Ensuring a Rights-Based Approach to Sexual and Reproductive Health Services:

A Quality Monitoring Tool for the Harm Reduction Model

Ensuring a Rights-Based Approach to Sexual and Reproductive Health Services:

A Quality Monitoring Tool for the Harm Reduction Model

// Prologue

Promoting women's health is a fundamental social justice and public health issue for the countries of Latin America and the Caribbean. Regional and international experience has demonstrated that fostering conditions in which women can exercise their sexual and reproductive rights and maintain good health allows women to live more productive, healthy and fulfilling lives. Given women's significant contribution to social and economic development, improvements in women's health lay the groundwork for societal growth at large. To date, there is no single investment that generates greater returns for social development than promoting gender equality[1].

Despite important efforts to improve women's health status, Latin America and the Caribbean continue to experience high rates of maternal mortality and unsafe abortion. In response to these concerning trends, Inciativas Sanitarias, a group of health care professionals in Uruguay, created an innovative model of care to reduce the risks associated with unsafe abortion and improve women's health outcomes. As described in the introduction that follows, the model developed by Iniciativas Sanitarias utilizes a harm reduction and rights-based approach to ensure that women facing an unwanted pregnancy receive the necessary information to make informed decisions about their health and lives. The model inherently recognizes the ethical responsibility of health professionals to respond to the consequences of unsafe abortion and to uphold clients' right to information, health, and autonomy. For service providers working in restrictive legal contexts, the harm reduction model provides an immediate response to the pressing needs of these women, identifying clear spaces for action and preventive measures.

This monitoring tool was created through the collaborative efforts of Iniciativas Sanitarias, Fundación Oriéntame, and the International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR), three institutions with a diverse range of experience on the issue of unwanted pregnancy and unsafe abortion. For over thirty years, Fundación Oriéntame has been providing comprehensive services for the prevention and management of unwanted pregnancy, in addition to carrying out health education and social development programs from a women's rights and social justice perspective. The organization's longstanding experience in the field and continuous focus on quality of care serve as the foundation of their contributions to this document.

IPPF/WHR has been a major provider of sexual and reproductive health care in Latin America and the Caribbean for the past forty years; annually, IPPF/WHR provides 19 million sexual and reproductive health services through its 41 Member Associations located throughout the region. The organization has developed a straightforward framework for its work on unsafe abortion based on three complementary strategies: promoting the right to safe and legal abortion, increasing access to abortion-related services, and reducing the need for abortion by promoting comprehensive sexuality education and access to contraception. In 2006, IPPF/WHR and Iniciativas Sanitarias developed a strategic partnership to expand and implement the harm reduction model on a regional level, both within IPPF Member Associations as well as the public health sector.

The tool is designed to monitor the implementation of the harm reduction services and to ensure that health institutions are providing a comprehensive model of care that offers immediate solutions and

---

[1] UNICEF (2007). State of the world's children 2007: Women and Children, the double dividend of gender equality. http://www.unicef.org/sowc07/docs/sowc07.pdf

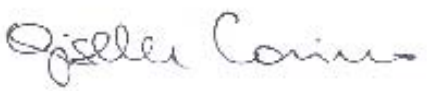
respects the decisions of women facing an unwanted pregnancy. To this end, the tool analyzes various components of the model including: health professionals' attitudes toward and interactions with clients; clients' perceptions of and satisfaction with the service; and whether existing institutional conditions enable adequate implementation of the service.

Successful expansion of this model in the public and private sectors remains a challenge and requires appropriate adaptation to local contexts and adequate follow-up on its implementation. To achieve this, it is essential that health institutions create systems to evaluate the impact and quality of their services. Additionally, it is important that health care providers have the necessary support and resources to effectively respond to clients' needs and offer real options. The monitoring tool presented here seeks to contribute to reaching this goal.

The three contributing institutions understand that providing comprehensive care to women facing an unwanted pregnancy often places health professionals in a challenging dilemma with regards to their personal beliefs. However, health providers must not forget their primary obligation to defend the life and health of these women and to base their actions on the decisions and needs of the women themselves. In fulfilling this obligation, it is incumbent upon health professionals to protect the health and human rights of their clients, and to adopt an understanding and empathetic attitude towards women who face an unwanted pregnancy and request our services.

This tool and a commitment to its application are the basis for successfully integrating the harm reduction model into the public and private health sectors. It is our belief that expanding the model will allow health professionals, health institutions, and society to take an active role in reducing the risks and harmful results associated with unsafe abortion, while simultaneously working to achieve laws and policies that support women's right to choose.





Leonel Briozzo
Executive Director
Iniciativas Sanitarias
Montevideo, Uruguay

Cristina Villarreal
Executive Director
Oriéntame
Bogota, Colombia

Giselle Carino
Regional Safe Abortion Focal Point
IPPF/RHO
New York, NY

We would like to thank Helena Acosta from Fundación Oriéntame, Rebecca Koladycz, Jennifer Friedman, and Carrie Tatum from IPPF/WHR, and Mónica Gorgoroso and Gabriela Tenchio from Iniciativas Sanitarias, without whose help and commitment the production of this tool would not have been possible. We are especially grateful to the Erik E. and Edith H. Bergstrom Foundation and an anonymous donor for their financial support.

General production and design: Sabrina López-Ivern, Jocelyn Ban, IPPF/WHR; Mireia Pons-Llorach

// Introduction

Millions of women around the world have no access to reproductive health services. Many more have little or no control in choosing whether or not to become pregnant, and have little or no information about safe abortion services. As a result, each year, approximately 19 million women resort to having an unsafe abortion. Many of these women die as a result; many more are permanently injured. Nearly all these women are poor and live in developing countries[2], a fact which renders unsafe abortion a pressing public health, social justice, and development issue.

Latin America and the Caribbean not only hold the unfortunate distinction of having the greatest level of inequality in the world[3], it is also the region with the highest rate of unsafe abortion. Every year, an estimated four million unsafe abortions occur in the region, 70% of which are performed on women under the age of 30[4].

Health institutions and non-governmental organizations within the region have been working to respond to this serious health and human rights issue. In an effort to reduce the risks associated with unsafe abortion in Uruguay, Iniciativas Sanitarias developed a unique harm reduction strategy based on the bioethical principles of autonomy, justice, and patient-provider confidentiality. The strategy seeks to empower women while also strengthening the commitment of health professionals and health institutions to address the reality of women facing unwanted and/or unplanned pregnancies. Recognizing that women facing unwanted pregnancies in restrictive contexts will resort to any of the options available to terminate a pregnancy, the harm reduction model encourages health professionals to acknowledge and inform women about the risks and complications resulting from unsafe abortion methods and the safer abortion methods potentially available.

