

Department of Maternal,
Newborn, Child and
Adolescent Health



A Handbook for Building Skills
**COUNSELLING FOR
MATERNAL AND
NEWBORN HEALTH
CARE**



World Health
Organization

A Handbook for Building Skills

COUNSELLING FOR MATERNAL AND NEWBORN HEALTH CARE



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Department of Maternal, Newborn, Child and Adolescent Health

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PART 1: INTRODUCTION	1
Session 1: Introduction to Handbook	3
PART 2: COUNSELLING	13
Session 2: Principles of counselling for maternal and newborn health	15
Session 3: Counselling skills	29
Session 4: Factors that can influence the counselling session	43
Session 5: Practical considerations in the counselling process	59
PART 3: TOPICS	71
Session 6: General care in the home during pregnancy	73
Session 7: Birth and emergency planning	83
Session 8: Danger signs in pregnancy	95
Session 9: Post-abortion care	103
Session 10: Support during labour and childbirth	113
Session 11: Postnatal care of the mother and newborn	121
Session 12: Family planning counselling	137
Session 13: Breastfeeding	149
Session 14: Women with HIV/AIDS	163
Session 15: Death and bereavement	183
Session 16: Women and violence	193
Session 17: Linking with the community	211
ASSESSMENT	221
ANNEX	225
Annex 1: Information sheets and counselling sheets from the PCPNC	

A Handbook for Building Skills

**COUNSELLING FOR
MATERNAL AND NEWBORN HEALTH CARE**

PART 1
Introduction

INTRODUCTION TO THE HANDBOOK



What is in this session?

This Handbook focuses on counselling and communicating with women, their families and communities to promote the health of mothers and newborns. When we talk about counselling in this book we are talking about counselling for maternal and newborn health specifically, and this is explored in more detail in the next session. This session provides an introduction to the Handbook. It gives an overview of the content of the Handbook and helps you understand how you can use the Handbook to develop skills in counselling for maternal and newborn health (MNH).

What am I going to learn?

By the end of this session you should be able to:

1. Describe the aims and objectives of the Handbook
2. Assess the relevance of the aims and objectives of the Handbook to your needs
3. Plan how to use the Handbook to meet your needs.

How do we define counselling in this Handbook?

Nearly everyone who uses this book will have had some experience in counselling, but this experience will vary greatly. Some people use the term counselling in the context of psycho-social counselling only, where people with emotional or psychological problems see a qualified counsellor to receive support and help. You may also be aware of other types of professional or trained counsellors such as Family Planning (FP) counsellors or Human Immunodeficiency Virus (HIV) counsellors. In this Handbook we use the term counselling in the context of maternal and newborn health.



WHAT IS COUNSELLING FOR MATERNAL AND NEWBORN HEALTH?

Counselling for maternal and newborn health is an interactive process between the skilled attendant/health worker and a woman and her family, during which information is exchanged and support is provided so that the woman and her family can make decisions, design a plan and take action to improve their health.

The goal of this Handbook is to help you as a skilled attendant (SA) to improve and further develop your counselling and communication skills for maternal and newborn health. This is in order to ensure that your interactions with women and their families go beyond merely providing them with information but also that you can support them to put this information into practice, specifically to meet their needs so that they can improve their health.

Activity 1



10 minutes



To help you reflect on your current needs and practice

Thinking about your role as a health worker may help you to clarify how you can improve the way you work. In a group or alone, write down your thoughts and answers to the following questions:

1. What are the primary objectives of your job? For example, is it to save lives? Promote health? Support the birth of babies? Ensure the efficient running of the department? Try to focus on three main objectives; the ones you think are the most important.
2. List the three biggest problems you face in achieving your main objectives.
3. What do you need to help you overcome those problems?



Our View

Each of us sees our work roles in a different way even if we are doing the same job. How we see the objective of our job depends on our personality, skills and even our outlook on life. The problems you face in trying to achieve your primary objectives will vary; they could be about needing to improve the service you provide, or about needing better resources or more time. They might be about the way you interact or the support you provide to your clients. Good counselling skills may help you achieve some of your objectives.

Improved counselling in maternal and newborn health can enable you as a health worker:

1. To better understand the needs of the women and the community to whom you provide services.
2. To support women in taking better care of themselves and their babies during pregnancy, birth and the postnatal period.
3. To support women and their families to take actions to improve maternal and newborn health which specifically meet their needs.
4. To contribute to increased confidence of women, families and the community in the health facility, services and personnel.
5. To contribute to the community's satisfaction with the health services and the care you provide.

Why was the Handbook developed?

The Maternal, Newborn, Child and Adolescent Health Department of the World Health Organization (WHO) developed a clinical guide entitled *'Pregnancy, Childbirth, Postpartum and Newborn Care: A guide for essential practice'* (PCPNC). The PCPNC covers the essential routine and emergency care of women and their newborn during pregnancy, childbirth, postnatal and post-abortion periods. This Handbook is a companion to the PCPNC and is designed to strengthen health workers' skills to counsel and communicate with women, their partners and their families about key issues and topics covered in the PCPNC. In order to work through this Handbook, it is not essential that you have the PCPNC. We have included within the different sessions the key information that you need to discuss with women and their families. In Annex 1 you will find the information and counselling sheets from the PCPNC.

How will this Handbook be useful for me?

To help you assess whether this Handbook will be useful for you, consider the aim and objectives of the Handbook:

Aim: To strengthen your skills to effectively counsel and communicate with women, their partners and families during routine and emergency care in pregnancy, childbirth, postnatal and post-abortion periods. Effective counselling will support women and their families to put information into practice so they can take action to improve their health.

Objectives:

After working through this Handbook you will be able to:

1. Understand the women and community to whom you provide your services; both the overall context in which they live as well as their specific needs.
2. Counsel and communicate more effectively with women, their partners and families during pregnancy, childbirth, postnatal and post-abortion periods.
3. Use different skills, methods and approaches to counselling in a variety of situations, with women, their partners and families in effective and appropriate ways.
4. Communicate key information on maternal and newborn health.
5. Support women, their partners and families to take actions for better health and facilitate this process.
6. Contribute to women and the communities' increased confidence and satisfaction in the services you provide.

In completing this Handbook, you will hopefully find that the advantages of improving your counselling skills help you personally, as well as the women, their husbands/partners and their families that you see. Even if you already have experience in counselling, you may find that the Handbook contains new information and knowledge that will be useful to you in your work.

How do I find my way around the Handbook?

The Handbook is divided into three parts: Part 1 of the Handbook is this introductory session designed to

provide you with an overview of the Handbook; Part 2 includes four sessions that focus on the principles of counselling and the different skills you will need for counselling in maternal and newborn health; in Part 3 you will learn how to apply the counselling skills and processes to specific topics in maternal and newborn health. Each session in Part 3 provides more detail and activities on different counselling skills applied to different maternal and newborn health topics. The skills are not unique to the topics. For example, in Session 9 the topic is 'Post-abortion care' and the skills focus includes forming an alliance with the woman. This is a key counselling skill you will use in all topics – it is just highlighted in this session as a practical way for you to further develop the skill within an MNH context. You can choose to focus on a particular skill or a particular topic or both – just remember they are interchangeable! The sessions of the Handbook follow a similar format:

What is in this session?

An overview of the session content is provided.

What skills will I develop?

This indicates the counselling skills to be developed.

What am I going to learn?

Here we state the objectives of the session. You can see what you will learn and also use this information to measure your understanding of the content and your skills in counselling for MNH.

Text:

This is the main content of the session. Headings and subheadings are used to help you find your way around.

Box:



Sometimes you will find text that is contained in a box like this. Boxes are used to summarize key information or to provide an example.

Activity:



Activities are designed to help you order your thoughts and reflect on your experiences. Some activities help you to improve your counselling skills or to facilitate sharing information or skills with your colleagues. These activities often involve practical tasks.

Our View:



This provides additional information to help you assess what you have learned through the activity.

What did I learn?



Enables you to:

- check if you have met the objectives of the session
- reflect on what you have learned and how you might use it in your work
- decide whether you are ready to move on to the next session or if you should review the material.

Can the Handbook be used in different ways?

The Handbook is designed primarily to be used by groups with a facilitator. The facilitator will take you through the sessions and will help to organize activities and assess your progress. Your facilitator may even organize additional materials, activities and discussions. However, it is also possible for groups or individuals without a facilitator to work through the Handbook. You and your programme should decide what works best for you and others, given available resources.

Whether working with a facilitator or alone, you do not need to work through the Handbook from start to finish. The Handbook is designed to be flexible for the use of people with various skills and needs. If you already have counselling skills and experience, you may want to focus on the topics in Part 3. If you are new to the field, you may prefer to work through each session. There is no right or wrong way to use the Handbook!

The Handbook provides a self-directed learning approach to counselling, which is open and flexible to meet the different needs of different users. Self-directed learning allows individual users or groups of users to work through the material at their own pace. It allows them to see how the information fits within the context of their social, cultural and working environment. All users are encouraged to critically reflect on their past and current practice to help them develop and improve their counselling skills. Information, ideas and activities are provided, but the key to self-directed learning is putting the skills and knowledge into practice in the work environment.

Role of the facilitator

Facilitators should be familiar with the content of the Handbook, and ideally have additional counselling experience. The key role of the facilitator is to review the material in the Handbook in advance, and to work out with the group how best to work through the content of the Handbook. It could be simply getting members of the group to work through the Handbook, or it could be through the use of case studies or additional material or presentations. The facilitator's role is to support the group members in seeking answers to questions and facilitate the different activities and discussions. For certain activities we have included suggestions for the facilitator about how to organize the group.

The facilitator should take time to assess what the group members' current knowledge is for each session. This can be done through a group discussion before beginning a new session. For example, during this discussion the facilitator can draw up two lists, one which lists what the group members know already, and another which identifies gaps or areas where they need more information or opportunities to build skills. These lists can also be used to measure progress and understanding by checking that the group has covered the gaps that they identified. The facilitator should try not to act solely as a knowledge resource. For example, if a group member has a question, the facilitator should see whether someone else in the group can answer or help to facilitate the group in finding the answer or reaching a conclusion.

Facilitators can add in other activities where they feel the group would benefit from more opportunities to practise and build skills. The facilitator can support group members in applying the skills to the



every day work environment by sitting in on counselling sessions with women, or discussing with the group real situations which the service has faced. The facilitator is also responsible for organizing how and when the group works. Another role for the facilitator is to work with the members in reviewing the material in the Handbook to make sure they understand it. The use of the 'What did I learn?' sections in each session can be expanded to include a brainstorm of the key points covered as well as a general discussion. This can then be measured against the objectives which were set for the session, to see what has been learned and whether all the information has been understood.

One other role that the facilitator should fulfil is one of motivation. They should encourage and support the members of the group to work through the Handbook and to help them stay on track and stay motivated to complete the activities and sessions.

Working in groups or alone

All the activities in this Handbook are designed so that you can do them in a group or alone. If a facilitator is working with you and others to go through the book, you can decide together if there are any activities which you would prefer to do alone. Primarily you should try and complete the activities in a group. If there is no facilitator and you and others decide to work together in a group, it is recommended that you have one person act as a facilitator, not just for the activities but for the whole session. You could rotate this job so that different group members take on the role of facilitator for different sessions or different activities.

Working as a group

The first job for the facilitator is to help you decide how and when you will work together as a group. You may find that you gain more from the activity if you work with others as you share ideas, thoughts, skills and experience: your facilitator will help you in this sharing process. You will also

benefit from shared motivation and support from both your facilitator and the other group members. The disadvantage of working in a group is that you may be rushed or held back by other people, or you may find it difficult to make a time convenient for you all. By being aware of the possible disadvantages in advance you can try to plan for them and work out with the facilitator how you can get around them.

Working on your own

If it is not possible to work in a group with a facilitator then you can still use the Handbook on your own. There are some advantages in working on your own. As you can go at your own pace, you will not be rushed or held back by others. You can also focus on the areas most relevant to your needs. The disadvantage is that you cannot learn and share from other people's experience, knowledge and skills. You cannot share the workload or practise the role-plays! You may also have less support and motivation to work through the book. Think about these disadvantages now and make some notes about possible ways to get around them.

Motivation and support

Your facilitator will help to motivate the group members to work through the book together. However, it is important to motivate yourself to work through the Handbook (even if you have a facilitator). One way to motivate yourself is to think about the benefits to you personally and to your work (think back to Activity 1). There may be other important motivators such as expanding your skills, or improving your career development.

Your facilitator will also help you to think about what support you need to work through this Handbook. You may need support for motivation and encouragement, or you may need support to help you reorganize your time or duties. Raise these issues with your facilitator and work together to identify possible solutions. For those working in groups, your facilitator may provide all the personal support you need, or you may need additional personal support from your supervisor or colleagues. From time to time, as a group, and individually, review whether your support needs are continuing to be met.

If you are working on your own, consider trying to identify someone to act as a supervisor or mentor who can provide advice and guidance. Ideally this person should have experience in the subject area. You might consider your supervisor or another team member or even someone from another discipline who has counselling skills such as a social worker or specialist counsellor.

What other resources do you need?

- reading materials
- other reference materials on MNH like the PCNPC
- paper and pens
- flipcharts or board
- anything else?

Keeping a notebook

You may find it useful to make notes as you work through the Handbook. These will provide a record of the work you have done to which you can refer later. It is useful to keep your notes in one place, preferably in a notebook or loose-leaf file. These notes can be used in many ways, for example:

- to record the work you do for the activities
- to record your thoughts and ideas as you work through the Handbook or as you counsel women and their families
- to record case studies of women you counsel
- to record feedback from women, their partners and families on your counselling
- to record feedback from colleagues or your facilitator on your counselling
- to record questions that you want to ask your colleagues or mentor
- to record your feelings or emotions; particularly when you have been counselling in a difficult situation or facing a difficult problem.

Finally you can use your notebook to answer the questions from the “What did I learn?” sections at the end of each session, and from the progress checks and self-assessment at the end of the Handbook.

You may wish to take some time now to organize your notebook before you continue working through the Handbook. Consider adding in any notes or questions that you have thought of so far, and then continue to use this notebook for the rest of this and subsequent sessions.

Activity 2



20 minutes



Aim To help you familiarize yourself with the Handbook and the counselling skills covered

Taking some time to look through the Handbook now will help you to see how the knowledge and skills you already have can be further developed. Write down in your notebook your thoughts in response to the following:

Note to facilitator: group members can focus on different sections of the Handbook or you can get the whole group to do every session. Get the group to discuss their thoughts and use this as a basis for planning together how you will work as a group.

1. Look at each session of the Handbook. Focus on the sections “What is in this session?”, “What am I going to learn?” and “What skills will I develop?”
2. Write down the name and number of those sessions that will be most useful to you and the reason why you think they will be most useful.
3. Make a list of the skills you are most keen to develop.

Activity 2 continued...**Our View**

This activity should have helped you to be more familiar with the content of the Handbook and be more focused about how it can best be used to meet your needs and develop your counselling skills. Refer back to the skills you have listed here in your notebook from time to time to see if the Handbook is helping you to develop them.

What did I learn?

In this session you have reviewed the aim and objectives of the Handbook and you have familiarized yourself with the layout and content of the Handbook. Use the following questions to help you reflect on what you have covered.

- What is this Handbook about?
- Why do I want to work through this Handbook?
- What are my expectations for using this Handbook?
- Which sessions am I going to concentrate on using?
- How will I work through the Handbook with my group and my facilitator? Or how will I work through the Handbook on my own?
- Do I need to ask someone to be a supervisor or mentor to help me improve my counselling or to provide me with additional support?
- What resources do I need?
- What else do I need to do or prepare before I am ready to move on to the next session?

Write down your thoughts in your notebook so that you can find them easily. You may find it useful to review them from time to time to keep you focused and motivated.

A Handbook for Building Skills

**COUNSELLING FOR
MATERNAL AND NEWBORN HEALTH CARE**

PART 2
Counselling

PRINCIPLES OF COUNSELLING FOR MATERNAL AND NEWBORN HEALTH



What is in this session?

This session provides an overview of the process of counselling for maternal and newborn health and looks at the six key steps of this process. It also explores the guiding principles which lay the foundation for improved counselling for MNH.



REMINDER:

Counselling is used in many different ways. In this Handbook we define counselling for maternal and newborn health as an interactive process between the skilled attendant/health worker and a woman and her family during which information is exchanged and support is provided so that the woman and her family can make decisions, design a plan and take action to improve their health.

What am I going to learn?

By the end of this session you should be able to:

1. Understand your current knowledge about counselling
2. Define and describe the counselling process
3. Outline the guiding principles of good counselling

What do I already know about counselling for maternal and newborn health?

Activity 1



30 minutes



Aim

An opportunity to reflect on your experience of counselling in MNH

Even if you have no formal training in counselling for MNH, you probably have experience of counselling in your work. Thinking about your past experience will help to re-orient and re-familiarize yourself with the topic.

Note to facilitator: Get group members to carry out this activity alone before discussing findings as a group.

1. What does the word 'counselling' mean to you? Write down some key words that come to mind when you hear the word counselling.

Activity 1 continued...

1. Look at the words you have written. Use them to come up with some examples of counselling in MNH that you have done already.

**Our View**

If we refer to the definition of counselling for MNH on the previous page we come up with a number of key words. “Counselling for maternal and newborn health is an *interactive process* between the skilled attendant/health worker and a woman and her family during which *information is exchanged* and *support is provided* so that the woman and her family can *make decisions, design a plan* and *take action* to improve their health.”

The words in italics are some of the key words that we drew out of our definition. Did you come up with similar words or similar concepts? If you did not, take some time to reflect on the definition we have and discuss this with others in your group. Consider why the definitions are different. As you look through the key words you can probably remember times where you have listened, or shared information, supported or helped women and their families make decisions and take action. At the very least you will have provided the woman with information. All these are part of counselling for MNH.

This Handbook will help you build on what you already know and your experience to help you improve your maternal and newborn health counselling skills.

The Counselling process

The diagram on the next page provides an overview of the counselling process. The main focus of this Handbook is for you to follow the counselling process (the top semi-circle), but to do this you need to understand the counselling context (the outer circle), the guiding principles and counselling skills (the bottom semi-circle). The counselling process takes place within a counselling context, which is why the counselling context is in the outer circle. It is important to be familiar with the context as this will give you guidance on how to act, what is appropriate and the situation, culture and norms of the women and families you are counselling. There are a number of guiding principles which support the counselling process. You need to adopt these guiding principles to strengthen your counselling skills. By focusing on the guiding principles and the counselling skills you will be able to improve your counselling for MNH skills, and follow the counselling process.

In this session we will provide more detail on the key steps of the process and principles which support good counselling. We will work with you throughout the Handbook to review in more detail these skills and to help you to better understand the context within which you provide counselling.



This diagram will be used at the start of every session in Part 3 of the Handbook. It will always have the 6 key steps of the counselling process outlined to help you remember what they are. Under the other headings (Guiding Principles and Counselling Skills) only the points which are being focused on in that session will be highlighted in the diagram. This way a quick preview of the diagram at the start of each session will help you see which areas of counselling for MNH the session is going to focus on.

How familiar are you already with the six steps in the counselling process? You may already be carrying out all or some of these steps, or perhaps this process for counselling for MNH is new to you.



KEY STEPS

The box below provides more information on the six key steps of the counselling process:

1. Assess the situation – engage the woman in interactive discussion. Ask questions to better understand the situation of the woman and her individual needs. You need to clarify what the situation is, and if it poses a problem and for whom (the woman, her partner, family, community, health worker etc.).
2. Define problems, needs and information gaps – review with the woman what it is about her situation that prevents her and her family from addressing her needs or those of her newborn. What makes the situation a problem, what are the causes of the problem? What does the woman know already – does she need additional information?
3. Generate alternative solutions – review with the woman or couple how she/they and the family can better address their needs by looking at what is currently being done, and what else could be done. Identify what other information, resources or support is needed.
4. Prioritize solutions – by reviewing the advantages and disadvantages of the various alternatives, work out with the woman which of the alternatives are most feasible to address the problem and/or meet the woman's and family's needs. Assist the woman or couple to work out how to overcome potential disadvantages.
5. Develop a plan – make a plan together, including how to discuss the problem and solution with her partner and with others in the household.
6. Review and evaluate – in subsequent counselling sessions review implementation of the plan with the woman. Is the plan working or should another alternative be sought?

Activity 2



40 minutes



To help you become more familiar with the six key steps in counselling for maternal and newborn health.

For this activity we are not going to use an MNH topic because the aim is to help you become more familiar with the process, and to assess why we carry out these six steps as part of the process. The activity you will carry out is to make some tea or other drink or snack. Two people will make the drink/snack. It sounds simple but, one of these people will have to wear a blindfold so they cannot see and the other will have their hands tied behind their back.

Activity 2 continued...

Note: If you are working alone you will need to find two people at work or home who will make the drink.

- Now work through the six steps of the counselling process. First assess the situation. You have to start a discussion with the two drink makers. What is it like for them to have their hands tied or not to see? How does it make them feel? It is important to get their perspective, and not just anticipate what you think it might be like. They may tell you something you have not seen or thought of. How are their needs different?
- Define problems, needs and information gaps. Do they know how to make the drink? Do they have all the things they need to make it? What aspects of making the drink are problematic for them? How is it different for each person?
- Generate alternative solutions. Can the two drink makers manage on their own to make the drink or do they need help from you? If so, what help? Can they work together? What options do they have? For example, the one with the hands tied could give directions to the one who is blindfolded. Will they be able to do the whole process themselves? Will they need additional help from you, e.g. when pouring the drink?
- Prioritize the solutions. Decide which of the alternatives that you came up with best meets the drink maker's needs. Do this by asking them which they are most comfortable with? Will they need to try more than one approach? Do not take the decision for them!
- Make a plan together. Work out all the different tasks that need to be done to make the drink or snack. Break them down into small parts. Go through each stage with them. Then support them as they carry out the task of preparing or making the snack/drink.
- Review and evaluate. Ask for feedback from the people who made the drink? How did they find the process? If they were to repeat the task, what would they do differently? Or how could it be improved? Do they need any additional support or help? Were they confident before making the drink that they could do it?
- As a group discuss the activity. Who was in control? Who made the decisions? Get feedback from the two drink makers as to how they felt about the way you facilitated the process.

Our View

Although this seemed like a simple task to complete, each of the people making the drink/snack had particular needs which were different. They probably had different needs in terms of the support, advice and help that they required or even the information they needed. Did you encourage and allow them to participate as much as they wanted to in the process? Or was control taken away from them? What could have been done differently or improved upon?

This activity was also trying to demonstrate to you the importance of facilitation in the counselling process. As a counsellor you should be facilitating the process, but you should not be taking control or carrying out the task or decisions for the person you are counselling. Consider how you raise a child. At first with a newborn baby, you have to meet all their needs. As they grow and develop new skills and knowledge you can reduce the amount that you do. What would happen if you continued to do everything for them? If we take control, then we do not share knowledge or skills, and the child cannot learn how to act for him or herself. The same is true in counselling. We need to provide support in assessing the specific needs of the person we are working with, we have to support them to assess the skills and knowledge they already have and then work with them to come up with options they could use to solve their problems. We can give support and guidance but we cannot make the decisions for them.

The guiding principles of counselling for maternal and newborn health

As previously discussed, there are a number of guiding principles which underpin the six key steps in the counselling process. In order to be able to effectively utilize these six steps you need to understand the foundation. We call this foundation on which the key steps in the counselling process are based, the guiding principles. If you follow these principles it will help you to put the six steps into action more effectively. In addition, an understanding of these principles is needed before you can begin to strengthen your counselling skills.

Self-reflection

It is important to think about your own attitudes, beliefs and values and how these might impact on the way you interact with people or the service you provide. For example, your religious or social beliefs might lead you to treat some women differently or unfairly if you do not agree with how they live their lives. The pressure of work or the home or frustration with certain situations might lead you to be rude or aggressive (either verbally or physically) towards women, their partners or families. Taking time to understand yourself and your emotions, beliefs and attitudes is very important if you are to be able to understand the people that you will counsel.

At the end of each session of this Handbook in the 'What did I learn?' section, there are questions to help you practise self-reflection. You can also use your notebook to write down different experiences and reflect on your feelings, beliefs and attitudes when counselling women and their families.



**REMINDER:**

Self-reflection is about being aware of who you are and analysing how your thoughts, attitudes and beliefs might influence the way you support, communicate and counsel women and their families. It is about knowing your own limitations and what you are usually most comfortable with. You need to critically reflect on who you are and how you act and the impact this may have on others. Decide whether you need to change and what you can change.

Empathy and respect

Counselling for MNH relies on you respecting the knowledge and skills of the person you are counselling and understanding the situation from their point of view, and empathizing with them. Empathy means trying to understand the situation the woman or family is in and how this may be affecting them; this is why understanding the context in which counselling takes place is so important. For example, a woman may tell you she can not make a decision about staying in the health facility until she gets permission from her husband and mother-in-law. You may not agree with this, but by empathizing with her you can support her to get the permission she needs.

Respect is about valuing peoples' knowledge and decisions, and treating them with regard and esteem. It can be helpful to think about treating people in the same way as you would like to be treated if you were in the same situation. If people are treated with respect, courtesy and friendliness, they are more likely to be satisfied with the services offered to them. They will also be more likely to participate in the counselling process and in return, value the skills that you have.

Respecting someone also means maintaining a non-judgemental attitude. In other words even if you do not agree with the actions a woman is taking or has taken you should treat her with respect and not condemn her or tell her she is wrong.

Respect also involves maintaining the confidentiality of the woman. This means that you should not talk about private or personal issues where you can be overheard. You should make sure she cannot be seen by other people when you examine her, and you should make sure that her notes are kept safely where they cannot be seen by others. You need to find out who she wants to share information with before you disclose information about her.

**REMINDER:**

All staff should treat people well, not just those involved in treatment and counselling. For example, the receptionist, the cleaning staff and even the guard must all be trained to respect women and their families.

Encouraging interaction

Encouraging interaction is about engaging the woman in discussion. Good counselling requires an interactive process, which allows for the two-way sharing and exchange of information and for involving and engaging the woman to participate in the session. It also means being able to debate, argue, clarify and discuss issues.

How can you encourage interaction in the counselling process?

- Get to know the woman's situation; encourage her to tell her story.
- Allow time for the woman to think about and answer your questions.
- Encourage questions from her.
- Review information together.
- Be friendly and non-judgemental.
- Ask questions so that you can better understand her situation and needs.

Do you have some other ideas to add?

Building on current knowledge and skills

In any interaction with a woman or her family you need to assess their current knowledge and skills before providing any further information, advice or skills building. Research has shown us that people learn best when they can build upon what they already know and understand. This is not a passive process, you have to allow them to question, discuss and integrate new ideas with their existing knowledge base. Together you can create 'new knowledge', by this we mean discussing what the woman knows, presenting any new knowledge you may have that may differ, allowing her to question and analyse the differences. Out of this discussion you will have a combination of the information you both have – each will have learned from the other. She may not agree with all you have to say and she may choose not to accept some of what you discuss. She may need more time to reflect on the discussion and how her knowledge has changed. What is important is not only to discuss knowledge but also to make sure that she can apply the information to her context or situation.

Shared problem-solving

There are many problems to be solved and decisions to be made by a woman, her partner and family and even by the broader community in relation to MNH. When counselling is done well, you work as a facilitator to help the woman clarify her needs, identify possible solutions, take decisions and make an action plan. You do not dictate, direct or impose solutions on her.

As we talked above about developing new shared knowledge, shared problem-solving is about exploring a range of options with a woman and her partner or family as part of the counselling process. An example of shared problem-solving might include you coming up with some possible solutions and the woman or couple coming up with some of their own. Together you can go through each of the solutions one by one looking at the advantages and disadvantages. You may need to provide more information at this point and equally they will provide you with information about their personal needs and situation which will affect their options. You can support them in arriving at a solution which is the most acceptable to them.

Sharing the problem-solving process with the woman and her family and facilitating the decision-making process may be a new way of working for you. Clinical practice and health care is often directive, and normally women are expected to comply with decisions and advice that the health worker provides for them. Many women will even expect that from you. But working in this way does not contribute to the development of their skills or knowledge to improve MNH; nor is it likely that they will implement the decisions you have made for them. When a woman and her family participate in finding the solutions, it is more likely that they will follow the plan you develop together. It can help them feel they have more control over their own choices and decisions, and can also help them to see how they can change the direction of their lives by taking increased control and responsibility for decisions and consequences.

Tailoring to her specific needs

Counselling is not something, like immunization, that can be done in the same way for everyone. You cannot ask the same questions and expect the same answers or the same point of view. Each woman you are counselling has to be treated on an individual basis. Each woman, couple or family has different personal situations, beliefs, expectations and needs. They also have different knowledge and skills. Think back to the different needs that the two people in Activity 2 had, even though they were involved in the same task.

In order for your session to be effective, you need to provide information which is relevant to their specific situation and discuss pertinent alternatives and preferences. Some women have special needs which require additional time and input in the counselling process.



There are many different groups of women with special needs.

Women with special needs

Within every community that you work with there are women who have special needs. Special needs can range from illness and disability, to women living on their own or in extreme poverty, or to adolescents. It is difficult to characterise someone with special needs; some women may cope better in particular circumstances than others. When you counsel women and explore the context of their lives, it will help you to understand their mental and emotional health in addition to any physical problems they may have. The purpose of counselling is to identify whether the woman needs additional support and care.



REMINDER:

A special need refers to the additional requirements that women may have in order to address their emotional and physical well-being.

While you are dealing with a woman who has special needs it is important to demonstrate your support and willingness to listen to her. Her special needs are part of her everyday life and experience and cannot be avoided in the counselling interaction. It may be that you need to refer her for specialist counselling, but while you are waiting to do this, or if there is no one for you to refer her to, your interaction with her can be extremely important in helping her take decisions regarding her pregnancy, birth and during the postpartum period. Women with special needs may often need additional time and sessions for counselling.

There are many different groups of women with special needs. There is not enough room in the Handbook to explore all these groups. Women living with violence and women who are HIV-positive are two groups of women with special needs who are looked at in more depth in Part 3 of the Handbook. Two other groups of women that you may come across are women with disabilities and adolescents.

Women with disabilities

Women with disabilities are often discriminated against. Their problems are often compounded because they tend to be poor. One problem which they face is low self-esteem. Women with disabilities are often thought of as being worthless and not able to contribute anything to the community. It is important to assess women with disabilities early on in pregnancy to identify any potential problems arising from their disability. Work with each woman to assess her problems and the potential solutions on an individual basis or with her family if she desires. It is especially important to support women with disabilities to solve their own problems as part of the process of raising their self-esteem and encouraging them to take more control over their own lives. Encourage them to focus on what they can do, not what they cannot do. Try to remember that women with disabilities also need counselling around sexuality issues. They may be shy about discussing such things and will need special support.

Special needs of adolescents

Adolescents are a special group because although they may be sexually mature and sexually active they may still be developing emotionally. This is a particularly important group because many adolescents in your community will be sexually active and may already be mothers. Adolescents are more likely to perceive attitudes of health care providers to be threatening and thus they will be reluctant to come to you for care. They may also be concerned about confidentiality especially if you are in a small community. They will need extra reassurance to feel more comfortable in a counselling environment.

Adolescents are often embarrassed to discuss issues relating to sexual health (even if they are sexually active). You need to help them feel comfortable and encourage questions. The emotions that adolescents may experience (embarrassment, fear, and anxiety) are often expressed in different ways. For example, they may giggle, or they may be aggressive or non-communicative. You can help overcome these difficulties by focusing on the self-esteem of the adolescent. By treating them with respect and assuring confidentiality they may feel more comfortable with the situation.

Some health workers show their disapproval of adolescents being sexually active when an adolescent attends antenatal care. This may be related to a community's disapproval of sexual activity among adolescents. This may result in the health care providers not giving adolescents adequate counselling so as not to acknowledge or suggest approval of their sexual activity. Sadly this may mean that the adolescent girl never learns more about preventing sexually transmitted infections (STIs) or avoiding unplanned pregnancy. By taking some time to self-reflect (one of the guiding principles) on how you feel about adolescents being sexually active, you may be able to gain some insight into your own attitudes. You can then consider ways in which you can be more open to discussing sexuality issues with adolescents, in such a way that they are provided with support and given information which helps them to take decisions to improve their health.

Women living with violence

Violence against women by their intimate partners affects women's physical and mental health including reproductive health. Violence does not just cause physical injury but can cause low self-esteem, anxiety, mental health problems, destructive behaviour such as alcohol or drug use, and sexual health problems (STIs, unwanted pregnancy and fear of sex). Session 16 covers in more detail issues affecting women who experience intimate partner violence.

Women who are infected with HIV

Women who are infected with HIV and who know their status have special counselling needs. Many women find out about their status during the course of antenatal care. On the practical side they need to know how to care for themselves and how to maintain good health with advice on diet and rest. They also need information on how to prevent transmission of HIV to their baby and safe infant feeding practices (see Sessions 14 and 13). They may also need information to avoid infecting their partner and to prevent re-infection with HIV. In addition they will need emotional support to help them cope with living with an illness for which there is considerable stigma and discrimination. They may also need support and advice about disclosing their status. Session 14 covers many of these issues affecting women with HIV.

What did I learn?



There was a lot of information in this session which helped you to examine the key steps and principles of counselling as defined in this Handbook. Take a minute to think about the content of this session and how much you have understood. Does this information differ from information you had previously about counselling?

The following questions may help this process of reflection:

- How would you define counselling for MNH? What do you think of our definition?
- Could you explain counselling for MNH to someone else?
- What are the six key steps in counselling?
- What are some of the guiding principles of counselling?
- How many of the principles were you already familiar with?
- How many of these principles do you already practise?
- Which will be difficult to put into practice? How will you address these difficulties?

In summary, counselling for MNH is about facilitating the provision of information, advice and support to help people (women, their families and communities) to make their own decisions and take the actions needed to improve the health of the woman and the newborn—counselling is not about persuading or obliging people to act in certain ways!

If you feel that you have an understanding of counselling as it is used in this Handbook, then you are ready to move on to looking at some of the key skills of counselling for MNH that you need to develop or build upon.

COUNSELLING SKILLS



What is in this session?

This section of the Handbook briefly describes the key skills that are needed for counselling in MNH:

- two-way communication
- forming an alliance
- active listening
- open questioning
- providing information
- facilitation.

In Part 3 of this Handbook, the different sessions will provide more practical information on each of the skills in the context of a maternal and newborn health topic, and provide you with activities so you can strengthen your skills. As you read through this section, you will notice that the different skills are linked to each other and also linked to the principles that you learned about in the last session.

What am I going to learn?

By the end of this session you should be able to:

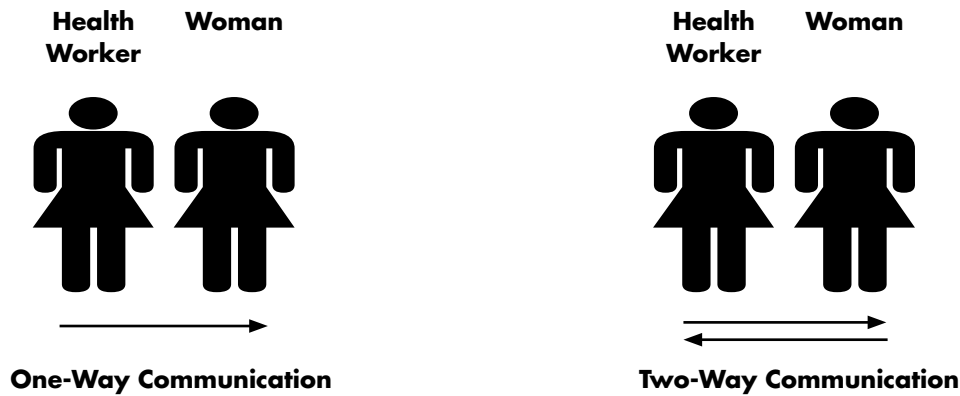
1. Describe the key skills of counselling for maternal and newborn health
2. Outline the elements of each of these skills
3. Make a plan of how to put these skills into practice.

Two-way communication

Good communication is central to good counselling. Many of the principles of counselling that you looked at in the last session are actually part of a foundation for good communication. Similarly if you refer back to the diagram in Session 2 page 18 you will see under counselling skills that active listening, open questioning, providing information and facilitation are all elements of effective communication. Before examining these in more depth we want to explore some general points about good communication, and to stress the importance of two-way communication.

Communication involves the exchange of information and is most productive when it is a two-way process which offers an opportunity for each of the parties involved to clarify issues, provide feedback and discuss topics. This is particularly true where you have to provide complex information, or have to have a sensitive discussion. In these cases two-way communication and interaction is needed. It is not enough to simply provide the woman with information or give instructions.

Effective communication is essential to good counselling, but we can make an important distinction between one-way and two-way communication (see diagram). For example, there are times in MNH when we simply provide and discuss information with the woman, such as what to bring to the

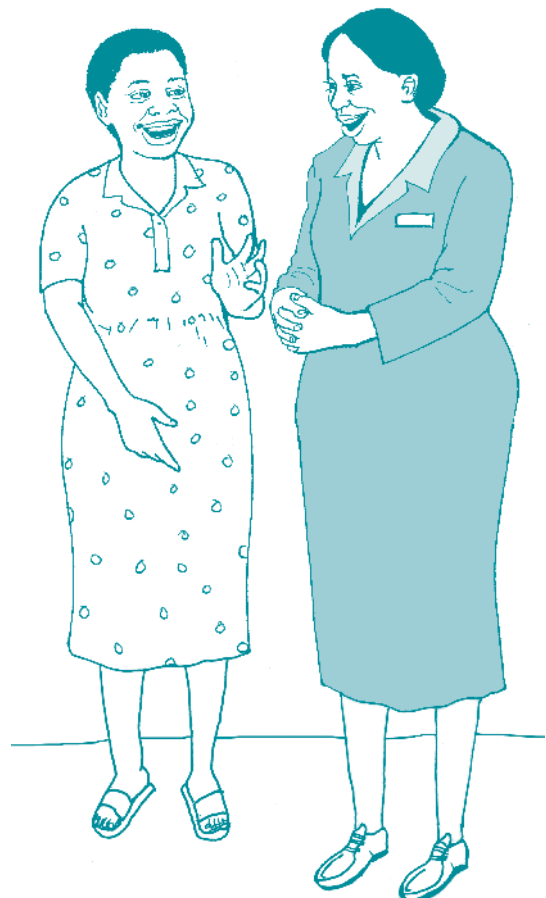


hospital for the birth. This is an example of one-way communication. However, when we want to support women and their families to apply and use this information, then we are involved in the process of counselling, for example, facilitating the decision as to where to give birth, and thinking about how to get there through a two-way discussion of options.

Many of the skills we discuss for good counselling are also important to good communication. This includes not just the language we use; it also involves gestures and body language, active listening and the demonstration of warmth and care. So it is important to be aware of the non-verbal messages we send (such as showing respect) not only through our words, but also through our gestures and our body language.

Forming an alliance

The counsellor's first communication task is to build an alliance, or a partnership, with the woman and, if present, her partner or family. This alliance serves as the foundation that encourages the woman to actively participate in the session. It is important that the woman knows that you are here to support her and that you have her best interest in mind. Applying the principles presented in Session 2 will help to establish the trusting and caring environment needed for her to feel that she can enter into this alliance. In a trusting and caring environment the woman is more likely to be at ease to talk about her situation and needs, and to discuss sensitive topics.



Forming an alliance allows for the two-way sharing and exchange of information.

**REMINDER:**

You can help form an alliance with a woman by identifying similarities between yourselves e.g. in terms of age, in parity, where you come from or likes and dislikes. By starting your interaction by sharing information about one another you help to put the woman at ease and engage her in interactive discussion on topics she is comfortable with. This will help her to be more relaxed when you enter your counselling discussion about her problems and needs; and will help her to ask you questions, and to share her important information with you.

Demonstrating active listening

Listening is more than just hearing someone else's words; it involves being attentive and demonstrating that you have heard and understood what is being communicated to you.

Demonstrating that you really are listening will increase the woman's trust and confidence in you as a counsellor, and will make her feel more at ease thus helping to form an alliance. Demonstrating that you have heard and understood what has been said to you can be done by paraphrasing, whereby you repeat back what has been said to you using different words. Consider this example:

Woman: "My husband does not approve of the use of family planning methods. He gets very angry whenever they are mentioned."

Health worker: "And here we are discussing contraceptive methods. I can imagine that you must be concerned about how you can talk to your husband about this."

The next step will then be to work with her to identify possible options and solutions for the woman to communicate with her husband. As said above, it is important the counsellor does not tell the woman how to solve the problem or suggest solutions for her, but together through a process of facilitation and two-way communication they should try and arrive at the best solution for the woman. The counsellor can then support the woman to carry out this solution.

Body language and gestures are also an important part of active listening. Non-verbal cues may encourage or deter the woman from sharing important information with you.

**RESULTS OF ONE STUDY**

"What is the most important factor in effective communication?"

- Body language 58%
- Tone of voice 35%
- Words used 7%

Source: Population Council. *A client-centered approach to reproductive health. A trainer's manual.* Islamabad, Pakistan, 2005.



Be aware of your body language and remember to make eye contact.

How can you show active listening?

- Reduce distractions by switching off telephones and closing doors and windows
- Make sure everyone is seated as comfortably as possible, and at the same level
- If appropriate, look at the woman as you talk
- Use a warm tone of voice
- Use gestures and body language such as nodding your head and smiling
- Use verbal affirmation such as saying 'yes', 'ok', 'I see'
- Ask questions pertinent to what she has told you to clarify your understanding
- Repeat back (paraphrase) what she has said to you
- Summarize key points of the discussion.

Activity 1



40 minutes

Aim

To help you improve your active listening skills.

If you are working alone, you will need to find two other people to help you with this activity. In your group organize yourselves into groups of three – a counsellor, a woman and an observer.

1. The person playing the woman should take five minutes to make up a situation about a maternal and newborn health problem. For example, a pregnant woman who wants to give birth with a skilled attendant but her family insists she give birth at home unattended, as they have done for many generations. Write down some notes to help you remember your story.

Activity 1 continued...

2. Two of you should play the role of the counsellor and the woman with the observer watching. If you are playing the counsellor try and show active listening skills through the use of body language, gestures, sounds and repeating back what has been said to you.
3. The observer should try and look for two or three examples of things the counsellor did which demonstrated active listening (use the list on the previous page). The observer should provide comments on any aspects the counsellor could improve upon. For example, did the counsellor's body language match their verbal language? Was the woman allowed to reach her own decisions or was she told what to do? Did the woman have the freedom to explore her feelings or did the counsellor block this in any way?
4. The woman should also describe how she felt during the role-play. Did she feel relaxed and comfortable expressing her opinions? Was she encouraged to ask questions? Did she feel involved in the decision-making process?
5. Change roles (and the story for the role-play) so that you each have a turn in each role.

**Our View**

You were probably very aware of showing that you were listening and so you were focused on what was being said to you. Do you normally listen this well? Keep practising your active listening skills so that they become more natural and easy to do.

