

Romanian Family Health Initiative

**A Comprehensive Reproductive Health Curriculum**

# Training of Roma Health Mediators in Reproductive Health



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Romanian Family Health  
Initiative



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# **TRAINING OF ROMA HEALTH MEDIATORS IN REPRODUCTIVE HEALTH**

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## INTRODUCTION



### **JSI Research and Training Institute (JSI)**

JSI is a US public health management consulting firm with its headquarters based in Boston and with more than 60 international office sites. The mission of John Snow, Incorporated and of the JSI Research and Training Institute, its non-profit affiliate, is to improve the quality and accessibility of medical services around the world. Its purpose is to develop and implement improved management systems and to increase the organizational efficiency and efficacy.

Since 1978, JSI has responded to pressing public health issues in 84 countries around the world and in the United States, developing more than 300 projects and managing 324 million USD in international contracts. JSI has done this by identifying and applying innovative solutions and by providing technical support to the development of governmental and non-governmental institutions and organizations.

In all its activities, JSI collaborates with local institutions, including community organizations and government ministries, and with international organizations.

JSI's multidisciplinary, international staff of over 400 specialists has proven its capacity to manage an extensive array of long-term multinational and country-specific programs.

JSI contributes to the improvement of the health of individuals and communities worldwide by:

- Developing systems of medical care for children, particularly in the areas of diarrheal disease control, oral re-hydration therapy, immunization of pregnant women and children, control of acute respiratory infections, and prevention and treatment of malnutrition.
- Designing and implementing accessible, high quality reproductive health services.
- Developing comprehensive maternal health projects, encompassing prenatal and postnatal care, nutrition, family planning, breast-feeding, and prevention and treatment of AIDS and other sexually transmitted diseases.
- Developing the private sector's capacity in the provision of family planning and primary care health services.
- Designing and implementing coherent logistic systems, without which no public health program can run efficiently.

## **Romanian Family Health Initiative (RFHI)**

Through the Partnership Convention signed in November 2001, the Romanian Family Health Initiative (RFHI), a USAID-funded program implemented by JSI Research & Training Institute, Inc. and its partners are working to increase access to and use of reproductive health (RH) services across Romania, and to expand the availability of these services at the primary health care level. To this end, RFHI supports the Ministry of Health and a number of NGOs in capacity building efforts to improve the effectiveness of family planning, pre and post-natal care, breast and cervical cancer, and HIV/AIDS/STI services for underserved populations. Objectives of this Initiative are to increase access to high quality client-oriented services, encourage the implementation of policies and regulations to promote reproductive health initiatives, mobilize resources toward primary health care and prevention, and increase population awareness about, and community mobilization in, all issues related to reproductive health.

Key approaches used by the Initiative to achieve these objectives include:

1. The integration of reproductive health services (family planning, pre- and post-natal care, breast and cancer cervical screening, sexually transmitted diseases including HIV/AIDS and domestic violence) into the primary health care system.
2. The development of an effective network of, and referral system for, reproductive health services.
3. The promotion of the use of reproductive health services by the Romanian population.

Some of the key anticipated results of the Initiative include:

- A reduction in the maternal and infant mortality rate, number of abortions and incidence of HIV/AIDS and other STIs;
- An increased awareness within the population about the importance and availability of reproductive health services, the screening for cervical and breast cancer and the prevention of HIV/AIDS and other sexually transmitted infections;
- An increase in the number of service delivery points offering basic reproductive health services;
- An increased rate of use of modern contraceptive methods by the Romanian population;
- An increase in screening for breast and cervical cancers;
- An improvement of the services provided to the victims of domestic violence.

## **Acknowledgements**

This manual was developed for a special category of community workers, Roma Health Mediators, taking into consideration their professional roles, and the cultural environments in which they work; and involved persons who pioneered the Roma Health Mediators' program from its conception to the present.

We would like to thank Mrs. Mariana Buceanu and Mr. Daniel Rădulescu for their continuous support and recommendations during the process of developing this training curriculum. Their contributions have helped orient the manual to the specific needs of Roma Health Mediators.

We would like to give our special thanks to Mrs. Hanna Dobronăuțeanu, Ministry of Health Counselor, who has worked closely with us and supported us in identifying specific learning needs of Roma Health Mediators.

We hope that through using the manual to train community workers, it will contribute to increasing access to health services by the Roma population, and that this will in turn lead to an improved health status for the Roma community.

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## About the manual

This manual is intended to be used for training Roma Health Mediators in reproductive health. It provides necessary instructions and materials to guide the trainers in the implementation of training workshops designed to improve the competence of Roma Health Mediators in promoting positive reproductive health practices in their communities.

The manual:

- Promotes a learner-centered, participatory approach to training.
- Leads learners through the core concepts of Reproductive Health.
- Develops and models concepts and skills essential to group education sessions.

By the end of the workshop, participants will be able to:

- Explain basic concepts of Reproductive Health and Family Planning to persons in their communities
- Describe in simple terms the anatomy and physiology of human reproduction
- Explain family planning methods to persons in their communities
- Promote Safe Motherhood (including prenatal and postnatal care) with members of their communities
- Promote the optimal care of newborns with members of their communities
- Promote breastfeeding of newborns/infants in their communities
- Describe to community members measures for reducing other reproductive health-related risks (STIs, HIV, abortion, infertility, and breast and cervical cancer)
- Conduct group education sessions on reproductive health issues in their communities

Each session guide contains:

- I. An overview of the session:
  - specific objectives of the session
  - training methods
  - estimated time
  - necessary materials and logistics
    - flipcharts/overheads
    - trainer materials (containing technical information for conducting activities)
    - handouts – to be distributed during the workshop, in relationship with training activities
- II. Instructions for implementing and processing the training activities

Based on the overview and instructions, trainers should prepare the training sessions as they are designed, including verifying and preparing needed materials and logistics before each session.

## **SESSION 1: INTRODUCTION**

**OBJECTIVES:** By the end of the session, participants should be able to:

1. Give the names the trainer and other participants wish to be called during the workshop
2. Describe their learning expectations for this workshop
3. Reconcile their workshop expectations with the objectives proposed for the training program
4. Name at least four group norms the group will respect in order to facilitate a productive workshop
5. Assess their knowledge of reproductive health

**TRAINING METHODS:** Interviews, Pre-test, Discussion

**TIME:** 1 hour 30 minutes

### **MATERIALS:**

Flip chart paper

Markers

Scotch

Note pads

Pencils and erasers

Pens

Pencil sharpeners

### Flip charts:

- Questions for Introduction Exercise
- General Objectives of the Workshop

### Participant documents:

- General Objectives
- Workshop Schedule
- Pre-test

### Trainer document:

- Pre/Post test key

## **INSTRUCTIONS:**

### **I-II. INTRODUCTION AND EXPECTATIONS (40 minutes)**

Welcome participants to the workshop.