The harm reduction strategy is based on the concept that while induced abortion may be illegal in some contexts, the procedure has a BEFORE and an AFTER. The intervention focuses on these “before” and “after” periods, recommending that women planning to have an abortion have at least one consultation before and another after the abortion if they decide to terminate their pregnancy. The intervention reinforces the notion that health professionals not only can, but have the responsibility to act in order to reduce (and in some cases eliminate) the risks and harm associated with unsafe abortion, by offering women information and counseling. During the initial consultation, a woman facing an unwanted/unplanned pregnancy is able to explore her different options and possible alternatives, including continuing the pregnancy, adoption and conditions for legal abortion. If she does decide to voluntarily interrupt her pregnancy, a trained multidisciplinary team provides comprehensive counseling, including information on the risks associated with the different means used to induce abortion, from the most unsafe practices (such as insertion of hangers or other sharp objects) to safer methods (such as the use of misoprostol); the team also provides medical exams and psychological and legal assistance. Services

---

[3] The Millennium Development Goals: A Latin American and Caribbean Perspective. June 2005. Economic Commission for Latin America and the Caribbean. http://www.eclac.cl/publicaciones/xml/0/21540/lcg2331.pdf

[4] Unsafe Abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003. Fifth edition, World Health Organization, 2007. Page 6. http://www.who.int/reproductive-health/publications/unsafeabortion_2003/ua_estimates03.pdf

[5] Briozzo, L. Iniciativas Sanitarias contra el aborto provocado en condiciones de riesgo. Montevideo: Editorial Arena (2007); Briozzo, L., et al. A risk reduction strategy to prevent maternal deaths associated with unsafe abortion. International Journal of Gynecology and Obstetrics (2006) 95, 221–226

after the abortion include contraceptive counseling, preventative measures against complications, and referrals to other services as needed[5].

The harm reduction model focuses on women as the primary decision-makers and promotes the idea that providing women with information during an initial consultation guarantees that they will be in a better position to make a decision about their pregnancy, according to their own personal situation, life circumstances, and values[6]. Within this model, access to information, in conjunction with access to reproductive health services and contraceptive methods ensures that health professionals and institutions help women reduce unwanted pregnancies and thus, the need for abortions in the future.

In Uruguay, the implementation of this model in the main maternity hospital has resulted in a reduction in the hospital's maternal mortality rate[7]. In addition, Iniciativas Sanitarias found that provider's knowledge about unsafe abortion increased, providers demonstrated a growing commitment to providing services to women faced with an unwanted pregnancy; and clients showed an increased demand for the harm reduction service (unpublished data). Based on these successful results, in 2004, the Uruguayan Ministry of Health formally approved the provision of the services through the health regulation 369/04, which created provisions for the implementation of the service in all public sector facilities and established clinical guidelines for the pre and post consultation sessions[8].

Iniciativas Sanitarias and IPPF/WHR's work to implement the harm reduction model in the private and public health sector provides a key opportunity to expand a rights-based approach to sexual and reproductive health, to transform the inequality currently present in the provider-client relationship and to inspire health professionals to see themselves as important advocates for legal and social change. On an even larger scale, the harm reduction model can serve as a crucial instrument for social change, as it stimulates the creation of public policies needed to achieve the Millennium Development Goals. While recognizing these transformative possibilities, we as health and rights advocates must still continue to work for long-term social change that can only truly be achieved through universal access to safe and legal abortion.

---

[2] Death and Denial: Unsafe Abortion and Poverty. International Planned Parenthood Federation, 2006. Foreword, page 1.

[6] Briozzo, L., et al. A risk reduction strategy to prevent maternal deaths associated with unsafe abortion. International Journal of Gynecology and Obstetrics (2006) 95, 221–226

[7] Briozzo, L., et al. A risk reduction strategy to prevent maternal deaths associated with unsafe abortion. International Journal of Gynecology and Obstetrics (2006) 95, 221–226

[8] Briozzo, L. Iniciativas Sanitarias contra el aborto provocado en condiciones de riesgo. Montevideo: Editorial Arena (2007)

Ensuring a Rights-Based Approach to Sexual and Reproductive Health Services:

A Quality Monitoring Tool for the Harm Reduction Model

// Table of Contents

I. Instructions for the Monitoring Tool

Objectives

The objectives of monitoring the harm reduction model are:

- To systematize the implementation of the model
- To assess the quality of the harm reduction counseling services in health facilities that adopt the model
- To identify and adequately respond to areas that need improvement using the monitoring tool and action plan
- To implement an ongoing monitoring and supportive supervision strategy

Description of the tool

The primary goal of the harm reduction monitoring tool is to evaluate and improve the quality of services from three different perspectives: the client, the health professional, and an external observer. In order to capture these diverse perspectives, three different instruments are available to evaluate the implementation of the model:

- An assessment tool
- A self-evaluation process for health professionals
- A client satisfaction survey

1. The Assessment Tool

The purpose of the tool is to evaluate the institutional components needed for implementing the harm reduction service and to monitor the quality and content of the counseling sessions. The tool contains the following:

I. Institutional components:
   A. Infrastructure
   B. Materials and equipment
   C. Educational materials and activities
   D. Privacy and confidentiality
   E. Human resources
   F. Norms and protocols
   G. Access

II. Client-provider relationship:
   A. Initial counseling session
   B. Follow-up visit

2. Case study review: Self-Evaluation for health professionals

The self-evaluation process should help the health professional who conducts the counseling session to "see him/herself" by examining key concepts, attitudes, and procedures in order to generate self-reflection regarding his/her practice. The goals of the self-evaluation are the following:

- To foster thoughtful attitudes regarding service delivery practice both at the collective and individual levels
- To deepen self-knowledge of strengths and weaknesses and how each affects the quality of and comfort level with the work at hand
- To strengthen the interdisciplinary team structure

Case studies are employed as a self-evaluation strategy to achieve these goals; this involves conducting a group analysis of a real-life case presentation (written, recorded, or filmed) led by a facilitator. The process should include the following steps: presentation of the case, analysis of the case, discussion of alternatives to the intervention presented, evaluation of options, and conclusions. The general guidelines and instructions for the self-evaluation process offered in this document should be used as a reference, and adapted as necessary to the needs of each institution.

3. Client Survey

Client satisfaction is evaluated using a questionnaire that asks clients their opinions about the services, including:

- Clarity and usefulness of information provided
- Treatment by staff
- Privacy and confidentiality issues
- Access issues (service hours, wait times, etc.)

Clients should receive the survey at the end of the initial counseling session and when they return for the follow-up visit.

Preparing for the Monitoring

Before the monitoring process begins, it is essential that the person coordinating the monitoring process schedules all of the necessary observations, interviews, and meetings and ensures that there is enough time assigned to complete the evaluation.

Organization of each section

Each section of the monitoring tool instrument has three main components: instructions and definitions, questions on quality criteria, and scoring. Furthermore, each component is organized as follows:

- Instructions and definitions
  - Specific instructions needed to complete the section
  - Definitions of terms used to evaluate quality

- Questions on quality criteria
  - Specific questions on quality criteria for each section
  - Four options the facilitator should choose from to classify the quality of each criterion:
    - "Yes, sufficiently"
    - "Yes, but needs improvement"
    - "No"
    - "Not applicable" ("N/A")
  - Space to write comments or recommendations
- Score chart
  - Lists at the end of subsections to add the number of answers in each category of options ("Yes, sufficiently," "Yes, but needs improvement," "No," and "N/A") and calculate the percentage of responses for each option
  - A score chart at the end of the section to calculate the number and percentage of answers in each of the four categories of options

Implementation of the monitoring tool

In order to collect the information needed on the quality of services, the primary collection techniques to be used are:

1. Visits to the clinic(s) in order to observe the team and services, as well as the general environment, friendliness towards clients, cleanliness, etc.
2. Interviews with administrative, medical, and general service staff, and with clients in order to understand: staff familiarity with and use of norms and protocols; clients' level of access to services; client satisfaction; and other less visible aspects of quality;
3. Observation of counseling sessions and follow-up visits;
4. Review of documents and systems, including written norms and protocols, client records, and data collection systems.

