategic sustainability priorities.

4.2 Defining a 'sustainability strategy': the process

The IFH-HCC Sustainability Strategy was formulated and 'set for implementation' over three technical assistance missions carried out by an AIDOS contracted independent International Expert (IE) in economic and institutional development. The intervening follow-up periods by AIDOS and NHF, with the IE ensured that Health Center staff and stakeholders would fully acquire objectives and strategies. This process included three main steps:

- A '**Sustainability Study**' divided into phases for: a preliminary documentation and consultation/agreement over selected methodology; an inclusive, field-based diagnosis at the project location (HCC venue and relevant target areas); a data analysis, additional desk-research and write-up.
- A '**Planning for Sustainability**' Mission, comprising awareness-raising, technical training and participatory planning sessions, as well as building consensus and jointly producing Sustainability Strategy (composed of strategic plans by dimension and corresponding work-plans).
- A '**Strategy Implementation**' Mission, comprising an intervention of organizational development aimed at mobilizing the human and technical resources for practical application of Strategy and setting up/modifying necessary structures/mechanisms.

These resulted in: three comprehensive reports, detailed sustainability plans, organizational charts and basic tools for financial monitoring, cost-recovery calculation and costing/pricing which were all validated, shared and utilized/ applied by the relevant actors as instruments/ tools of day-to-day progress towards the chosen sustainability objectives.

4.3 Methods of information gathering and analysis

The most important components of the Sustainability Study were carried out at project location (in Jordan) and used the following for collecting information:

a. *'participant observation'* of all IFH health and counselling activities, both at Institute's premises and in the field:

- individual consultations (Clinic and CDU – Child Development Unit)
- counselling sessions in groups and one-to-one (psycho-social and legal counselling team)
- home visits (awareness raising, baby-massage, reproductive health)
- yoga, relaxation and reflexology sessions
- information sessions on reproductive health
- information campaigns
- presentations, workshops and seminars (at local community centers and schools)
- planning and technical meetings;

b. *daily meetings and briefings with IFH management* (Institute's Director);

c. *participatory techniques* (brainstorming/ mind-mapping, clustering, ranking) applied within *focus groups* and *plenary sessions*, aimed at clarifying the developmental focus of

HCC, the sustainability framework for IFH and in particular the concept of '*cost-recovery*';

d. *one-to-one interviews* with all staff (at administration, technical and support level);

e. *meetings and interaction with users* and local community organizations;

f. *meetings and networking with governmental institutions and international development agencies* relevant to the work of HCC;

g. *review of MIS data and project documentation*, with a focus on budgets, financial reports, target groups demographics and documents containing agreements or contracts with other institutions.

Allow for adequate periods of time for consultation over potential methodology and identifying relevant tasks/activities. These periods should extend to cover sustainability-related missions/activities, extensive field-based participatory analysis, diagnosis, planning and setting up of implementation mechanisms built, through a systematic and inclusive process, based on solid stakeholder consensus. Appropriate technical assistance inputs (e.g. external consultants) should be supported by consistent executing/ implementing agencies follow-ups.
Two major priorities are:

- To sensitise SRH programme/center's human resources on meaning of and/ or need for sustainability
- To train/prepare/support them to achieve it through team-work.

4.4 Financial and economic sustainability

Economic and financial sustainability objective
To sustain SRH programme/health center with sufficient and well-managed internally- and/or locally-generated financial resources.

The application of 'economic' and 'financial' sustainability to the *specific* case of the HCC project (and connected institution IFH) entailed the approach outlined below:
a. The Sustainability Study looked at '**financial' sustainability** from the point of view of:

- the external and internal sources of income;
- how average annual income (based on actual data and projections for a 5-year period) had been/would be utilized;
- the institution spending capacity (an indicator of its ability to deliver services planned and its cost forecasting skills);
- other potential financial flows, from 'traditional' and 'new' sources;
- the main issues of financial management and monitoring between donor, executing and implementing agencies.

b. The Sustainability Study considered the **'economic' sustainability** of the Institute in terms of:

- A strategy for 'cost analysis, reduction and recovery'
- The criteria for costing and pricing of the Institute's services
- The possible specialization / expansion of the Institute's service portfolio
- The promotion and marketing of existing and new services
- The need for continuous investment
- A basic outline for Institute's prospects as viable 'social enterprise' (or other type of independent organization).

4.4.1 Sources of income

The income for the Institute for Family Health at the time of the Sustainability Study Mission (SSM), were from sources as listed below – data covers year 2003 (actual) and 2004-2005 (forecast):

TABLE 1

The percentage contribution of each source to the total Institute's income is indicated. Furthermore, a 'partial' cost-recovery percentage was calculated as a ratio of the Institute's own income compared to the amount of external funds available locally and managed directly by NHF/IFH. An even more realistic picture of the IFH progress towards sustainability would be given by the calculation of cost-recovery as a ratio of locally-generated resources (of various type, not only service fees) to the total funds spent for the Institute (despite being partially managed from elsewhere). Locally generated funds: total funds spent for Institute.

4.4.2 General calculation of 'average yearly income'

The average income per year provided by this project budget was € 238,231. This is the 'reference value' to forecast financial resources required to sustain the level of service delivery ensured by this project also after its end. E.g.: to continue HCC activities in a sustainable way, approximately € 240,000/year would be needed (n.b.: unless the view is taken that less and less external technical assistance would be required.) The yearly average needs to be adjusted by inflation (including possible salary adjustments linked to the national price index), as well as corrected for exchange rate fluctuations. Furthermore, the yearly average is inflated by the bulk of start-up investment (these are additional resources in the first year budget and the largest of the four yearly budgets, as it is mainly utilized to buy, install equipment and to supply intensive technical assistance to 'kick-start' the Project). However, an extent of continuous investment is needed also in subsequent years of implementation to compensate for depreciation of physical capital and to continue updating technical know-how (to counteract the 'deskilling' of human capital).

4.4.3 Budget analysis and forecasting / Running costs and investment

Throughout HCC Project life-span, the portion of funds managed at field level was about 70% of the total project budget.
The majority of project funds were obviously spent on salaries - as the IFH is a service-based organization and therefore relies heavily on personnel for technical, managerial support. However the use of some human resources can be rationalized in view of future sustainability. The IFH salary expenses are also relatively 'deflated' because some staff in this study was assigned by the Government (MoH and MoE) and IFH only had to top-up their salaries with a monthly allowance. In similar cases, the sustainability scenario should be considered where governmental support is discontinued, or non-existent and the Institute needs to cover the actual full cost of human resources.
Further below a method is suggested for IFH to calculate the composition of its own available budget, including all funds allocated by other development projects/agencies and its own locally-generated income, without referring to the overall Project's budget of which at least one section (e.g. expatriate personnel, international travel, technical assistance) is spent 'for' but not 'by' the Institute.
The Institute's forecast of financial resources needed for its self-sustenance (from the end of the HCC co-funding budget) had to take into account not only the expenses required for institution's day-to-day running but also necessary 'investment' resources for:

skills upgrading, equipment depreciation and replacement costs, and - if relevant – infrastructure expansion and/or personnel endowment[4].
Therefore for a realistic picture of sustainability financial requirements, IFH had to estimate the cost for 'minimum continuous investment' to be provided by Institute's own resources after the end of the Project.

4.4.4 Cost analysis / Average and marginal costs

Cost analysis, i.e. the calculation of unit and total costs of production or service-delivery, is crucial for calculating sustainability for it provides fundamental information to assess:

- whether production or delivery is being carried out efficiently (if not, a margin for cost-reduction should be identified as specified later)
- whether products or services are priced appropriately, i.e. to cover costs and generate a margin (if not, there is an opportunity for revenue increase through a revision of pricing policy)

The IFH was thus advised to develop a costing strategy, to be then complemented by an appropriate pricing policy.
The **first phase of the costing exercise** entailed calculating the *average cost of service-delivery 'per case', independently from the type of service delivered*. The Institute had already initiated this by dividing direct and indirect costs by the total number of cases dealt with during a certain period like one financial year. This basic type of measure can act as an indicator of increase or decrease in cost-efficiency.
In view of its future sustainability, the Institute had to pinpoint areas where cost-efficiency could be improved or categories of service-delivery from which sufficient revenue could be made to cover the relevant costs. At the time of the SSM, the Institute was covering some costs through project funds (e.g. all counselling services), while other services (part of the medical and most of the child development services) were part-funded by cost-recovery through charging fees. The need was identified for all services to be at least partially funded through cost-recovery and for some degree of internal cross-subsidization to take place (for funds to be used from those services that generate more income to cover expenses and costs from other lower cost-efficient sectors; some target groups can afford to cover a higher percentage of the cost of services accessed by them). However, as IFH's work is divided up into operational units (clinic, counselling, child development, etc.), each unit was expected to agree and work towards cross-subsidization (sharing their fees) for the sustainability of IFH as a whole, but staff did need to be motivated by incentives (such as the reassignment of a reasonable percentage of cost-recovery resources to the unit that generated them, and/or participation in decision-making with regard to reinvestment).
In view of the what was set out previously, the **second phase of the costing exercise** was initiated using the following the step-by-step procedure :

- Divide services offered by IFH in categories according to similarity of cost structure
- Spell out types of inputs for each category of service
- Separate direct from indirect fixed costs, and variable costs
- Determine unit costs of various inputs
- Record actual amount of inputs for each service (or per x number of cases) and allocate relevant total costs per service
- Calculate total cost per service (per x number of cases)

4 In the HCC Project phase of the Institute's life, the 'investment' (for start-up and consolidation purposes) was being administered and delivered by the executing agency (AIDOS) mainly through technical assistance, management/co-ordination backstopping and M&E.

- Calculate average cost per service per case (or per unit of time)
- Compare costs across categories
- Compare costs across time
- Compare costs with other institutions
- Compare costs vs. current fees
- Define a strategy for re-pricing

More specific details can be found in TABLE 2 (see Annex 5).
It is strongly recommended that any Institute designs and adopts appropriate formats to record input utilization and unit costs for every service as soon as possible. Some useful information (especially the totals of services delivered per period of time) was already being systematically collected through Institute MIS use. This is a good start to establishing a proper costing methodology.
Once this data type is gathered for approximately 6 months in a HCC, a thorough economic and financial analysis is possible, to form basis for new efficiency policies and, possibly, for a re-pricing initiative.
In the **long-run**, after the transition from development project to independent organization, if IFH (or other HCC) is run as a '**social enterprise**' (commercializing its services, cross-subsidizing the ones for the underprivileged, and reinvesting its profits for social purposes into further expansion, outreach and quality improvement), it is crucial for its viability to operate at the scale (and price level) where profit maximization is ensured. The costing strategy outlined in this chapter, if properly applied, can build a HCC capacity in this regard.

4.4.5 Spending capacity

Before considering additional sources of funding that might support investments geared towards future sustainability, an SRH center should consider its own ability to utilize the already available resources not only efficiently and effectively, but also *timely*.

The first tool to assess the latter aspect is the calculation of the center's *spending capacity*. Budget monitoring should contribute to ensuring that activities are carried out as planned and within allocated time frame, especially in the case of donor-funded projects. This is because sometimes unspent funds cannot be shifted from one year to the following financial year if they come from a donor agency i.e.: when a no-cost extension cannot be granted, this consequently results in a loss of resources. Furthermore, a clear picture of spending capacity also provides vital hints as for the most appropriate scale of operation and or restructuring needs in a service-based center.

4.4.6 A 'cost-reduction' approach

Most experts agree that sustainability in health care tends to focus on '*cost-recovery*', advocating for user charges to cover at least the operational costs of health structures. However, one of the main critiques to this approach is that (even before setting up a cost recovery strategy costs through commercialization of services and other income-generating activities) it is imperative to consider an institution's cost structure to verify its cost-efficiency and define a **cost-reduction** (or **cost-containment**) policy aimed at enhancing it.
In the specific case of IFH – *based on the data provided by AIDOS and NHF and on the observations carried out during the SSM*, it appeared that both strategies - 'cost-reduction' and 'cost-recovery' - could be run in parallel. A few basic elements of both had in fact already been initiated by the Institute: the fees charged by IFH for some of its services already allowed for a limited cost-recovery; from the point of view of cost-reduction, the Institute's management had been encouraging staff to contain costs of consumables and communication (e.g telephone) as much as possible. The IFH management also emphasized the limits and unpredictability (in the longer term) of external funding so

that personnel would be aware that careful consideration was needed when using 'scarce' resources. The preoccupation with a cautious and precise management of external funds was certainly an asset, however IFH future sustainability also depended on:

- All relevant staff being aware of actual amount of financial resources available for various services, the reasons for allocation decisions, the options for improving spending strategy and – for cost-containment – the areas where savings or cuts can be operated without compromising adequate service delivery. By involving the technical personnel in these aspects, the cost-reduction objectives are internalized and their sense of responsibility increases, and the chances of success increase in turn.
- A clear definition of a cost-reduction strategy, and its distinction from (and pre-condition for) the much more challenging and complex cost-recovery strategy. A detailed analysis of the cost-structure needs to be followed and complemented by setting objectives and targets for cuts and savings.
- Encouraging suggestions and initiatives from the technical, administrative and support staff concerning possible cost-cutting and cost-saving measures.
- Realizing that cost-containment is essentially a short-term measure, (=more 'survival' rather than 'sustainability'). Ultimately cost-recovery and income-generation are factors allowing *targeted investment* needed to build up institutional capacity and technical know-how that are indispensable for a self-reliant organization. Cost-cutting and cost-saving measures are mostly useful in the short-term.
- The only acceptable cost-reduction methods are those that do not compromise *quality* of and access to the services provided by a HCC.

Cost-cutting and cost-saving

Based on the above premises, measures of cost-containment in the delivery of a HCC services may include:

TABLE 3

Cost-efficiency vs. cost-effectiveness

These two concepts are related but different, and pertain to two separate levels of economic evaluation in the analysis of sustainability. When considering cost comparisons, it is in fact necessary to clearly distinguish between cost-efficiency and cost-effectiveness:

- **Cost-efficiency** is concerned with the cheapest way to accomplish a defined objective.
- **Cost-effectiveness** is concerned with quantity of the output achieved for a given sum of money, but also with the quality of that output.

Therefore, it is possible for a delivery system to be more cost-efficient than another, but less cost-effective when **quality** is concerned. In the particular case of service delivery in the public or non-profit sector, where social returns on investments are a priority, the welfare aspect of 'fair distribution' or 'fair access' has to be taken into account. However, (cost)-effectiveness cannot be related exclusively to the 'technical' quality of the services offered, but also to their access and distribution within the targeted communities. Evaluation of cost-effectiveness is only possible when:

- the actual cost-structure for individual services is defined and analyzed
- cost-efficiency is appraised
- technical / quality effectiveness is assessed
- equity of access and distribution is verified
- the aspects under points c. and d. are compared with resources employed through a basic form of CBA (cost-benefit analysis)

In the medium to long term, the economic evaluation of a HCC effectiveness is one of the crucial steps towards sustainability as including the social and developmental aspects of the center's mandate. (In this context it is important to remember the World Health Organization position on efficient and effective delivery of health services as focusing on their 'goodness' (i.e. how well health services respond to what people expect) and fairness (i.e. how 'equally' well the health services respond to everyone, without discrimination) as well as on performance (i.e. how much can be accomplished with currently available resources) and on stewardship (the careful and responsible management of something entrusted to one's care -- in this case of the health of others and public resources).

4.4.7 Cost-recovery: theory, policy and evidence

Cost-recovery in health care is normally attempted for five main reasons: lack of funding; inefficiency; inequity and based on raising revenues; improving efficiency; ensuring more equitable access.
Considering that health care financing mainly comes from public revenues, insurance schemes, community funds and user charges, the issue of whether health care should be 'free at the point of delivery' ultimately depends on two main considerations: the distinction between primary care and emergency care vs. other services; and the actual availability (and sustainability over time) of public (national) / donor (international) funding.
Cost recovery (as shown below) can be calculated by dividing the amount paid by Users - through fees, taxes, insurance or direct community contributions - by the total cost of services (including salaries, operational costs, overheads); normally only the direct and indirect costs of delivering services are considered, i.e. those costs that are clearly linked to such delivery.
A more complete version of the cost-recovery calculation, especially in view of future sustainability, would also include the 'net' investment costs needed for new equipment or new skills. If only considering depreciation, the investment is limited to what is needed to preserve a constant amount/value of capital (with no capital expansion or skill upgrade allowed for).

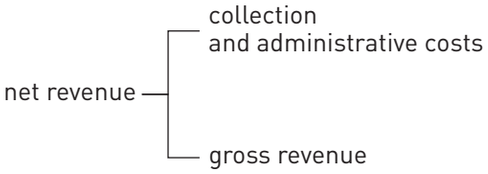
TABLE 4

The two main methods of cost-recovery are the following:

- increasing the amount paid by Users (health service charges, taxes, insurance, community contributions);
- improving revenue through income-generating activities (e.g. training services).

The ratio indicated by the above formula could be increased by making the denominator smaller, e.g. reducing costs, but this strategy is technically not part of cost-recovery as such. It is rather defined as 'cost-reduction' or 'cost-containment' (discussed earlier). It is a short-term measure and can represent an initial step on the path to financial and economic sustainability.
It is important to emphasize that cost-recovery in the strict sense of the term is only obtained through locally-generated funds. Therefore, any increase in external funding (e.g. from international donors, through cash or in-kind donations) has no impact on cost-recovery.
It only represents an additional fund-raising channel and **does not contribute to long-term sustainability**.
Cost-recovery as a process also entails its own specific administrative costs (deriving from: staff/stakeholder consultation, fee calculation and design of collection system, information / awareness-raising, training and induction of staff, enforcement and control systems,

local management and decision-making over the use of revenue), therefore:



It is also argued that User charges have an allocative efficiency effect through the use of price signals in the market, as well as encouraging a disciplined use of the health care system. However for under-privileged Users, waiting time, distance and discomfort of services already represent a deterrent from any superfluous use.

Any services that will be charged have to be appropriately identified and selected. For example: treatments for contagious diseases and STDs are usually those that remain free of charge, and this should also apply to all those ailments whose 'social cost' – cost to the community as a whole - exceeds the private costs. However, the expenditure related to avoiding such social costs should rather be absorbed at national level, i.e. the government (through MoH or other body) should subsidize such services at point of delivery (the HCC).

When a cost-recovery system allows for widening access through new venues or more outreach work in the disadvantaged areas, then the effect of user charges is pro-poor.

When designing a sustainable user charge system, the following fee-setting options should be considered: (a) Differentiating by: service level; type of illness; type of patient. (b) *Either* flat rate registration / consultation fees or variable charges according to: number of items prescribed; use of diagnostic services; length of stay/use.

Below are some essential conditions for success of cost-recovery programs:

- Appropriate selection of chargeable services and fee-setting criteria
- Perceptible quality improvements
- Suitable information and publicity strategies
- Reduction of inefficiency and waste
- Reduced cost of access to effective care, especially for the poor
- Retention of fees (for local reinvestment)
- Revision of fees (e.g. adjusted by price-index)
- Appropriate management structure and skills
- Adequate induction and motivation of staff to enforce the system
- Monitoring of effects of cost-recovery on health-seeking behavior
- In community management, accountability of committees overseeing revenue utilization

4.4.8 Cost-recovery and income-generation strategy of IFH/HCC

Three levels of cost-recovery.

HCCs have a limited range of tools to improve cost-recovery ratio and raise the revenue needed for sustainability:

- fees, i.e. user-charges
- income-generating activities (IGAs)
- community contributions

The *first* category relates directly to the existing services of the HCC, for some of which IFH was already charging fees. The *second* refers to all those services that a HCC can 'sell', ranging from the expansion, diversification and commercialization of existing activities to the design and development of completely new ones (e.g. training, consultancy, etc.), as well as the more extended or intensive utilization of the center's infrastructure (i.e. rental and profit-share contracts).

The design, development and promotion of Income Generating Activities (IGAs) should constitute the core of the economic sustainability strategy of a HCC. Like those outlined in the

income generation framework for the IFH. See TABLE 5 (see Annex 5).The *third*, usually the most labor-intensive and with comparatively lower returns, is concerned with local fund-raising, in-kind donations and volunteer (skilled or unskilled) labor. Despite being legitimately defined as locally-sourced funds, they tend to be one-off and unplanned or discontinuous. They can be defined as 'sustainable' insofar as they are 'local', but they might actually not be 'sustained' over time. However, in particular the component of volunteer work (e.g., internship work, or employee overtime work carried out for free in the local community) should somehow be valorized and accounted for - in view of a future 'social audit' of an organization with enhanced 'developmental' sustainability.

4.4.9 Costing and pricing policy / The "two-tiered fee-charging system"

Appropriate fees vs. affordable services.
This section deals with a central aspect of IFH's cost-recovery and, in perspective, income-generation, i.e. the Institute's approach towards setting user fees payable for the core services commercialized so far: children's services (e.g. newborn medical exam, vaccinations); women's clinic services (ultrasound, IUD, etc.); lab tests (pregnancy test, etc.). Initially the only criterion to determine which fees IFH could apply was to compare them with prices charged by both public and private sectors, as IFH strived for competitiveness and affordability. When compared with fees payable to MoH hospitals or private clinics, IFH rates consistently emerged as the *cheapest*.
This observation prompted the following analysis:

- Despite lower prices possibly attracting more users and appear to increase the chances of IFH's sustainability, this led to the risk of the Institute operating at a loss and/or missing opportunities to raise revenue. Costs of delivering the services had to be taken into account, to make sure that prices were at least covering costs.
- When comparing IFH's user charges with the fees charged in the public and private sectors, services that appeared to be similar were not assumed to be 'identical' and thus perfectly interchangeable (i.e. price is not the only factor in customer's preference for a service provider). Health services (especially doctor's consultations relying on individual skills and knowledge) are not homogeneous goods, but rather differentiated ones. Thus competition takes place by price only up to a point, and within an 'affordable range' the User's choice will be based on quality, trust, comfort and convenience.
- In a typically imperfect market such as health care (characterized by asymmetric information and limited user control), marketing success might be linked more to technical specialization, innovation and location rather than price itself.
- There are non-fee costs associated with health care consumption, such as transport and waiting time. Users will thus balance the amount charged against the other costs and go for what is more convenient as a whole (e.g. perhaps the most expensive – by a reasonable margin, but also closest and most time-efficient clinic).

Considering the above points, it became clear that IFH should reconsider its price policy and possibly raise its fee levels, at least marginally. As for the aim of keeping services affordable to benefit the most underprivileged, the IFH had to consider the following:

- Services were utilized at a very cheap rate by all members of public, including residents outside target area and belonging to middle-income groups. This amounted to repeated cases of misdirected targeting.
- Ensuring that service provision for the

poor can be sustained over time requires it to be cross-subsidized, so that ordinary Users pay appropriate fees (covering costs and generating some margin) while exempting or discounting the services for the underprivileged.

The so called 'two-tiered' fee system has been successfully adopted in several developing countries (where scarcity of resources has called for intensification of cost-recovery), usually based on three minimum conditions:

- Criteria for exemption or discount are clear and rigorously applied
- Price 'certainty' is ensured by publishing only the normal standard level of fees, together with eligibility criteria for 'exempt status' – any further fee levels might become confusing for the public.
- Adequate publicity about reasons for fee-charging and the aim to cross-subsidize social development

The IFH enjoys the advantage of direct knowledge of its beneficiary Users, through home visits, counselling and daily contact with the local community which is very socially varied.
The Institute's ability to record information about local households, through the MIS or by other means, contributed towards a relatively 'de-personalized' targeting process which determined which Users really needed free access or discounted services. The only alternative is relying on self-targeting, through self-selecting user fees. This means that services are delivered, packaged and priced in a way to minimize free-rider or frivolous use risk and facilitate a rational allocation of resources[5].
Cost-recovery should not induce the health provider to compromise on quality. The latter should be guaranteed also when the service is free at point of delivery.

Costing and pricing principles.
A strategy for IFH to determine costs by category of service and per case was outlined earlier in the chapter. Only a few reminders are needed here with regard to costing (how much a service actually costs) as a precondition to pricing (how much a service can be sold for):

- Without proper costing, a HCC would be unable to determine whether its commercialized activities are producing a *surplus* (more money than they are spending), are going to *break-even* (generating the same amount of money that they are spending), or are resulting in a *deficit* (spending more money than they are producing/generating).
- When considering the costs of an activity, a HCC should distinguish between its **fixed costs (direct and indirect/overheads)** and **variable costs**[6].

Pricing will be influenced by HCC policy (e.g. has the center a social mission or is it more preoccupied with making profit?). – and objectives (e.g.: after having been established as a charitable organization it will try in the future to enhance its business-oriented side).
Besides of course depending on its **market / environment**).

- If the plan is to provide services at cost level, then the P=Price will be:

P = break-even cost + contingency margin

5 If a service is priced higher as a sort of luxury good, it is "justified" as added 'comfort', e.g. priority tracking. However core service quality should be consistent throughout price range for the same type of consultation or test.

6 This also has a bearing on decisions regarding its scale of operation (because adjusting its operations to serve more or less Users will have a bearing on unit costs and thus on margins).

- If services are to be subsidized, then the P=price will be set where P is less than the break-even cost:

P < break-even cost

- If one of the main aims is to generate profit, then the P=price will be where P is more than the break-even cost:

P > break-even cost

In the latter case, the question is "how much higher to set the price"?
The diagram below visualizes the options that a HCC is presented with.

- The **Price Floor** is the minimum price, or 'cost price', i.e. the lowest price at which all costs will be covered. If this price is set, the services will break-even (=be equal to) at the planned number of cases. (e.g.: estimate of service delivery over a period of time)
- The **Price Ceiling** is the maximum price that can be charged while still achieving required volume of sales. It is determined by User demand and prices charged by competitors. Determining the price ceiling is not an exact science: it requires knowledge about Users and the price-elasticity of their demand for services. To maximize surplus, the price should be set as close to the price ceiling as possible.
- The **Price Range** is the area between the two limits, floor and ceiling. Setting the price too close to the price floor may mean a lost opportunity for raising revenue, as users would actually be prepared to pay more. This is what IFH had done before. Furthermore, by only considering the competition – its own prices were also set very low.

For instance based on the above here is a summarized list of possible pricing methods:

- **'Cost plus'** : a simple method to set a price by adding a set percentage on total cost for a given sales target. if the mark-up is decided arbitrarily and without reference to the price ceiling, it might result in uncompetitive fees and lost business.
- **Competition-based** : price is set in line with the competition/what is available; difficult to apply when there are no comparable services, and unrealistic in a market where competition is not only by price (but rather by quality and/or innovation).
- **Customer demand**: prices are set as close as possible to the ceiling in the attempt to maximize surplus. It might be difficult to ascertain how much customers are prepared to pay. In any case it needs to be complemented by strong differentiation (through advertising and branding), so to engender trust and quality awareness in the clients.

And this was what the IFH was advised to apply a reasoned mix of the above three methods and following approaches:

a. Calculate what type of **mark-up** was necessary to start raising the revenue needed for prospective sustainability.
b. Compare the price obtained through (a) with the competition and attempt to place IFH prices within the range of public (floor) and private (ceiling) sectors, while also comparing with similar services in the non-profit sector.
c. Carry out market research to assess the possible price levels that ordinary Users might be prepared to pay, and the potential volume of sales.

d. Design a **marketing and promotion strategy** creating awareness on IFH service quality and IFH policy of **cross-subsidization** (of affordable/free services for the underprivileged by means of cost-recovery and income-generation).

4.4.10 The need for a marketing strategy

Making commercialized services successful is ultimately about good marketing. Price is just one component of the classic **marketing mix** of **Product, Place**, **Price** and **Promotion** (also known as the **'4 Ps'** of marketing).
Despite IFH had started providing some of its services at a price for at least partial cost-recovery and was planning to sell additional services for income-generation and future sustainability, it had not yet developed a comprehensive and systematic marketing strategy for the Institute as a whole or by categories of activity. This emerged as a serious gap that needed to be filled in parallel with the actual design of most IGAs. To this end, the following steps were suggested:

- **market segmentation**, identifying potential customer categories – and relevant purchasing power / need for assistance[7];
- undertaking **market research**, related to actual price-elasticity and health/ SRH care-seeking behavior in relation to medical services and lab tests and for additional commercialized services like training courses and yoga sessions, in different User categories[8];
- **Service Design & Development (SD&D)[9]** related to the analysis of potential demand for services and taking into account competition (at least within same target area);
- defining and improving **IFH's corporate image[10]**;

7 e.g.: affluent households (Jordanian and expatriate), from upmarket areas of Amman; development agencies, international organizations; large-scale companies; Government bodies; Universities, training institutions, research institutes; Middle-income households, from Sweileh and surrounding areas in Amman; Community organizations, schools and kindergartens in Sweileh; Underprivileged residents of Sweileh, under a set income-poverty line; Vulnerable individuals in Sweileh, e.g. women suffering violence; children with disabilities.

8 Part of the market analysis was carried out through participant observation during field activities, means testing (assessment of income and assets needed for poverty targeting) during registration with the IFH, or by specifically designed data-gathering.

9 This aspect has implications for technical and methodological sustainability.

10 This aspect was directly linked to IFH's institutional sustainability, and entailed: clarifying name and mission of IFH/WHCC, making appearance of buildings more conspicuous through signage, providing staff with badges/nametags and business cards, defining IFH/WHCC's logo, setting up a web-site, circulating an email newsletter, etc.