Introduce the trainers.

Suggest that participants likely already know each other since they have been together in the previous workshop(s). However, the trainers would like to be sure that everybody

knows everyone in the room. Ask participants to introduce themselves (give their name and name a flower that begins with the same letter as their name). As each person in turn introduces herself, she must first repeat the names and flowers of those who have previously introduced themselves.

Suggest that we are interested also in knowing what participants' experience is in discussing reproductive health with people in their communities and what they feel their strengths are in discussing this issue as well as what aspects they would like to improve. Ask participants to find a partner and to sit together.

- Post the flip chart *Questions for Introduction Exercise* and ask each pair to discuss the questions and record the responses of their partners. Explain that what participants can hope to get out of the training will depend in part on what they put into it. An important element of what they put into it is sharing what they feel they need to, and want to learn, from the workshop.
- In the large group, members of each pair introduce their partners and share their partners' responses to the interview questions. Note on a flip chart the answers to question 3.

### **III. GENERAL OBJECTIVES OF THE WORKSHOP (10minutes)**

Post the flip chart *General Objectives*. Read through them with the group and ask if there are any questions or clarifications.

Lead a discussion on the similarities between the proposed workshop objectives and participant expectations. Where there are differences, discuss with the group the possibilities of responding to their stated concerns. If an expectation cannot feasibly be met during the workshop, discuss other ways in which it might be met.

Distribute copies of the *General Objectives* of the workshop.

Distribute copies of the proposed *Workshop calendar/schedule* and review it with the group.

### **IV. GROUP NORMS (10 minutes)**

Explain that in training:

- Everyone is responsible for their own learning
- Each member of the group contributes to the learning environment (in either a positive, or a negative, way).

Ask participants to think of what group norms they feel they should respect in order to facilitate everyone's participation and learning. Suggest important group norms, including rules of the workshop venue, if they do not come from the group.

Common group norms:

- Respect the workshop schedule
- Respect and encourage everyone's participation
- Do not interrupt people when they are talking
- Listen to others
- Respect confidentiality of what others share
- Do not make personal attacks
- No smoking in the training room
- No mobile phone conversations in training room

**V. PRE-TEST (30 minutes)**

Explain that it is very important to assess the progress of the group in training and that one way to do this is to conduct a pretest. A pretest, followed by a post test at the end of the training, also contributes to the assessment of the effectiveness of the workshop.

Distribute the pretest. Ask each participant to put her name on her test so that she will be able to identify her test when the tests are returned at the end of training. Allow participants 30 minutes to complete it.

Collect the pretests. Correct the pretests in the evening and use test results to better orient the training program to participants' needs.

Flip chart

**QUESTIONS FOR INTRODUCTION EXERCISE**

1. Where do you work and what is your experience in reproductive health?
2. Describe an aspect of your work in which you feel comfortable and confident.
3. Please consider the interpersonal communication aspect of reproductive health and any problems or frustrations you have encountered in discussing reproductive health issues with women, men and/or couples in your community. In what ways can this workshop help you to improve your skills in these areas? Please be specific!

## **TRAINING OF ROMA HEALTH MEDIATORS IN REPRODUCTIVE HEALTH**

**Goal:** To improve the competence of Roma Health Mediators in promoting positive reproductive health practices in their communities.

**General Objectives:** By the end of the workshop, participants will be able to:

1. Explain basic concepts of Reproductive Health and Family Planning to persons in their communities
2. Describe in simple terms the anatomy and physiology of human reproduction
3. Explain family planning methods to persons in their communities
4. Promote Safe Motherhood (including prenatal and postnatal care) with members of their communities
5. Promote the optimal care of newborns with members of their communities
6. Promote breastfeeding of newborns/infants in their communities
7. Describe to community members measures for reducing other reproductive health-related risks (STIs, HIV, infertility, and breast and cervical cancer)
8. Conduct group education sessions on reproductive health issues in their communities

Handout

**TRAINING AGENDA**

	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
9,00	9-10,30 <b>Introduction</b> (90 min) Participants and trainers' introduction Objectives Group norms Pre-test	Where we are (15 min) 9,15 – 11,00 <b>S4: FP Methods</b> (cont.) Hormonal contraception DIU, SCV, CU	Where we are (15 min) 9,15 – 10,15 <b>S7: Postnatal Care</b> (60 min) 10,15 – 11,15 <b>S8: Newborn Care</b> (60 min)	<b>S13 Communication</b> (225 min)	9,00 – 10,15 <b>S15 Group Education – overview</b> (85 min) 10,15 – 11,15 <b>S16 Preparing group education sessions</b> (60 min)
15 min	Coffee break	Coffee break	Coffee break	Coffee break	Coffee break
	10,45 – 12,15 <b>S2: FP/RH</b> (90 min) 12,15 -13,00 <b>S3: Anatomy &amp; physiology</b> (75min)	11,15 – 13,30 <b>S5: Standard Days Method</b> (135 min)	11,30 – 13,10 <b>S9: Breastfeeding</b> (100 min)	11,15 – 13,15 <b>S13 Communication</b> (cont)	11,30 – 13,00 <b>S17 Implementing group education sessions</b> (3-5 ore)
13,00-14,00	Lunch break	Lunch break	Lunch break	Lunch break	Lunch break
	14,00 -14,30 <b>S3: Anatomy &amp; physiology</b> (cont.) 14,30 – 15,45 <b>S4: FP Methods</b> (180 min) Contraception overview Natural FP methods	14,30 – 15,45 <b>S6: Pregnancy and prenatal care</b> (150 min)	14,10 – 15,10 <b>S10: STIs</b> (60 min) 15,10 – 15,40 <b>S11: Breast and Cervical Cancer</b> (30 min)	14,15 – 15,45 <b>S14 Practicing interpersonal communication</b> (150 min)	<b>S17 Implementing group education sessions</b> (cont)
15 min.	Coffee break	Coffee break	Coffee break	Coffee break	Coffee break
	<b>S4: FP Methods</b> (cont.) Barrier methods	<b>S6: Pregnancy and prenatal care</b> (cont)	16,00 -17 <b>S12: Behavior Changing</b> (60 min)	<b>S14 Practicing interpersonal communication</b> (cont)	15,30 -17,00 <b>S18 Evaluation</b> (90 min) Post test Final Evaluation
17,00	Summarization	Summarization	Summarization	Summarization	Ending

**HEALTH MEDIATOR TRAINING IN REPRODUCTIVE HEALTH  
PRE/POST-TEST**

**True/False Questions**

For each of the following phrases, put a T in the space indicated at the left of the statement if the phrase is true or an F if it is false. Each correct response is worth one point.