It is important to note that all observations of consultations may only be conducted with prior client consent. The provider should explain to the client that the clinic wants to guarantee high quality services, and that as part of this process, they would like to observe sessions/consultations to make improvements as needed. The provider should then request the client's consent to have her session observed. If the client declines, the observation should not be completed.

Note-taking when conducting the evaluation

The assessment tool is meant to provide a quantitative, global vision of the quality of the different components of services, as well as a qualitative description of what needs to be improved (for the action plan). Therefore, the facilitator or other external observer responsible for the monitoring should mark the results of each criterion, and always take notes whenever the answer is "Needs improvement," "No," or "N/A." Although these notes do not need to be detailed, they should indicate what the problem is so a solution may be identified and implemented in the action plan and through follow-up.

At the end of each section, the facilitator or other external observer responsible for the evaluation should take the time to make additional notes in order to better understand what aspects are sufficient, what needs improvement, and if there is anything that is highly deficient. These notes should be clearly written so that all participants involved can understand and use them in the follow-up stage. Additionally, during the observation of counseling sessions, notes should be taken while observing the whole session, with the forms completed afterwards.

It is important to recognize that the scoring system has limitations, as the numbers do not specifically indicate what needs to be improved; generally, the scores are most useful in identifying aspects that are working well and priority areas that need attention. Therefore, it is important to use the scoring in conjunction with qualitative information and action planning, where specific changes to improve quality are noted.

Estimated Time of Completion

Generally, 2 or 3 days should be set aside to complete the entire monitoring process. This includes an introductory meeting with staff; monitoring of the services at one of the health facilities or hospitals; conducting interviews with key staff members; administering the client satisfaction survey; conducting the self-evaluation process with professionals; and a closing meeting. The estimated time will vary depending on the size of the health facility and number of clients.

Who should participate

The implementation process of the tool should be defined by each institution. The team implementing the monitoring tool for the first time should include at least: a qualified observer to administer the institutional evaluation components and conduct the observation of client-provider relationships, a facilitator qualified in case study methodology and the self-evaluation process, and other key staff.

Action Plan

To close the monitoring process, a meeting should be held with all staff involved in the harm reduction services in order to:

- Present the initial results of the monitoring tool: strengths, areas needing improvement, etc.
- Request feedback on the process
- Collect suggestions for the action plan
- Assign a team that will be responsible for developing and following-up on the action plan

Steps for the action plan

It is important to discuss the process for completing the plan, explaining how the results of the tool should provide information to plan future actions. The goal of the action plan discussions is to facilitate a process of supportive supervision where staff of all levels participate in identifying additional areas in need of improvement and possible solutions. Ideally, supportive supervision should be a continuous

process of empowering staff in order to help them improve the quality of their work and their personal performance.

The team should use the completed monitoring tool as the basis for developing an action plan. Once the team has been selected, each section of the tool should be systematically reviewed. Whenever “Needs improvement” or “No” has been noted, the team should analyze this area and determine how to respond to this need. Once the priority issues have been selected, the team should record each issue in the action plan format, including the action that will be taken to improve it, the person responsible for completing the action, and the date by which the action will be completed.

Follow-up

Re-implementation of the monitoring tool should be adapted to the particular needs of each health facility. While the facility may choose to administer the entire tool again on an annual basis, it may also choose to only re-evaluate a few specific sections that were identified as needing improvement. For example, the facilities could complete the health professionals’ self-evaluation 3 or 4 times a year; additionally, the facilities could implement the client survey as a routine part of all client visits.

Ensuring a Rights-Based Approach to Sexual and Reproductive Health Services:
A Quality Monitoring Tool for the Harm Reduction Model

Health Facility: _____

City: _____

Date(s) of Observation: Observer(s):

Days and hours of clinic operation: _____

Number of professionals working in the harm reduction counseling services:_____
and gender: W:_____ M:_____

Fees for the following services:

- ☐ Initial Counseling visit: _____
- ☐ Follow-up visit: _____
- ☐ Contraceptive methods _____
- ☐ Other: _____

Average number of counseling sessions per month: _____

Emergency services:

Are emergency services available 24 hours a day? Yes ☐ No ☐

Is an emergency phone line available for clients to call? Yes ☐ No ☐

Ensuring a Rights-Based Approach to Sexual and Reproductive Health Services: A Quality Monitoring Tool for the Harm Reduction Model

II. Institutional Components

A. Infrastructure

In order to monitor the quality of the clinic's infrastructure, the facilitator responsible for the evaluation, along with a representative from the clinic, should conduct a walk-through of the institution's facilities, noting all of the conditions described in each question and considering the following definitions:

Definitions of Terms:

Yes, sufficiently" means:

- The clinic's physical structure is in good condition, is clean and well maintained, has all infrastructure components listed and does not need any type of repairs or improvements.

"Yes, but needs improvement" means:

- The clinic's physical structure has all basic requirements and has the majority of infrastructure components required, but needs: some repairs; improvements in cleanliness and sanitary conditions; and/or to integrate essential infrastructure components.

"No" means:

- The clinic's physical structure does not meet basic sanitary requirements, does not have the minimum infrastructure components, and/or has significant physical deterioration.

"N/A" means that the question is not applicable to the clinic (for example, the clinic does not offer the service or does not have the capacity for this type of procedure) or the facilitator was not able to evaluate this aspect of the instrument (please explain why in the comments section).

CRITERIA OBSERVED	*Yes, sufficiently*	*Yes, but needs improvement*	*No*	*N/A*	*Comments*
1. Is the waiting room clean (washed floors and walls, no litter on the floor) and well ventilated?					
2. Does the waiting room have educational materials and messages that support a woman's right to choose?					
3. Is the waiting room adequately lit?					
4. Is the counseling/consultation room clean?					
5. Are there comfortable chairs in the counseling/consultation area?					
6. Does the counseling/ consultation area offer adequate space (chairs for the counselor, the client and a partner/family member)?					
7. Does the counseling area have educational materials and models (pamphlets, informational posters, pelvic models, etc.)?					
8. Are the staff and client bathrooms clean and up to sanitary code?					
SUBTOTAL OF A. INFRASTRUCTURE *add all of the boxes marked in each column and enter the totals here:*	_____	_____	_____	_____	= _____ *(add the 4 totals - should be 8)*
PERCENTAGE IN EACH CATEGORY: *Divide the total in each column by the total number of questions and multiply by 100*	_____ /8= ____x100= _____%	_____ /8= ____x100= _____%	_____ /8= ____x100= _____%	_____ /8= ____x100= _____%	

B. Equipment and Supplies

To evaluate the quality of the clinic's equipment and contraceptive supplies, the facilitator responsible for the evaluation and the clinic medical director or service coordinator should conduct a walk-through of the facility to directly evaluate if the equipment and supplies needed are available and in good condition.

The individuals conducting the evaluation should take into account the following definitions:

"Yes, sufficiently" means:

- The *equipment* specified is working and readily available.
- The *materials* or contraceptives specified are adequately stored (in a dry and safe place, contraceptives are not stored directly on the floor and are away from the wall); contraceptives are not expired; and there are sufficient stocks (within the minimum and maximum levels established by the clinic).

"Yes, but needs improvement" means:

- The *equipment* specified is almost always (but not always) available and in working condition when needed, but may be outdated and/or need to be repaired or replaced.
- The *material* or contraceptive specified is available but not adequately stored; the contraceptive specified has less than 3 months of shelf life; or the clinic has occasionally run out of particular supply or contraceptive, or occasionally has an overstock.