11 Direct promotion in the local community through home visits, school visits and presentations at local community centers. Dissemination (in Sweileh and other targeted areas in Amman) of improved IEC materials: IFH brochures and leaflets by service category; videos, CD-ROMs, web-site, e-mailing lists, posters, banners. Well-designed, appealing and systematic advertising on newspapers, radio & TV (making sure that IFH technical staff and users present their 'real stories' during interviews), local buses and other public spaces. Ensure different type of adverts are well targeted to different types of audience. Ensure that all advertising messages emphasize the Unique Selling Points (USPs) of IFH services, to emphasize differentiation and 'branding' and shift from price competition to competition by innovation/quality.

12 Extend IFH opening hours. Offer transport and nursery services at cost-sharing rates
Intensify home visits and on-site delivery. If relevant, target specific areas beyond target area i.e.: where target area market is already saturated, purchasing power inadequate or type of service irrelevant. Advertise 'package offers', 'inducements' and 'promotional rates', especially when launching new service. Offer flexible modes of payment, e.g. membership cards, discount prepaid carnets and gift vouchers.

- intensifying and improving **promotion and publicity** of IFH services at various levels[11];
- flexibilizing delivery modes, to **improve distribution** channels and widen **access**[12].

As a general consideration on the nature of *markets in health care*: when developing their marketing strategy, the management and technical staff of a HCC should be aware that they are not dealing with a 'typical' market. Commercialized services in health care, i.e. any service that is not free at the point of delivery, are in fact the object of transactions in two special types of markets:

- A '**quasi-market**' -- where the transaction occurs between a public entity (like MoH) and the health care provider (like IFH); in this case the HCC is not just a provider but also a sort of implementing agency of Governmental policies. This makes it accountable for more than just the provision of an X number of cases for an X financial reward. Negotiation will not take place just based on price and quality, but also based on trust/credibility and institutional role.
- A '**social market**' -- where some of the services are marketed at subsidized/ discounted prices or at cost-recovery / cost-plus rates for cross-subsidization of social development activities. Here as well, bargaining will not occur as in any market place: while the users of the discounted services tend to be poor or vulnerable persons with very limited customer sovereignty, the Users paying standard rates need to be sensitized regarding the social mission of the non-profit institution.

4.4.11 Resource mobilization and investment plan

Resource mobilization, though important, is technically not central to a strategy of sustainability based on locally-generated funds. As shown by the formula for the cost-recovery ratio, the objective of increasing the value of such ratio is actually hindered by the mobilization of additional resources from external funding. These would in fact contribute to inflating the denominator of the ratio and make its value even smaller (in simple terms, the more the external funds, the more the money to recover!). However, the option of resorting to additional/ alternative funding channels from international organizations and development agencies (like AIDOS and EC - in the case of the HCC project) could not be discounted as simply inadequate. 'Investment' (a recurring concept in this sustainability analysis) has a key role not just in counter-acting depreciation and erosion of project's resources over time, but especially in ensuring those improvements in capital endowment (e.g.: improved equipment and technology) and skill upgrading that will prove crucial for technical and economic sustainability. IFH was therefore advised to carefully assess its investment requirements and timing, i.e. to identify whether additional investment be needed for the Institute's capacity building even beyond the amount that the HCC project would provide in terms of technical assistance and equipment. In such a case, it may be judged appropriate to seek additional funds from the same or other donors, however with the clear aim of investing them into the strengthening of the HCC and in line with a specific sustainability strategy. However, if the new external funding were raised only to temporarily counter financial problems or to simply cover operational costs, this would mean that cost-recovery has not achieved any meaningful impact yet. This in turn casts doubts on the viability of the HCC and discourage potential investors. If investment resources are needed, then the HCC should define and promote

its investment plan, package it in the form of specific project proposal(s) that should fit in the overall sustainability strategy, and initiate systematic efforts of resource mobilization from the following potential sources:

- Local and national **fund-raising** (e.g.: through events like charity events, bazaars, gala dinners, etc. These are not really part of cost-recovery when generating only one-off and discontinuous donations.)
- Funding applications with **bilateral and multilateral donors** and international foundations.
- Social responsibility funds of **MNCs** (Multinational Corporations)
- **Concessionary finance** (e.g. soft loans) from MFIs, development banks and ethical investment funds.

4.5 Technical and methodological sustainability

Objective of technical and methodological sustainability:
To enhance the relevance and appeal of IFH-HCC through services delivered
in the needed quantity and variety, at an adequate technical level
and with the appropriate methodology

Technical assistance was mainly provided by AIDOS experts in the specialist fields relevant to upgrading the ICHD/IFH into a HCC.
This 53-month process considered the Institute's range of services and spelling out the skills and qualifications of the human resources required to offer the services of such an organization, thus contributing towards the technical and methodological sustainability of IFH-HCC.
The IFH advertises as its main mandate the provision of services characterized by a '*holistic approach*' and is aimed at meeting the different health needs of the household, while contributing to disseminating and promoting reproductive health principles. Consequently IFH services target women of all ages (generally of reproductive and menopausal age), adolescents and children. TABLE 6 in Annex 5 outlines a classification of IFH's units and activities.
Possible technical and methodological sustainability of IFH was based on:

- the *range and quality of available know-how and facilities* – (i.e.: what isn't available from other similar organizations)
- the way IFH *adds value* to the local community by means of its '*specificity*' (i.e.: which services and products are specific to the IFH)

When compared to the average type of services offered by other health centers in Amman, the four main features that afforded IFH a certain degree of **'comparative advantage'** were:

- Its **integrated, interdisciplinary** nature (its 'holistic approach')
- The emphasis on alternative and conventional therapies that promote **well-being** as a **preventative** attitude to health care – targeting also **adolescents** and **menopausal** women.
- The involvement of **male members of households** (both adolescents and adults) through men's counselling groups and awareness raising workshops[13].
- The **outreach** dimension of HCC's work: home visits, home-based counselling and awareness raising groups carried out by professional counsellors and field workers.

13 This approach is based on the principle that the male section of the targeted community can and should be involved in and share the objective of raising the quality of life for women and children in the local area. Given the socio-cultural context, this is a highly positive challenge that the HCC Project set for the Institute, and its implications are discussed more in detail under "Socio-cultural sustainability".

The range of IFH activities required an astounding variety of technical and professional skills, as shown by this list of the Institute's service providers:

*	GP (General Practitioner)
*	Pediatrician
*	**Gynecologist**
*	**Midwife**
*	Staff nurse
*	**Practical nurse**
*	Lab Technician
*	**Psychologist**
*	Special Educators
*	Speech Therapist
*	**Physio-Therapist**
*	**Lawyer**
*	**Yoga / gym trainer**
*	**Male counsellor**
*	**Social worker**
*	**Field workers**
*	Field officer
*	Communication officer

The service providers in GREY are not included in the main job descriptions list in this guide, but correspond to the IFH case study list.

Together with the Management and Support staff, the personnel listed above form the core requirement of the IFH's technical sustainability; for a service-based organization, the human resources – with their qualifications, know-how, experience and institutional memory represent its cornerstone, main 'factor of production' and source of competitiveness.
Most of the personnel was supported by the HCC project, apart from CDU's staff and those seconded by MoH and MoE. The continued support from these Ministries is also an important ingredient of the technical (and not just financial) sustainability – given that specific staff with special competencies and skills adapted to the IFH approach and some degree of institutional memory, are not easily replaced.
Such a complete range of human resources as listed above can support a HCC sustainability - if properly motivated, stimulated, engaged in the appropriate roles and at the correct level of decision-making. **Participation, inclusiveness and continuous consultation - aimed at a rational utilization of all available in-house resources and skills** – are key factors of technical sustainability. Please also see AIDOS guide section dedicated to encouraging Team Work and its importance.
To fully understand the scope of IFH human resources and consequently be able to use its full potential, the IFH was therefore advised to compile a **roster of skills** and check how they matched with the relevant staff positions and the possibility/availability to use those skills more effectively or strategically.
Following further AIDOS consultant inputs, the Institute would then proceed to **review job descriptions** to provide staff with the opportunity of contributing even more actively to the Institute's successful future self-reliance.
More about organising personnel is discussed later in Managerial and organizational sustainability.

HCC tend to be knowledge-based service-delivery organizations and thus should mostly compete by innovation/quality rather than just price (fees). The quality and continuous upgrade of their human resources' technical and organizational skills are thus key elements of sustainability and require investment, mainly through principle AIDOS inputs like for capacity building, technical assistance and strategic HR policies.

(please note that we are here discussing the different types of competition as the assumption is that a health center will have to resort to some form of cost-recovery and income-generation if it wants to pursue sustainability; this means operating in some sort of market for health services).

4.5.2 Participant observation of methodological issues / Quantity vs. quality

During the SSM, the IE had the opportunity to directly observe and take part in most part of IFH activities (in particular, those related to the counselling, awareness-raising, family planning and information delivery of the HCC unit; some CDU activities were also observed). The participant observation of group or individual sessions and other center services was not aimed at a 'technical assessment' of such activities or of the know-how involved (as no one Expert could adequately evaluate such a variety of skills and specializations) but to appraise the offer range and delivery for local target groups features and needs, verify commitment and motivation of the technical, management and support staff and finally to pinpoint which technical or methodological factors might work better for sustainability.
While it is generally true that specialist knowledge, quality of service and relational skills are pre-conditions for a HCC success - and the HCC project definitely supported IFH in acquiring or strengthening such elements, the following specific points were noted through **'participant observation'**:
a. In the delivery of IFH services, both in-house and in the field, the staff at all levels appeared to be knowledgeable and committed, and was – at least at a satisfactory level - able to:

- target potential users and their needs
- identify main issues needing attention
- carry out preliminary sensitization / mobilization
- deliver advice, treatment or information clearly/effectively
- cope with and respond to 'crises' of emotional/relational nature [14]
- refer users in-house to other 'specialists' as needed
- organize and manage events / sessions
- deal with changes of program and emergencies
- ensure some form of follow-up (although at times informal or unstructured)

b. Not all staff had fully internalized the concept of 'team-work' introduced by HCC project as a cornerstone of the implementation methodology. A tendency to work 'in fixed pairs' indicated some tension or non-integration amongst the members of staff.
Some of the work was thus not fully integrated/ coordinated across the counselling sub-teams, which may cause duplications, inconsistencies, inefficacy and/or lost 'knowledge'.

c. More emphasis needed to be put on participatory techniques and inclusive communication, as most group-based sessions (either at the Institute, home-based or with other local organizations) tended to be delivered in a 'lecture' format (even when formally labeled as 'workshops' or 'seminars').
The Users thus absorbed information passively. This 'top-down' delivery mode seemed to be influenced by four factors:

- Limited knowledge of participatory techniques
- 'Status' factor of maintaining a 'distance' between 'tutor' and 'tutees'
- Group size (sometimes too large to encourage full participation)
- Time constraints

14 e.g. in the case of counselling vulnerable women suffering abuse

d. The staff generally seemed to be highly preoccupied with targeting 'numbers' of users and therefore tended to plan their activities around a very tight schedule. The staff worked towards yearly targets (either set by the HCC project or IFH) and relevant data were entered into the MIS. While meeting 'minimum' coverage requirements in the target area and ensuring acceptable level of access by the local beneficiaries, IFH was advised to revise – with the support of NHF and AIDOS – its criteria of target-design and agree on guidelines to improve 'quantity' vs. 'quality' balance.
In a typically labor-intensive activity such as 'counselling', appropriate time and establishing a rapport are crucial to the success of the activity, which otherwise loses sense and credibility.

e. From participant observation and interaction with IFH personnel, some incoherence of approach was noted which can lead to mutual mistrust. This revealed the need for additional team work and capacity building. This inconsistency was registered on different levels: motivational, commitment-related, socio-cultural (respect or challenge of established norms), preparedness and technical competence, relational skills (in a general sense).

For a HCC technical and methodological effectiveness all staff should ideally be inspired by the same objectives and principles and committed to the same guidelines. Despite this, social and cultural differences should be valorized and respected. However, when these or other individual preferences and interests seriously interfere with the mandate and technical functioning of the organization, sustainable solutions should be sought. Without aiming for total standardization, discrepancies and contradictory statements should be avoided by means of joint planning, common discussion and agreement on the messages that the HCC is entrusted to share with the local community.

4.5.3 Need for capacity building and technical assistance: a 'thinking and learning' organization

A mind-mapping workshop carried out during the SSM with all the IFH staff established a clear link between technical / methodological sustainability and *capacity building* as promoted by AIDOS, in its various forms.
Capacity building priorities, at the time of the SSM, included:

- re-qualification or upgrade in technical areas;
- upgrading ICT skills;
- training in English language;
- improving communication skills;
- being updated on latest developments of each area, through documentation, exposure and exchange of information or advice amongst colleagues;
- ensuring an appropriate 'division of labor' through enhancing and valorizing specific skills.

AIDOS' consultants carried out an assessment of the needs for additional training or exposure in the specific areas of specialization. Some cross-cutting abilities (e.g. English language and computing skills) are also crucial for an institution that needs to enhance its interaction at national level and has the potential to acquire international profile as a role model.
All these elements can contribute towards sustainability.
IFH's management was advised to make every effort (with the support of NHF) to find convenient and affordable solutions as HCC Project resources were unlikely to cover the full cost of sourcing training in the above fields from the private sector[15].
Other more flexible, informal and synergistic forms of capacity building were also considered:

- Keeping constantly updated about developments in various technical areas or on relevant policy issues, and sharing

information/references with colleagues as relevant[16].

- Sourcing/reviewing latest documentation related to HCC fields of activity and enabling all relevant staff to access it easily[17].

Setting up internal working groups, technical committees and task-forces (on specialized or cross-cutting issues) to analyze specific objectives and targets of HCC work, skill transfer, joint technical planning[18].

As a general rule for sustainability, any form of training, skill transfer and on-the-job learning does carry a cost (in monetary, time/labor or transaction terms)[19] .

One of the most effective ways to increase the chances of sustainability is therefore to limit staff turnover: this is crucial to optimize technical know-how and expertise accumulated and ensure HCC work continuity (a precondition for quality) whilst preserving institutional memory. Whenever a considerable level of investment in training or induction is foreseen for a specific post, the HCC could consider the inclusion of a 'retention clause' that commits the employee/s to remain in the job for a minimum specified period of time (from contract signing) or alternatively to cost-share part of the training in case of resignation before an agreed cut-off date.

A specific area of the IFH services where the need for capacity building became evident was the one of *socio-economic counselling*. This may be a strategic complementary service in a HCC (by direct delivery or referral to other organization/program). The package of the HCC social counselling services was appropriately designed to provide women with information and linkages to seek employment or identify self-employment options. Some initial training in women's micro-enterprise promotion was later provided. IFH was advised to enhance its capacity to deliver the above support, while still preserving the focus of its mandate: IFH's role in (self-) employment promotion should mainly consist of facilitation and connection with other organizations, schemes and projects that could

15 Local organizations (like the Chechen Society in Sweileh) offered computer training courses at affordable fees, while some NGO projects in Amman offered them free of charge with particular eligibility criteria. Raising support for this kind of capacity building and for English courses, was considered highly likely as IFH was a non-profit entity promoting social development. Private tuition usually works out very expensive, but sponsorships could be requested from institutions like the British Council or other cultural centers of English-speaking countries in Amman. Launching 'an appeal' to foreign NGOs, international development agencies and diplomatic missions was also considered, to source some volunteer teachers for IFH staff. Improving communication skills or learning participatory techniques for instanced, were other needs catered for by AIDOS Consultants during their technical assistance missions. Alternatively, training was sourced locally, also within NHF, at contained cost.

16 This is easily attainable by means of Internet and the media. E.g.: one person per week could be in charge of screening for and reporting to colleagues about articles and news on issues about SRH center's work and also providing references to track the information on the web or elsewhere.

17 E.g.: IFH's library needed to be reorganized, rendered more user-friendly and to valorise available documents/information. A library / information center upgraded for staff use, can subsequently also be opened to students and the public – depending on the context - for a small registration fee and with service charges included in the cost of photocopying (as a minor IGA contributing towards sustainability).

18 This should not result in an aimless addition of groups and panels, rather in a focused articulation of technical and policy dialogue within an institution whose long-term survival chances reside in its ability to become a 'center of excellence' in its own field (which cannot be done without a continuous thinking and learning at all levels of the SRH center).

19 The most apparent costs obviously emerge from any out-sourced training service (e.g. if a trainer is paid to provide sessions at the HCC). At the IFH, in terms of project budget the technical assistance missions had a considerable cost: actually representing the bulk of investment in HCC human resource development.

lend direct support (in financial or non-financial terms) to set up or improve a micro-business. The **technical assistance** that IFH received from AIDOS represented a core element of technical and methodological sustainability[20] and invited the following considerations:

a. The impact of the various forms of technical assistance was visible and tangible in the day-to-day activities of IFH and the positive feedback from the Users.

b. The delivery of further technical assistance in specific sectors needed to be carefully assessed and agreed by AIDOS with NHF/IFH, with an emphasis on areas of work linked to the best chances of sustainability[21].

c. AIDOS as executing agency was invited to use its international experience and networking skills to propose solutions for continuous capacity building after the lifespan of the HCC Project[22].

d. A way to make *'technical assistance 'spot' interventions'* more sustainable is for experts to ensure adequate follow-up and reinforcing measures to their missions, through:

- detailed and usable reports, written recommendations, manuals /handbooks, and other learning/teaching materials related to skill-transfer carried out during missions;
- identification of key people suitable and willing to disseminate/reinforce new skills and information in HCC's daily work;
- including a certain Training of Trainers (ToT) component to induce multiplier effect in terms of organizational learning;
- Remote follow-up (e.g. by email) targeted directly at the technical staff level and monitored by NHF and IFH management for co-ordination purposes.

4.5.4 Data gathering and information sharing. 'Best practices' and 'lessons learnt'

It is appropriate to emphasize the importance of documentation also in relation to *technical and methodological* sustainability - for any HCC, in connection with potential income-generating opportunity to document, analyze and publish case-studies and technical papers from HCC field experience.
Best practices and *lessons learnt* from similar organizations and/or in comparable SRH contexts are accessible through Internet, libraries and documentation centers of universities and development agencies, but they also represented a priority area of AIDOS experts' mandate when sharing their professional knowledge and international experience with IFH's personnel. Internalizing and utilizing relevant information should enhance efficiency and effectiveness, as well as reducing the risk of replicating mistakes.
The 'active' aspect of recording lessons learnt,

20 Other sections of this publication describe AIDOS' expert inputs provided in a range of specialist areas (psychology, gynaecology, counselling, team-work and communication skills, yoga, reflexology, relaxation techniques, etc.)

21 This could be seen as a part of the 'investment plan' as per 'Economic and Financial Sustainability' focusing on capacity building and continuous skill upgrade in a strategic manner (beyond HCC Project life-span).

22 This is the typical problem of a service-based organization subsidised by a development project (like a HCC): e.g. how would IFH ensure continuous learning and avoid deskilling or obsolescence within its organization once AIDOS and/or other development agencies pulled out? Human capital is comparable to physical capital: it depreciates and needs at least 'replacement investment' (if not net investment) to ensure consistency in the quantity and quality of services offered. It was recommended that AIDOS and NHF/IFH should start devising tools and linkages for future (low-cost) sources and channels of capacity building for WHCC.

identifying and testing solutions, and formulating a number of best practices, is a further step towards sustainability. However, this activity could not just rely on the technical competence absorbed from outside experts. It involved the nurturing of methodological skills *within* IFH, e.g. through the development of a working culture that encouraged:

- Systematic recording of information on cases and experiences, in a standard corporate format.[23]
- Participatory and comparative analysis of the above information by the relevant staff, with the aim of elaborating on it, drawing tentative conclusions and utilizing it as empirical evidence for the evaluation of their methodological approaches.[24]

4.5.5 Monitoring and evaluation

An acceptable level of technical and methodological competence cannot be reached and maintained without a suitable monitoring of processes and evaluation of outcomes. Various mechanisms were in place at IFH at the time of the SSM, in particular based on HCC Project implementation requirement:

- Internal monitoring of activities were carried out informally and on a daily basis by the Institute's Director, mainly in the form of verbal reporting by all levels of staff and when revising planning meetings minutes. Feedback tended to be individual and *ad hoc*.
- Quantitative progress towards project-based or internally-set targets was mainly recorded through the MIS set up by the HCC project.
- Progress monitoring and co-ordination missions from AIDOS executing agency took place twice a year, and *ad-hoc* distance monitoring was ensured by AIDOS Project Coordinator (both at NHF and IFH level).
- Technical monitoring was covered by the consultants' assistance missions.
- External evaluation activities were implemented at the end of the HCC Project.

Improvements in M&E procedures and approaches could contribute towards technical and methodological sustainability of the HCC and IFH as a whole:

- Criteria for internal (self-) evaluation should be made more explicit and clarified, e.g. through the adoption of a suitable 'performance appraisal cycle'.
- Monitoring carried out by each expert according to her/his competence and discretion should adopt common criteria previously agreed on by the consultancy team(s) to ensure consistency (at least on cross-cutting issues).
- The preparation for external evaluations should be an opportunity to set criteria well in advance – so that evaluation is fair and data obtained are comparable over time and across sectors.

23 This entailed extending Institute's MIS use from recording purely quantitative information to include reliable and systematic quantitative data. A format that allowed for consistency and scientific utilisation of information generated had to be agreed on (quantitative data should be comparable, qualitative statements should be based on shared criteria, etc.)

24 This could have a wide scope: improving the technical quality of services; producing interesting and useful publications; preparing IFH to play a role in strategy design and policy dialogue at national level.

4.6 Managerial and organizational sustainability

Objective of managerial and organizational sustainability
To develop and maintain an efficient, effective, flexible, responsive and participatory
internal organization and management system.

4.6.1 Analyzing 'managerial and organizational' sustainability

This analysis relates to the *internal* aspects of organizational structure, management model and style, co-ordination, co-operation and working modalities, i.e. the *functioning* of a HCC as opposed to its *identity* in the institutional environment and its *external* relations (networking, partnership) with other institutions/organizations.
The SSM reviewed the organizational model of IFH with a view to its potential sustainability as an efficient and effective organization and whether the way it functions reflected the social purpose and participatory human rights-based approach towards its human resources and target groups. Some recommendations pointed to easy-to-adopt short term, marginal or gradual improvements, with minimum effort. However, IFH also appeared in need of some radical changes in the organizational model, management practices and planning/implementation/monitoring mechanisms. The analysis was based on participant observation of IFH work and direct interaction with staff at all levels and not influenced by an appraisal of staff performance (i.e.: non-personalized).

4.6.2 IFH's management model: strengths and weaknesses

The first step of this dimension of the sustainability analysis was to identify and assess:

- Structure (hierarchical levels of individuals/teams/units)
- Functions and roles (at individual and team level)
- Decision-making and supervisory processes (top-down flows)
- Reporting lines (bottom-up flows)
- Consensus building and planning mechanisms (circular or network flows)

Following this exercise, a revised organizational chart (structure-related) and the framework for a flow diagram (process-related) were proposed to illustrate the vision of a more sustainable organization.The starting point at the time of the SSM, in terms of structural analysis, was represented by the 'Personnel Structure Plan' adopted by IFH in the year 2003 - reproduced in TABLE 7 (see Annex 5). This plan revealed some formal features of IFH's organizational model that raised concerns for sustainability:

- The office/position of the Director was seen as an autonomous entity, placed at the top level and independent from any administration/management organ. i.e. the staff visualized this position as a synonym of 'decision-making'.
- No 'heads of units', 'coordinators' or 'focal points' were indicated in this organizational chart. There was therefore no 'middle management' level, i.e. more than 30 employees were directly monitored by only one person (the Director).
- Hierarchical levels and reporting lines were not clear.
- Decision-making, co-ordination and delivery processes were also formally undefined.

Concerning day-to-day operations, the *'real' structure* (emerging from observation

of activities and interaction with IFH staff) was visualized as in TABLE 8 (see Annex 5).
The *'intermediate layer'* (composed of coordinators, office manager and finance officer) only **conveyed** information or requests 'bottom-up' and information or instructions 'top-down', between senior management (the Director) and the two main groups of staff (technical / operational and support). The lack of a properly identified and structured middle management in IFH meant that there was no 'clearing chamber' to:

- effectively filter/convey strategic issues to the Director;
- timely process any micro-management questions potentially obstructing decision-making at senior level and impacting negatively on co-ordination, timeliness and efficiency.

The layer of technical / operational staff was, in functional terms, organized in different units (CDU, Counselling team, Clinic), but no hierarchy or networking organigram was formalized and no distinction was made between professionally qualified and non-qualified staff. This can have negative effects on staff motivation, mentoring and reporting and consequently also on staff effectiveness (potential overlapping, lack of information, not taking responsibilities). Furthermore, staff seemed to have different levels of bargaining power that were determined by informal criteria such e.g.: salaried staff vs. seconded staff; HCC staff vs. staff not supported by external projects.
The IFH organizational structure examined by the SSM was pictured as a relatively flat, non-articulated pyramid (see Table 5.7) with the following characteristics:

- Relatively paternalistic and un-flexible management style
- Centralized decision-making too directly involved in micro-management
- Process- and/or output-oriented rather than results-oriented; quantity rather than quality
- Diminishing sense of shared responsibility (in the staff at large) as decision-making not inclusive
- Lack of challenge and motivation, dampening staff's initiative, creativity and developmental focus

The 2-layered pyramid depicted in TABLE 8 is not well suited to a highly complex organization employing more than 30 staff and delivering a wide range of complementary but highly specialized services. Highly hierarchical management style and lack of delegation and participation are contrary to and inappropriate for an organization, which aims to facilitate social change in terms of women empowerment and protection of human rights. It was therefore concluded that, for optimal performance, IFH should transform its organizational structure, from the 'pyramid' into a more complex framework (as visualized in TABLE 9).
This multilayered structure displays some overlaps because of cross-cutting functions of some of the staff and/or units. These were detailed and explained in reference to specific tasks and functions represented in a flow diagram.
This analysis thus recommended three major changes for managerial/organizational sustainability:

- The establishment of a proper 'middle management', i.e. Unit Co-ordinators with decision-making authority appropriate to their level of responsibility and capacity - to execute organization's strategy.
- The redistribution of senior management power through the role of (volunteer) associate advisors (either from NHF and/or from a Project Steering Committee) and through the consultation mechanism of a Management Committee for an agile system of checks, avoiding the pitfalls of multiple layers of bureaucracy and complications in decision-making.
- The clarification of the Administration's

role of transversal support (to both management and service-delivery units), as well as of control/monitoring over financial and operational issues.

In this alternative model any crucial/strategic decisions would still be ultimately taken by the Director but only after consulting: senior managers/advisors from the IFH-NHF-AIDOS structure and in the medium term with a (local) Steering Committee. An ideal transition was envisaged from project-based organization (guided by a more participatory and better balanced management) towards an independent sustainable institution, guided by a Steering Committee that would assist managing the agreed change and support strategic planning needed to implement the Institute's sustainability strategy.

Here below are examples of weaknesses in the IFH organizational model and management style:

- from a rights-based perspective, it was not sufficiently democratic and participatory;
- from the technical and human resource development point of view, the non-empowering system failed to engender commitment/motivation, collective responsibility and creativity regarding sustainability solutions;
- processes were slowed down and efficiency decreased by the 'bottleneck effect' and the absence of clear intermediate reporting lines and consulting mechanisms.

However, some positive aspects emerged:

- A 'cautious' management style instilled a sense of discipline, timeliness and order; considerate and rigorous use of physical or financial resources of the IFH-managed projects; a broadly 'lay' approach encouraging the ethos of working as 'health workers / professionals', with a scientific rather than ideological approach.
- The secondment of staff from MoH (including the Director) and MoE helped to induce a sense of 'public service' in the organization.
- The technical background of the Director in specific aspects of child health and medicine contributed to the 'authoritative' aspect of management style and to a positive institutional image to some extent.
- The formal reporting to the executing and donor agencies for the projects managed by IFH was satisfactory. Following the adoption of a more systematic use of MIS for monitoring.

4.6.3 Organizational development and alternative management practices

Having analyzed the condition of the IFH from the organizational and managerial point of view, possible changes were proposed to achieve sustainability by improving productivity, efficiency and effectiveness, which essentially support some aspects of economic and financial sustainability.

Key changes were recommended along the following lines:

a. **Shift in the organizational model.**

IFH was advised to change from a flat two-layer pyramid and a centralized decision-making process (as described earlier) to a more complex structure along the following vertical and horizontal lines:

- in a *hierarchical* (*vertical*) sense, the model should remain in the participatory sense of the term, "flat" but multilayered to share monitoring and problem-solving tasks and to emphasize 'guidance' over 'control'. Appropriate degrees of decision-making should be formally and practically delegated by creating an agile and efficient *middle management* with members of staff who have relevant technical and managerial skills. This emphasizes the "authoritative" (perceived as fairer) over the "authoritarian" approach, favoring

communication, which also enhances motivation and compliance with Institute's strategy and objectives.