- \_\_\_\_\_1. Mothers younger than 18 and older than 35 are at greater risk of prenatal complications and pregnancy-related death than are mothers between the ages of 18 and 35.
- \_\_\_\_\_2. Most adults know how to use condoms effectively.
- \_\_\_\_\_3. Vaseline and cooking oil should not be used to lubricate a condom
- \_\_\_\_\_4. A pregnant woman does not need to go for antenatal check-up if she does not have any complaint or health problem
- \_\_\_\_\_5. The condom is the only family planning method that also protects individuals from sexually transmitted infections.
- \_\_\_\_\_6. Health check-ups are recommended within six weeks of delivery, for both mother and child.
- \_\_\_\_\_7. Reproductive tract infections are more common in women than in men
- \_\_\_\_\_8. Reproductive tract infections are most commonly caused by sexually transmitted infections
- \_\_\_\_\_9. Untreated STI lead to a greatly increased risk of getting HIV/AIDS
- \_\_\_\_\_10. In Romania, maternal mortality (the number of women who die as a result of complications of pregnancy and childbirth) is one of the highest in Europe

### Multiple Choice Questions

Each of the following questions is followed by a certain number of possible responses. For each question, choose the best response/s, according to the number of correct responses indicated in the trunk of the question. Indicate your response by circling the appropriate letter/s next to your choice/s. Each correct response is worth one point. If you circle more than the requested number of responses to a question, you will receive no points for the question.

1. Which of the following is not a criteria for using Lactational Ammenorhea Method as a family planning method (one correct answer):
  - a. The mother must be less than four months postpartum
  - b. The mother must breastfeed the baby regularly at least every four hours during the day and at least every six hours at night and the baby must not receive any other foods
  - c. The mother has had no menstrual periods
  
2. Which of the following statements about breastfeeding is not true? (3 correct answers)
  - a. The hormone that causes milk to flow through a mother's breasts also causes a mother's uterus to contract after delivery
  - b. For the first several weeks postpartum, mothers generally produce the same amount of milk regardless of how often they breastfeed
  - c. The uterine pain and a rush of blood during a feed for the first few days is good for the healing of the woman's uterus
  - d. A breastfeeding baby needs to take much of the areola into his mouth
  - e. If a baby is sucking effectively, he makes smacking sounds when he sucks
  - f. During the first three days, it is especially important to feed the baby the thick yellowish fluid called colostrum
  - g. When semi-solid foods are introduced, it is important to give them first so that the baby develops a taste for them and then breastfeed.
  
3. Which of the following are characteristics of infection in a newborn? The baby: (4 correct responses)
  - a. Is hungry all of the time
  - b. Does not want to sleep
  - c. Vomits or spits up a lot
  - d. Has green watery stools
  - e. Skin feels hot or cold
  - d. Breathes too fast or too slow
  - e. Has colic
  
4. Which of the following statements are true about HIV/AIDS? (2 correct responses)
  - a. Condoms are not very effective in preventing HIV transmission
  - b. A pregnant woman can pass the HIV virus to her unborn child
  - c. A person can get HIV by using dirty injection needles, other needles, or razors
  - d. HIV can be cured if diagnosed early

### **Matching questions**

Below are two lists: 1) contraceptive methods, and 2) characteristics of contraceptive methods. Read the characteristics “a” through “j”. For each item, identify the method of contraception to which it applies. Put the letter of the item (a, b, c, d, e, f, g, h, i, or j) in the space next to the contraceptive method to which it applies. Note that each item may only be used once. Please write clearly.

#### Contraceptive methods

- \_\_\_\_\_ Combined Oral Contraceptives (pill)
- \_\_\_\_\_ Condoms
- \_\_\_\_\_ Sterilization
- \_\_\_\_\_ Lactational Ammenorhea Method
- \_\_\_\_\_ Progestagen-only Contraceptives (pill)
- \_\_\_\_\_ Spermicide
- \_\_\_\_\_ Natural Family Planning Methods
- \_\_\_\_\_ IUDs
- \_\_\_\_\_ Injectable
- \_\_\_\_\_ Emergency contraceptives

#### Characteristics of contraceptive methods:

- a. Can only be used by breastfeeding mothers under certain conditions
- b. Effectiveness is low as the method is commonly used
- c. Provides protection against STIs & HIV/AIDS to both partners
- d. Destroys sperm so that they cannot reach the egg/ovum to fertilize it
- e. Often causes irregular menstrual periods or absence of periods
- f. The method involves blocking the fallopian tubes (in a woman) or the vas deferens (in a man)
- g. Often leads to lighter, regular periods with less cramping
- h. It usually takes 6-10 months to become pregnant after stopping the method
- i. The method should not be used on a regular basis
- j. Is a safe, effective, long lasting method (up to 10 years)

**HEALTH MEDIATOR TRAINING IN REPRODUCTIVE HEALTH  
PRE/POST-TEST KEY**

**True/False Questions**

For each of the following phrases, put a T in the space indicated at the left of the statement if the phrase is true or an F if it is false. Each correct response is worth one point.

- T 1. Mothers younger than 18 and older than 35 are at greater risk of prenatal complications and pregnancy-related death than are mothers between the ages of 18 and 35.
- F 2. Most adults know how to use condoms effectively.
- F 3. Vaseline and cooking oil should not be used to lubricate a condom
- F 4. A pregnant woman does not need to go for antenatal check-up if she does not have any complaint or health problem
- T 5. The condom is the only family planning method that also protects individuals from sexually transmitted infections.
- T 6. Health check-ups are recommended within six weeks of delivery, for both mother and child.
- T 7. Reproductive tract infections are more common in women than in men
- F 8. Reproductive tract infections are most commonly caused by sexually transmitted infections
- T 9. Untreated STI lead to a greatly increased risk of getting HIV/AIDS
- T 10. In Romania, maternal mortality (the number of women who die as a result of complications of pregnancy and childbirth) is one of the highest in Europe

### Multiple Choice Questions

Each of the following questions is followed by a certain number of possible responses. For each question, choose the best response/s, according to the number of correct responses indicated in the trunk of the question. Indicate your response by circling the appropriate letter/s next to your choice/s. Each correct response is worth one point. If you circle more than the requested number of responses to a question, you will receive no points for the question.

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  - a. The hormone that causes milk to flow through a mother's breasts also causes a mother's uterus to contract after delivery
  - b.x For the first several weeks postpartum, mothers generally produce the same amount of milk regardless of how often they breastfeed
  - c. The uterine pain and a rush of blood during a feed for the first few days is good for the healing of the woman's uterus
  - d. A breastfeeding baby needs to take much of the areola into his mouth
  - e.x If a baby is sucking effectively, he makes smacking sounds when he sucks
  - f. During the first three days, it is especially important to feed the baby the thick yellowish fluid called colostrum
  - g.x When semi-solid foods are introduced, it is important to give them first so that the baby develops a taste for them and then breastfeed.
  