"No" means:

- The specified *equipment*, *material* or contraceptive is not available or working; the material or contraceptive is not adequately stored; the contraceptive has passed its expiration date; or the clinic consistently runs out of a particular contraceptive or has frequent overstocks.

"N/A" means that the question is not applicable to the clinic (for example, the clinic does not offer the service or does not have the capacity for this type of procedure) or the facilitator was not able to evaluate this aspect of the instrument (please explain why in the comments section).

CRITERIA OBSERVED	*Yes, sufficiently*	*Yes, but needs improvement*	*No*	*N/A*	*Comments*
1. Does the health facility offer an ultrasound exam?					
2. If there is not ultrasound equipment, does the health facility have the capacity to confirm a pregnancy with a urine test?					
Does the laboratory at the facility have the capacity to provide exams to screen for: 3. STIs?					
4. Blood group and type?					
Does the unit have a full range of contraceptive methods available: 5. Contraceptive pills					
6. Injectables					
7. IUDs					
8. Condoms					
9. Female condoms					
10. Diaphragms					
11. Emergency contraception					
12. Voluntary surgical sterilization					
SUBTOTAL OF B. EQUIPMENT AND MATERIALS *add all of the boxes marked in each column and enter the totals here*	_____	_____	_____	_____	= _____ *(add the 4 totals - should be 12)*
PERCENTAGE IN EACH CATEGORY: *Divide the total in each column by the total number of questions and multiply by 100*	_____ / 12= ____x100= _____%	_____ / 12= ____x100= _____%	_____ / 12= ____x100= _____%	_____ / 12= ____x100= _____%	

C. Educational Materials and Activities

In order to evaluate the quality of the educational materials and activities related to the harm reduction model, the facilitator responsible for the evaluation should review the materials and speak with key staff about activities, taking into account the following definitions:

"Yes, sufficiently" means:

- Educational *materials* include simple, complete, and scientifically correct information and use everyday language and reliable sources.
- Educational *activities* include simple, complete, and scientifically correct information; clients are informed of their rights and the services available at the clinic; and activities are conducted frequently.

"Yes, but needs improvement" means

- Educational *materials* include simple, complete, and scientifically correct information but use technical and complicated language.
- Educational *activities* include simple, complete, and scientifically correct information but clients are not informed of their rights or of services available at the health facility, or activities are conducted inconsistently.

"No" means:

- Educational *materials* include incorrect or inaccurate information, do not use reliable sources, or are not available to clients.
- Educational *activities* include incorrect or inaccurate information or are only conducted a few times a year.

"N/A" means that the question is not applicable to the clinic (for example, the clinic does not offer the service or does not have the capacity for this type of procedure) or the facilitator was not able to evaluate this aspect of the instrument (please explain why in the comments section).

CRITERIA OBSERVED	*Yes, sufficiently*	*Yes, but needs improvement*	*No*	*N/A*	*Comments*
1. Does the facility have high quality educational materials available (in the waiting and counseling rooms) on contraceptive methods, gender, client rights, and sexual and reproductive rights?					*Note what type of materials*
2. Are there educational materials available that explain the harm reduction counseling service?					
3. Do clients receive written materials that explain how misoprostol is used, and its dosage, safety, and efficacy in inducing abortion?					
4. Do clients receive written materials indicating warning signs and how to contact medical services in these circumstances?					
5. Do staff members facilitate educational workshops or give talks on sexual and reproductive health in the waiting room?					*Note topics and number per month:*
6. Does the health facility conduct educational activities in the community?					
7. Does the health facility conduct promotional or marketing activities related to the harm reduction counseling service?					
SUBTOTAL OF C. EDUCATIONAL MATERIALS AND ACTIVITIES *add all of the boxes marked in each column and enter the totals here:*	_____	_____	_____	_____	= _____ *add the 4 totals - should be 7)*
PERCENTAGE IN EACH CATEGORY: *Divide the total in each column by the total number of questions and multiply by 100*	_____ /7= ____*x100*= _____%	_____ /7= ____*x100*= _____%	_____ /7= ____*x100*= _____%	_____ /7= ____*x100*= _____%	

D. Privacy and Confidentiality

It is important that the clinic follows all steps needed to guarantee clients' privacy and confidentiality and ensures that information shared with a health professional is not accessible to other clinic staff or external persons without client authorization. The facilitator responsible for the evaluation should assess the quality of privacy/confidentiality measures taken by the clinic during his/her observations of the counseling sessions and during the visit to the facilities.

For this section, refer to the following definitions:

"Yes, sufficiently" means:

- The specified aspect of client privacy/confidentiality is met in all cases and is protected and respected.

"Yes, but needs improvement" means:

- The specified aspect of client privacy/confidentiality is met and respected, in most but not all cases.

"No" means:

- The clinic does not take any measures to ensure that the specified privacy aspect is met, protected, or respected.

"N/A" means that the question does not apply to the clinic or the facilitator was not able to evaluate this aspect of the instrument (please explain why in the comments section).

CRITERIA OBSERVED	*Yes, sufficiently*	*Yes, but needs improvement*	*No*	*N/A*	*Comments*
1. In the reception area, are clients given the option of being called by number instead of by name?					
2. Do providers handle client records and clinical histories discreetly when reviewing them (i.e. they are not left open or on desks where clients can see them)?					
3. Are client records and clinical histories stored in a secure space with access strictly limited to authorized staff?					
4. Do the facilities have a private space where counseling sessions cannot be seen or heard by others?					
SUBTOTAL OF D. PRIVACY AND CONFIDENTIALITY *Add all of the boxes marked in each column and enter the totals here:*	_____	_____	_____	_____	= _____ *(add the 4 totals - should be 4)*
PERCENTAGE IN EACH CATEGORY: *Divide the total in each column by the total number of questions and multiply by 100:*	_____ /4= ____x100= _____%	_____ /4= ____x100= _____%	_____ /4= ____x100= _____%	_____ /4= ____x100= _____%	

E. Human Resources, F. Norms/Protocols, G. Access

These institutional systems are a key aspect of high quality services. Human resources refer to systems that adequately provide training and institutional support to staff at the health facility. Institutional norms and protocols refer to established procedures for clinics and client-provider relationships, and clear protocols to ensure that the health facility meets state and national guidelines. Access refers to systems that ensure that all clients can access services at the facility free from barriers or obstacles to care. The facilitator responsible for the evaluation should assess the presence and effectiveness of these systems through interviews with key staff and the medical director.

"Yes, sufficiently" means:

- The human resources system, the institutional norm specified, or the criteria for access to services exists, is up-to-date, and is fulfilled in all circumstances.

"Yes, but needs improvement" means:

- The human resources system, the institutional norm specified, or the criteria for access to services exists but is not up-to-date or is not always fulfilled.

"No" means:

- The human resources system, the institutional norm specified, or the criteria for access to services does not exist or is never fulfilled.

"N/A" means that the question is not applicable to the clinic (for example, the clinic does not offer the service or does not have the capacity for this type of procedure) or the facilitator was not able to evaluate this aspect of the instrument (please explain why in the comments section).