- from the *network* (*horizontal*) point of view, IFH's structure could also be seen as "polycentric" (with more than one center) and so the following needed to be strengthened:
  - *consultation and consensus-building*
  - *joint planning*
  - *collaboration, synergy*
  - *joint delivery*
  - *peer monitoring, self-assessment*
  - *skill transfer*
  - *information sharing*
  - *updating of know-how*
  - *dissemination and internalization of inputs from technical assistance*

In summary, from the two-layer pyramid [diagram (a), TABLE 10], the organizational development process should follow two directions:

- diagram (b) - the decision-making/ control/monitoring/reporting functions are redistributed/rationalized;
- diagram (c) - channels of collaboration, advice, collaboration and consensus building are established and articulated more 'organically'.

b. **Internalization of holistic approach and team-work principles.**
The upgrading of the Institute of Family Health to a fully-fledged 'Women Health and Counselling Center' was designed by the HCC Project as a gradual process based on the multidisciplinary and integrated nature of the services offered to women users, to be delivered through a participatory and collaborative working approach. Consistent technical assistance was provided to IFH on the project methodology and team-work. Knowledge was shared/transferred and recommendations formulated by AIDOS consultants. IFH was thus advised to fully apply and internalize that know-how. Additional inputs of capacity building provided by AIDOS in the last phase of project implementation were also crucial to the organizational, as well as technical/ methodological, sustainability of IFH.

c. **Setting up mechanisms for joint planning.**
Both team-based and individual work at IFH needed to be jointly planned by the main actors involved, through clear and agreed upon mechanisms. Co-ordination should not be limited to mere discussing logistics but should include: strategic, technical and methodological issues to be shared amongst or within teams/units. Planning meetings and relevant procedures needed to be set up, from the strategic to the operational level, also based on good practices on regular meetings shared by AIDOS consultant(s).

d. **Human resource management (HRM) and development (HRD).**
Rational utilization of in-house skills: IFH was advised to carry out an in-depth review of staff skills functional to IFH's mandate; allocate tasks based on such 'skill inventory'; assess the matching of ToRs to skill endowment and functions performed in practice.
Reduced staff turnover: As a service-delivery organization, IFH's main asset is its qualified, trained, inducted and experienced staff; considerable investment in technical assistance and capacity building has been made by the HCC Project. It is crucial that personnel turnover is contained to a minimum level, by: adopting a more flexible and participatory management style; creating a more appealing working atmosphere; offering opportunities of career advancement and professional development; setting up a system of incentives and rewards or non-financial inducements like training courses, seminars and exposure to media events etc.
Improved productivity through staff support and motivation measures: clarify M&E

system; set up a fair and objective appraisal system, with corresponding rewards and incentives schemes; formalize a 'complaint procedure' and nominate an Ombudsperson with a counselling and mentorship function; improve staff morale through flexible working time arrangements and opportunities for socialization and sharing of experiences; offer opportunities of professional and personal development (training/capacity building, mobility).

Enhance efficiency / build capacity through improved communication and documentation: set up mechanisms for systematic and in-depth information sharing; nominate focal points for received technical assistance and organize internal on-the-job training for transfer and internalization of useful skills and know-how; improve management and access of IFH's Library; encourage its use and other information sources, including relevant Internet documentation; organize exposure visits and focus groups; find appropriate ways to depersonalize the problems and solve internal conflicts.

4.6.4 'Vision' of IFH as an independent organization

The vision of IFH as a prospective sustainable organization was influenced by which institutional (and legal) format IFH would adopt to become independent and self-standing. At the time of the SSM, this option still needed to be explored by its 'mother' organization (NHF), sponsor organizations (EC, UNICEF, UNFPA), AIDOS and other local stakeholders.

The least labor-intensive option, and requiring the least investment in organizational development terms, would be for IFH to improve its service-delivery performance, specialization, efficiency and income-generating capacity, so to remain formally linked to NHF as one of its 'departments' but *de facto* becoming self-reliant and independent from NHF (or others) subsidies. This would not require any major change in the structure and legal format of IFH as it currently stands. It could be said that most elements of the 'change process' would in fact being strictly managerial, rather than more broadly organizational and institutional.

The other options identified regard the possibility of IFH becoming an independent organization. It was seen as unlikely (but not impossible) that in the short to medium term any Jordanian Ministry or other public body would propose to absorb IFH in the Governmental structure as one of its health service delivery structures. Therefore, IFH might choose to define and establish its independence in the private sector.

IFH operates as a service-delivery organization with social aims (health care and counselling). However, the need to raise income for self-sufficiency calls for the commercialization of some services. The Institute could therefore gradually migrate towards the status of 'social enterprise' or 'not-for-profit company', i.e. a sort of service-delivery charity run as a business but whose revenue is systematically reinvested in the performance of its core activities (provision of health, counselling and support services to the local community, with a focus on vulnerable women).

4.7 Institutional sustainability

Objective of institutional sustainability
To enhance the status, credibility and synergy of IFH / HCC
in relation to the User community and Jordan-based institutions.

4.7.1 Background to institutional analysis of IFH and the HCC Project

'Institutional sustainability' refers to the capacity of an institution to project a clear image of its mandate, features and capacity, and to initiate and sustain mutually beneficial relationships with the different stakeholders of a project/ program/sector at all institutional levels (from the local community to government and international organizations, as relevant).
The institutional identity of IFH as well as the institutional context in which the Institute worked were explored with the aim to:

- clarify the status of IFH as an institution and how this affected its external relations with the community and other organizations at national and local level;
- identify the typology of existing/potential partners and other actors in the relevant fields of SRH care and counselling services;
- assess, in terms of frequency, the quality of institutional relations established by IFH at various levels and with different objectives;
- propose means and methods to define/ improve the Institute's co-operation and networking strategy, based on those options of collaboration and synergy that would enhance IFH's sustainability, e.g.: both through improved contractual instruments, cooperation policies and marketing, by improving corporate image and promotional tools.

4.7.2 IFH's institutional status and stakeholder analysis

The institutional status of IFH was one of 'dependent' organization, formally part of the Noor Al-Hussein Foundation (NHF) and with facilities/resources set up through several development co-operation projects. The vision of IFH as a prospective 'independent' and self-sustainable institution could evolve in different directions: charity, public sector agency, private sector clinic, social enterprise or non-profit company to be selected in consultation with its stakeholders. At the time of the SSM, the Institute was already in a position to entertain institutional relations with a wide array of organizations and social groups.
The IFH institutional map DIAGRAM 1 (Annexes) exemplifies the framework for a 'stakeholder analysis' that assisted IFH to visualize its position within an 'institutional map' and explore linkages with other organizations that could lead to sustainability.

4.7.3 Current and prospective institutional relations

The SSM provided specific indications regarding the definition and improvement of a co-ordination and networking strategy, based on the current **internal and external relations** of IFH with its own project partners and with some of the actors identified on the 'institutional map' (as previously shown on DIAGRAM 1).
Relationship with NHF.
The relationship with Noor Al-Hussein Foundation was identified as one of formal dependence, insofar as IFH was technically a part of NHF. Similarly to the branch or department of an organization, IFH represented one of NHF's development 'projects' set up as semi-separate entities. However, the direct financial support of NHF from its core resources to IFH has not been continuous. Hence the need to accelerate the process of achieving economic self-reliance,

which would also lead to the possibility of formal independence. At the time of the SSM, there was a clear reporting line from the IFH's Director to the NHF Director, as NHF was the implementing agency of the HCC Project. The 'intra-institutional' relationship IFH/NHF was therefore already clear. It only needed to be adjusted in terms of NHF providing IFH with more intensive strategic assistance on the way to sustainability. No major changes would be required until IFH is prepared to achieve formal independence as a registered organization .

Relationship with AIDOS.

For more than four years, AIDOS was the main provider of technical assistance to IFH. It fulfilled functions of overall project management, co-ordination and periodical monitoring, as well as reporting to the funding body EC. AIDOS entertained a linear and well-defined relationship with IFH through NHF or directly. The inputs of technical assistance and specialized capacity building were delivered as planned and appreciated by the local counterpart. AIDOS' role in this respect was fulfilled within the framework of the HCC Project, however three ways to enhance it were identified:

- Intensifying the follow-up and reinforcement of technical assistance interventions.
- Negotiating AIDOS' role as 'advisor' to the IFH beyond the scope of the HCC project, in order to 'accompany' IFH through to the completion phase of its sustainability strategy.
- Assisting in the establishment of networking channels and specific linkages of IFH with research and training institutions (e.g. in Europe or the Middle East) that would respond to IFH's needs for capacity building after the withdrawal of 'external aid'.

(It should be noted that the points suggested above did not rely on contractual obligations but rather on ethical and developmental objectives that AIDOS might have with regard to the future sustainability of IFH-HCC.)

Community-level institutional relations.

IFH developed a local network of institutional relations, mainly within its most immediate target area of Eastern Sweileh.

Through the intensification of home visits and related field-work, medical and counselling staff, as well as communication and field officers, greatly contributed towards the local promotion of the Institute's services and the establishment of collaborative linkages with various community organizations both in the non-profit and private sectors, at local level including community development centers, charitable societies, hospitals and schools.

A roster was also compiled and updated by IFH, detailing a list of governmental authorities, private companies, educational institutions and charitable organizations with a relevance to the Institute's mandate, within and outside its target area of Sweileh.

IFH was advised to actively construct linkages and liaise with other non-profit or commercial organizations operating in the fields of SRH care and counselling within the same target area. By understanding their scope of action and differences in approach, IFH can better identify its own comparative advantage, unique selling point(s) and if relevant, market niches in terms of target areas and services.

More specifically the IFH was advised to link up strategically with similar projects or bodies, to try and facilitate synergy where applicable.

National level institutional relations.

IFH' activities directly related to its target area in Sweileh (and few other areas in and around Amman). However, the relationship of IFH to national level institutions (e.g. Ministries, other Governmental bodies, aid agencies, etc.) was also analyzed with regard to institutional sustainability.

a. IFH signed an MoU with the Department of Family Protection detailing the referral procedure for cases related to physical violence or sexual abuse.

b. IFH was already linked to the Ministry of Health through the secondment of staff and an agreement to exchange services with other benefits from MoH[1].

c. IFH built up a special relationship with the Ministry of Education as well, through the secondment of three members of staff.

d. The partnership with UNFPA, based on project activities implemented by IFH, was reviewed and the opportunity of contributing towards policy dialogue on sustainability of SRH services was identified.

4.7.4 Enhancement of the 'networking and collaboration strategy'

All the recommendations related to community-level and national-level institutional relations were channeled into the Institute' *networking and collaboration strategy*, whereby IFH more clearly defined:

a. Its institutional status (and relevant evolution).

b. The organizations to closely co-operate with; and those to liaise with for networking and co-ordination.

c. The sector - public, private, non-profit - to which IFH partner institutions belong

d. The level at which IFH should focus its action (local to national level; service delivery to policy formulation)

e. Ways for IFH to improve its approach to the following key priorities of institutional sustainability:

- presenting its institutional identity;
- communicating its mandate and specificity;
- actively promoting its services for various audiences, according to a well-defined marketing strategy;
- entertaining clear, fluid and mutually beneficial relationships with various partner institutions;
- developing and sustaining a positive and effective institutional status for the benefit of its target community.

For the achievement of the above priorities, immediate intervention by IFH in relation to the following issues was emphasised:

- The improvement, formalization and improved coordination of the 'referral system'.[2]
- The definition of an **'MoU policy'** for IFH's management of partnerships and collaborations .
- The definition of guidelines for initiating institutional communications and managing the process of negotiating

1 MoH agreed to:

- provide recommended vaccinations for mothers and children
- provide standard cards and forms
- support in applying for international aid funds
- second two doctors specialised in maternal and child care
- refer relevant cases to IFH
- a yearly subsidy not exceeding a fixed threshold

IFH agreed to:

- offer training and internships for physicians, nurses, midwives, social workers and other personnel active in the maternal and child health field, including early detection of children disabilities
- offer the services of a psychologist qualified to carry out assessments of children with special needs
  carry out the vaccinations recommended by MoH

2 The 'referral system' was not yet developed/formalised in Jordan, and required analysis by IFH re: its rationalisation and inclusion of specific agreements and co-ordination mechanisms. Referral Cases already existed although un-coordinated.

contracts, striking the optimal balance between formal and informal relations (so to achieve useful 'institutionalization' while avoiding excessive 'bureaucratization').
- The improvement of IFH's corporate image also through (e).[3]
- The intensification/improvement of promotion and publicity at various levels, enabling a more broad-based / better targeted marketing of IFH services and the shift from price-based competition to competition based on quality and innovation (through more effective differentiation and branding).[4]

Enhanced relationships with MoH, national hospitals, private clinics, laboratories, educational institutions and complementary development projects, should focus on setting up clear and manageable procedures for referral and follow-up.

3 Suggestions to improve IFH's corporate image: clarify name and mission; highlight Centers buildings appearance through eye-catching signage and banners; provide staff with badges/name-tags and business cards; define IFH's logo (this issue needed to be discussed with NHF – a project logo - possibly associated to NHF's logo); web-site set up (with links to NHF's and Jordan' Dev-net web-site, and relevant sites about health, counselling and women rights in Jordan / the Middle East), and/or update the information related to IFH on the NHF's web-site; provide local youth participating in the HCC groups and other volunteers with an IFH T-shirt or cap or other recognizable gadget(s).

4 Direct promotion in local community through home, school visits and local community center presentations. Dissemination (in Sweileh and other targeted areas in Amman) of improved information and educational materials: IFH brochures and leaflets by service category; videos, CD-ROMs, web-site, posters, banners; circulating an email newsletter, etc. Well-designed, appealing and systematic advertising using all Media (ensuring that IFH technical staff and user interviews present their real life experiences); local buses and other public spaces (leaflets could even be distributed through local taxi drivers in exchange for discounted Institute services). A range of specifically designed adverts targeting different audiences, all emphasizing USPs (Unique Selling Points) of IFH's services thus emphasizing differentiation and 'branding' enabling a shift from price-based competition to competition by innovation/quality.

4.8 Socio-cultural sustainability

Objective of socio-cultural sustainability
To maintain a harmonic and co-operative relationship with the user community, by facilitating positive social change in the respect of cultural values and local priorities.

4.8.1 Impact of the HCC Project and the activities of IFH on social change

Most of IFH's work consists of service-delivery targeting the local community and relating to the well-being of families - a private and sensitive sphere of social life. The activities of IFH thus interact with social value-systems and carry cultural connotations. Of all the IFH initiatives implemented, those connected with the HCC Project have had so far the most significant implications in terms of social and cultural dimensions of the Institute's work, both internally (within the organization) and externally (in the relationship with the local community and other institutions).
The WHCC Project's social and cultural implications stem from various elements:
- a health and counselling center devoted specifically to women, emphasizing their status and importance in the local society;
- women users of all age brackets, also including adolescent girls and menopausal women, highlighting the role of women in society as not strictly reproductive and maternal;
- a focus on gender awareness, women's rights and empowerment through information and access to services;
- consultation and counselling work on sensitive issues, ranging from reproductive health to domestic violence - with different degrees of 'sensitivity';
- an innovative, holistic approach to service

delivery, aiming at multi-dimensional empowerment;
- the inclusion of male household members in integrated initiatives of gender-related awareness raising;
- the policy choice of facilitating positive social change for the well-being of local women users and their families, choosing to work through dialogue and to valorize differences while avoiding or mediating conflicts over the most sensitive issues.

IFH has evolved from predominantly health-related clinic (with initial focus on children) to a more comprehensive institution with a social role in the community and acts as an interface with different 'cultural' systems.
The HCC project was designed and set-up based on principles of openness and tolerance, complemented by the objective of facilitating social change to improve local community quality of life. However, for the socio-cultural sustainability of IFH-HCC's positive role in the target area, such principles needed to be consistently internalized and applied by its staff; certain key aspects of IFH-HCC's socio-cultural dimension had to be tackled both at the internal and external levels.

4.8.2 Internal socio-cultural sustainability

IFH's make-up is considerably diverse in terms of gender, social, education and professional backgrounds and lastly, with different cultural approaches. Such diversity is an asset as it enhances the Institute's appeal and response to an equally varied target community. HCC staff individual characteristics were reflected to some degree in the way cases were approached. When the most apparent qualities were motivation and professionalism this was positive. However, IFH was advised to seriously work on any overly subjective approaches which undermined objective and scientifically-based service-delivery; the HCC project was also designed to positively acknowledge and valorize diversity and avoid any 'partisan' association or allegiance to specific systems of social norms and cultural values, other than the lay, neutral and internationally recognized umbrella of the protection of human rights (those of the women in particular) and the respect of cultural differences. Appropriate attention had to be paid to the following aspects:

a. The social development and human rights protection objectives of IFH's activities should constitute a common platform for the whole staff and consequently be reflected in their actions and approach.

b 'IFH/HCC jobs' should acquire a distinctive character, as they carry not only technical competence and professionalism but also social mandate of enhancing user well-being and empowerment.

c. Such focus on the motivational aspects can be managed through a mix of external technical assistance. It was noted that a conscious commitment to the protection of human rights and especially the work on the respect of multi-culturalism would need additional capacity building) to ensure that awareness of these dimensions were raised and made consistent across the IFH staff.
Motivation should be interpreted at two levels:
- 'social responsibility', a form of 'civic sense' whereby citizens are expected to participate in the betterment of society
- 'individual motivation', a genuine interest in the technical aspects of a job, and the appreciation of its potential impact in terms of poverty reduction, women empowerment, human rights promotion...

d. The internal adoption of an inclusive and participatory approach was also identified as a need consistent with IFH's external impact, for methodological consistency and ethical coherence.

e. Team-work was also seen as a common effort to preserve institutional memory and to ensure information sharing, so that service delivery is not highly dependent on specific people. A major cultural change was needed in the shift from 'oral tradition' to 'written culture'.

4.8.3 External socio-cultural sustainability

Several measures for HCCs also directly reflect its socio-cultural sustainability on an external level, e.g. awareness and motivation with regard to social development goals and respect of multiculturalism. The following major priorities emerged about IFH staff's relationship with the target community:

- adequate resources should be devoted to needs assessment to ensure that project activities respond to community priorities and that IFH's work is socially acceptable;
- focus on awareness raising about fee-charging for sustainability and 'empowerment'[5];
- cultivate flexibility and tolerance, build constructive relationships with users, with appropriate time/work to build up trust and facilitate gradual change in social habits and cultural norms[6];
- concentrate on mainstreaming gender awareness especially in schools and within households (i.e.: involving male members in counselling groups).

One of the major inconsistencies in the IFH staff working approach that emerged concerned different personal religious attitudes in aspects of their work (e.g. associating religious beliefs with technical recommendations provided to Users in relation to SRH). This had an impact on intra-organizational relations, but became even more apparent during service-delivery, in direct contact with the local community.
The HCC staff should enable women users to access impartial, objective information supported by scientific and technical knowledge and through these 'neutral' consultations and/or counselling sessions, they should be able to make their own informed choice and be free to balance different aspects (including user's own religious beliefs).
Local Users might need some clarifications to feel at ease with a positive evolution of their social/family life in line with prevalent cultural norms.
The HCC addressed this question by officially inviting a professor of Islamic studies to give a talk for community leaders and Users: this served the purpose of solving all main doubts on the compatibility of HCC's work with the norms and values predominant in the local community. This proved effective as issues were openly tackled through informed debate and facilitated by the charisma and status of a highly educated person.
The coherence of the HCC depends on how these sensitive issues are dealt with consequently. Staff should feel supported by clear guidelines to deal with these sensitive socio-cultural issues, further emphasizing the need to clearly define a common approach on this aspect of SRH care. There is no 'one-recipe' approach to solve these sensitive situations. Once a HCC has defined its own ground-rules they can be clearly applied across the board in situations with potentially controversial socio-cultural relevance.
For sustainability objectives such guidelines should preferably be formulated through a participatory process. Lastly, another medium to long-term measure is to establish a sort

5 Contrary to widespread prejudice on the 'dependency syndrome', low-income groups may have the ability and willingness to contribute to their community's welfare. Charging adequate fees for services also allows for cross-subsidization and assigns a nominal value to services.

6 This is based on the assumption that 'social capital' can be nurtured and is not a predetermined endowment in the community.

of 'clearing chamber' for the mediation of socio-cultural issues like a 'local committee' representing the target community or alternatively the co-optation of local community leaders on a project 'steering Committee'. Such choice needs careful consideration and an in-depth knowledge of the socio-cultural fabric and power relations (and other relevant institutional factors) in the project target area.

4.9 Developmental and policy-related sustainability

Objective of developmental and policy-related sustainability:
To contribute towards poverty reduction and promote human-rights (with a gender focus), thus becoming a reference point and 'center of excellence' that enhances the definition and implementation of policies and strategies for local and national social development.

4.9.1 'Poverty reduction' focus / Targeting issues

This dimension of the sustainability analysis, is designed to highlight those development-related issues that impact on prospective sustainability not only at the micro/project level, but also at the macro/policy-related one.
The economic and financial sustainability analysis considered the pros and cons of cost-recovery through charging fees. Such system would allow for income-generation while introducing cross-subsidization.
The latter would be key to maintaining an extent of affordable or free services, consistently with providing women – and especially those in vulnerable circumstances – with integrated health and counselling services that contribute towards the reduction of 'deprivation'[7] in the target area.
In this sense, any Project's **'poverty reduction' focus** (and of other IFH initiatives) should be considered as one element of sustainability insofar as it defines and 'justifies' a socially useful role of the IFH in the local and national context. From the cost-recovery and marketing strategy perspectives, it emerged that IFH clients come from a varied socio-economic background, even within the same target area of Sweileh. However, the main mandate of the Institute is to cater to needy Users, especially for women who are powerless and unaware of their rights and entitlements, needing targeted support to overcome health, psychological, social and legal problems. IFH was thus advised to develop a specific set of guidelines about **targeting** its services, i.e. to distinguish potential clients into six main groups, here prioritized from the developmental point of view:

- vulnerable women (e.g. divorced/widowed/ heads of households, unemployed, victims of domestic violence)
- children suffering physical disabilities and learning difficulties
- women from target area who need more awareness/information and better access to services of reproductive health, well-being therapies and counselling
- children and other household members

7 In development studies literature, in particular according to Nobel laureate Amartya Sen, aid interventions should not just aim to alleviate income/food poverty and respond to basic needs, but also reduce level of 'deprivation' (here: broad concept including respect of civil, political, social, cultural and economic rights) thereby expanding scope of 'people's choices', transforming passive 'beneficiaries' into subjects – Users - who are empowered by fair and equal opportunities to choose the best living standard they can achieve. The delivery of information and services regarding health and other fundamental aspects of well-being is thus included in the framework of 'poverty reduction' as defined here.

eligible for IFH services: at discounted rates or free of charge (due to their level of indigence or vulnerability)
- the Sweileh community at large, and in particular those who are interested in expanding their knowledge and participate in open debates regarding the social, psychological and rights-based issues covered by the counselling services of IFH
- clients from in and around target area willing to pay adequate market-level fees for clinical, therapeutic and counselling services (cross-subsidizing Institute's activities focused on deprivation reduction).

This classification may be modified depending on how IFH's **'social development policy'** evolves. IFH was advised to invest appropriate time and skills in definition and communication of its own approach to develop action in cooperation with its social development stakeholders and local community.

4.9.2 Awareness of a HCC "developmental" mandate

To sustain the identity and mandate of a HCC devoted to social promotion through health and counselling services, the target community needs to be aware of the center's role and action. Therefore, the center's own human resources need to be conscious of the impact of their work and be familiar with the linkages that SRH care may have within the wider framework of local development. The following concerned were raised on the HCC development objectives:

- Emphasis should be placed on awareness-raising on human rights protection (with a gender focus)
- 'Poverty targeting' should be improved through better classification and prioritization of user groups.
- User-friendly criteria should be set for fee-charging and subsequent cross-subsidization of developmental services.
- Protection and empowerment of vulnerable women should include the enhancement of their economic independence and social dignity. Services should be improved/strengthened with regard to employment advice and support for self-employment through information, training and institutional linkages (e.g. with organizations offering Business Development Services).

4.9.3 Valorizing data and know-how / Interaction at policy level

Two main elements can substantially contribute towards a HCC policy-related sustainability:

- The accurate and systematic gathering and recording of information regarding the medical, therapeutic, counselling and mobilization work (as qualitative and quantitative data stored in a data base / MIS; and as a compilation of case studies, 'best practices' and 'lessons learnt').
- The analysis and sharing of data and know-how with key institutions (e.g. Government, NGOs and international agencies) aimed at positively contribute towards national sectoral policy formulation and fine-tuning and strategies for social development.

Regarding point (b) in particular, IFH's attention was drawn to the opportunities offered in policy-making by working with institutions such as MoH, MoE, UNFPA, UNICEF and UNDP for stakeholder organizations (with existing or potential linkages with IFH) were identified as the following:

- cost-recovery in the delivery of SRH care, with a view to sustainability;
- SRH in the framework of human rights, in particular women's rights;
- targeting methods and efficiency of service-delivery for enhanced affordability and access of SRH care.

4.10 Planning and implementing the sustainability strategy of IFH

4.10.1 Sustainability as a 'work in progress'

The **SSM (Sustainability Study Mission**, Dec 2003) resulted in an in-depth analysis, as detailed in the previous sections and a period of remote and on-site follow-up by AIDOS and the IE. This was followed by two other technical assistance missions aimed at supporting IFH-HCC to kick-start the process of planning and implementing the proposed sustainability strategy:

- the **Planning for Sustainability Mission (PfSM)**, Aug 2004
- the **Sustainability Implementation System Mission (SISM)**, 2005

It should be noted that the actual implementation and subsequent impact of a sustainability strategy for a HCC (or similar organization) is a complex and demanding process that needs to be viewed in a medium to long-term perspective. In the case of IFH-HCC, the organization is still applying those recommendations and tools developed through the SSM, PfSM and SISM. Positive outcomes have already been recorded e.g. in terms of enhanced capacities, increasing self-reliance and decreased dependency from outside support. However, it will still take some time before the IFH-HCC can operate independently while maintaining effectiveness and relevance in all dimensions. Nevertheless, the development and application of a methodology for the analysis and planning of sustainability have indeed benefited the IFH-HCC, its clients and partners.
There is however, no one blue-print for all and these sustainability results should primarily be seen as specific to this case study. Consequently, the sustainability analysis and planning methodology adopted by the IFH-HCC should be modelled for other contexts using a 'point of comparison' approach, so to avoid the risks of rigid blueprinting and superficial generalizations.

4.10.2 Participatory strategic and action planning

During the above mentioned missions, it emerged that main concepts underpinning the multiple aspects of sustainability should be understood and internalized by all key staff of a HCC so that staff can feel committed to shared objectives, fully support implementation processes and make informed choices for planning future of their organization. With this in mind, the PfSM and SISM included intensive and inclusive sessions of sustainability-related participatory planning and capacity building/ technical assistance, carried out in plenary groups (especially for validation purposes) or in focus/working groups as well as one-to-ones, as needed.
Systematic consultations at all managerial levels were also carried out, with an emphasis on strategic and institutional aspects.
It emerged that IFH should endeavor to implement sustainability recommendations by following a logical pattern comprising:

- A **Strategic Plan**: providing overall and specific objectives, time-scale and/or priority of the objective under consideration. Short-, medium- and long-term were specifically defined for IFH and its HCC Project.
- An **Action Plan**, specifying one or more practical steps meant to achieve each specific objective in the relevant Strategic Plan. Time frame and responsibility were also spelled out for every group activity.
- A **Work-Plan** for every activity described in the Action Plan, which requires a good extent of organization and co-ordination.

The planning exercise during the PfSM attained the first two steps of the above process for every aspect of sustainability.
This approach to planning was thoroughly explained to IFH staff and strongly recommended that plans be used as 'working tools', which entails continuous consultations within and across relevant teams, and re-adjusting plans as objectives shift, context changes and resource levels vary.

4.10.3 Technical assistance on financial monitoring and cost-analysis

During the PfSM and SISM, technical assistance was provided for several aspects of sustainability. Considerable support was devoted to key financial dimensions of sustainability, covering the following areas:

- Key concepts of economic and financial sustainability
- Financial monitoring principles
- Costing and pricing principles
- Utilization of delivery capacity and productivity rates
- Setting-up of a consumption control system
- Evaluation of business performance
- Forecasting of investment needs
- Introducing viability and profitability calculations
- Introducing a system of Daily Income Records
- Introducing and testing a tool for financial monitoring

4.10.4 Technical assistance on business planning and economic viability

The design of a business plan for any current or prospective IGA run by the IFH (for viability and a correct pricing policy as well as marketing approach) was recommended in order to prevent income-generating service delivery from being carried out on a supply basis, without a specific demand analysis.
Technical assistance was provided on the analysis of available resources, actual demand, delivery capacity, realistic pricing policy and promotion of IFH services in the appropriate market niches.
The principle of cross-subsidization[8] needed to be better internalized for Institute to reconcile its social role in the community with its need to improve its economic and financial sustainability as a 'non-profit' business approach. The role of marketing and of innovation/quality-based competition was reiterated and mainstreamed through practical examples. The main concepts of business planning, the basic format of a business plan and simple calculations of viability and profitability based on estimates, were further reinforced through case studies of specific IFH services (e.g. the nutrition clinic, gym-based activities, child vaccinations, etc).
A basic viability assessment was needed for all IFH activities including non-fee charging HCC counselling services. This is crucial for a full picture of IFH status in terms of subsidized services as well as potential sustainability (or at least decreasing dependency on external supporters and donors).

4.10.5 Management consultations and tools

The need for institutional/'external' support for implementing sustainability strategy was also examined, and visualized in the diagram included in TABLE 11

8 Charging at market rates, proportional to quality and innovative character of certain services, but still competitive – in order to be able to reinvest the margin into discounts and exemptions for the underprivileged and destitute.