Asking questions

Many of the skills and principles of counselling depend on your skill in asking questions. This is not as easy as it may seem. There are many different types of questions and ways to ask questions so that you do not make the woman feel uncomfortable. We will discuss four types of questioning that are helpful, and one that should be avoided.

Often in counselling we use open-ended questions, such as 'How have you been feeling since the birth?', 'Tell me about your last pregnancy', 'What happened when you tried to discuss going to the health facility?' Open-ended questions are ones which can have many possible answers. They are useful when you are trying to encourage the woman to talk about her situation and to explore her emotions, feelings, beliefs, attitudes, knowledge and specific needs. Open-ended questions will also help you acquire more information about her situation, about decisions she has made and help you to get feedback from her as to how she feels about the services you are providing. These can be used at any time during the interview but are often very helpful when used early on to gather as much information as possible.

Closed questions such as 'How old are you?' or 'Are you married?' are questions where there is a definitive answer such as 'yes' or 'no'. Sometimes they are useful in counselling to get information about the woman's situation, her medical history for example, or to ascertain whether you have been understood. As a general rule, in counselling you will tend to use open ended-questions far more than closed questions.

Sometimes if people are hesitant to respond to the questions you ask, you need to think of prompts or ways to encourage them to open up to you. Many women are not used to a health worker listening to them or wanting to know more about their situation. For example, if you asked a woman 'How have you been since the baby was born?' and she does not answer or says 'fine', you could prompt by saying 'How are you coping?' or 'Are you getting some help from others?'

Indirect questions are often asked to cover sensitive subject matters, such as domestic abuse, or issues related to abortion. For example: "How did you receive this bruise?"

Suggestive questions should not be used in a counselling context, as these lead or force the woman or her family into an answer they may not have ordinarily given you. Examples are: "Was it your husband who told you not to come to the health centre today?" or "Did your husband hit you?" You may have even experienced this type of questioning yourself.

It is equally important to make sure that you ask questions in a non-judgemental way, which is supportive. Consider the examples below. Can you see that health worker B is more supportive and non-judgemental?

A: Health Worker: "Why didn't you come to the antenatal clinic as soon as you knew you were pregnant?"

B: Health Worker: "It is good that you have come to the antenatal clinic now. Is there any reason why you were not able to come before?"

Asking questions fulfils a number of roles:

- It identifies what is already known and reveals any information gaps.
- It identifies specific needs.
- It explores a particular situation/context including attitudes and beliefs.
- It generates discussions and options for problem-solving.
- It helps to understand the reasons behind decisions or actions.

Providing information

As a health worker you need to provide clear and understandable information, pertinent to the woman, her family and their situation. Often, health workers routinely - because they are busy - provide the same information in the same way to all the women they see. There may not be time to allow the women to ask questions. Much of the information is then unused by the women, because they do not understand or it does not correspond to their needs.

The more complex, difficult or unknown the subject, the more important it is to provide simple and appropriate information. This allows the woman to ask questions to clarify, and share her thoughts, so that then the woman with her family can take the decisions. Remember, with good questioning skills you can find out what is already known so you only need to provide additional and relevant information. You can also find out about beliefs and any misconceptions and explain why they may be wrong as well as discuss different ideas. You should also use your questioning skills to make sure that the information you provide is culturally appropriate, and relevant to the situation and context of her life.

Finally, it is important to make sure that the information you provide has been understood. You can ask if there is anything that needs further explanation or clarification, or sometimes you may wish to ask the woman to repeat back in her own words what has been discussed.



AN EXAMPLE OF HOW TO PROVIDE INFORMATION AND MAKE SURE IT HAS BEEN UNDERSTOOD.

- Health Worker: Do you know how to take care for yourself in pregnancy?
 Woman: Yes, I should rest more and eat more food.
 Health Worker: You are right, that you should rest more, and that you may need to eat more food, but you should also try to eat more of certain foods than others. Do you know what foods they are?
 Woman: Vegetables, meat.....
 Health Worker: Yes try to eat more meat and vegetables. But also try to make sure you have fruits, beans, fish, eggs, cheese, and milk. Do you know why we recommend you eat these foods?
 Woman: To make the baby strong
 Health Worker: Yes, they will help the baby to grow and keep you healthy during your pregnancy. Is there anything else you want to ask me about what you should be eating?

Facilitation

Facilitation is the word we give to the process of assisting problem-solving. Facilitation is about assisting women and their families to find their own solutions, as well as supporting them to take the action they need. Facilitation is something that you will do in differing amounts depending on the knowledge and skills of the woman and her family (think back to Activity 2 in Session 2 where you facilitated the process of making the drinks). For example, for some women, the situation they are in can affect their problem-solving capacity and they may need a lot of help from you to facilitate generating alternatives and finding a solution, whereas others may be clear about what they need to do and just need your support. Your skill is in assessing how much facilitation is needed by an individual, couple or family, and in what areas.

Learning when to stay back and when to offer help is an important counselling skill and is crucial to the process of supporting a woman in making decisions and taking actions. It is important not to force people into a particular problem-solving approach or to provide them with solutions that are not appropriate for their needs. You facilitate a process in which the woman, couple or family explore all the options that are open to them; then you continue to facilitate the decision-making process by helping them assess the advantages and disadvantages of the options for their situation and needs.

Remember, in a counselling situation, if you make decisions for a woman then responsibility and control is taken away from her and it may lead to greater dependency and feelings of inadequacy. It is important that a woman is provided with the opportunity to think out her situation and try to resolve her needs or those of her newborn. Often, to do this she will need to go home and discuss with her family and friends, before making a final decision or plan which she can then act on.

One way to facilitate is to ask the woman, couple or family to list all the possible solutions that they have identified. If you can think of others, you might suggest them to be added to the list of alternatives, but do not push your ideas too strongly. Then explore each alternative one by one. Get them to think about the advantages and disadvantages – if appropriate you could even write this list out for them. Ask questions to help them explore if there are any ways around the disadvantages. Keep summarizing what they have discussed and feed this back to them so they can keep track of where they are. Once they reach a decision, you can follow a similar process to help facilitate a plan of action to carry out the decision.

Putting the methods into practice

You should now have a basic understanding of the different counselling skills. Take some time to think about those which you particularly wish to strengthen. All the skills need practice for you to be really able to use them. As you complete the remainder of the Handbook, activities have been provided for you to practise each of these skills specifically. However, you may like to begin to use some of these skills in your everyday work from now on. Use your notebook to reflect on your interactions with women and their families and on your counselling skills. Pay particular attention to the areas where you feel you need more practice or to areas you found difficult.

If you have time, in your group you might consider discussing a different case study each week, taken from a different person's notebook. Discussing case studies can help clarify what worked well and get feedback and support on areas which you can improve.

Activity 2



30 minutes



To review the different counselling skills and to prioritize which skills you need to focus on.

Group members should carry out this activity alone before discussing as a group.

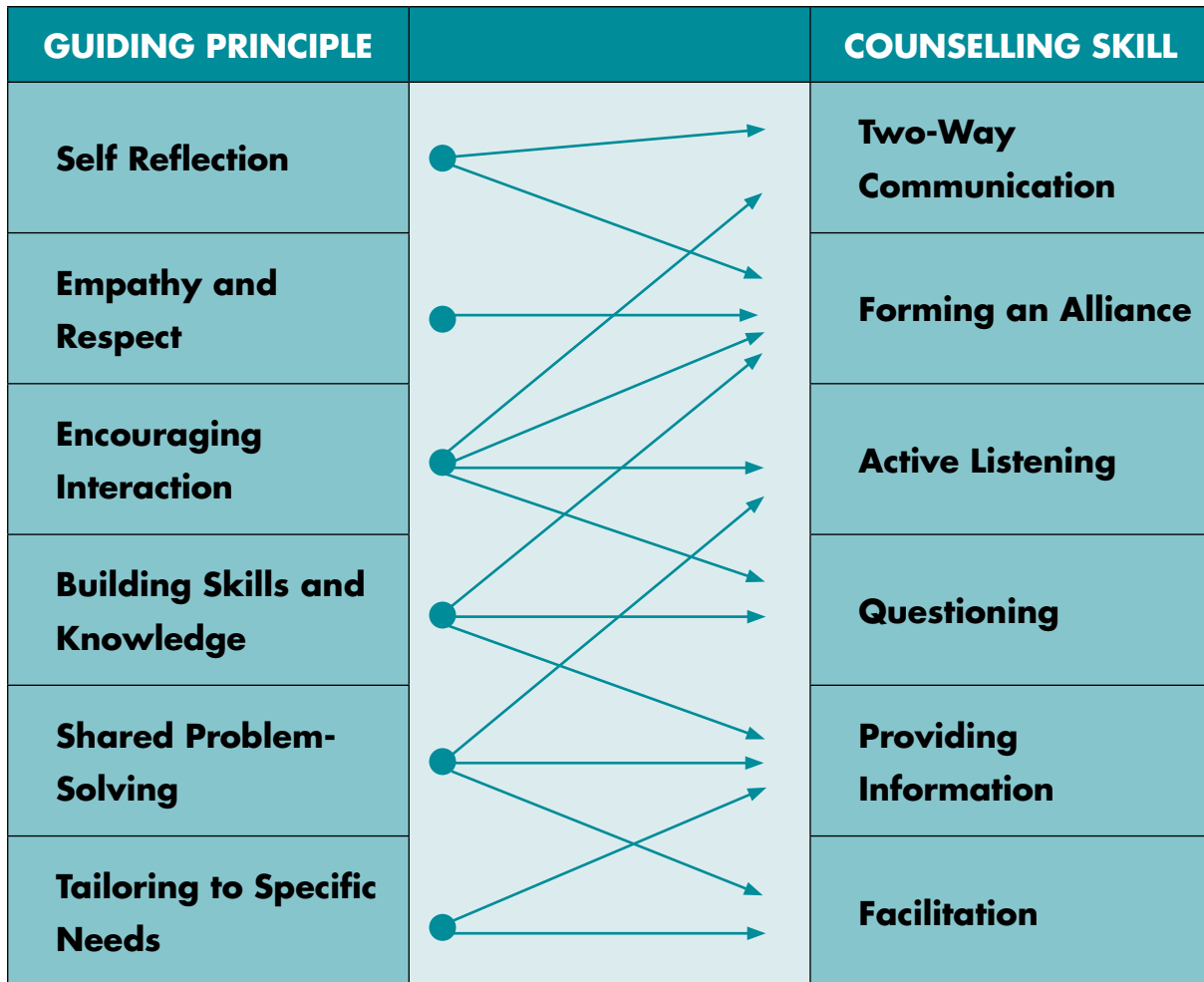
In the first session you went through the Handbook and made a list of the skills you were most keen to develop. Now that you have read in more detail about these skills, take some time to review your list.

1. Do you want to add any skills to your list?
2. Re-write your list in terms of which skills you would like to prioritize, in other words which skills do you feel you need to focus on first. Think about which skills you are good at, which skills you feel you know least about, or which skills you have never practised to help you prioritize your list.
3. Think about how you might be able to practise each skill. This could be in role-plays, or in interactions either at work, or outside of work.



Our View

You have probably used all the different skills at one time or another. To improve your ability to counsel for MNH you need to be able to use these skills consistently, every time you interact with a woman, her partner or family. At first you may find that some skills are difficult to practise or even to remember because you will be used to working in a particular way. This is why it is important to have a list which you can refer to, and also to think about all the different situations in which you can practise your skills. For example, you can practise your active listening skills in any conversation. You can practise your skill in forming an alliance every time you meet a new person – on the bus, or in a social setting. You can practise providing information with children at home or with colleagues. If you take some time to think about it, you will find many opportunities outside of the work you do in this Handbook to practise your counselling skills.



The diagram above may look a little complicated at first sight but what it is trying to show you is how each of the guiding principles feeds into the different counselling skills. So for example, if you follow the principle of self-reflection this will help you with skills of two-way communication and forming an alliance.

If you have time, you might like to consider how each of the principles and skills feeds into the different steps in the counselling process.

Activity 3



30 minutes



Aim

To review the different counselling skills and to prioritize which skills you need to focus on.

1. Using the diagram, take time to consider each guiding principle and each skill that it feeds into. You may decide to add in some additional arrows. For example, you might consider empathy and respect as being important for two-way communication.
2. Now write down an example for each relationship between the different guiding principles and skills to demonstrate how they are linked. For example, self-reflection is important for forming an alliance because being aware of your own attitudes, values and beliefs will help you to be non-judgemental of others.
3. Are there any relationships between the guiding principles and the skills which you do not understand? Try and discuss them in your group or with a colleague.



Our View

As mentioned, your foundation for good counselling skills and an improved counselling process is an ability to practise the guiding principles of counselling. So for example, the principle of encouraging interaction potentially feeds into all the skills but in particular, forming an alliance, two-way communication, listening, and questioning. Improving your understanding of how the guiding principles and skills are linked will improve your overall ability to follow the six steps in the counselling process.

What did I learn?



You have focused on core skills for counselling in MNH. You have looked at how to use two-way communication, how to form an alliance, as well as how to improve listening and questioning skills. You have also looked at how to provide information and facilitate the counselling process.

Progress check

The list below summarizes some different elements of the guiding principles, the key counselling skills and the six steps in the counselling process we have outlined in the last two sessions. Look through the list and see whether you can identify which of the principles, steps or skills the element is referring to.

Elements of good counselling

- Focus on the woman's needs and knowledge
- Assess the context of the problem with the woman
- Actively listen and learn from her
- Engage in interactive discussion
- Utilize skilled ways of asking questions
- Explore situations and beliefs
- Do not be judgemental
- Build trust
- Explore options together
- Facilitate problem-solving
- Make a plan of action together
- Encourage and reinforce actions
- Evaluate together your plan of action.

You now have established the principles which support the six key steps in counselling for MNH and you have reviewed and begun to practise some of the key skills. One final area that needs to be covered which supports the key steps in counselling for MNH is an understanding of the counselling context and environment. (If you remember, this constitutes the outer circle of our counselling diagram in Session 2.)

FACTORS THAT CAN INFLUENCE THE COUNSELLING SESSION



What is in this session?

This session focuses on some of the different factors that can affect or influence counselling for MNH. These include the larger social and cultural context, including socio-economic conditions, cultural and social norms, gender roles, and household decision-making processes.

These diverse factors will impact upon your counselling session; therefore a deeper understanding of their influence is required. This session also considers specific situations such as couple counselling, and counselling on sensitive issues such as sexuality.

What am I going to learn?

By the end of this session you should be able to:

1. Explain the key contextual factors which have an impact on counselling for maternal and newborn health.
2. Analyse the effect these factors may have on the counselling relationship.
3. Explain the importance of couple counselling and counselling on sensitive issues.

The counselling context

The term 'counselling context' does not refer here to the physical location where counselling takes place (which we call the counselling environment) but relates to the social, cultural, economic, religious and political factors of the place where you work, and the communities in which the people you will counsel, live. This section examines how these different factors may influence the counselling context.

It is important for you to be aware of the different factors that have an effect on the counselling context within the community you work. In the previous sessions we highlighted how important it is to assess and understand the woman's own knowledge, skills and individual situation. It is also important to assess and understand the wider cultural and social context in which you work.

Economic conditions

Economic status refers to one's financial status and is strongly related to health and educational status. So in general, most people with a low economic status (e.g. a low income) are also likely to have a lower educational and health status.

On the other hand, those with a higher economic/financial status will have better access to education and health services and will have higher status in these areas. It is important to take into account the socio-economic status of a woman, couple or family because this status will affect the decisions they have to make as well as the needs they have. For example, a woman who is poor may not have money to attend a health facility (either for child care, transport or where she must pay user fees). Similarly if a woman has a low educational status she may not appreciate the benefits of birth in a health facility and her low health status may mean she is at higher risk of poor health outcomes for

both her and her baby. Educational status is also related to literacy. You need to know the literacy level of people that you counsel so that you do not give them complex advice or instructions in words which are unfamiliar to them, materials that they cannot read, or forms which they are unable to understand or complete.



UNDERSTANDING A WOMAN'S SOCIO-ECONOMIC SITUATION

Be aware that this may be a sensitive topic for some women.

Try open-ended questions as you try to form an alliance:

"I'd like to get to know you a little more; perhaps you can tell me something about yourself and your home situation?"

At other times you will have to be more direct e.g. "What level of education did you finish?"

How does your household earn its income?"

It can help you to form an alliance with the woman if you are open with her about why you want to know this information. Tell her that knowing this type of information will help you to tailor the service you provide to her specific needs.

Social and cultural context

Culture is a term we use to describe the values, beliefs, practices and ways in which a community or society lives. It also includes the way the people express themselves, communicate, and interact with one another. The social context refers to how people are organized, in terms of family groupings (do they live in extended or nuclear /traditional families? or do husbands have several wives?) It also refers to group interactions and hierarchies within communities. For example, are there group leaders, chiefs, or headmen or women, and what role do they play? The cultural and social context affects all aspects of life, from how people greet one another, to how they interact in the household and how they make decisions.



REMINDER:

Being aware of the social and cultural context will help you form an alliance with the woman or couple you are counselling and will help you decide appropriate ways to communicate in terms of how you ask questions, how you approach sensitive issues, and how you facilitate the process of problem-solving. It will also enable you to tailor your counselling to their specific needs.

Issues such as religion or social status affect peoples' ideas or feelings and this can influence communication and counselling. The cultural and social context can be expressed differently depending on the setting such as the home, schools, the workplace, or the health service. Your professional training took place within a particular perspective on health and you may feel it is the most appropriate way of approaching health issues. Other communities and cultures have their own ways of talking about health which may be different from yours. Thus it is important to *reflect* on what these different beliefs and values are, as they will have an impact on the way in which you interact with women and their families and the way they interact with you.

Pregnancy and birth are normally very social and cultural events and thus tied to many specific beliefs and practices. In order to better support a pregnant woman and her family, it is important to know these beliefs and practices. Some may be very good for the woman and her baby, others may not be beneficial but also do no harm; you can build upon these beliefs and practices, and try to incorporate them into your practice and service. Other beliefs and practices may cause harm. You will need to discuss these with the women and her family and the broader community to see how they can be changed.

Activity 1



1 to 2 hours



To assess whether local practices in your community are helpful, harmful or harmless for maternal and newborn health.

Note to facilitator: You can divide the group into 3 smaller groups and have each group look at a different aspects, e.g., one group looks at antenatal, another group looks at childbirth and the third group looks at postnatal practices. Then bring them back together as one larger group to discuss their findings.

Within different cultures or social systems there can be ceremonies or ways to mark important events such as childbirth. For example, pregnant women may be expected to act or behave in certain ways. They may be given medicines or special foods. There may be ceremonies or activities to mark the arrival of the new baby, or practices carried out during labour and birth.

Understanding the context in which you are working and counselling is very important. This activity looks at local practices to help you to assess some important aspects of your context. Consider talking to women and community groups to help you answer these questions.

1. Write down in your notebook all the local practices and beliefs that you have come across regarding pregnancy, childbirth and the postpartum/postnatal period. Ask women or groups if there are any other practices and beliefs you should add.

Activity 1 continued...

2. For each one of the practices you have identified, consider whether it is good for the health of the woman and/or baby, if it is harmless or harmful. Organize your list of practices under the three headings:

Helpful**Harmless****Harmful**

You may need to find out more information to be able to make your classification. A helpful practice is one that supports the advice and information that you give to women (for example, exclusive breastfeeding), a harmless practice is one that does not contribute to improving the health status of the mother or newborn but also does not have a damaging effect (for example, beliefs/rituals surrounding the care of the placenta after birth). Harmful practices cover anything which might carry a risk of infection, loss of blood, transmission of an STI or make the mother or newborn weak. Harmful practices may also delay the woman's access to appropriate care (for example, beliefs that announcing the onset of labour will result in an evil spell being cast). The following questions may help you as you think about this.

- a. Does the practice involve animal or human waste? For example, a common practice of rubbing manure onto the baby's umbilical cord can cause dangerous infections.
 - b. Does the practice involve allocating different amounts of food, work or rest? For example, some cultures routinely give women less to eat than men. This could be potentially harmful to a pregnant or breastfeeding woman. But a cultural practice which encourages a woman who recently gave birth to rest in bed can be helpful.
 - c. Does the practice involve sexual intercourse? For example, sexual cleansing where a woman with STIs has sex with a traditional medicine practitioner is unlikely to do any good, and can transmit STIs/HIV if condoms are not used. However, sexual intercourse between a woman and her husband during pregnancy is harmless, unless one or both of the couple are HIV-positive and are not using condoms.
 - d. Does the practice involve taking blood from the woman outside of the health service? For example, taking blood from pregnant women to cleanse her of demons could be harmful as there is risk of infection and too much blood could be taken.
 - e. Does the practice involve local herbs, remedies or medications? For example, taking local remedies to stimulate contractions could be harmful, but other herbs or foods to promote better nutrition might be harmless or helpful depending on the ingredients.
 - f. Does the practice involve delays in reaching a skilled attendant? For example, the belief that infidelity causes obstructed labour may result in reluctance to give birth in a health facility.
3. Think about how you might incorporate some of the helpful and harmless practices into your advice and counselling with pregnant women and their families. Think about how you will discuss the harmful practices with women, their partners and their families and the community so you can improve your mutual understanding.

Activity 1 continued...**Our View**

Your list will be divided into those practices which are helpful, for example, a pregnant woman should be given an additional portion of meat or fish to help her stay strong. They could be harmless practices, such as the placenta after birth should be buried. Or they could be harmful, such as putting cow dung on the umbilical cord. Whether helpful, harmless or harmful, you should try to better understand the practice and belief. Where practices are helpful, they should be encouraged. Where harmless, there is no point in discouraging them. You may find you get more respect and better support from the community if you respect their harmless practices which may have great significance to them and their cultural and social context.

Discuss with women, their families and others in the community those practices which are harmful or which could endanger the health of the mother or newborn. Listen to their explanations about the practice and discuss the reasons why the practice is harmful. In many situations a replacement harmless practice can be substituted, instead of the harmful practice. In the case of female genital mutilation, for example, you could still conduct a “passage of rites” ceremony but simply replace the words in the traditional song used during the ceremony and provide a beaded necklace or some culturally suitable symbol instead of performing the cutting ceremony.

**REMINDER:**

Many practices are deep rooted in social and cultural norms and gender roles and perceptions. However, health workers can play an important role in stimulating discussions on these issues in the community.

Gender roles

Two of the differences between men and women are sex and gender. Sex is the physical, biological difference between women and men. It refers to whether people are born female or male. Gender, is not physical like sex. Gender refers to the expectations people have from someone or a community because they are female or male. Gender attitudes and behaviours are learned and the concept can change over time. Sex is biologically determined while gender is socially determined in terms of the roles and responsibilities that society or family assigns to women and men.

Men and women usually accept the roles defined and perpetuated by their community which can have both advantages and disadvantages for them. There are many factors that influence gender roles. These include: age, culture, marital status, education, economics, profession, and the country or society itself. Understanding the gender roles in the community can help you to better understand the situation of the women and men you counsel, and thus improve your counselling interactions.



Understanding local gender roles and how they affect men and women in your community can improve your counselling interactions.



EXAMPLES OF GENDER ROLES

- Women should stay at home and look after the home or family.
- Men should not do housework.
- Men should not cry.
- Women should not disagree with their husbands.
- Women should keep their bodies covered.
- Women should not drink alcohol.

How are women and men expected to think, feel and act in your community? How do they learn to do this? Gender roles are learned from a young age as parents may treat girls and boys differently. In addition, children often copy the behaviour of their parents.

Many women find the gender role of wife, mother and housekeeper very satisfying, providing them with status in the community. However, it can be a disadvantage to other women who want to have only a few children or want to pursue a career or other interests. Some women manage to combine a number of different roles. For the family and the community it can be beneficial for women to look after the children and remain at home, but it could also be a disadvantage as women who have paid employment could bring other benefits to the family and community.

Gender roles also teach men and women to express themselves differently. Women are often allowed to be more emotional whereas men are taught to keep their feelings inside. Men may get less support

when they have problems due to expected gender roles. Sometimes it will be important for you to counsel men and it will be particularly important to take into account the community's norms for gender roles as you do so. For example, a woman may want her partner or husband to be present when she gives birth but the man may feel pressure from others in the community or fear the reaction of others in a community where this is not usual practice.

Similarly we can see examples of gender roles in the community. In some communities the opinions of men may be valued more highly than women's opinions. Women may not be encouraged to speak or participate in discussions. This means that the community hears more about what men think about problems and issues. The community or family may not benefit in this situation as women's knowledge and experience are undervalued or overlooked. You may need to be aware of this when you work with communities, in order to support women to share information, and discuss their knowledge.



EXAMPLES OF GENDER INEQUALITIES

- Women make up two-thirds of the illiterate population in the world, and in many countries, there exists a gender gap in education - far fewer women than men are educated.
- Women carry out two-thirds of the world's work, but earn only one-tenth of the world's income.
- Maternal mortality in developing countries is 22 times greater as an average than in developed countries.
- In many places, women are twice as likely to work for nothing as men.

Think about these statements. You may like to use them as a discussion point with the community when you discuss gender roles and inequality.

Source: Population Council. *A client-centered approach to reproductive health. A trainer's manual.* Islamabad, Pakistan, 2005.

The impact of gender roles on health

Gender roles have an impact on beliefs, attitudes and values. Gender roles can also greatly affect health behaviour and the sexual and reproductive health of men and women in your community. For example, in some communities adolescents are encouraged to have sex with older men; thus gender roles can effect the transmission of STIs including HIV/AIDS and can also lead to unwanted pregnancies. Gender roles can lead to other undesirable sexual behaviours such as women having sex when they do not want to, and even rape and violence against women. Alternatively gender roles may prohibit women from expressing their own sexual needs or desires. Gender roles can have an impact on decision-making. For example, in some societies where there is a female hierarchy, young mothers will not be allowed to take decisions about seeking care on their own. This may not always be negative. In certain cases, adolescent girls may want support from older women in taking decisions.

Household decision-making processes

People do not make decisions in isolation from the context of their lives, and this includes asking advice from other family members and even the wider community. Research has shown that both the context in which decision-making occurs and the social influences such as those of a partner or the family, often have more effect on decision-making than merely information and education or the provision of communication materials.

You may need to facilitate the decision-making process among all those in the household who have important contributions to make. Cultural practices and gender roles often heavily influence the decision-making process. A woman may be unwilling to commit to a plan of action or take a decision until she has discussed the issues with her partner or other family members such as her mother or mother-in-law. You can support women in these discussions by reviewing the advantages and disadvantages of different options and her needs in that situation.



AN EXAMPLE OF COUNSELLING WITHIN THE CONTEXT OF HOUSEHOLD DECISION-MAKING

Situation: Counselling a woman about the need to exclusively breastfeed her baby up to six months.

Problem: Her mother is encouraging her to introduce porridge at three months.

Process:

1. Establish with the woman what she wants to do through open questioning and active listening.
2. Review the advantages and disadvantages with her to help her make her decision.
3. If she wants to continue breastfeeding exclusively then facilitate the process of generating options of how she can address this subject with her mother. She might want information from you to give to her mother; she may want her mother to join you in a discussion; she may want to practise different scenarios with you.

Activity 2



45 minutes



Aim

To assess how gender roles and household decision-making contribute to the health of the women you see.

This activity explores the context of gender roles and household decision-making and how these impact on maternal and newborn health.

Note to facilitator: consider splitting the group up into smaller groups and give them different parts of the activity to complete, which they can then share with the whole group.

1. Are there different ways in which women and men are expected to behave in the community?
2. Do these different patterns of behaviour depend on the age or marital status of women?
3. What impact might these behaviours have on MNH?
4. What other reproductive health problems might these roles contribute to?
5. What can you as a health worker do, in a counselling session or during your interactions with the community, to have an impact on gender roles so that women can better care for themselves and their babies?
6. In general, in your community, how are decisions in the household made regarding the care of a pregnant woman?
7. How does this affect MNH?
8. How might you support women in the decision-making process in their homes about MNH?
9. How might you include other key family or community members in the counselling and decision-making processes?



Our View

Some gender roles are influenced by religious beliefs while other gender roles are based on traditions or culture. Social norms and gender roles can lead to women not valuing their own bodies, or not understanding how their bodies work. This means they do not know what to expect or what is “normal”. Sometimes gender roles can lead to women paying more attention to the sexual needs and desires of men than to their own needs. This can lead to unwanted sex or having sex by force or to women not using contraceptives because of pressure from men. Other reproductive health problems may arise such as STIs.

Activity 2 continued...

You can play an important role in teaching women about the different parts of their bodies and the role that they play in sex and reproduction. Discuss with women what is normal (for example, routine vaginal discharge) and when they need to seek care (in cases of abnormal or infected vaginal discharge). You can also support women to take more control over their lives so that they can negotiate safer sex practices and contraception and participate in decision-making, especially where it concerns their sexual health, or the health of their baby.

Some communities have negative views about women's bodies. For individual women this can lead to feelings of shame and a lack of knowledge of their own body. Problems can arise because:

- Women are embarrassed.
- They do not know how to protect themselves from STIs or unwanted pregnancy.
- They are not in control of their own sexual health decisions.

Help women to understand how their bodies work in relation to sexual and reproductive health. If it is socially and culturally appropriate, help them to explore their sexuality which includes their feelings and attitudes towards sexual relations.

Recognize when it is important to include partners and other family members in counselling for MNH. Also support women in how to deal with family involvement in their decisions. Do this through interactive discussions with the women. Sometimes you may need to work with partners or other family members in the absence of the woman (for example, when she is too ill to take decisions on her own). Your skill is in supporting her in determining who should be involved in the decision-making process. But remember to respect confidentiality in terms of the woman's wishes.

**REMINDER:**

Involving the partner and other family members in counselling may require additional time and resources. However, if you only counsel a woman, the decisions she makes may be overruled later by her family.

Activity 3



3-4 hours



To explore the counselling context in your community.

Before moving on to Part 3 of this Handbook where you will examine topics and practice skills, you may benefit from a more in-depth exploration of the counselling context in your community.

Note to facilitator: divide the work of this activity among the group. Get them to plan and decide who will interview each different community group (as outlined in number 1), and to agree how the interviews should be conducted and which questions to ask.

1. Set up interviews, meetings or informal discussions with religious leaders, traditional healers, chiefs, and political leaders, in addition to other health providers and members of the community.
2. Make a guide of some of the questions and topic areas you would like to discuss in advance. The topics you explore might include areas such as:
 - a. Local culture and social systems
 - b. Politics and religion
 - c. Poverty
 - d. Gender roles
 - e. Family structure and household decision-making
 - f. Women with special needs
 - g. Local beliefs and practices related to maternal and newborn health
 - h. Opinions about the health service.
3. Take notes of the discussion and share them with your colleagues – imagine you are trying to explain the context to someone new that has never been to your community before.
4. Discuss how your findings might have an impact on maternal and newborn health.



Our View

You may find that you are working with a community where the context is the same for the majority of the population. Or you might find that you work in a community where there are lots of differences; for example, a community where there is more than one dominant religion, tribe or ethnic group. Different groups in the community will view maternal and newborn health and reproductive health in different ways. It is important to understand all the different factors and views that contribute to the social and cultural context of the area where you work. Understanding the context that communities live in can help you to counsel more effectively as you will understand the context in which decisions have to be taken and how the context may affect maternal and newborn health.

Activity 3 continued...

With this understanding, you can better facilitate processes for women and their families to find culturally and socially acceptable solutions for their problems. By doing this they are more likely to be able to follow the action and decisions they have taken.

Couple counselling

Just as it is important to consider the household decision-making processes, there are many times during counselling for maternal and newborn health where you will need to work with couples - the woman and her partner/husband. There are some obvious instances such as counselling about family planning where you could work with a couple, but there are other times also such as when you counsel about care during pregnancy, discuss support during labour or following birth.

When counselling a couple it is important to acknowledge that they may not have the same attitudes, beliefs and values. They may not even have the same perception of the problem or need that you are discussing. They may have different educational, social and literacy levels, and this is particularly true if culture gender roles in your community do not support women's education. Therefore you cannot treat them as a couple, but rather you must tailor your counselling skills to two individuals who need to reach a mutual decision.

You may find that you want to agree or disagree more strongly with one of the couple compared to the other. This is where the principles of self-reflection, and empathy and respect come in. You need to be aware of how your own attitudes, values and beliefs (which are shaped by the cultural, socio-economic and gender context that you live in) affect the way you think. Even if you disagree with one of the couple, you must maintain your respect for that person's point of view. It is not your role to support either the man or the woman in the argument.



It may be important to include her husband/partner in the counselling process.

If you can form an alliance with both partners, it allows for a situation of trust and mutual respect. You can then follow the steps in the counselling process, making sure you give them both an equal chance to participate in the discussion. It is possible that sometimes when you counsel a couple, the situation may become heated with one person becoming abusive or aggressive. It can be a good idea in these situations to spend time with each person individually before bringing them together so that they both have a chance to talk freely. When you bring them together you can take some time to agree upon some ground rules for your discussion.



EXAMPLE OF GROUND RULES

- No interrupting one another
- No shouting or aggressive behaviour
- Mutual respect
- Consider all options before discarding them.

In deciding upon these ground rules together you also have to take into account what is appropriate socially and culturally in terms of how men and women behave.

Counselling on issues of sexuality

For most health care providers, sexuality will probably be the most difficult and challenging area of counselling during pregnancy and the postpartum period. We are all reasonably comfortable talking about STIs and family planning methods, but discussing and counselling for other sexuality issues and in particular sexual intercourse is more challenging and as a result often avoided. There are many priorities in the provision of good health care to women during pregnancy and childbirth such as preparing for the birth, learning what danger signs to look for, all aimed at reducing morbidity and mortality from pregnancy and childbirth and providing women with good care. It is easy for issues of sexuality to be put to one side. In comparison to other clinical conditions, they are not as high on the priority list for providing good care.

However, sexuality issues do contribute to anxiety for many women in pregnancy and after birth. There is often little opportunity for these anxieties to be allayed or even discussed. This is mostly due to our own limitations in discussing matters of sexuality frankly and openly. There is also a lack of evidence in this area, which means that, there is little clear guidance.

Many women will not need extensive counselling around sexuality issues. It is useful for the health care provider to give women an opportunity to discuss sexuality issues when appropriate. Giving women the opportunity to discuss sexuality can be done simply by quietly saying to a woman that if she has any problems or questions of any kind during her pregnancy or after birth, including things that she may not feel able to talk about to other people, she can discuss them with the counsellor.

We have already mentioned the importance of the cultural and social context in counselling. This is particularly important regarding sexuality issues. Most cultures and societies have well-defined attitudes about sexuality, and also well-defined ideas as to what sexual practices are acceptable. Many of these social attitudes or morals are closely linked to the religious practices within a community. Many religious texts provide clear guidance on sexuality issues during pregnancy. Counselling around sexuality issues should always start with you familiarizing yourself with the cultural and religious context and the specific information needed around the sexuality practices of each community. If you are from the community in which you are counselling then you may already be familiar with many of the local practices. If you are not from the community then this information can sometimes be learnt from other health care providers, from the elder women, or other respected people in the community. In some communities sexuality is not an open subject and even gathering information about sexual practices needs to be done respectfully and sensitively.

Different communities use different terms for sexual intercourse. For example, some communities would not be comfortable with the term 'sexual intercourse' or 'sex' and may prefer to say 'sleeping together'. Using the same terms and names that are acceptable in a community demonstrates respect for the community and may be a useful tool to paving the way for open discussion. It would be appropriate for you to support local sexual practices that are not harmful. For example, many communities prohibit sexual intercourse at different times during pregnancy. While there is little evidence to prohibit sexual intercourse in an uncomplicated pregnancy, it would not be harmful for couples to follow their community sexual practice in this instance and therefore you can support this practice. However, it would be inappropriate for you to actively support harmful sexual practices such as Female Genital Mutilation (FGM).

Many of the questions and concerns that women have related to sexuality issues during pregnancy are related to the physiological changes of pregnancy. For example, women may think that the normal increase in vaginal discharge that happens during pregnancy (leucorrhoea) is a sign of an STI. Providing this information as well as screening and testing for STIs is important. Women are also often unprepared for the changes in their sexual desire during pregnancy. This changes as pregnancy progresses: during the first part of pregnancy when women are often feeling nauseated and sick their desire is typically reduced; in the middle part of pregnancy women often feel much better and therefore their desire returns to normal; in the last part of pregnancy women feel very uncomfortable due to the size of the baby they are carrying, they are tired and their interest in sex decreases. These changes are all related to the body processes in pregnancy and are normal. They also may vary greatly from woman to woman.

Counselling during pregnancy is limited by time and sometimes the environment may not enable you to speak to a woman about sensitive or private topics. Sometimes the barriers of language, culture or age may become a barrier between you and the woman, particularly in discussing sexuality issues. In such instances it would be appropriate for you to encourage the woman to open up perhaps to another health care provider or community leader.

In talking about sexuality issues you may encounter a situation when a woman discloses a sexual problem that you feel unable to deal with. Examples of this may be a woman who discloses abuse or incest or a couple who have a long-standing sexual dysfunction. In this situation it would be appropriate for you to seek help from another more experienced counsellor or someone with special experience in these matters.

Note for working group facilitator:

The key issue is to try to prevent the working group from totally dismissing any need for counselling around sexuality issues because they have been offended by some of the suggestions in the Handbook. The role of the facilitator is to encourage the working group to voice their concerns on this topic, demonstrate that these concerns are respected and that local custom will guide the counselling. At the same time the facilitators should try to ensure that counselling around issues of sexuality is considered to be valuable and not abandoned. It is useful for the facilitator to acknowledge the importance of counselling on issues of sexuality and the potential benefits to pregnant women as outlined in the handbook and to consider that local custom and taboos, sometimes influenced by gender discrimination may be a potential barrier to providing women with important counselling.

What did I learn?



After completing this session you should be more aware of the wider context of counselling and key factors that can affect it. These include: socio-economic status, culture, gender roles, traditional practices, and the wider support and decision-making network from the partner, family and community. You have also considered how to improve your skills in couple counselling and counselling on sensitive issues around sexuality.

Progress check

- Do I understand the influence gender, the socio-economic system and culture have on maternal and newborn health in my community?
- How can I discuss practices and beliefs which are not harmful?
- How can I discuss practices and beliefs which are harmful?
- What are the different ways I can facilitate the decision-making process with couples and other family members?
- How can I address sexuality concerns of women during pregnancy or after birth?

PRACTICAL CONSIDERATIONS IN THE COUNSELLING PROCESS



What is in this session?

In this session we first examine how to establish a good counselling environment. Then we review some of the tools and aids you can use to support your counselling activities and assist in communication; these include educational materials such as posters, flip charts, and home-based records. We also discuss group work as an aid to counselling.

What am I going to learn?

By the end of this session you should be able to:

1. Organize the counselling environment both at the health facility and for home visits.
2. Use a range of different tools and aids to support your counselling activities.
3. Evaluate which tools and aids are most appropriate for your needs as a counsellor and tailor them to the needs of the woman or couple.

Establishing the counselling environment

As well as needing a thorough understanding of the wider context in which counselling takes place, it is important that you establish a good environment for counselling whether in the health facility or in a home. For many in the community, the health facility is a strange environment, so there is a lot you can do to improve the counselling environment. Even when visiting the home, you can create a better counselling environment by going to a separate room or asking friends and relatives to wait outside.

When we talk about the counselling environment, it is not just the physical environment we are referring to. It also includes how you greet people, how you talk to them and other aspects of non-verbal communication such as eye contact and body language. How you treat people in these ways is all part of setting up a good counselling environment, and you are demonstrating your use of empathy and respect (a key guiding principle from Session 2).

Preparing a good counselling environment lays the necessary foundation for forming an alliance and building trust.



Does the health facility offer a welcoming environment?

Activity 1



Variable



Aim An opportunity for you to reflect on how you interact with people and the factors that influences this.

1. Use your notebook to record how you greet and treat people and how you are greeted and treated over the course of a few days. Try to include different interactions, for example, in a shop or bank, at work, or in a new place.
2. How did the different interactions you had make you feel? Did you feel welcome and included? Did you ever feel unwelcome or isolated?
3. If you did not visit a new place during this time, think about a time when you have visited a new place, especially a new institution such as a government building or an official office. How did you feel? What was done or could have been done to make the experience better?
4. If you are working in groups, share your findings and discuss them.
5. What are the most important things that people can do to make others feel welcome and comfortable? What things should you try to avoid? What influences the way you interact with other people?



Our View

You probably found that you had different types of interactions with different people depending on how well you knew them. You may also have found that the physical context in which you met influenced the interaction e.g. was it a familiar or strange environment to you? Also the nature of your social and socio-economic status relative to the other person or people will also have affected the interaction. Think how differently you would feel before meeting your friends to how you would feel before meeting the Minister of Health! You may have found that where people are friendly and courteous that the interaction felt more comfortable. Other things which improve the interaction include where someone takes time to explain a situation or procedure which is new to you. For example, if you were to meet the Minister of Health you would probably feel more comfortable if someone told you in advance how to greet the Minister, where the meeting would take place, and what would be expected of you. For some women or couples, entering a health facility can be as daunting to them as it would be for you to meet the Minister. Take time to reflect on this and think about what you can do to help put them at ease. Remember as mentioned in Session 2 it is important to maintain courtesy at all times.



THE COUNSELLING ENVIRONMENT SHOULD BE:

- welcoming (e.g. greet clients appropriately, show them where to sit)
- comfortable (e.g. have comfortable seats, try to sit at the same level)
- a place with few distractions (e.g. no telephone, or interruptions from other staff or family members)
- somewhere where privacy and confidentiality can be maintained (e.g. somewhere away from other people)
- non-threatening (e.g. a place where people can feel relaxed and comfortable).

When you visit people in their homes it is difficult to organize the counselling environment to meet all your needs. However, you can make sure you sit somewhere comfortable and quiet away from other family members. You can try to minimize distractions by switching off radios or televisions.

Confidentiality and privacy

Welcoming and greeting people is the first step to establishing a good counselling environment. But part of creating a safe and welcoming counselling environment includes the need for both auditory (hearing) and visual (seeing) confidentiality in order to promote trust. A lack of trust may decrease an individual's participation in the counselling process or may even threaten or scare them. Creating an environment of trust and confidentiality is especially important for women who are distressed or women with special needs such as those with disabilities, women who have been abused (see Session 16), or adolescents.

Activity 2



20 minutes to several hours depending on the level of reorganization required



To improve the counselling environment in your health facility.

Within the health facility there is a lot that you can do to make sure the counselling environment is appropriate.

Note to facilitator: this activity can either be done as one big group or you can divide the work between smaller groups giving each group one of the questions to tackle.

1. Go to the entrance of the health facility. Is it clear where people should go to find you? Decide what you could do to improve access, e.g., place signs which include a welcome and/or drawing; have all staff greet people in an appropriate manner; train staff, including non-medical staff (e.g. guards, cleaners etc.), with courtesy and respect.

Activity 2 continued...

2. Now look around the immediate area that you work in. Is it a welcoming environment? Is it obvious where people should go? Where they should wait? Are the different rooms and areas labelled? Is it clean and tidy? Does staff look friendly and welcoming?
3. Where do physical examinations take place? Is this area private? How could you ensure greater privacy? E.g. using curtains, ensuring everyone knocks before entering.
4. Where does counselling usually take place? Is it appropriate? You can assess whether it is appropriate by answering the following questions: Is it comfortable? How is the room arranged? Are you able to sit next to each other and at the same eye level? Can your conversations be overheard? What could you do to ensure greater privacy? How can you minimize distractions? How could you make it a more welcoming environment?