3. Which of the following are characteristics of infection in a newborn? The baby: (4 correct responses)
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  - a. Condoms are not very effective in preventing HIV transmission
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### Matching questions

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#### Contraceptive methods

- g   Combined Oral Contraceptives (pill)
- c   Condoms
- f   Sterilization
- a   Lactational Amenorrhea Method
- e   Progestagen-only Contraceptives (pill)
- d   Spermicide
- b   Natural Family Planning Methods
- j   IUDs
- h   Injectable
- i   Emergency contraceptives

#### Characteristics of contraceptive methods:

- a. Can only be used by breastfeeding mothers under certain conditions
- b. Effectiveness is low as the method is commonly used
- c. Provides protection against STIs & HIV/AIDS to both partners
- d. Destroys sperm so that they cannot reach the egg/ovum to fertilize it
- e. Often causes irregular menstrual periods or absence of periods
- f. The method involves blocking the fallopian tubes (in a woman) or the vas deferens (in a man)
- g. Often leads to lighter, regular periods with less cramping
- h. It usually takes 6-10 months to become pregnant after stopping the method
- i. The method should not be used on a regular basis
- j. Is a safe, effective, long lasting method (up to 10 years)

## **SESSION 2: BASIC CONCEPTS OF REPRODUCTIVE HEALTH AND FAMILY PLANNING**

**OBJECTIVES:** By the end of the session, participants should be able to:

1. Define the concepts Reproductive Health and Family Planning
2. List reproductive health services available in their communities
3. Describe:
  - The rights of the clients receiving reproductive health services
  - Principles of family planning
4. Define the benefits of family planning for individuals, families, and the community
5. Identify barriers to practicing family planning
6. Explain the role of health mediators in helping community members access and use reproductive health and family planning services

**TRAINING METHODS:** Discussion, Brainstorming, Presentation

**TIME:** 2 hours

### **MATERIALS:**

#### Trainer documents

- Reproductive Health
- Family Planning
- RH/FP Services
- The Rights of the Client in a Family Planning Service
- Relationship Between Maternal and Child Mortality and High-risk Factors
- Story: Barriers to Family Planning
- Papers of different sizes with the word “motivation”

#### Participant document:

- Roma Health Mediator’s Manual

### **INSTRUCTIONS:**

#### **I-II. REPRODUCTIVE HEALTH AND FAMILY PLANNING: CONCEPTS AND SERVICES (20 minutes)**

Ask participants:

- What does the term “reproduction” mean?

Reproduction means procreation, having offspring or babies.

- Within a couple, who is responsible for making reproduction happen?

Both the man and the woman are responsible for reproduction. They each have

reproductive organs which are necessary to carry out this important function.

➤ What are the various steps during reproduction?

- A man and a woman have sexual intercourse
- Conception may occur and lead to pregnancy
- Birth of a baby

➤ What do you understand by the term “reproductive health”?

Possible responses:

- Healthy reproductive organs
- The ability to reproduce and to regulate fertility
- Access to adequate medical services which allow women to go safely through the pregnancy
- Safe delivery
- The ability to have sexual relations free of the fear of pregnancy and of contracting sexually transmitted diseases

After listening to participants’ answers explain that:

- Reproductive health is a state of complete well-being in all aspects of the reproductive system and its functions.
- Reproductive health implies that people:
  - Are able to have a satisfying and safe sex life
  - Have the capability to reproduce and the freedom to decide if, when and how often to do so
- Men and women have the right to:
  - Be informed and have access to safe, effective, affordable and acceptable methods of family planning of their choice
  - Have access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

Use the trainer document *Reproductive Health and its Implication* as your guide to explain the health implications to all matters related to reproduction. *[Note: the document presents the “ideal situation” regarding reproductive organs, sexual intercourse, pregnancy, delivery and newborn babies. In addition to being influenced by access to and use of quality health care, these items are also influenced by heredity, congenital abnormalities, personal practices etc.]*

Explain that family planning is an important component of reproductive health. Ask participants:

➤ What is meant by the term family planning?

List answers on the flipchart.

*Possible Answers:*

- Not to have children
- To control births
- Population control
- To have less children

Explain that family planning means that a person or couple decides freely the number of children they want to have and when they want to have them. It is the right of a couple to have children by choice and not by chance.

Review with the group the objectives of family planning, using the trainer document *Family Planning* as your guide.

Ask participants:

- Based on our discussion of reproductive health and family planning, what kinds of health services are related to reproductive health (RH) and family planning (FP)?

After the group has mentioned the services they are aware of, use the trainer document *Reproductive Health / Family Planning Services* to review with the group the types of RH/FP services that should be available in local health facilities (or by referral).

### **III. CLIENTS' RIGHTS, AND PRINCIPLES OF FAMILY PLANNING SERVICES (15 minutes)**

Explain that when a person asks for/receives any of these RH/FP services he/she is not considered ill or in-need for medical assistance and is treated more like a "client".

Make a short presentation about the client's rights, using the trainer document *The Rights of the Client in a Family Planning Service*.

Briefly explain to the group the basic principles of FP services and explain to participants where to find the Client's Rights and Principles of Family Planning in the Manual.

Emphasize that despite the fact that health mediators are not reproductive health service providers, they need to respect the same principles as health care providers during their discussions with women about family planning. Treating women in the community with respect and giving them the chance to make decisions is a way of encouraging them to look for services at health settings.

### **IV. BENEFITS OF USING FAMILY PLANNING (40 minutes)**

Divide participants in 4 small groups (depending on the size of the large group). Give to each group a flipchart paper and a marker and ask them to work together and to write the

benefits of using FP; each small group focus on one of the following “category” of people:

- women
- children
- men/family
- community

Allow them 10 minutes for completing the task.

Ask each group to delegate a person to present their results in front of the colleagues.

Benefits to women:

- Lower rate of abortion and abortion complications
- Fewer women dying during pregnancy and delivery
- Fewer pregnancy or delivery-related problems
- Prevention of ectopic pregnancy, genital cancer, ovary cysts, breast diseases
- Prevention of STIs, including HIV/AIDS
- Better relationship with partner

Benefits to children:

- Children receive better care and education from the family when they are desired
- Fewer children born premature or small for date
- Fewer children dying during the first year of life (if babies spaced by at least a two year interval)
- Fewer children dying of diarrhea and respiratory diseases caused by malnutrition
- Breastfeeding protects infants against diarrhea and other infectious diseases

Benefits to men/family:

- Benefits from wives’ care and attention (if they are not overloaded with many children)
- Better couple relations
- Prevention of STIs, including HIV/AIDS
- Better allocation of financial resources for family needs
- Greater possibility of providing good education for children

Benefits to the community:

- Prevention of child abandonment
- Fewer children in orphanages
- Healthier population
- Better allocation of existing resources in the community

After each presentation ask the other groups if they have anything to add. Make sure that the lists contain the benefits of reducing maternal and child mortality and morbidity.