CRITERIA OBSERVED	*Yes, sufficiently*	*Yes, but needs improvement*	*No*	*N/A*	*Comments*
E. HUMAN RESOURCES ** to complete this section, the medical director or the clinic manager should be interviewed*					
1. Do health professionals at the facility have the knowledge and skills needed to provide quality comprehensive management of unwanted pregnancy, STIs, and other sexual and reproductive services?					
2. Do staff members regularly participate in training events to improve or gain new skills in sexual and reproductive health issues; STIs; gender, rights and sexuality; and/ or the comprehensive management of unwanted pregnancy?					
3. Have medical and counseling staff members been trained on the prevention and transmission of STIs/HIV/AIDS?					
4. Have medical and counseling staff members been trained on the issue of gender-based violence?					
SUBTOTAL OF E. HUMAN RESOURCES *Add all of the boxes marked in each column and place the totals here:*	_____	_____	_____	_____	= _____ *(add the 4 totals - should be 4)*
PERCENTAGE IN EACH CATEGORY: *Divide the total of each column by the total number of questions and multiply by 100:*	_____ /4= ____x100= _____%	_____ /4= ____x100= _____%	_____ /4= ____x100= _____%	_____ /4= ____x100= _____%	

CRITERIA OBSERVED	*Yes, sufficiently*	*Yes, but needs improvement*	*No*	*N/A*	*Comments*
F. NORMS AND PROTOCOLS					
1. Does the facility have written protocols or clinical guidelines for the delivery of the harm reduction service?					*Review protocols/ guidelines and note comments:*
2. If the facility does not have the capacity to offer uterine evacuation in cases of complications or incomplete abortion, does a protocol exist to refer clients to another health facility?					
3. Is the health facility prepared to offer adequate transportation for clients in emergency cases?					
4. Do providers conduct systematic screening for gender-based violence?					
SUBTOTAL OF F. NORMS AND PROTOCOLS *Add all of the boxes marked in each column and enter the totals here:*	_____	_____	_____	_____	= _____ *add the 4 totals - should be 4)*
PERCENTAGE IN EACH CATEGORY: *Divide the total of each column by the total number of questions and multiply by 100:*	_____ /4= ____x100= _____%	_____ /4= ____x100= _____%	_____ /4= ____x100= _____%	_____ /4= ____x100= _____%	

CRITERIA OBSERVED	*Yes, sufficiently*	*Yes, but needs improvement*	*No*	*N/A*	*Comments*
G. ACCESS TO SERVICES					
1. When clients request a harm reduction counseling session, is the wait time for an appointment less than a week?					
2. When clients request a gynecological visit, is the wait time for an appointment less than 2 weeks?					
3. Are there harm reduction counseling sessions available during the evenings and weekends?					*Note hours here:*
4. Is there an informational phone line available that provides clinic hours and directions?					
5. Upon arrival at the clinic, are clients given an accurate estimate of their wait time?					
6. Is clients' wait time for a scheduled visit 30 minutes or less?					
7. Are friends/partners/family members allowed to join the counseling session (with client consent)?					
SUBTOTAL OF G. ACCESS *Add all boxes marked in each column and enter the totals here:*	_____	_____	_____	_____	= _____ *(add the 4 totals - should be 7)*
PERCENTAGE IN EACH CATEGORY: *Divide the total of each column by the total number of questions and multiply by 100:*	_____ /7= ____x100= _____%	_____ /7= ____x100= _____%	_____ /7= ____x100= _____%	_____ /7= ____x100= _____%	

INSTITUTIONAL COMPONENTS *Write the subtotals of each part in the spaces below.* *Add the numbers in each column to obtain the section total*					
SUBSECTIONS	1. TOTAL OF YES, SUFFICIENTLY	2. TOTAL OF YES, BUT NEEDS IMPROVEMENT	3. TOTAL OF NO	4. TOTAL OF N/A	5. Total responses (1+2+3+4)
A. Infrastructure					= _____ *(=8)*
B. Equipment and Materials					= _____ *(=12)*
C. Educational Materials and Activities					= _____ *(=7)*
D. Privacy and Confidentiality					= _____ *(=4)*
E. Human Resources					= _____ *(=4)*
F. Norms and Protocols					= _____ *(=3)*
G. Access					= _____ *(=7)*
H. TOTAL OF SECTION: *(A +B+C+D+E+F+G)*					= _____ *(=46)*
PERCENTAGE: *Divide the total in each column by the total number of responses and multiply by 100*	_____ */46* *____x100=* *_____%*	_____ */46* *____x100=* *_____%*	_____ */46* *____x100=* *_____%*	_____ */46=* *____x100=* *_____%*	

III. Observation of Client-Provider Relationship

Initial Counseling Session

In order to evaluate the quality of the initial harm reduction counseling visit offered by the clinic, the facilitator responsible for the evaluation should silently observe and assess the counseling session (with the client's previous consent). It is important that the person leading the evaluation observe at least three counseling sessions with providers from different disciplines if possible. The following definitions should be employed when determining the quality of the counseling session:

"Yes, sufficiently" means:

- The provider covers the specified information clearly, supportively, and empathetically; focuses on the client's needs and helps to clarify her thoughts, feelings, and decisions; respects her rights and protects her right to privacy and confidentiality.

"Yes, but needs improvement" means

- The provider covers most but not all of the specified information; respects client's feelings and thoughts, but could engage further with the client or exhibit more empathy.

"No" means:

- The provider offers incorrect or false information or does not provide the specified information; does not respect the client's confidentiality or privacy; or openly discriminates against certain clients based on their age, sexual orientation, etc.

"N/A" means that the question does not apply to the health facility, does not apply to the particular clinical case, or the facilitator responsible for the evaluation could not evaluate this aspect of the instrument (please explain why in the comments section).

For each client, indicate if the component is sufficient (S), needs improvement (NI), is not done satisfactorily (N), or does not apply to the health facility (N/A).

For each client, indicate if the component is sufficient (S), needs improvement (NI), is not done satisfactorily (N), or does not apply to the health facility (N/A).

CRITERIA OBSERVED	*Client 1*	*Client 2*	*Client 3*	*Comments and Recommendations*
A. INITIAL COUNSELING SESSION				
Conceptual aspects				
1. Does the provider explain the goals, content, and length of the counseling session?				
Do service providers conduct a clinical evaluation using: 2. Clinical history records?				
3. A pregnancy test?				
4. A pelvic exam including an inspection using a speculum?				
5. A general physical exam?				
6. An ultrasound exam (if available)?				
7. If an ultrasound exam is available, does the provider explain why it is administered?				
8. If an ultrasound is available, is the client informed that she has a right to decide whether to view the sonogram images or not?				
9. Does the professional inquire if the pregnancy is wanted or unwanted?				
Does the provider inform the client regarding the legal framework of the consultation in terms of: 10. Her right to access services and information?				

CRITERIA OBSERVED	*Client 1*	*Client 2*	*Client 3*	*Comments and Recommendationss*
11. Confidentiality?				
12. Is the option of continuing the pregnancy discussed, including help available? (explores family situation, support systems, such as programs to support single mothers)				
13. Is the option of adoption discussed with sufficient knowledge of the conditions in the country, clarifying any doubts the client has?				
14. Is the option of abortion discussed, including information on the legal framework in the country?				
15. Does the provider inquire if the client has additional doubts or questions?				
When the client chooses to interrupt the pregnancy: 16. Does the provider explore if the client is comfortable with the decision (reasons for the interruption are discussed, investigates if she is being coerced)?				
17. Does the provider review the client's medical history and risk factors?				
Does the provider explain: 18. The circumstances in which abortion is legal in the country?				
19. Higher risk methods for interrupting a pregnancy?				