**Our View**

Hopefully you have been able to make some changes that will allow the women and families you see to feel more welcome and more comfortable. You will have considered how to ensure privacy and minimize distractions, how to label rooms and make signpost directions. To assess how well you have done, pretend you are a woman on her first visit! Also ask for feedback from people who use your health facility through discussions, a mini questionnaire/survey or a suggestions box.

Tools to aid counselling

The best way to communicate information as previously mentioned involves an interactive, two-way discussion. It can sometimes be helpful to have prompts to remind us of the information we need to cover. Prompts can take many forms, it could be a checklist of activities or it could be a poster or flipchart or other type of visual aid.

Visual aids

Visual aids can be used to reinforce your discussion. Visual aids can also stand alone as methods of providing information. The main disadvantage of using them alone without discussion is that they do not allow for interactive communication and therefore may be misunderstood. If you do give out visual aids without having a discussion you can overcome this difficulty by providing people with an opportunity to ask questions at a later point either in group or individual discussions.

Visual aids and other tools for counselling:

- posters
- leaflets or fact sheets
- flip charts
- overhead projector and transparencies
- slide shows
- models (such as female pelvis, penis)
- chalk or whiteboards
- pictographs (picture leaflets)
- songs, drama or poems
- real life examples, testimonies or case studies from women
- written notes to remind you of points to cover.

Note: Remember to ensure that all materials/tools are developed with a consideration of the literacy levels of the women and families you are counselling.

Activity 3



1 hour



Aim To review existing visual aids and materials that you may have at the health facility.

1. Gather all the tools and materials that you have at your health facility.
2. What topic areas do they cover? Have they been field tested with women from the zone to ensure they are suitable, appropriate and understandable? Do they need further explanation?
3. Are there any other support materials that you like? Can you identify the topic areas?
4. How could you go about developing or obtaining more materials? What resources would you need to do this?



Our View

Developing good visual aids and tools is a skilled activity and many people specialize in this as a job. You may well have a department within the health service which does just that. Where possible you should try and use existing tools and visual aids because they will have been tested and reviewed. However, there are some instances where there will be no tool available for a topic. This is where you can develop your own tools. It could be something simple like a fact sheet, or a list of support organizations on a particular topic. It could be a simple poster or a prompt sheet to remind you of all the information you need to cover. You might also consider working with local women or communities to develop and create some materials although this will take time. As you work through the Handbook you will find suggestions of tools and aids that you can create yourself. Another thing you should consider doing is organizing a resource library at your health facility where you keep all your tools and aids – both professionally-developed aids as well as those that you and your colleagues have put together.

Home-based records

In some communities, women are encouraged to have their own home-based maternal health records. These records often consist of personal information such as marital status, parity and information on past pregnancies and births. These home-based records can be an excellent counselling tool. They provide a means to record what has been discussed in individual counselling sessions which can then be built upon in future discussions. You can also include the woman's birth and emergency plans as part of the records (see Session 7 which provides more details on birth and emergency plans). As the record is home-based, a literate woman can refer to the discussions between visits. If she does not read, you will need to find other ways (such as images) to remind her of the key points discussed. It is useful to remember that if the records are home-based women need to be consulted as to what will be recorded. Other people may easily read the records, and the woman may not want all of her pregnancy information available for anyone (including her husband or partner) to read. For this reason sometimes women will not inform you about their full medical history or past pregnancy history. A common example is that women will not inform you about a past termination of pregnancy or miscarriage and may only reveal this verbally to a counsellor. It is important to respect her wishes with regards to her home-based records and to remember confidentiality.

If you do not have home-based records in your community, why not consider starting them up?

Role of records in counselling

- to stimulate discussion and interaction
- to remind the counsellor of the information to be communicated
- to communicate information in a simple relevant way to the woman and her family
- to act as a reminder to the woman and family of previous communication
- to illustrate examples and consequences of action/inaction
- to strengthen links and communication between the different levels of the health system.

Programme tools

It is likely that you will already have a number of tools developed for the services you offer. You might not have considered their role as tools to aid counselling. For example, you may have checklists, charts or clinical decision-making tools such as the WHO PCPNC. These can all be used to help you remember information you need to cover and when to discuss it. You may also have some more specialized programme tools or guides for topics such as breastfeeding or family planning.

Why not consider making an inventory or list of all the tools that you have (building on the list you generated in Activity 3) and how you might be able to use them in counselling for maternal and newborn health?

Group information sessions

It is not always possible to spend time providing detailed information to individual women on every aspect of MNH. There are a number of topics where it is beneficial to work with groups of women, or groups in the community. For example, basic care in the home during pregnancy are topics which can be communicated in a group and which do not necessarily need individual counselling. You might just counsel the woman on the plans she has made to get the care she needs when you see

her individually, following the group session. Given the volume of work that some skilled attendants have, and the limited time you have with each woman, using groups which are already in existence, such as in the waiting room, or community groups can be beneficial. This can also help to increase general awareness and support for maternal and newborn health needs.

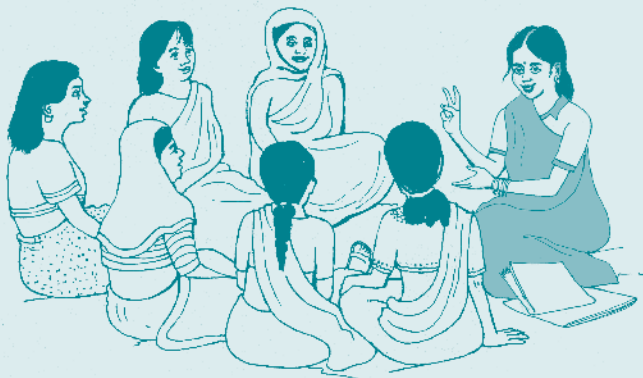
You can also consider holding discussion and support groups for women with different needs, including new mothers, women who have had a miscarriage or abortion, or for special groups of mothers such as adolescents. Support for breastfeeding is also a good example of a group which can be formed where women can share experiences and support each other.

Some topics are more difficult to discuss in a group session but can still be addressed, such as providing general information on STIs and condom use (including demonstrating condom use). Other issues, such as more personal sexuality issues would not appropriately be discussed in a group. However, addressing some general points and raising awareness in a comfortable, non-intimidating group setting can then encourage women to seek or raise points in individual counselling sessions to address their own concerns.



FACILITATING A GROUP SESSION

- Make sure you can be heard.
- Make sure any visual aids you use can be seen.
- Ask the participants for feedback as to whether they can see and hear.
- Talk slowly and clearly.
- Use an interesting and animated style of talking to keep people's attention.
- Maintain eye contact (if appropriate in your culture).
- Change the tone of your voice.
- Move around.
- Allow time for group to ask questions.
- Ask questions to make sure the topic has been understood.



Sometimes it can be beneficial to share information with women in groups.

Encourage interaction, discussion and questions. Women can learn a lot from one another in a group session. Try to get feedback on whether the information has been understood. Try to avoid lecturing your audience with long lists of do's and don'ts – find out what they already know and what they already understand. Encourage the audience to share information with one another and facilitate a discussion among them on the topic. Be brief and avoid overloading the group with too much information. Also remember to maintain courtesy and confidentiality within the group setting. It is important to tell the group that they can see you individually after the group session if they have issues they want to discuss in private.

Activity 4



2 hours preparation plus the group presentation/discussion



To improve skills for working in groups.

1. Review all the material in this section, taking notes to help you.
2. Plan the content of a group discussion about the foods that pregnant women should eat to maintain a healthy pregnancy. Then carry out the session with a group of women. It may be easiest to do this with a group of women attending antenatal care.
3. If you are not working in teams or do not have a facilitator for the Handbook, ask colleagues to act as observers. Give them the following checklist to use to evaluate your session:
 - a. Did the facilitator greet the women warmly, introduce herself or himself and explain the purpose of the session?
 - b. Could the facilitator be heard?
 - c. Was the pace and style of the language appropriate?
 - d. Were visual aids used appropriately?
 - e. Were women provided with an opportunity to participate?
 - f. Was the group's prior knowledge assessed? Did the facilitator build upon this knowledge?
 - g. Were women encouraged to participate in the group discussion?
 - h. Were the women asked if they had any questions or if there was any point that could be explained more clearly?
 - i. Were the women asked what they thought about the session and what they would like to see improved?

Activity 4 continued...

4. Get your observers to also take notes and write down examples under broad headings of what went well and what could be improved.
5. At the end of the session write down your own thoughts under the heading of what you thought went well and what could have been improved upon.
6. Get feedback from the observers and also if you can from the women who were in the session.
7. Use the feedback to reflect on your skills and how you might improve them.

**Our View**

Like any skill, working with groups needs to be practised. When leading a group, it is easy to overlook many things such as talking as if to only one person, not talking loud enough or talking too fast. We might forget to involve the participants or assume they have prior knowledge or tell them what they already know. We might end up lecturing them or providing too much or too little information. Getting feedback from an observer or from groups themselves is an important way to improve your skills. Take time to reflect on what you have learned about your style and how you might try to change it. Use your notebook to write down how you are progressing.

Team work

One of the biggest constraints to better counselling in MNH is lack of time. Working with groups can be one way to reach more women and their families and free up more time for individual counselling sessions. Another useful aid to counselling can be to utilize the team of people you work with. Examine ways you can share the workload and contribute to improving a better service. As a team you can also discuss cases or situations together in order to pool your ideas or resources, to improve the counselling you offer. Working as a team can also help to ensure continuity of care, for example, if a woman who is attending antenatal clinic sessions is likely to see different staff each time she comes, then making sure you discuss her needs and situation or keeping accurate records means that you and your colleagues are all informed about her specific situation.

What did I learn?



In this session you learned about the importance of organizing the counselling environment as a basis for a better counselling process. You looked at how to make people feel more welcome and how to ensure confidentiality and privacy. You also examined other practical things you can do to improve the counselling process such as the use of tools and visual aids, working with groups and team work. Each of these areas can help to support the service you provide to women, couples and their families.

This is the end of Part 2 of the Handbook. You should now be confident in the definition of counselling for MNH. You should be able to describe the six key steps to the counselling process, and guiding principles which form their foundation. You should also be familiar with the skills needed for effective counselling. You should be confident that you understand the diverse factors influencing counselling, and the importance of the counselling context. Finally, you should also be more aware of the counselling environment, and the many useful tools/aids which facilitate your role as a counsellor. Before moving onto the next part of the Handbook which focuses more on specific topics, spend some time reviewing all the work you have done in Part 2.

A Handbook for Building Skills

**COUNSELLING FOR
MATERNAL AND NEWBORN HEALTH CARE**

PART 3
Topics

GENERAL CARE IN THE HOME DURING PREGNANCY



What is in this session?

The focus here is on how to counsel and communicate with women about care in the home during pregnancy, also called self-care.

What skills will I develop?

- Two-way communication: communicating with groups
- Forming an alliance: facilitating partner and family involvement
- Counselling context: providing support to household decision-making processes
- Addressing socio-cultural beliefs and practices.



What am I going to learn?

By the end of this session you should be able to:

1. Counsel and communicate effectively with women on self-care in the home during pregnancy.
2. Consider cultural and religious beliefs in the community affecting the care a pregnant woman receives in the home and the support she receives from her partner and family.
3. Assess how to involve partners and other key family members in counselling.
4. Consider household decision-making dynamics.

General management and care during pregnancy

This topic is about the care a woman during pregnancy needs to receive in the home – focusing on pregnant women who do not appear to have problems or complications. This session seeks to address the following questions: How should you as a health worker support women in taking better care of themselves during pregnancy? How can their partners, their families and the broader community support and care for pregnant women? How can cultural practices affect the care a pregnant woman needs and receives?

Not all topics require counselling; some are points of communication and discussion - others require a more in-depth process to determine how women will take better care of themselves with support from their families. Limited time and resources mean it is not always possible to counsel all women in all aspects of care during pregnancy. Learn to identify with each woman which points should be prioritized and how to best respond to the individual needs of each woman. Find a balance between general communication and the need to provide specific counselling and support to individual women.



WHO RECOMMENDATIONS FOR SELF-CARE DURING PREGNANCY

- Visit your health centre at least four times during your pregnancy, even if you do not have any problems.
- If you have any concerns about your health or your baby's health, go to the health centre.
- Bring your home-based maternal record to every visit.
- Eat healthier foods including more fruits and vegetables, beans, meat, fish, eggs, cheese, milk.
- Take iron tablets and any other supplements or medicines you have been given every day as explained by your health worker.
- Rest when you can. Avoid lifting heavy objects.
- Sleep under a bednet treated with insecticide.
- Do not take any medication unless prescribed by the health centre.
- Do not drink alcohol or smoke.
- Practise safe sex, including use of a condom correctly in every sex act to prevent STIs or HIV/AIDS, if you or your partner is at risk of infection.
- Know the signs of labour – painful contractions every 20 minutes or less; bag of waters break; bloody sticky discharge.
- Know the danger signs and when to seek care (see Sessions 7 and 8).

Activity 1



1 to 2 hours

Aim

To help you prioritize aspects of self-care for counselling and communication with women and their families.

Part 1: This part of the activity encourages you to reflect on what you already know about care in the household of pregnant women in your community.

1. What are the general practices for care of the pregnant women in your community? Consider religious and socio-cultural practices, including sexual practices and taboos, and topics such as nutrition, hygiene, rest, work, vaccinations, medicines and supplements. (Refer to the work you have done in Session 4, Activity 1 on local practices).
2. Are most women in your community seen by a health worker for antenatal care? How many times do they receive care during pregnancy, and in what months of the pregnancy do they receive care?
3. For those who do not receive antenatal care, why not? How can they be supported so that they would receive care? What can you do to support them? What can others, including the family and the community, do?
4. What things can a woman do for herself to maintain a healthy pregnancy?
5. Are most women aware of the changes that will happen to their body during pregnancy?
6. Are there any harmful local practices during pregnancy? (See Session 4)
7. What is the role of the partner during pregnancy? Who makes decisions in the household related to how a woman should be cared for during pregnancy? Are these decisions supportive? How could you talk to families about the decisions they make, and help them to consider the consequences of them?
8. How can you consider socio-cultural and religious practices when counselling and communicating on self-care of women during pregnancy?
9. Refer to the above list "WHO recommendations for self-care during pregnancy". How do the WHO recommendations compare to the advice and information you routinely give women on general care during pregnancy?

Activity 1 continued...

Part 2: This part of the activity aims to help you prioritize the most important information that needs to be communicated to women and other family members.

1. Review all the information that you have on the general care and management of pregnant women: nutrition, hygiene, physical activity, vaccinations and preventing diseases and infections. Any other topics to add? Think how you can best use this list.
2. When are the best times during pregnancy to communicate and counsel women on the different topics?
3. Consider which points are best for communication and which need more interaction or a counselling process. Consider where you can be the facilitator or where other resources or people can be used.
4. Which information should be shared with her partner and other family members; consider the importance of different family members and their roles during pregnancy: the pregnant woman, her partner, her mother, her mother-in-law, other women, and elders.
5. Consider if there are women in the community with special needs who may require additional information or support for care during pregnancy (i.e. adolescents, women with HIV, women with a handicap, and women who live with violence. (See Sessions 14 and 16)

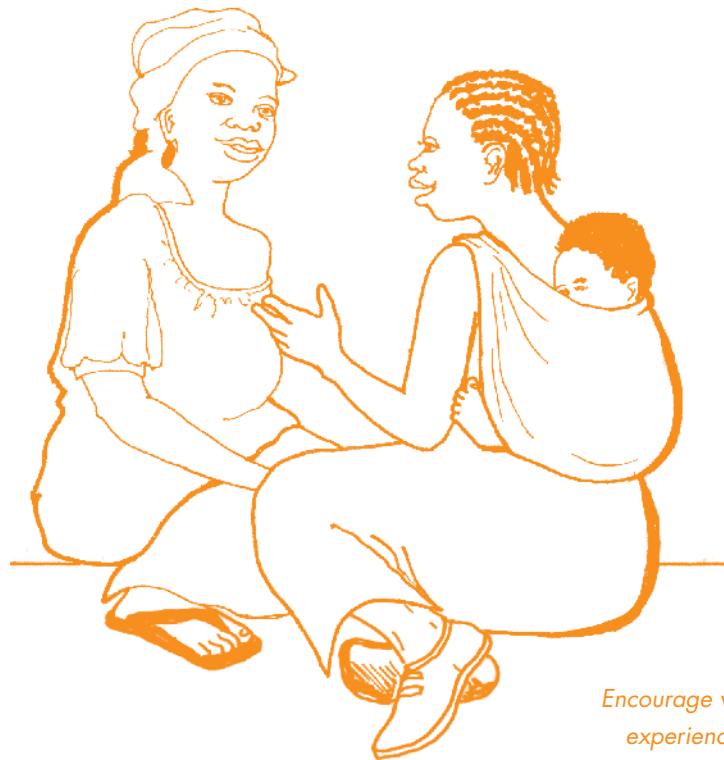
**Our View**

Considering the local context, develop a list of key points on self-care during pregnancy and use it during your interactions with women to review key information. If no other material exists, give your list out to women and their families. You could also use it as a guide when discussing with groups in the community, women, or with family members. It is as important to talk to families and partners as it is to talk to women about self-care during pregnancy because they play an essential role in support and care of the pregnant woman and are often the key decision-makers. They need to be aware of their role.

It is also important to consider the beliefs and practices that exist in your community which might have an effect on self-care, or make it difficult for women or their families to better care for the woman in the home. Some women may need more counselling than others to help them follow the recommendations on self-care. Consider each woman and her needs individually, and how you can best support her.

Communicating to groups

Care in the home of women during pregnancy is perhaps the most suitable topic for group discussions. This is because the topic does not have to be personalized as it is not about specific situations or individuals. As well as discussing general care issues with community groups, encourage them, particularly groups of women, to discuss these issues among themselves. By sharing their experiences women can support each other in identifying feasible solutions to problems they face. It is also a source of comfort to hear that other women have been through similar experiences.



Encourage women to share their experiences with one another.

Sometimes group discussions surrounding antenatal care are carried out in a very authoritarian manner with little or no participation from the group. A health worker stands in front of the group and tells them the things they should do, without considering the local context or finding out what women already know and do, or without letting the group discuss and ask questions. With groups, your role is to be a facilitator using the core principles outlined in the counselling process (refer to Session 2).

To be a facilitator means to promote participation so that all the skills and knowledge of the group members are used. In other words, everyone should have the opportunity to participate and contribute to the discussion. The facilitator needs to show warmth and empathy to encourage group members to interact. You can also work with groups in other ways, for example, by breaking up into pairs or small groups to discuss issues before presenting back to the wider group. Alternatively you could use a 'brainstorm' technique whereby people provide different ideas to be discussed or where you make a list with the group about what they already know and practise. Remember to have them consider the information you are presenting with the local practices, customs and traditions in mind. Together you should discuss how they differ, share points of view and work towards finding a solution that ensures the health of pregnant women.

Another approach might be having educational material or an image such as posters or flipcharts to serve as prompts and help initiate a discussion.

Although working in groups can be helpful, especially if time or resources are scarce, you must still be aware of individual needs. It is possible to create a supportive environment for problem-solving within a group, but some women's problems will need your individual attention. Thus in the individual antenatal care session with the woman, the different points can be summarized and you can determine with her which points require more discussion and/or counselling.



REMINDER:

With time and practise you can find ways to help people actively participate in group discussions. For example, you can help to relax the group by getting everyone to say something easy to begin with to get used to the idea of talking, like getting them to introduce themselves and say when their baby is due.

Activity 2



90 minutes

Aim

To help you prioritize aspects of self-care for counselling and communication with women and their families.

This activity builds on Session 5 Activity 4 where you were observed facilitating a group. This activity provides you with another opportunity to practise your group facilitation skills, but in addition, helps you to practise communicating to partners and families about their role in ensuring the pregnant woman has the care she needs in the home. Review the activity and notes in Session 5 and your own notes, as well as the material in this session before completing this activity.

1. Plan in advance a group work session with partners and family members of pregnant women to discuss the needs of the woman during pregnancy.
2. Ask colleagues to watch and act as observers.
3. Conduct the session.

Activity 2 continued...

4. Following the session, ask for feedback from the group participants using the following questions (or it may be preferable for one of your colleagues to get the feedback from the group, so that participants feel free to answer).
 - Were you able to say what you felt?
 - Were you given an opportunity to ask questions?
 - Were you able to share your knowledge with the group?
 - Did you disagree with anything the health worker had to say? Were you able to express this disagreement easily?
 - Did you still have questions that are unanswered or points you would like clarified? What are they?
 - Did you feel that the facilitator allowed everyone to participate? How did she do this?
 - Was the session interesting? Why or why not?
 - What do you think could have been done better?
5. Following the session, use the following checklist with your observers and yourself (in addition to the questions above):
 - Was the information you provided clear?
 - Were you aware of the groups' interactions?
 - Did you only give information or did you allow for discussions?
 - How did you handle people's questions?
 - How did you handle opposing points of view?
 - Did you facilitate the identification of problems and solutions?
 - What did you do well and what do you need to improve?
 - How will you go about improving these skills?

**Our View**

Facilitating a group session is a skill you can learn with practise. In a group session, you need to ensure that everyone has the chance to share their knowledge, express their questions and concerns, and to participate in identifying problems and solutions. But at the same time you need to lead the group and make sure that questions or other information which you may not agree with is explored and discussed. At times, when appropriate you need to be directive, for example, if one person is talking over another, dominating the discussion or not sticking to the key points of the discussion. However, you also need to find a balance; sometimes people want to bring in other issues which are relevant for their situation. Each group you facilitate will be different because people have different needs, knowledge and beliefs; your skill lies in being able to bring these into the discussion and in being able to establish an atmosphere of trust where everyone feels they can talk and participate freely.

What did I learn?



In this session you have reviewed the information to be communicated to women and their families about self-care during pregnancy. You have considered how to communicate in groups, and how to encourage sharing and discussion of common problems and their solutions.

Now take some time to reflect on what you have learned in this session. Which skills do you want to strengthen or develop further? Plan some time to practise them. You might like to think about how you can involve partners and families more in the counselling process, and how in particular you can get them to be more involved with the general care of women during pregnancy. Use your notebook to write down your group work skills and to reflect on how to improve these. You could also consider making some notes on how you might be able to identify those women who will benefit more from additional one-to-one counselling. These may be women with high-risk pregnancies, women with special needs such as adolescents, women with multiple pregnancies, women with disabilities or women who show signs of abuse. Some of the other sessions in this Handbook will help you to identify these women (refer to Sessions 2 and 16).

BIRTH AND EMERGENCY PLANNING

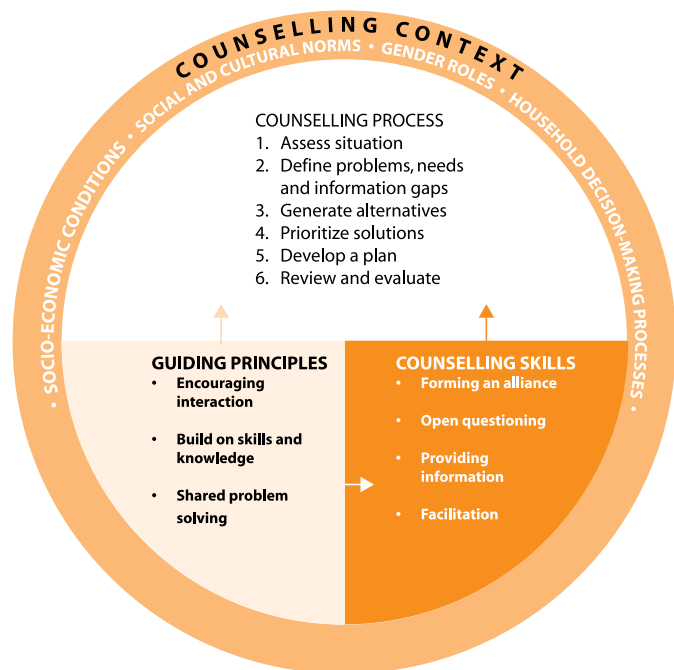


What is in this session?

This session reviews the essential preparations for birth with a skilled attendant, either at a health facility or at home, and describes how to prepare a plan with women and their families for birth and for the possibility of an emergency.

What skills will I develop?

- Open questioning: to support women in developing a birth and emergency plan
- Providing information: to facilitate the preparation of a birth and emergency plan building on existing knowledge
- Defining problems: to identify possible problems, explore solutions and generate alternatives, and take action with the woman and with the involvement of her family
- Forming an alliance: to work with the community to support birth and emergency plans, including available transport.



What am I going to learn?

By the end of this session you should be able to:

1. Appreciate the importance of interaction and counselling to support women in developing plans for birth and emergencies.
2. Assess with women the availability and quality of community and social support available to them and their families to implement their birth and emergency plans.



DEFINITION OF A SKILLED BIRTH ATTENDANT

WHO recommends that all women give birth with a skilled attendant who can provide safe care for a normal labour and childbirth and manage or refer complications for both the woman and newborn.

A skilled attendant is defined as “an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborn.”

Source: World Health Organization, International Confederation of Midwives and International Federation of Gynaecology and Obstetrics. Joint statement on skilled attendants. Geneva, World Health Organization, 2004

What is a birth and emergency plan?

As said above, WHO recommends that all women give birth with a skilled attendant. Based on the woman’s health and other considerations, suggestions can be made by the health worker as to where it would be best to give birth: in a hospital, health centre or at home – but always with a skilled attendant. In order to ensure birth with a skilled attendant, the woman and family must think out and plan several elements in advance. This is also true in case of an emergency.

Most women have a healthy, normal pregnancy, childbirth and postpartum period. These women will be cared for within their home and will receive health services at the first level of care – the primary health care level.

However, some women and newborn babies will have complications that require care at a higher level. In many cases ***it is not possible to identify in advance which women or babies will face these complications***. It is important that a woman, her family and others in the community know the signs of danger (refer to Session 8) and support the woman in reaching the care she needs. In order for the woman to reach the care she needs in an emergency, the woman and family must also prepare an emergency plan in advance.

The box below outlines some of the key questions to ask a woman and her family in order to help them to develop a birth and emergency plan:



PREPARING A BIRTH AND EMERGENCY PLAN - QUESTIONS TO ASK:

Where does she plan to give birth?

If birth is at home with a skilled attendant, ask:

- Who do you choose to be the skilled attendant for birth? How will you contact the skilled birth attendant to advise that you are in labour?
- Who will be there to support you during labour and childbirth (your partner, family member, friend, etc.)?
- What supplies do you have ready for the birth? You will need the following items:
Clean cloths of different sizes, blankets, buckets of clean water and some way to heat the water, soap, 3 bowls (2 for washing, 1 for the placenta), plastic for wrapping the placenta.
- Who will be close by for at least 24 hours after birth?
- Is there anyone who can transport you to a health facility should sudden complications arise?

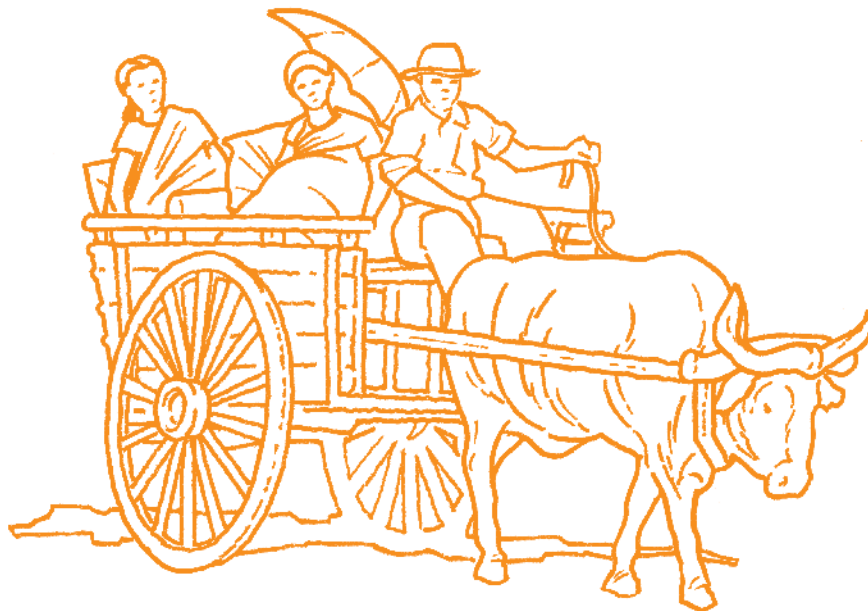
If birth at a health facility, ask:

- How will you get there? Will you have to pay for transport? How much will it cost? Can you start saving for these possible costs now? (If not, discuss alternatives)
- When will you go to the health facility? (advise on timing depending on how far away the woman lives from the health facility and her health status)
- How much will it cost for childbirth at the facility? Will you be able to pay these costs? Can you start saving for these costs now? (If not, discuss alternatives)
- Who will go with you to provide you with support during labour and birth? What information do you want them to have about your past history and condition? (see Session 10)
- Who will help you to care for your home and other children while you are away?
- What supplies do you have ready for the birth? You will need the following items:
Home-based maternal record, clean cloths of different sizes for the bed, for drying and wrapping the baby and for you to use as sanitary pads; clean clothes for the baby; food and water for you and your support person.

continued...

To help the woman and family prepare for an obstetric or newborn emergency, ask:

- What are the danger signs that indicate you should immediately seek care during pregnancy? During birth (if birth is at home)? After birth for the mother? For the newborn? (see session 8)
- Where would you go for emergency care?
- How will you get there?
- Who will take you to the health facility?
- How will you pay for transport? How much will it cost? Can you start saving for these possible costs now? (If not, discuss alternatives)
- Who will stay with you to provide you with support?
- Who will help you to care for your home and other children while you are away?
- What costs will you have to pay at the health centre? How will you pay for these? Can you start saving for these possible costs now? (If not, discuss alternatives)
- Have you identified a blood donor in case it is needed? In other words, are there relatives you can bring who share your blood group?



Encourage women and their partners to plan how they will get to the health facility.

Skills for supporting planning

The process of planning for birth and a possible emergency involves the health worker asking the woman a series of questions and supporting her to make decisions to establish the plans. In many places, a woman may prefer to discuss this with her partner or a family member present - someone who can support her in implementing the plan or in discussing it with the rest of the family. The skilled attendant will require different skills to support women in developing birth and emergency plans. These include questioning, providing information and facilitating problem-solving.

Asking questions

Finding out what information the woman or family already have and what additional information they will need is a good way to help them to make decisions for birth and emergency planning. You can do this by asking questions. Remember from Part 2 the difference between open and closed questions. Once you understand what information the woman already has, you can then determine any additional information you need to provide to help her assess the benefits and costs of the different issues required for the birth and emergency plan, including whether to give birth at a health facility or at home. At every antenatal care visit, the birth and emergency plan needs to be reviewed and updated. Make sure to ask her about her situation at every visit; situations can change, the woman may start to experience complications, or the home situation might change.

It is important to not only ask questions, but through the questions, support the woman and her family to make decisions. Once they have thought through the different issues, it would be best to set down the plan in writing, and provide the woman with a copy which she can take home to discuss with her family. If she is not literate and there are many others in the community who also cannot read, perhaps you can come up with some pictures to help convey the plan to others. There are also pictorial birth and emergency planning cards available that make this easier. If your programme does not have them, perhaps you and others can get together to design some and ensure copies are available to work with those who do not read or write very well.

Make sure you remind her to bring the plan with her for every antenatal visit so that you can review it together and make any changes as required.

BIRTH AND EMERGENCY PREPAREDNESS CARD FOR PREGNANT WOMEN

NAME OF WOMAN

AGE

ADDRESS

EXPECTED DATE OF CHILDBIRTH

NAME AND ADDRESS OF LOCAL SKILLED BIRTH ATTENDANT

DATE

NEAREST HEALTH FACILITY

	Activity	Indicate response
1.	Skilled birth attendant identified for birth	
2.	Preferred location for birth	
3.	Health centre identified in case of emergency	
4.	Companion identified to accompany during birth, 24 hours after birth and in case of emergency	
5.	Support person identified for care of the home and children during birth or in case of an emergency	
6.	Transportation to the health centre identified including costs	
7.	Estimated costs of care in case of emergency identified	
8.	Arrangements made to cover costs	
9.	Supplies for birth	
10.	Possible blood donors identified in case of haemorrhage/ emergency	

Sample of a birth and emergency plan.



REMINDER:

Every pregnant women and her family should have a birth and emergency plan.

For women who are HIV positive, see Session 14 Activity to consider how her needs may be different.

Activity 1



1 hour



Aim To practise developing a birth and emergency plan taking into account local and cultural beliefs and practices.

The questions you have covered so far focus on the practical issues for a woman's birth plan. There are a number of other issues that can be planned for in advance which consider local and cultural practices such as what to do with the placenta, positions for birth, foods and drinks which she can take while in labour, etc.

1. Consider the local practices and beliefs surrounding birth that you know of in your community and review the work you did for Activity 1 in Session 4. Talk to women to add to this list and ask them who they would prefer to have present with them as a birth companion.
2. Carry out the same process you did for the activity in Session 4 for any new information by grouping the issues under harmful, helpful and harmless practices.
3. As you make birth and emergency plans with women ask them which of the helpful or harmless practices they would like to include in their plan. If they have included harmful practices, discuss alternative solutions for these. Make sure you ask them to think about birthing positions.
4. Review with them how they might include these practices and what, if anything, they might need to have available for birth (e.g. a bag or box if they want to take the placenta home with them).
5. If there are any practices which are helpful and harmless that require changes at the facility, consider how you might be able to discuss with others and facilitate discussions between the community and the health managers/workers to assure consideration and sensitivity for local practices at the health facility.



Our View

Women will feel more comfortable giving birth in a health facility that shows awareness of the local beliefs and practices (where they are not harmful). Discussing these beliefs and practices in advance can help to ensure the woman knows what to expect, that you have made the necessary arrangements together to address personal preferences, and that she will be more at ease during birth.

Providing information for birth and emergency plans

We have discussed that before birth there are a number of decisions that need to be taken in advance. Discussing these points during routine antenatal visits will give the woman and family more time to plan and prepare. Remember, your job is not to provide her with the solutions, but to explore with her possible options. Once the options have been discussed, ask the woman or family to consider the benefits and problems associated with each option until they can arrive at a decision that suits their situation. You can then work together to make a plan of action to achieve the solutions.

Some women will prefer to give birth at home. Explore with the family their reasons for this decision. If they want to deliver with a traditional birth attendant (TBA), family member or with no help, explain to them the importance of having a skilled attendant who can provide the needed care for a routine birth, but also manage any complications that may arise, ensuring the woman gets promptly to the facility where life-saving treatment can be given. If there are good reasons why she should not give birth at home, then try to explain to her why it is important that she gives birth at a health facility.

If birth is planned in the home with a skilled attendant, provide details on the needed preparations (see below). She should review this information with the whole family. She may ask your help in doing so. It would also be helpful if you could provide them with a list or some easy way to remember the preparations they need to make.

PREPARATION FOR BIRTH IN THE HOME

Organize the following:

- a clean and warm room or corner of a room
- home-based maternal health record
- a clean delivery kit which includes soap, a stick to clean under the nails, a new razor blade to cut the baby's cord, 3 pieces of string (about 20 cm each) to tie the cord.
- clean cloths of different sizes: for the bed, for drying and wrapping the baby, for cleaning the baby's eyes, and for you to use as sanitary pads
- warm covers for the woman and the baby
- warm place for the birth with a clean surface or clean cloth
- bowls: two for washing and one for the placenta
- plastic for wrapping the placenta
- buckets of clean water and some way to heat the water
- for hand washing, water, soap and a towel or cloth for drying hands of the birth attendant
- fresh drinking water, fluids and food for the mother.

IT IS IMPORTANT to make sure that women and families know the signs of labour.



SIGNS OF LABOUR

If she has any of these signs she should go to the health centre or contact the skilled birth attendant if planning to give birth at home, as soon as she can. If these signs continue for 12 hours or more, she needs to go immediately:

- Painful contractions every 20 minutes or less.
- Bag of water breaks.
- Bloody sticky discharge.

Emphasize that complications can develop without warning and the family needs to be prepared to leave quickly and to follow the advice of the skilled attendant in case of emergency.

Facilitating individual and household problem-solving

It is important to explore with each woman any problems or difficulties she expects in implementing her birth and emergency plan. Do not assume that you understand why an issue can be a problem; encourage her to tell you in her own words what the issue is, and then feed back this information to her in different words to check that you have understood. Once you have clarified what the issue is you can begin the process of problem-solving.

First work with the woman to analyse the problem, discuss possible causes, and generate possible options for solving the problems. Then go through each option and discuss the advantages and disadvantages of each – these should be defined by the woman with your help, not defined solely by you. It may be clear to the woman what solution she should take, or she may need to talk it over with her partner or family, or just take time to think about it before she makes a decision.

In many societies, women alone do not make the decision about where to give birth. Remember the work you did in Activity 2, Session 4 on decision-making. Many women must discuss the decision in the household with other individuals; some women must follow the wishes of their families. When working with a woman to develop her birth and emergency plan, it is important to know who else in the family needs to be involved in making decisions. Help the woman think about how she can discuss the birth and emergency plan with her family on her own. In some cases, she may want your support in doing this. Encourage her to bring the family decision-makers with her to the antenatal sessions, or, if you can, visit them at home. Your role as a facilitator is to help the family assess the benefits and problems associated with each option for birth. You may have to act as a mediator to help them reach a decision or take a step back and leave them to discuss together the information to reach their decisions.

**REMINDER:**

Plans can be difficult to establish. There are many options and choices to weigh. Each has its benefits and difficulties. Thinking about these in advance helps women and their families consider the different options and consider which ones best meet their needs.

Establishing links with the community to support birth and emergency plans

Health staff are not the only providers of care and support within a community. In addition to the family there are many other people and places who can offer care and support to pregnant women and women after birth, such as TBAs, women's groups, etc. Identifying these additional resources in advance can help you to share the workload and offer continuity of care to women. In Session 17, later in this Handbook, you will examine different ways to establish links with the community.

Complications and problems can happen quickly and unexpectedly during pregnancy, birth or in the postpartum period. Planning in advance for what to do in an emergency can save time and lives. Everyone in the community needs to be aware of the danger signs and what to do when they occur (see Session 8).

Sometimes communities have already developed plans to support care-seeking behaviour for birth and emergencies. For example, many communities have organized a transport scheme like a bicycle ambulance or a homemade stretcher to help women reach a skilled attendant for birth or to reach the services in the case of an emergency. Some communities have organized finance schemes to support families to meet expenses in the case of emergencies.

Other communities may still need to come together to develop a plan and you can be an important source of support. You could facilitate the process of analysing current local problems and possible solutions. You may also be able to provide ideas that community members might not have thought about themselves.

Whether developing a community plan, drawing on an existing community plan, or an individual family plan, they all need to be drawn up in advance and understood by the woman, her family and the community.

What did I learn?



You can now outline the different elements to consider in developing a birth and emergency plan. You can provide appropriate information, advice and support for exploring options and for making decisions related to birth and emergency planning. You are also aware of the roles that partners and other family members may have in making decisions and in providing support for the woman during labour.

Which of these skills do you need to practise the most? Write these down in your notebook so that you can remind yourself of the skills you have decided to focus on. Over the next week or so, consider making notes on sessions with women where you have discussed birth and emergency plans. Later reflect on these sessions with the following questions: What went well? What could have been done better? What would I do differently next time?

DANGER SIGNS IN PREGNANCY

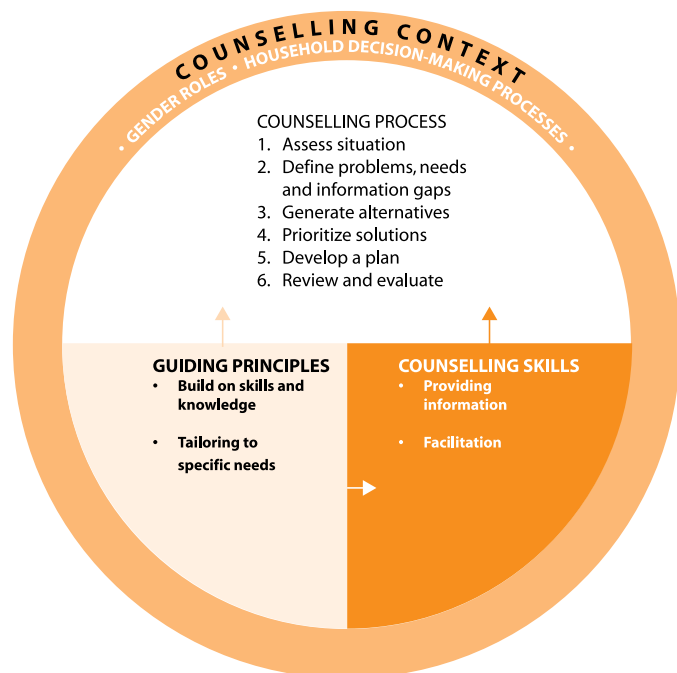


What is in this session?

It is important to share information with women and their families about the early detection and recognition of danger signs and complications as part of birth and emergency planning. You need to discuss with them what the danger signs are and help them to think about and decide where they will go if they experience one or any of these.

What skills will I develop?

- To provide information about danger signs and complications during pregnancy and childbirth
- To support women in planning where to go and how to get there quickly if an emergency arises.



What am I going to learn?

By the end of this session you should be able to:

1. Know the danger signs and complications.
2. Be able to effectively communicate danger signs to women and their families.
3. Be able to effectively communicate how to access emergency care when a danger sign is recognized.

Danger signs and complications

All pregnant women, their partners and families should be aware of the signs of complications and emergencies and know when to seek care from the skilled attendant.



DANGER SIGNS DURING PREGNANCY

If any of the following signs occur, the woman should be taken immediately to the hospital or health centre.

- vaginal bleeding
- convulsions/fits
- severe headaches with blurred vision
- fever and too weak to get out of bed
- severe abdominal pain
- fast or difficult breathing.

If she has any of these signs she should go to the health centre as soon as possible:

- Fever
- Abdominal pain
- Feels ill
- Swelling of fingers, face and legs

Communicating danger signs

Most women have uneventful pregnancies and childbirth but sudden and unpredictable complications may happen at any time to any woman. Where problems do occur it is important to ensure that they are acted upon without delay. You need to find a way to explain in familiar terms (using local words) the danger signs, so that the woman, her family and others in the community can recognize them if they should occur, and to ensure they know where to go in case of an emergency. It would also be helpful here to refer to Session 7 on birth and emergency plans as many elements, including transport, where the nearest health facility is located, and logistical details regarding persons to support the family, should already have been discussed and planned in advance.

Activity 1



2 hours
55 minutes



Aim

To begin reflecting on how to inform pregnant women and their families on the danger signs during pregnancy and build on women's past experience where possible.