4.11 Sustainability Implementation System

The setting up of a **SIS (Sustainability Implementation System)** entailed the following actions:

- Review and updating Strategic and Action Plans for sustainability through a participatory process: brainstorming, SWOT analysis of the IFH activities by team/unit, and realignment/rescheduling of priorities and responsibilities.
- Identifying a more effective managerial, organizational and technical set-up to form a more conducive environment to pursue sustainability. The results of this analysis were visualized in an updated IFH Flow-diagram, a revised IFH Organizational Chart (see TABLE 12 in annexes and proposed changes in the Personnel Structure. A system of Alternates was also envisaged to ensure continuity and appropriate drive in the process of sustainability strategy implementation.
- The selection and appointment of **'middle management'** members: 3 Unit Coordinators, Finance Officer, Office Manager (i.e. Administrator/PR Officer). The establishment of a streamlined and results-oriented **Management Committee**.
- The identification of **'external support'** needed by IFH-HCC especially on institutional and technical advice terms, e.g. through Steering Committee mechanism to build its capacity to reach sustainability. The technical and managerial follow-up by AIDOS, the systematic coordination of its experts' inputs with the IFH Sustainability Strategy, as well as the institutional support from the NHF and – if relevant – from a Steering Committee mechanism, were identified as key preconditions for the success of the IFH-HCC sustainability process.
- All professional and efficient work is crucial to sustainability. However, a clear assignment of responsibilities and allocation of tasks related to sustainability was also recommended to enhance the focus on the proposed strategic/action plans, through the system of **Sustainability Focal Points** responsible for the different dimensions (e.g. economic-financial, institutional, socio-cultural, etc.)[9], linked to **Sustainability Task Forces**[10] on specific topics and reporting to the Management Committee, as well the relevant **cycle of consultation and feedback**.[11]

9 Table 13 (see in Annex 5)

10 Table 14 (see in Annex 5)

11 Table 15 (see in Annex 5)


The Italian NGO - AIDOS
Co - Financed by
European Community (EU)
عيادة المرأة
WOMEN'S HEALTH CENTER
FETAL MONITORING
FAMILY PLANNING
GYNECOLOGY + INFERTILITY
PAP - SMEAR - MAMMOGRAM

5.1 Baseline Survey and Impact Assessment

For the implementation of RH projects, generally AIDOS carries out two studies, a baseline survey at the beginning and an impact assessment at the end of the project.

The main objective of the **baseline survey** is to assess the existing situation in the country with regard to the RH needs of the target population, facilities, accessibility and demands of the local population with a special focus on the reproductive health service needs of women and adolescents and KAP (knowledge, attitude and practice) towards RH issues before and after the project. The survey reveals which indicators for project monitoring and evaluation need to be set.

At the end of the project an **impact assessment** is carried out to compare data, determine the project impact over the period of its implementation and identify and develop lines for future intervention(s).

The surveys mainly focus on the reproductive health status of women (aged 20–50) and of adolescents (aged 12-19) about existing RH services and assesses any intervention(s) required in the target area.

Local research organizations are contracted to conduct the studies with the technical assistance of AIDOS consultants.

The activities carried out for the conduction of the surveys include:

a. Identification of project target areas

b. Review and analysis of literature (ad hoc surveys, censuses and official yearbooks) concerning RH issues in the country and in particular in the project target areas.

The review and analysis of literature focus on:

- Availability of infrastructure and services in the project target areas
- Socio-demographic structure of the population in the target area
- Demographic situation (fertility, marriage, family planning, morbidity, mortality) among target groups (female and male adolescents, women and men in reproductive ages, women in menopause/ climacteric stage of life)
- Diseases related to RH
- Physiological/cultural/social conditions (menarche, inter-family marriage, employment, poverty, etc.) inter-linked with RH issues
- Attitudinal information related to RH issues (safe motherhood, FP, couple relationship, values and norms, etc.) and identification of possible factors which may limit people to answer questionnaire freely (such as reluctance to answer sensitive questions)

The literature review produces a report including the:

- Description of project target areas (location, characteristics and services availability - health, education, transportation, etc.)
- Description of socio-demographic characteristics in the target area
- Identification of main issues concerning RH in target area
- Themes to be explored by survey

c. Drafting of questionnaire and pre-test, sampling design, questionnaire and field work, finalization of the questionnaire, recruitment of interviewers and briefing

d. Field work

e. Data recording, checking, processing and analysis

f. Organization of focus groups

g. Drafting of report on main findings and conclusion

The subjects covered by the surveys include:

- general information about respondents and their family;
- information about level of knowledge concerning their own bodies, ability to understand whether symptoms are signals of being unwell, and how they are dealt with;
- family planning: type of methods used, advantages and disadvantages, family planning service providers, reason(s) for non-use, intention for future use;
- marriage: knowledge about consequences of inter-family marriage, attitude towards

inter-family marriage, knowledge of risks of early marriage, importance of independent choice of spouse;
- pregnancy and ante-natal care: desired timing of first pregnancy, risks of early pregnancy, knowledge about ante-natal care, its importance, and ANC service providers;
- post-natal care: knowledge of post-natal care, its importance and PNC services providers;
- menopause: knowledge of symptoms, of ways to mitigate them, of places for assistance;
- STDs and HIV/AIDS: knowledge of ways of transmission, of ways to prevent transmission/infection, of places / ways to receive information.

The surveys in Jordan: a case study

In Jordan, the **baseline survey** was conducted in 2003. The questionnaires were administered to a total of 800 women, between 20 and 50 years old, and 500 adolescents (female and male) between 12 and 19 years old, after the approval from the Department of Statistics to conduct interviews in private homes.
The main outcomes of the survey can be summarized as follows:

Results of the Survey on Women.
The study showed a fair awareness of general issues but findings were less reassuring with regard to more specific aspects relevant for the creation and spread of an aware RH culture. Women seeking treatment in public health centers lacked proper information concerning available preventive services and how important they are to the well being of both mother and child. Inter-family marriages amounted to almost 38% of all marriages, highlighting the need to educate men and women about the risks of marriages and childbearing among relatives thus enabling them to take informed decisions. About Family Planning: modern contraceptives were used by 48.3% of ever-married women and 40,6% of ever-married women were currently using contraceptives. The results of the survey raised the need for more education and dissemination of knowledge on ante-natal and post-natal care and knowledge of where such services could be accessed, as well as making services both accessible and affordable. With regard to menopause, women residing in Sweileh did not have any services for this menopausal period in their life, unless they dealt with simply curative services to address physical ailments. The most known sexually transmitted disease of the target sample was HIV/AIDS, so there was a significant need to educate people on other STDs and their symptoms, ways of transmission, and preventive measures to be taken. One of the major sources of information regarding STDs was the media, which is the most vulnerable source. There was the need to provide different sources of information in this field and health education should include media people as they are a primary source of information concerning STDs, although media coverage was superficial and this also pointed to the need for qualified personnel who can provide more extensive, in-depth information.

Recommendations for Actions directed to Women.
While comprehensive health services were provided at the Institute for Family Health, there was still the need to raise the awareness of the Sweileh population on the Institute's services and provide them with equal opportunities to attain these services in the best possible way. RH practices were associated with attitudes and knowledge so to modify behaviours information should be provided to make women believe in the essentiality of these services for their own well-being and the well-being of their children. Efforts should be directed to achieve common understanding among community members of Sweileh regarding advantages and disadvantages of kin marriages and empower women to make a decision, which corresponds to their beliefs and attitudes. The types of contraceptives used concerned mainly women as only 1.8 % of the women's husbands used condoms and shared the responsibility of family planning. Indeed, men believed that the responsibility of family planning

lied with the wife alone. Therefore efforts should be directed to involve men in family planning practices and share the burden with their wives. Efforts should be directed to educate women to any changes associated with menopause and ways to manage them with the aim of leading a healthy and productive life. Women did not access the services targeted to menopause and if they did, it was as a curative response to specific physical discomforts. Therefore, the reasons of the lack of access must be studied and actions must be taken to resolve them.

Results of the Survey on Adolescents.
Schools in Sweileh were not providing adequate information regarding reproductive health issues. Early marriages were widespread among females and most of the early marriages were inter-family marriages from the father's side. Parents proved to have a strong influence on the decisions of their children regarding marriage especially at early age. Young people had not formed their own ideas about the advantages and disadvantages of early marriage, as their answers were not consistent. Women's role was limited to a family role and a public role for women was held only by 25.7% of the adolescents' mothers. Adolescents needed more information about changes accompanying puberty especially concerning religious teachings on puberty and body changes during puberty. Emotional changes accompanying puberty were not within their priorities. Adolescents had a high consideration for religious teachings regarding puberty but preferred to access the information from teachers. Reproductive health issues were not highly considered by adolescents. Their concerns reflected immediate needs but to ensure a healthy future generation, adolescents have to be involved in health educational sessions.

Recommendations for Actions directed to adolescents.
The Institute for Family Health (IFH) should provide quality reproductive health services for adolescents to raise their awareness of these services and involve their educators in training sessions and awareness campaigns. The IFH should educate adolescents directly, in addition to providing training on FP, HIV/AIDS and STDs to local school teachers of schools in view of the fact that the study proved that schools and teachers were one of the major sources of information for young people. Efforts should be directed to raise the awareness of adolescents with a focus on changes accompanying female puberty, and more specifically on psychological and emotional changes involving the other sex. Teachers and parents should be trained in this area to provide accurate knowledge to adolescents as they also were sources of information. The IFH should provide quality psychological services and raise the awareness of adolescents and mothers to the need for these services and provide all the facilities for attaining such services. Health education concerning advantages and disadvantages of early marriage and inter-family marriage should start as early as possible to avoid the complications that these bring. Both parents should be involved in health education sessions to ensure support for their children's informed decisions. To reduce the incidence of early and undesired pregnancies the IFH should educate young mothers and fathers on the use of different contraceptives to help them make correct informed choices. The Institute has to raise the awareness of the adolescents concerning available ante-natal services, directing and encouraging them to attain these services. It was finally recommended to provide this segment of the population with accurate information on HIV/ AIDS, in addition to relevant services. Support groups attended by adolescents were highly recommended where behaviour pertaining to HIV/AIDS should be openly discussed and preventive measures should be tackled.
The **impact assessment** was conducted in the last 3 months of project implementation (from April–July 2006) in order to assess the impact of IFH's women health counseling services on the community, to improve and develop IFH services, to identify RH issues which require further attention by IFH, to upgrade the knowledge emerging from the study previously conducted, to assess the role of religion and family in RH issues in Jordan and Sweileh.

The study included a qualitative and quantitative survey, and a review and analysis of the literature regarding the role of religion and family in RH issues in Jordan.

A **qualitative research** was conducted through four focus group discussion sessions with the beneficiaries of the IFH outreach program implemented in four areas (Salhoub, Marsa, Abu Nuseir, and Shafa Badran). The findings of the focus group discussion showed that most of the women were satisfied with the awareness programs related to women's health in terms of timing and quality of sessions.

The outreach program implemented by IFH enlarged the number of their clients and gave the community the chance to know about the services it offered. The variety of the topics presented and discussed in the educational sessions and workshops contributed to increasing the knowledge of a wide sample of the four areas' residents. The results proved that attending few sessions is not enough to change people's perceptions and attitudes; therefore, the program should be maintained and promoted because the limited information cannot be filled up in a short period but requires a long process.

A **quantitative research** (a case–control study) was carried out as a socioeconomic and demographic analysis of 200 IHF users (age, sex, household, education, employment, etc,) and 200 non-users (control group from the community). The survey targeted IFH female clients and non-clients aged 18-55. The main objectives of the quantitative research were the assessment of women's trends and positions towards IFH services. More specifically, the objectives of the survey were to identify the:

- services women were receiving from the IFH
- quality of the services offered by IFH and the satisfaction of the users
- knowledge women have on RH issues
- reasons of their practices
- source of knowledge (brochures, campaigns, counseling, etc); and
- reason for using or not using the center services.

The analysis of the qualitative and quantitative data showed the following:

Both IFH users and non-users indicated that lab services, antenatal and postnatal care services, gynecological services and family planning were the most common services offered by IFH and other centers. However, IFH offered additional services to women such as social, psychological and legal counseling; working groups; adolescent services and sport and yoga activities.

Factors that contributed to using IFH services.

Besides, measuring the knowledge of IFH users and non users regarding reproductive health and the available services, the study measured a number of factors that played an essential role in attracting patients and visitors to IFH and provided an insight towards future steps that need to be taken into consideration in order to create a better environment, enhance its services and satisfy their patients and visitors.

Accessibility came among the very first reasons to select IFH given that most of its clients were from the nearby neighborhood.

Another two reasons for selecting IFH, were the qualified and friendly staff. These factors played a major role in attracting patients and visitors. However, it appeared that qualified staff came in favor of other centers for the lab and gynecological services.

Providing an integrated service also had a considerable effect on IFH users. Generally, the per cent of patients and visitors of IFH came out higher in comparison to other centers. With more promotion on IFH integrated services, it can attract a larger number of visitors and may become the leading center in the area.

Many other factors; e.g. a physician examines the patient each visit; presence of a female physician; short waiting time; these all came in favor of IFH. Continuation of such performance and availability of necessary staff will always play a role in the satisfaction of patients that is very important for the success of any organization.

Recommendations

IFH users were receiving a wider variety of health services and were more educated regarding these services than the control group. The study provided the following recommendations:

- IFH needs to focus more on the antenatal and postnatal services and ensure that all pregnant women receive such services in addition to continuing education related to caring for mothers.
- More focus must be given to nutritional needs of women according to age group and during pregnancy and after delivery.
- Increase the educational sessions related to: adolescence, menopause, importance of antenatal and postnatal care on the mother and baby's health, workshops related to early detection of breast and cervical cancer in terms of breast self-exam and the importance of pap smears, women's rights with focus on domestic violence, sexual education.
- Increase the number of sessions related to massage, working groups, yoga and sports.
- The continuity and sustainability of the outreach program was highly recommended to promote the awareness about women's health and rights in order to promote behavioral change among participants. The program can be enlarged with the support from students from medical, nursing, social science, and psychology schools.
- As it seemed that the ancillary staff played a considerable role in promoting many services whether for the IFH or other centers, more attention should be paid to them in terms of giving them accurate information as they present an open information channel for patients and others.
- More efforts should be made in terms of IEC material that explains what domestic violence is and its types.
- The study provided the center with very good baseline indicators, which can be used as a benchmark and quality assurance tools within their routine reports.
- Continue providing its services at the best level of professionalism and friendliness.
- Continue upgrading its services and training its staff (on-the-job training, external training...) to improve the quality of services.
- Promote IFH integrated services more, through brochures and pamphlets in order to reach as much individuals in the area of Sweileh and beyond it.
- Explore more insurance companies and the possibility to reach agreements with these companies.

5.2 Computerized Management Information System

A computerized Management Information System is introduced in all HCCs with a data bank on women attending the centers and information on health care throughout the country.
The system represents an essential tool to monitor project achievements and to identify and develop lines for future intervention(s).
The indicators set on the basis of the surveys and of the formats of the registration systems developed for the HCC established by AIDOS in other countries, represent a reference tool for developing and/or upgrading software. The staff analyse the indicators, review the formats used by other centers and select, adapt and integrate whichever indicators are useful for their system.
In order to be effective the HCCs flow of information needs to be systematized in a way to be accessed by all members of the staff and allow for an integrated delivery of services.
The overall aim of an MIS is to be a mechanism that can consistently gather data in a way that these can be aggregated, compared and evaluated. The MIS operates at two levels: the level of the HCC office management and level of the HCC services and activities.
A specific software is purchased/developed and installed in the HCCs' computer system by a local company and staff are trained on its use, data analysis and reporting. The MIS is compatible with other national level systems.
The **HCC management data** include data on infrastracture and equipment, financial resources and financial information, human resources, documentation center, referral

system, networks and institutional linkages, workplanning, reporting, events and occasions. This information should allow monitoring the performance of the HCC as an office at any moment in time, through a continuous update of data.

The **HCC users data** include general information on the User, type of service requested/need identified, type of service delivered (clinic, psychological, social, legal, gymn). These data should allow for an updated clinic file for each User that can be monitored and assessed at any moment in time. It should contain information of all HCC Users. Clinic files can be sorted either by the User's name, area of origin and type of service. Each Clinic file should have an introductory general data part and more specific sections which will be filled depending on the service provided. A new section should be filled for any Users's new visit so that to monitor her/his situation over time, this allows for accurate record keeping, comparing between visits and verifying whether any improvement has taken place.

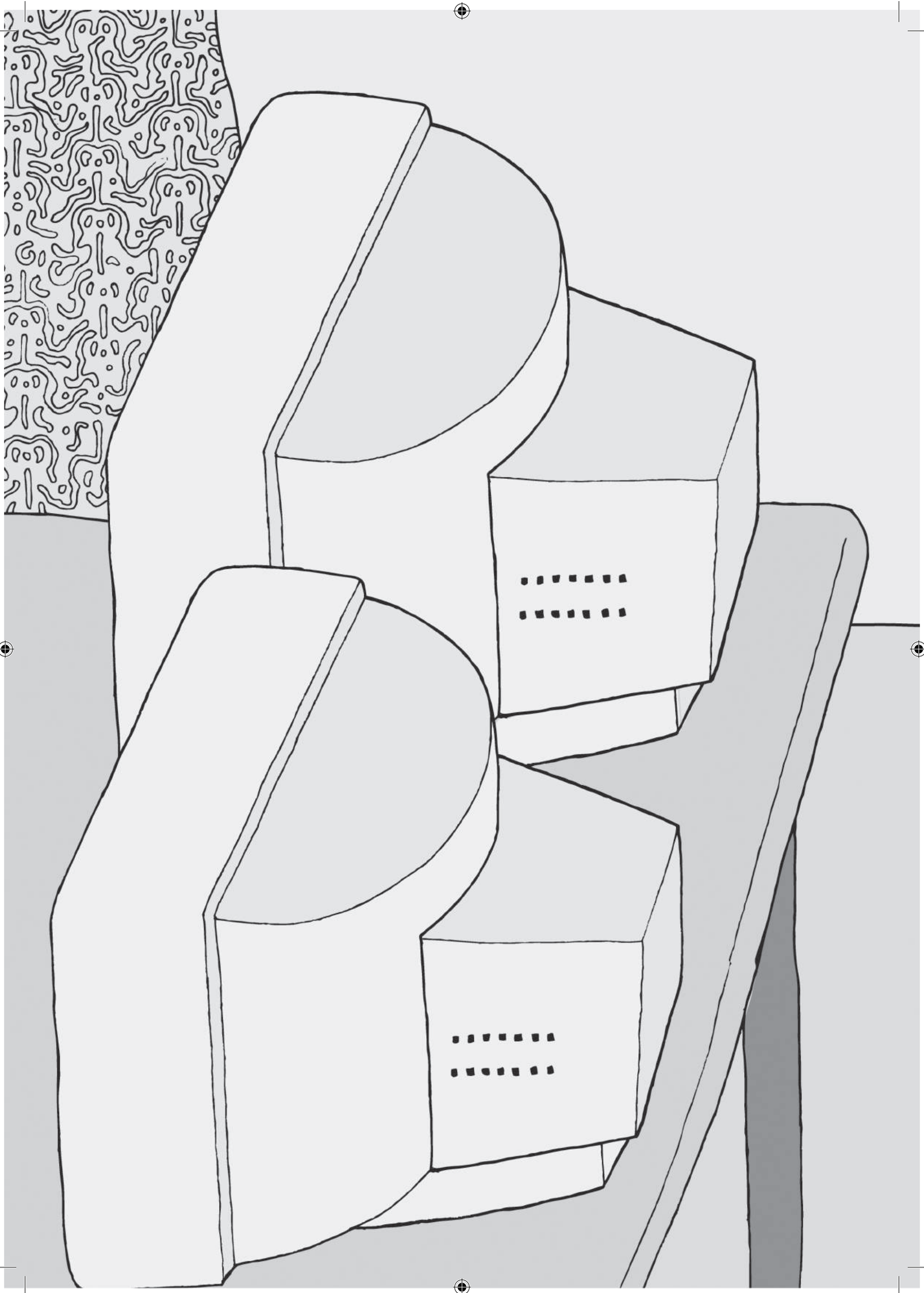
Once the MIS is developed and functional, the MIS consultant company will train the staff on the use of the software for data entering, analysis and reporting. The company will have also to guarantee technical assistance and maintenance and be available for any request fro integration for a period of at least one year after delivery.

The list of possible data to be included in a MIS is attached in Annex 6. These data are those used in the MIS of the Syrian HCC.

5.3 Monitoring system

The monitoring of the HCC project performance is conducted at two levels: the monitoring of the project implementation modalities is carried out through monitoring and technical assistance missions by AIDOS staff and international experts who monitor the project activities through extensive meetings with the partners, review of the training and operational procedures in the HCCs, center attendance, and through visits to the outreach workshops. The partners ensure continued project monitoring through a coordinator, who functions as a liaison officer to coordinate the relationship between the organizations and the HCCs, and supervise on a regular basis the HCCs' activities on behalf of the organization. The partners submit quarterly activity and financial reports to AIDOS to update on the project achievements and constraints.

The monitoring of the project results and impact on the target population is implemented through regular staff meetings, meetings with the community and the beneficiaries, the management information system of the HCCs.



Name: EL-BUREIJ WOMEN'S HEALTH CENTER

Location: El-Bureij refugee camp, Gaza Strip

Year of establishment: 1995

Implementing organization: Culture and Free Thought Association (CFTA), Khan Younis, Gaza Strip. CFTA is a women's organization aiming to promote ideas of civil society and values of equality, cooperation and democracy within the Palestinian society. CFTA was established in 1992 by the women from five political organizations in the Gaza Strip with support from the European Commission and a French NGO. CFTA has created 5 community centers for children, adolescents and youth and is implementing a loan program for women living in difficult economic circumstances. Since 1995, CFTA has been implementing the HCC project in El Bureij.

Background: The project proposal was motivated by the dramatic conditions of the Palestinian refugee population living in the Gaza Strip and the scarce endowment of RH services in the area. The center was created as a response to the Palestinian women's needs, as assessed in 1994 by a study conducted by UNDP and by a gender strategy paper that AIDOS had written for the European Commission. Although great efforts to improve the living conditions were being carried out by the Palestinian National Authority, the population in the Gaza Strip was facing dramatic problems due to overcrowding,lack of water and of sewage and waste collection systems which severely affect health conditions.
The social environment was problematic as well, as the long military occupation, land confiscation and lack of employment opportunities had dramatically impoverished the population.
Women were particularly affected by the situation, which was aggravated by the fact that the fear among Palestinian of disappearing as a nation has contributed to a dramatic increase in the number of pregnancies, few of them spaced and medically attended. El-Bureij, like many other Palestinian refugee camps, has one of the highest birth rates in the world. According to a demographic survey of 1997, in the Gaza Strip total fertility rate was estimated at 6.9 births per woman, in 2007 the rate decreased to 5.06 (UNFPA, 2007).
This high fertility rate, which has been going on for several decades, has resulted in a very young population structure. The El-Bureij HCC has been operational since December 1995 and is perfectly in tune with the integrated approach to reproductive health and women's empowerment as indicated in the ICPD Program of Action.
It was the first of this kind being set up in the Gaza Strip, addressing physical, psychological and social needs of women in a comprehensive and community focused manner. The project methodology has been adapted to take into consideration the Islamic context and the socio-political and economic situation, with a particular attention to individual and collective aspects, prevention and care, information and education.
The project was conceived as a positive action for the empowerment of Palestinian women and was meant as a demonstration project that would show how to meet the real needs of women in order to influence Government policies. Since 2006, the population of the Gaza Strip has been experiencing a dramatic downturn in the humanitarian situation determined by a number of key political, security and economic developments including: a) the intensification of Israeli security and other access measures in the Occupied Palestinian Territory (OPT); b) the rise of the poverty level to 79% of the population; c) Israeli shelling and air strikes which have caused heavy displacement for hundreds of families in all Gaza Strip; d) the worsening in levels of violence experienced by Palestinians, especially children and women; e) because of the freeze on aid and tax revenues, health and sanitation services are collapsing, threatening a public health disaster. The HCC needs continued support to keep on serving the impoverished refugee population, especially in the high-tension areas where services are difficult to access.

Building: The premises of the HCC have been provided free of charge by the United Nations Relief and Works Agency for Palestine refugees (UNRWA).

Technical assistance: AIDOS ensured continued and intensive technical assistance to the project

staff throughout the years through its staff and experts (administrative experts, gynecologist, midwife, psychologists, economist, AIDOS coordinator and AIDOS President), who have so far conducted a total of 22 months of missions to Gaza according to the project specific needs. During the first year of project implementation AIDOS ensured a continuous presence through its project coordinator and a gynecologist. Theproject has also renovated the HCC premises and provided all medical and office equipment and furniture and a vehicle.

Services provided by year: Every year the El-Bureij HCC provides its services to more than 20,000 people including women, men, adolescents and children. The Clinic provides women's health care and prevention services, including detection and primary care of gynaecological problems, ultrasound examinations, prevention and detection of breast and cervical cancer, ante and post-natal care, advice and treatment for menopausal women; preventive program on reproductive tract infections, including STDs through a screening program with pap smear collection. Women are provided with information and counselling regarding all possible contraceptive methods: natural and modern methods in order to facilitate optimal and responsible free choice. The laboratory conducts tests for pregnant and menopause women with chronic illnesses. Pre-delivery courses are offered to women in the last quarter of pregnancy consisting of suitable exercises, relaxation and breathing techniques and informal lectures regarding pregnancy, delivery, breastfeeding, baby-care and family planning. Post-delivery counselling is offered for women who have recently given birth during which women receive information on breast-feeding, family planning, and baby care and attend exercise classes. Psychological counselling for individuals and couples is provided to women suffering from psychological disorders, depression and/or are victims of domestic violence or sexual abuse. Group sessions are held on most frequent and recurrent topics such as depression, anxiety and violence. Social counselling is provided mainly for problems of economic nature. The HCC facilitates women's access to donations of food, clothes and financial aid by the community. Legal counseling is offered to women on legal issues, including Islamic law, marital law (divorce, custody, alimony, marital rights) and domestic violence. The lawyer also represents cases in the Court. Socio-psychological counselling for men and male adolescents is provided by the male counsellor who conducts workshops on reproductive health, gender roles, gender-based violence and men's role in women's reproductive life. GBV program. Specific workshops on GBV are addressed to adolescents as a way to prevent its future occurrence. Information materials including post cards and leaflets about sexual harassments, oral abuse and physical abuse are produced and displayed at the HCC and distributed in the community. Particular GBV cases are externally referred for psychological and legal intervention. Community-based workshops on specific topics regarding several aspects of reproductive health are organized at the HCC, throughout the camp in co-operation with various organizations. The HCC has established an effective referral system with governmental and non-governmental organizations working in the health, legal, social and psychological fields. This network has contributed to the improvement of the quality of the services provided. The regular and mutual referral of cases between the HCC and qualified and experienced organizations allows the HCC to offer women of the camps an integrated and comprehensive package of services and to coordinate programs and optimize the distribution of the scarce available resources. A special and consolidated networking has been established between the HCC and UNRWA clinics, which refer to the HCC cases for ultrasound examinations, pre-delivery courses and post delivery home visits. The HCC organizes workshops in UNRWA clinics for pregnant women on family planning, health education, childcare and delivery.

Yearly Costs: € 120,000.00

Sources of funding: The European Union, UNFPA, CFTA, AIDOS, the Waldensian Church, the Open Society Institute, Users' fees.

Name: JABALIA WOMEN'S HEALTH CENTER

Location: Jabalia refugee camp, Gaza Strip

Year of establishment: 1998

Implementing organization: The Red Crescent Society for the Gaza Strip (RCS), Gaza city, Gaza Strip. RCS is the longest standing Palestinian institution dealing with health care, having been founded in 1969 as a charity association with the mission of providing health, educational, cultural and social services for poor people in the Gaza Strip. RCS implements programs including medical and preventive care, education, literacy programs, and women's health care. RCS has a long reputation for community care and involvement. The Society has branches in Gaza, Khan Younis, Abassan and Jabalia. Since 1998, RCS has been implementing the HCC project in Jabalia.

Background: The El-Bureij Center remarkable success has encouraged the establishment of a new Health Counselling Center in the Jabalia refugee camp. The initiative is realized along the guidelines of the Palestinian National Health Plan. The Jabalia refugee camp is among the most impoverished refugee camps with unemployment in the 50-60% range. With little other access to comprehensive counselling and support services, women and children are the most vulnerable groups of society. Enhanced mobility restrictions further isolate families from their support networks, limit their access to services and undermine the coping mechanisms. The worsening of the political and economic situation and the increase of the social tensions have produced significantly higher levels of public and private violence. A process of normalisation of violence and the deterioration of the socioeconomic situation, including social problems entailing a change in gender roles and the male breadwinning model of relations, have all contributed to rising tensions and heightening risks of violent episodes within the family environment. With the closure regime, the HCC has had to adapt its services so to ensure availability of psychological, social and legal counselling to those least able to access it.

Building: The premises of the HCC are the property of RCS.

Technical assistance: AIDOS has ensured continued and intensive technical assistance to the project staff throughout the years with its staff and experts (administrative experts, gynecologist, midwife, psychologists, economist, AIDOS coordinator and AIDOS President), who have so far conducted a total of 18 months of missions to Gaza according to the project specific needs. In the first year of project implementation AIDOS ensured the continuous presence of its gynaecologist expert for a period of 3 months. The project has also renovated the HCC premises, constructed an additional floor and provided all medical and office equipment, furniture and a vehicle.