CRITERIA OBSERVED	*Client 1*	*Client 2*	*Client 3*	*Comments and Recommendations*
20. Lower risk methods for interrupting a pregnancy?				
21. Is comprehensive information provided on the dosage, administration route, and effectiveness of misoprostol?[1]				
22. Does the provider give the client information on buying safe misoprostol (sealed blister packet)?				
23. Does he/she explain the importance of taking analgesics starting ½ hour before using misoprostol and continuing every 2 hours during the first 6 hours?				
Does she/he explain in detail that the following most common side effects may occur and how to manage them: 24. Chills and/or fever after administering MSP (first two days)?				
25. Moderate to severe cramps?				
26. Heavier vaginal flow (up to double the client's regular menstrual flow) including clots and tissue?				
27. Diarrhea and nausea?				
28.Does he/she explain that it is possible the procedure will fail and what to do in this case?				
29. Are the possible teratogenic effects explained as well as the low probability of their occurrence?				

[1] The recommended dosage is 800 µg by vaginal route every 12 hours, until completing 3 doses, or 800 µg by sublingual route, every 3 or 4 hours, until completing 3 doses. The vaginal route may be used in pregnancies up to 12 weeks and sublingual route in pregnancies up to 9 weeks. The vaginal route should be the first choice, but the sublingual route may be used if this is a woman's preference (FLASOG, 2007).

CRITERIA OBSERVED	*Client 1*	*Client 2*	*Client 3*	*Comments and Recommendations*
30. Does the provider explain the importance of immunoprophylaxis and obtaining blood group and type?				
Does he/she explain the following warning signs for which the client should seek help immediately? 31. Vaginal hemorrhaging: more than two sanitary pads are soaked in less than an hour for a period for two consecutive hours				
32. Severe cramps that do not abate with analgesic indications				
33. Fainting				
34. Does the service provider inform the client about where to go if she experiences any of the warning signs?				
35. Does the client receive information on when to return for follow-up?				
36. Does the provider explain the importance of follow-up care (whatever the client's decision may be) and what it consists of?				
37. Does the provider address the immediate risk of becoming pregnant again if a safe and effective contraceptive method is not used?				
38. Is the client offered referrals to other services?				
39. Does the provider schedule a follow-up appointment?				

CRITERIA OBSERVED	*Client 1*	*Client 2*	*Client 3*	*Comments and Recommendations*
Client-provider interaction and provider attitudes				
To ensure respect towards clients and their privacy and confidentiality, do counselors and providers: 40. Close the door?				
41. Ensure their cell phones do not ring?				
42. Conduct the counseling in a private space where sessions cannot be seen or heard by others?				
43. Ensure that there are no interruptions or interferences during the consultation?				
44. Does the provider establish a positive rapport with the client (introduces him/herself, calls the client by her name)?				
45. Does the provider exhibit open body language (i.e. smile and establish eye contact with the client)?				
46. Does he/she show interest in the client's situation and respond empathically to her reality?				
47. Does he/she actively listen to the client's reason for her visit and help her explore and understand what she is going through?				
48. Does he/she actively help the client explore any ambivalent feelings in terms of religion, economic situation, family, or her partner and help her to resolve these conflicts?				

CRITERIA OBSERVED	*Client 1*	*Client 2*	*Client 3*	*Comments and Recommendations*
49. Does he/she respect the client's rights to make decisions and help her consider what the decision could mean for her in the future?				
50. Does he/she respect the client's values while also exploring how they were constructed?				
51. Does he/she respect the client's reasons for choosing to terminate her pregnancy while actively reflecting on them with her?				
52. Does he/she empower the client with information that will help her validate her decision (regardless of her marital status, age, economic or social situation)?				
53. Does the provider inform the client that the decision is hers and that she can always count on the health service no matter what she decides?				
54. Does the provider explore what support systems the client can count on to help her during the procedure?				
55.Are clients' clinical histories or medical records adequately completed with essential information for continuity of care? (ex: legibility, objectivity, accuracy)				

Initial Counseling Session SCORE CHART					
Initial Counseling Session	1. Client 1	2. Client 2	3. Client 3	4. Total in each category (by the 3 clients) (1+2+3)	5. Percentage
A. Total of "Y" (yes, sufficiently)					_____\165= *(col 4)* _____x100= _____%
B. Total of "NI" (yes, but needs improvement)					_____\165= *(col 4)* _____x100= _____%
C. Total of "N" (no)					_____\165= *(col 4)* _____x100= _____%
D. Total of N/A (not applicable)					_____\165= *(col 4)* _____x100= _____%
E. TOTAL OF RESPONSES (A +B+C+D)	*55*	*55*	*55*	*=165*	

B. Follow-Up Visit

In order to assess the quality of the follow-up visit offered by the clinic, the person facilitating the evaluation should silently observe and evaluate the counseling session (with the client's prior consent). The following definitions should be employed to determine the quality of the counseling session:

"Yes, sufficiently" means:

- The provider covers the specified information clearly, supportively, and empathetically; focuses on the client's needs and helps her clarify her thoughts, feelings, and decisions; respects her rights and protects her right to privacy and confidentiality.

"Yes, but needs improvement" means:

- The provider covers most, but not all, of the specified information; respects clients feelings and thoughts, but could engage further with the client or exhibit more empathy.

"No" means:

- The provider gives incorrect or false information or does not provide the specified information; does not respect the client's confidentiality or privacy; or the counselor openly discriminates against certain clients based on their age, sexual orientation, etc.

"N/A" means:

- That the question does not apply to the health unit, is not applicable to the particular clinical case, or the facilitator responsible for the evaluation could not assess this aspect of the instrument (please indicate why in the comments section).

For each client, indicate if the component is sufficient (S), needs improvement (NI), is not done satisfactorily (N), or does not apply to the health facility (N/A).

For each client, indicate if the component is sufficient (S), needs improvement (NI), is not done satisfactorily (N), or does not apply to the health facility (N/A).

CRITERIA OBSERVED	*Client 1*	*Client 2*	*Client 3*	*Comments and Recommendations*
B. FOLLOW-UP VISIT				
Conceptual aspects				
1. Does the provider explain the goals, content, and duration of the follow-up visit?				
Does the service provider review the legal framework of the consultation, including: 2. The client's right to services and information?				
3. Confidentiality?				
4. Does the provider discuss which abortion method the client used, when, and how?				
5. Does he/she ask the client about the signs and effects of abortion (vaginal bleeding, pain, and clotting)?				
6. Does he/she rule out any complications?				
7. Does he/she inquire about how the client feels about her experience of abortion?				
8. Do clients have the opportunity to discuss any other issue/problem?				
9. Does the provider evaluate if the client needs specific psychosocial assistance and offer referrals if this is the case?				

CRITERIA OBSERVED	*Client 1*	*Client 2*	*Client 3*	*Comments and Recommendations*
10. Do clients receive information about the immediate risk of becoming pregnant again after an abortion if a safe and effective contraceptive method is not used?				
11. Does the provider explain to the client how to use each method, how it works, and its limitations?				
12. Is dual protection emphasized to prevent STI/ HIV/AIDS?				
13. Do providers immediately offer clients the contraceptive method they choose? *(If the answer is yes, write the method in the comments section)*				
14. Are all clients informed that they may return at any time if they have questions or concerns about their sexual and reproductive health?				
Client-provider interaction and provider attitudes				
To ensure privacy, confidentiality and respect, do counselors and providers: 15. Close the door?				
16. Ensure their cell phones do not ring?				
17. Conduct the counseling in a private space where sessions cannot be seen or heard by others?				
18. Ensure that there are no interruptions or interferences during the consultation?				