1. Review the list of danger signs above.
 - What problems do women and families have in identifying each of these? Are there local terms that are used for any of them? Are there any local beliefs, explanations, or ways of handling danger signs that stop people from seeking care in a timely manner?
 - How do women prioritize the main danger signs? Are there certain signs that they feel need more urgent attention than others?
 - Are all women told about danger signs or just those women who are thought to be at high risk?
2. Organize a discussion with a group of women. Ask the group for their past experience with danger signs and complications.
 - Have any of the women experienced danger signs before? If so, how did they recognize them?
 - What did they do? Who did they see?
 - Did they find transport urgently? If not, what could be done next time?
 - What information did they have or were there any gaps?
 - How could health workers have better prepared them?
3. Review the list of danger signs once again.
 - Is the community aware and able to recognize danger signs in pregnancy?
 - Think of ways to help the broader community in identifying danger signs and supporting women to reach appropriate care in a timely fashion.
 - Do you or other health agencies currently discuss danger signs in pregnancy with the broader community? What are the advantages of doing so?
4. What kind of support materials might improve the communication of danger signs?
 - Take into account the educational and cultural background of your audience (e.g. the counselling context) and the resources you have to develop, or to obtain materials.
5. Finally, think about whether there are any other groups or providers in the community that you could work with to help alert the whole community to the danger signs in pregnancy and labour.

Activity 1 continued...

Write down some ideas in your notebook that could help you discuss danger signs with women and their families, both on a one-to-one basis and in a group setting.

**Our View**

WHO recommends that health services work with women, their families and the broader community so that they have appropriate and comprehensible information on the danger signs during pregnancy, as any woman can develop complications, and to ensure that all are aware of where to seek care in the case of an emergency.

Explore with women what they know about danger signs and make sure they know them all. Some danger signs are more difficult than others to recognize such as oedema. When counselling women about danger signs you need to explore with them what is normal, what is unusual and what is a danger sign.

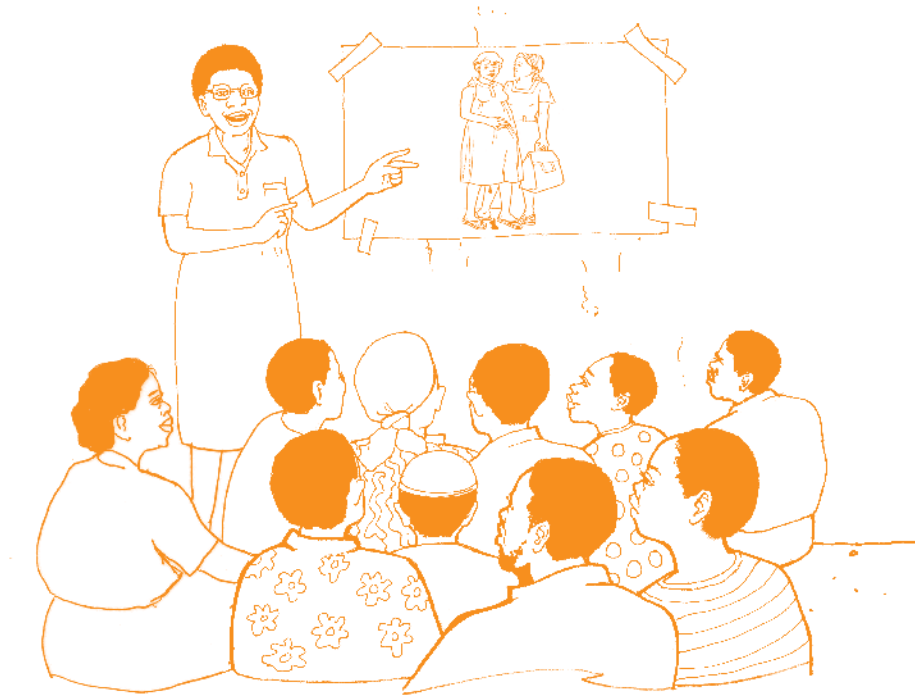
The next important step is to help the woman and her family plan where they will go and how they will reach the skilled attendant if they have any of these signs. Refer to Session 7 as much of this information should already have been discussed and drafted into a birth and emergency plan.

**HOW CAN YOU HELP WOMEN AND FAMILIES BETTER UNDERSTAND THE DANGER SIGNS?**

Women and their families need to be able to recognize danger signs accurately and act appropriately. For example, bleeding requires immediate transport to a health facility because a woman, particularly with anaemia, can die in a matter of hours.

Knowing about the danger signs in advance will help communities and families implement their birth and emergency plans.

If you have a highly literate population you might consider communicating all the danger signs in a leaflet or fact sheet or some other method that can be given out at routine antenatal care. If your population is less literate, you will have to rely on verbal or pictorial methods. It is difficult to remember all the danger signs, particularly if a person has little formal education. You need to work with the community and with other health providers to increase awareness of women and other community members of the danger signs, and of the importance of reaching an appropriate care provider urgently if any should appear. Once again it is important to ensure emergency transport schemes are in place (Session 7).



All women and their families need to be given information on danger signs.

Communicating danger signs without fear

Research has shown that using fear-based messages about danger signs is not effective unless used correctly.

It will be hard to communicate danger signs without creating fear. When discussing danger signs with women and their families, provide a realistic description that would help them to identify the signs in an emergency. Avoid frightening the woman with the worst-case scenario of what might happen. While complications such as bleeding, obstructed labour or infection are relatively rare, the focus should be on recognition of the signs and awareness of what to do if they occur. While as a health worker you are used to seeing complications, remember for the woman it can be very frightening. Reassure her that you will do everything you can to help her, try to alleviate her fears, and support her, but remember to answer her questions and concerns truthfully. It will not be helpful to make false promises or reassurances about pregnancy outcomes.



REMINDER:

Pregnancy is a normal and natural process. Most women do not experience emergencies during pregnancies, but any woman could. Women need to know when to seek care from an appropriate provider. A good counsellor will get the balance right between informing women and their families of the possible danger signs and what to do, and supporting women and their families to enjoy their pregnancy as a happy experience.

What did I learn?



You have considered how to communicate danger signs to a woman and her family, as well as the larger community. This has helped you to decide what format can be used to convey issues relating to danger signs. Furthermore, it is important to link discussions of danger signs with a concrete plan (such as the birth and emergency plan in Session 7) in order to ensure that women and their families know where to go during an obstetric emergency, and how to get there urgently.

Do you feel confident about communicating danger signs to women and their families? What else could you do to improve the way you communicate danger signs? What kinds of support materials can you develop? Who else can you work with in the community to raise awareness of emergency signs and the importance of seeking appropriate care when they occur?

The next time you counsel a woman about danger signs, write up what happened and what you did in your notebook. You could then share this with a colleague and ask for feedback on what could have been improved or done differently, as well as what you did well.

POST-ABORTION CARE

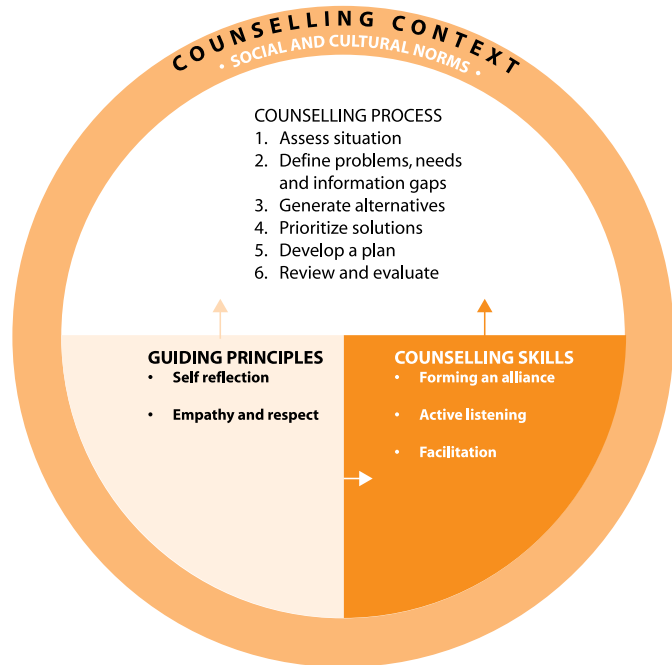


What is in this session?

This session focuses on the specific counselling needs of women who have experienced an abortion. This includes women who have experienced a miscarriage as well as women who have had an induced abortion.

What skills will I develop?

- Forming an alliance: Building a relationship with the woman
- Active listening
- Self-reflection
- Empathy and respect



What am I going to learn?

By the end of this session you should be able to:

1. Reflect on your own beliefs, attitudes and values.
2. Understand the key components needed to develop a relationship with the woman.
3. Demonstrate active listening skills.
4. Understand the key local resources in your area to support women.

What is miscarriage and abortion?

The term abortion refers to the termination of a pregnancy. Spontaneous abortion or miscarriage is an unintended pregnancy termination. Induced (elective) abortion is an intentional pregnancy termination by surgical, medical or other means. The emotional needs of a woman who has had an induced abortion may differ from the needs of a woman who has experienced a spontaneous abortion. However, in both circumstances, a wide range of emotions are common. Some women may feel upset, anxious or sad. In the case of a spontaneous abortion a woman may worry that something she did caused the pregnancy loss. Some women feel relieved after an abortion.

Your skill as a counsellor will be to support a woman in working through all the feelings and emotions she may be experiencing (regardless of whether the abortion was induced or spontaneous), to help her to deal with these emotions and with any practical issues such as how to tell other people, as well as to support her in planning for the care she needs to take of herself thereafter.

What is post-abortion care?

The WHO PCPNC outlines the key clinical examinations, treatment and care that should be provided to a woman who has experienced bleeding in early pregnancy or an abortion. If you do not have access to the PCPNC, use the national guidelines for the management of post-abortion care. In this session the focus is on developing your skills to improve counselling with women who have experienced an abortion, and to respond to the information needs of these women.



KEY ISSUES TO COVER WITH THE WOMAN AFTER AN ABORTION

WHO recommends the following advice be reviewed with a woman after an abortion:

SELF-CARE

- Some women prefer to rest for a few days, especially if they feel tired.
- It is normal for women to experience some vaginal bleeding (light, menstrual-like bleeding or spotting) for several weeks after an abortion.
- Some pain is normal after an abortion, as the uterus is contracting. A mild painkiller may help relieve cramping pain. If the pain increases over time, the woman should seek help.
- Change pads every 4 to 6 hours. Wash pad or dispose of it safely. Wash perineum.
- Do not have sexual intercourse or put anything into the vagina until bleeding stops.
- Practice safe sex and use a condom correctly in every act of sexual intercourse if at risk of STI or HIV.
- Return to the health worker as indicated.

continued...**FAMILY PLANNING** (See Session 12)

- A woman can become pregnant as soon as she has sexual relations. Use a family planning method to prevent an unwanted pregnancy and a condom to prevent infection with STIs/HIV/AIDS.
- Assuming there are no complications from the abortion, almost any contraceptive method can be started immediately
- Talk to the health worker about choosing a family planning method which best meets you and your partner's needs.
- After a spontaneous or induced abortion, the recommended interval to the next pregnancy is at least six months, both for the mother's and the baby's health.

DANGER SIGNS

If she has any of these signs she needs to go to the health centre immediately, day or night. **DO NOT** wait:

- Increased bleeding or continued bleeding for 2 days
- Fever, feeling ill
- Dizziness or fainting
- Abdominal pain
- Backache
- Nausea or vomiting
- Foul-smelling vaginal discharge.

In addition to these points, women may need to discuss with you issues related to resuming sexual relations. Some women may not want to have sexual intercourse for some time afterwards. This may continue even after she has physically recovered. These feelings may be complex and represent fear of getting pregnant again, or grief or guilt related to a spontaneous or induced abortion. The counsellor should try to provide support around this issue, starting with acknowledging to the woman that this is a well-known effect after an abortion.

Activity 1



1 to 1 ½ hours



Aim

To reflect on your own beliefs and attitudes with respect to spontaneous and induced abortion.

Before beginning this session, it is important to first explore your own beliefs and attitudes about spontaneous and induced abortion and towards a woman who has had an abortion, as these can affect the support you provide her.

This activity should be done in a group. If you are working on your own, ask some colleagues or friends to help you with this activity. Be prepared for some intense discussion, as abortion is a topic about which many people hold strong opinions and which may be influenced by religious values and other social norms.

Note to facilitator: if you have a group where everyone agrees with each other and you are worried that certain beliefs or attitudes are being reinforced by the group, divide the group into two smaller groups. Ask one group to agree with the statement and supply their reasons, and the other group to disagree with the statement, also giving reasons. By exploring/debating opposing views the participants will gain a deeper insight into different perspectives, thus helping to generate a meaningful and thought-provoking discussion.

1. Discuss the following statements. Make sure everyone participates. Encourage differences of opinion but protect each person's right to express her/his attitudes, values and beliefs. You may find it useful to set some ground rules for the discussion such as: do not interrupt one another, do not personalize information, and do not raise your voice. Remind the group that there are no "right" answers.
 - "A woman has the right to choose whether to terminate her pregnancy."
 - "If a woman deliberately induces abortion she is committing murder."
 - Women "cause" their own miscarriages.
 - "Some women want to terminate a pregnancy as they are too poor to feed another child."
 - "Women should feel guilty if they have had an abortion."
 - "Women who deliberately induce abortion do not deserve the same level of care as women who experience spontaneous abortion."
 - "Choosing to terminate a pregnancy is a hard decision to make and women need support and encouragement to carry out their decision."
2. Did everyone in the group have the same attitudes, values and beliefs?
3. Which statement caused the most disagreement?

Activity 1 continued...

4. How did people feel if their beliefs, values or attitudes were different from the majority of the group?
5. How might some of these attitudes, values and beliefs regarding spontaneous and induced abortion be expressed directly or indirectly to women?
6. How do you think this might make them feel?
7. Think about your own responses - do you feel you have any negative attitudes towards women who have had an abortion? What kind of support would you need to overcome these negative attitudes? Do you feel or act differently towards women who have had a spontaneous abortion or an induced abortion? Why do you think this is?

**Our View**

We all have different views about these statements. Holding a belief, value or attitude different from the majority of the group can make you feel insecure or defensive. This will help you to understand what it feels like in a situation where a woman knows that health workers disagree or disapprove of her. Be aware that if you have very strong attitudes and beliefs about abortion, you might communicate them indirectly through your body language, tone or the courtesy and respect you show or even more directly to the woman by telling her how you feel.

The health worker's role is to support women to make decisions to take better care of themselves. In order to do this, you need to discuss with women and this discussion can only happen by treating all women with respect, including respect for their beliefs. Try to overcome your own negative attitudes and beliefs and provide care and information in a neutral and non-judgemental manner in order not to impair your counselling relationship. If you feel unable to overcome your beliefs or attitudes, then you should ask a colleague to take over from you.

How to provide information and support after an abortion

Women undergoing an abortion should receive clear, simple oral and written information about how to care for themselves after leaving the health facility and how to recognise danger signs that require attention. In addition, information and counselling should be provided on contraception. Women may experience a range of different emotions after an abortion. The health worker can provide needed support to them during this difficult time. Below we have outlined some different skills you will need to do so, including:

Building an alliance with the woman

The counsellor's first task is to build an alliance, or a partnership, with the woman. This alliance serves as the foundation that encourages the woman to engage in the session. Building a relationship is especially important after the trauma of an abortion. The important skills in building relationships include showing empathy, overcoming beliefs, values and attitudes and active listening.

Ability to empathize with the person you are counselling

Empathy means understanding the woman's situation from her perspective and trying to focus on her feelings. To empathize is to put yourself in the woman's shoes and to try to see the situation as she sees and feels it, taking into account the impact her family, education, culture and life circumstances will have on these feelings. This can be a difficult thing to do, especially if we disapprove of the actions someone has taken because of our own beliefs, values, and attitudes.

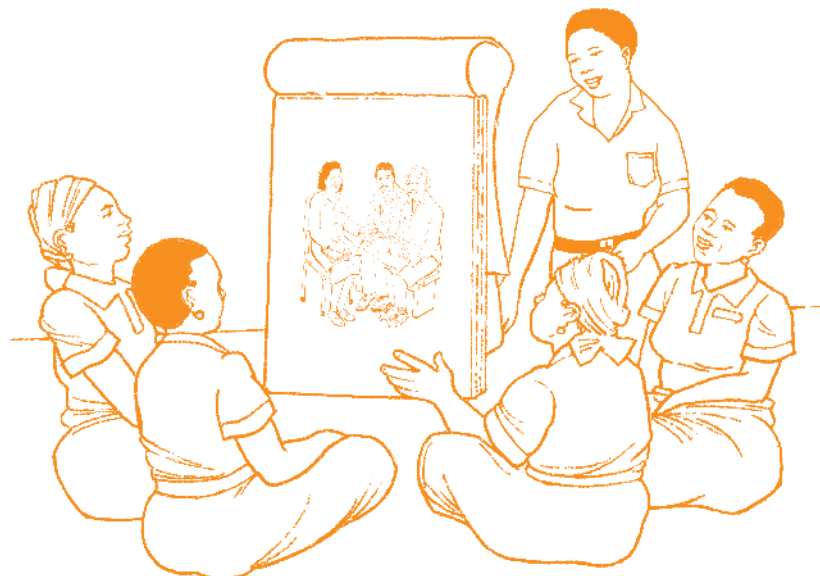
Ability to overcome beliefs, values and attitudes

Sometimes health workers do not want to provide services if they believe that the person has carried out an action with which they disagree. They can also treat a woman rudely if they feel she is suffering because of her own lack of knowledge or incorrect behaviour. This is particularly true in the case of an induced abortion about which many people have strong beliefs and attitudes. Can you think of examples of this where you work?

We all have values and beliefs and it is important not to impose these on others. Our values will have come from our experiences and will change at different points in our lives. Within any community it is unlikely that everyone will hold exactly the same attitudes, values and beliefs because they are shaped by many factors related to individual experiences. While each person is entitled to her/his own beliefs and attitudes, health workers have a professional obligation not to allow these to become a barrier to providing care. It is important to take a look at yourself and to be aware of how your own beliefs, values and attitudes influence how you interact with any individual woman, or influence what you say and do.

Active Listening

Active listening is another step that you need to practise to build a relationship. Active listening is about demonstrating that you are listening carefully. You can do this through gestures, sounds and body language. You can repeat back what has been said to you. Other methods of active listening include using questions which reflect that you have heard what the woman is saying. Refer back to Session 3 for more details on active listening before you carry out the next activity.



Take time to clarify with your colleagues your different beliefs, attitudes and values to abortion and how these might affect your counselling.

Activity 2



40 minutes

Aim

To help you improve your ability to show empathy and respect, manage your own attitudes, beliefs and values, and practise your active listening skills. This activity will build on the active listening activity in Session 3.

If you are working alone you will need to find some other people to help you with this activity. If you are working in a group, organize yourselves into groups of three – a counsellor, a woman and an observer.

1. The person playing the woman should take five minutes to make up a role-play focused on the following example: A woman comes to a health facility with sepsis following an induced abortion in the community which has gone wrong. Write down some notes to help you remember your story.
2. The counsellor and woman should carry out the role-play with the observer watching. If you are to play the counsellor try to show active listening through the use of body language, gestures, sounds and repeating back what has been said to you. Try to demonstrate empathy by expressions of understanding, including clarifying to her what you understand the woman is feeling, in terms of her worries, concerns, emotions and needs. You also need to be aware of your own values, attitudes and beliefs and how these may affect your counselling and interactions with her.
3. As the observer try to look for two or three examples of things that the counsellor did which demonstrated active listening and empathy appropriately. Comment on any aspects the counsellor could improve. Could you tell what the counsellor's attitudes, values and beliefs were? Use the checklist below to help you provide honest and accurate feedback to the person acting as the counsellor.
4. Ask the person playing the woman how she felt during the interaction. Did she feel at ease to speak her mind? Did she feel that the counsellor understood her feelings? Her situation? Her problems? What were the good things the counsellor did that helped her to feel supported? What were things that could have been improved?
5. Switch roles so that everyone has the chance to play each of the different roles.

OBSERVER'S CHECKLIST

Counsellor:

- maintains good eye contact (where culturally appropriate)
- nods and smiles at appropriate times
- demonstrates open body language

- demonstrates empathy and respect through understanding/caring language
- does not give direct advice but helps woman to explore her options
- does not sound harsh or judgemental despite own beliefs and values
- paraphrases questions back to show understanding
- asks clarifying questions when the woman does not understand what is being said
- allows an opportunity for the woman to ask questions.



Our View

You were probably very aware of being observed and it may have been difficult to concentrate on active listening, showing empathy and being aware of your own feelings, attitudes, values and beliefs. As you practise these skills when counselling women you will hopefully find that they become easier to carry out. Use your notebook to reflect on your skills following counselling sessions, until you feel more confident that you are able to put into practice these different skills.

Evaluating needs for further support

Many women will need continued support following an abortion whether it is induced or spontaneous. As you talk to the woman, her story may suggest other social or health concerns, such as concerns about infertility, violence in the home or isolation. Find out from the woman if she is interested in getting additional support and from whom she prefers that support. You can help the woman identify someone she would like to talk to who could listen and help to share her feelings and emotions.

She might prefer anonymous support in the form of a counsellor or specialized counsellor if she has a particular problem such as violence in the home (refer to Session 16) or infertility issues. Remember she has a right to maintain privacy.

Depending on the circumstances surrounding the abortion or miscarriage, she may or may not wish to involve others such as her partner or family members. If she wants her family involved, together you might be able to work out some emotional and practical ways that they can support her and also talk to them about post-abortion complications so that they are aware of what to do and what signs to look out for.

There may be other support mechanisms available in the community, or you may know of other women who have experienced an abortion and who would be available for support. You and others in the health centre should be aware of these possibilities and have the information available for those women who need it.

In addition, it may be appropriate to refer a woman to other sexual and reproductive health services, such as HIV/STI screening, cervical cancer screening or other preventative health measures.

Activity 3



variable



Aim

To develop a list of sources of support for women who have experienced an induced or spontaneous abortion. This activity links up with work you will be doing in Session 17.

1. Talk to colleagues, other health care providers, volunteer organizations, NGOs, religious and support groups to make a list of organizations that provide support to women following both spontaneous and induced abortion.
2. Once you have made this list, make it available for staff in your workplace. Also consider making it into a leaflet to give to women who have had an abortion. You could also combine it with the information on danger signs following abortion.



Our View

This list of sources of support will be a useful tool for your staff in communication and counselling. The list could be used as an aid to discussion and to facilitate counselling as well as providing important information to women.

What did I learn?



You have reviewed your attitudes towards women who have experienced an abortion and you should know if these present a barrier to how you provide them with care. You have examined how to provide care and counselling in a non-judgemental way. You know the importance of establishing a professional relationship with women, encouraging them to actively engage in the session. You have practised your active listening skills and how to show empathy and respect. You also made a list of additional support available for women following an abortion.

When counselling a woman after an emotional experience such as an abortion, you may feel emotionally drained yourself. It is important to maintain an awareness of how you are feeling and your own emotional state. Take some time now to reflect on what you can do to take care of your own emotional needs. Write these things down in your notebook. They might include activities such as talking through sessions with a colleague, friend or your mentor (remembering to maintain confidentiality). They might involve doing something for yourself like spending some time with your family, or taking a walk or any activity which you find relaxing. Learn to recognize signs of stress in yourself and develop practical ways to relieve it.

SUPPORT DURING LABOUR AND CHILDBIRTH

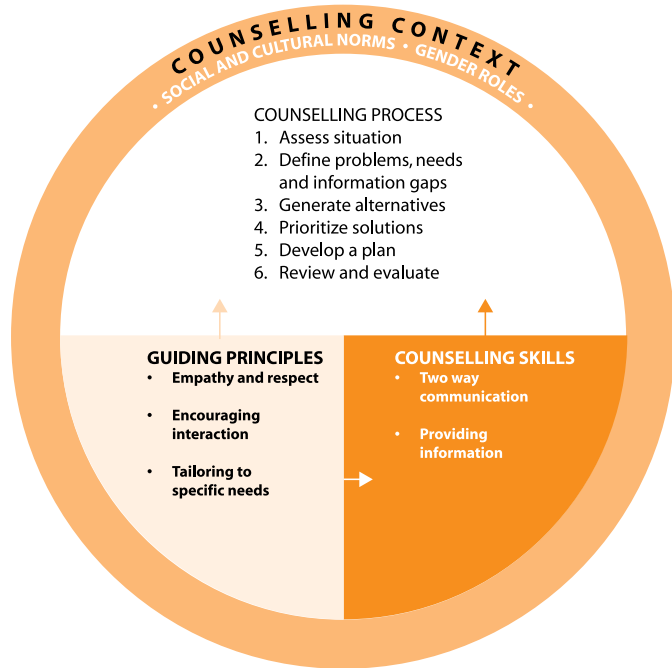


What is in this session?

A childbirth companion (or social support during birth) has been found to improve the whole birth experience. Research shows that women who receive good social support during labour and childbirth tend on average to have shorter labours, to control their pain better and to have less need for medical intervention. This session focuses on the emotional support, reassurance and respect that you can give to a woman during the birth experience, and how you can encourage a childbirth companion to take on some of these roles.

What skills will I develop?

- Empathy and respect – communicating courtesy, maintaining privacy and confidentiality, and showing respect
- Providing support, encouragement and reinforcement.



What am I going to learn?

By the end of this session you should be able to:

1. Maintain privacy and confidentiality during labour and childbirth.
2. Maintain respect and courtesy to a woman in labour and her childbirth companion.
3. Demonstrate support and encouragement for a woman during labour and childbirth.
4. Communicate to the childbirth companion the value of their role and what it involves.

Support and care throughout labour and birth

Labour can be a very frightening experience for women, especially first births. In addition, women will experience physical sensations ranging from discomfort to severe pain. Helping the woman to be as relaxed as possible and aware of her situation can help minimize the physical pain and emotional distress of labour and birth. Women can be helped with this by receiving adequate care, timely information, comfort, support and reassurance during labour and birth. It is also important to maintain respect and courtesy whenever possible by explaining what you are going to do and why, and by being courteous to her and her family. It is equally important to maintain respect for privacy throughout the birth, by keeping the woman covered as much as possible for all procedures, or by providing curtains.

It is important to be familiar with the birth and emergency plan (refer to Session 7) and to know if the woman and family have any preferences regarding labour and birth. If a skilled attendant respects the woman's and family's preferences regarding labour and birth they are more likely to have a better birthing experience.

In the birth and emergency plan, a woman will have also indicated a companion to support her during birth, and this childbirth companion can take on a central supporting role.

Supporting the role of the childbirth companion

Women should be encouraged to have a companion of her choice present during labour and birth. Some women like to have their husband or partner; others prefer a close family relative, friend, or a traditional birth attendant (TBA). Experiences from different settings have shown that the best person to have as a childbirth companion is often an older woman from the community, someone who has had children herself. However, encouraging the husband/partner to be more involved with the birth, where it is acceptable, may also be beneficial for the whole family. Birth is a very emotional experience and for some people (especially the husband/partner) having more active involvement can make the whole process particularly special.

Talk to the childbirth companion, either with the woman present or alone, to understand their feelings and wishes. Give the birth companion practical information about his/her role and offer advice on things he/she can do to help the woman. Providing support will draw on your skills and awareness of gender and social norms (e.g. the counselling context) within the broader community. The childbirth companion and skilled attendant should work together as a team during labour – plan (as a team) how to do this in advance when you discuss the birth and emergency plan (Session 7) with the woman during her antenatal visits.

It can be useful to talk to the childbirth companion during pregnancy or at the onset of labour to find out how much he/she already know about labour and birth, and to discuss with him/her what they might expect to see and what he/she is expected to do. You should encourage the companion to give support using local practices which do not disturb your work (and the rest of the health team) during labour or birth. The companion can also help and encourage the woman to move around freely as she wishes and to adopt the birthing position of her choice.

Discuss with the woman in advance any situations when the birthing companion may not be allowed to remain in the room. If the health facility currently does not allow birthing partners to remain with women who are giving birth, consider opening this topic up for discussion with your colleagues. Even if you decide that companions cannot be there for the actual birth, you might consider encouraging them to be there to support the woman during labour or to assist with breastfeeding and postnatal care. Sometimes if there is little privacy in the birthing room it can be easier if the companion is another woman instead of a man. Suggesting that women be encouraged to bring a female childbirth companion can often overcome issues related to lack of privacy in the birthing room.

Activity 1



20 minutes



Aim To draw up a list of roles the childbirth companion can fulfil.

1. Draw up a list of tasks that the childbirth companion can carry out during labour. Think of the possibilities, including practical tasks, emotional or supportive roles. How could he/she help in the birth of the baby? Can he/she cut the cord? Try to make your list as complete as possible.
2. What are some tasks that the childbirth companion should avoid doing? Why should they avoid doing them?
3. Review your list with others in the facility. Does the facility have any regulations that you need to consider before finalizing the list?
4. How can you best use the information you have drawn up to support a childbirth companion in assuming the role? Consider producing material to be given out or a checklist to go through with childbirth companions. When would be the best time to discuss this with them?



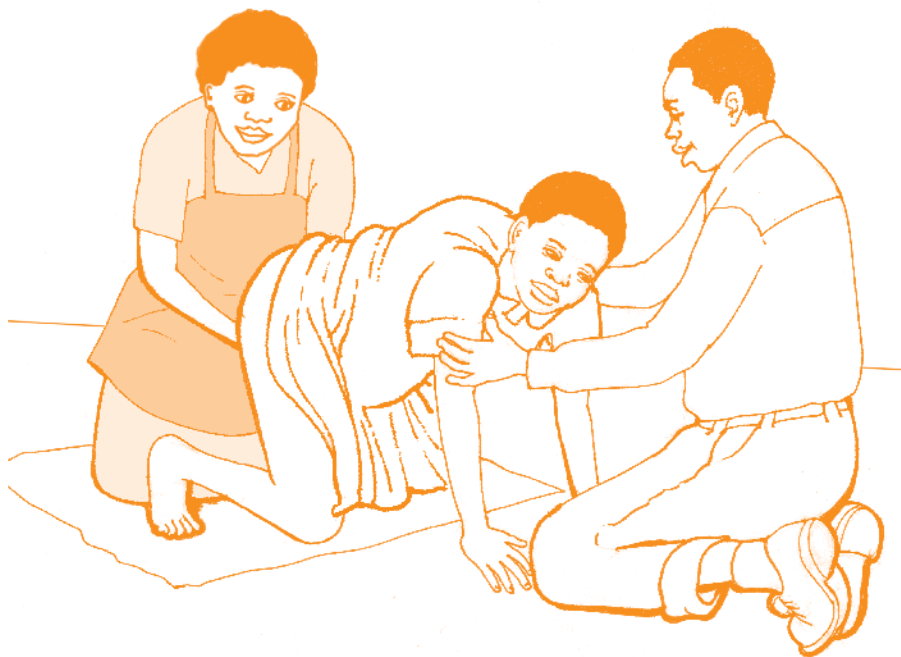
Our View

The key role of the companion is to help support, encourage and reassure the woman throughout labour. The companion should always try to be with the woman and praise and encourage her throughout the process. The companion can also carry out simple tasks such as helping her to breathe and relax or rubbing her back, providing sips of water as allowed, wiping her brow with a wet cloth, or doing other supportive actions.

Activity 1 continued...

It is important to tell the birth companion what they **SHOULD NOT DO** and explain why:

- **DO NOT** encourage the woman to push.
- **DO NOT** give advice other than that given by the health worker.
- **DO NOT** keep the woman in bed if she wants to move around.
- **DO NOT** administer any local herbs or medicine.



Women who are supported by a companion of choice during labour and birth often have a better birth experience.

Communication

During labour maintain communication with the woman and her companion. Maintaining communication means informing the woman whenever possible of everything that is happening and everything that you are doing or planning. Explain all procedures that will be carried out, even minor ones. This will help to minimize anxiety and provide reassurance that things are routine. Before you carry out any procedure, seek permission. This is part of courtesy and respect. You should also discuss any measurements or results and their implications with the woman. Keep the woman and her family informed about the progress of the labour. Labour can take many hours. Women need to know how they are progressing. Women who have experienced labour before still need to have information on their progress because labour is different for each woman.

Encourage self-care

Labour can sometimes take many hours and there are a number of things you can do to encourage the woman (and her companion) to help her through the process. Encourage the woman to bathe, shower or wash her genitals at the onset of labour and as often as she feels she wants to. Encourage her to move around and get into the position she feels most comfortable in. It is also important to encourage her to drink fluids and eat as she wishes throughout labour (as long as a C-section/surgery is not indicated), and to empty her bladder frequently. You can also teach her breathing techniques. Teach her to notice her normal breathing and then encourage her to breathe out more slowly, or to pant at the end of the first stage or at the height of a painful contraction to prevent pushing. During the birth of the head, ask her not to push but to breathe steadily or to pant.

Following the birth of the baby, it is important to maintain communication with the mother and childbirth companion and inform them of how the baby is doing. Encourage skin-to-skin contact, and put the baby directly on the mother's upper abdomen and cover both of them, ensuring skin-to-skin contact that will help to stimulate breastfeeding. Keep them both warm in the immediate hours following birth. It is also important to offer the mother drinks and food as she is likely to be dehydrated following labour.

Talking to the woman

Often during labour, especially if a birth companion is present, health workers can sometimes talk about the woman as if she is not there, or talk about her to the companion. Anything you have to say should be directed to the woman. If you need to talk about her with colleagues or with the companion, you should go elsewhere. Demonstrate respect – talking about her when she can overhear you is not respectful and not inclusive. It also may make her feel she is less in control of the situation.

Dealing with distress

Labour can be distressing for women and their families, regardless of whether there are any complications. Women may scream or shout, or they may become uncooperative or difficult. As a health worker it can be very hard to deal with women who are distressed in labour. It is important to remain calm and focus on maintaining your professional relationship. Under no circumstances should you raise your voice, complain that she is doing something wrong, or physically or verbally abuse her in any way.

Women can become even more distressed if the labour or birth becomes complicated. It is important that those around the woman remain calm. You are used to seeing difficult labour and birth, but most women are not. Similarly her childbirth companion or family may also become distressed. Try to reassure them all and advise them to remain calm and supportive to the woman to help her through the labour and birth. It is especially important to maintain communication with the woman and her companion if there is a problem with the baby. If you have to take the baby away immediately following birth, explain to them as soon as you can what is going on and what you are doing.

Support and reassurance

Labour is physically and emotionally demanding. Women need to be praised, encouraged and reassured that things are going well and that they are doing what is necessary for the safe birth of their baby. We all respond better to encouragement and support. A woman who is discouraged or made to feel she is doing something wrong is less likely to endure her labour well.

Let the childbirth companion know his/her job is to encourage the woman to do what she feels she needs to do to feel comfortable during labour. This may mean walking around or changing position frequently. Some women like to be held, or to have their backs rubbed or to have someone to help them with their breathing.

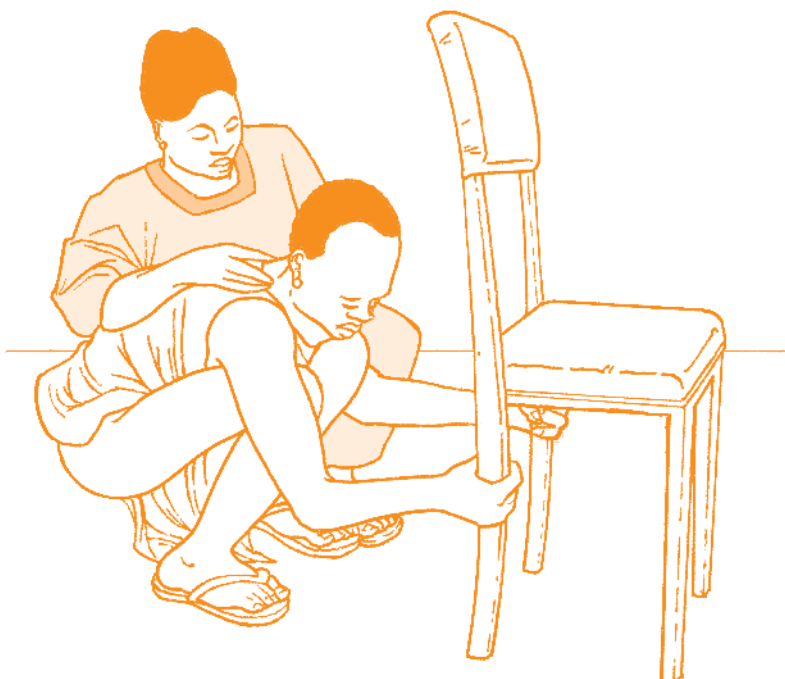


REMINDER:

Work with the woman and her companion to find out what she wants to do and how she wants to be supported and helped through her labour. Ask open-ended questions, paraphrase and provide feedback on what she has said for clarification. Avoid giving her orders. You can make suggestions that may help her but respect her choices if she does not want to follow your suggestions.

Confidentiality and privacy

The companion also needs to be kept informed on the progress of the labour and of any complications or difficulties. First, find out from the woman how much or what information she wants shared with the companion, and what she wants to remain confidential. It is best to find this information out during pregnancy when you are discussing her birth and emergency plan (Session 7). Be careful to maintain the confidentiality and privacy (both seeing and hearing) of the woman. If you have to carry out any physical examinations ask her whether she wants her companion present, and get her consent before you touch her body. Refer back to the guidelines on confidentiality you made in Session 5.



Encourage women to change positions and find what is comfortable for them.

What did I learn?



You have considered the ways you can help to support and encourage a woman during labour and birth. You have considered how to involve childbirth companions in a caring way and how to maintain courtesy, confidentiality and respect.

You have learned to support the woman by encouraging her to move into positions she feels comfortable in and to walk around. You have also learned the value of the role of her birthing companion, and of the need to provide accurate information on her labour progress or any complications which may arise.

Make some notes in your own words following this session to help you remember and revise the key points. You might also consider asking a colleague whom you trust to comment on your interactions with a woman and her companion during labour and birth, particularly during the stressful times of a birth where the woman might be in distress and uncooperative.

POSTNATAL CARE OF THE MOTHER AND NEWBORN

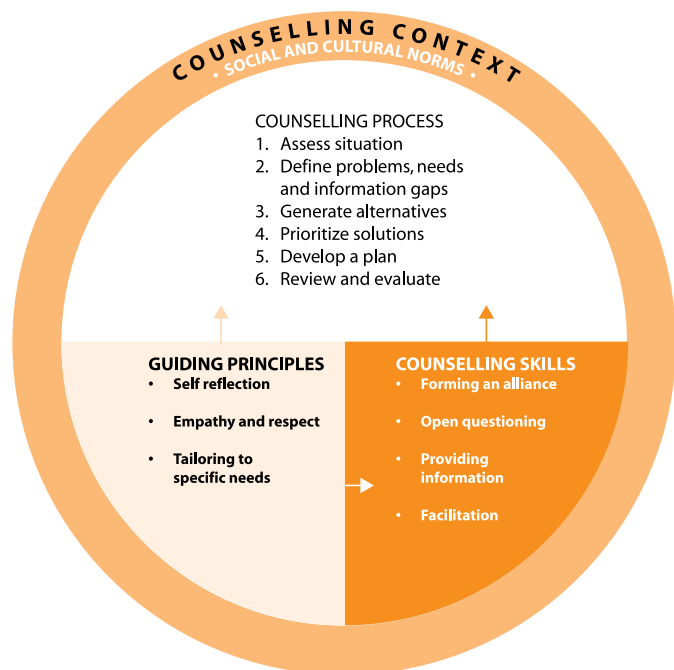


What is in this session?

In this session we review the key information to be communicated to women who have just given birth and their partners and/or families. This covers general care of both the mother and the baby as well as danger signs in the postnatal period. Special mention is made for supporting women with depression. This topic is used to practise the skills of facilitating family and group support and respecting the concerns of women. See Session 12 on birth spacing and postpartum family planning and Session 13 on breastfeeding which are also important counselling topics for women and their families immediately after birth.

What skills will I develop?

- Facilitating family and group support of women
- Respecting the concerns of women
- Providing information on postnatal care and danger signs in the new mother and baby
- Tailoring to the specific needs of the depressed postnatal woman.



What am I going to learn?

By the end of this session you should be able to:

1. Communicate key information on postnatal care including complications for the mother and baby.
2. Provide support to women with depression.

Care of the mother and newborn after birth

Some women will give birth in the home with a skilled attendant; others may not have a skilled attendant present. Some women who give birth in the facility will spend time there following childbirth. WHO recommends that a woman not be discharged before 24 hours after birth. Regardless of the place of birth, it is important that someone accompanies the woman and newborn for the first 24 hours after birth to respond to any changes in her or her baby's condition. Many complications can occur in the first 24 hours. Following childbirth at home, it is important that the mother and baby receive a postnatal examination as early as possible, preferably within 24 hours of birth. If the birth was at a facility, mother and baby should receive a postnatal examination before discharge.

There are a number of important points to discuss with the woman and her family following birth to ensure that the woman has adequate care. See the WHO PCPNC for additional information.



IMPORTANT ISSUES TO DISCUSS WITH WOMEN AND THEIR FAMILIES, IMMEDIATELY FOLLOWING BIRTH:

- The importance of having someone nearby for the first 24 hours.
- The importance and recommended timing of postnatal visits.
- The importance of the new mother eating more and healthier foods – discuss in the context of local practices and taboos to ensure women have access to good nutrition. The new mother should also drink plenty of clean, safe water.
- The importance of rest and sleep and the need to avoid hard physical labour.
- Discussion of normal postpartum bleeding and lochia – discuss with women how much blood loss they can expect, for how long. When bleeding is more than normal, they should seek care urgently.
- Discuss the danger signs for the woman and baby and the importance of seeking help quickly.
- Personal hygiene in the context of local practices and the environment. Discuss with women the type of pads they will use and their disposal, and care of episiotomy in the context of home conditions. Hand washing is particularly important to prevent infections. It is also important not to insert anything into the vagina.
- Talk to them about when they can resume sexual relations and the importance of condom use to prevent STI and HIV transmission (see Sessions 12 and 14). Sexual intercourse should be avoided until the perineal wound heals. Discuss the importance of birth spacing and counsel on the use of a family planning method.
- Discuss infant feeding and breast care (see Session 13) and the importance of only taking prescribed medicines when breastfeeding.
- Discuss the importance of the home environment for promoting the health of the baby and recovery of the mother. For example, discuss the need for warmth, good ventilation and hygiene for both mother and baby.
- In an area with malaria, discuss the importance of mother and baby sleeping under an insecticide-treated bednet.

Timing of postnatal visits

Following childbirth the woman and newborn should be examined within 24 hours by a health worker. At this time also discuss with the woman and family the timing of subsequent visits and the immunization schedule for the baby. WHO recommends that the mother and baby be visited at home by a trained health worker, preferably within the first week after birth. If your facility does not carry out home visits, discuss with the mother how she will come to the facility or local clinic for these scheduled visits. These visits early in the postnatal period are important for the mother and baby. It is also an important opportunity to ensure the establishment of breastfeeding and address any difficulties with attachment and positioning.