Services provided by year: Every year the Jabalia HCC provides its services to more than 16,000 people including women, men, adolescents and children. The Clinic provides health care and preventive services, including detection and primary care of gynecological problems, ultrasound examinations, prevention and detection of breast and cervical cancer, advice and treatment for menopausal women, follow up during pregnancy, prevention and treatment of RTIs. Also adolescents access the clinic for counselling and treatment. Information and awareness activities for adolescents are conducted in schools and training centers on several issues related to this age (health, psychological, social, legal and others topics). Menopausal women accessing the HCC preventive and curative services are offered counselling and information about physiological and psychological changes at this stage. Family planning counselling services are offered to promote the concept and practice of responsible family planning and enable women, men and adolescents to make informed choices regarding their family size and promoting a sense of responsibility in sexual behaviours.
Pre-natal counselling services are offered to pregnant women attending the Clinic as well as pre-delivery courses consisting of relaxation and breathing techniques and informal lectures regarding pregnancy, delivery, breastfeeding,

baby-care and family planning.
The HCC is endowed with an equipped laboratory to conduct medical laboratory tests to facilitate the diagnostic work of the medical doctors. The HCC offers exercise and gymnastic classes combined with dietary lectures and physiotherapy services.
Psychological counselling is provided to women and couples on domestic violence, rape, incest, sex selection during pregnancy and the physical and psychological effects of menopause, through information and support meetings. Group sessions are also held divided by age and needs. Each group is fixed and is composed of participants homogeneous in age, characteristics, life situations, problems and needs. The organization of group sessions allows the participants to share experience with others with similar problems and break their isolation; it encourages self-expression and social relations and is proving to be an effective method for problem solving.
The social counselling service does not provide financial assistance but offers social counselling and advice, refers women to institutions offering financial or in kind support and facilitates women's access to employment, training and credit opportunities to start a small business. This service has empowered many women increasing their self esteem and improving their social and economic situation through the creation of income generating activities in coordination with other organizations and traders. Legal counselling is provided to the women by the part-time lawyer to increase active participation of women in the decision making process through better knowledge, awareness and understanding of their legal rights. This service provides advice and assistance regarding a wide range of legal issues, including Islamic law, marital law (divorce, custody, alimony, marital rights) and domestic violence. The lawyer also represents cases in the Court.
Socio-psychological counselling for men and male adolescents is provided by the male counsellor in collaboration with the psychologist and the social worker. The service aims to induce men to support the concept of the empowerment of women and create a better family environment. Men are also advised regarding income generation activities, employment opportunities and micro-credit.
The male counsellor also conducts workshops on reproductive health, gender roles, gender-based violence and men's role in women's reproductive life. The workshops are addressed to men and male adolescents and carried out at the HCC, in public places and at schools. GBV program.
The counsellors implement also specific workshops on GBV addressed to adolescents as a way to prevent its future occurrence. Information materials on GBV including information about where to get help, TV spots, drama, posters and leaflets are produced, distributed and displayed at the HCC and off-site (schools, shops, meeting places, centers, homes). For those GBV cases, which can be assisted by the HCC, the staff conducts an in-depth assessment and on-site treatment. Particular GBV cases are externally refferred for psychological and legal intervention.
The Jabalia HCC conducts workshops on GBV and awareness sessions on the UN Resolution 1325 concerning women in war and applying to the situation in Gaza.
Community-based workshops on specific topics regarding several aspects of reproductive health are organized at the HCC, throughout the camp in co-operation with various organizations involved in the health/social sector and in public meeting places such as schools, community-based organizations, training centers, societies, clubs, homes, unions and committees.
The workshops are targeted to female adolescents, pregnant women, mothers, elderly women, widows, women victims of violence, but also to male adolescents and adult men according to the needs. In particular, the HCC reaches adolescents through the involvement of schools, youth clubs, women program centers, community centers, private homes and community leaders and men through community workshops, regularly organized at the HCC or with other community centers.

Yearly Costs: € 120,000.00

Sources of funding: The European Union, UNFPA, RCS, AIDOS, the Waldensian Church, Open Society Institute, Monte Paschi Asset Management SGR, Users' fees.

Name: INSTITUTE FOR FAMILY HEALTH (IFH)

Location: Sweileh - Amman, Jordan

Year of establishment: 2002

Implementing organization: The Noor al Hussein Foundation (NHF), Amman, Jordan. NHF is a non-profit, NGO, working since 1985 in five main areas: integrated community development, child and family health, women and enterprise development, culture and arts, and microfinance. NHF has given Jordan a number of pioneering projects that have served thousands of needy families, have become part of Jordan's development achievements, and that have received regional and international recognition as development models. NHF works with local community at the grassroots level. Since 1991, NHF and AIDOS have been partners in the implementation of female entrepreneurship development and reproductive health projects. Since 2002, NHF has been implementing the HCC project in Sweileh, Amman.

Background: The Hashemite Kingdom of Jordan has a population of approximately 6 millions people, with an annual population growth rate of 2.1 %. Population in Jordan is young. The rapid population growth is the most significant challenge to sustainable socioeconomic development, and the fragile natural resource base is an underlying cause for poverty, unemployment and economic disparities. The total fertility rate declined from 7.3 children per woman in 1976 to 3.15 in 2007, also due to a significant rise of age at first marriage since the 1990s. However, birth intervals are becoming shorter and the incidence of contraceptive use (56%) has not changed over the last 10-15 years. (UNFPA, 2007). At primary health care level, the Ministry of Health (MOH) has established a widely accessible system of mother and child health and family planning services and is trying to increase the quality of and access to services and counselling for women. However, the integration of such services into the public health system has not reached desired levels. Also the access to other RH services, such as HIV/AIDS testing, counselling and treatment for reproductive tract infections and STIs, is still limited. Preventive services like pap-smears and breast exams are not provided by primary health care centers. Menopause is the forgotten phase of women's life. Standards and protocols, especially those covering high-risk pregnancies and RH concerns, have not been operationalized.
The project has upgraded the Institute for Child Health and Development to serve as a reproductive health center for family.
The Institute had been established in 1986 NHF, in cooperation with the Swedish NGO Save the Children to provide services and develop diagnostic and intervention methods for Maternal and Child Health with emphasis on preventive services and early detection of different child disabilities. With the technical assistance from AIDOS, the Institute upgraded its capacities and in addition to the services offered to children, since 2002 has been offering a wide range of reproductive health services.

Building: The premises of the IFH are the property of the Noor al Hussein Foundation.

Technical assistance: AIDOS has ensured continued and intensive technical assistance to the project since its beginning through its staff and experts (administrative experts, gynecologist, midwife, psychologists, economist, AIDOS coordinator and AIDOS President), who have so far conducted a total of 13 months of missions to Jordan according to the project specific needs. The project has also renovated the gym premises and provided medical and office equipment, furniture and a vehicle.

Services provided by year: Every year the IFH provides its services to more than 12,000 people including women, men, adolescents and children. The IFH provides a wide range of women's health care and preventive services, including detection and primary care of gynecological problems, ultrasound examinations, prevention and detection of breast and cervical cancer (including teaching women breast self-examination), advice and treatment for menopausal women. Also adolescents access the clinic for counselling and treatment.
The laboratory conducts tests for pregnant

women, tests for abnormal pregnancies and for menopause women with chronic illnesses. The laboratory has a special agreement with private laboratories for the conduction of specific tests. The clinic staff offers ante and post-natal counselling. A gym hall established in the basement of the Institute is used to conduct bodily activities and to implement psychological support programs for children victims of violence. Women are provided with information and counselling regarding all possible contraceptive methods in order to facilitate an optimal and responsible free choice. Contraceptives are provided by the Jordanian MOH free of charge.

Psychological counselling is provided by the psychologist to women and adolescents victims of domestic violence, suffering from stress, behavioral disorders, anxiety and with problems related to adolescence.

Social counselling services consist of individual and couple counselling, community education and a referral system in collaboration with other organizations. Advice regarding income generation activities and employment opportunities is provided to women in economic difficulties, with problems of domestic violence, unemployed and interested in gaining entrepreneurial skills. The legal counselling provides advice regarding a wide range of legal issues, including Islamic law, marital law and domestic violence, labor rights. For cases of domestic violence the IFH has established linkages with the Family Protection Department of the Jordanian Ministry of Interior and other Jordanian NGOs specialized in legal issues for cooperation in the field of counselling for women and children victims of violence, physical and emotional abuses. The implementation of the program for men involvement in RH and gender issues is supported by a group of volunteers, who facilitate the creation of focus groups and the conduction of awareness activities in male schools on STDs, sex education and violence. The experience of men involvement program attracted other organizations, which consider it as a success that should be strengthened and enhanced. The counselling services for men include individual and group sessions and are designed to supplement the women's counselling and to offer assistance in dealing with psychological disorders and family violence. The service reaches men in their meeting places and introduce the counselling activities an the IFH on the basis of men's knowledge, beliefs and needs regarding reproductive health.

A wide variety of community-based educational workshops and seminars are conducted at the IFH and throughout the Sweileh area for various target groups on reproductive health, social, legal and psychological issues. Awareness and education activities are also implemented through the organization of group discussions for girls and boys in schools, pregnant women, menopausal women, mothers and men which takes into consideration common cultural experiences in order to facilitate communication, empathy and exchange among participants. Groups include pre-wedding, pregnancy, women in reproductive age, baby massage, menopause, women victims of domestic violence, men and children. Formal contacts with communitybased organizations and government health structures are established or strengthened through meetings and seminars for the creation of a referral system for those cases beyond the IFH capacity. The IFH conducts training activities for institutions and organizations working in RH including universities and colleges for nursing, psychology, nutrition, social work and special education. The IFH acts as a training center for the MOH staff on psychological and social subjects. Doctors from the MOH regularly visit the Institute as an example of model community center. The Institute plays a major advocacy role in many national committees and debates on national strategy for early childhood" (maternal health component) and in the reproductive health team and national population strategy of the Higher Population Council. In 2005, the Institute obtained a recognition as a model center and attracted the interest of several Jordanian and international organizations.

Yearly Costs: € 115,000.00

Sources of funding: The European Union, UNFPA, IFH, USAID, AIDOS, The Region of Sardinia (Italy), American Cancer Society, Freedom House, Users' fees.

Name: HEALTH COUNSELLING CENTER FOR WOMEN, ADOLESCENTS AND MEN

Location: Halbouni, Damascus, Syria

Year of establishment: 2007

Implementing organization: the Syrian Family Planning Association (SFPA), Damascus, Syria. SFPA is a Syrian NGO established in 1974 and approved by the Syrian Ministry of Social Affairs. It belongs to the International Planned Parenthood Federation IPPF.
SFPA runs 19 Clinics across the Country and also disposes of a mobile Clinic to reach underserved areas in Rural Damascus. SFPA cooperates with the Syrian Ministry of Health as well as with UN agencies, EU and international NGOs. SFPA is committed with expanding the scope of its external support by implementing projects in line with the national RH policy, as well as with the action plan of ICPD+10, and the Millennium Development Goals to achieve better standards of reproductive health and continue improving the quality of its services. SFPA envisages a society in which every woman, man and young person has access to the information and services they need; a society in which reproductive rights are recognized as a fundamental human right, where choices are fully respected and where stigma and discrimination have no reasons to be. Since 2007, SFPA has been implementing the HCC project in Halbouni, Damascus.

Background: Syria has a population of about 20 millions inhabitants. It has a relatively young population. The demographic growth rate is still high despite the decline occurred during the last decades: from 3.3% in the eighties to 2.4% in 2007. The average total fertility rate (TFR) in 2007 was estimated at 3.11. Despite the increase in the use of FP methods deriving from the efforts exerted by the Syrian Government to support this policy, the percentage of women recurring to FP methods did not exceed 40% in 2007. Early marriage, particularly for females, is prevalent among poorer segments of the population and the less educated. Women illiteracy accounts for 26% of the population above 15. (UNFPA, 2007). While gender parity in primary education has nearly been achieved, there are still many areas were girls are more likely to drop out of school than boys. This is due to a prevailing attitude that girls should be brought up to become wives and mothers only and therefore it is not important for them to be educated beyond basic literacy. Large family size is accompanied by frequent marriages among relatives leading to higher incidence of genetic and hereditary disabilities. Certain cultural and social barriers discourage women from being active in the socio-economic growth of their country. Awareness of HIV-related issues is weak, particularly in terms of prevention. Issues related to sexuality and sexual behaviour are still inefficiently addressed and closely affected by socio-cultural and religious factors. The project intends to upgrade one the 19 Clinics of the SFPA into a Health Counselling Center through training and introducing new services to respond to an increasing demand for qualified and integrated reproductive health care. It aims at attaining higher standards of physical, psychological and social well being, by adopting a holistic approach to reproductive health. The HCC targets underprivileged people living in Damascus and its suburbs. The HCC has enhanced the clinical and family planning services formerly provided by the SFPA clinic of Halbouni area through: psychological and legal counselling, socio-psychological counselling for men, treatment of menopausal women, testing and implementing UNFPA guidelines to combat gender based violence, social-counselling, gymnastic and physiotherapy. The Project intends to introduce the HCC approach also to the other SFPA Clinics of Syria.

Building: The premises of the HCC are the property of SFPA.

Technical assistance: AIDOS will ensure continued and intensive technical assistance to the project staff through its staff and experts (administrative experts, gynecologist, midwife, psychologists, economist, AIDOS coordinator and AIDOS President), who, during the first phase of project implementation, will conduct a total of 16 months of missions to Syria according to the project specific needs. Moreover, an AIDOS international project coordinator based

in Syria is responsible for the overall conduction, coordination and monitoring of the project.
The project has also renovated the Clinic's premises and provided medical and office equipment, furniture and a vehicle. Also the staff of the Jordanian IFH is involved to provide ad hoc technical assistance and in order to share with the SFPA its experience of comprehensive approach to women's reproductive health and management of HCC.

Services provided by year: Every year the Halbouni Clinic provides its services to more than 8,000 people including women, men, adolescents and children. The Clinic is fully operational and provides a wide range of women's health care and preventive services, including detection and primary care of gynecological problems, ultrasound examination, prevention and detection of breast and cervical cancer, advice and treatment for menopausal women, follow up during pregnancy, prevention and treatment of RTIs. Family planning counselling services are offered to promote the concept and practice of responsible family planning and enable women, men and adolescents to make informed choices regarding their family size and promoting a sense of responsibility in sexual behaviours. Ante –natal services include gynecological and ultrasound examinations, blood pressure measurement, weigh measurement, laboratory biological tests. Post natal care services include also counselling sessions on the use of family planning methods after delivery. The HCC offers exercise and gymnastic classes combined with dietary lectures in order to help women to gain self-confidence.
Psychological counselling for women, men and couples is provided for problems related to anxiety, low self-esteem, family, domestic violence, sexual abuse, depression, behavioural disorders.
Social counselling includes advice regarding income generation activities, employment opportunities, training opportunities to gain entrepreneurial skills, community education. The socio-economic aspect represents a fundamental component of the project as it is related to poverty, unemployment and social exclusion, which have a strong effect on women's reproductive health. The service does not provide financial assistance but offers social counselling and advice, refers women to institutions offering financial or in kind support and facilitates women's access to employment or training opportunities.
Legal counselling is provided to women by the part-time lawyer to increase active participation of women in the decision making process through better knowledge, awareness and understanding of their legal rights.
Men counselling is provided at individual and group level by a male socio-psychological counsellor who complements the women's counselling and offer assistance in dealing with psychological disorders and family violence. The service aims to induce men to support the concept of the empowerment of women and create a better family environment.
Youth counselling is provided through information sessions on sexually transmitted diseases, attended by girls and boys regularly visiting the youth center in HCC. Free HIV tests, provided by UNICEF, are also offered.
Problems related to handicaps, psychiatric disorders, bed wetting, study, low self-esteem, are the main reasons for adolescents and children to address the counselling service.
Awareness and preventive campaigns are organized with the aims of raising community awareness on the HCC activities and on the specific services offered, encouraging the community participation and involvement and promoting the concept of prevention.
The campaigns cover issues such as pre-marital counselling, family counselling and gender.
Workshops are organized inside and outside the Clinic, promoting HCC services and discussing different reproductive health topics such as men involvement in family RH, breast cancer prevention, depression, parenthood, legal rights, HIV/AIDS/STDs, marriage, family planning and use of contraceptive methods, and ante-natal care.

Yearly Costs: € 95,000.00

Sources of funding: The European Union, UNFPA, IPPF, AIDOS, SFPA, Users' fees.

Job Title	*Director*
Working time	full-time
Job purpose	Ensuring efficient implementation and quality of center's activities and correct adoption of holistic approach to reproductive and sexual health by the HCC
Key tasks	• Manage Center's personnel • Manage Center's financial resources and supervise expenditures • Manage Center's equipment and assets and monitor their utilization • Plan Center's initiatives/ activities and coordinate their execution with HCC Staff • Be responsible for organizing workshops promoted through HCC and for all technical and administrative tasks carried out at Center's level • Coordinate preparation of training/ information/ sensitization and education materials and their dissemination strategy in collaboration with HCC Staff • Produce regular narrative and financial reports • Contribute to setting out a Management Information System (MIS) • Participate in conferences, seminars and workshops and present Center's activities • Ensure timely follow up to technical assistance missions of international consultants and ensure that their inputs and recommendations are adopted in Center's daily work • Facilitate international consultant missions • Liaise with other health, education and social institutions • Establish a referral system for treatment of patients beyond Center's capacity • Organize Staff meetings on a regular basis • Ensure the correct implementation of Center's internal policy guidelines • Conduct regular monitoring of HCC Staff performance • Be responsible for promoting HCC activities and potential marketing of its services • Participate in all training and capacity building initiatives conducted for the HCC Staff
Responsibilities	The job holder will be responsible for all personnel recruited by and based at the Center.
Education & qualifications	University degree in medicine, science, business administration. Post-graduate specialization in public health / social sciences or medicine. At least 5 years of experience in medical or public health field.
Skills	Significant managerial and coordinating skills; analytical skills; good communication skills - written and verbal; fluent English; able to maintain high levels of confidentiality; strongly motivated involvement in development projects; able to adopt a gender-oriented approach in daily work; knowledgeable about holistic approach to sexual and reproductive health; knowledgeable about local socio-economic situation; Good IT (information technology) skills.
Personal requisites	Team player; flexible; dynamism and proactiveness; friendly and cheerful disposition; able to remain calm under pressure; working to deadlines and priorities work load; quality and result-oriented; approachable; mature and sensitive approach to dealing with issues; consistent in her/his work; meticulous attention to details and accuracy.

Job Title	*Gynecologist / Deputy Director*
Working time	full-time
Responsible to	HCC Director
Job purpose	Ensure correct delivery of medical and gynecological services in line with Center's holistic approach to reproductive and sexual health
Key tasks	• Be responsible for the delivery and coordination of obstetrical, gynecological and clinical services (detection and primary care of gynecological problems, ultrasound examinations, detection of breast and cervical cancer, ante- and post-natal care, treatment of menopausal women, testing during pregnancy) • Be responsible for providing family planning services (advice on contraceptive methods and identifying most appropriate methods based on User needs, including inserting of intrauterine devices (IUDs) • Advise on treatment and ensure the appropriate care or referral of patients affected by sexually transmitted diseases (STDs) • Coordinate pre-delivery and post-delivery courses to be conducted by the Midwife, the Physiotherapist and the Psychologist • Organize and conduct meetings and other sensitization/ information activities in collaboration with other Staff, at the HCC or in other external locations • Contribute to the drafting of education and sensitization materials • Adopt inputs of technical assistance in daily work • Contribute to producing clinical procedures guidelines • Be responsible for the management and update of User medical files • Compile and be accountable for monthly clinical reports • Participate in all training and capacity building initiatives conducted for the HCC Staff
Responsibilities	Job holder is responsible for the Midwife and the Practical Nurse; collaborates closely with all HCC Staff
Education & qualifications	University Degree in medical science and specialization in gynecology. At least 10 years experience as gynecologist. Previous experience in counselling center is an asset.
Skills	Fluency in English; analytical skills; good communication and interaction skills; able to maintain highest levels of confidentiality; consolidated experience in ultrasound machine use.
Personal requisites	Team player; confident in own abilities; friendly and cheerful disposition; capable of working under pressure and to deadlines; approachable, mature and sensitive approach to addressing issues; consistent in work; open to learning; committed; motivated to working in development projects.

Job Title	*Midwife*
Working time	full-time
Responsible to	HCC Director, Gynecologist
Job purpose	Ensuring correct and timely delivery of gynecological and health care services with HCC Gynecologist and Practical Nurse
Key tasks	• Assist Gynecologist during delivery of obstetrical services (insertion of IUDs under gynecologist supervision) • Inform and provide Users with family planning methods as advised by Gynecologist • Compile monthly reports on contraceptive consumption • Be responsible for managing and storing medical stock • Be responsible for ensuring hygiene of gynecological instruments and environment • In collaboration with other HCC Staff, organizing and conducting meetings and sensitization/ information activities at HCC premises and/or other locations • Collaborate in elaborating information, training and sensitization materials • Conduct pre-delivery and post-delivery courses in coordination with the Physiotherapist and the Psychologist • Adopt inputs of technical assistance provided by international consultants in daily work • Contribute producing guidelines for clinical procedures • Refer social cases if needed • Participate in all training and capacity building initiatives conducted for the HCC Staff
Responsibilities	The Midwife has no direct responsibility over any of Staff
Education & qualifications	Ministry of Health Midwifery Certificate. At least 5 years referenced work experience. Previous work experience in counselling HCC is an asset.
Skills	Fluency in English; analytical skills; good communication and interaction skills; able to maintain highest levels of confidentiality.
Personal requisites	Team player; confident in her own abilities; friendly and cheerful disposition; capable to work under pressure and to deadlines; approachable, mature and sensitive approach to addressing issues; consistent in work; open to learning; committed; motivated to work in development projects.

Job Title	*Practical Nurse*
Working time	full-time
Responsible to	Center's Director, Gynecologist
Job purpose	Assist Gynecologist and Midwife in providing appropriate health care services
Key tasks	• Receive Users, carry out registration procedures for new Users • Refer Users to appropriate HCC Specialist(s) • Provide Gynecologist with User files • Be responsible for organizing User file archive • Be responsible for collecting Users' fees for clinical services, with receipts for payment • Keep track of monthly income for clinical services and produce a report (for Accountant), check it against activity report and contraceptive consumption report • Coordinate and perform animation activities in the HCC waiting room • Assist Psychologist in adolescent group meetings • Contribute to pre-delivery and post-delivery courses, conducted by the Midwife, the Physiotherapist and the Psychologist • Perform information/awareness activities for adolescents • Collaborate with the Gynecologist and the Midwife in all HCC activities from the anamnesis collection to discussing different clinical cases • Participate in all training and capacity building initiatives conducted for the HCC Staff
Responsibilities	The Practical Nurse has no direct responsibility over any of the Staff
Education & qualifications	Nursing Certificate. At least 5 years of referenced work experience. Previous experience in counselling centers is an asset.
Skills	Elementary knowledge of English; analytical skills; good communication and interaction skills; computer skills; able to maintain highest levels of confidentiality.
Personal requisites	Team player; confident in her own abilities; friendly and cheerful disposition; capable of working under pressure and to deadlines; approachable, mature and sensitive approach to addressing issues, consistent in her work; open to learning; committed; motivated to working in development projects.

Job Title	*2 Field Workers*
Working time	full-time
Responsible to	HCC Director, Social Worker
Job purpose	Promote HCC services among potential Users, sensitize and increase their awareness of reproductive and sexual health through community-based and individual meetings carried out in the field
Key tasks	• Contribute to designing and implementing Center's out-reach program in collaboration with the Social Worker and other HCC Staff • Organize and conduct community-based workshops about different aspects of sexual and reproductive health both at HCC and in public meeting places, in coordination with community leaders and other organizations involved in health/social sector • Promote HCC services among women, adolescents and men by reaching them at their own houses or workplaces, schools and universities • Implement 'post delivery home visits' programs on a regular basis • Organize and provide information and awareness sessions with HCC Staff • Contribute to producing sensitization and promotional materials • Compile monthly reports of field activities • Participate in all training and capacity building initiatives conducted for the HCC Staff
Responsibilities	Job holders have no responsibility over any of HCC Staff
Education & qualifications	University or diploma in social sciences. Proven working experience in social services. Previous experience in a counselling center is an asset.
Skills	Capable of maintaining high levels of confidentiality; proficient in English; analytical skills; good communication and interaction skills; convincing aptitude.
Personal requisites	Team player; dynamic; friendly and cheerful disposition; approachable, mature and sensitive approach to addressing issues; open to learning; committed; sensitive to social norms and traditions; knowledgeable about socio-economics of target area; motivated to work in development projects.

Job Title	*Physiotherapist*
Working time	full-time
Responsible to	HCC Director
Job purpose	Improving physical and psychological well being of women through the provision of bodily and relaxation activities
Key tasks	• Design a weekly program for the Center's Gym and be responsible for its implementation • Conduct ad-hoc counselling for women who want to benefit from bodily activities • Conduct pre-delivery and post-delivery courses, including physical exercises and lectures • Conduct gymnastic classes • Provide weight-loss advice and conduct dietary lectures • Conduct sessions on relaxation techniques • Ensure a favourable environment among gym Users • If specific physical problems are detected consult with Director and refer User to relevant health facilities • Collaborate in drafting sensitization and educational materials • Ensure correct utilization of Gymnasium • Ensure maintenance of gym equipment • Ensure technical assistance inputs are incorporated in daily work and gym classes. • Collect User fees against a receipt and provide it to accountant • Compile a monthly report for the Director • Participate in all training and capacity building initiatives conducted for the HCC Staff
Responsibilities	The Physiotherapist has no responsibility over any of HCC Staff
Education & qualifications	University or diploma in physiotherapy or physical education; proven working experience as gym trainer; strong knowledge of anatomy.
Skills	Strong coordination skills; analytical skills; proficient English; able to maintain high levels of confidentiality; Knowledgeable about Center's holistic approach to sexual and reproductive health; knowledgeable about local socio-economic situation.
Personal requisites	Team player; dynamic; patient, friendly and cheerful disposition; approachable, mature and sensitive approach to addressing issues; open to learning; committed; sensitive to social norms and traditions; knowledgeable about socio-economic context of target area; motivated to work in development projects.

Job Title	*Psychologist*
Working time	full-time
Responsible to	HCC Director
Job purpose	Provide psychological assistance to HCC Users
Key tasks	• Assist women suffering from psychological disorders, depression and/or victims of domestic violence or sexual abuse • Conduct psychological therapy sessions for single patients, couples and adolescents • Conduct sessions specifically for adolescents' mothers • Refer specific cases to relevant external health care institutions, if needed • Organize group discussions on different topics including: depression, anxiety, violence • Participate in information and sensitization activities • Conduct pre-delivery and post-delivery courses in coordination with the Physiotherapist and the Midwife • Contribute in producing general information, training and sensitization materials • Consult and collaborate with other HCC Staff, to ensure comprehensive and accurate assistance for each single case • Supervise and coordinate socio-psychological counselling for men • Compile monthly reports • Participate in all training and capacity building initiatives conducted for the HCC Staff
Responsibilities	The Physiologist is responsible for the socio-psychological male counsellor
Education/ & qualifications	University Degree in psychology or social sciences. At least 5 years of proven working experience
Skills	Proficient English; analytical skills; strong communication and interaction skills; ability to maintain highest levels of confidentiality. Strong motivation to work in development projects.
Personal requisites	Team player; confident in own abilities; friendly and cheerful disposition; capable of working under pressure and to deadlines; approachable; mature and sensitive approach to addressing issues consistent in work; open to learning; committed; deeply motivated to work in development projects.

Job Title	*Socio-Psychologist male counsellor*
Working time	part-time
Responsible to	HCC Director, Psychologist
Job purpose	Sensitize men to issues related to reproductive and sexual health and encourage them to take an active role in improving family conditions
Key tasks	• Provide counselling to men and male adolescents through individual and group sessions • Conduct couple social and psychological counselling with the HCC Psychologist • Refer specific cases to relevant external health care institutions, if needed • Promote Center's counselling service among men and invite them to come to the HCC • Provide advice in terms of income generation activities, employment opportunities and micro-credit in coordination with the social worker • Compile monthly reports with the Psychologist • Contribute to producing information and education materials • Participate in all training and capacity building initiatives conducted for the HCC Staff
Responsibilities	Job holder has no responsibility over any of Center's Staff
Education & qualifications	University degree in psychology or social sciences. At least 5 years work experience in social services (with references).
Skills	Fluent English; analytical skills; good communication skills and interaction skills; ability to maintain highest levels of confidentiality.
Personal requisites	Team player; confident in own abilities; friendly and cheerful disposition; capable of working under pressure and to deadlines; approachable; mature and sensitive approach to addressing issues; consistent in work; open to learning; committed; deeply motivated to work in development projects.