CRITERIA OBSERVED	*Client 1*	*Client 2*	*Client 3*	*Comments and Recommendations*
19. Does the provider establish a positive rapport with the client (introduces him/herself, calls the client by her name)?				
20. Does he/she exhibit open body language (i.e. smile and establish eye contact with the client)?				
21. Does he/she show interest in the client's situation and participate empathetically in her reality?				
22.Does he/she empower the client with information that will help her validate her decision (regardless of her marital status, age, or economic or social situation)?				
23.Does he/she treat the client with respect, without judgment, and consider her emotions, fears, and wishes regarding the service?				
24. Are clients' clinical histories or medical records adequately completed with essential information for continuity of care (i.e. legibility, objectivity, accuracy)?				

Follow-Up Visit SCORE CHART					
Follow-up visit	1. Client 1	2. Client 2	3. Client 3	4. Total in each category (by the 3 clients) (1+2+3)	5. Percentage
A. Total of "S" (yes, sufficiently)					_____\72 = *(col 4)* _____*x100*= _____*%*
B. Total of "NI" (yes, but needs improvement)					_____\72 = *(col 4)* _____*x100*= _____*%*
C. Total of "N" (no)					_____\72 = *(col 4)* _____*x100*= _____*%*
D. Total of "N/A" (not applicable)					_____\72 = *(col 4)* _____*x100*= _____*%*
E. TOTAL OF RESPONSES (A +B+C+D)	*24*	*24*	*24*	*=72*	

IV. Client Survey

YOUR OPINION WILL HELP US TO IMPROVE OUR SERVICES NOTE: Please DO NOT write your name on this form

We want to provide you with excellent care, which is why we need your opinion. Please answer each of the following questions, marking with an X the answer that is most appropriate. Some of the questions are followed by the option Other and a line, where you may place your own answer if it is not included in the options given. Thank you for your participation!

General questions

1) What is your age:
a. ☐ 10-14
b. ☐ 15-19
c. ☐ 20-24
d. ☐ 25 and over

2) When I called the health center/hospital for information, the person who answered was:
a. ☐ Friendly
b. ☐ Impatient
c. ☐ I didn't call the health center/hospital
d. ☐ Other: _____

3) When I called the emergency hotline:
a. ☐ I received an answer quickly
b. ☐ I couldn't get through
c. ☐ I didn't use this service
d. ☐ Other: _____

4) The people at the reception area were:
a. ☐ Friendly
b. ☐ Inattentive
c. ☐ Other: _____
_____

5) The people at the reception area made me feel:
a. ☐ Respected
b. ☐ Judged (please explain: _____
_____)
c. ☐ Other: _____
_____

6) During my time at the health center/hospital, my partner and/or other companion:
a. ☐ Was actively included in the counseling session
b. ☐ Was ignored
c. ☐ I didn't come with a partner/companion
d. ☐ Other: _____

7) I felt that the health center/hospital:
a. ☐ Respected my privacy
b. ☐ Did not respect my privacy (please explain: _____)
c. ☐ Other: _____

8) The level of cleanliness at the health center/hospital is:
a. ☐ Good
b. ☐ Poor
c. ☐ Other:_____

9) The health center/hospital's facilities are:
a. ☐ Comfortable
b. ☐ Uncomfortable
c. ☐ Other: _____

10) The provider who counseled me made me feel:
a. ☐ Respected
b. ☐ Judged (please explain:
_____)
c. ☐ Other: _____

11) The provider who counseled me:
a. ☐ Was sensitive and compassionate

b. ☐ Was hostile and indifferent
c. ☐ Other: _____

_____

12) When I compare how long I had to wait at the clinic with how long they told me:
a. ☐ The wait time was what they said it would be
b. ☐ I waited longer than I was told
c. ☐ I waited less time than I was told
d. ☐ I wasn't told how long I would wait

13) The time I had to wait to see the provider was (please note time here_____):
a. ☐ Too long
b. ☐ Appropriate
c. ☐ Other: _____

14) During my visit to the health center/ hospital:
a. ☐ I received the support and care I needed
b. ☐ I didn't receive the care I expected
c. ☐ Other: _____

15) Did you come today for an:
a. ☐ initial counseling session (please answer question 16)
b. ☐ follow-up counseling session (please answer questions 17-19

Questions for the **initial** visit:

16) The provider who counseled me gave me clear and complete information about (mark YES or NO):

a. When and how to use the medication
☐ Yes ☐ No

b. The possible common effects of the medication, including, chills, fever, strong cramping, vaginal bleeding, diarrhea, and nausea
☐ Yes ☐ No

c. Warning signs which I should immediately seek help for, including vaginal hemorrhaging, severe cramping, and fainting
☐ Yes ☐ No

d. The date of my follow-up visit
☐ Yes ☐ No

e. Where I should go in case I have any doubts, fears, or an emergency
☐ Yes ☐ No

Questions for the **follow-up** visit:

17) The provider I saw:
a. ☐ Cleared up my doubts
b. ☐ Didn't answer all of my questions
c. ☐ Other: _____

18) The provider I saw:
a. ☐ Gave me clear and complete information on different contraceptive methods
b. ☐ Gave me confusing and limited information on contraceptive methods
c. ☐ Did not give me information on contraceptive methods
d. ☐ Other: _____

19) During the follow-up visit, my wait time to see a provider was (please note time here_____):
a. ☐ Too long
b. ☐ Appropriate
c. ☐ Other: _____

Other comments: Note below any other comment, opinion, or critique of this service

_____

V. General Guidelines for the Case Study Review

General Information

The case study is a self-evaluation method; it is intended to provide a space for reflection and professional growth rather than didactic information. The content and process are equally important as they help to shape providers' ability to face new situations using their own judgment.

What is it?

The case study is a group analysis activity based around a real-life situation or case led by a facilitator. The case study reflects how the client's reality is perceived by providers and the ways in which these perceptions are conditioned by the past experiences, knowledge, assumptions and feelings of those analyzing the case.

What are the goals of the case studies?

- To facilitate reflection of one's practice and to maintain the ability to understand and question one's own ways of operating. The activity also allows us to understand our peers' interventions and decide as a group if these are appropriate or need to be modified.
- As an environment for peer interaction, the activity should help the team of health professionals to channel any tensions or conflicts in this area, promoting better relationships among them.

Steps of the case study

1. Identify the individual who will act as a facilitator for the case study activity (i.e. convene, coordinate, and lead the activity).

His/her role will be:

- To identify and convene the participants; ideally, each group will include providers from diverse disciplines since discussing the case from multiple perspectives will enrich and expand approaches to the intervention.
- To determine the goals of the activity and how it will be conducted.
- To foster and encourage critical reflection regarding provider actions in the case study, including active participation from all group members.
- To systematize and document the case, the challenges identified, and the strategies proposed to overcome these challenges.

2. Select the cases: these should be real and meaningful to the group in order to appropriately involve all aspects related to provider involvement.

3. Conduct the activity:

- Presentation of the case: this could be through a transcript, recording, or video. The case should be presented for discussion from the provider's or health team's perspective.
- Lead the discussion based on the needs identified.

- Analyze: empathy, content, and interventions. Identify challenges and propose alternatives, remembering that there is not a single approach and therefore, no absolute results. Whoever requests their case to be analyzed will decide how relevant the options discussed are.
- Conclusion: the health team should decide what was accomplished, what should be changed or improved, and through what actions.
- Evaluate throughout the activity: if the proposed goals are fulfilled, participant attitudes, mutual respect, length of intervention.

What knowledge and skills should the facilitator have?