How to provide information and support for the care of the mother after birth

The PCPNC provides a list of practical tasks that need to be carried out following birth, if you do not have the PCPNC you should follow the norms and standards established in your facility. Explain the reasons behind the tasks you are carrying out and discuss with the woman any advice or recommendations you have for her to ensure appropriate care in the home during the postnatal period (refer to the points above). Encourage her to ask questions during the examination and use your active listening skills to reflect on and clarify what she is telling you. Help her to think of ways she can implement your advice. Sometimes, when women are unsure or hesitant they voice concerns in an indirect manner rather than directly raising an issue. Be aware of her body language and the non-verbal signs she may be showing you. Repeat back to her in different words what you think she is saying to see if you have understood. At the end of the postnatal examination, remind her that she can come to the health facility at any time if she has questions, reassure her and make sure she feels supported.



SCHEDULE OF POSTNATAL VISITS FOR MOTHER AND NEWBORN:

- First visit (could be a home visit) within 1 week, preferably on day 3
- Second visit 7-14 days after birth
- Third visit 4-6 weeks after birth

Explain subsequent immunisation schedule

Sexuality issues

These visits are a good time to discuss sexuality issues. Often the woman will come to see you or be on her own at home with the baby. This can give you more privacy to discuss topics about which she may feel 'shy'. The timing of when a couple resume sexual relations after childbirth is often guided by local sexual practices. Different communities and religious groups have different suggested periods of abstinence after childbirth. It would be useful to be aware of this and to be respectful of these practices. A woman is often embarrassed to ask when she can resume intercourse and may already be pressured by her husband or partner. In some cases, the partner may have had sexual intercourse outside the relationship during the period of abstinence following childbirth and hence the woman may be at risk of contracting STIs and HIV.



Make women aware that a health worker may come for a home visit for postnatal care three days after birth. Encourage women to return to the health facility with their newborn babies for routine health checks or if any danger signs are present

It is important to tell women about the changes to her body after childbirth that may affect resuming sexual relations. The tiredness that many women feel after childbirth means that they often have little desire for intercourse. The first time they have sex may be painful especially if they had stitches to their perineum. Damage and strain to their internal pelvic muscles which happens during childbirth will mean that sex may 'feel different'. Many women will need information about these normal changes and some reassurance that these things usually improve with time.

Providing adequate care in the home

In the immediate weeks following childbirth women need extra care, including partner and family support. Labour and childbirth are physically demanding, as is breastfeeding and looking after a newborn baby. It is therefore very important that women regain their strength and maintain their health as they adjust to life with their new baby.

Women in the postnatal period need to maintain a balanced diet, just as they did during pregnancy. Iron and folic acid supplementation should also continue for 3 months after birth. Women who are breastfeeding require additional food and should drink sufficient clean water. You should spend more time on nutrition counselling with women who are very thin and with adolescents who may need additional information to help them get a balanced diet. In some cases you may need to refer women to a nutrition counsellor, where available. It is important to note that poverty may prohibit women from accessing certain foods. Exploring less expensive options can be a helpful part of the counselling session.



COUNSELLING ON NUTRITION:

- Advise the woman to eat a greater amount and variety of healthy foods, such as meat, fish, oils, nuts, seeds, cereals, beans, vegetables, cheese and milk to help her feel strong and well (give examples of how much to eat).
- Reassure the mother that she can eat any normal foods – these will not harm the breastfeeding baby.
- Discuss any taboos that exist about foods which are nutritionally healthy.
- Talk to her partner or other family members to encourage them to ensure that the woman eats enough and avoids hard physical work.

The first few weeks with a new baby are very demanding, physically and emotionally. Women need to rest and take care of themselves as they recover from labour and birth. This often requires that other family members and friends help out. Work with families to make sure everyone is aware of the care a mother needs. Use your questioning skills to find out whether women are looking after themselves and find out the level of support they are getting from their families. Find out if she is getting enough rest and support. Work with her to identify ways that this could be improved. The postnatal period is a time when you may have to discuss issues with the family as a whole to help them identify solutions to problems that may have arisen since the birth. Some women are overwhelmed following the birth of a child, but despite this they feel that they must get back to their usual routine as quickly as possible to show that they are coping. As a health worker, you need to be able to identify women who are coping, from women who are having trouble coping.

During each postpartum visit you should also discuss how breastfeeding is progressing (see Session 13). Also talk to women about any plans they have to return to work or school, how this might affect breastfeeding and the care of the baby. Find out whether they have made any plans and review them together, or help them to make a plan if they do not already have one.

Danger signs for the woman

All women and their families need to be aware of danger signs during the postnatal period. Review the emergency plans they made during pregnancy and see whether they are still valid. Remind women to bring their maternal health record with them even for an emergency visit. It is important that you discuss danger signs with every woman as the majority of maternal deaths occur in the first week after birth. Consider making a tool or an aid for women to take home with them following birth.



POSTPARTUM DANGER SIGNS IN THE WOMAN

She should go to the hospital or health centre immediately, day or night.

SHE SHOULD NOT WAIT if she has any of the following danger signs:

- vaginal bleeding has increased
- fits
- fast or difficult breathing
- fever and too weak to get out of bed
- severe headaches with blurred vision
- calf pain, redness or swelling; shortness of breath or chest pain.

She should go to the health centre as soon as possible if she has any of the following signs:

- swollen, red or tender breasts or nipples
- problems urinating, or leaking
- increased pain or infection in the perineum
- infection in the area of the wound (redness, swelling, pain, or pus in wound site)
- smelly vaginal discharge
- severe depression or suicidal behaviour (ideas, plan or attempt)

Depression

The birth of a new baby can lead to many emotional changes. Many women go through a period of mild depression following the birth of a baby. There is a need to differentiate between postnatal 'blues' (feeling down) which usually occur in the first week and can last up to two weeks after birth, and postnatal depression which is much more severe and usually lasts for a longer period. You may well have a local word for the mild depression or 'blues' that women experience following birth. Use this word when you discuss the topic with women and their families to differentiate it from postnatal depression, which is different.

When the mother experiences low energy, fatigue, sleep or appetite problems, then she may have postnatal blues. True postnatal depression is when a woman is depressed considerably for more than two weeks, enough to disturb her routine activities. She may also experience any of the following:

- persistent sad or anxious mood, irritability
- low interest in or pleasure from activities that used to be enjoyable
- difficulties carrying out usual work, school, domestic or social activities
- negative or hopeless feelings about herself or her newborn
- multiple symptoms (aches, pains, palpitations, numbness) with no clear physical cause.

In addition she may be suffering from guilt or have negative feelings towards herself or her newborn. In some cases a woman may feel so depressed that she wants to end her life. If you identify a new mother with depression then you should refer her as soon as possible to the nearest health care facility. Support groups can also help. If that is not possible then you may need to support her through this period yourself. If possible, meet her on a regular basis and use your skills to show empathy, listen to her and support her. Ask her consent to discuss with a family member or friend who she feels may also be able to provide her with support. Involve her in social activities and activities that used to make her happy in the past. If depression is mild, regular physical exercise can help a lot.

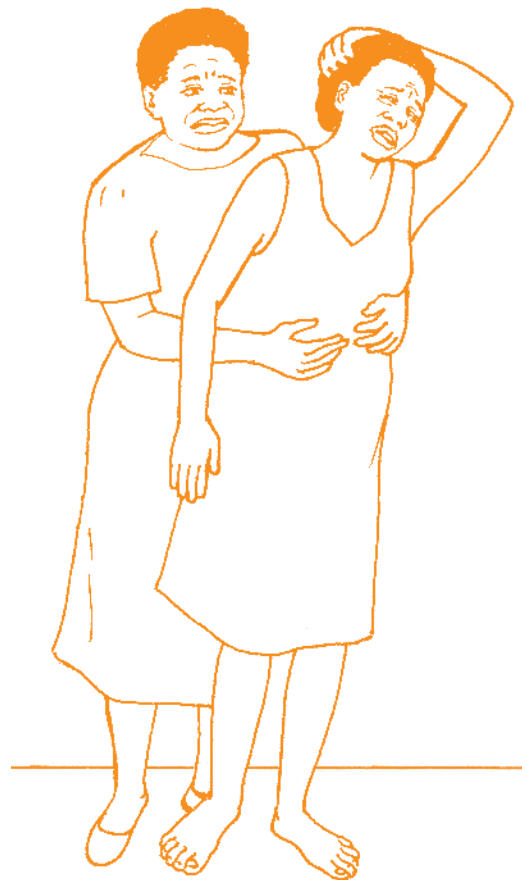
Supporting depressed women

Women who have depression need emotional support. Reassure them that this is usually a temporary condition that happens to some women who have given birth. It sometimes helps if women know that feeling depressed following the birth of a baby is normal and many women experience these feelings. Try and talk to the woman's family and explain to them the need for extra support at this time. Verify that she and the newborn are getting the care they need.

Some relatives and even sometimes health workers may not take the concerns of women they see seriously. If women feel their concerns are not taken seriously, this may make them feel inadequate as mothers, which will contribute to their depression. Some mothers may not be able to care for themselves or their baby properly. This is particularly true for women with special needs and adolescents in particular. Under no circumstances should anyone verbally or physically abuse a mother who is having problems caring for her baby.

Reflect on your own attitudes towards women who suffer from the postpartum blues or a more severe form of sadness and depression. Have you been able to be supportive of them? Do you think this is a serious issue? How prevalent is it in your community? What is the attitude of the community towards women who are experiencing postnatal depression? Discuss with some colleagues to get their impression about how many women may suffer from this. Interview some women who have recently given birth and ask them if they have felt any of the signs mentioned in the box on the previous page.

You can play a vital role in encouraging the partner and family to listen to the woman and to be sensitive to her condition. You can encourage them to offer practical and emotional support and to reassure her. Try to maintain regular follow-up with women who are suffering from depression and their families, to ensure they are getting the support they need.



Offer practical and emotional support to women who are suffering from depression after birth.

Activity 1



1 hour



Aim

To help you find ways to support women who are experiencing depression or who require additional emotional support.

Although this activity is written in the context of depression following birth, there will be many other times when you have to counsel depressed women or women who are feeling sad. Women with special needs may be more likely to experience periods of intense sadness or depression and may require additional emotional support.

In addition you or your colleagues may also suffer from periods when you require extra support and understanding as a consequence of the roles you have to play and the support you give to others. The tasks you carry out in this activity can be used for all the women you see, as well as for your colleagues and yourself!

1. Write a list of things that a woman can do for herself to improve her mental health. For example, walking, resting and quiet time, spending time with friends, praying or singing songs.
2. Write a list of things that other family members can do to support her, such as helping out with the work load, sitting and listening to her, providing an environment of care and support.
3. Now write down things that a group of women could do to help improve their mental health. For example, giving one another emotional or practical support or discussing problems and sharing solutions.
4. Do any support groups currently exist in the community? How could you help women in your community to start their own support groups or to better support each other?
5. Discuss the lists with colleagues and finalize them together. Distribute copies of the list so you and your colleagues can use them as a resource with women who are experiencing mental or emotional health problems.
6. In cases where depression is so severe that it does not respond to your interventions, are there more specialized counsellors available to whom you can refer?

Activity 1 continued...**Our View**

Women often find it beneficial to have a group of people with whom to discuss and share their problems and emotions. Some women get support and reassurance from their partners and families but for others a group outside the home might be more beneficial. Women can help one another think through problems and generate options that help to solve these problems.

Find out if a support group exists, and build on this group. If none exist, you could start a new group but starting up a support group can be a difficult and time-consuming task. You could encourage new mothers to consider forming a group. Provide suggestions for what they might discuss and help them set ground rules for privacy and confidentiality.

**REMINDER:**

If the mother suffers most of the time and cannot function normally, neglects herself and/or the baby, you need to refer her to more specialized help. Health workers or counsellors trained to treat depression can offer more advanced psychosocial treatments or if this does not work, they can prescribe some medication, or refer to mental health specialists.

If there is a risk of self harm, or the mother is having thoughts about suicide it is important that she gets urgent help and support and is not left alone. Remove means of self harm and assign someone to ensure her safety while you arrange specialist mental health care.

**ENCOURAGE WOMEN TO DO THINGS FOR THEMSELVES THAT THEY ENJOY SUCH AS:**

- meeting a friend
- getting out of the home or walking, or things which help them to let their feelings out
- singing, drawing or writing
- spiritual relief through prayer
- meditation

Support the woman in whatever way you can. This may include a home visit and/or extra postpartum appointments. Encourage her partner and family to support her practically and emotionally.

How to provide information and support for the care of the newborn after birth

In addition to physically assessing the newborn, you will need to be able to communicate effectively with the mother, father and family to assess how the newborn is doing. You need to provide practical guidance and support for breastfeeding (see Session 13) as well as information on cord care and other care in the home for the baby.

As you ask the mother questions, remember to use simple, appropriate language. Treat any concerns she raises about her baby or her role as a mother with respect, even if her worries might appear unnecessary to you. You should maintain her trust at this time so that she will come to you when she has other concerns, which you may consider more serious. All mothers (but especially first time mothers) need lots of support and reassurance that they are caring for their babies appropriately. You can communicate some of this information by active demonstration, for example, showing the new mothers how to hold or lift a baby, so that they can see what to do, and giving them opportunities to ask questions and clarify any problems.



REMINDER:

It is important to provide mothers, fathers and families with practical advice on how to care for the baby during the first few days.

- Keep the baby warm - a baby should wear 1-2 layers more than an adult. If cold, put a hat on the baby's head.
- Care for the umbilical cord. Do not put anything on the stump.
- Keep the baby clean. It is not necessary to wash the baby every day, but wash baby's face and bottom when needed. Make sure the room is warm when undressing baby.
- Provide nothing but breast milk day and night.
- You should see a health worker on day 3 and between 7 and 14 days and 4-6 weeks after birth. At the 6 week visit the baby will be immunized.
- Let the baby sleep on his/her back or side.
- Keep the baby away from smoke.
- It is not recommended to expose the baby to direct sun.

Some women may need extra support with a particular issue such as breastfeeding. Women may also want information or support about any problems that their babies have. Remember when an issue is raised the first thing you should do is find out how much the woman already knows and what she is already doing – many times she is doing the right things and just needs reassurance. If there are problems which she identifies, follow the counselling procedures you have been practising to help her

identify possible solutions. Together with her, weigh the advantages and disadvantages of solutions and put together a plan of action that she feels she is able to carry out.

At this time you may also want to review any local practices that families may want to carry out with the baby. Discuss with them the consequences of some practices which may be harmful (Review the list of harmful, harmless and helpful practices you developed in Session 4 Activity 1).

Danger signs for the newborn

In addition to advising parents and the family on general care of the newborn, it is important to alert them to danger signs.

As for the mother, there are also danger signs for the newborn that mothers and families need to identify and respond to immediately. Think about how to discuss and review this information with families. Consider obtaining or developing support materials, which will help you to communicate this information more effectively and that will help women and their families to remember the danger signs.



DANGER SIGNS FOR THE NEWBORN

Advise the mother and family to seek care immediately, day or night. They should not wait if the baby has any of these signs:

- difficulty in breathing or indrawing
- fits
- fever
- feels cold
- bleeding
- not feeding
- yellow palms and soles of feet
- diarrhoea

The mother and family should go to the health centre as soon as possible if a baby has any of the following signs:

- difficulty feeding (poor attachment, not suckling well)
- is taking less than 8 feeds in 24 hours
- pus coming from the eyes or skin pustules
- irritated cord with pus or blood
- yellow eyes or skin.
- ulcers or thrush (white patches) in the mouth - explain that this is different from normal breast milk in the mouth

When explaining the danger signs to parents and caregivers, when possible show them what you are describing. Use the baby as a visual aid and for example, show them the normal breathing, show them where pustules might appear, or where the redness of cord infections will be seen. Take some time to observe normal feeding patterns, techniques and positioning and discuss the most common difficulties they are likely to experience.

**REMINDER:**

Advise families on the importance of birth registration. Consider making a list or instructions on where and when to go that you can give to families.

Newborn babies with special needs

A baby who had difficulties breathing at the time of birth and needed resuscitation should be carefully monitored over the next 24 hours, with particular attention to the danger signs in the newborn. For these babies it is particularly important that they are kept warm and that extra attention is paid to the initiation of breastfeeding. These babies may have some difficulties in starting to breastfeed and the mother and baby might need more support. It is also important to explain to the parents of the baby what happened at the time of birth and the possible consequences of their baby not starting to breathe by him/herself, such as developmental delays.

Some babies are born very small, either because they have been born before nine months, or because their growth was restricted in the uterus. Mothers who are very young; who are expecting twins; who are involved in hard physical work during pregnancy; or who are over- or underweight, anaemic or have suffered from malaria or another infection during pregnancy; are at greater risk of giving birth before time or giving birth to a low birth-weight baby. Low birth-weight babies or babies born under 2500 gs are at greater risk of infections and dying. Make sure the parents of low birth-weight babies are aware of the danger signs in the newborn and know to seek help quickly. In particular, low birth-weight babies may have difficulties with breastfeeding. See Session 13 on breastfeeding for further information on how to support the mother of a low birth-weight baby to breastfeed.

Low birth-weight babies can be cared for using Kangaroo Mother Care. The Kangaroo Mother Care: Practical guide published by WHO (http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/9241590351/en) gives further information on how to initiate Kangaroo Mother care in hospital. Kangaroo mother care involves skin-to-skin contact between mother and baby and exclusive breastfeeding. It allows the mother and baby to bond, while also keeping baby warm and able to breastfeed often.

Activity 2



1 hour



Aim To practice your skills at counselling new mothers

This is a role-play activity. If you are not working through the Handbook with a group, try to find two colleagues who can help you with this role-play. If you are part of a group, take turns playing the role of the new mother and the health worker.

This activity will build on some of the skills you practiced in Activity 2 in Session 9. Remember to:

- maintain eye contact, where culturally appropriate, nod and smile at appropriate times
- demonstrate open body language
- demonstrate empathy and respect through understanding/caring language
- do not sound harsh or judgemental, despite your own beliefs and values, or the time constraints of your job
- ask open-ended questions and listen actively
- do not give direct advice, but explore what the mother already knows
- paraphrase questions back to check understanding
- build on the mother's knowledge, so she can best engage in a solution.

Take some time to discuss the reasons mothers come to the health facility with their newborn. Make a list of possible scenarios. The person playing the mother can choose one and start the role play. For example:

- A young mother brings her 2-week old baby to the clinic with an infected umbilicus. Her mother-in-law had insisted it was necessary to apply a poultice to the cord.
- An adolescent mother brings her 1-week old baby in with a very mild rash, but really she wants to find out about family planning, as her boyfriend is pressuring her to resume sexual relations.
- A mother with 4 children and a new baby comes in complaining of fatigue. She looks sad, overwhelmed and she has been crying.
- A mother comes in for a routine check-up at 6 weeks. She is very thin and weak.

Think of other scenarios that you have encountered in your work, or that might occur in the community and setting you are working in.

The person doing the counselling should also consider:

What open questions you can use to establish two-way communication and put the mother at ease?

Have you explored what it is about the mother's situation that prevents her from addressing her and her baby's needs?

Have you avoided using judgemental questions?

Activity 2 continued...

Have you reflected back what the mother said and built on her knowledge?

What information can you give her and how can you work with her to find a solution?

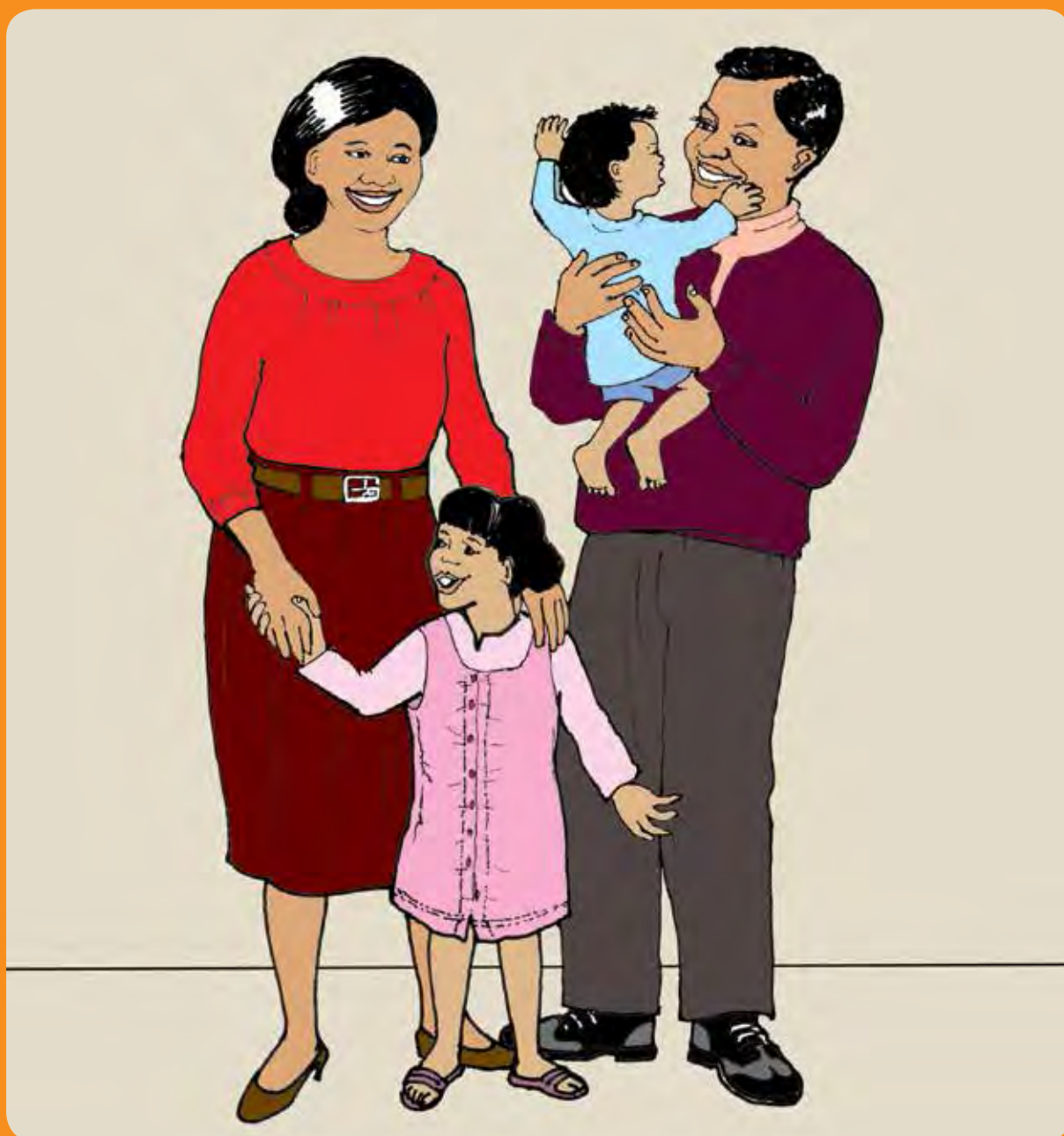
One participant should observe the role-play. S/he will comment afterwards on what the person playing the health worker did well and make suggestions on how to improve the counselling session in future. Try to point out what was good in the counselling session and then make some suggestions about what could be improved next time.

What did I learn?

You should be able to communicate the essential messages relating to care of the mother and the newborn in the home after birth. You have learned the danger signs in the postnatal period for the woman and newborn and thought about how best to communicate these to women and their families. You have also learned how to care for and support women who are experiencing depression and how to mobilize support from families, communities and other women in similar situations. Remember, that often we ourselves may need support after providing emotional support to others. Some of the aids discussed here may be of use to you and your colleagues.

To help yourself, remember to reflect on what you are doing and how you are feeling. Take time for yourself to recharge your batteries, particularly if you have been through an emotional or stressful experience at work. Use your notebook to record your thoughts and feelings and share these with a trusted colleague if you think that will help, or identify other things you can do for yourself. Remember, an exhausted, unhappy health worker is unlikely to be able to provide the care and support the woman or family need.

FAMILY PLANNING COUNSELLING



What is in this session?

It is important to help women and their partners to gain increased control over their reproductive health. One of the main ways you can do this is through counselling on family planning methods during late pregnancy, the postpartum and the post-abortion periods.



IMPORTANT:

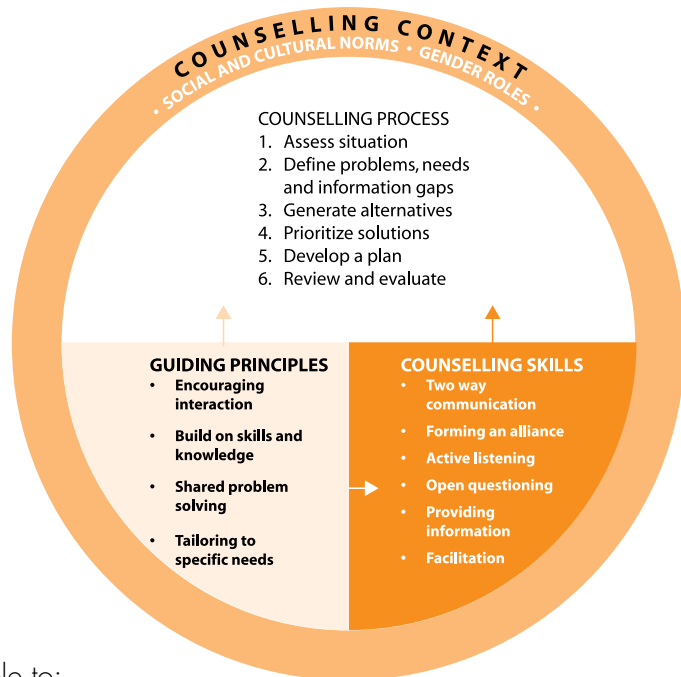
This session only provides an introductory overview on family planning counselling. If necessary and where possible, you should refer women to see a trained family planning provider and/or use family planning support materials, such as the WHO 'Decision-Making Tool for Family Planning Clients and Providers'.



http://www.who.int/reproductivehealth/publications/family_planning/9241593229/en/index.html

What skills will I develop?

- Providing information that builds on existing knowledge
- Facilitating shared problem-solving and decision-making
- Tailoring to specific family planning needs.



What am I going to learn?

By the end of this session you should be able to:

1. Assess the family planning needs of individual women
2. Communicate information on the importance of birth spacing and on family planning method use.
3. Communicate information on the importance of family planning in the postpartum and post-abortion periods.

Birth spacing and postpartum family planning

Family planning is about deciding how many children you choose to have and when you want to have them (timing of pregnancies and birth spacing). The recommended interval before attempting the next pregnancy is at least 24 months in order to reduce risks to the mother and infant. A woman can become pregnant within several weeks after birth if she has sexual relations and if she is not breastfeeding exclusively. It is important that as a health worker you discuss the importance of family planning and birth spacing, and help couples in choosing the contraceptive method that is right for them.

The role of family planning counselling is to support a woman and her partner in choosing the method of family planning that best suits them and to support them in solving any problems that may arise with the selected method. During late pregnancy, after giving birth and after an abortion, it is important that the woman or the couple receives and discusses correct and appropriate information so that they can choose a method which best meets their needs. If a woman, preferably with her partner, is able to make an informed choice, she is more likely to be satisfied with the method chosen and continue its use.



THE HEALTH BENEFITS OF BIRTH SPACING AND FAMILY PLANNING:

- Delaying having children can give people the opportunity to complete education or further studies
- Waiting to become pregnant at least 24 months after birth can lead to health benefits for the mother and baby.
- Spacing births allows the mother to recover physically and emotionally before she gets pregnant again, and faces the demands of pregnancy, birth and breastfeeding.
- Limiting the number of children in a family means more resources for each child and more time for the parents to dedicate to each child.
- Family planning can also help couples in a sexual relationship not to be worried about the woman getting pregnant.
- STIs including HIV/AIDS can also be prevented with correct and consistent use of condoms.
- Younger women (adolescents) can delay pregnancy until their bodies are mature and they are ready in terms of their life course.
- Older women (over 35) can prevent unwanted pregnancies that are often risky for their health and can lead to complications for both mothers and infants.

When to counsel on birth spacing

You should begin discussing family planning during pregnancy, particularly during the third trimester, after birth and in the immediate postpartum period. Pregnant women need to know that if they are not exclusively breastfeeding they can get pregnant as soon as four weeks after the birth of their baby, even if they have not yet started their menstrual cycle. Several methods of family planning can be started immediately after birth, but others may need to be delayed if the woman is breastfeeding.

If the woman wants female sterilization or an Intrauterine Device (IUD) inserted immediately after childbirth, she should inform her birth attendant and plan to give birth in a health facility.

Advise women about the benefits of using breastfeeding as a family planning choice, known as the Lactational Amenorrhoea Method (LAM). LAM provides protection when the following three requirements are met:

1. the woman is exclusively breastfeeding a baby, day and night
2. during the first six months after birth and
3. her menstrual periods have not returned.



REMINDER:

Exclusive breastfeeding means that the baby is not given any other food or drink, not even water. She or he is only given breast milk. See Session 13 for more information on breastfeeding.

Once the baby reaches six months, or receives complementary foods or the mothers' periods have returned, she should use another family planning method. Before this time she needs to start thinking about what method she will use after LAM.

Counselling a woman on family planning after an abortion:

When advising a woman how to care for herself after an abortion (see Session 9 as well), remember that it is important to discuss the use of a family planning method to prevent another unwanted pregnancy. Explain that she can become pregnant as soon as two weeks after an abortion if she begins to have sexual relations. A woman who has recently experienced an induced or spontaneous abortion should wait at least six months before another pregnancy to reduce risks to her health and to her future baby.

You can support her and her partner in choosing a method that meets their needs:

- If she has no post-abortion complications or infection, she can safely use any family planning method, and can start all methods immediately post-abortion (except for the natural calendar method, when she should wait for 3 months).
- If an infection is present or suspected, advise her to avoid intercourse until the infection is ruled out or fully treated. Delay female sterilization and IUD insertion until an infection is fully treated, but offer other methods to use in the meantime.
- For IUD insertion or female sterilization after a second trimester abortion, the provider may need special training because of the changed uterine size and the position of the fallopian tubes.
- If she thinks she could be at risk of getting STI/HIV, she should use a condom in all sexual relations.
- It may also be helpful to explain emergency contraception, and offer her emergency contraceptive pills to take home in case she needs them.

Male partner

The partner should be encouraged to take part in family planning counselling sessions, especially if the chosen method involves his cooperation, for example, condoms or natural methods. In some places research has shown that family planning method use is more successful when partners choose and agree upon a method together. First, ask the woman whether she would be happy for her partner to be involved. In some cases women may feel more comfortable if their partners are not present or if their partners are counselled on their own and/or by a male counsellor.

Within the community, men also need to participate in discussions on the importance and benefits of family planning and birth spacing. Men need to understand their role in reproduction so that they can share the responsibility for family planning and birth spacing. This can be done through outreach work or through discussion with men when they accompany their wives or partners to the health facility.



Partners should be encouraged to take part in family planning counselling sessions.

Women with special needs

Women with special needs may require extra time for family planning counselling. For example, adolescents who are not in a stable relationship, need emphasis placed on the importance of dual protection from STIs/HIV, as well as from pregnancy (see box next page). They may also need special assistance in obtaining the family planning method that suits them best. Women who are in violent relationships may also need special counselling and support to explore their alternatives (i.e. condom use may be unlikely). These women may also not be able to discuss family planning with their partners and may need extra help and support in using family planning methods. Women with physical disabilities may have special requirements in terms of which methods are suitable for their situation and disability. Women with severe physical or mental disabilities may have become pregnant due to rape or abuse. The family needs to be involved in such instances to ensure that this does not recur and also possibly to be involved in discussions around family planning for this woman. Women with HIV must be counselled on the necessity of using dual protection methods, even if their partner is HIV-positive, to prevent other STIs and strains of HIV developing.



REMINDER:

Adolescents or unmarried women should also be offered family planning counselling. Sometimes this is difficult if the family or community disapproves of adolescent sexual activity and pregnancy. Explore ways you can work with adolescents, youth groups and schools to reach adolescents who may need support. Consider the counselling context, specifically any cultural norms you identified in Session 4 to help you locate any key gatekeepers in the community to help you address this topic with adolescents.

When working with a pregnant adolescent, it is particularly important to discuss birth spacing and support her in planning when she would be ready for a next pregnancy.

Dual protection (also see Session 14 on HIV)



REMINDER:

Correct and consistent use of condoms with another family planning method for every sexual encounter is the best way to ensure dual protection against unwanted pregnancy and HIV/AIDS transmission.

Dual protection against both pregnancy and STIs, including HIV/AIDS, is an increasing concern for many women. You may need to counsel women and their partners about their options for dual protection.

Issues for women and their partners to consider are:

- Some people are more at risk than others (for example, those with new or multiple partners).
- Often people do not know if they or their partner has an STI as they may have no symptoms.
- A person with HIV can look and feel healthy.
- If someone is unsure about sexually transmitted infections, a test may be available.
- If you are sexually active (and are not 100% sure that your partner is not infected) then consistent and correct condom use is the only way to protect fully against STIs/HIV.
- Condoms can be used together with another method to ensure very effective protection from pregnancy and STIs.

Remember that only condoms protect against both pregnancy and STIs/HIV.

Helping a woman to choose a method that is right for her

There is no single method of family planning which should be recommended for everyone. Family planning counselling can help a woman, and/or her partner choose which method best suits him or her.

There are various models of family planning counselling that can be applied, including the GATHER model (Greet the client, Ask about situation and needs, Tell about different methods and options, Help clients choose, Explain how to use a method, Return) or the REDI model (Rapport-building, Exploration, Decision-making, and Implementing the decision). In general, the steps or actions outlined below should be covered to counsel on family planning. To start the counselling process, remember the steps and skills outlined in Session 2.

1. Assess the situation, her needs and information gaps

In order to help counsel a woman on family planning, it is very important to discuss her and her partner's specific needs and situation.

- a. you can ask if she knows about family planning, what she has heard about it, and if she knows it is important;
- b. explain that it is important to know that she can become pregnant soon after giving birth if she is not exclusively breastfeeding;
- c. you should also ask whether the woman or couple already have a family planning method in mind – those people who receive the method that they have planned for are much more likely to use it successfully. You can then help them assess if this method suits their situation and needs (e.g., Are you confident you could remember to take a pill every day?), or it may also be helpful to discuss other options in case there is a method that better suits his/her or their needs.

When discussing her needs and situation, you can ask about:

- plans for having more children;
- whether she and/or her partner want to use family planning;
- previous methods used and reasons for success or failure;
- experience with side-effects;

- popular beliefs about family planning and how these affect her decision to choose a particular method;
- her relationship and situation; Is she in a stable relationship? How often does she see her partner? How many partners does she have?; Is there need for dual protection from STIs, including HIV?
- her and her partner's HIV status or risk factors for HIV;
- regularity of sexual intercourse (especially for adolescents or unmarried women);
- partner's or family's views about family planning methods;
- ability to keep to routines.

2. Help to prioritize solutions, narrow down options and make a good choice

You can then discuss various family planning methods based on the needs and situation of the woman and her partner. Possible methods are listed in the table below. Key method characteristics that can be discussed include:

- Can the method be used while breastfeeding?
- How effective is it?
- Are there any side-effects?
- Does it provide protection from STIs or HIV?
- Does it impact on sexual relations?
- How easy is it to use?
- Is it easy to stop using the method?
- Is the method reversible?
- How quickly will fertility return once method is stopped?
- Is there a need to do something before sex? (e.g. putting a condom on, inserting a diaphragm)
- Is it used continuously, or only used when needed?
- Is there a need to touch genitals?

3. Check if she is eligible to use the chosen method

Before giving out detailed information on method use, check if the woman is eligible to use the method. Some women who have recently given birth or who are breastfeeding may be unable to use certain methods (see table below). You can also check if she is able to start using the family planning method straight away. Some health conditions may prevent a woman from using certain methods.

4. Provide useful information on the chosen method

Women and their partners need accurate information to use a family planning method correctly. Although too much information can be unhelpful or off-putting, there are some key pieces of information that must be explained:

- What the method is and how it works
- How effective it is at preventing pregnancy
- Side-effects: what the user can expect, and what to do about them
- How to use the method correctly
- What to do in case of a mistake in the use of the method or problems (missed pills, late for injection, condom splits)
- Information on when to return to the clinic
- Signs of complications to watch out for.

The best way to check whether a woman knows how to use the method is to ask her to explain to you in her own words how to use the method. You could also ask her to demonstrate the use of certain methods such as condoms or diaphragms, or you could consider demonstrating their use to her first, asking for her to repeat back the demonstration afterwards to ensure that she has fully understood.

Table: Starting family planning methods after childbirth

Method	Breastfeeding	Not breastfeeding	Effectiveness
LAM (Breastfeeding)	Start immediately after childbirth; can use if exclusively breastfeeding day and night for up to 6 months or until periods return	N/A	Very effective with correct use, few side effects
IUD	Insert within 2 days of childbirth, or from 4 weeks after childbirth	Insert within 2 days of childbirth, or from 4 weeks after childbirth	Always very effective, long term method but may have side-effects
Female sterilization	Perform within 7 days, or from 6 weeks after childbirth	Perform within 7 days, or from 6 weeks after childbirth	Always very effective, permanent method, fewer side-effects
Combined pill (estrogen-progestogen)	From 6 months after childbirth	From 3 weeks after childbirth	Very effective with careful use, may have side-effects
Monthly injection (combined)	From 6 months after childbirth	From 3 weeks after childbirth	Very effective with careful use, may have side-effects
Mini-pill (progestogen-only)	From 6 weeks after childbirth	From immediately after childbirth	Very effective with careful use, may have side-effects
DMPA and NET-EN (3 or 2 month injection)	From 6 weeks after childbirth	From immediately after childbirth	Very effective with careful use, may have side-effects
Implants	From 6 weeks after childbirth	From immediately after childbirth	Always very effective, long term method but may have side-effects
Condoms	From immediately after childbirth	From immediately after childbirth	Effective with careful use
Diaphragm	From 6 to 12 weeks after childbirth (depending on when the uterus and cervix return to normal)	From 6 to 12 weeks after childbirth (depending on when the uterus and cervix return to normal)	Effective with careful use
Fertility awareness-based methods	When periods return to normal	When periods return to normal	Effective with careful use

Activity 1



variable



Aim To practise your skills at family planning counselling

If you are working in a group carry out this activity as a role-play, rotating the roles. Take time in advance to come up with a number of different roles. If you are working alone, ask a colleague to observe you counselling women.

1. Review the material covered in this session and make your own notes or reminders to help you with family planning counselling. Focus on:
 - finding out what is already known
 - dispelling any myths or misunderstandings regarding contraception
 - engaging the woman and her partner in interactive discussion
 - filling information gaps
 - discussing the woman's/couples needs
 - tailoring methods to their circumstances (physical, social)
 - discussing characteristics of different methods
 - joint decision-making
2. Get the person who will be observing you to review this session beforehand. Remember to get permission from the woman or couple for the observer to be present if you will be carrying out this activity in a real situation rather than a role-play.
3. Ask the observer to give you feedback on your strengths and weaknesses during the counselling process using the points outlined above as a checklist. You can also refer back to Session 9 Activity 2 for a more general observer's checklist.



Our View

Because of expertise and knowledge and the respect person in the community have for this knowledge, we can sometimes inadvertently push people towards decisions that they are not ready to make or are not happy with. Skilled counsellors facilitate the process while taking a 'back seat' when it comes to making a decision. In other words they let the woman or couple reach their own decision. Your questioning and listening skills will help you to make accurate assessments and know where to provide guidance and where to take a step back, as people work through the information.

What did I learn?



The importance of establishing family planning during the post-abortion and postpartum periods cannot be underestimated. Providers need to work in an interactive way with women and their partners to discuss their family planning needs and to establish which methods will best satisfy their particular needs. Are you confident that you can discuss family planning issues with women and their partners during pregnancy and the postpartum period? Which skills do you need to develop and practise? Do you have access to Family Planning tools to assist you? Do you know where to refer women and their partners for specialist family planning advice?

Write down the answers to this information in your notebook, but also consider putting it together as a resource to share with your colleagues. Remember also that as you practise your counselling skills you should try and reflect on where you have improved and areas you feel you need to strengthen.

BREASTFEEDING



What is in this session?

Breastfeeding plays a crucial role in the health, growth and development of babies and has benefits for the mother too. Women may need some help to successfully feed their babies. They need support and reassurance as they learn this skill. This session focuses on the initiation of breastfeeding following birth and when and how to refer women who are experiencing difficulties.

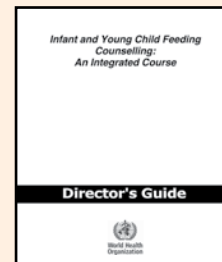


IMPORTANT:

If necessary and where possible, you should refer women to see a trained breastfeeding counsellor and/or use support materials, such as “the WHO and UNICEF training materials”.

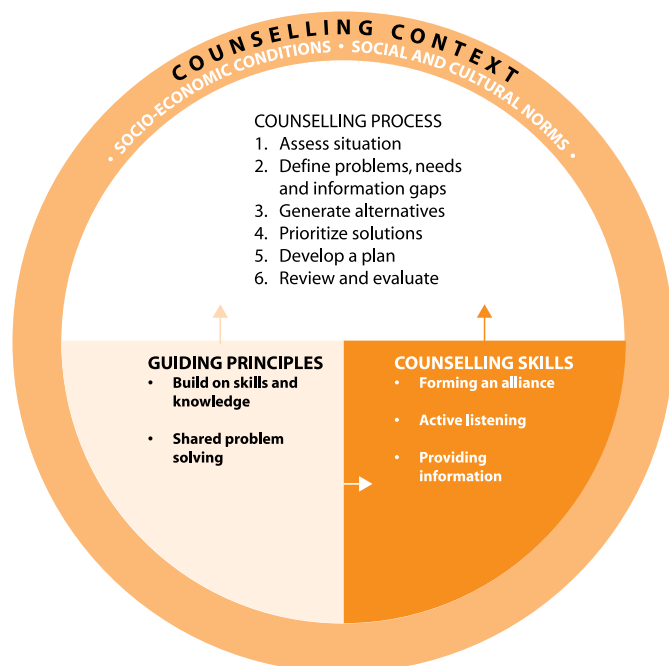
Breastfeeding counselling, a training course (1993) http://www.who.int/child_adolescent_health/documents/who_cdr_93_3/en/index.html

Infant and young child feeding counselling, an integrated course (2006) <http://www.who.int/nutrition/publications/infantfeeding/9789241594745/en/>



What skills will I develop?

- Providing information and demonstrating breastfeeding techniques
- Encouragement and support
- Shared problem-solving



What am I going to learn?

By the end of this session you should be able to:

1. Communicate the advantages and benefits of breastfeeding for both mother and baby
2. Demonstrate how to breastfeed a baby, including positioning and attachment
3. Assess actual and potential difficulties and how to work with women on ways to overcome them
4. Explain the opportunities for HIV-infected mothers to breast feed and improve HIV-free survival of their baby

Breastfeeding

During pregnancy and after the birth it is important to discuss with women the importance of exclusive breastfeeding for six months. Try to include the partner or other family members and communicate to them all about the benefits of breastfeeding for the mother and baby, the process of breastfeeding and when and how long to feed for. You should also discuss continued breastfeeding after six months and introduction of other foods in addition to breast milk. You might find it useful to refer to more specialized breastfeeding tools and materials to support your discussion.