Job Title	*Social worker*
Working time	full-time
Responsible to	HCC Director. Job holder collaborates with Gynecologist, Psychologist and Lawyer
Job purpose	To provide ad hoc counselling for women, adolescents and men on a variety of issues ranging from health to employment opportunities and refer them to appropriate service providers within the HCC or appropriate external institutions
Key tasks	• Evaluate cases based on reports from field workers and other HCC Staff • Provide individual and group counselling at the HCC • Refer social cases to institutions/organisations specialized in social assistance • Collect information and be updated on new opportunities and services provided by institutions in social sector (youth associations, non-government organizations (NGOs), Community-based organizations (CBOs), governmental establishments) • Coordinate and supervise the implementation of out-reach programs organized by Center's Field Workers with other HCC Staff • Design an out-reach program and monitor its timely implementation with Field Workers • Contribute to designing all awareness and information materials for out-reach program with other HCC Staff • Advise women on income generating activities, job opportunities and credit programs • Produce monthly activity reports in coordination with the field workers • Participate in all training and capacity building initiatives conducted for the HCC Staff
Responsibilities	Field workers
Education & qualifications	University degree or higher in social sciences. At least 5 years work experience in social services.
Skills	Fluent English; analytical skills; good communication skills and interaction skills; ability to maintain highest levels of confidentiality; computer skills.
Personal requisites	Team player; confident in own abilities; friendly and cheerful disposition; capable of working under pressure and to deadlines; approachable; mature and sensitive approach to addressing issues consistent in work; open to learning; committed; deeply motivated to work in development projects

Job Title	*Lawyer*
Working time	part -time
Responsible to	HCC Director
Job purpose	Increase awareness of women's rights as per the national and local law and contribute to their enforcement taking positive social norms into account.
Key tasks	• Address family and social problems from a legal perspective • Provide legal counselling to women victims of domestic violence and other abuses and raise awareness on their rights • Advise on legal issues, including Islamic law and family law • Collaborate in drafting educational materials • Conduct home visits and workshops, if needed • Refer single cases to relevant public institutions or legal experts if needed in agreement with HCC Director • Participate in all training and capacity building initiatives conducted for the HCC Staff
Responsibilities	The Lawyer has no responsibility over any of HCC Staff
Education & qualifications	University Degree or higher in legal studies with a specialization in local private and family law; at least 5 years work experience as legal counsellor.
Skills	Proficient English; analytical skills; good communication skills and interaction skills; ability to maintain highest levels of confidentiality.
Personal requisites	Team player; confident in own abilities; friendly and cheerful disposition; capable of working under pressure and to deadlines; approachable; mature and sensitive approach to addressing issues; consistent in work; open to learning; committed; motivated to work in development projects.

Job Title	*Secretary*
Working time	Full-time
Responsible to	HCC Director
Job purpose	Provide secretarial support to HCC Director and to HCC Project.
Key tasks	• Carry out secretarial work as requested by Director and Project Coordinators • Be responsible for maintaining HCC documentation • Coordinate Staff transfers and field trips in collaboration with HCC Staff and Driver • Keep mileage record • Receptionist work and answer phone calls • Take care of correspondence and maintain files archive • Contribute to the organization of any public activity promoted by the HCC, such as training, meetings, small gatherings • Keep minutes of staff meetings • Keep an inventory of equipment, furniture and supplies in the center • Keep records of presences and absences
Responsibilities	The Secretary supervises driver and cleaner
Education & qualifications	High school diploma or higher, 5 years of secretarial work experience.
Skills	Proficient English; good communication and interaction skills; ability to maintain highest levels of confidentiality; excellent IT skills (including typing).
Personal requisites	Team player; friendly and cheerful disposition; capable of working under pressure and to deadlines; approachable; motivated to work in development projects.

Job Title	*Accountant*
Working time	part-time
Responsible to	HCC Director
Job purpose	Ensure correct administration of Center's financial resources following the book-keeping and accounting procedures of the implementing agency and donors
Key tasks	• Carry out daily book-keeping necessary for project and HCC functioning, following donors' accounting procedure guidelines • Prepare quarterly financial reports • Provide support for purchasing HCC equipment, furniture and supplies and ensure its maintenance and correct use • Conduct administrative tasks in accordance to donors' rules and regulations • Compile invoices and other documents in official local language and English required for overall HCC administration in line with local legislation • Cooperate with HCC Director in planning activities, monitoring and reporting on resource management and availability • File administrative documents and make them available and comprehensible for any appraisal from national and international staff • Translate all financial documents into English for reporting purposes • Maintain excellent working relations with colleagues • Maintain petty cash balance to agreed limit. Issue petty cash as authorized. • Be responsible for monthly payroll • Reconcile balance as appropriate between HCC and other potential partners • Participate in all training activities relevant for accounting and overall HCC administrative management
Responsibilities	Job holder has no responsibility over any of HCC Staff.
Education & qualifications	Job requires recognised specific qualifications. Job holder should also be familiar with modern computerized accounting systems.
Skills	IT proficient in accounting software; fluent in English; analytical skills; good communication and interaction skills; ability to maintain highest levels of confidentiality.
Personal requisites	Team player; confident in own abilities; friendly and cheerful disposition; capable of working under pressure and to deadlines; approachable; mature and sensitive approach to addressing issues consistent in work; open to learning; committed.

Job Title	*Cleaner*
Working time	part-time
Responsible to	HCC Director
Job purpose	Maintaining hygienic and cleanliness standards in the HCC
Key tasks	• Clean Center daily, ensuring high level of hygiene for medical equipment and workplace • Weekly in depth cleaning of all rooms
Responsibilities	The job holder has no responsibility over any of HCC Staff
Education & qualifications	Proven working experience
Skills	• Awareness of health and safety • Friendly, sociable manners • Elementary ability to understand English is desirable • Punctuality • Understand HCC mission and objectives • Day time availability • Able to work on own initiative • Traceability
Personal requisites	Able to maintain highest levels of confidentiality

Job Title	*Driver*
Working time	part-time
Responsible to	HCC Director
Job purpose	To provide a punctual and safe driving service in a way to ensure timely realization of Center's activities and reduce transportation costs
Key tasks	• Accompany HCC Staff during field activities • Accompany HCC Director and other Staff to meetings outside Center • Accomplish any task requested by Center Director such as delivery of material/ documents, small purchases, etc. • Ensure good maintenance of car through regular checks • Daily car meter checks with HCC secretary • Provide accountant with any relevant invoices/receipts
Responsibilities	Job holder has no responsibility over any HCC Staff
Education & qualifications	A faultless driving record; good knowledge of HCC target area(s).
Skills	• Friendly and sociable manner • Capable of interacting in English is desirable • Capable of keeping appointments and punctuality • Understand HCC mission and objectives • Day time availability • Traceability
Personal requisites	• Able to maintain highest levels of confidentiality

The following section sets out goals, actions and indicators for the following Component Objectives groups:

- Antenatal Care
- Postnatal Care
- Resources Optimisation

Goals	Actions	Indicators
	Antenatal care	
Intensifying post-abortion information, counselling, services and care on contraceptive use and distribution. Helping women choose most appropriate family planning options. Reducing number of high-risk abortions as one of the main maternal mortality causes.	Providing high quality care based on "customised care" and "referral systems" to find most adequate option. Meeting women's needs rather than focusing on population goals. Targeting disadvantaged groups, i.e. single women and adolescents. Improving emergency contraception.	Contraceptive prevalence rate (CPR). Coverage of family planning training. Community knowledge of family planning. Contraceptive prevalence rate among single women, young people and men. Incidence of unsafe and spontaneous abortion. Management of abortion complications.

Goals	Actions	Indicators
Raising prenatal care quality levels to humanised childbirth standards. Promoting holistic approach and women's involvement and awareness, strengthening their self-esteem.	Providing information on natural pregnancy and associated complications to women in fertile age. Providing high quality perinatal care based on evidence based written guidelines (EBG) on natural pregnancy and childbirth. Organising childbirth preparation training courses aimed at disseminating information, providing women with "focal" points about childbirth experience and listening to the natural language of the body during pregnancy, and raising their awareness of being able to give life. Experimenting body work including yoga, relaxing techniques, deep and aware breathing, pelvis mobility and dynamics, voice use, massage; reflexology - to ease most common pregnancy disorders and naturally induce delivery.	Knowledge of at least two signs of complications during pregnancy. Coverage of ante-natal care training. Coverage of ante-natal course with holistic approach

Goals	Actions	Indicators
Granting continuity between perinatal quality care and delivery assistance. Prevent pregnancy complications and/or ensuring they can be handled properly.	Setting up and enacting ante-natal testing protocols, depending on relevant pregnancy period and any pregnancy and/or delivery associated pathologies (Hypertensive Disorders of Pregnancy (HDP) or Pre-Eclampsia, Labour and delivery complications)	Number of pregnant women experiencing natural childbirth after receiving at least three ante-natal visits.
	Provide double immunisation protocol tetanus vaccination during pregnancy.	Tetanus vaccination coverage.
	Applying pregnancy screening programmes for Syphilis, Streptococcus, AIDS and other STDs.	Coverage of Syphilis, HIV/ AIDS, STDs and Streptococcus screening. Syphilis infection among pregnant women.
	Promoting pregnancy ultrasound tests (for 21st and 30-32nd week).	Percentage of early detected foetal and maternal pathologies.
	Clinical screening for iron and folic acid deficiencies on anaemic women. Administering dietary integrators, mainly proteins and other nutritionals (vitamin A, Iron and Folic Acid), in top risk areas.	Percentage of Anaemia in pregnant women.

Goals	Actions	Indicators
Post natal care		
Promoting supporting actions for breastfeeding along principles set out by the *Baby Friendly Initiative* (WHO-UNICEF).	Setting up mother-child contact schemes from delivery room through to puerperium. Rooming-in	Rate of newborns latching on mother's breast within the first two hours of life.
Promoting puerperium home assistance schemes to favour breastfeeding and meeting social and psychological needs.	Setting up easy access puerperium schemes in disadvantaged settings. Setting up a psychological, social and health care network by appropriately trained service providers to cater to various needs within first month of childbirth.	Percentage of social and health care wards that set up easy access schemes. Percentage of women receiving postpartum care. Percentage of women that continue breastfeeding after third month, through paediatric data collection forms. Percentage of satisfied Users of both sexes that solved medical and psychological-social problems triggered off by pregnancy, detected through psychological and social data collection forms, updated by HCC psychologists and field workers in month following childbirth.

Goals	Actions	Indicators
Promoting family support home assistance schemes directed to new parents and aimed at increasing male involvement after childbirth (schemes lasting from six months to one full year after childbirth).	Setting up easy access for women and family support schemes in disadvantaged areas lasting six months to one year after childbirth. Setting up networked psychological, social and health care by qualified staff (including male counsellors) capable of addressing various needs in a period of six months to one year after childbirth. Setting up an info-desk for social and legal topics, and male involvement in the motherhood experience within HCC.	Percentage of social-health care wards that set up easy access for women and family support schemes of six months to one year after childbirth. Percentage of satisfied Users that solved medical and psychological-social problems detected through data collection forms updated by HCC psychologists and field workers.

Goals	Actions	Indicators
Resources optimisation		
Optimizing resources and cross-level action integration (HCC, as 1° level and 2° and 3° level inside all Referral Systems). Drafting long term action plan(s) to develop, women during their reproductive life and mother and child care protocols. Set-up comprehensive staff lifelong training and update scheme.	Optimising resources and cross-level action integration (HCC, as 1° level and 2° and 3° level inside all Referral Systems). Drafting long term action plan(s) to develop, women during their reproductive life and mother and child care protocols. Set-up comprehensive staff lifelong training and update scheme Setting up a database and an information system. Annual review of ante-natal and maternal and perinatal health indicators. Annual review of overall staff training levels.	

I - Overview of Gender-based Violence: the roots of GBV

Goals

- An introduction to key concepts related to gender-based violence
- Definition of what violence means in your community
- An introduction to causes and contributing factors of gender-based violence
- Exercises for raising awareness about gender inequality and service provider barriers

Training outline

Session 1 / Setting the Mood

- Welcome and Introduction
- Training Overview and Logistics
- Participant Expectations
- Establishing Ground Rules

Session 2 / Understanding Key Concepts

- Sex vs. Gender: example of a practical activity
- Gender-based Violence (GBV). Group activity: Violence Jeopardy Game
- Examples of GBV in your community and in the world
- GBV in Your Community: Causes, Contributing Factors, Consequences. Small groups activity: proverbs

Session 3 / Barriers in dealing with GBV

- Limiting beliefs: Exercises (9 points)
- Barriers to talking with Users about sexual assault

II - Strategies in Working with Survivors: Who is a GBV victim?

Goals

- An understanding of GBV survivors needs and concerns
- An introduction to basic engagement techniques in working with survivors
- How to screen
- Differences between assessment, assumption, and diagnosis
- Service Provider Responsibilities and Community Referral
- Knowledge of the principles of record keeping and confidentiality

Training outline

Session 1 / Understanding the Survivor

- Basic Psychological Needs
- Brief Introduction to Trauma Theory
- Definition of Trauma
- Identifying Common Reactions to Trauma
- Post Traumatic Stress Disorder
- In the User's shoes

  Individual activity: Visualizations for traumatic experience

Session 2 / Introduction to Engagement Techniques

- Service Provider Effectiveness
- Self-Assessment

  Individual activity: Why I chose...

  Small group activity: Reflecting on Values
- Medical power and control
- Assessment vs. Assumption

Session 3 / Record Keeping, Confidentiality and Referral

- The Fundamentals of Record Keeping
- Ensuring Confidentiality
- Screening Form
- Coordinating a Community Response

III - Effective Engagement Strategies: How to treat victims

Goals

- An introduction to roles of service providers
- Complexity in working with survivors, including safety planning, cultural sensitivity
- Responding to special populations (like Users with other problems, like being alcohol dependent or with a bipolar disorder)
- Instituting safety precautions for service providers (when dealing with for instance 'special populations': as above)

Training outline

Session 1 / How to deal with GBV victims

- Active Listening
  Individual activity: Visualization
- Barriers to Good Listening

Session 2 / The Role of Values

- Improving Active Listening
  Working in pairs activity: Looking for Values
- The Pyramid of Values
  Group activity: The "Magic" Sale
- Interaction techniques
- Advising vs. Informing
- Role Playing
  Small group activity: Dealing with Survivors

Session 3 / Specific Issues in Working with Survivors

- Special Populations e.g.: drug or alcohol abusing survivors-indicators of substance abuse; suicidal/homicidal survivors, e.g.: recognising signs of depression, suicidal risks, violence
- Protocols for Action

Session 4 / Safety Precautions for Service Providers

IV - Group Activities

Goals

- An introduction to basic group techniques in working with survivors
- Relaxation techniques; trust activities
- How to debrief each activity

Training outline

Session 1 / Treatment groups and educational groups

Session 2 / Why groups for GBV?

- Breaking through the loneliness and shame
- The group as a resource

Session 3 / General Issues on Working with Groups

- Setting up the Group: Establishing a Contract, Ground Rules
- The "Here and Now"
- Dealing with Feelings and emotions
- Dealing with "Projections" (a psychological term to describe an unconscious ascription of a personal thought, feeling or impulse onto someone else, which can often happen in a group)
- Types of resistance and defensive mechanisms
- Debriefing

Session 4 / How to lead a session (experiential)

- Relaxation exercises
- Stretching
- Trust activities
- Drawing
- Role-playing in groups

V - Supporting the Service Provider: the Burn Out Risk

Goals

- An understanding of vicarious trauma, its causes, and ways of managing and preventing vicarious trauma
- Knowledge of and practice in self-care techniques
- An introduction to supervision, including the roles and responsibilities of the supervisor and supervisee
- Training Review and Evaluation

Training outline

- Defining and Coping with Vicarious Trauma
- Introduction to Self-Care
- Role of the Supervisor
- Responsibilities of the Supervisee
- Training Review and Evaluation

TABLE 2

Costing 'per case treated' – by category of service		
	Procedure	**Application to IFH's case**[1]
1.	Divide services offered by IFH in categories according to similarity of cost structure	Medical - GP consultation Medical - specialist consultation Medical - nurse consultation Medical - nurse home visit Medical - vaccination Medical – lab…
		Counselling – reproductive health Counselling – psychological Counselling – legal Counselling – social…
		Child development – IQ assessment Child development – Speech therapy Child development – special education Child development – physiotherapy…
		Body conditioning – relaxation exercises Body conditioning – yoga (general) Body conditioning – yoga (pregnant women) Body conditioning – reflexology…
		Awareness raising – workshops Awareness raising – campaigns Awareness raising – seminars Awareness raising – school visits Awareness raising – home visits…
		Etc.

1 The classification is provided as an example and does not necessarily reflect the entirety and/or the precise articulation of the services currently provided by IFH.

	Procedure	Application to IFH's case
2.	Spell out types of inputs for each category of service	Labor, specialist / technical staff Labor, admin / support staff
		Consumables, specialist (drugs, syringes, ...) Consumables, admin / support (stationery, refreshments, ...).
		Equipment (purchase[2], maintenance and depreciation), specialist Equipment (purchase, maintenance and depreciation), support[3].
		Transport, local Transport, international
		Technical assistance – specialist, locally-sourced Technical assistance – specialist, internationally-sourced Technical assistance – co-ordination & management, backstopping, internationally sourced Technical assistance – strategic planning, internationally sourced
	Procedure	**Application to IFH's case**
		HRD – Induction HRD – Internships HRD – Training, in-house HRD – Training, outsourced HRD – Documentation HRD – Exposure (study tours, visits...)...
		Management – strategic planning Management – Monitoring & Evaluation Management – Performance Appraisal

2 Purchase costs are one-off (start-up investments) and can be equally or proportionally divided amongst the services utilizing those pieces of equipment.
The higher the number of cases, the lower their average cost also in terms on absorption of initial investment. On the other hand, maintenance costs are 'running' costs and tend to increase with the number of cases. At the same time, also depreciation needs to be factored in, as calculated by the 'straight line' depreciation formula. 'Depreciation' is defined as the decline in value of capital equipment due to age and wear&tear effects.

3 The cost of equipment (purchase and maintenance) initially weighs considerably on the cost per service, until the number of cases treated (and in future the corresponding cost-recovery) is large enough to absorb the initial capital investment (at least the purchase portion). Despite one could assume that the actual 'direct' cost of a service (per case) is given by the resources directly needed to deliver that service (labour and capital), in order to determine whether the IFH (or other SRH centre) is heading towards sustainability, it is crucial to factor in all costs (per period of time) and verify which proportion of overall costs can be 'allocated' to a certain service – and therefore how much cost-recovery should in theory be 'expected' from that service (or also from other categories, when applying a concept of cross-subsidisation). The key point is that sooner or later all resources to cover all types of costs will have to be internally generated (see principles of cost-recovery).

	Procedure	Application to IFH's case
		Administrative (if not covered under the above headings).
		Operational (if not covered under the above headings; including rent and utilities if relevant)
		Miscellaneous
3.	Separate direct[4] from indirect[5] fixed costs, and variable[6] costs	Analyze every sub-category of services and list the direct and indirect fixed costs, and the variable costs for each of the above[7].
4.	Determine unit costs of various inputs	Analyze each type of (direct or indirect fixed costs; variable costs) and calculate the average unit cost (e.g. doctor labor/hour; counsellor labor/ hour; transport/ km; support staff labor / hour; etc...)[8].
5.	Record actual amount of inputs for each service (or per x number of cases) and allocate relevant total costs per service	Design and implement a recording system (e.g. time sheets, inventories, etc.) and assign to each sub-category of costs the number of unit inputs related to direct costs and indirect costs per number of cases (e.g. every 100 cases).
6.	Calculate total cost per service (per x number of cases)	Multiply number of unit inputs per x number of cases for the unit cost (for each input) to obtain total cost (e.g. cost of vaccinating 100 children, or cost of counselling 100 women).
7.	Calculate average cost per service per case (or per unit of time)	Divide total cost (point 6.) by the number of cases and obtain average cost of each service for each person. Or divide total cost by number of months or days and obtain monthly / daily costs.
8.	Compare costs across categories	Verify which service is more or less expensive per case.
9.	Compare costs across time	Verify whether the cost-efficiency of a service is improving or worsening.

4 Direct fixed costs = directly related to the activity, but stay the same over a period of time irrespective of the amount of activity

5 Indirect fixed costs = overheads = must be met irrespective of the amount of business activity; difficult to apportion them to specific activities (normally an un-weighted average is used)

6 Variable costs = directly dependent from the amount of activity

7 Example:

8 When calculating the cost of durable goods, depreciation needs to be taken into account.

10.	Compare costs with other institutions'	Collect data on costs in other organizations and compare with own cost structure to identify in which area the Institute has a comparative advantage.
11.	Compare costs vs. current fees	Verify profit or loss (by applying the formula Profit = Revenue – Cost) for every sub-category of service.
12.	Define a strategy for re-pricing	Charge / adjust fees as needed, aiming at covering costs but at the same time maintaining competitiveness and affordability of health and counselling services.

TABLE 5

Income-generation for IFH's sustainability	
Expanding existing markets	
OBJECTIVES	**ACTIONS**
i. Intensify usage by existing clients of medical services	• Awareness-raising, publicity, promotions, follow-up • Charge appropriate fees, and provide information about the reasons and criteria for user charges • Set and disseminate eligibility criteria for discounts and exemptions (to ensure access for the poor) • Connect different services in appealing and convenient 'packages' for clients already familiar with IFH (group members, local women) • Explore solutions for the problem of drugs prescription[9], and consider the option of setting up a small on-site pharmacy[10] • Offer transportation services at cost-sharing rate for the beneficiaries from remote sections of the target areas • Offer nursery services at cost-sharing rate for the clients with children
ii. Attract new customers for medical services	• Awareness-raising, publicity, promotions, follow-up • Charge appropriate fees, and provide information about the reasons and criteria for user charges • Set and disseminate eligibility criteria for discounts and exemptions (to ensure access for the poor) • Improve referral system in collaboration with MoH and their Sweileh Health Center • Emphasize flexibility, extend opening hours and strengthen home delivery • Identify weaknesses of referral system and propose solutions. Review and improve agreement with MoH • Negotiate and establish sub-contracts and other agreements with MoE[11] and MoD[12] • Design and establish membership schemes: define regulations and fees for card utilization • Insurance agreements: establish contracts with the Insurance department of MoH, of the Jordanian Army, and/or with private insurance companies; carefully define accountability, scope and criteria for health care delivery.

9 At the time of the SSM, IFH prescriptions were not recognised by the local MoH centre for provision of free drugs.

10 Availability of drugs is one of the major determinants of health service-seeking behaviour

11 e.g. within their school nutrition programme

12 Especially in relation to their certificates of indigence, as one of the means to define eligibility for free or discounted care

	• Provide health services by private contract for local organizations, e.g. schools and kindergartens[13] • Same contracts as above with other employers in the project target area of Sweileh (local businesses) • Explore solutions for the problem of drugs prescription, and consider the option of setting up a small on-site pharmacy • Verify costs and feasibility of setting up a 'hotline' for psychological and social 'emergencies, and assess potential returns in terms of IFH's promotion. • Offer transportation services at cost-sharing rate for the beneficiaries from remote sections of the target areas • Offer nursery services at cost-sharing rate for the clients with children
Opening up new markets	
iii. Commercialize services (counselling and alternative therapies)	• Design, develop and market one-to-one and group services: - individual psychological counselling - legal counselling (civil and commercial cases - not related to human rights abuses) - socio-economic counselling: consultancy on CV writing and interview skills; information and orientation on self-employment, business skills and access to micro-finance; confidence-building training; etc. - yoga, reflexology, relaxation techniques, body-conditioning (individual tuition or group sessions) • Calculate fees (define pay-per-use, membership card or therapy 'bulk' rates) and publicize them.
iv. Lease infrastructure	• Define which spaces are under-used in the IFH buildings and explore possibilities of leasing them to private individuals or local organizations / companies, e.g. rent the training room for conferences or functions. • In associations with the above, offer ancillary services such as events coordination, conference secretariat, reception/secretarial support, catering/refreshments, etc. • Verify the conditions for renting of some clinic space after-hours and negotiate profit-share agreements with private practitioners (doctors and therapists) willing to running their practices at IFH in the afternoons.

13 This had already been attempted by IFH in the Sweileh area and a preliminary agreement was signed with local schools and kindergartens

v. Provide training courses	• Design, develop, promote and sell group training courses or private tuition and other capacity building services (e.g. sponsored apprenticeships) and other forms of capacity-building for organizations. Training topics could include: - On-the-job practice / observation of medical, nursing and lab-technical skills - Counselling and community development/mobilization techniques - Communication and presentation skills - Project management - Web-design and ITC (skilled in-house staff available) - ToT in yoga, reflexology, relaxation and body-conditioning techniques • Negotiate training contracts with educational institutions and universities.
vi. Provide consultancy services	• Compile a 'skill and know-how roster', to list and verify which particular knowledge areas (in the medical, psychological, legal, social, special education and management fields) in IFH are upgraded and updated enough to be marketed. • Offer consultancy services - mainly targeted to development agencies, the Government and universities/research institutes - in areas such as: Technical advice; Field research; Data gathering (through MIS and other) and analysis; Collection of case studies
vii. Produce and market publications	• Document and disseminate (especially in the development co-operation context) relevant case-studies from IFH clinic and counselling work • Produce working and technical papers (possibly under the IFH-NHF-AIDOS banners) and market them in specialist environment of the various professions • Develop and publish training curricula for private individuals and organizations involved in capacity building (in the areas listed above as possible training topics, e.g. document yoga exercises for a beginner course)[14]

14 A member of staff has already documented (in writing and graphically) this particular training and such materials should be utilized under the IFH name, before some other organization fills this gap in the market. It should be noted that there are currently no publications on alternative therapies and relaxation techniques created for the Jordanian public.

Classification of IFH activities					
Unit		**Function**	**Sub-units**	**Services**	**Associated activities**
1.	HCC	Meet physical, psychological, social and legal needs of women.	*Gynecological, family planning, ante-natal and post-natal Clinic*	Pregnancy monitoring and awareness-raising on nutrition, physical exercise and prevention – including yoga, relaxation and baby massage sessions Provision of family planning methods, including information and counselling Treatment of gynecological conditions Early detection of STDs, cervical and breast cancer (Pap smear, mammogram) Monitoring through Ultrasound	Pregnant Women's Group Baby Massage Group Menopause Group Adolescent (Youth) Group Pre-wedding Group Men's Group
			Menopause Clinic	Integrated counselling on biological and psychological changes in menopause Awareness raising and monitoring on conditions associated to menopause, e.g. osteoporosis Yoga, relaxation and reflexology sessions	
			Adolescent clinic	Awareness-raising and counselling on physical, psychological and legal issues affecting youth between 10 and 19 y.o.	
			Laboratory	Blood, serum, urine and stool tests for all family members	

2.	CDU	Provide services related to child development. Detection and treatment of speech, movement and learning difficulties	*CDU Team: psychologist / IQ specialist, physiotherapist, speech therapist and special educators*	Intellectual, emotional, psychological, social and sensory assessment of children of age 0-12 Assessment of language and articulation skills Treatment of speech disorders Diagnosis and treatment of learning difficulties Diagnosis of children with movement difficulties, physiotherapy and occupational rehabilitation Guidance and training for parents of children with special needs
3.	Child Health Clinic	Follow up the growth and development of pre-school children. Early detection and prevention of diseases and disabilities.		Routine checks of growth and development Vaccinations (prescribed by the National Vaccination Program and additional ones) Vision and hearing tests Health education and counselling Treatment of common child diseases

TABLE 7 Personnel Structure Plan (2003) / Institute for Family Health (Noor Al-Hussein Foundation)

Institute Director *

Administration

1. Office Manager
2. Accountant

Child Development Unit

1. Psychologist **
2. Special Educator
3. Special Educator
4. Physiotherapist
5. Language and Speech Therapist
6. Learning Disabilities Teacher **

Maternal and Well / Baby Clinic Units

1. Gynecologist / Obstetrician
2. General Practitioner *
3. Family Doctor *
4. Midwife
5. Staff Nurse
6. Practical Nurse
7. Lab Technician
8. Receptionist

Administration Support Employees

1. Driver
2. Driver
3. Maid
4. Maid
5. Guardian

Training and Programmes Unit

1. IEC Officer
2. Social worker
3. Lawyer
4. Field officer
5. Field worker
6. Field worker
7. Psychologist **
8. Male Counsellor
9. Gym trainer ***
10. Psychologist

* seconded from MoH

** seconded from MoE

*** part-time

TABLE 8

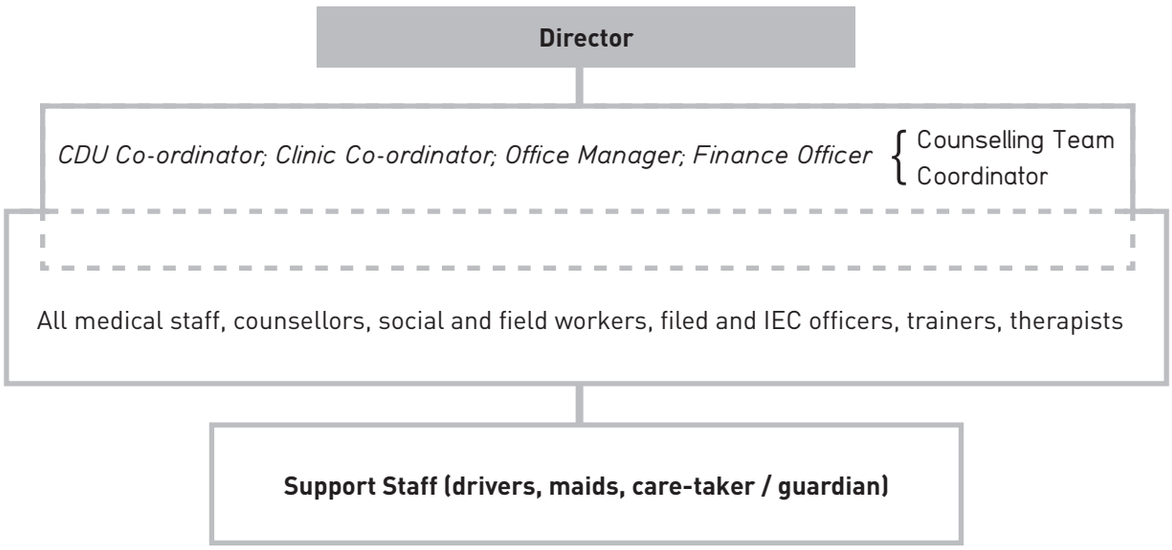

Director
CDU Co-ordinator; Clinic Co-ordinator; Office Manager; Finance Officer
Counselling Team Coordinator
All medical staff, counsellors, social and field workers, filed and IEC officers, trainers, therapists
Support Staff (drivers, maids, care-taker / guardian)