Ask the following questions to the group (ask for 2-3 volunteers to respond to each question):

- How many children do you have?
- At what age did you have children?
- What is the number of children a woman can have without risks for her health?
- What is an appropriate age to have children?
- What is the optimal interval between childbirths?

Based on their answers, conduct a group discussion, emphasizing the importance of the relationship between maternal and child mortality and the high-risk factors (“too young, too old,” “too many”, “too close”). Use the trainer document *Relationship between maternal and child mortality and high-risk factors* to provide explanations.

## **V-VI. BARRIERS TO FAMILY PLANNING; AND HEALTH MEDIATOR ROLE IN FAMILY PLANNING (40 minutes)**

Tell a story of a woman from our community and her interest in getting services. (see Trainer document *Story: Barriers to Family Planning*)

The story should bring out common individual factors (ignorance, denying the risks, fear), but also certain social obstacles (traditions, religion).

While you tell the first part of the story, hold the large "motivation" sign in front of you. Each time the woman in the story experiences an obstacle, tear a piece of the paper indicating that the client has lost a little of her motivation to practice FP.

Among the obstacles may be the fact that the client is obliged to make a visit to the family doctor’s cabinet for receiving FP services. In this case, discard what remains of the first paper and hold the second (which is half the size of the first, indicating that the woman is less motivated, that she has been discouraged). Continue with what happens to the woman during the visit, tearing a part of the "motivation" paper each time the woman confronts other obstacles (long period of waiting, judicative attitude of medical personnel, impossibility to receive the method which is her first choice, small amount of contraceptives received).

After the visit to the family doctor, the woman talks with friends about the contraceptive method she received, and finds different information than the information given by the doctor. As the story continues, discard the remainder of the second paper and hold the 3<sup>rd</sup> (smaller one) and tear away the sign/paper as the obstacles tear away the woman's motivation for using contraception.

Ask the group:

- What are the barriers to the motivation of the woman? What has been the effect of each one on her motivation of using contraception?

Note responses on a flip chart.

- We speak often of the lack of motivation of women to use family planning, beside the lack of information. Could we have a positive or a negative influence on their motivation? In what sense?

Responses will vary according to the experiences and perceptions of the group.

- The obstacles in the story, obstacles encountered in our communities: how can one categorize them?

Individual (personal) factors:

- Lack of information
- Denying the risks
- Fear (partner, community, relatives)
- Embarrassment
- Lack of communication and negotiation skills with the partner

External factors:

- Limited access to services
- Inappropriate attitude of service providers
- Unavailability of a range of contraceptive methods

Ask participants:

- Are there any other factors which influence women to use or not contraceptive methods?

Most often the lack of correct information and preconceptions are the stronger barriers to family planning.

Suggest that during this workshop participants will learn correct information about the contraceptive methods, which will help them to dispel the rumors and misconception encountered into communities.

Summarize (5 minutes)

Ask the group:

- What should be your role in promoting RH and FP? What are the key-messages to be transmitted to the population?

- There are a range of services available free-of-charge to all women and men
- Family planning is one of the most important measures that a nation or a couple can practice to reduce the mortality of mothers' and their infants.
- The prevention of unwanted pregnancies and spacing births by at least two years has

an important effect on reducing maternal and child mortality and morbidity.

- The risk of death from pregnancy and childbirth is far greater than the risk of death from contraceptive use.
- There are some external barriers: political and social barriers, organization of the health system, but most often the barriers are internal factors like ignorance and misconceptions; providing correct information to people about contraceptive methods, existing services and their rights will help us to overcome these barriers and to facilitate access to family planning.

## **REPRODUCTIVE HEALTH**

### **Definition:**

Reproductive health is a state of complete well-being in all aspects of the reproductive system and its functions.

### **Health Implications:**

**Reproductive Organs** - Free of disease, functioning properly.

**Sexual Intercourse** - Free from discomfort and free from the fear of pregnancy and sexually transmitted diseases.

**Pregnancy** – Woman remains free from serious complications and fetus grows well in her womb.

**Delivery** – Woman delivers normally and is free from serious complications during and after delivery.

**Newborn Baby** – The newborn is delivered normally and is not endangered by serious conditions.

## FAMILY PLANNING

### **Definition:**

Family planning means that a person or couple decides freely the number of children they want and when they want to have them, at the right time and the right interval between births for them. It is the right of a couple to have children by choice and not by chance.

### **Objectives:**

The main objectives of family planning are:

**Child spacing** to enable individuals or couples to space their pregnancies/births according to their wishes

**Limiting family size** – to enable individuals or couples to limit the number of children they have according to their wishes.

**Ensure informed choice and correct use of contraceptives**– to ensure that individuals or couples interested in family planning are able to choose family planning methods, and use them correctly, based on accurate and adequate information

**Treatment and prevention of infertility** – to prevent infertility by 1) counseling individuals/couples about the causes, symptoms and consequences of sexually transmitted infections, and 2) diagnosing and treating STIs in clients as necessary.

### **Basic principles:**

**Voluntarism** – every person has the right to make decisions by him/herself without any force or violence (to choose if he/she wants to use family planning); no one has the right to force a person to use family planning nor to impose the method to be used.

**Informed choice** – every person has the right to choose a method based on correct and adequate information about all available methods.

**Protection against STIs/HIV** –when a person chooses a method, it is important to know if the method provides any protection against STIs/HIV.

**Diversity** – all settings/providers must have an adequate number of types of contraceptive methods to allow the clients to choose methods that are convenient for them.