What is so good about breastfeeding?

- Breast milk provides all the nutrients that a baby needs for the first six months of life to grow and develop.
- Breast milk continues to provide high-quality nutrients and helps protect against infection up to two years of age or more.
- Breast milk protects babies from infections and illnesses.
- Babies find breast milk easy to digest.
- The baby's body uses breast milk efficiently.
- Breastfeeding can contribute to birth spacing.
- Breastfeeding helps the mother's uterus to contract reducing the risk of bleeding after birth.
- Breastfeeding lowers the rate of breast and ovarian cancer in the mother.
- Breastfeeding promotes a faster return to mother's pre-pregnancy weight.
- Breastfeeding promotes the emotional relationship, or bonding, between mother and infant.



REMINDER:

As well as benefits for the baby in terms of survival, breastfeeding has other advantages. It is easier to carry out than feeding formula; it takes no preparation; is always at the correct temperature, it is always clean and is always available. It is the perfect nutrition for babies.

Communicate information on the advantages of breastfeeding (including health benefits, economic benefits, etc.), to help women decide which method of feeding they will choose. Be sure to also discuss the risks of not breastfeeding. Answer any questions or concerns the woman may have. For example, some women do not realize that it is normal for the baby to lose weight in the first three or four days after birth and that this is not a reflection of how she is breastfeeding or the quality of her breast milk. Women can still breastfeed while taking most medications, such as antibiotics, antiretroviral or TB medication.

Some women may choose not to breastfeed. You should respect this decision, even if you disagree with it and support her to replacement feed safely.



Women need support to help them decide and carry out their infant feeding choice.



RISKS OF NOT BREASTFEEDING

- Babies may get sick more often with diarrhoea, malnutrition and pneumonia and are at increased risk of dying.
- Babies do not get natural protection to illnesses.

Initiating skin-to-skin contact and breastfeeding

After birth, dry the baby. Place him/her on the mother's chest, preferably with skin-to-skin contact. Use a blanket to cover both baby and the mother, to keep the baby warm. When the baby seems ready, encourage the mother to help the baby to her breast. Babies show they are ready to take the breast when they start "rooting", or looking for the breast. Some babies need encouragement to latch-on at this stage.

It is important for all mothers to start skin-to-skin contact from birth as soon as possible following birth – preferably in the first hour. They should let their baby suckle when they appear to be ready. Some babies may take longer to start breastfeeding. As a health worker you have an important role in helping the mother to do this. Early contact will help a mother to bond with her baby - that is, to develop a close, loving relationship. It also makes it more likely that she will start to breastfeed.

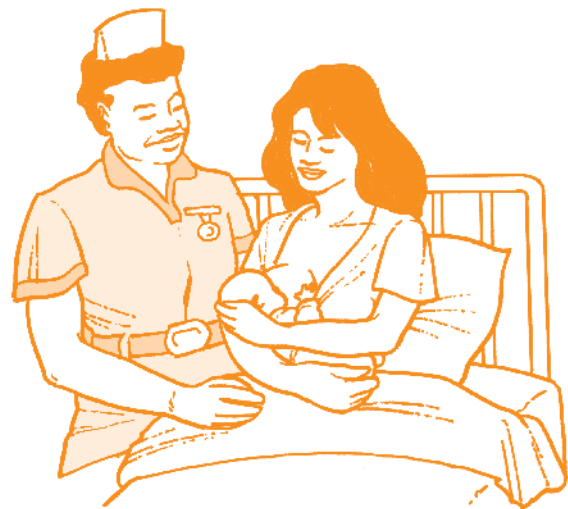


SKIN-TO-SKIN CONTACT HELPS:

- to keep the baby warm
- to establish breastfeeding
- to encourage mother-child bonding.

Positioning and attachment

To help a mother learn how to breastfeed first encourage her to get herself into a comfortable position. Show her how to hold the baby straight, with both the baby's head and body turned to face her breast and with the baby's nose opposite her nipple. She should hold the baby close supporting the whole body, not just the neck and shoulders. Refer to breastfeeding aids and materials to help you become more familiar with correct positioning and attachment.



Encourage and support women as they learn to breastfeed.

Observe the mother breastfeeding her baby and offer help and assistance if needed. Look for signs of good attachment and effective suckling (slow deep sucks with pauses). If the attachment is not good, encourage the mother to reposition the baby. Show the mother how to take the baby off the breast, by inserting her little finger into the corner of the baby's mouth. Keep encouraging and reassuring the mother the whole time. Encourage her to reposition the baby until she feels comfortable and the baby is sucking well. Reassure her that there is no need to rush, even if the baby is crying.



REMINDER:

Correct breastfeeding positioning occurs when the baby's:

- head and whole body are well supported and held close to mother
- face and stomach face the mother
- ear and shoulder are in one straight line, neck is not twisted.

Good attachment occurs when the baby's:

- mouth covers most of areola (dark part of the nipple) with some of the areola visible above the mouth
- mouth is wide open
- chin touches the breast
- lower lip is turned outwards.

Effective suckling occurs when:

- slow, deep firm sucks alternate with bursts of suckling
- no other sounds except swallowing sounds are heard.

Exclusive breastfeeding

All mothers should be encouraged to exclusively breastfeed their babies until they are six months old. Exclusive breastfeeding means that the baby is not given any other food or drink, not even water. They are only given breast milk. Make sure that you or others in the facility do not give the baby anything that will interfere with exclusive breastfeeding.

**REMINDER:**

To encourage and support exclusive breastfeeding there are key things you can do:

1. Encourage breastfeeding frequently, day and night, and advise the mother to allow the baby to feed for as long as he/she wants. Tell her it is quite normal for a baby to feed up to eight times a day. Explain to her the signs a baby will show when he/she needs to be fed (such as “rooting”, looking for the nipple, sucking on the hand).
2. Reassure the parents that there is no need to give the baby any other drink or food, not even water – breast milk has all a baby needs.
3. Help the mother whenever she needs assistance and especially if she is a first time or adolescent mother or a mother with other special needs.
4. Explain to the mother she should let the baby finish the first breast and come off on its own before offering the second breast.
5. Encourage the mother to start each feed with a different breast. For example, if the left breast is used to start one feed, at the next feeding start with the right breast.
6. If it is necessary to express breast milk, show the mother how to do this and show her how to feed expressed breast milk by cup. You may need to refer her to a trained infant feeding counsellor for this.
7. Reassure the mother that her body will make enough breast milk to satisfy her baby’s needs. Just because a baby is crying, it does not mean that she does not have enough breast milk. A baby who is demanding more breast feeds may be growing. By allowing the baby to suckle more often, her body will produce more breast milk to meet her baby’s needs.
8. Explain that the mother can provide all the breast milk her baby needs for the first 6 months and beyond.
9. Explain that the mother can continue breastfeeding if she has to return to work or school, either by expressing breast milk or feeding more often when she is at home.
10. Advise her to seek help (or come back to see you) if the baby is not feeding well or if she has any difficulties or concerns with breastfeeding, sore nipples or painful breasts. If needed, refer her to a trained infant feeding counsellor.

Activity 1



variable



Aim To examine ways to improve how breastfeeding is supported and communicated to mothers.

In many health facilities breastfeeding is supported in a number of different ways. This activity is designed to get you and your colleagues to assess how you provide breastfeeding counselling and support, and what could be improved or strengthened.

1. Gather the following information from ten women who have recently given birth. If you are working in a group, each group member should do the same.
 - At what point in pregnancy did the health worker discuss breastfeeding with them?
 - Do they think these discussions should have started earlier in pregnancy or later, or was this the right time?
 - Do they remember what was discussed with them? (Make a list of the different points discussed.)
 - Did they feel the information was clear and easy for them to understand?
 - After birth, what advice and support was given to them to breastfeed their babies? When was this given?
 - Was skin-to-skin contact promoted after birth (the baby placed on the mother's upper abdomen)? How soon after birth was it started?
 - Was ongoing support, advice and reassurance given to them? How was this given?
 - Who gave them support and advice once they were home? Did they feel they had enough support and advice or did they need more? What additional support and advice did they think would be helpful?
 - What are some of the barriers women face to exclusive breastfeeding and how can the health staff help them to solve these?
 - Ask women for suggestions on how staff could better respond to their needs.
2. Discuss the responses with the rest of the group working through this handbook if applicable. Do you need to do anything differently? How can you as a team better respond to the support women need to successfully breastfeed? With the manager, make a plan for any changes that should be introduced, including reviews to check on how you are progressing. For example, you could carry out this activity again, six months after making changes to evaluate whether you have made any improvements.

Activity 1 continued...**Our View**

Discussion of breastfeeding should start during pregnancy by asking women how they plan to feed the baby. At this time you do not need to overload women with too much information. Stick to the basic facts about the benefits of breastfeeding for the baby and for the mother. Talk to women about the benefits of initiating skin-to-skin contact as soon as possible following the birth (preferably within one hour) to facilitate early initiation of breastfeeding. You should help the mother with the first breastfeed to show her how to position and attach the baby. Demonstrations are important as breastfeeding is a skill that mothers learn. Have dolls available to demonstrate position. Remember to provide as much support and reassurance as each woman needs – it will vary according to the woman.

Consider how you might be able to provide support and reassurance to women once they have left the health facility and are at home. Once home many women experience feeding problems such as engorged breasts or cracked nipples. Others may be pressured by family members to offer supplementary foods or drinks. How can you work with women to overcome some of these problems? One way is to talk with all family members on the importance of exclusive breastfeeding. You can also make sure you assess breastfeeding at any visit or meeting during the postnatal period. Also consider holding a special session for breastfeeding problems.

Often in the community, groups exist to support women who are breastfeeding. Find out what support exists, or contact women who have successfully breastfed and see if they would be available to support women after birth.

Before discharge and if the mother returns to the health facility during the postnatal period you need to assess how breastfeeding is going. You should also assess breastfeeding and provide relevant information during routine visits and at any time if there is feeding difficulty or the mother is concerned about feeding.

Supporting breastfeeding

Women need extra support, encouragement and reassurance while breastfeeding. Although we view breastfeeding as a natural process, it is still a skill that has to be learned. Initially breastfeeding can seem demanding, as the baby may have a desire to feed/suck frequently. Babies however, begin to establish their own pattern over time, and the mother will begin to feel more comfortable and at ease.

Some women also find that the initial 'let down' reflex is very strong which causes them pain or they get strong after-pains as their wombs contract. Reassure them that this will pass. The 'let down' reflex may also cause them to leak milk when they have sexual intercourse. Reassure them that this is normal and that they may need to tell their husband or partner that this is normal.

Sometimes husbands or partners may feel excluded from the breastfeeding process. Encourage them to be involved in other ways. This may ease the situation and help men to provide more support for breastfeeding; for example, by asking him to fetch the baby for the feed, helping make the woman comfortable, or looking after the other children while she is feeding. Massaging the baby, and humming to calm a crying baby are other very useful ways of involving men.

Many women find breastfeeding difficult due to problems such as engorgement or sore nipples. Engorgement may happen a few days after birth or at any time when the baby's feeding pattern changes. The breasts become overfull with milk and tissue fluid; milk does not flow well and the skin is tight (especially the nipple). This makes it difficult for the baby to latch on. Sometimes the skin looks red and the woman has a fever which usually disappears in 24 hours. To prevent engorgement, help women to start breastfeeding soon after birth, ensure good attachment and encourage unrestricted breastfeeding. To treat engorgement, recommend that the mother puts warm compresses on her breasts or takes a warm shower and expresses enough milk to reduce discomfort which helps make attachment easier. After expressing milk she can use cold compresses to reduce the inflammation. Cracked or sore nipples occur mainly because the baby is not attaching properly. Help the mother to make sure the baby is attaching properly.

Support for feeding preterm and/or low birth weight babies

Low birth-weight or preterm babies should be fed their mother's own breast milk. The mother may need extra support to initiate breastfeeding or expressing breastmilk as soon as possible after birth. Because low birth-weight babies can sometimes get easily tired when feeding, it is particularly important that the mother feeds her baby as often as possible, responding to demand and at least 8 feeds during 24 hours, during the day and night

If a mother cannot feed her own baby, it is still best for a low birth-weight baby to be fed human breast milk. Another woman could feed the baby, so long as she is not HIV-infected. Some facilities have established breast milk banks, where breast milk from healthy donor women is collected, pasteurised and kept frozen. If your facility does not have a breast milk bank, maybe the local referral hospital can put you in contact with a breast milk bank. Try to find out about breast milk banks in your area

and keep this information available for mothers who cannot breastfeed for a while due to health problems. If the low birth-weight or preterm baby cannot be fed breast milk, either by the mother, a wet nurse or from a breast milk bank, then the baby can be given standard infant formula by cup. Look at Session 26 of the WHO Breastfeeding Counselling: A training course (http://www.who.int/maternal_child_adolescent/documents/who_cdr_93_3/en/), for further information on how to help a mother breastfeed a low birth-weight baby.



Encouraging continuous skin-to-skin contact can help low birth weight babies keep warm and support breastfeeding on demand. Make sure parents are aware of all the newborn danger signs and that they understand it is especially important to bring a low birth-weight newborn to a health facility if they have any worries, as these small babies are at particular risk from infections and feeding difficulties.

Support for the mother who is not yet breastfeeding

If the mother or baby is ill or the baby is too small to suckle you need to give extra support and help. First teach the mother how to express milk and feed the baby by cup. If you have not been trained to do this, you should refer to an infant feeding counsellor where possible. If the mother and baby are separated for any reason then reassure the mother about the baby's progress whenever she asks. Encourage the mother to start breastfeeding the baby as soon as she or the baby is able.

Support for breastfeeding twins

Many mothers who give birth to two or more babies are worried they will not have enough milk. Reassure her that she will have enough milk for both babies. Encourage the mother to feed one baby at a time until breastfeeding is established. You can then show her different ways she can feed the babies and work with her to find out which method she is most comfortable with. If one twin is weaker or smaller than the other, make sure that the weaker twin also gets enough milk.

Advice to women who are not breastfeeding

Some women may not be able to breastfeed and others may choose not to. A woman's right to take an informed decision should be supported and respected. If after discussing the benefits of breastfeeding and the risks of not breastfeeding the mother decides not to breastfeed, she should be shown alternative methods.

These mothers need to learn how to safely prepare and feed formula to their babies. You may also have other women whose babies have died or who have had a stillbirth. These women may experience discomfort in their breasts for a period of time. Advise them not to stimulate the breasts or nipples. Show them how to support the breasts with a firm well fitting bra or a cloth. Teach the mother how to express just a little milk to relieve discomfort but not enough to stimulate more milk production.

**REMINDER:**

Advise all women to seek care if their breasts become painful, swollen, and red or if they feel ill.

Mothers who are HIV-positive

Babies of HIV-positive mothers can benefit from breastfeeding for all the same reasons outlined above. HIV may pass from an HIV-infected mother to her baby during pregnancy, childbirth and breastfeeding. Antiretroviral treatments can dramatically reduce the risk of mother-to-child transmission during breastfeeding and increase the chance of HIV-free survival of the baby (that is, staying free of HIV infection and also staying alive). Although there is still a small chance that the baby could become HIV positive even when the mother is being treated with antiretroviral drugs, babies who are not breastfed, but given replacement feeds, are more likely to die from infections.

National health authorities should have a policy to indicate whether health services should promote and support breastfeeding or replacement feeding among HIV-infected mothers. You need to be aware of this recommendation and you should develop the skills to support women to achieve this. However, it is a mother's right to choose how to feed her baby and you will need to support her choice. Mothers who are aware they are HIV infected should be counselled on safe infant feeding by a trained infant feeding counsellor. Where specialist help is not available, you should support women as best you can.

Ask her to repeat back to you in her own words to make sure she has understood the information correctly. Work together to make a plan that she can implement in order to carry out safe infant feeding.

Women who are HIV-positive and plan to breastfeed need support, particularly in the early stages when breastfeeding is being initiated. Try to help the women to avoid getting mastitis or nipple damage, as these difficulties increase the risk of transmission to the baby. Advise the woman to return if she has any problems with her breasts.

Women who have chosen replacement feeding for their babies must have regular follow-up to ensure that the baby is growing and to support replacement feeding. These women need extra support and reassurance, especially if they are from a community where breastfeeding is the norm. Many communities may stigmatize or shun a woman who chooses replacement feeding. Work with families and communities to support women in their choice of infant feeding.



WHO RECOMMENDATIONS FOR INFANT FEEDING FOR HIV-POSITIVE WOMEN:

Mothers known to be HIV positive should be provided with lifelong antiretroviral therapy or antiretroviral prophylaxis (preventative treatment) to reduce HIV transmission to the baby during pregnancy, childbirth and breastfeeding.

National health authorities should decide whether health services in that country should principally promote and support breastfeeding or promote and support replacement feeding among HIV-infected mothers.

In settings where national authorities recommend breastfeeding, HIV infected mothers and/ or their babies should be given antiretroviral treatment or prophylaxis to reduce the risk of transmission throughout the breastfeeding period.

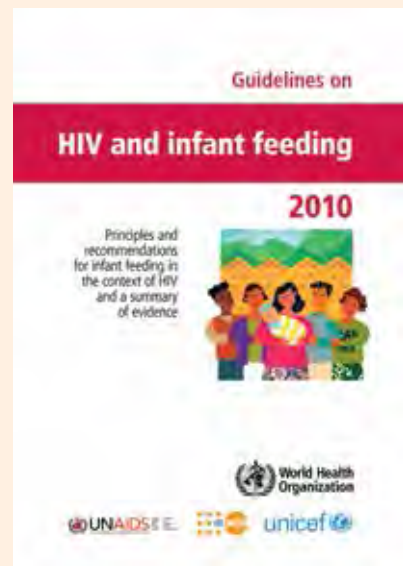
These mothers should exclusively breastfeed their babies for the first 6 months of life, then introduce appropriate complementary foods with continued breastfeeding for the first 12 months of life. Mothers should stop breastfeeding only when they can provide a safe and adequate diet.

If a mother decides to stop breastfeeding, she should do so gradually within one month.

HIV infected mothers should only give commercial infant formula milk as a replacement feed to their baby when specific conditions of safety and hygiene, affordability and supply of formula, access to health care and family support for replacement feeding are met.

Guidelines on HIV and infant feeding 2010. Principles and recommendations for infant feeding in the context of HIV and a summary of evidence

http://www.who.int/maternal_child_adolescent/documents/9789241599535/en/



What did I learn?



Breastfeeding should be encouraged and supported for all women. In this session you examined how to explain the importance of exclusive breastfeeding for six months and continued breastfeeding up to two years or beyond. You learned how to support women and how to demonstrate ways to effectively breastfeed soon after the birth. You also learned that mother who are HIV-infected can also breastfeed and give their baby all the benefits of breast milk with very little risk of transmitting HIV.

Take some time to reflect on how you can improve your own skills in communicating breastfeeding and demonstrating how to position and attach the baby. You could use your notebook to write down tips or advice you can give to women who are experiencing problems.

Encourage women to learn from one another; often women have helpful home remedies or suggestions for alleviating some of the discomforts associated with breastfeeding in the early stages. Determine what support exists in the community. Make contacts with these groups.

Finally, remember that it is important for successful breastfeeding that the woman has the support of her partner and her family.

WOMEN AND HIV/AIDS



What is in this session?

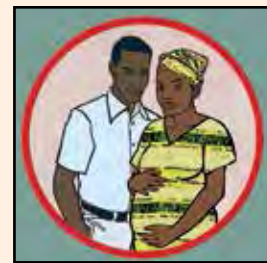
In many countries, HIV/AIDS prevalence is increasing rapidly among women of reproductive age, and has become an important contributing factor to high maternal morbidity and mortality. All women should know their HIV status and understand the importance of HIV prevention. Knowledge of HIV status, through HIV testing and counselling, is especially important during pregnancy, childbirth, and breastfeeding, since women with HIV can transmit the virus to their infants during these times.

Talking to women about HIV/AIDS may be a new topic area for many skilled attendants. Midwives and nurses who provide services to women are already a trusted source of information and advice. Building on this foundation of trust, skilled attendants can be an important source of caring and provide supportive HIV/AIDS counselling.



IMPORTANT:

It is not possible to cover in one session of this Handbook all of the skills and knowledge needed to provide comprehensive HIV/AIDS counselling. This session only provides an introduction with a focus on HIV and pregnancy. You are encouraged to discuss with your colleagues and programme managers how the services can best provide support for the different themes covered. If HIV is very prevalent in your community, you might consider discussing in your group or with your supervisor opportunities for additional training to help staff in supporting women. Tools developed by the CDC, World Health Organization (WHO), UNICEF, USAID, and partners can provide useful strategies for learning about how to address HIV. For testing and counselling for prevention of mother-to-child transmission of HIV support tools see



<http://www.who.int/hiv/pub/vct/tc/en/index.html>

What skills will I develop?

- How to motivate women to accept HIV testing and counselling, prevent HIV, and prevent mother-to-child HIV transmission (PMTCT).
- How to help women overcome actual or perceived HIV-related stigma and discrimination and other barriers that influence their decision-making about HIV prevention and testing and use of PMTCT services.
- Self-reflection: how to explore your own beliefs and attitudes around HIV/AIDS.



What am I going to learn?

By the end of this session you should be able to:

1. Explain the benefits of testing and counselling for HIV during pregnancy, the need for partner testing and counselling, and the importance of sharing HIV status with partner.
2. Discuss ways for all pregnant women and their partners to prevent exposure to HIV.
3. Help pregnant women understand mother-to-child HIV transmission and how to prevent it.
4. Motivate women with HIV infection to participate in PMTCT interventions.
5. Assist pregnant women who test HIV-positive to cope with their diagnosis and support them to make a plan to get the special care they and their infants will need.

Activity 1



45 minutes



Aim To reflect on your own attitudes, beliefs and values towards women who are HIV-positive.

This exercise is best done in a group or with another person so that you can discuss the topic. If you are working alone, try and find a colleague who will carry out the exercise with you.

1. Is it important to know whether a woman has HIV? Why or why not?
2. Are there certain types of women more likely to be infected with HIV or can any woman get HIV?
3. Whose fault is it if a woman gets HIV?
4. Should women who have HIV be allowed to get pregnant? Should they be allowed to have more than one pregnancy?
5. Should women who have HIV get the same care or different care to women who do not have HIV? If different, how should it be different?

Think about how some of the answers you have given to these questions may impact on the way you treat and counsel women that you see. Do these present a barrier to providing appropriate care and support? Keep these points in mind as you read through the session. You may wish to review the questions and answers after you complete the session, to see if your answers have changed and to think about the barriers your beliefs and attitudes may pose.

Activity 1 continued...**Our View**

In answering these questions you will have had to explore some of your own attitudes, values and beliefs towards HIV.

Anyone can get HIV. Some people are more at risk because of the behaviours they have such as multiple sexual partners, or because they inject drugs. It should not matter how a woman or man got HIV in terms of how you treat them. All women that you see, whether they are HIV-positive or negative, should be treated with respect. As you will not know who has HIV and who does not, you should treat all women the same way and take the same clinical precautions. Women who are HIV-positive have the same human rights as all other women and they can make choices and decisions about whether to have children or not, and how many children and whether they want to breastfeed. If a woman is HIV-positive, she may need additional information, support and counselling including the possible effects of childbirth on her health status, but the decisions are still hers to make.

You may agree or you may not agree with some of the views expressed here. Whatever your views, you need to think about how they might impact the women that you treat and counsel. Are you likely to treat them differently? How could you try to overcome some of the negative attitudes that you have?

Counselling to increase acceptance of HIV testing

Identifying women with HIV infection and their partners is a “gateway” to helping women, partners and children to receive the HIV treatment and care they need. All women in high prevalence countries, especially pregnant women, should be tested and counselled for HIV. Counselling during routine antenatal and postpartum care is an important way to reach women with information about HIV/AIDS and encourage HIV testing. New emphasis is placed on providing essential HIV/AIDS information at the first antenatal care visit, to be sure that as many women as possible receive the information.

**HIV COUNSELLING TOPICS**During pregnancy

- basics of HIV transmission and prevention
- PMTCT
- HIV testing and counselling processes

HIV COUNSELLING TOPICS continued

- benefits and risks of HIV testing
- right to refuse testing (opt-out)
- confidentiality
- implications of positive and negative test results
- identification of supportive HIV services and treatment available
- identification of PMTCT services and treatment available
- family planning/dual protection and provide condoms (See page 167 below for a definition of dual protection)
- identification of sexual risks and plan for reduction of risks
- availability and benefits of testing and counselling services for couples
- importance of infant feeding and nutrition

Counselling after an HIV test

- explain HIV test result and the possibility that in the first 3 months following infection the test may still come back negative (“window period”)
- assist in understanding result/ coping with diagnosis
- provide information to HIV-negative women on how to stay negative
- discuss immediate concerns
- explain available services, treatment, care and support and make appropriate referrals
- support safe and voluntary disclosure
- discuss best and most feasible infant feeding option
- discuss the importance of good nutrition for staying healthy
- explain essential PMTCT issues
- encourage partner dialogue/disclosure
- encourage partner testing and counselling
- discuss family planning/ dual protection and provide condoms
- reinforce HIV prevention/risk reduction and develop a plan to reduce the risk of HIV reinfection
- revise the birth and emergency plan and discuss the need to give birth in a facility with a skilled attendant

In many countries, provider initiated testing and counselling of all pregnant women during ANC has become national policy. This is called “opt-out” HIV testing. In “opt-out” testing, getting an HIV test is a part of the regular ANC care package for all pregnant women, like haemoglobin tests. All ANC clients are offered the test, and counselled on the benefits and risks of knowing HIV status during pregnancy. But testing is still voluntary and women may refuse if they wish. Women are more likely to accept HIV testing if their health care provider counsels in favour of the procedure and recommends it.

If a woman refuses testing and counselling, spend a bit of extra time with her to find out why she refused (use your open questioning and active listening skills), and see if you can help her with any problems related to accepting the HIV test. But remember to present the information in a neutral, non-biased way without pressure or judgement.

Some women may be afraid to get an HIV test, do not want to know their HIV status, or do not want to discuss results with their partner. Real and perceived stigma and discrimination against those who are known to be infected with HIV is a big problem in many communities and may be a barrier to testing. Counselling women about the benefits and risks of knowing their HIV status, not only for themselves but for their infant and partner, can help to overcome the fear of stigma, discrimination and other barriers.

Allowing women to express their concerns is also important. Fear of bad outcomes is more common than actual bad outcomes for most women, and many women who disclose their positive HIV status report positive outcomes, support and understanding. When counselling, be sure to assist women to evaluate the real chances of bad outcomes and help make a plan to minimize them.



BENEFITS OF PREGNANT WOMEN KNOWING HIV STATUS INCLUDE:

- Being sure of her status, if HIV-positive or HIV-negative
- If HIV-negative, she can learn how to remain negative
- If HIV-positive, she can learn how to live positively and care for herself and her baby
- Revision of her birth and emergency plan to make sure she gives birth in a facility with a skilled attendant
- She can share HIV test results with partner and encourage him to get tested
- Special care and treatment to prevent HIV transmission to the baby is available
- Care, nutrition support, counselling, and follow-up is available for women infected with HIV and HIV-exposed infants
- Long-term treatment (Anti-RetroVirals-ARVs) for women infected with HIV, baby, and family are available in many places

Assuring the confidentiality of test results can help women decide to get an HIV test

Confidentiality means that only health staff directly involved in her care will know her test results; that it is her decision if and when she wants to share her test results with anyone else. Assure women that they will get good ANC whether or not they accept HIV testing and counselling. Where available, refer women who refuse testing and counselling at ANC for specialized HIV testing and counselling.

If a woman does not accept HIV testing and counselling at her first visit, ask again at every future visit if she is ready to be tested. Briefly review with her the benefits of knowing her and her partner's HIV status, and the care that is available for HIV-positive women and their babies, at each clinic visit to help her decide.

Discussing HIV test results with HIV-negative women

Post-test counselling for a pregnant woman who has tested HIV-negative should focus on helping the woman decide how she can stay HIV-negative. Support should also be provided to help her decide if she will discuss her results with her partner, so that he can be tested and actively participate in risk assessment and risk reduction for the two of them.

The main ways to prevent HIV infection and STIs:

- Correct and consistent use of condoms during every sexual act
- Practising safer sex (choosing sexual activities that do not allow semen, fluid from the vagina, or blood to enter the mouth, anus or vagina of the partner, or to touch the skin of the partner where there is an open cut or sore.)
- Reducing the number of partners
- Sexual fidelity
- Abstinence.

Sometimes pregnant women may need help in adopting these prevention behaviours, or in getting their partner to agree. A first step in negotiating safer sexual practices between partners is for them to do a risk assessment, to identify any risky behaviour they might currently be involved in. This requires a frank and honest discussion between partners about their own sexual practices as a couple, and any other sexual activity that might be taking place outside of their relationship.

The second step is for the woman or couple to decide what changes need to be made to better protect against HIV/STIs, and how they will make those changes. All women should consider dual methods of protection, to protect against HIV and to avoid unwanted pregnancy. (See Session 12 on family planning for more information on dual protection).

Dual protection:

Many couples are successful in adopting safer sexual practices. If you have developed the appropriate skills and experience, it is often helpful to offer to counsel the couple together so they can then talk with you as a couple about these issues, to help them better understand risks, and find solutions that are agreeable to both.

**REMINDER:**

Correct and consistent use of condoms with another family planning method for every sexual encounter is the best way to ensure dual protection against HIV and avoid unwanted pregnancy or to space desired pregnancy.

Another key to HIV prevention is partner testing and counselling. Every pregnant woman should ask her partner to get an HIV test. It is not unusual for a pregnant woman to test HIV-positive and for her partner to test HIV-negative, or the other way around. This is called “discordance”. Couples with discordant HIV test results can present a counselling challenge, as partners often have difficulty understanding how the results can be different. You may want to refer discordant couples to more specialized counselling services where available.

Retesting

Repeat testing late in the pregnancy should also be recommended to HIV-negative women if HIV is very prevalent in your community.



Health workers need to assess if condoms are easily available in the community or if there are barriers which limit their availability.

Activity 2



1 hour



Aim To develop or improve your counselling skills so you can help women to address common barriers to HIV prevention behaviours, and to negotiate safer sex with their partners.

Remember as previously discussed, the main ways to prevent STI/HIV infection: use of condoms (including dual protection), practising safer sex, fidelity, partner reduction, or abstinence.

1. Discuss with colleagues, women and men in the community and make a list of the different reasons why men and women do not put HIV prevention behaviours into practice. Also talk about barriers to partner HIV testing and counselling. Consider how the counselling context (e.g. culture, gender roles, household decision-making, and the social system in your community) may contribute to these barriers.
2. Discuss possible solutions – make this into a list of things that women can do for themselves, things that health workers can implement, and things that can be addressed by the wider community.
3. Think of ways you can help to implement the solutions you have proposed. With regards to things women can do for themselves, how can you support them to do these things? What information will they need? How can you improve your couple counselling skills to work with partners to involve them in the solutions?
4. What work needs to be done in the broader community? Who else can support you in this effort?
5. Finally what can health workers do? Discuss the solutions among staff and develop a plan together to improve the support you can provide.



Our View

Whether women are infected with HIV or not, it is important for them to understand how to prevent HIV transmission (or reinfection). Helping a woman overcome her own or her partner's resistance to partner testing and counselling, condom-use and other safer sexual practices for example, partner reduction or abstinence, will require you to have a frank, open discussion about sexual issues. You may need to discuss sexual attitudes and practices that you have not addressed in your counselling before. You may find that women would like an opportunity to role-play condom negotiation and introduction of dual methods with you before they discuss the issues with their partners. Before they do so, make sure to provide her with condoms.

See session 16 below on women and violence will also be of use to you if you suspect there may be a problem of violence.

Discussing HIV test results with women infected with HIV

Helping a woman cope with positive HIV test results is among the most difficult counselling challenges faced by health workers today. Pregnant women who find out that they have HIV have to cope not only with their own diagnosis, but that their baby has been exposed to HIV, as well as the normal concerns all women have during pregnancy.

Post-test counselling for pregnant women who test HIV-positive can present challenges of time, space, and privacy/confidentiality. If it is not realistic to provide counselling to women infected with HIV during the regular antenatal care session, it may be possible to ask the woman to return at a time when it would be possible for you to have more time for a more in-depth discussion, after she has had time to think over the basic information you provided her during post-counselling at ANC. Some women who test HIV-positive may want to bring their partner or a family member back to the clinic to participate in couple or family counselling. If you cannot provide counselling of this type, refer them to other available HIV counselling services.

There are several key post-test counselling topics:

- coping with the diagnosis
- learning the actions to take to keep a woman and her baby healthier and prevent mother-to-child transmission, including antiretroviral drugs and infant feeding
- deciding whether to share her test results with others, especially her partner, so he can also get tested.

Helping pregnant women cope with their diagnosis is the first counselling objective and requires special skills. Factors that influence a woman's acceptance of a positive HIV test results include:

- the content and quality of the counselling and support she receives
- awareness of the options that are available to her for treatment, care and support
- her perception of what the reaction of family and friends will be
- her willingness to share her HIV status with others (disclosure).

It is important to discuss the pros and cons of disclosing her status to others from the woman's own perspective and to discuss any problems that a woman thinks she might have if she shares her HIV status with others. Help her decide who she might like to tell about her diagnosis and help her make a plan to share her results if she wants to. If a woman would like your support to disclose results, offer to participate in "mediated disclosure". Invite family and partner to the clinic or go to their home if appropriate, to participate in the sharing of HIV test results.

Provide women who have a positive test result with multiple opportunities for disclosure. Even women who choose not to disclose when results are first given to them can later change their minds.

Remember to assure women that all discussions about HIV results and related issues are confidential. Only you and essential members of the health care team will know about her status, and that you will maintain confidentiality among yourselves.

In many settings, women infected with HIV decide not to disclose their HIV status. Fear of stigma and discrimination, real or perceived, against people with HIV/AIDS, including fear of partner violence

and rejection by family, can be a major barrier to getting tested for HIV test and disclosure of HIV-positive test results. Despite efforts to change attitudes towards people living with HIV/AIDS, stigma and discrimination persist in many communities.

Some women infected with HIV who disclose test results do experience violence or some of the other negative things that can happen. Remember, as mentioned earlier, fear of bad outcomes is more common than actual bad outcomes for most women. Most women who do tell others their HIV status receive support and understanding from their partner and family. When counselling, try to determine if there is a real risk of bad disclosure outcomes, and help think of alternative sources of support for women who cannot or will not disclose to their partner, family or close friends.



BARRIERS AND MOTIVATORS TO DISCLOSURE OF HIV STATUS

Disclosure means a woman sharing her HIV status with her partner and/or family.

Barriers

- shock, anger, denial, fear, isolation, loss, grief, guilt
- fear of abandonment- economic and family support
- fear of rejection/stigma/discrimination
- fear of violence
- blame - fear of accusations of infidelity
- shame - to admit to family and friends, employers and embarrass them
- fear of loss of job
- fear of effect on her marriage, current pregnancy or implications on future childbearing
- depression, anxiety, low self-esteem, suicidal ideas.

Motivators

- avoiding burden of secrecy, no fear of involuntary disclosure
- allows opportunity for treatment, partner testing and counselling
- ability to discuss testing, prevention/protection, treatment with partner
- ability to protect partner/ baby from transmission
- access to emotional and practical support
- ability to discuss symptoms and concerns
- easier access to health care
- easier to adhere to medication - no need to hide medication
- easier to adhere to infant feeding style of choice.

Activity 3



1 hour



Aim To practise helping HIV-positive women to make a disclosure plan.

1. Review the box above which lists barriers and motivators to disclosure. Think these over and discuss with colleagues, women and men in the community to make the list appropriate for your setting.
2. Practise disclosure doing some role-plays where the counsellor will:
 - discuss advantages/disadvantages of disclosure
 - help the woman identify barriers and fears about disclosure
 - explore options to overcome fear of disclosure
 - identify readiness to disclose
 - give the woman time to think over the results and her specific needs.
3. Continue the role-play but move on to develop a disclosure plan. Be sure to include the following elements in the plan:
 - who to inform (disclosure) and impact on family
 - partial disclosure or full disclosure - who to tell first, where, and how
 - how to break news
 - assist the woman to anticipate likely responses after disclosure
 - provide reassurance, offer to mediate (e.g. act as a go-between) disclosure to partner or others. Offer couple counselling (see session 4).
 - identify sources of support
 - develop coping strategies for managing stress of diagnosis
 - discuss risk reduction, protecting partner and baby
 - assist the woman in understanding the need for her existing children to know her status and for them to receive testing and counselling in an age-appropriate way.



Our View

Taking some time to review barriers and motivators to disclosure in advance will enable you to practise your counselling skills on this topic area. Counselling women or couples who are HIV-positive can be very emotional and is a sensitive topic. With the use of plays, you can explore different ways of facilitating and supporting the decision-making process.

Develop a sheet with the different elements of the disclosure plan and keep it handy so that you can use it as a support when working with women.

Treatment for herself and her baby, including preventing mother-to-child HIV transmission (PMTCT)

The second counselling objective for HIV-positive pregnant women is to explain in detail the care that will help her stay healthier and help her prevent passing HIV to her baby, and to motivate her to accept that care. Explain the prophylaxis (preventive treatment), treatment and care that may be available for her, her infant, and her partner. Explore with her if there are any barriers she might face receiving care and treatment, such as costs, transport, or family resistance.

Efforts to prevent mother to child transmission of HIV should be as comprehensive as possible and acknowledge that both mothers and fathers have an impact on transmission of HIV to the infant:

- Both partners need to be aware of the importance of safer sex throughout pregnancy and breastfeeding.
- Both partners should be tested and counselled for HIV.
- Both partners should be made aware of and provided with PMTCT interventions.
- Both partners should be provided with condoms.

When the male partner is involved and informed, the woman is more likely to be able to participate in PMTCT interventions, including using condoms during pregnancy and lactation, and receive needed maternal and HIV services.

Some things that help prevent transmission from mother-to-child, such as exclusive replacement feeding or exclusive breastfeeding (see Session 13), can be difficult for women to adopt, especially if they do not share their HIV status with family. For example, new mothers often experience pressure from mothers-in-law or other female relatives to use breast milk substitutes or to feed babies traditional porridge early in life, in addition to breast milk. This type of “mixed feeding” is especially dangerous for HIV-exposed babies, and you should help women develop strategies to maintain exclusive breastfeeding even if there is resistance in the home environment.



Women need support to help them decide and carry out their infant feeding choice.

Activity 4



1 hour

Aim

To improve counselling content and techniques for the special needs of HIV-positive women during pregnancy, postpartum and breastfeeding.

1. Review the key facts about PMTCT in this session or in the PCPNC. Are there any facts about PMTCT that you yourself would like to know more about to better counsel HIV-positive women?
2. Think about the questions you ask all pregnant women when helping them prepare a birth and emergency plan (See Session 7). Think about how counselling HIV-positive women and their families for birth and emergency planning is different. Also consider the impact of stigma and discrimination from health workers and from the community. What will you need to add to the questions you developed for birth and emergency planning to consider the needs of the HIV-positive women? How could you strengthen your current counselling techniques to help HIV positive women with PMTCT and make a birth and emergency plan?
3. Brainstorm possible barriers that women could face trying to carry out the recommended actions for PMTCT, such as disclosure, difficulties with adherence to antiretroviral interventions, planning to give birth in a facility and infant feeding recommendations. Talk with HIV-positive women and ask them what some of the barriers are. Use the information from Activity 2 in this session.
4. Talk with staff members who may be involved in providing care to HIV-positive women during labour, birth and the postpartum period. Get them to review their own attitudes towards HIV-positive women, and whether they treat them differently, or view them differently. You can use Activity 1 of this session to guide your discussions. Ask for their comments on how each of them could contribute to more effective counselling for birth and emergency planning for PMTCT, infant feeding support and postnatal follow-up of HIV-positive women and their infants.
5. Using the comments from women and staff, and your insight, put together a sample "PMTCT Birth and Emergency Preparedness Counselling Session". Practise doing it. How long does it take to cover all the key facts? Probably more time than you actually have in your busy schedule! If your focus is more on giving information than about the woman's participation and a two-way communication process, consider how you can involve her more. Think of ways to cover all the information and allow time for the woman to participate and express her concerns in less time. You may need to break it up into several sessions.

Activity 4 continued...

6. Make some notes in your notebook on how working with HIV-positive women for PMTCT has made you feel. Are there any things that you and the staff think you could do to make your facility more “PMTCT Friendly”?

**Our View**

There is a lot of information to be conveyed in PMTCT counselling. However, it is important that the counselling on PMTCT does not become information giving only. Remember the foundations of good counselling (Sessions 2 through 5) – find out what the woman already knows and build on that knowledge. Ask about her situation and share information that is relevant to her. Help her to identify solutions and together work out how she can implement them. In some cases you may feel out of your depth, or unable to provide the level of support and care a mother who is HIV-positive needs. It may be appropriate in these instances to refer women for specialized counselling.

Supportive counselling for women infected with HIV

Making sure that women with HIV continue to get the additional care and counselling they need after the baby is born, during breastfeeding and the baby’s first year of life presents special challenges. New mothers who are infected with HIV continue to need supportive counselling well into the baby’s first year of life, to assure better follow-up of mother-baby pairs (HIV-positive mothers and HIV-exposed infants).

As your experience in counselling women infected with HIV increases, you will be able to identify common responses to positive HIV diagnosis and living with HIV. But remember to tailor your counselling to the specific needs of each woman: careful counselling can uncover deeper issues, problems and concerns that may be unique to each woman. Supportive counselling for women infected with HIV requires confidential two-way communication to help them define the problems and challenges related to HIV and make more informed choices about treatment, care and support. Women infected with HIV with special needs such as adolescents, or women living with intimate partner violence, may need even more support.

As a health worker you can provide hope and encouragement, and help give women a sense of control so they can find practical, realistic ways to cope with lifelong care and treatment needs for a serious illness like HIV. The box on the next page can help you determine some of the issues that may need to be addressed as you counsel women infected with HIV after the birth of their baby. Keep this information as a resource and reminder.



COUNSELLING TOPICS FOR WOMEN INFECTED WITH HIV

- practice safer sex and appropriate family planning for HIV-positive women; use condoms (See Session 12 and box below.)
- understand care and support needs for HIV-positive women and infants and access services
- understand ARV treatment, assess treatment readiness, and access services if available
- identify personal strengths and resources
- living positively with HIV, personal care and improved nutrition
- identify additional emotional, social, spiritual support required and potential sources - family, peers, community organizations
- identify needs for material assistance and ways to mobilize local resources
- define and address barriers to treatment, care and support.
- identify ways to tell other children and caregivers about HIV status.

Some women infected with HIV may want to have additional children. Be supportive and respect a woman's wishes but explain that pregnancy carries risks for herself and her baby. Explain that women infected with HIV may have difficulty becoming pregnant. Discuss the need to plan for care and treatment for her, and for her children if she or her partner becomes ill.