DIAGRAM 1 IFH Institutional Map

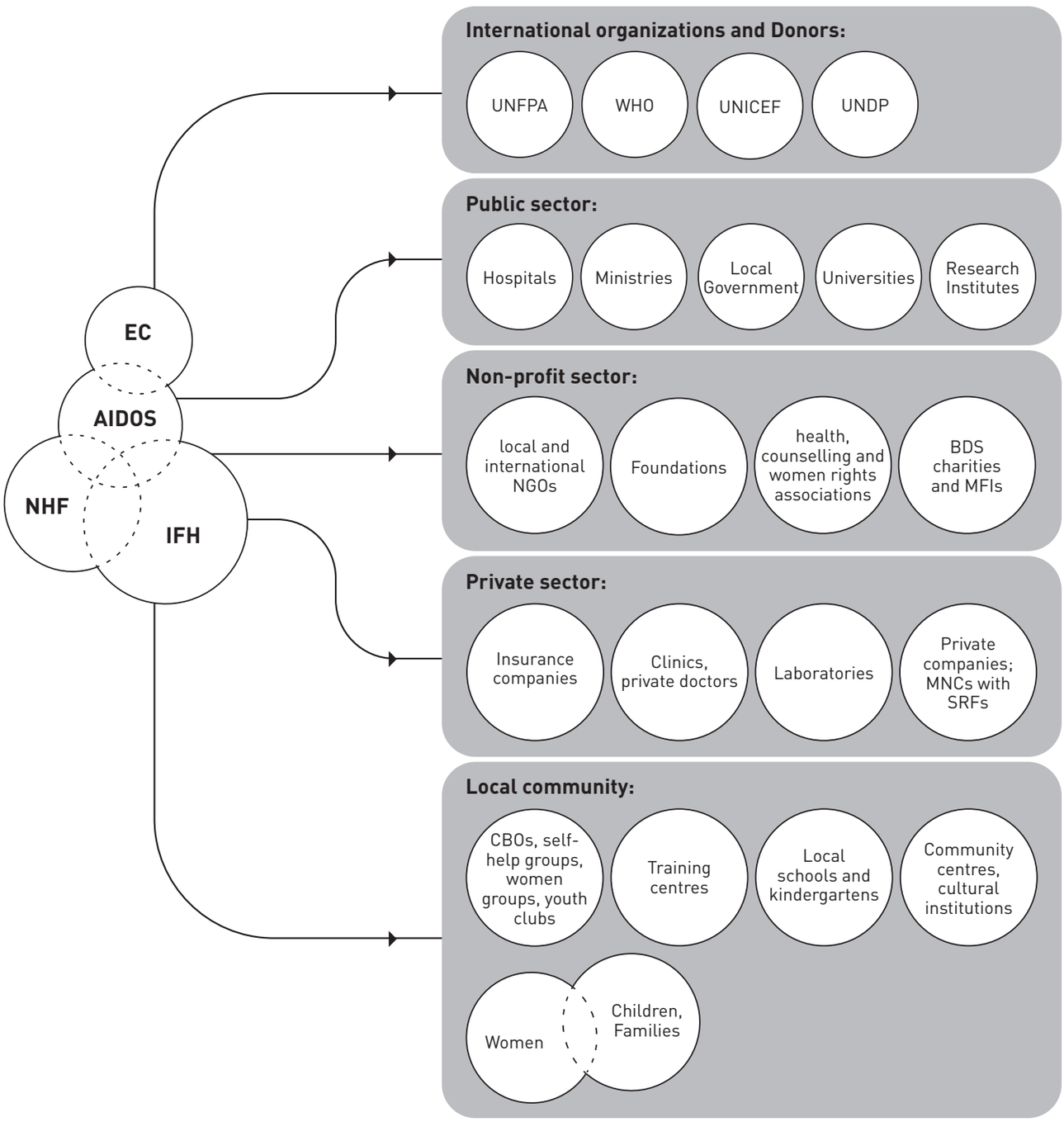


TABLE 12

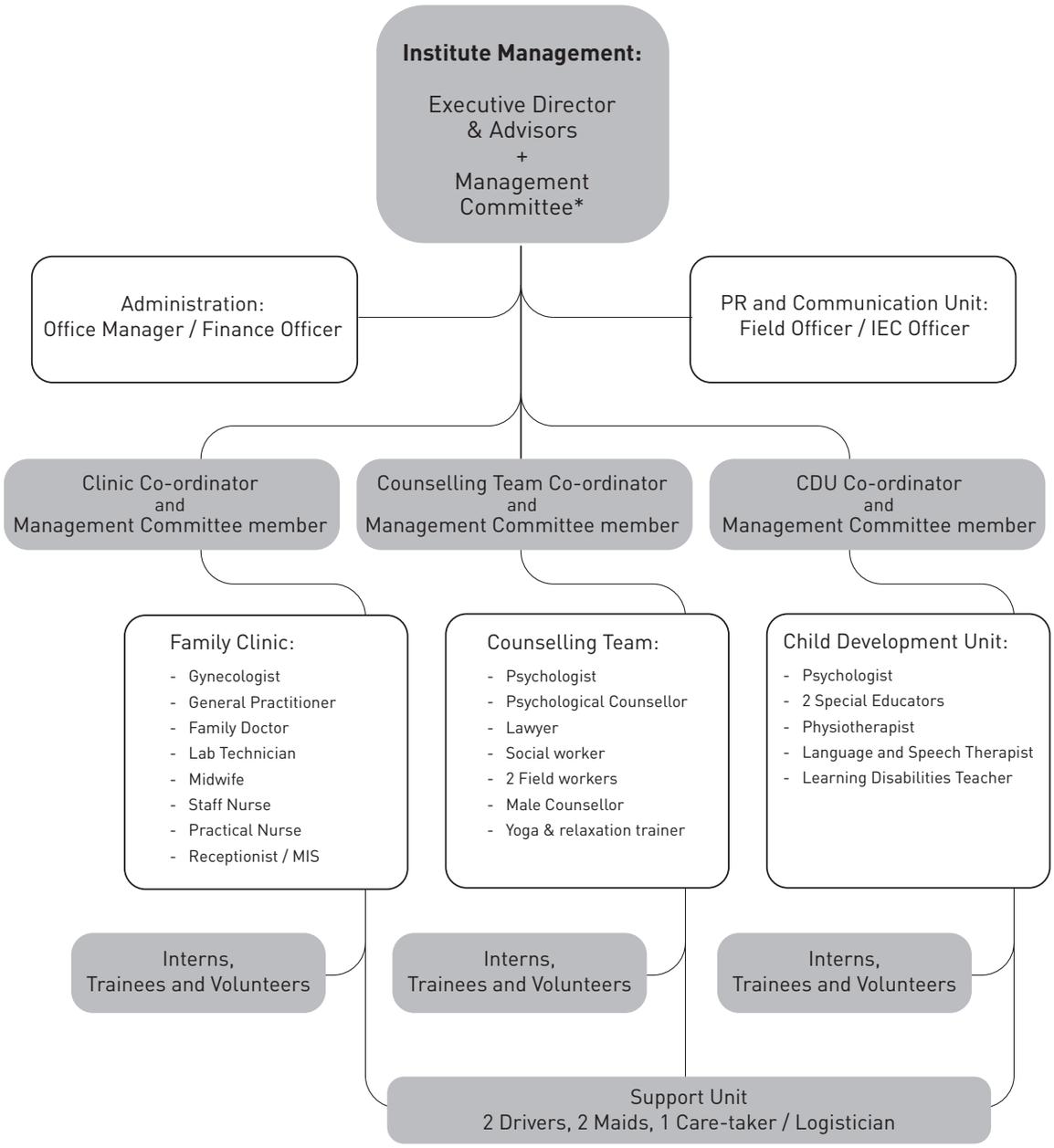

Institute Management:
Executive Director
& Advisors
+
Management
Committee*
Administration:
Office Manager / Finance Officer
PR and Communication Unit:
Field Officer / IEC Officer
Clinic Co-ordinator
and
Management Committee member
Counselling Team Co-ordinator
and
Management Committee member
CDU Co-ordinator
and
Management Committee member
Family Clinic:
- Gynecologist
- General Practitioner
- Family Doctor
- Lab Technician
- Midwife
- Staff Nurse
- Practical Nurse
- Receptionist / MIS
Counselling Team:
- Psychologist
- Psychological Counsellor
- Lawyer
- Social worker
- 2 Field workers
- Male Counsellor
- Yoga & relaxation trainer
Child Development Unit:
- Psychologist
- 2 Special Educators
- Physiotherapist
- Language and Speech Therapist
- Learning Disabilities Teacher
Interns,
Trainees and Volunteers
Interns,
Trainees and Volunteers
Interns,
Trainees and Volunteers
Support Unit
2 Drivers, 2 Maids, 1 Care-taker / Logistician

TABLE 13 Sustainability Implementation System (SIS):
Human Resources – Focal Points & Task Forces

SUSTAINABILITY ACTION PLANS

SUSTAINABILITY STRATEGY

Eco_Financial S. FOCAL POINTS:	Task Forces:	**Manage_Org S.** FOCAL POINTS:	Task Forces:
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Tech_Meth S. FOCAL POINTS:	Task Forces:	**Institutional S**. FOCAL POINTS:	Task Forces:
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Socio_Cultural S. FOCAL POINTS:	Task Forces:	**Devt.&Policy S.** FOCAL POINTS:	Task Forces:
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

TABLE 14 Example of articulation between Sustainability Focal Points and Task Forces

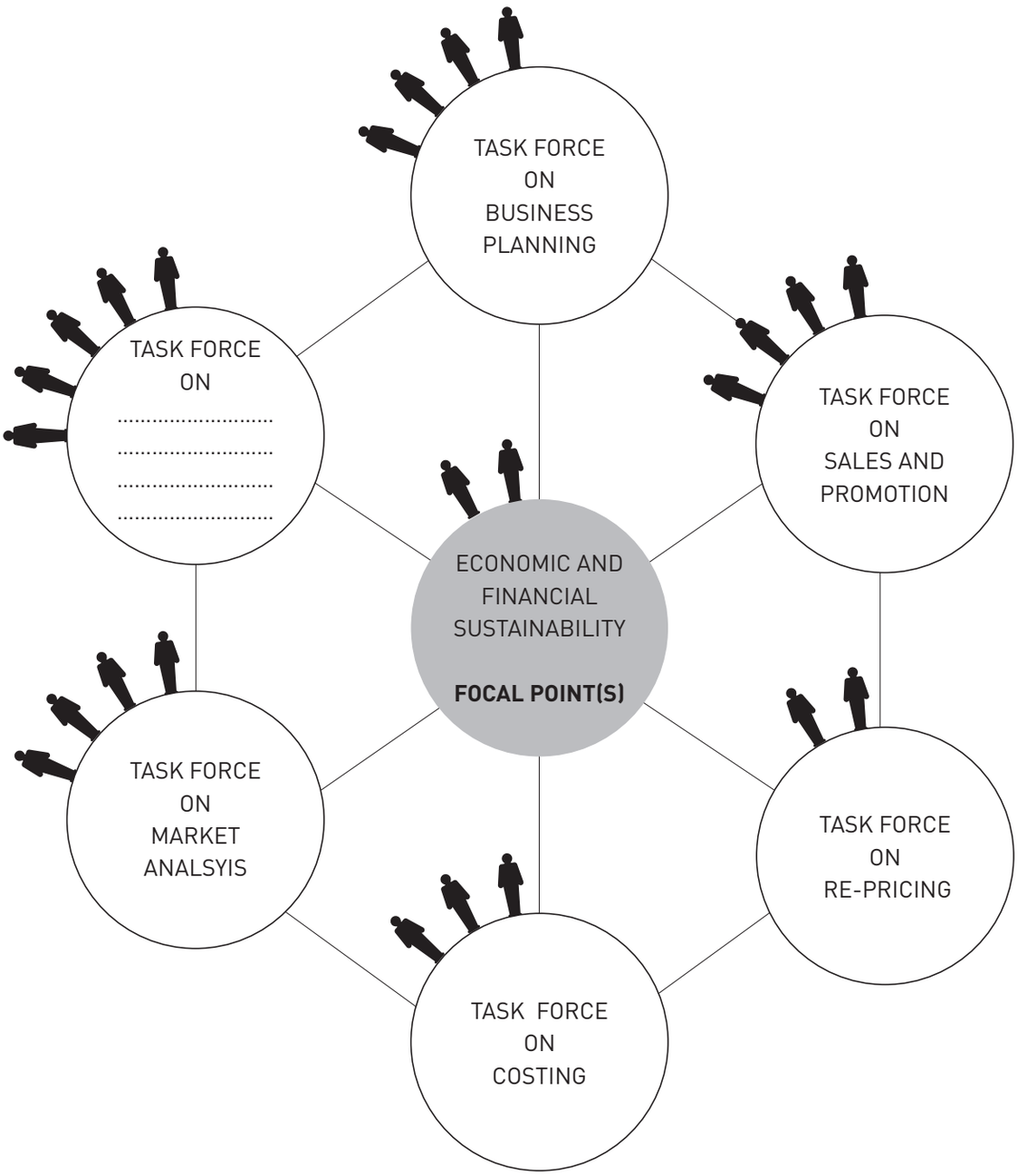
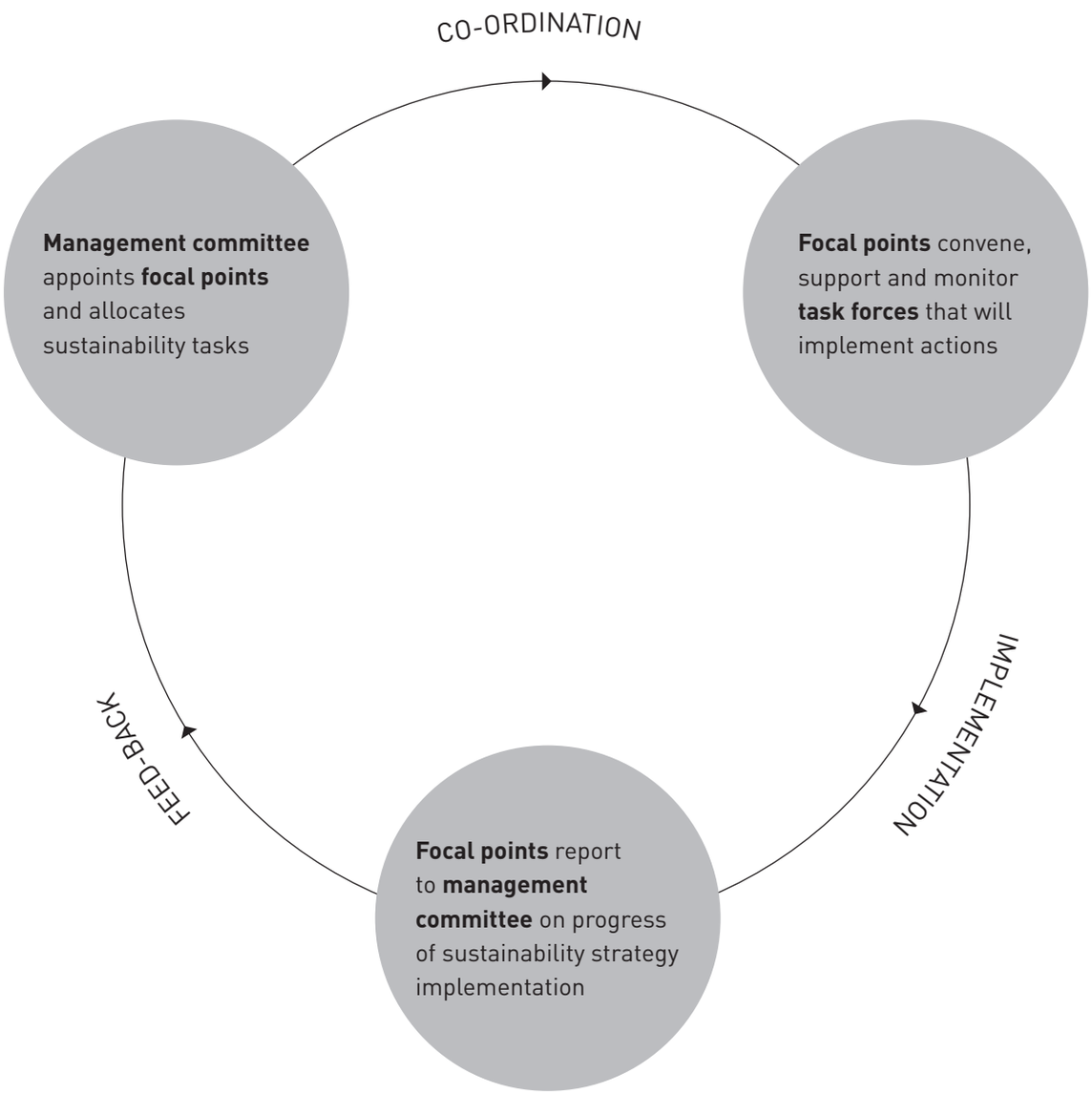


TABLE 15


CO-ORDINATION
Management committee appoints **focal points** and allocates sustainability tasks
Focal points convene, support and monitor **task forces** that will implement actions
IMPLEMENTATION
Focal points report to **management committee** on progress of sustainability strategy implementation
FEED-BACK

The office management data to be collected include:

a) HCC Management

Infrastructure and equipment

- Premises: list of utilities, equipment, furniture/ maintenance
- Transportation: fuel consumption/ mileage, log book information, mobility of the HCC Staff
- Car insurance

Financial resources and financial information (confidential)

- Financial resources managed at HCC level
- Accounting
- Income generated through clinic and counselling services, gym training
- Petty cash
- Yearly allocation / updated availability
- Financial donations
- Depletion of in kind resources
- Payroll
- Procurement materials, relevant procurement and service contracts
- Financial data (info on bank account)
- Forms used for payment of the expenses (invoice, acknowledgement of service, payment request)

Human Resources

- CVs and profiles of the staff
- Personal data, skills, qualifications
- Length of contract; increase of salaries
- Training and capacity building (exposure to events, study tours)
- Contact list
- Attendance sheet
- Leave request and leave planning
- Monthly evaluation of staff's performance

Documentation Centre

- Library Catalogue (including statistics and baseline survey)
- Borrowing books and documents
- Electronic materials (e-books & other e-documents)
- Technical assistance missions (TAM) Reports (confidential)

Referral System & Networks & Institutional Linkages

The referral system should be implemented for all cases going beyond the HCC direct capacity.

It should include all those organizations operating in fields, which are relevant to the HCC work and which can complement the assistance already provided by the HCC (hospitals, private clinics, laboratories, development projects, etc.).

In particular it should include the name of the organization, the address and telephone number, the name of the contact person; the referral agreement; the type of services for which the agreement was made.

As per the networking component, the HCC contact/ mailing list should be categorized as follows: governmental organizations; international organizations, Syrian and international NGOs, "HCC Friends" (donors and supporters), embassies, clients.

Work planning

- Yearly and quarterly Work Plans (a Work Plan designed with Excel);
- Weekly calendar of activities;
- Training of trainers activities

Reporting
(delivery of services – should be linked to Clinic filing described after)

- Data on service delivery (calendar of training, gym courses, field visits, etc., cost of services; n. of counselling sessions)
- Reception and client registration
- Clinic services delivery (ultrasound examination; IUD insertion; pap smear breast self examination; etc)
- Counselling services (psychological; social and legal counselling)
- Gym activities (pre-natal and post natal yoga sessions; stretching, aerobics courses, gym machines; reflexology)
- Outreach (field visits; awareness workshops, monitoring and follow up)

- Information and sensitization campaigns (type of campaign, material used, number
- of women sensitized evaluation).

Events and occasions

- Events attended by the HCC staff in quality of attendees (such as training, workshops, etc...)
- Events organized by the HCC (such as national workshops, general meetings, official ceremonies, etc).
- For all above components indicators should be identified both at the quantitative and qualitative level.

b) Situation of HCC clients (clinic file)

Recording: general data on the client; type of service requested/need identified; type of service delivered (clinic; psychological; social; legal; gym).

General data on the User

- User CODE
- Date of birth
- Address
- Telephone number
- Education level
- Profession
- Personal status
- Date of marriage
- Nr. of marriages of husband. Nr. of children
- Major illness had in the past or health problem;

Clinic services

- Date of the visit
- Nr of the visit
- Accompanying person
- Pathology
- Service required (ultrasound examination; IUD insertion; breast examination, etc.);
- Service provided
- Diagnosis
- Posology
- Referral (internal and/or external)
- Examination and tests required
- Observations
- Date of next visit
- Name of the service provider

RH Counselling services

- Date of the visit
- Nr of the visit
- Accompanying person
- Pathology
- Counselling requested
- Counselling provided (contraceptive methods; nutrition and dietary information
- Personal hygiene; breastfeeding; pre and post natal care)
- Observations
- Referral (internal and/or external)
- Date of next visit
- Name of service provider

Psychological services and Socio-psychological counselling services for men

- Date of the visit
- Nr of the visit
- Accompanying person
- Symptoms and main problems
- Counselling requested
- Counselling provided
- Diagnosis
- Posology
- Referral (internal and/or external)
- Observations
- Date of next visit
- Name of the service provider

Social counselling services and Legal counseling services

- Date of the visit
- Nr of the visit
- Accompanying person
- Reason for the visit
- Counselling requested
- Counselling provided
- Referral (internal and/or external)
- Observations
- Date of next visit
- Name of the service provider

Participation in group awareness sessions

- Date of the session
- Topic of session (breast feeding; ante and post -natal care, menopausal women, HIV/AIDS and Sexually Transmitted Diseases STD; etc.).
- Nr. of participants;
- Observations;
- Name of the service providers.

Participation in group therapy

- Date of the session;
- Type of session (GBV support group, parenthood group, etc.)
- Nr of participants;
- Observations;
- Name of the service providers.

Field visits (community workshops)

- Date of the workshop;
- Location;
- Nr. of participants;
- Main topic of the workshop:
- Material distributed;
- Referral (internal and/or external);
- Observations;
- Date of next workshop;
- Name of the service providers.

Field visits (home visits)

- Date of the visit
- Location
- N. of participants
- Main reason for visit
- Referral (internal and/or external)
- Observations
- Date of next visit
- Name of the service providers

Field visits (campaigns)

- Date of the campaign
- Location
- N. of participants
- Main topic of campaign
- Referral (internal)
- Observations
- Date of next campaign
- Name of the service providers

Gym services

- Type of service (yoga pre natal; yoga post natal; stretching; aerobics; machines
- relaxation; reflexology)
- Date of service
- Nr of service
- Activity requested
- Additional counselling provided
- Referral (internal and/or external)
- Observations
- Name of the service provider

Reports required:

- HCC User base (Nr.) sorted by geographic area; age group and gender;
- Nr. of women participating in each activity;
- Nr. of new users of the HCC;
- Nr. of old users of the HCC;
- Nr. of services (visits, counselling, awareness sessions) provided on a monthly basis;
- Nr. of new users to a specific service (clinic, psychological, legal etc.);
- Nr. of old users of a specific service (clinic, psychological, legal etc.);
- Nr. of field visits (community workshops and home visits);
- Nr. of people involved in the workshops sorted by gender and age group;
- Nr. of group awareness sessions;
- Nr. of people involved in the group awareness sessions by gender and age group;
- Nr. of therapy groups;
- Nr. of campaigns;
- Nr. of people involved in all campaigns sorted by gender and age group;
- Nr. of sessions for each counselling service on a monthly basis;
- % of Users who are recurrently visiting the HCC;
- % of clients externally referred (to what kind of institutions);% of Users internally referred (to what service);

Ratio required :

- Ratio between Nr. of new Users and old Users;
- Ratio between all services delivered inside HCC.

Activating skills	Where skills already exist: they are initially identified and then used or allowed to be used i.e.: "activated"
Active birth	An approach to delivery/labor where a woman can decide what is best for her
Active offer	By offering a range of services and information women or users are then informed on their right to knowing and being aware of all the implications of their choices affecting their reproductive and sexual health
AIDOS	*Associazione Italiana Donne per lo Sviluppo* – Italian Association for Women in Development
Ante-natal assistance	Assistance prior to birth – during pregnancy for instance
APGAR score	A score that is given after assessing the condition of a newborn baby in the five areas of heart rate, breathing, skin color, muscle tone, and reflex response.
Benchmarks	Standards against which something can be measured or assessed
Breast-feeding on request	Breast-feeding when baby asks for it rather than according to a specific daily feeding timetable
Breathing exercises	Exercises used in controlling ones breathing – normally used for relaxation purposes
CBO	Community-based organizations
Capacity building	Adding or building capacities – e.g.: through courses or additional learning and teaching
"Circular" communication	A type of communication which "circulates" and presumes that there is continuous feedback between the parties communicating
Clinical audits	A systematic check or assessment, of different clinical cases mainly in plenary meetings with all the staff
Collateral effects	Unintended effects
Continuity of care	Where health care is not a one-off intervention but needs follow-up and is consequently continuous
Cross-cultural exchange	Exchanging aspects or knowledge acquired from experiences in different cultures
Customized assistance	To alter or make something in order to make it fit to or address the users requirements
Disseminating principles or information	To distribute or spread information or principles
Empowerment	The process to give somebody power or authority and/or to give somebody a sense of confidence or self-esteem

Endometriosis	A medical condition in which the mucous membrane (endometrium) that normally lines only the womb is present and functioning in the ovaries or elsewhere in the body
Exchange programs	Programs set-up to exchange information or services between organizations or institutions
Experiential	Learning something derived from or relating to experience as opposed to other methods of acquiring knowledge
Facilitators	Somebody who aids or assists in a process, especially by encouraging people to find their own solutions to problems or tasks
Family planning	The use of birth control methods to choose the number and timing/spacing of children born into a family
Feedback	Comments in the form of opinions about and reactions to something, intended to provide useful information for future decisions and development
Gender equality	Rights, treatment, quantity, or value equal between different genders
Gender violence or Gender Based Violence (GBV)	Violence perpetrated by groups or individuals on another group or individual because of power inequality
Gender mainstreaming	To put into the "mainstream" – to render it more widely acceptable – the concept of gender
Ground rules	The basic rules or main rules
Holistic approach	An approach which includes or involves *all*, or the *whole* of something, especially all of somebody's physical, mental, and social conditions, not just physical symptoms, in the treatment of illness
Horizontal communication	Communication being at or between a group of people or organizations on the same level
Information sharing group	A group whose members share information: be it personal, or not
Informed choice	A choice which is based upon a set of information, which includes information about process and results
Institutions	A large organization such as a hospital or college or something having influence in a community – like governmental ministry
Interactive workshops	Workshops where both facilitators/trainers and participants can inter-act or exchange ideas and information
Key to entering community	A "way" to contact community and become part of it (like opening the door into a community)

Know-how	Lit. from "Knowing how" – which is not just knowledge as information but also used to define skills
Male involvement programs	Programs which aim specifically to involve male members of any given community or section of a community
Massage	A treatment that involves rubbing or kneading the muscles, either for medical or therapeutic purposes or simply as an aid to relaxation
Monitoring	To ensure the good order or proper conduct of something or project
Mutual support group	A group whose members help each other through either exchanging their similar experiences or merely through empathy
Non-standard timetable	A time-table which is not fixed; can be customized or changed according to different people's requirements
Outreach program	From verb "to reach out": where service providers leave the centre and go out into the community to reach out to potential users
Plenary session or "in plenary"	A meeting or session where everyone involved is present
Prevention in health care	An action or actions taken to prevent something – here illness - from taking place
Projections	Psychological term to describe an unconscious ascription of a personal thought, feeling or impulse onto someone else, which can often happen in a group
Promoting skills	Identifying skills and making full use of them
Puerperium	Period immediately after childbirth approx. 6 weeks
Re-assessment audits	A systematic check or assessment, especially of the efficiency or effectiveness of an organization or department, typically carried out by an independent assessor
Referral	The act or process of referring somebody to somebody else, or other organization - especially sending a patient to consult a medical specialist (or legal in this case)
Referral network	A system or network of different organizations which can refer or send someone to each other
Reflexology	A form of massage in which pressure is applied to certain parts of the feet and hands in order to promote relaxation and healing elsewhere in the body
Risk-free maternity	Being able to live through maternity with the minimum of risk – hopefully free of risks

Role-play(ing)	To act out or 'play' out a role – pretending to be something or someone else
Self-Care	Caring for one-self – being able to heal oneself
Self-determination	The ability or right to make your own decisions without interference from others
Sensitizing – to sensitize/Raise awareness	To make somebody sensitive through information, especially to a situation, or condition,
Sequential	The order of things, or sequence in which they are undertaken
Service integration	A combination of parts or services that work well together, or are complementary
Service provider	Someone who provides a service: in this case Health services and information pertaining to all aspects of well-being
Sexual self-determination	To determine one's own future, and have power of choices for one's own body
Sexual health	All aspects of health concerning sexual activities – before, during and after
Skill retention	Retaining or keeping skills
Special populations	To indicate survivors of either GBV, or Users with other problems like alcoholism; substance abuse or with bi-polar disorders
Strategies	A carefully devised plan of action to achieve a goal, or the art of developing or carrying out such a plan
Targets for outreach program	People or sections of community that the program aims to affect or involve
Target area	A particular area which has become the focus (or target) of a specific project or initiative
Therapeutic pact	Freely choosing a treatment with service provider, based on information provided in the centre
TOT	Training of Trainers
Ultrasound scan	An imaging technique that uses high-frequency sound waves reflecting off internal body parts to create images, especially of the fetus in the womb, for medical examination.
Unequal relations	An unbalanced relationship: where two things are not equal
Upgrading a centre	To improve the quality, standard, or performance of a centre, especially by incorporating new advances
User(s)	Anyone who requests any services from the HCC –consequently anyone who Uses the centers