## **REPRODUCTIVE HEALTH / FAMILY PLANNING SERVICES**

- Family Planning
  - Information regarding contraceptive methods
  - Contraceptive supplies
  - Counseling for using family planning methods
  - Monitoring the use of contraceptive methods
- Mother and Child Care
  - Prenatal care
  - Assisted delivery
  - Post-natal care
  - Newborn care
- Counseling in case of abortion
- Prevention and early detection of cervical and breast cancer
- Prevention and treatment of sexually transmitted infections
- Diagnosis (and treatment) of infertility
- Counseling in the case of domestic violence and sexual abuse
- Education for sexual and reproductive health

## **THE RIGHTS OF THE WOMAN IN A FAMILY PLANNING SERVICE**

1. **Right to information**  
The community has the right to information about the benefits of family planning, for themselves and for their families. They also have the right to know where and how to obtain additional information about services to help them plan the number of children they wish to have. Thus, providers of family planning services should ensure that such information is available at least within their clinics.
2. **Right to access to services**  
Everyone of the age to procreate has the right to benefit from family planning services regardless of their social and/or economic situation, religion, political convictions, ethnicity, civil status, place of residence or all other characteristics which may stereotype them in a particular group.
3. **Right to choose**  
Individuals and couples have the right to decide freely to use, or not to use, family planning. Those who decide to adopt a modern family planning method have the right to choose their contraceptive method as long as there are no absolute contraindications to their choice. Providers of family planning services must assist clients to make an informed choice by giving them adequate information and by offering them an appropriate range of contraceptive methods.
4. **Right to security**  
Family planning clients have the right to be protected from all possible complications associated with the use of a contraceptive method which has a negative effect on their physical or psychological health. Clients also have the right to be protected against risks of infection linked to the use of unsterilized instruments.
5. **Right to privacy**  
Family planning clients have the right to privacy in their discussions with providers of family planning services concerning their needs and preoccupations. All medical examinations must take place in conditions which respect the physical privacy of the client. The client has the right to be informed of the role of all persons present during discussions with a family planning service provider and during medical examinations. The client has the right to be informed of the type of examinations to be done, to refuse an examination or to be examined by a person of her choice.

6. **Right to confidentiality**  
The client has the right to know that all information communicated by him/her as well as all the details of services or treatment received will not in any way or form be shared with anyone else without his/her consent.
7. **Right to dignity**  
Family planning clients have the right to be treated with courtesy, consideration, attention and respect regardless of their level education, their social standing and all other characteristics which may otherwise provoke certain forms of discrimination.
8. **Right to comfort**  
Clients have the right to receive family planning services in a comfortable environment. The waiting time must not be excessive.
9. **Right to continuity**  
Clients have the right to benefit from family planning services and have access to contraceptive methods as long as they need them. The services must not be interrupted except if the decision is taken with the client. Access to other services must not depend upon the client's decision to use, or not to use, his/her contraceptive method. The client has the right to change service providers and to have her/his file transferred to the new provider.
10. **Right to expression of opinion**  
Clients have the right to express their opinions about the quality of the services they receive, whether their comments be positive or negative.

## **RELATIONSHIP BETWEEN MATERNAL AND CHILD MORTALITY AND HIGH-RISK FACTORS**

### *Age ("Too Young, Too Old") for having children*

- Mothers younger than 18 and older than 35 are at greater risk of prenatal complications and pregnancy-related death.
- If pregnancy could be averted in women under age 20 and over age 35, maternal mortality could be reduced by 8-40%.
- If childbirth could be postponed until the "too young" mother was old enough, and averted in mothers "too old" and "too ill," the impact on both maternal and
- infant mortality would be significant.

### *Birth Number ("Too Many")*

- The more children a woman bears, the greater her risk of dying as a result of pregnancy and/or childbirth.
- Women who have had five or more deliveries:
  - are more likely to experience problems during pregnancy and labor and to require Caesarean section (which is often not readily available or not performed early enough).
  - have a significantly higher risk of miscarriage and perinatal mortality than women undergoing their second or third delivery.

### *Birth Interval ("Too Close")*

- There is a strong, direct relationship between birth intervals and infant/child mortality.
- Babies born less than two years after the previous baby are **twice as likely to die** as babies spaced by at least a two year interval.
- The child who has been displaced by the new baby is also at increased risk--on average, s/he is about one and a half times as likely to die if the new baby is born within two years of his or her birth because of early weaning and its accompanying risks of diarrheal disease and malnutrition.
- The shorter is the birth interval, the higher is the risk of pregnancy complications and maternal mortality.

## **BARRIERS TO FAMILY PLANNING (story)**

I am going to tell you the story of Maria, a woman in one of our communities.

My name is Maria, I am 32 years old, I'm married and I have four children and six abortions. My husband "protected" me from time to time, but I'm not sure if this is good or not and I'm worried that one day and I will get pregnant again. I heard some women in the community talking about "family planning", and I would like to know more about this. (HOLD THE BIGGEST SIGN "MOTIVATION" IN FRONT OF YOU).

After the last abortion, four weeks ago, we didn't use anything to avoid a pregnancy, because I know that is impossible to get pregnant again immediately after an abortion (TEAR), but a friend of mine told me that this is not true. I tried to find out what I could do, but none of my friends knew to inform me (TEAR). When I told my husband about my interest in using "something" against pregnancy he started to yell at me, asking if I'm interested too to find another man (TEAR). Finally one of my neighbors informed me that our mediators in the community could help me with some information. I have had some reticence to talk with almost stranger about my problem (TEAR), but I decided to contact her, in my desire to obtain information. She was nice, but when she started to list a lot of "methods" with different inconvenient and to told me that none of them is 100% sure, I had doubts about whether or not it is a good decision to use one of the methods (TEAR). One day, my cousin visited me and she told me that she went to a doctor two months ago and he inserted an IUD and now she is feeling very well and she is relieved because she is sure that she cannot get pregnant while using this method. I decided to go to my family doctor to ask her an IUD, although I knew that she is not very respectful with us Roma People. (TEAR AND THROW THE BIG SIGN AWAY)

(HOLD THE SECOND SIGN IN FRONT OF YOU).

When I arrived at the clinic, there were a number of people already there, so I knew that I would have to wait some time (TEAR). One of my neighbors was waiting too, and he asked me what my problem was. I was ashamed to tell him the real reason for coming to the doctor, so I invented something to justify my presence there (TEAR). After waiting for 1 hour (TEAR), I finally got my turn to go in the doctor's cabinet. As soon as the doctor called me into the consultation room, another woman came in and the doctor spent 15 minutes writing a prescription for her, telling me that this was an emergency (TEAR). Finally, the doctor asked me what I wanted and I said: "Something to keep me from getting pregnant, like an IUD". The doctor said that IUD is not available in her cabinet and that instead of referring me more that 10 kilometers away to a gynecologist working in the city she would give me some pills (TEAR). She instructed me to take a pill every day, and said that if I take them correctly, it is impossible to get pregnant anymore. She didn't give me any additional explanations. When I tried to ask her when I need to come back, she told me: "You should know that is obvious: come back after you finish the pills" (TEAR). I left the clinic very disappointed (TEAR AND THROW THE SECOND SIGN AWAY), but still determined to use the pills for avoiding pregnancy.

(HOLD THE THIRD/SMALLEST SIGN IN FRONT OF YOU).

The next day I met an old friend and I happily shared with her that I started using contraception. She seemed to be very reluctant, and finally she told me that she herself has used some pills few years ago and she got a pregnancy (TEAR).