COUNSELLING WOMEN INFECTED WITH HIV ON FAMILY PLANNING

(Refer also to Session 12 on Family Planning)

- Explain that future pregnancies can have significant health risks for her and her baby including transmission of HIV to the baby (during pregnancy, birth or breastfeeding), miscarriage, anaemia, wasting, preterm labour, stillbirth, low birth weight and other complications.
- If she does wish to get pregnant again, birth spacing is important. Advise her to wait at least 24 months from birth to the next pregnancy, as that is healthier for her and the baby.
- Condoms are the best family planning method for women with HIV. Condoms provide protection from STIs/ reinfection with HIV and pregnancy. Advise on correct and consistent use of condoms.
- With the condom, another family planning method can be used for additional protection against pregnancy (dual protection). However, not all methods are appropriate for the HIV-positive woman:
 - A woman who has HIV, can insert IUD. If she has AIDS, do not insert IUD. But if the woman is being treated with antiretrovirals (ARVs) and is healthy, the IUD can be inserted.
 - Fertility awareness-based methods may be unreliable to use if she has AIDS or is taking ARVs because of changes to the menstrual cycle and higher body temperature.
 - Women with HIV should not use spermicides or diaphragms with spermicides.
 - Women who have HIV and TB, or any women taking Rifampin for TB, should not use hormonal birth control pills, monthly injectables, implants or patches.
- As for HIV-negative women, Lactational Amenorrhoea Method (LAM) can only be used as a family planning method in the first 6 months after birth if the woman is exclusively breastfeeding her baby (that is not giving any other foods or drinks to the baby, not even water) both day and night and her menstrual periods have not returned.
- Counsel about permanent methods if a woman has completed desired childbearing.

Activity 5



1 hour



Aim

To help HIV-positive women plan to receive treatment for her and her baby and reduce MTCT during pregnancy, birth and in the postpartum period

It is important to help women develop a plan to seek out and adhere to treatment, care and support for themselves and their infants. This activity aims to help you to provide supportive individual or family counselling to HIV-positive women and their families after birth.

1. Review the recommended topics for counselling HIV-positive women in the first year after birth. Identify additional information you need or counselling skills you will need to strengthen. For example, did your previous counselling experience include counselling partners and family members, or outreach to solicit support from community or religious groups?
2. Review the clinic records of some of the HIV-positive women you have counselled during pregnancy who have now given birth. Think about the counselling and support you provided during antenatal care sessions and during labour and birth. Did it include recommending follow up for the mother and baby after routine postpartum visits are completed? What would you need to change so that supportive counselling to HIV-positive women throughout the first year after birth becomes a routine part of your counselling services?
3. Think about the list of counselling, care and support recommended for HIV-positive women and their babies. Talk to some HIV-positive women to get their actual experiences caring for themselves and caring for a baby exposed to HIV. Make a list of the possible barriers they face. Divide this list into internal barriers (things like shame, fear, and low self-esteem) and external barriers (lack of funds or transport, no family support). Think of ways to support them to overcome each barrier. Focus on ways to provide hope, encouragement, and practical, realistic ways to cope.
4. Decide which needs of HIV-positive women and babies you and your staff can address through counselling, and what things you will need external help to achieve. How can you create broader awareness of the problems of HIV-positive women and families? Consider the possibility of creating peer support groups, so HIV-positive mothers can share their experiences with other HIV-positive women. Will you need to recruit the support and resources of local community and government organizations?

What did I learn?



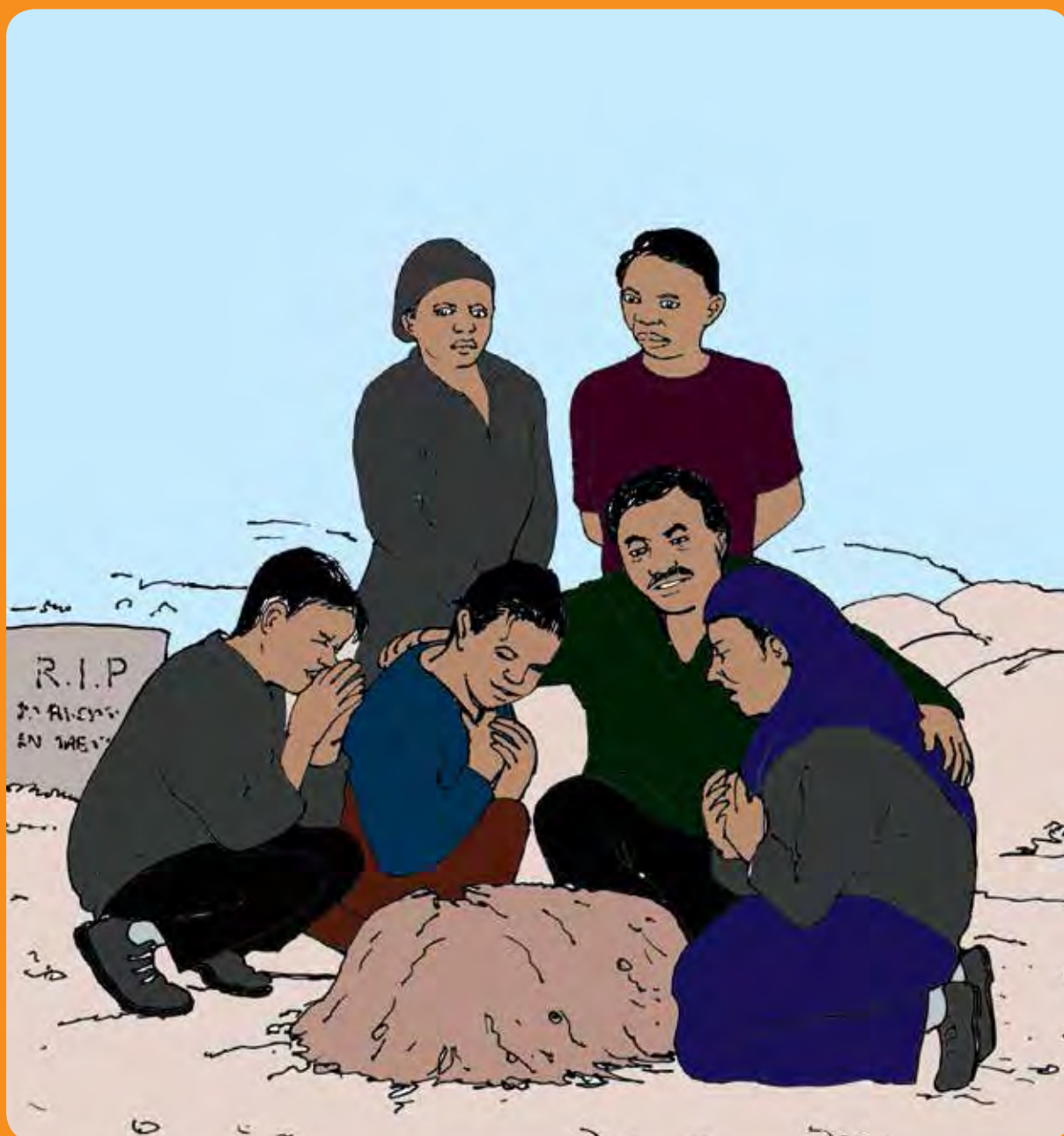
After finishing this session you should be better prepared to counsel all pregnant women about issues of HIV in pregnancy, and the importance of getting tested for HIV. You should know how to counsel women to practise safer sex to prevent HIV, and how to prevent MTCT. You can provide initial supportive counselling to women who test positive for HIV, and you have practised helping women to decide about disclosure of HIV test results, and to deal with stigma and discrimination that often results when a woman tests HIV-positive.

You have learned more about the many concerns and challenges facing both HIV-negative and HIV-positive pregnant woman and their families. Are you more comfortable talking to women about their sexual practices that may put them at risk for getting HIV? About how to adopt safer sex practices within their relationships? Are you confident you can counsel women infected with HIV without allowing any personal attitudes you might have to influence the counselling relationship?

Do you have all the necessary information you need to be able to counsel pregnant women about HIV/AIDS or to refer them to specialized counselling? If completing this session made you want to expand or formalize the basic HIV/AIDS counselling skills you learned, try to identify local sources for HIV counselling and testing in your area, such as government programs, NGOs and community-based organizations.

Write down in your notebook a summary of the key lessons you have learned in this session.

DEATH AND BEREAVEMENT

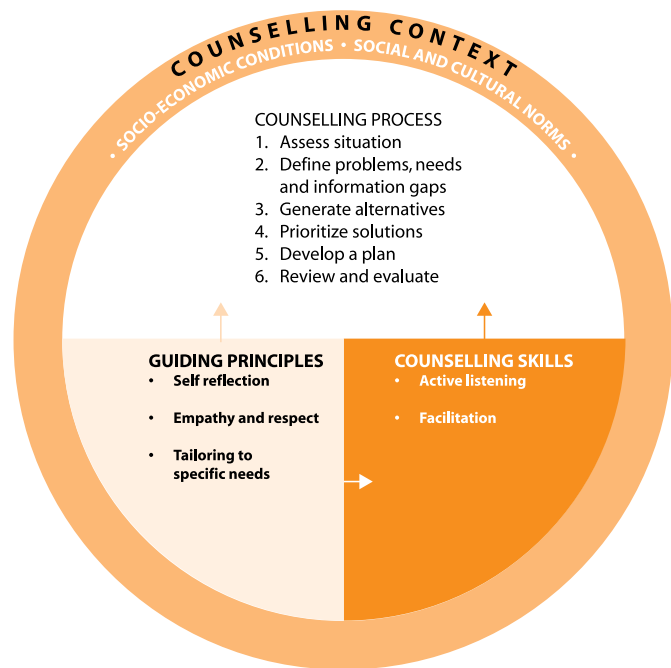


What is in this session?

Death is something we all have to contend with. However, the death of a baby at birth or the woman during birth is particularly difficult. People’s reactions to death vary greatly; it is not something that can be predicted in advance. There are a few practical steps you can take to help someone through the bereavement process but most support activities are reactive to the needs and wishes of the family members. Bereavement support groups exist; you may wish to refer some women or families to these. In this session we provide you with information to strengthen your understanding of bereavement processes and focus on developing your skills to better support family members in bereavement.

What skills will I develop?

- Active listening
- Exploring beliefs
- Providing information and support
- Demonstrating empathy.



What am I going to learn?

By the end of this session you should be able to:

1. Describe some of the processes involved in bereavement and grieving.
2. Outline practical steps to help family members.
3. Identify issues for discussion with family members to help them with decisions they have to take.

Death and bereavement

Death of a family member is something that everyone experiences at some point. How people react to death varies enormously and it is not possible to predict what a person's reaction will be. The death of a family member affects not only the individuals in the family, but also the family unit as a whole. The specific difficulties the family faces and the manner in which they cope with them depends on the particular circumstances of the family and of the death. For some, sudden death of the woman or baby during birth can often be more difficult for family members to cope with than death following a long illness, where there was opportunity for family members to prepare themselves in some way. This is not always the case, so do not assume that a family will react in a certain way.

The way in which people act following the death of a family member can change over time. A range of emotions may be experienced from anger, shock and disbelief, to sadness, and even long term depression. All these emotions are normal. The usual stages of grief are denial, anger, bargaining followed by depression and eventual acceptance. For some people there can be a delay as long as several weeks or even months before they begin to grieve for the loss of the dead person. In order to provide support you need to be prepared for all and any of these emotions and at different times.

You may find providing support following death a particularly hard task for yourself emotionally. Remember to ensure that you get extra support at this time. You need to look after yourself in order to continue to support others.



The death of a baby or newborn is a hard time for any couple. The death of the baby may also be linked to the woman herself being ill and hospitalized for sometime after the death of the baby. This places major stress on a couple's relationship. Sometimes it brings the couple closer together; sometimes it can push them apart, especially if one of them blames the other for the death. In many communities, the death of a baby is often sadly blamed on the mother, who then has to deal with her own grief and feelings of guilt, and she may be subjected to blame from her partner or family. This requires additional support to both the woman and her partner. It is important to help the couple to better understand the cause of the baby's death by going over the circumstances of the death.

In some communities the couple will be encouraged to have another baby to 'make up' for the loss of the baby that died. This places another stress on the couple and particularly on the woman who, even if she has physically recovered from the loss of her baby, will often not want to have sexual intercourse for some time. This may make her feel guilty that she is not able to be more loving to her husband or partner. Another more serious response is that she may then be coerced or forced to have sex with her husband. In such situations you can play an important role in encouraging the couple to take the time to grieve over the loss of their baby before thinking of having another child.

If there are other children in the family, these children also need ongoing care and support and involvement in the grieving process.



REMINDER:

Support groups or others who have gone through similar experiences can provide valuable support to a grieving family. Make a list of support groups or other contact persons to offer a family affected by the death of a baby or the mother.

Preparing for death

In some situations it may be apparent that the mother and/or baby are going to die. Where it is culturally appropriate you can help to prepare the mother, parents or family for the death by explaining to them what is happening. Facilitate the needs they have; the family may want to have time alone with the woman or baby, or they may want a quiet place to pray. Remember to maintain confidentiality and to respect their wishes when possible.

Communicating death

One of the hardest things that you may have to do as a health worker is tell someone that their wife or baby has died. No matter how often you may have to do this, it is still a difficult task. One of the most important things is to communicate the death as quickly as possible. Even if the parents or family members are present when the baby or mother dies, it may not be immediately apparent to them. As soon as the death has occurred, you must find the next of kin and notify them.

If possible take them to a private room where you can talk to them in confidential surroundings. Let them remain in the room for as long as they need to be there. Try to accommodate their needs, for example, some people will want to spend time with the deceased and may not want to be in a separate room.

Explaining cause of death

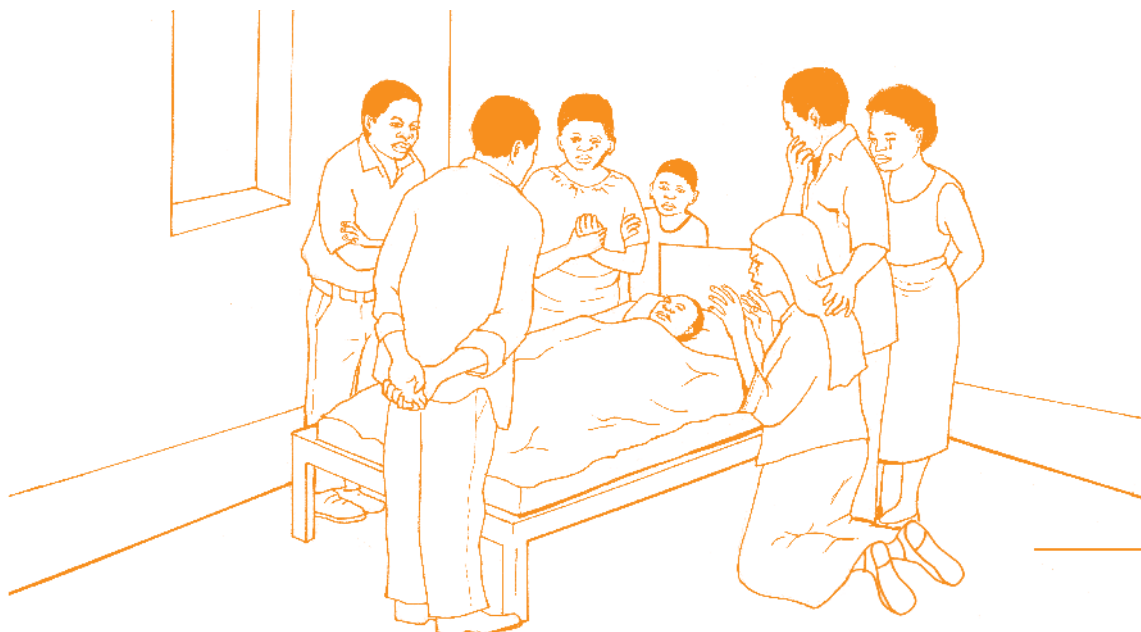
When the death of a mother or baby is first communicated to family members they may or may not want to know the cause of death. If you are fairly certain of the cause at that time, you can explain this to them in simple terms, and give them an opportunity to ask questions and express their grief. It is important to give information about the cause of death. If you are not certain of the cause you can give the probable cause and explain some of the contributing factors. Ask the family how much information they want at this time, you can always provide more details later. It is a good idea to come back later and check whether the first information that you provided has been understood or if the family have any new questions later, once the initial shock has subsided.

It can be useful to go through the different events leading up to the death and how these may or may not have contributed to the outcome. The purpose of this is not to blame or point out where people may have failed. Remember to show empathy and respect as you hold this discussion. Just as people need reasons to follow actions we suggest, people need to understand the reasons why death has occurred. Sometimes this information is needed because family members may be feeling guilty that they did something wrong, or failed to do enough to prevent the death. Over time this information may help with the bereavement process.

Time with the deceased

How people deal with death varies in different communities. Where it is culturally acceptable, people should be encouraged to spend time with the dead person if they want to. You can help to facilitate this period of being with the deceased person following death by providing a quiet place, away from distractions, where privacy can be maintained. It may be helpful to designate a space within your health facility where families can spend some time together following a death. Encourage family members to spend as long as they need with the dead person.

Where a baby has died, parents may find it helpful to keep something that was linked with their baby, if culturally acceptable, such as a strand of hair, a photograph or some clothing.



Family members should be able to spend time with the deceased in a private place, if they so desire.



TIME WITH THE DECEASED CAN BE BENEFICIAL AS:

- It provides an opportunity for the relatives to say goodbye.
- It can help to see them looking peaceful as a last memory.
- It can help to confirm the death and make it real.
- It provides an opportunity to hold or embrace the deceased person.
- For stillbirths it provides parents with an opportunity to see their child and have an image for a memory.
- It can provide a sense of closure.

Remember, be aware and respectful of context, cultural and individual preferences.

Practical tasks

There are a number of practical tasks that health workers are responsible for when a woman or baby dies.

- A first task includes providing the family with a certificate of death and notifying the relevant authorities or instructing the family how to do this.
- A second task relates to discussing where the family wants the body sent. In some cases the body may be sent to the mortuary. In others, the family may wish to take the body home for disposal or burial according to their local customs or religion. In these cases it is important to check the identity of the body before wrapping it for the family to take with them.
- You might also be able to provide them with information on how to organize a funeral or burial if they do not know how. If you do not have this information at your health facility, consider putting it together in an information sheet to serve as a reminder for health staff.

- Other practical tasks may involve providing families with a list of sources of support within the community.
- You may be in a position to refer people for more specialized counselling in the case of abnormal or prolonged bereavement. If possible, you can also offer follow-up visits and on-going support to the mother whose baby has died.
- Where a mother has had a stillbirth or the baby has died shortly after birth you will also need to advise the mother on breast care (see Session 13 under advice to women who are not breastfeeding) and counsel her on an appropriate family planning method and the importance of birth spacing (see Session 12).
- Mothers who have lost their babies also need physical care just like any other woman after birth. Encourage her to rest and sleep and to make sure she eats well to regain her strength. Make sure she does not remain in a postnatal ward with other mothers who have just given birth.

Activity 1



30 minutes

Aim

To put together the relevant information on death and bereavement to help people in the community you serve.

1. Make a list of all the tasks that family members are required to do following the death of a baby or mother (for example, obtain death certificate or register death, organize the burial or disposal of the body, care needs for the mother if the baby has died or for the baby if the mother has died).
2. Note down how the family needs to go about burying/cremating or disposing of the body and which organizations or people can help them in this task.
3. Identify a place or room where families can spend some time with the deceased following a death in the health facility. This place should be private.
4. Make a list of all the groups, community leaders, religious leaders and service providers in your area who can offer support to families following a death.
5. Put all this information together in one place. You might consider turning it into an information sheet to share with your colleagues or to give out to families.



Our View

Death can be an emotional time for health staff as well as family members. By putting this information together in one place it will serve as a useful reminder of the key tasks that need to be carried out, as well as providing additional information on sources of support and practical help and advice that might get overlooked due to the emotional difficulties surrounding a death.

Activity 2



Up to 2 hours (group)
30 minutes (individual).



To learn how to show empathy.

This activity is to help you learn how to demonstrate empathy. If working alone, write your answers down on some paper. If you are working in a group, take turns to talk and share information.

1. Take a few minutes to think about a situation where you have experienced grief or loss of some kind.
2. Briefly describe what happened.
3. What were your first reactions? How did you feel? How did you express those feelings?
4. How did your feelings and the expression of those feelings change over time?
5. What support did you need during this time? What did you find useful? What did you find difficult? What could have helped you more during this time?



Our View

Everyone experiences grief or loss in their own unique way. However, there are some things that may be common to many people. If you did this as a group activity you may have been able to identify some common themes. The emotions contributing to grief are very strong and can be overwhelming; they can be expressed both physically and emotionally. Write some notes on this activity in your notebook to help remind you of what it is like to feel grief. These notes may help you to empathize with women and their families who are experiencing the death of a family member.

Support

The most important thing that you can do for a family or person who is bereaved is to offer your support. Sometimes it can be helpful to discuss with the bereaved the process of what they believe happens to the dead person. Every culture has a system of beliefs about death and ideas about what happens to the body, spirit or mind after death. These beliefs and the traditions that go with them can be useful in comforting families and parents. Long-term support for family members who have been bereaved is most likely not possible for most health workers. You already have many other tasks, roles and activities. However, sometimes you may wish to offer support beyond the immediate time following death.

Other support can be offered just by listening to the feelings and emotions of the bereaved. They might not want any practical support or feedback about what they are saying, just someone to listen to what has happened. This is where it can be important to demonstrate your active listening skills,

to show you are listening intently and to reflect back to the person what you hear them say. Some family members may not want to talk but want an opportunity to express their feelings in a safe environment, especially if it is not considered appropriate for them to show their feelings elsewhere, or if they are unable to show them for other reasons. As a health worker, an important role can also mean providing physical comfort such as holding or embracing the bereaved person or whatever is culturally appropriate in your situation.

Some family members may benefit from more practical advice and support, particularly if they are finding it difficult to cope with household chores or caring for other family members. Bereavement can often reveal previously hidden problems or underlying tensions within a family. If you have the time, work with families to find solutions which suit the context of their lives and which are appropriate for their situation or consider referring them to specialist services where they exist.

Self-care and colleague support

As we have already discussed grief and bereavement can produce very strong emotions. As a health worker you will also experience a range of emotions when someone you are caring for dies. It is important that you take time to think about your feelings and reflect on the situation and what has happened. You may just want to spend some quiet time alone, but it can also be beneficial to get support from your colleagues. This can be done informally or you may want to schedule some time to discuss your feelings and/or the event as a group.

What did I learn?



In this session you have looked at some of the ways in which you can offer practical and emotional support to women and their families following a death. Your role is generally in the immediate time following the death, however, some people can benefit from on-going support either through referral to other organizations or from you. It is also important to remember the extra strain and pressure death and bereavement can put on you as an individual. Make sure you make time for yourself and get the support and attention you need so that you have the energy and emotional capacity to continue to support those around you. Use your notebook to write down your own feelings and emotions and try to identify any needs you have and how you might take care of them.

WOMEN AND VIOLENCE



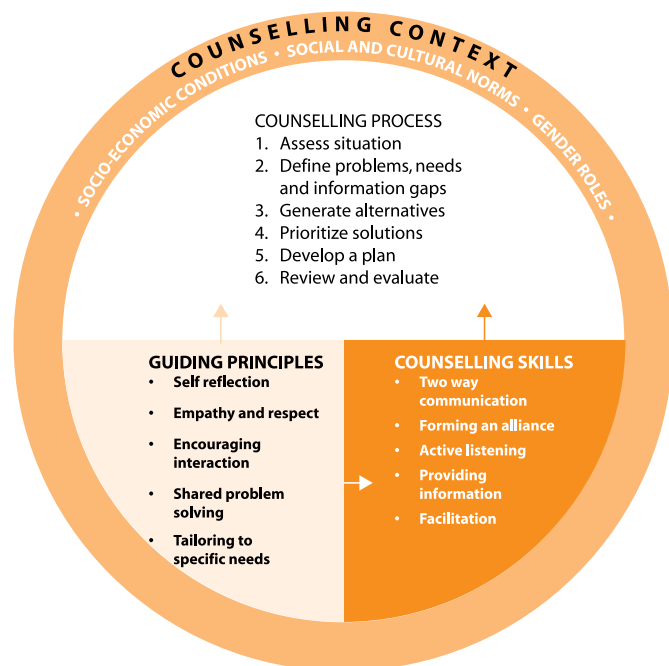
What is in this session?

Domestic violence is part of the lives of many women worldwide. This session provides an overview of domestic violence and some of its consequences. It also examines some of the signs and symptoms of abuse and how to ask questions to give support and facilitate counselling for women who are experiencing violence. In addition, we examine how to plan to enhance their safety and how to put them in contact with other support groups to enable them to make decisions about their health.

Despite the fact that violence may be very common in the community, discussing violence with women may be a new topic area for many skilled attendants. Those who provide MCH services to women are already a trusted source of information and advice and by building on this foundation of trust, skilled attendants can be an important source of caring and support. It is not possible to cover in one session all of the skills and knowledge needed to provide comprehensive counselling and support for this topic. This session only provides an introduction; you are encouraged to discuss with your colleagues and programme managers how the services can best provide support to women. If violence against woman is very prevalent in your community, you might consider discussing in your group or with your supervisor opportunities for additional training to help staff in supporting women.

What skills will I develop?

- Ability to show empathy and respect
- Ability to provide support and guidance to women experiencing violence
- Ability to self-reflect on own beliefs and attitudes about violence.



What am I going to learn?

By the end of this session you should be able to:

1. Describe the forms and patterns of domestic violence in relationships and the impact on women's mental and physical health
2. Support women to talk about domestic violence and plan with them to increase their safety
3. Review how violence may impact on women's ability to follow health advice and health service use, and support women to develop plans to reduce this impact
4. Support women who experience violence to gain help in their lives
5. Reflect on your own views and attitudes about domestic violence

Women and violence: an overview

Women are most commonly abused by their husband or partner (or ex-husband or partner). In addition to the immediate physical harm, this violence can have great impact on women's mental and physical health. This violence often persists, and may even get worse, during pregnancy, although for many women in abusive relationships the violence decreases during pregnancy. Other women find violence in the home starts when they are pregnant.



REMINDER:

Women who have been abused tend to have:

- low self-esteem and sense of self-worth
- more anxiety and depression
- destructive behaviours such as use of tobacco, drugs, alcohol and self-harm.

They are more likely to have:

- sexually transmitted infections
- unwanted pregnancies
- a range of other gynaecological problems.

Health workers are often the first people women have ever spoken to about violence. A process of self-reflection is important for you so that you are aware of the problem and understand your own views and concerns on the topic - see Activity 1. Even if you have not had any specialized training, there are a few practical steps that you can take to help women who are experiencing violence.

What is domestic violence?

When we think of domestic violence the image that usually comes to mind is that of a man beating his wife. Physical violence is a big part of domestic violence and may take many forms. For example, a woman may be slapped, kicked, pushed, have her hair pulled, or be hurt with a weapon. We often witness such violence in our homes and community and you may have even experienced it yourself. Domestic violence is usually committed by a husband or a partner (or ex-husband or partner). It can also be committed by someone else at home, for example, a mother-in-law.

Sexual violence often accompanies physical violence but is more hidden. A woman may be forced into sex when she does not want it, or forced to do a sexual act that she finds degrading or shameful. Some country's laws do not recognize rape in marriage, but married women never the less feel violated if they are forced to have sex when they do not want it.

Domestic violence may also be in the form of controlling behaviours, such as not allowing a woman to go out of the home, or to see friends, or seek health care without permission.



REMINDER:

Some women experience emotional or financial abuse, with or without physical and sexual violence. For example, being:

- criticized repeatedly
- called names
- told she is ugly or stupid
- shouted at
- isolated from family and friends
- left without enough money to run the home when her partner has money for non-essential items such as alcohol.

Dynamics of intimate partner violence

Intimate partner violence has particular characteristics that make it different from other forms of violence. First, it occurs in the context of a relationship that is usually expected to be intimate and trusting; so when violence occurs, there is a strong feeling of betrayal and helplessness. Second, in many societies men have higher social status; they are seen as being more important and having more authority and rights than women. Many men think that because they have higher status they can, and should, exercise power and control over women. In many communities men even feel they own their wives and have a right, or even a responsibility, to punish them by using violence.

Some women experience violence at the start of their relationship and then it stops. For other women, violence seems like a reign of terror and complete obedience is demanded at all times. Often a man controls a woman through more subtle approaches. A man may be very violent and abusive for a

time, and then stop and be affectionate. A woman may feel relieved that the violence has stopped, and hopeful that it is a sign that her man has changed and the abuse will not happen again. It usually does happen again, however, and may even be more severe next time, forming a 'cycle of violence'. Many women feel controlled by the periods of kindness and these reprieves often stop them from leaving.

Who causes domestic violence?

Violence between adults is usually against the law. If cases are brought to court, the person who committed the violent act is held responsible and usually punished. Domestic violence and rape are the only forms of violence, in most communities, where the victim of violence is often held responsible.

This is because of gender roles and inequalities. (You may wish to go back and review Session 4 where gender roles are discussed.) In most communities men have more power than women. As a result of this people often assume that if there is a problem between a man and a woman, the man must be right and must have acted reasonably, and the woman must have caused the problem.

The United Nations and World Health Organization recognize that domestic violence is a violation of women's human rights, it is not acceptable behaviour, and women should not be held responsible for it. Although domestic violence is very common in many countries, you will also find that in every setting there are many men who do not abuse their wives and girlfriends, and these men show us that it is quite possible for men to live with women without using violence.

Ending abuse

It is very difficult to change the behaviour of men who are controlling and violent. Some men become less abusive as they get older, but others continue throughout their lives. Women can often only free themselves from the emotional and physical hold that violent partners have over them by leaving. However, many women do not want to leave their partners, or do not feel it is an option for them. Leaving often does not solve women's problems, as many continue to experience forms of emotional and physical violence even after they leave. The time of leaving is also one where women are at higher risk of being hurt or killed. For those women who do leave, it is commonly the conclusion of a process, rather than a single act. This process starts with the abused woman beginning to talk about violence, recognizing that domestic violence is what she is experiencing and asking for help. Very often she will leave for short periods and then return on several occasions before the final separation.

The process of talking with a health worker is an important first step to help women rebuild their self-esteem and understand what they are experiencing. For some women this will be a stage in a process that will end in leaving. Some women may use it to start actions that may lead to a reduction in the frequency and severity of violence and other women will just find it beneficial in terms of helping them cope with their daily lives.



WHY DO WOMEN STAY IN ABUSIVE RELATIONSHIPS?

- Cultural expectations of women as wives: Many cultures expect (or even force) women to be married and financially supported by their husbands.
- Economic and social reasons: Many women choose to stay in violent relationships because their man provides for the family financially.
- Women's role in upholding culture, family values and raising children: Many women believe this is their responsibility, and they should raise their children in a home with a father. They think that their welfare is less important than this ideal.
- Belief that this is a 'woman's lot' and 'how men behave': Some women believe violence is normal in relationships and that all men will be violent and controlling.
- Fear of an extreme reaction to leaving: The time of leaving is one where a woman is at higher risk of being hurt or killed.
- Low self-esteem: Some women may believe they could not manage without their partner.
- Love: Even though a man is violent, a woman may stay because she loves him, or she remembers the good times of the past or acts of affection in between episodes of abuse.

Activity 1



Up to 1 hour (group)
30 minutes (individual)



Aim To understand your own views and attitudes about domestic violence.

Domestic violence is something that many people are familiar with in their own lives. You may have seen women with injuries from it, friends or relatives who have experienced it, or have experienced it yourself. Because you are familiar with it, it is very likely that you already have a lot of views on domestic violence. You may also have ideas on whether and how it should be addressed in a health care setting. In this activity we would like you to explore your views. It is much better to do this exercise in a small group, or with at least one other person if possible.

1. This activity uses Table 1 below. If you are in a group the person facilitating should have this table open and other group members should not look at it yet. If you are working alone you should take a sheet of paper to cover up the 'Responses' column. You should start by focusing your attention on the column 'Myths/barriers'.
2. Read out the first barrier and ask them if they agree with it. Give everyone a chance to raise their views. Then read out the 'response'. What do you and your colleagues think of the response? If you are doing this alone, write down the barrier in your note book and write down along side it, if you agree with it or not. Then look at the response.
3. Continue down the list discussing each barrier/myth in turn.

Activity 1 continued...**TABLE 1. Understanding your own views and attitudes about domestic violence**

Myth/Barrier	Our Response
This does not happen to women in our community.	Domestic violence occurs in just about every country and in also every age, ethnic and social group.
Unless the abuse is physical it will not do much harm to her.	Violence takes many forms and many women find controlling behaviour and undermining words worse than being hit. All violence is problematic and unacceptable.
Women often lie about rape.	It is common for women who have been raped to conceal it, especially to avoid being blamed and stigmatized.
It is a private matter or it is not part of my job or I have not time.	This is a human rights and public health problem. Addressing violence takes a bit of time but may save health workers' time in future.
Victims do not want to talk about it or will get upset if the issue is raised.	Women usually do want to talk to someone who shows empathy towards their situation.
She must have done something to provoke it.	No one deserves to be hit or sexually abused whatever they did.
Violence happens to all women and a woman should just deal with it.	Violence is very common, but it is unacceptable, it has an important impact on health, and support can and should be given.
This probably happened in the past and it cannot be affecting her now.	The effects of violence on a woman's physical and mental health can last for a lifetime.
I do not want to have to talk about it as it makes me think too much about my life.	Talking about violence always makes people think about their own experiences of violence and can be upsetting. Health workers who provide support often need support, but this should not stop them from doing it.
I can see why her partner beat her or if a woman does something wrong, she should expect to be corrected.	Just because a woman did something to make him angry does not mean she deserved to be hurt. If a man or woman does not like something their partner does, they should talk about it and not use violence.
Unless she leaves him, it is a waste of my time talking with her.	Leaving is difficult and is not an option for many women. There are many things that you can do that can help a woman who does not leave her abuser.
In this culture women think beating is a sign of love.	In all countries women who experience violence have worse health. There are sometimes local sayings or beliefs that minimize or legitimize violence, but none the less most women greatly suffer because of it.

Activity 1 continued... **Our View**

The attitudes and views expressed in the 'myths /barriers' column are very commonly held and can prevent health workers from adequately addressing this topic. Sometimes we respond to violence a) with denial acting as if it is not occurring; b) by rationalization or thinking of all the 'reasons' why we should not try to address violence in women's lives; c) by minimization of the problem - we may recognize that violence is common but we act as if it is not so common and minor; d) by identifying with the situation - it occurs when we feel we understand very well what the woman may have experienced and it makes us uncomfortable, or we feel we can understand what the perpetrator (person responsible for the violence) was thinking and identify with him. If you are identifying with the perpetrator, it is important to remember that you are not taking care of him, and as a health worker your responsibility is towards the woman in front of you.

These defensive responses to violence are common. They can interfere with the ability of a health worker to be empathetic, to avoid judgement and victim-blaming and to accept that violence is something that they should be addressing in their work.

Some people hold very strong attitudes on the question of domestic violence that do not seem to change very much when they learn more about the problem. They find it very difficult to accept that women are not to blame and that domestic violence is a violation of human rights, and an important health problem. If you feel that you strongly disagree with many of 'our responses' in this exercise and if, after reading this session, you still disagree, you should ask yourself if you will be able to separate your personal views from what we are saying is 'good practice'. If you do not think you can respond with empathy, it is better that you do not talk to women about domestic violence, and try to refer any cases to a colleague.

Signs and symptoms of abuse

Women who experience physical and sexual violence and use health services may or may not have obvious signs or symptoms of abuse. Some women will reveal their partner injured them. If a woman has injuries, you should always ask how it happened and who caused the injury.



INDICATIONS A WOMAN MAY BE SUFFERING ABUSE:

- if the woman seems very afraid or embarrassed
- if the woman seems very sad or depressed, or thinking of killing or harming herself.
- if she gives an explanation of the injury that does not sound right
- if she has an injury that is usually caused by an assault, such as a black eye, or an obvious cigarette burn.
- if she has repeated, unexplained symptoms or repeated visits for health care or injuries.

Women who are beaten in pregnancy are often hit on their abdomen. This may cause a placental abruption and there may be vaginal bleeding, she may miscarry and the fetus can die. You should always ask about whether there has been violence if you see a woman with vaginal bleeding in pregnancy or a miscarriage or bruises on her abdomen.

In women who are not pregnant, chronic pelvic pain of no obvious cause can be a common sign of domestic violence. Pain during sexual intercourse may also be a sign of a previous rape. Sometimes a woman visits health facilities very often with vague aches and pains, and staff can find no physical cause. This may be a sign that she experienced domestic violence or has been raped in the past. If you see a woman with these problems you should try to find out whether she is being, or has been, abused.

Mental health problems are very commonly associated with domestic violence. Women lose their self-esteem and self-confidence, often become anxious and depressed and may attempt suicide, or harm themselves in other ways. In communities where alcohol or drugs or tobacco are accessible for women, they may smoke very heavily, or use drugs or abuse alcohol, and they may do this in pregnancy. Substance abuse is often a way of trying to deal with the psychological pain and fear of being in a violent relationship.

Notes for discussing and supporting women on domestic violence

What can you do?

Many women who experience domestic violence feel completely alone. They may try to hide the abuse. They may feel ashamed and fear being blamed. You as a health worker can talk with a woman and show you are interested in her, that you care about what happened to her, and do not believe it was her fault – you can demonstrate respect and empathy. This will be of great initial support.

If you suspect there may be a problem of domestic violence you should try to discuss it, but it is important to do this in a way that is supportive. The information below on discussing and supporting

women experiencing domestic violence provides an outline of how this can be done. In summary, you first need to establish privacy for this and enough time to talk properly. You may want to arrange to meet on more than one occasion to talk through all the issues, but you should try and do everything outlined in the session on the first visit.

When she has told you what has happened, it is useful to repeat the statement that it is not her fault. This simple message is very important for women. It can help them start a process of rebuilding their self-esteem and understanding what is happening in their lives.

Who should you ask?

We do not recommend that you ask every woman you see about violence, but you should ask any woman where you suspect there may be a problem of violence. This should include women with: inadequately explained injuries, bruises, miscarriage, vaginal bleeding in pregnancy, STIs, persistent aches and pains without a clear cause, anxiety, depression and substance abuse. You may also want to ask women who miss their own or their children's appointments and book late, mothers of children with emotional and behavioural problems, and those who cannot stop smoking and drinking alcohol during pregnancy or while breastfeeding.

Safety Precautions

Never ask about abuse within earshot of a woman's husband, partner or his relatives. If necessary, think of an excuse to see the woman alone, such as by sending the person off to fill in a form, or asking a colleague to 'distract' them with a conversation. Also remember to maintain confidentiality in the health facility, ensure privacy and do not write anything down about abuse unless you know it can be kept confidential.

Introducing the topic: showing empathy

You might want to start off in the following way that demonstrates that the woman will be safe disclosing violence to you and that you will support her:

"Many women experience violence from their husband or partner, or even someone else they live with. It often causes health problems and can stop women visiting health services when they need to and from following health advice. I have seen women with problems like yours who have been experiencing domestic violence. I would like to ask you a few questions because I want to help you and to help you find others who can also support you. Anything you say to me will be kept between ourselves. Before we go further, I want to tell you that if you have been experiencing violence you should not blame yourself for it, as a woman's behaviour never justifies abuse. "

Screening questions

These are some simple and direct questions that show you want to hear about her problems. You might want to adapt them a little to fit in with your own style and to ask about forms of violence you know are common in your area.

- Has your husband (or partner) or someone at home ever threatened to hurt you or physically hurt you in some way? If yes, when did it happen?
- Were you ever forced into sex or to have sexual contact you did not want?

- Does your husband (or partner) or someone at home bully you or try to control you or put you down or stop you doing things you want to do?
- Are you afraid of your husband (or partner)?
- Has your husband (or partner) threatened to kill you?

If a woman answers 'yes' to any of these questions you should use open-ended questioning and active listening skills to encourage her to give you a full account of what happened (or happens).

Show respect and that you believe her

Acknowledge that you can understand that everything she has told you must have been very distressing for her and tell her again that no woman deserves these things to happen to her.

Reviewing the impact on her health, how to reduce this, and sources of support

You should then ask her how she thinks it impacts on her health, her ability to follow health advice and use of health services and discuss ways of reducing this impact. Then you should help her to think about how she could get help and assess her safety. Arrange to see her again.

It is very important to review with her what she thinks might help her. Remember to facilitate the process, so that she might identify someone she can talk with about her problems. Most women will benefit from exploring whether there is a family member, friend, or religious leader in whom they could confide, and from whom they could get support. She might suggest someone who could talk with her husband (or partner) although you should warn her that if this is not done carefully, it could lead to retaliatory violence. We do not recommend that health workers do it. You should also talk about anything that might help her protect her health more effectively.

Developing a Safety Plan

Finally, before a woman leaves, you should discuss safety issues to ensure that she is not at high risk of severe physical harm. If she is, you should advise her of this and support her in developing a plan for her (and her children's) safety. Women find it much easier to take an action, such as fleeing when they are under threat, if they have thought it through beforehand.

Safety assessment: a woman who answers 'yes' to any of these questions needs a safety plan

1. Has your husband/boyfriend threatened to kill you?
2. Does he have a gun, or knife, or other weapon he might use at home?
3. Has he threatened you with a weapon?
4. Have you been beaten recently? Is the violence getting more frequent and severe?

The idea of a safety plan is that it enables a woman to be able to leave her home very quickly if violence escalates or she becomes particularly afraid, and to stay away for at least a few days, if necessary, until she can return in safety.



QUESTIONS FOR THE SAFETY PLAN:

1. If you need to leave your home in a hurry, where could you go?
2. Would you go alone or take your children with you?
3. How will you get there? Do you need money for this?
4. Do you need to take any documents, or clothes, or other things with you when you leave? What is essential?
5. Can you leave a few items with someone for safe keeping just in case?
6. Do you have access to money if you need to leave? Where is it kept? Can you get it in an emergency?
7. Is there a neighbour you can tell about the violence who can call the police or come with assistance for you if they hear sounds of violence coming from your home?

Documenting abuse

Everything a woman discusses with you must be kept confidential. Remember to assure her that all discussions about her situation and related issues are confidential, or explain the limits of confidentiality if, for example, it is mandatory to report cases of abuse. Only you and essential members of the health care team will know about her status, and you will maintain confidentiality among yourselves.

Some women have experienced violence when their husband or partner has discovered they discussed their experiences with other people. In many health facilities confidentiality is hard to guarantee. It is only helpful to record injuries, or other consequences of violence in the health records if domestic violence is against the law in your country and the police actively pursue cases. In this case, it can be useful to make a note in a woman's health records documenting as completely and accurately as possible everything she has told you and any injuries or other health consequences. In communities where there is no legal solution, it may be better not to write anything down, just in case it is ever held against her in some way.