- Understanding of the concepts and theories relevant to the cases:

  Familiarity with the literature and ideas currently being discussed in the sexual and reproductive health (SRH) field. This background may help to guide interventions and create hypotheses in terms of how to approach cases.

- Ability to ask questions appropriate to the goals of the self-evaluation exercise:

  In successful communication, how a question is asked is crucial. To encourage reflection, it is much different to simply say, "Maria, what do you think"? as opposed to, "Maria, can you relate this to what Claudia said a moment ago"? It is important to motivate the discussion by summarizing, determining how to ask questions appropriately or giving examples. For example, asking Juana to "in a few words" assess what has been discussed, proposing to Sofia, "if you had to choose just one response, what would you say?," or suggesting to Beatriz, "could you give us specific examples of what you're talking about?"

- Active listening skills:

  Active listening is an essential part of the case study process. It implies the ability to respect each individual's contribution, give consideration to everyone's opinions, and provide a space for dialogue. Active listening values a message as a whole, capturing both the content and the feeling of the message being communicated. In addition to the verbal messages, active listening also involves paying close attention to body language, movement, and eye contact in order to capture the essence of the message as a whole.

These guidelines provide a brief overview of the case study as a method for self-evaluation and reflection for health professionals involved in the harm reduction counseling service. This method and the accompanying guidelines are flexible and should be adapted to meet the individual needs and context of each institution

VI. A. Annex

Action Plan Format

Areas identified that need strengthening	*Interventions/Actions*	*Person responsible*	*Deadline*	*Technical assistance required*	*Estimated cost of activities*

International Planned Parenthood Federation, Western Hemisphere Region (IPPF/WHR) was founded in 1954 with the mission of improving the sexual and reproductive health of women, men, and youth throughout the Americas. IPPF/WHR's work is grounded in the belief that access to high-quality sexual and reproductive health information and services is a basic human right. IPPF/WHR primarily works through a network of 41 Member Associations in North America, Latin America, and the Caribbean, which offer over 100,000 service delivery points. IPPF/WHR provides technical assistance and financial support to these and other reproductive health organizations; facilitates the exchange of information among its members; and acts as an advocate for sexual and reproductive rights at the regional and international levels. IPPF/WHR is one of the six regions that make up the International Planned Parenthood Federation (IPPF).

http://www.ippfwhr.org

Fundación Oriéntame

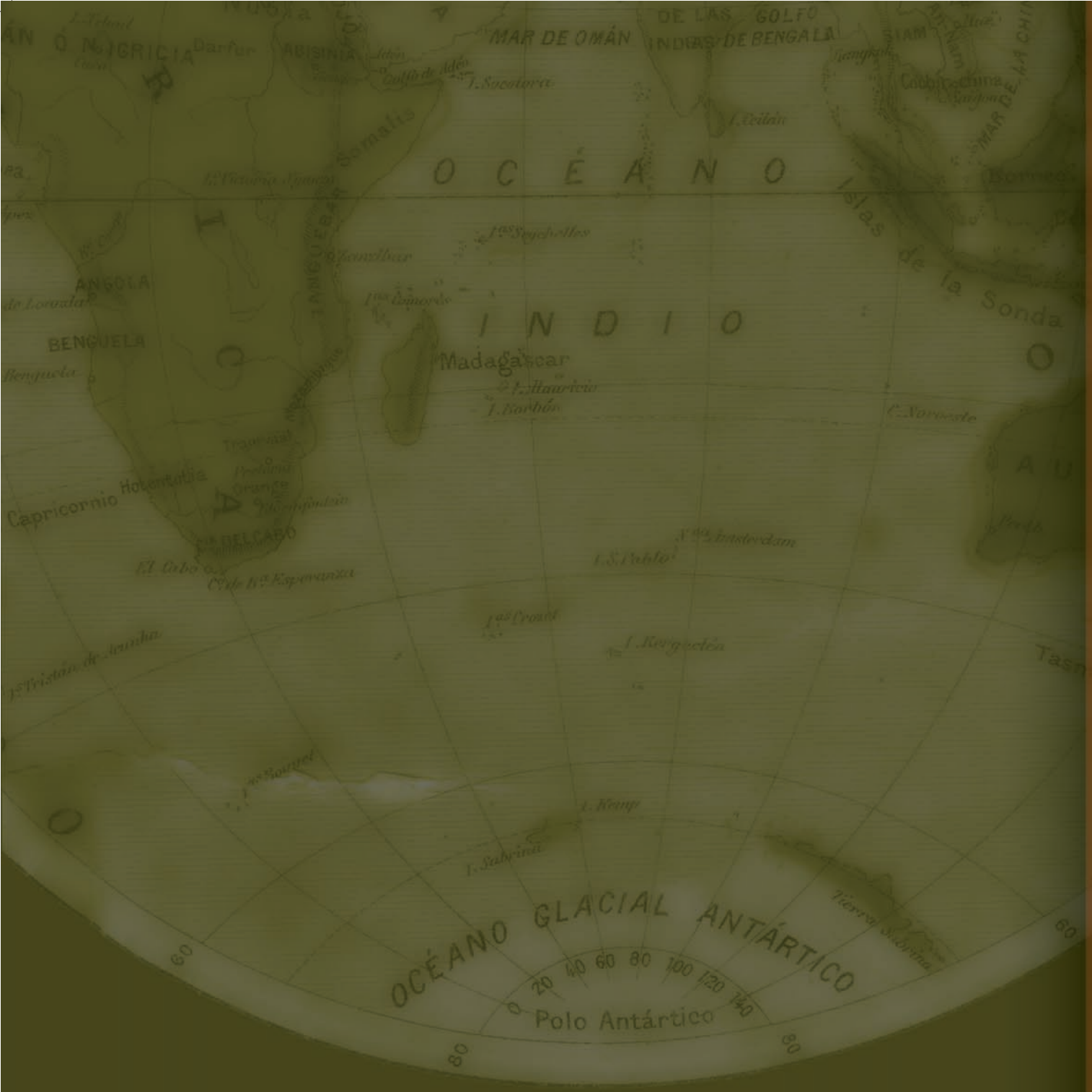
Fundación Oriéntame was founded in 1977 as a private not-for-profit organization dedicated to providing services, education, and social development programs in sexual and reproductive health, based on a public health, women's rights, and social justice perspective. Since its founding, it has particularly emphasized the prevention and comprehensive management of unwanted pregnancy, as established by law. Fundación Oriéntame currently has three clinical service points, an administrative headquarters, and a community program office, as well as a highly qualified team of professionals trained on the issue of unwanted pregnancy.

http://www.orientame.org.co

Iniciativas Sanitarias

Iniciativas Sanitarias (IS) is a Civil Society Organization of health professionals, made up of doctors, obstetricians, midwives, social workers, and psychologists, among others. IS promotes the theoretical development and exercise of sexual and reproductive rights as basic human rights. IS works to reposition health professionals towards a greater commitment to changing clinical relationships at the individual and collective levels, to contribute to improving men and women's health, as well as enacting social, cultural, and political change. IS's unique contribution was the design and implementation of a harm and risk reduction model for unsafe abortion. The goals of this model are to: reduce maternal morbidity and mortality due to abortion; reduce the need for induced abortion, particularly unsafe abortion; and position unsafe abortion as a pressing public health and social justic issue that requires a comprehensive response from health professionals and society at large.

http://www.iniciativas.org.uy



IPPF International Planned Parenthood Federation
Western Hemisphere Region

Iniciativas Sanitarias

Orientame