After two weeks I was very worried because my period was continuing (not like usual, but still every day) (TEAR). I asked one of my friends what it means and she told me that these pills are not good; they are provoking cancer (TEAR). In the same day my mother came to visit me and she observed that I had cried. When she asked me what's happening I told her the whole story and she said: "what is happening to you is a punishment from God, because you have tried to do against our religion; it's a sin not to have children, on God's will" (TEAR). She left my house immediately. After my mother's departure I took the decision to throw the pills away. (TEAR AND THROW THE THIRD SIGN AWAY).

**If you were Maria, would you use a family planning method anymore?**

Trainer document

(needs to be copied before each workshop, in 3 different sizes)

# MOTIVATION

### **SESSION 3: ANATOMY AND PHYSIOLOGY OF HUMAN REPRODUCTION**

**OBJECTIVES:** By the end of the session, participants should be able to:

1. Describe the principal organs of human reproduction and their functions
2. Define the terms: menstrual cycle, menstruation, ovulation, fertility
3. Describe the processes of fertilization and conception

**TRAINING METHODS:** Exercise, Presentation, Discussion, Bead Game

**TIME:** 1 hour 30 minutes

**MATERIALS:**

Colored paper

Scissors

Balloons

Plastiline

Visual tools (flip charts, transparencies, or charts)

- Female & Male Reproductive System
- Menstrual Cycle
- Fertilization and Conception
- Fetal Development from Conception to Birth

Trainer documents

- Male Reproductive Organs and Functions/Processes
- Female Reproductive Organs and Functions/Processes
- The Bead Game

Participant documents:

- Male Reproductive System
- Female Reproductive System-External Genitalia
- Female Reproductive System-Internal Genitalia
- Menstrual Cycle
- Male & Female Fertility
- Fertilization & Conception

### **INSTRUCTIONS:**

#### **I. STRUCTURE AND FUNCTIONS OF MALE & FEMALE REPRODUCTIVE ORGANS (30 minutes)**

Explain to participants that in order to give correct information on reproductive health to people in their communities, it is essential for health mediators to understand the anatomy and physiology of the female and male reproductive organs. This session will begin with an exercise.

Divide participants into two groups.

- Ask one group to draw a silhouette (outline) of the female body, including the following parts of the body/organs:
  - Eyes, nose and mouth
  - Heart, lungs
  - Stomach, liver
  - Breasts
  - Reproductive organs
- Ask the second group to draw a silhouette (outline) of the male body, including the same body parts/organs.

Participants may use any of the following materials: a sheet of paper A0 format, markers, balloons, plastiline, scotch, colored paper

Encourage participants to discuss the task among themselves as they work. Give them 15 minutes to complete the work.

During the exercise, move around and observe the exercise without giving comments or correcting any mistakes.

After the group exercise is over, use the visual tool *Female and Male Reproductive System* and the trainer documents *Male/Female Reproductive Organs and Functions/Processes* as your guide to explain the structure and functions of male and female reproductive organs in a simple way. Encourage questions and comments from the participants and answer any questions. Clarify any misunderstandings participants may have had in drawing the reproductive organs.

Distribute the participant documents *Female Reproductive System-External Genitalia*, *Female Reproductive System-Internal Genitalia*, *Male Reproductive System* to each person in the group.

## II. MENSTRUAL CYCLE (30 minutes)

Ask participants what the term “menstruation” means to them. Listen carefully to their answers as many misconceptions regarding menstruation may come out.

After participants have shared their definitions of menstruation, confirm or correct their statements.

Menstruation: the monthly shedding of the inner lining and blood from the uterus, which comes out of the woman’s body through the vagina as menstrual flow

Using the participant document *Female Reproductive System—Internal Genitalia*, and the trainer document *Female Reproductive Organs and Related Functions/Processes* for additional information, explain the following aspects of the menstrual cycle:

- What is menstruation?
- What is the sign that menstruation has started?
- What is the menstrual cycle?
- What is the length of the menstrual cycle?
- What is ovulation?
- What is menopause?

Explain to participants that a woman’s menstrual cycle happens in phases:

1. She has her period and bleeds.
2. There is no bleeding for a few days.
3. She may start to have secretions.
4. She ovulates.
5. She has no secretions.
6. She may start to experience bodily or emotional changes just before her next period.
7. The cycle starts all over again.

Discuss the importance of proper menstrual hygiene:

- Menstruation is a normal physiological process in the lives of women. However in our society, it is often viewed as something ‘dirty’.
- It is very important to observe proper menstrual hygiene. Poor hygiene can lead to reproductive tract infections. The blood that comes out during menstruation can become the medium for growth of many germs if the sanitary napkins are not changed frequently.

Ask the group:

- What do women need to do in order to have proper menstrual hygiene?

- |  |
|--|
| <ul style="list-style-type: none"> <li>• Use clean napkins</li> <li>• Change the napkins frequently</li> <li>• Do not use dirty cloth</li> <li>• Shower daily during menstruation</li> <li>• Wear clean underwear</li> </ul> |
|--|

### III. FERTILIZATION AND CONCEPTION (30 minutes)

Explain what the term “fertility” means (the ability to reproduce). Distribute the participant document *Male and Female Fertility* and emphasize that the male is fertile throughout his life starting with puberty, while the female is fertile only during few days each month, starting at puberty and continuing until she reaches menopause.

Using the chart *Fertilization and Conception*, explain how pregnancy occurs and how the baby grows in the mother's womb. Encourage questions and answer them. Use the information from the trainer’s documents *Male Reproductive Organs and Functions/*

*Processes and Female Reproductive Organs and Functions/ Processes* for providing explanations.

Encourage participants to tell the local names of organs and parts like placenta, umbilical cord, bag of water (in order to start linking the popular names with the medical terms).

Ask 2-3 participants to come forward one by one and explain to the large group how pregnancy occurs (using the available visual tools to do the presentations). Praise them for correct explanations, and correct any mistakes.

Ask the participants why is it that sometimes a fertilized egg grows into a girl and the other times it grows into a boy. Listen carefully to their answers.

Then invite them to play a game:

- Give each participant one brown bead (the brown bead represents an ovum with an X-chromosome.)  
[**Note to the trainer:** you can use Cycle Beads to get two different colored beads.]
- Put an equal number of white and brown beads in a pouch. (The brown bead represents the sperm with X chromosome and the white bead represents the sperm with Y chromosome.)
- Go to each participant and ask her/him to put his/her hand in the pouch and pick up one bead out of it.
- Ask each participant to show the two beads she/he now possesses.
- Those participants who have picked a brown bead from the pouch (male sperm with X-chromosome) now have two identical beads (XX), i.e., a female baby.
- Participants who have picked up a white bead from the pouch (male sperm with Y-chromosome) now have two different colored beads (XY), i.e., a male baby.