Activity 2



Up to 1 hour (group)
30 minutes (individual)



Aim

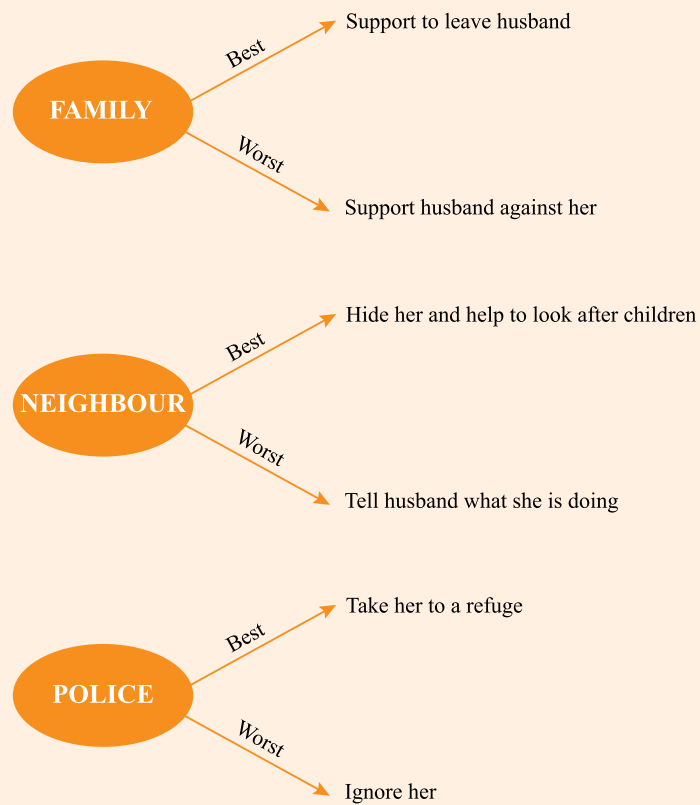
To help you think of sources of help for women experiencing domestic violence.

Sometimes we feel there is little we can do to help women who experience domestic violence, but there may be more sources of help and influence than you may think. Some cultures have established ways of trying to address domestic violence, for example, by the intervention of older people. Sometimes people who are asked for help are really useful, and sometimes they may not be. We want you to think about this, do some research on the topic, and have a list of possible sources of help in your community so you are better able to advise women.

Activity 2 continued...

1. Are there local practices for trying to address domestic violence? Write in your notebook a list of all the people and places in your community where a woman experiencing domestic violence might go to for help, or who may become involved if she is being abused by her husband or partner or other family members. Think of all the formal services for help (such as police, social workers, and women's groups) and informal sources (such as mothers, sisters, neighbours). Leave a space between each source of help on your list so you can add more information about each source on the page.
2. Now draw two lines coming from each source of help. For each, think of the best form of help they could give a woman and note this against the top of the two lines. Then think of the most unhelpful response a woman can get from that person or place, and write this against the lower of the lines.

Example



3. How can you make it more likely that possible sources of help will provide the best form of support?
4. For those groups or sources that could help women, do you have information on how to contact them? If groups do not exist, how could you help women start their own support group or support each other? Could you help facilitate setting up such a group?
5. Keep a list of the best sources of support and contact information so you can share it with colleagues and use it to assist you when reflecting on options with women.

Activity 2 continued... **Our View**

Many women want to talk with people they already know such as relatives, friends, neighbours or religious leaders. These people can sometimes be very helpful and may have formal roles in the local culture for intervening when there is domestic violence. But sometimes they can be very unhelpful. They can make a woman feel worse, by telling her it is her fault and that the violence will only stop when she changes her behaviour. If more people speak about domestic violence, talk about the health consequences, question why this form of violence should be treated differently from other forms, and question why women should be blamed, it is possible to begin to change attitudes. Is it possible for the health services in your community to take on this role? You may want to talk about this with your colleagues and the programme manager. There are usually many people who do not agree with domestic violence in a community and raising awareness of it can help them take action in the families and social networks to support women who they see need support.

In some communities women may be able to get legal protection. You should find out what the situation is in your country. Social workers may also provide help, and there may be women's organizations or other non-governmental or community-based organizations that can provide assistance and support for women. It is useful to ask around and put together a contact list.

Helping women who experience domestic violence support one another can be very useful. If there is no support group in your community, think about how you could help them meet and talk through their experiences and generate options.

Domestic violence, health and the use of health services

A woman who experiences domestic violence may use health facilities more often because her health is worse than the health of other women. However, she may find some types of services difficult to use, or may fear using them, because it could anger her partner. Violent men sometimes prevent their partners from using essential health services, such as antenatal care, as a form of punishment or control, or because they will not spend money on their wives. If a woman books late, or misses antenatal appointments, or has health problems that normally you would expect would have been brought to the attention of a skilled attendant earlier, you should ask her if anyone was preventing or discouraging her from attending.

Can you think of anything you or others could do to help abused women attend antenatal care regularly?

A woman experiencing domestic violence often finds her husband (or partner), or his relatives, limits her ability to make decisions on her own about her health. You may see this with breastfeeding. She may experience pressure from home to either breastfeed, or formula feed, when it is against her wishes, and her health interests. She may, for example, be coerced to give traditional foods to her baby when she has chosen to exclusively breastfeed when she has HIV because her husband or mother-in-law insists it is best for the baby, yet she is afraid to tell them her HIV status and explain why it is especially important to exclusively breastfeed. Can you think of a way to help in such situations?

Sometimes it is possible to help an abused woman use services she needs more safely. If a woman wants contraception against her husband's wishes, for example, you can suggest a method such as an injectable contraceptive. You can also arrange it so a woman does not have to attend a family planning clinic for contraception.

Men who are violent often have more sexual partners and are more likely to have sexually transmitted infections, including HIV. A wife may discover she has a sexually transmitted infection, possibly HIV, and may be very fearful of telling her husband, while recognizing the need for him to get tested or treated. If a woman is tested and found to have HIV or an STI and is afraid to tell her partner, you could suggest that she pretends she has not been tested and tries to get him to attend with her so that they can both have an HIV test. That way they are both counselled and receive their results at the same time. Look at Session 14 on Women and HIV/AIDS for further suggestions on couple counselling and mediated disclosure.

Domestic violence can impact on the health of a child in many ways. A man who abuses his wife will often also be violent towards his children, and children suffer psychological distress, that can be very severe, when they witness such violence. You may suspect there are problems of violence at home if you recognize behavioural and emotional problems in children. A woman who has severe mental health consequences of violence may be less able to give her children all the care another mother would give. Can you think of a way of helping women who experience such problems remember they need to attend clinics for immunization and other aspects of infant and child health care?

Activity 3



30 minutes



To practise your skills at talking about domestic violence.

If you are working in a group you should carry this out as a role-play, rotating roles. If you are working alone, ask a colleague or a friend to sit with you to act as the 'person being counselled'. If you are in a group you might want to have some people presenting with injuries, some with vaginal bleeding in pregnancy, and others with depression, then practise asking them questions in different situations.

Activity 3 continued...

1. Prepare to provide support and remember to go through all the following stages:
 - Make sure that you are in a completely private place and no one can listen in.
 - Introduce the subject sensitively and with empathy.
 - Ask one or more open-ended questions about violence and encourage her to tell her story. You can also try indirect questioning.
 - Show you respect her and believe her by actively listening and demonstrating empathy.
 - Talk to her about how she thinks domestic violence impacts on her health and health service use, discuss ideas for helping her to follow health advice and attend services that she wants and needs.
 - Talk with her about what support she wants and what might help her with the violence.
 - Assess her safety, and if she is at risk of very severe violence, support her in developing a safety plan (refer back to safety assessment and planning in this session).
 - Document her medical problem, but do not write anything down about the violence unless it is safe to do so, and provide any treatment that is required.
 - Organize follow-up.
2. Ask the person you have been 'counselling' how it felt for her. Did she feel safe enough to 'reveal' her problems? Did she feel supported? Ask her to tell you your strengths and weaknesses, remembering to draw from the key counselling skills and process learned in Sessions 2 and 3.



Our View

We may have strong opinions about what we believe a woman should or should not do if she is being abused. We may want to use our position in the community to call the man in and tell him to stop beating her. At other times we may want to tell a woman just to leave him. These seem like obvious solutions but they can cause a lot of problems if the woman could be punished for even having told you about her abuse and it is often difficult to leave (and stay away). It is very important to maintain a non-directive and supportive approach based on the principles of counselling and not to tell people what they should do. It is important that we support the woman experiencing domestic violence in exploring her options and in deciding for herself what she can do to help herself.

Often, one of the most helpful steps for a woman experiencing abuse is to know that someone cares. Make her feel supported and let her know that a woman should not have to suffer through this. If you think she is experiencing abuse and does not want to tell you about it, it is best not to force her but to let her know that if she (or someone she knows) ever does experience abuse, she can come and talk with you about it.

Supporting health workers

Talking about violence with women regularly stirs up strong emotions in health workers, especially if they have close personal experience of violence. It is important to find a way of supporting yourselves in a way that does not breach the confidentiality of the woman who you have been counselling. You can do this by talking with sympathetic colleagues. Can you make a plan now for whom you can talk to and when you can meet?

What did I learn?



After finishing this session you should be aware that domestic violence can take many forms, but it is always a violation of human rights. You should be able to better understand the dynamics of violence in relationships and why it can be very difficult for a woman to leave a violent relationship. You should also understand that it can affect her health in very many ways, both physically and emotionally, and influence her use of health and other services.

It is important to learn how to ask women about violence. It can be a difficult thing to start doing, as you may feel it is a private matter or you may have your own experiences of violence that are still painful. You have taken time to learn how to ask women safely about abuse and how to support them, even if there are few resources or services available to help them. It is important to remember that just showing kindness can be very helpful, and can give women courage and reassurance.

Are you confident you could ask about violence if you suspected it? Are you clear what your role is? Do you have information about the law in your country and what services and support groups are available? Do you think you could help abused women form their own group? In your notebook write down the answers to some of these questions and any key points you have learned from this session.

LINKING WITH THE COMMUNITY



What is in this session?

This session describes what you can do as an individual health worker. However, active participation of non-health actors and community representatives in planning maternal and newborn services should be addressed by the programme manager.



IMPORTANT:

WHO has developed a framework for MNH programmes for working with individuals, families and communities to improve maternal and newborn health.

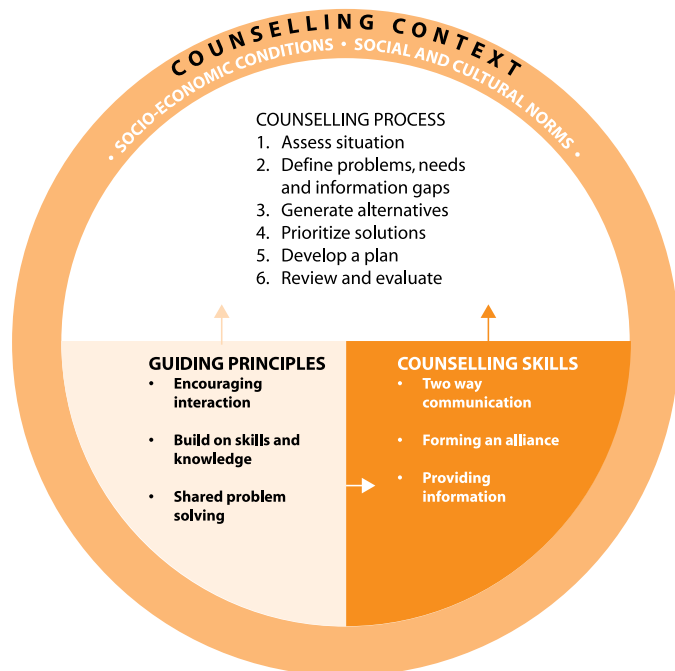
http://www.who.int/making_pregnancy_safer/documents/who_fch_rhr_0311/en/index.html



A toolkit for supporting implementation will soon be available, so check the web page when you can for more information or write to us to request a copy at mncah@who.int.

What skills will I develop?

- Forming an alliance with the community
- Establishing links with other health care providers and leaders
- Practical skills for efficiently planning and organizing productive meetings.



What am I going to learn?

By the end of this session you should be able to:

1. Outline the benefits and problems of team work/working with others
2. Identify the relevant groups, organizations and providers that you can establish links with
3. Facilitate joint action.

Working with the community

Ideally, everyone within the community should be aware of the specific needs of a woman and her newborn, and informed about the situation of women and neonates in the community. The health services together with the community can find different ways to solve problems, thus becoming jointly involved in the processes of improving health.

Advantages of health services and communities working together

Collaboration, or forming community partnerships, is a difficult challenge, particularly between parties who may not be used to working together. However, it can bring many benefits:

- It allows for increased knowledge and understanding of what different groups can contribute.
- It helps to clarify roles and avoid duplication of effort and work.
- It leads to a more effective use of resources.
- It supports groups who would not normally see themselves as having a role in maternal and newborn health understand how they might contribute.
- It allows for a more comprehensive analysis of health problems and for the identification of realistic solutions.
- It helps to minimize gaps in the provision of care and provides better coverage of services.
- It co-ordinates information and advice among different providers, assuring uniformity rather than conflicting information. Information can also be formulated with the community so that it is more easily accepted and more pertinent to the reality.
- It helps the health services and personnel learn more about local traditions and practices, and whether they present barriers to health service use, and if so, how these can be overcome.

Ways for health services and communities to work together

Additional skills which can help to improve working with other groups include communication, facilitation in meetings, and institutional strengthening of partners in management processes.

The different groups you work with have different roles and responsibilities which they currently fulfil, and different ways of working to meet their objectives. It is important to work out how you can reach a shared vision of what you want to achieve.

For example, if you have all agreed on a skilled attendant at birth for all pregnant women and newborns as a common objective, you could follow the steps described below:

1. You would need to work with the other groups and providers to define what you mean by birth with a skilled attendant - make sure you have a good measure of what the current use is and a target of what level of use you want to achieve over a defined time period.
2. The next step would be to assure that all parties understand who the women are who are currently seeking care (as you have defined) and why these women are not using the services. You may need to gather additional information, through exit interviews, focus groups or in-depth interviews, and not just rely on what the groups think they know. It is important you find ways to hear from women themselves.

3. After there is a good understanding of the problem, together you can discuss possible solutions and elaborate a plan to overcome the barriers to use of care and to increase the use of services with a skilled attendant.
4. Together you can map out all the different resources you have in your community to see how they fit together e.g. see who currently provides which services, who would best be suited for the different tasks in the plans, what other groups you may need to involve, and how to divide roles and the responsibilities to achieve the plan.

You also need to work out how you will liaise and communicate with one another and which group or organization or even individual will take the lead and responsibility for coordinating the work together.

Different actors in the community

It may not be possible to work with the whole community, but you can work with certain groups or key individuals in the community. A community is made up of different groups and individuals:

- Community leaders: e.g. political, religious or informal
- Community groups: e.g. women's groups, youth groups, income generating groups
- Community health volunteers
- TBAs, traditional healers.

Since our focus is maternal and newborn health, it is important that you hear from women directly and include groups who work with women and who can best represent them.

Link with community leaders

Every community has a number of different community leaders. Some of these will be religious leaders, some political, some tribal or natural leaders, or people in positions of authority. These leaders can have many roles, for example, they can be influential on social norms, beliefs and attitudes. They can be influential decision-makers and planners, so that they are important for organizing transport for referrals or may be important for the provision of information. We often refer to leaders in the community as the 'gate keepers', they are the key people who have access to the wider community as a whole. As it is often not possible to work with the whole community, it is important to identify those leaders who can provide access to and represent the whole community. These are the key people that we need to work with. Do you know who the key community leaders are in your community? How can you find out who these people are? Consider making a resource list with the names and contact details of all the key community leaders in your area. Often these lists have already been put together by another group – find out what exists in your area.

Working with community groups

Different community groups exist either health related or non-health related, e.g. breastfeeding groups, agricultural groups, etc. The dynamics of these groups can be used to mobilize their members on maternal and newborn health issues as you have examined throughout this Handbook. For example, you have looked at:

- cultural and gender practices in your community
- seeking community support and engaging the community in birth and emergency plans such as village transport plans
- knowledge of danger signs and when to seek care
- ways to support women during pregnancy, after an abortion and after birth
- healthy and harmful practices
- strengthening and supporting mother's groups and support groups.

What other ways can you work with the community? For example, you can also have an input into changing gender and cultural norms which have a negative effect on women's health. You could consider getting feedback from the community about the quality of the services which are provided to them. You can also work with the community to get feedback on health information you provide and what they understand by this information. Consider including the community in developing practical action plans on how they can support women during pregnancy and after birth, for example, by looking after other children, helping the woman with household chores, or support for payments that need to be made.



GOOD TEAM WORK INVOLVES:

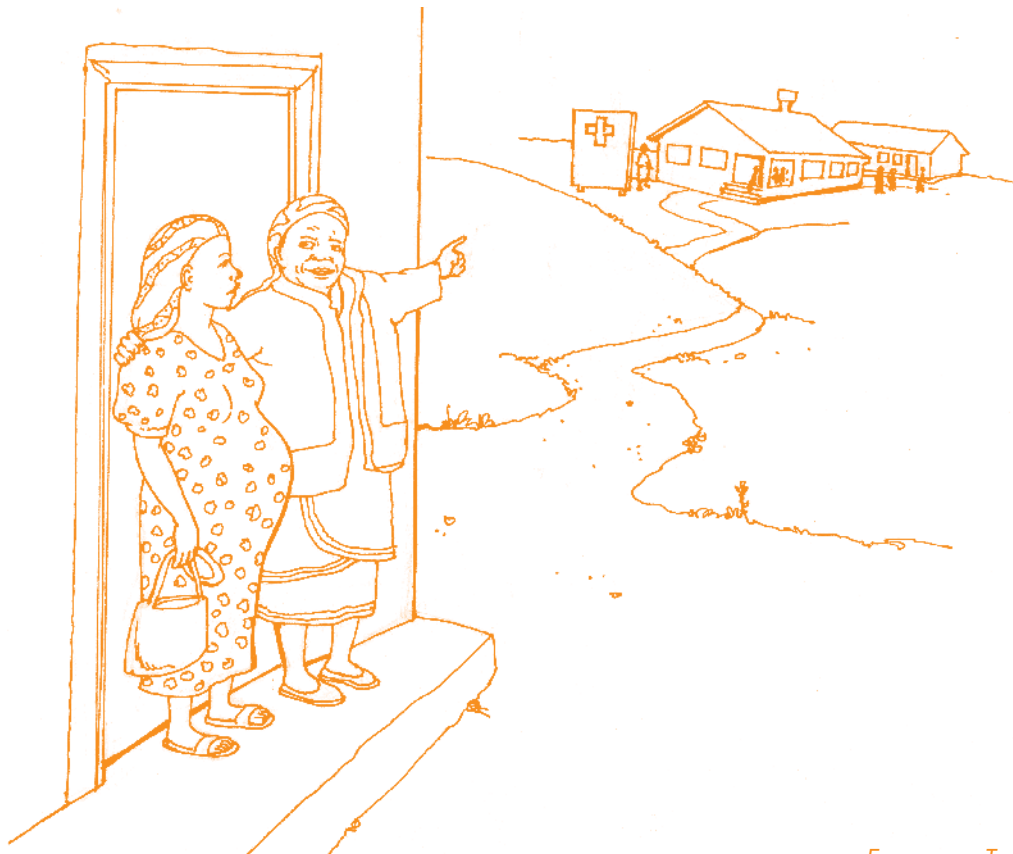
- a common task or purpose
- clear definition of roles and responsibilities of the different players
- different expertise for different functions/tasks
- supporting one another in different tasks
- skills and personalities complementing one another
- commitment to achieving functions/tasks
- a leader to take responsibility and coordinate.



Discuss in advance how you can work together.

Links with Traditional Birth Attendants and Traditional Healers

Traditional healers and TBAs are two groups involved in the provision of health care and who are often well respected and trusted members of the community. WHO recommends that you invite them to the health facility so that you can share with them the work, knowledge and advice that you have. Health services should make real efforts to establish relations with the TBAs as they can offer insight into local pregnancy and childbirth traditions and highlight areas for concern. They are also often the only ones who have confidential insight into the needs of women and their fears. Sexuality issues may sometimes only have been discussed between the woman and her TBA. Encouraging the TBAs to 'come on board' with any new pregnancy and childbirth practices is an effective means of developing the trust that women and the community will place in the new practices.



Encourage Traditional Birth Attendants to refer women to you.

There are several practical ways that you can establish links with TBAs and traditional healers:

- Include them in your referral system: encourage them to refer women to you. and provide them with feedback on women they have referred to you.
- Clarify together what constitutes harmful, harmless or helpful practices.
- Examine what resources you could share, e.g. leaflets, posters or condoms or disposable gloves.
- Share with them your knowledge and expertise. Discuss points where you differ, respecting each other's right to express their views, but each presenting the statements to support their opinion.
- Work with them to explain the key information of the PCPNC related to pregnancy, birth and postnatal care for women and newborns including family planning, STIs, breastfeeding and care of the newborn.
- Invite them to participate in meetings that you hold for community groups and providers.
- Ask for their help in identifying women who may be at risk.
- Encourage them to persuade all women to give birth with a skilled birth attendant.
- Encourage them to ensure each woman has a birth and emergency plan.
- Encourage TBAs to act as labour companions for women and provide support immediately after birth.
- Consider using them as a valuable source of feedback about the services you provide.
- Encourage them to work through this Handbook.

Activity 1



Variable (you may need to carry this activity out over several weeks).

Aim

To help you establish links with other health care providers, community groups and leaders and to establish ways of working with them.

If you are working in a group, then divide up the activities so you each have responsibility for a different area of preparation and follow-up.

1. Make a list of providers and groups that work in your community.
2. Find out what each of the different groups/providers currently do with respect to the care of the woman and newborn during pregnancy, birth and after birth. Collate this information into a document to be used as a future resource.
3. Identify the most common health problems related to pregnancy, childbirth and postpartum/postnatal periods in your community. Use local morbidity (illness) and mortality (maternal and newborn deaths) data to help you. You may be able to get this information from health service or district annual reports or from your health information registers in the maternity wards.

Activity 1 continued...

4. Work out a way to co-ordinate and unify information on these common health problems related to the care of the woman and newborn during pregnancy, birth and the postpartum/postnatal period.

Think about how you might be able to do this in advance of setting up a meeting:

- a. You could consider generating key information together.
- b. You could provide a list in advance that you discuss at the meeting.

Try to keep it simple and focused on the most important information relevant for the community.

5. Organize a meeting/meetings where representatives and leaders from these providers or groups can attend. Remember to prepare an agenda in advance.
6. At the meetings define the roles and responsibilities different people and groups can make with respect to maternal and newborn health. Try to come up with ideas for things that you can do to improve maternal and newborn health.
7. During or after the meeting, prepare an action plan defining responsibilities and activities (including a timeline) that each of you have to do and circulate it to all participants.
8. Decide upon a person or group who will be responsible for monitoring how the implementation of the action is occurring according to the action plan.

Tips for planning a meeting

- Make a list of all the people who need to be invited.
- Ensure you have a place to meet, which is big enough to take the whole group. You may need to think about transport and ease of access.
- Make sure you send out invitations to the meeting well in advance to make sure people are free. One way is to find out available dates in advance and then pick the day that most people can attend; it is unlikely you will get a day when everyone is free to come. Another way is to see if it is possible to add some points of your agenda to a meeting that is already organized for another purpose.
- Plan what you want to cover in the meeting in advance – write down some aims and objectives. Use these to come up with an agenda and send this out with the invitation. If you have any other supporting materials you may want to send these in advance so people can prepare for the meeting.
- On the day of the meeting organize the space so that everyone is comfortable and can see one another – if you can, organize the space so you are sitting in a circle or round a group of tables.
- Consider whether you can provide refreshments, especially for those who have had to travel a long way.

Activity 1 continued...

- Choose someone to chair the meeting, and someone to take minutes, which is a way of recording what has been discussed, and any plans or action that you come up with, and dates for future meetings.
- Remember to also remind people of the aims and objectives of the meeting before you start going through the agenda items.
- Sometimes it can be helpful to set ground rules for the meeting – suggestions might be things like addressing questions through the chair, not talking over one another, respecting different points of view.
- Have an item 'any other business' on your agenda so people can raise other issues that you might not have thought about.

**Our View**

This activity is to help you unify the information, care and advice that is given to women for pregnancy, childbirth and after birth in your community and to identify the most pressing problems and possible solutions for women and newborn. It is important that women are not given conflicting advice and that you can advise women where to go for additional support and advice within the community. As health care providers you are part of a network of wider care and support and it will help you to be able to utilize the resources of this network. Health problems can be tackled from many different angles. By working in partnership you may be able to achieve far more than by working in isolation.

What did I learn?

You should be aware of the usefulness of establishing links with different providers and groups within the community. Are you more confident about how to work with them as partners? It should be a long-term goal of the health service to develop and maintain partnerships.

A Handbook for Building Skills

**COUNSELLING FOR
MATERNAL AND NEWBORN HEALTH CARE**

ASSESSMENT

Assessment

This assessment is to help you assess your skills and knowledge in counselling for maternal and newborn health now that you have completed this Handbook. If you are working in groups you should carry out the assessment on an individual basis but present your assessment to the rest of the group for discussion and feedback from both the group members and the facilitator. If you are working on your own, consider presenting your assessment work to your colleagues or mentor, for some feedback on how you have done.

PART 1



1 hour

Aim

The first part of the assessment is for you to reflect on the work you have done in the Handbook.

1. Take some time to review your notebook and the Handbook to remind yourself of all the material that has been covered. Then note down the following:
 - a. The most important things you have learned
 - b. The skills that you have developed
 - c. The areas that you would like to practise or improve.
2. Refer back to your motivation for working through the Handbook that you wrote down in Session 1. How far did you manage to fulfil your own personal objectives?

PART 2



variable

Aim

This part of the assessment is for you to review case studies of women you have counselled for maternal and newborn health and reflect on your counselling skills.

1. Write up three case studies of women you have counselled. You can either use three new case studies, or use case studies from your notebook from previous sessions or a combination.
2. Your write up should include the following:
 - a. Brief description of the person/people you were counselling
 - b. Outline of the problem, issue or topic that was discussed
 - c. How you approached the counselling session
 - d. A review of the interaction (you might consider audio or video taping a session if you have access to the equipment and if the woman consents)
 - e. What you felt went well, and what you felt could have been improved upon or done differently
 - f. The outcome in terms of the decisions made and any action that was taken
 - g. Any follow-up or further information
3. If possible try to get some feedback from the women or people you counselled on how they felt the session went and what they think was good and what could have been done differently or was missing.
4. Look to see if there are any common themes in your case studies in terms of what went well, and what could have been improved upon. How might you address the areas which need further work or skills building?
5. After you have presented your case studies, ask your group or colleagues for their comments, ideas or advice on what you have done.

A Handbook for Building Skills

**COUNSELLING FOR
MATERNAL AND NEWBORN HEALTH CARE**

ANNEX

Annex 1 : Information and Counselling Sheets
from the PCPNC

INFORMATION AND COUNSELLING SHEETS

M4 CARE DURING PREGNANCY
 Visit the health worker during pregnancy
 Care for yourself during pregnancy
 Routine visits to the health centre
 Know the signs of labour
 When to seek care on danger signs

M5 PREPARING A BIRTH AND EMERGENCY PLAN
 Preparing a birth plan
 Preparing for delivery at home
 Preparing an emergency plan
 Planning for delivery at the hospital or health centre

M6 CLEAN HOME DELIVERY (1)
 Delivery at home with an attendant
 Instructions to mother and family for a clean and safer delivery at home

M7 CLEAN HOME DELIVERY (2)
 Avoid harmful practices
 Encourage helpful traditional practices
 Danger signs during delivery
 Routine visits to the health centre

- These individual sheets have key information for the mother, her partner and family on care during pregnancy, preparing a birth and emergency plan, clean home delivery, care for the mother and baby after delivery, breastfeeding and care after an abortion.
- Individual sheets are used so that the woman can be given the relevant sheet at the appropriate stage of pregnancy and childbirth.

M8 CARE FOR THE MOTHER AFTER BIRTH
 Care of the mother
 Family planning
 Routine visits to the health centre
 When to seek care for danger signs

M9 CARE AFTER AN ABORTION
 Self-care
 Family planning
 Know these DANGER signs
 Additional support

M10 CARE FOR THE BABY AFTER BIRTH
 Care of the newborn
 Routine visits to the health centre
 When to seek care for danger signs

M11 BREASTFEEDING
 Breastfeeding has many advantages for the baby and the mother
 Suggestions for successful breastfeeding
 Health worker support
 Breastfeeding and family planning

M12 CARE FOR THE MOTHER AFTER AN ABORTION
 Self-care
 Family planning
 Know these DANGER signs
 Additional support

INFORMATION AND COUNSELLING SHEETS

Information and counselling sheets

M1

Care during pregnancy

M2

INFORMATION AND COUNSELLING

CARE DURING PREGNANCY

Visit the health worker during pregnancy

- Go to the health centre if you think you are pregnant. It is important to begin care as early in your pregnancy as possible.
- Visit the health centre at least 4 times during your pregnancy, even if you do not have any problems. The health worker will tell you when to return.
- If at any time you have any concerns about your or your baby's health, go to the health centre.

■ During your visits to the health centre, the health worker will:

- Check your health and the progress of the pregnancy
- Help you make a birth plan
- Answer questions or concerns you may have
- Provide treatment for malaria and anaemia
- Give you a tetanus toxoid immunization
- Advise and counsel on:
 - breastfeeding
 - birthspacing after delivery
 - nutrition
 - HIV counselling and testing
 - correct and consistent condom use
 - laboratory tests
 - other matters related to your and your baby's health.
- Bring your home-based maternal record to every visit.

Care for yourself during pregnancy

- Eat more and healthier foods, including more fruits and vegetables, beans, meat, fish, eggs, cheese, milk.
- Take iron tablets every day as explained by the health worker.
- Rest when you can. Avoid lifting heavy objects.
- Sleep under a bednet treated with insecticide.
- Do not take medication unless prescribed at the health centre.
- Do not drink alcohol or smoke.
- Use a condom correctly in every sexual relation to prevent sexually transmitted infection (STI) or HIV/AIDS if you or your companion are at risk of infection.

PREGNANCY IS A SPECIAL TIME. CARE FOR YOURSELF AND YOUR BABY.

Routine visits to the health centre

- 1st visit** Before 4 months
- 2nd visit** 6-7 months
- 3rd visit** 8 months
- 4th visit** 9 months

Know the signs of labour

- If you have any of these signs, go to the health centre as soon as you can.
- if these signs continue for 12 hours or more, you need to go immediately.**
- Painful contractions every 20 minutes or less.
 - Bag of water breaks.
 - Bloody sticky discharge.

When to seek care on danger signs

Go to the hospital or health centre **immediately, day or night, DO NOT wait**, if any of the following signs:

- vaginal bleeding
 - convulsions/ fits
 - severe headaches with blurred vision
 - fever and too weak to get out of bed
 - severe abdominal pain
 - fast or difficult breathing.
- Go to the health centre **as soon as possible** if any of the following signs:
- fever
 - abdominal pain
 - water breaks and not in labour after 6 hours
 - feel ill
 - swollen fingers, face and legs.

PREPARING A BIRTH AND EMERGENCY PLAN

Preparing a birth plan

The health worker will provide you with information to help you prepare a birth plan. Based on your health condition, the health worker can make suggestions as to where it would be best to deliver. Whether in a hospital, health centre or at home, it is important to deliver with a skilled attendant.

AT EVERY VISIT TO THE HEALTH CENTRE, REVIEW AND DISCUSS YOUR BIRTH PLAN. The plan can change if complications develop.

Planning for delivery at home

- Who do you choose to be the skilled attendant for delivery?
- Who will support you during labour and delivery?
- Who will be close by for at least 24 hours after delivery?
- Who will help you to care for your home and other children?
- Organize the following:
 - A clean and warm room or corner of a room.
 - Home-based maternal record.
 - A clean delivery kit which includes soap, a stick to clean under the nails, a new razor blade to cut the baby's cord, 3 pieces of string (about 20 cm, each) to tie the cord.
 - Clean cloths of different sizes: for the bed, for drying and wrapping the baby, for cleaning the baby's eyes, and for you to use as sanitary pads.
 - Warm covers for you and the baby.
 - Warm spot for the birth with a clean surface or clean cloth.
 - Bowls: two for washing and one for the placenta.
 - Plastic for wrapping the placenta.
 - Buckets of clean water and some way to heat this water.
 - For handwashing, water, soap and a towel or cloth for drying hands of the birth attendant.
 - Fresh drinking water, fluids and food for the mother.

Preparing an emergency plan

- To plan for an emergency, consider:
 - Where should you go?
 - How will you get there?
 - Will you have to pay for transport to get there? How much will it cost?
 - What costs will you have to pay at the health centre? How will you pay for this?
 - Can you start saving for these possible costs now?
 - Who will go with you to the health centre?
 - Who will help to care for your home and other children while you are away?

Planning for delivery at the hospital or health centre

- How will you get there? Will you have to pay for transport to get there?
- How much will it cost to deliver at the facility? How will you pay for this?
- Can you start saving for these costs now?
- Who will go with you and support you during labour and delivery?
- Who will help you while you are away and care for your home and other children?
- Bring the following:
 - Home-based maternal record.
 - Clean cloths of different sizes: for the bed, for drying and wrapping the baby, and for you to use as sanitary pads.
 - Clean clothes for you and the baby.
 - Food and water for you and the support person.

Care for the mother after birth

M4

INFORMATION AND COUNSELLING SHEETS

CARE FOR THE MOTHER AFTER BIRTH

Care of the mother

- Eat more and healthier foods, including more meat, fish, oils, coconut, nuts, cereals, beans, vegetables, fruits, cheese and milk.
- Take iron tablets as explained by the health worker.
- Rest when you can.
- Drink plenty of clean, safe water.
- Sleep under a bednet treated with insecticide.
- Do not take medication unless prescribed at the health centre.
- Do not drink alcohol or smoke.
- Use a condom in every sexual relation. If you or your companion are at risk of sexually transmitted infections (STI) or HIV/AIDS.
- Wash all over daily, particularly the perineum.
- Change pad every 4 to 6 hours. Wash pad or dispose of it safely.

Family planning

- You can become pregnant within several weeks after delivery if you have sexual relations and are not breastfeeding exclusively.
- Talk to the health worker about choosing a family planning method which best meets your and your partner's needs.

Routine visits to the health centre

First week after birth:



6 weeks after birth:



When to seek care for danger signs

Go to hospital or health centre **immediately, day or night, DO NOT** wait, if any of the following signs:

- Vaginal bleeding has increased.
 - Fits.
 - Fast or difficult breathing.
 - Fever and too weak to get out of bed.
 - Severe headaches with blurred vision.
- Go to health centre **as soon as possible** if any of the following signs:
- Swollen, red or tender breasts or nipples.
 - Problems urinating, or leaking.
 - Increased pain or infection in the perineum.
 - Infection in the area of the wound.
 - Smelly vaginal discharge.

CARE AFTER AN ABORTION

Self-care

- Rest for a few days, especially if you feel tired.
- Change pads every 4 to 6 hours. Wash used pad or dispose of it safely. Wash perineum.
- Do not have sexual intercourse until bleeding stops.
- You and your partner should use a condom correctly in every act of sexual intercourse if at risk of STI or HIV.
- Return to the health worker as indicated.

Family planning

- Remember you can become pregnant as soon as you have sexual relations.
Use a family planning method to prevent an unwanted pregnancy.
- Talk to the health worker about choosing a family planning method which best meets your and your partner's needs.

Know these danger signs

If you have any of these signs, go to the health centre **immediately, day or night. DO NOT wait:**

- Increased bleeding or continued bleeding for 2 days.
- Fever, feeling ill.
- Dizziness or fainting.
- Abdominal pain.
- Backache.
- Nausea, vomiting.
- Foul-smelling vaginal discharge.

Additional support

- The health worker can help you identify persons or groups who can provide you with additional support if you should need it.

Care for the baby after birth

M6

INFORMATION AND COUNSELLING SHEETS

CARE FOR THE BABY AFTER BIRTH

Care of the newborn

KEEP YOUR NEWBORN CLEAN

- Wash your baby's face and neck daily. Bathe her/him when necessary. After bathing, thoroughly dry your baby and then dress and keep her/him warm.
- Wash baby's bottom when soiled and dry it thoroughly.
- Wash your hands with soap and water before and after handling your baby, especially after touching her/his bottom.

CARE FOR THE NEWBORN'S UMBILICAL CORD

- Keep cord stump loosely covered with a clean cloth. Fold diaper and clothes below stump.
- Do not put anything on the stump.
- If stump area is soiled, wash with clean water and soap. Then dry completely with clean cloth.
- Wash your hands with soap and water before and after care.

KEEP YOUR NEWBORN WARM

- In cold climates, keep at least an area of the room warm.
- Newborns need more clothing than other children or adults.
- If cold, put a hat on the baby's head. During cold nights, cover the baby with an extra blanket.

OTHER ADVICE

- Let the baby sleep on her/his back or side.
- Keep the baby away from smoke.

Routine visits to the health centre

First week after birth:

 _____

At 6 weeks :

 _____

At these visits your baby will be vaccinated. **Have your baby immunized.**

When to seek care for danger signs

Go to hospital or health centre **immediately, day or night, DO NOT wait**, if your baby has any of the following signs:

- Difficulty breathing.
- Fits
- Fever
- Feels cold
- Bleeding
- Stops feeding
- Diarrhoea.

Go to the health centre **as soon as possible** if your baby has any of the following signs:

- Difficulty feeding.
- Feeds less than every 5 hours.
- Pus coming from the eyes.
- Irritated cord with pus or blood.
- Yellow eyes or skin.

BREASTFEEDING

Breastfeeding has many advantages

FOR THE BABY

- During the first 6 months of life, the baby needs nothing more than breast milk – not water, not other milk, not cereals, not teas, not juices.
- Breast milk contains exactly the water and nutrients that a baby's body needs. It is easily digested and efficiently used by the baby's body. It helps protect against infections and allergies and helps the baby's growth and development.

FOR THE MOTHER

- Postpartum bleeding can be reduced due to uterine contractions caused by the baby's sucking.
- Breastfeeding can help delay a new pregnancy.

FOR THE FIRST 6 MONTHS OF LIFE, GIVE ONLY BREAST MILK TO YOUR BABY, DAY AND NIGHT AS OFTEN AND AS LONG AS SHE/HE WANTS.

Suggestions for successful breastfeeding

- Immediately after birth, keep your baby in the bed with you, or within easy reach.
- Start breastfeeding within 1 hour of birth.
- The baby's suck stimulates your milk production. The more the baby feeds, the more milk you will produce.
- At each feeding, let the baby feed and release your breast, and then offer your second breast. At the next feeding, alternate and begin with the second breast.
- Give your baby the first milk (colostrum). It is nutritious and has antibodies to help keep your baby healthy.
- At night, let your baby sleep with you, within easy reach.
- While breastfeeding, you should drink plenty of clean, safe water. You should eat more and healthier foods and rest when you can.

The health worker can support you in starting and maintaining breastfeeding

- The health worker can help you to correctly position the baby and ensure she/he attaches to the breast. This will reduce breast problems for the mother.
- The health worker can show you how to express milk from your breast with your hands. If you should need to leave the baby with another caretaker for short periods, you can leave your milk and it can be given to the baby in a cup.
- The health worker can put you in contact with a breastfeeding support group.

If you have any difficulties with breastfeeding, see the health worker immediately.

Breastfeeding and family planning

- During the first 6 months after birth, if you breastfeed exclusively, day and night, and your menstruation has not returned, you are protected against another pregnancy.
- If you do not meet these requirements, or if you wish to use another family planning method while breastfeeding, discuss the different options available with the health worker.

Clean home delivery (1)

M8

INFORMATION AND COUNSELLING SHEETS

CLEAN HOME DELIVERY

Regardless of the site of delivery, it is strongly recommended that all women deliver with a skilled attendant. For a woman who prefers to deliver at home the following recommendations are provided for a clean home delivery to be reviewed during antenatal care visits.

Delivery at home with an attendant

- Ensure the attendant and other family members know the emergency plan and are aware of danger signs for yourself and your baby.
- Arrange for a support person to assist the attendant and to stay with you during labour and after delivery.
 - Have these supplies organized for a clean delivery: new razor blade, 3 pieces of string about 20-cm each to tie the cord, and clean cloths to cover the birth place.
 - Prepare the home and the supplies indicated for a safe birth:
 - Clean, warm birth place with fresh air and a source of light
 - Clean warm blanket to cover you
 - Clean cloths:
 - for drying and wrapping the baby
 - for cleaning the baby's eyes
 - to use as sanitary pads after birth
 - to dry your body after washing
 - for birth attendant to dry her hands.
 - Clean clothes for you to wear after delivery
 - Fresh drinking water, fluids and food for you
 - Buckets of clean water and soap for washing, for you and the skilled attendant
 - Means to heat water
 - Three bowls, two for washing and one for the placenta
 - Plastic for wrapping the placenta
 - Bucket for you to urinate in.

Instructions to mother and family for a clean and safer delivery at home

- Make sure there is a clean delivery surface for the birth of the baby.
- Ask the attendant to wash her hands before touching you or the baby. The nails of the attendant should be short and clean.
- When the baby is born, place her/him on your abdomen/chest where it is warm and clean. Dry the baby thoroughly and wipe the face with a clean cloth. Then cover with a clean dry cloth.
- Cut the cord when it stops pulsating, using the disposable delivery kit, according to instructions.
- Wait for the placenta to deliver on its own.
- Make sure you and your baby are warm: Have the baby near you, dressed or wrapped and with head covered with a cap.
- Start breastfeeding when the baby shows signs of readiness, within the first hour of birth.
- Dispose of placenta (describe correct, safe culturally accepted way to dispose of placenta)

DO NOT be alone for the 24 hours after delivery.

DO NOT bath the baby on the first day.

Avoid harmful practices

FOR EXAMPLE:

- DO NOT** use local medications to hasten labour.
- DO NOT** wait for waters to stop before going to health facility.
- DO NOT** insert any substances into the vagina during labour or after delivery.
- DO NOT** push on the abdomen during labour or delivery.
- DO NOT** pull on the cord to deliver the placenta.
- DO NOT** put ashes, cow dung or other substance on umbilical cord/stump.



Encourage helpful traditional practices:



Danger signs during delivery

If you or your baby has any of these signs, **go to the hospital or health centre immediately, day or night. DO NOT wait.**

MOTHER

- If waters break and not in labour after 6 hours.
- Labour pains (contractions) continue for more than 12 hours.
- Heavy bleeding (soaks more than 2-3 pads in 15 minutes).
- Placenta not expelled 1 hour after birth of baby.

BABY

- Very small.
- Difficulty in breathing.
- Fits.
- Fever.
- Feels cold.
- Bleeding.
- Not able to feed.

Routine visits to the health centre

- Go to the health centre or arrange a home visit by a skilled attendant as soon as possible after delivery, preferably within the first days, for the examination of you and your baby and to receive preventive measures.
- Go for a routine postpartum visit at 6 weeks.



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A Handbook for Building Skills

COUNSELLING FOR MATERNAL AND NEWBORN HEALTH CARE



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