User-friendly	Used to describe something which is easy or accessible for a User
Vertical communication	Communication between groups or people or organizations on up and down different levels
Vicarious trauma	Trauma experienced through another person rather than at first hand, by using sympathy or the power of the imagination
Yoga	A system or set of breathing exercises and postures derived from or based on Hindu yoga, used to relax and acquire better control over ones body

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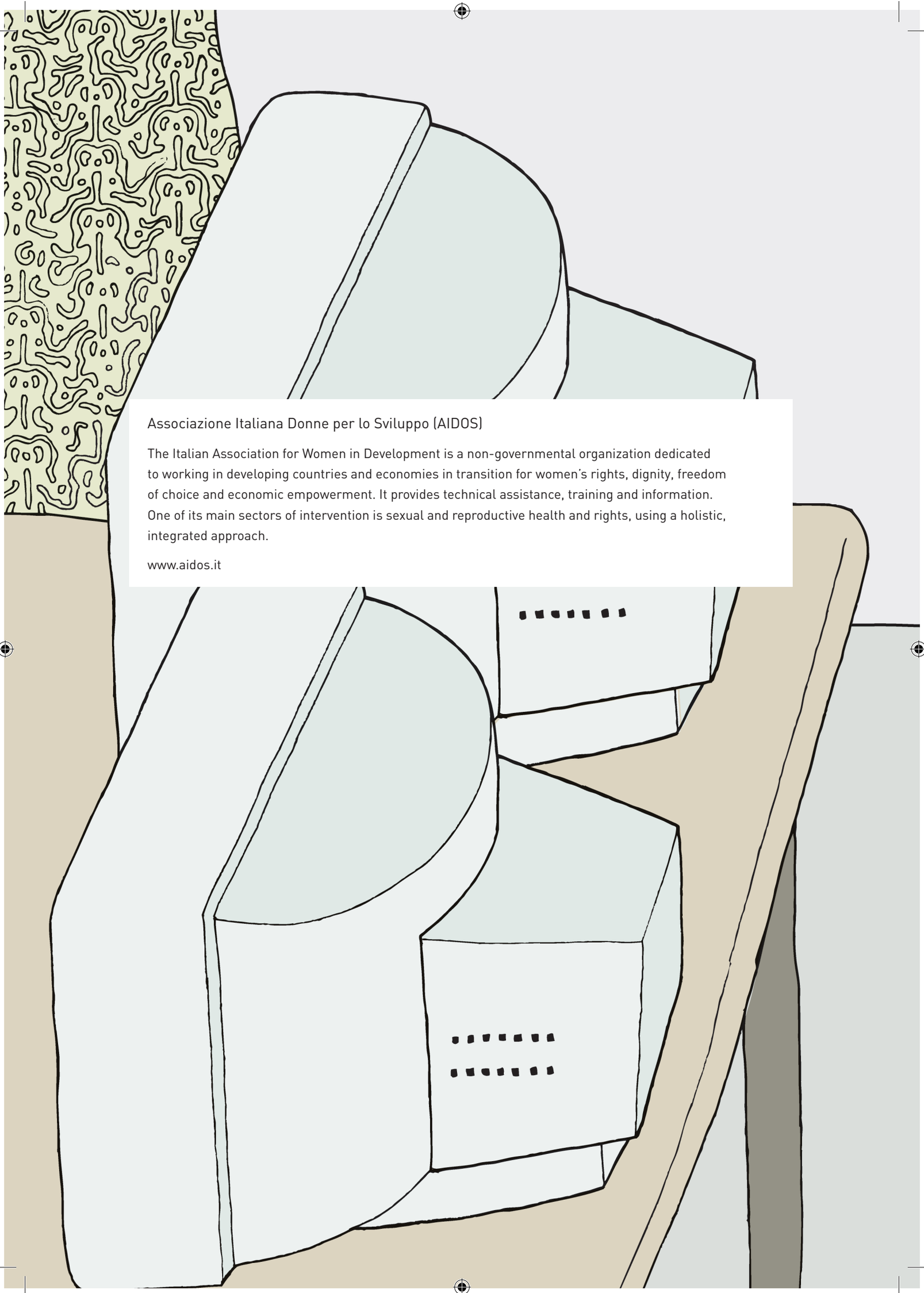


Associazione Italiana Donne per lo Sviluppo (AIDOS)

The Italian Association for Women in Development is a non-governmental organization dedicated to working in developing countries and economies in transition for women's rights, dignity, freedom of choice and economic empowerment. It provides technical assistance, training and information. One of its main sectors of intervention is sexual and reproductive health and rights, using a holistic, integrated approach.

www.aidos.it

1

Methodology: an integrated and holistic approach to reproductive and sexual health

2
The services of the Health Counselling Centers

3
Training methodology and contents

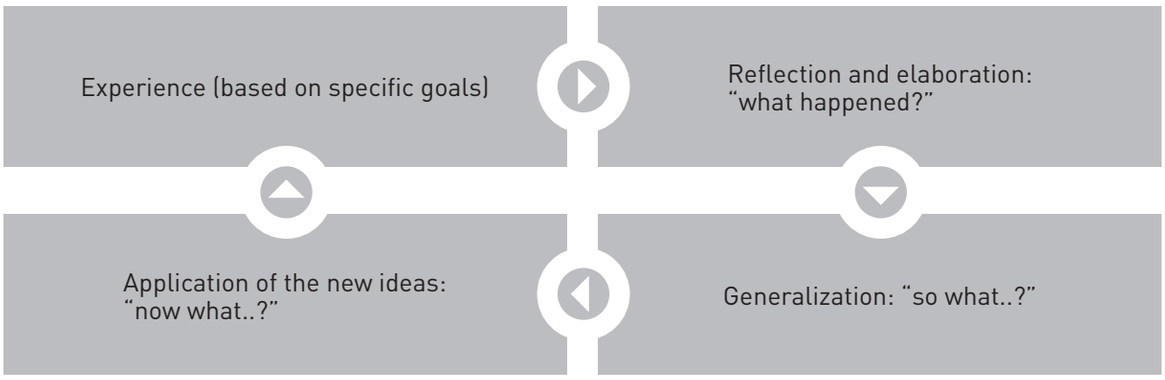
4

Sustainability analysis and strategyplanning for the Health Counselling Center (HCC) in Jordan

5
Monitoring and Evaluation

FIGURE 1

The experiential learning cycle:



"I hear, and I forget;
I see, and I remember
I do, and I understand"

Lao-Tsu, Chinese philosopher, 600 BC

FIGURE 1 INGRATED APPROACH TO SUSTAINABILITY

FIGURE 2 COMPOSITION OF IFH IN TERMS OF PROJECTS/ACTIVITIES

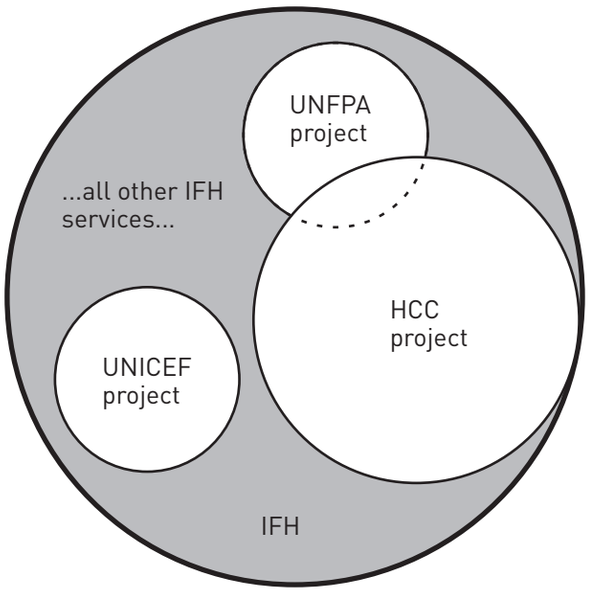


TABLE 1

IFH's income and cost-recovery of locally-managed funds, 2003-2005			
External funding			
	% of total funds	% of total funds	% of total funds
NHF*	0%	0%	0%
Ministry of Health	9.8%	7.2%	7.6%
EC/AIDOS (HCC Project)	62.4%	51.5%	64.5%
UNFPA	0%	18.6%	12.7%
UNICEF (Better Parenting Project)	2%	1.75%	0%
American Cancer Association	2.8%	0%	0%
Sub-total	**77%**	**79%**	**75%**
Internally-generated income			
Revenue from IFH's service delivery	**23%**	**21%**	**25%**
Cost-recovery (of 'local funds')	**29.8%**	**26.4%**	**33.7%**

* NHF used to support part of the operational expenses of the Institute. However this contribution had ceased at the time of the SSM and was not expected to resume in the immediate future.

TABLE 3

Cost-cutting	• 'Eliminate' internal costs where possible, by identifying which expenses and services are not adding value to core business functions when carried out in-house. This might include eliminating some expenses altogether, or rather outsourcing some services, as well as flexibilizing some jobs (carried out as hourly paid rather than by permanent employment).
Cost-saving	• 'Decrease' costs where possible, by formalizing control system over transport and communication facilities use. Extend this control system to use of consumables (stationery, photo-copying, etc.). • The most effective form of cost-saving, however, is rationalizing production or delivery processes, which ensures waste-minimization through improved working method efficiency, and capacity building as well as staff 'incentives' – mainly 'motivational' – aimed at increasing productivity.

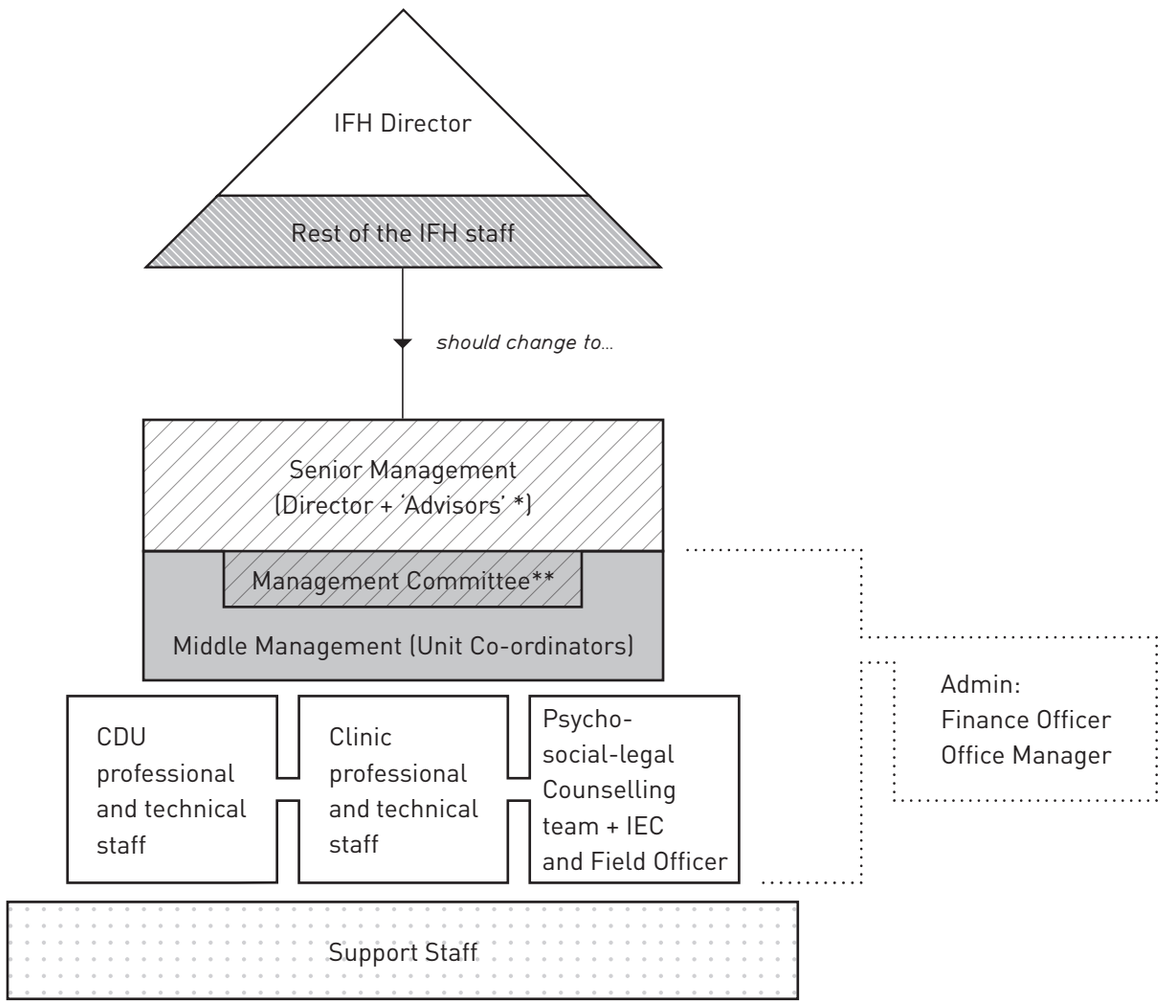
TABLE 4

TOTAL COSTS (MAINLY EXTERNALLY-FUNDED)	LOCALLY-GENERATED INCOME
salaries	user fees
running costs	taxes
overheads	insurance
in-kind contributions	community contributions
depreciation	revenue from IGAs

$$\text{COST RECOVERY} = \frac{\text{LOCALLY-GENERATED INCOME}}{\text{TOTAL COSTS (MAINLY EXTERNALLY-FUNDED)}}$$

The value of cost recovery can be expressed as a ratio (above formula) or as a percentage (above ratio multiplied by 100)

TABLE 9

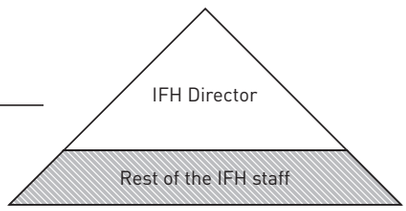


* either from NHF and/or from a project Steering Committee

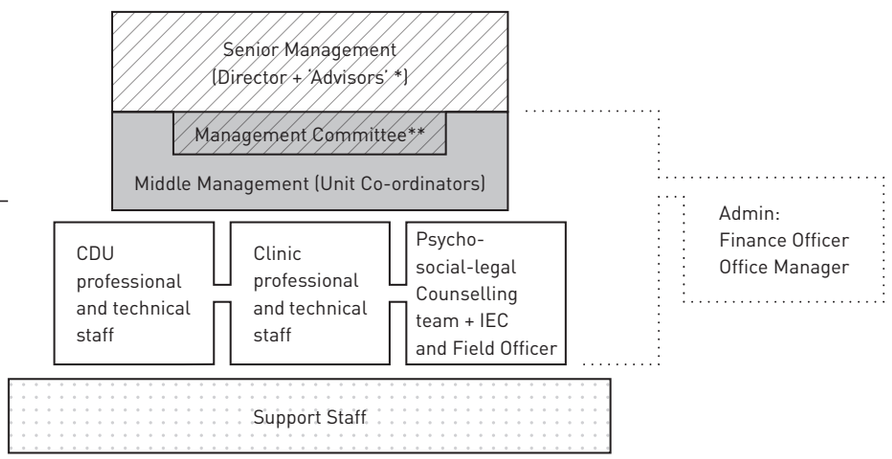
** composed by Director + Unit Coordinator + (Finance Officer, Office Manager?)

TABLE 10

a)


IFH Director
Rest of the IFH staff

b)


Senior Management
(Director + 'Advisors' *)
Management Committee**
Middle Management (Unit Co-ordinators)
CDU professional and technical staff
Clinic professional and technical staff
Psycho-social-legal Counselling team + IEC and Field Officer
Admin:
Finance Officer
Office Manager
Support Staff

c)

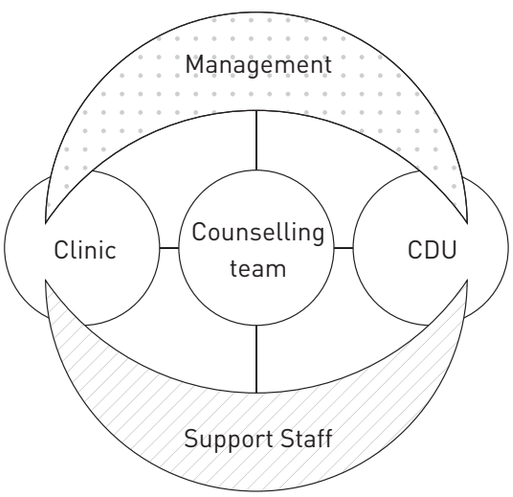
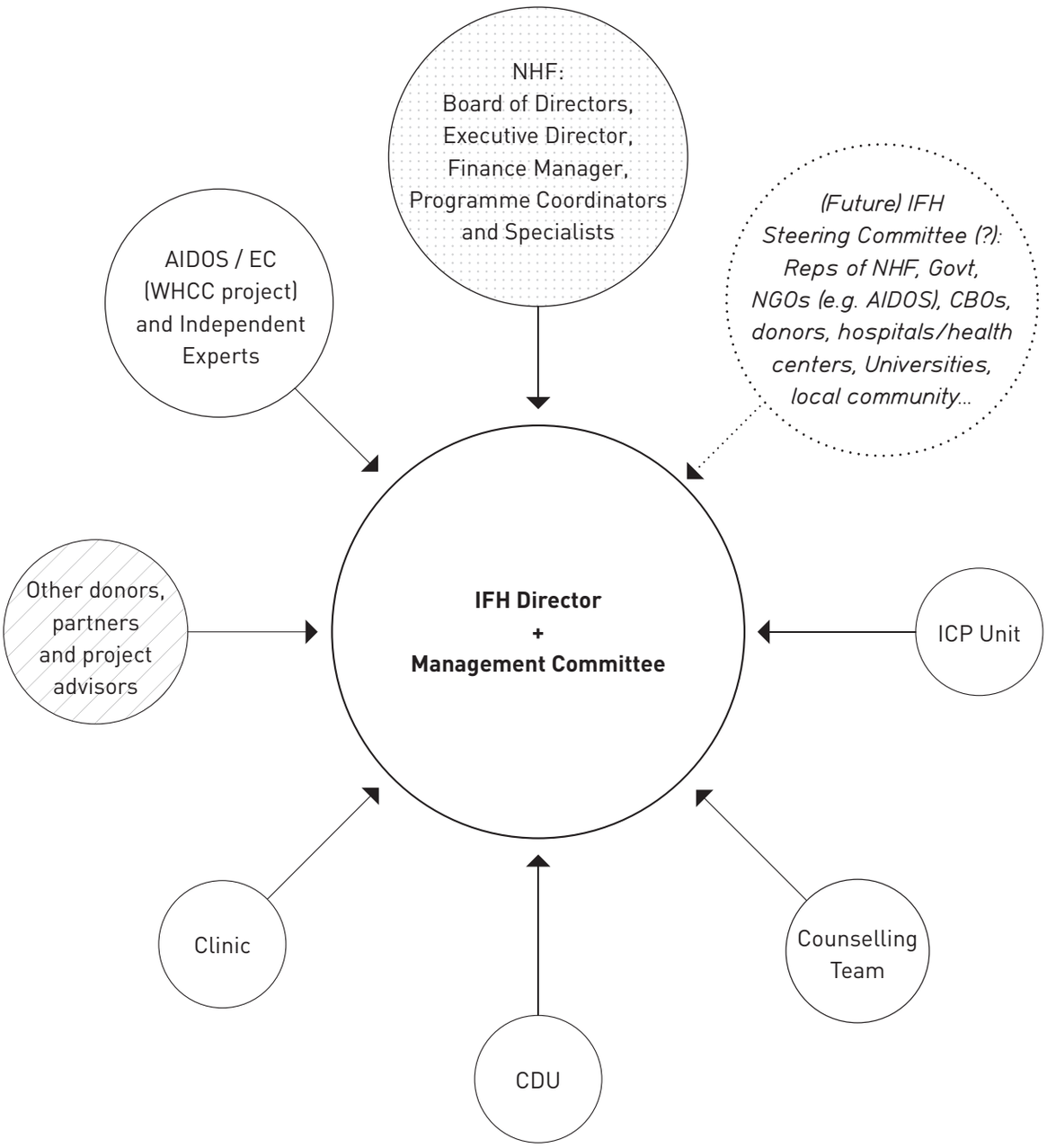

Management
Clinic
Counselling team
CDU
Support Staff

TABLE 11 External support, advice and guidance for IFH



ANNEX 1

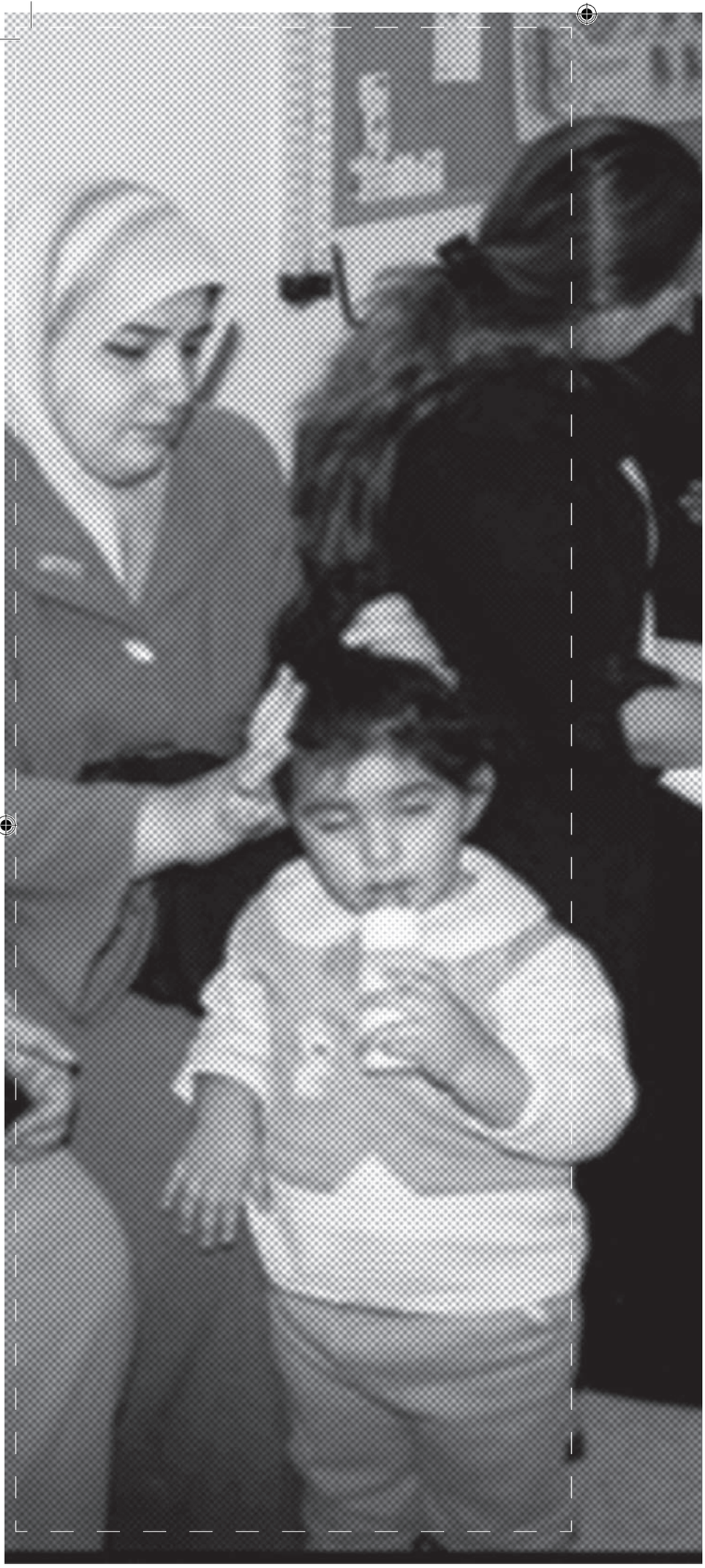
Health Counselling Centers established by AIDOS in the Middle East

ANNEX 2

Job descriptions

ANNEX 3

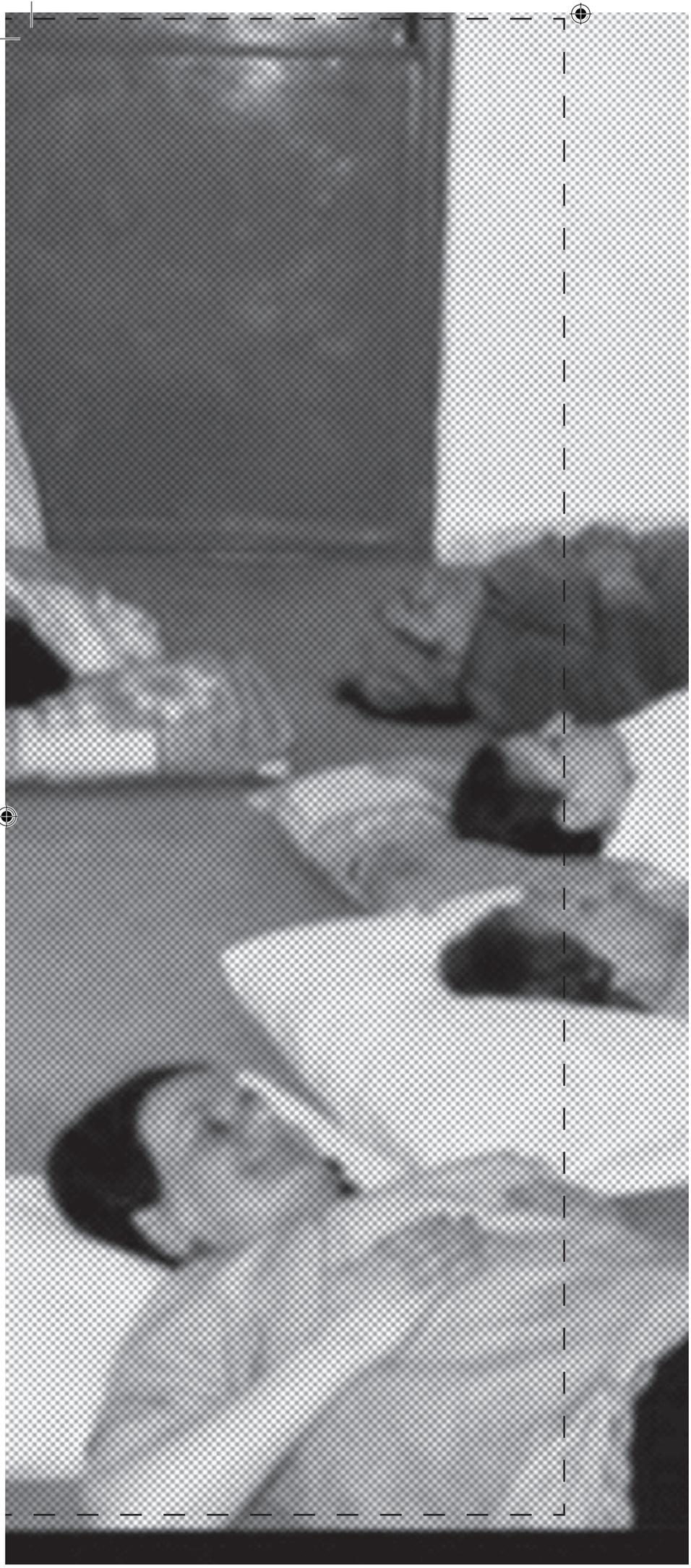
Indicators for clinic services



ANNEX 4

Dealing with gender / based violence / training curricula

ANNEX 5
Sustainability annexes



ANNEX 6

Management information system - data

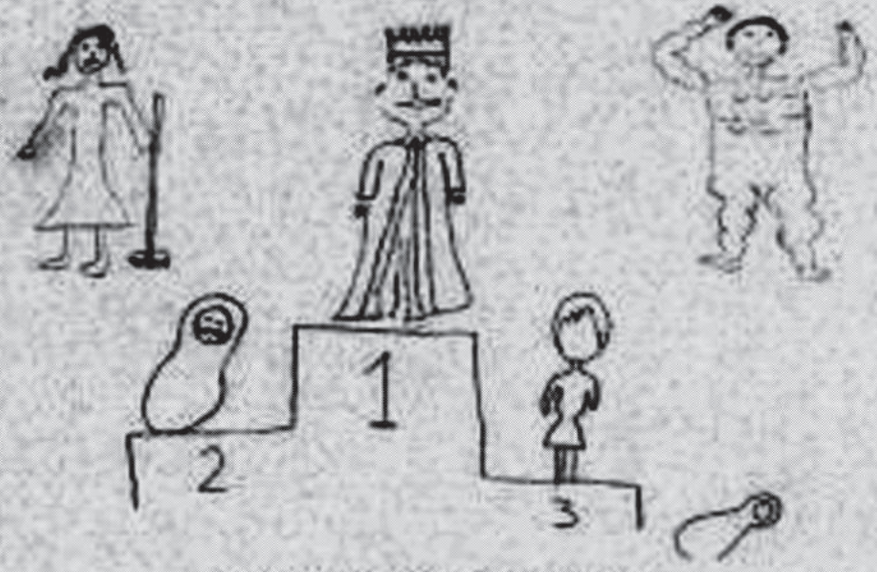
ANNEX 7
Glossary


Nutrition Corner

ANNEX 8
Reference bibliography

نظرة المجتمع للمرأة

نظرة المجتمع للرجل



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