As a **conclusion** explain that all women have only one kind of ova. Men have two kinds of sperm. If one kind of sperm fertilizes the ovum, a female baby is born. If the second type of sperm fertilizes the ovum, a male baby is born. This happens by chance and not by choice, but it is the man who is responsible for the sex of the baby. Mothers are not to be blamed or condemned for giving birth to daughters or sons.

## **MALE REPRODUCTIVE ORGANS AND FUNCTIONS/PROCESSES**

- **Penis** - External male organ through which semen or urine leaves the body. During sexual intercourse it deposits semen in the female body
- **Urethra** - a thin, long tube passing through the penis. It conducts semen or urine out of the male body.
- **Urethral (or urinary) opening** – Spot from which a man urinates or ejaculates semen.
- **Scrotum** –The pouch located behind the penis, which contains the testes, provides protection to the testes and controls the temperature necessary for sperm production and survival.
- **Testicles (or testes) (2)** – The round male reproductive glands lying in the scrotum, which produce and store sperm from puberty onward. They also produce the male sex hormone responsible for male characteristics.
- **Epididymis (2)** – Organs where sperm mature after they are produced in the testicles.
- **Vas deferens (2)** - Thin, long tubes that transport sperm from each epididymis to the urethra.
- **Seminal Vesicles (2)** - Sac-like structures lying behind the urinary bladder. They secrete a thick milky fluid that provides energy for sperm and forms part of the semen.
- **Prostate Gland** - A gland located in the male pelvis, which secretes a thick milky fluid that enables the sperm to swim and become part of the semen.
- **Erection of Penis** - In response to thoughts, fantasies, temperature, touch or sexual stimulation, the penis fills with blood and becomes hard and erect for sexual intercourse.
- **Ejaculation** – The forceful release of semen from the penis after sexual excitement. This may occur at night and is commonly called a ‘wet dream’.

From puberty on, **sperm** are continuously produced in the **testicles (or testes)**, which are located inside the **scrotum**. As the sperm mature, they move into the **epididymis**, where they remain to mature for about two weeks. The sperm then leave the epididymis and enter the **vas deferens**. These tubes pass through the **seminal vesicles** and the **prostate gland**, which releases fluids that mix with the sperm to make **semen**. During **ejaculation**, the semen travels through the **penis** and out of the body by way of the **urethra**, the same tube that carries urine. The **urethral (or urinary) opening** is the spot from which a man urinates or ejaculates.

## **FEMALE REPRODUCTIVE ORGANS AND THEIR FUNCTIONS/PROCESSES**

### **External Organs**

- **Vulva**– The external genital organs of the female, including labia majora, labia minora, clitoris, the vaginal and the urethral openings.
- **Labia Majora** (or **outer lips**) - Two folds of skin (one on either side of the vaginal opening) that cover and protect the genital structures
- **Labia Minora** (or **inner lips**) - Two folds of skin between the labia majora that extend from the clitoris on each side of the urethral and vaginal openings.
- **Clitoris** - A small round and fleshy structure located above the urethral opening at the point where the labia minora meet; the focal point of sexual stimulation for the female.
- **Urethral** (or **urinary**) **opening** – Spot from which a woman urinates.
- **Vaginal opening** - Located between the urethral opening and the anus; usually covered by a thin membrane called the hymen; outlet for the menstrual flow and childbirth. It is the opening for penetration of the penis during intercourse.
- **Hymen** - A thin fold of mucous membrane partially covering the opening of the vagina.

### **Internal Organs**

- **Vagina** - Passageway extending from the outside of the body to the uterus. Canal through which a baby passes during delivery; passageway for the menstrual flow to the outside; place where intercourse occurs. Capable of expanding during intercourse and childbirth, lubricates during sexual arousal.
- **Cervix** - The narrow lower portion of uterus (with opening into the uterine cavity) that protrudes into the uppermost part of the vagina.
- **Uterus** - A pear-shaped muscular organ located in the pelvic region; beginning at puberty, the lining sheds periodically (usually monthly) during menstruation; it is the organ where the fetus (and then the baby) is held and nourished during pregnancy, from the time of implantation until birth.
- **Fallopian tubes** (2) - Two thin tubular structures arising from the upper part of the uterus and having funnel-shaped open ends. Passageway for the egg from the ovary to the uterus; place where fertilization occurs.
- **Ovaries** (2) – The oval-shaped female reproductive glands, located in the pelvic region; contain many immature egg cells at birth; produce female hormones, i.e., estrogen and progesterone; begin maturation and release of eggs from puberty onward.

Every female is born with thousands of eggs (ova) in her **ovaries**. The eggs are so small that they cannot be seen by the naked eye. Once a girl has reached puberty, a tiny egg (ovum) matures in one of her ovaries each month and then travels down a **fallopian tube** on its way to the **uterus**. This release of the egg from the ovary is called **ovulation**. The uterus prepares for the egg's arrival by developing a thick and soft

lining like a pillow. If the girl/woman has had sex in the last few days before she ovulates, by the time the egg arrives in the fallopian tube, there may be some sperm waiting to unite with the egg. If the arriving egg is united with the sperm (called **fertilization**), the egg travels to the uterus, and attaches to the lining of the uterus (implantation) and remains there for the next nine months, growing into a baby. If the egg is not fertilized, then the uterus does not need the thick lining it has made to protect the egg. The lining is shed, along with some blood and the unfertilized egg. All of this flows through the **cervix** and then out of the **vagina**. This flow of blood is called the “period” or **menstruation**.

**Ovulation** is the release of a ripe egg from one of the ovaries once a month. This egg is picked up by the broad, funnel-shaped end of the Fallopian tube and starts moving in the tube towards the womb. A woman can become pregnant only if: 1) she ovulates, and 2) the released egg is fertilized by a sperm after sexual intercourse with a man. Usually only one egg is released during ovulation. Sometimes, however, two eggs are released at the same time. If this happens and both are fertilized, twins will be born.

**Menstruation** happens every month. When an egg ripens in the ovary, the inner lining of the uterus (womb) starts becoming thick and spongy (due to increased blood-supply) as it prepares to receive the fertilized egg. However, after ovulation, if the egg does not get fertilized, it dies. The uterus is “disappointed” that the “expected guest” will not come this month. So it sheds its inner lining and blood, which comes out of the woman’s body through vagina as menstrual flow.

This cycle is repeated every month. The period of time between a menstruation and the next one is called the **menstrual cycle**, with all these events taking place repeatedly. The length of the menstrual cycle varies from 21-40 days. The average length of the cycle is 28 days.

Menstruation begins at puberty and continues until menopause around age 45 to 50 years. Then it stops forever because the ovarian function stops at that stage.

Any bleeding from the vagina after menopause could be a sign of dangerous disease like cancer or a tumor of the uterus and should not be ignored.

**Fertilization** takes place when a male sperm cell meets the female egg.

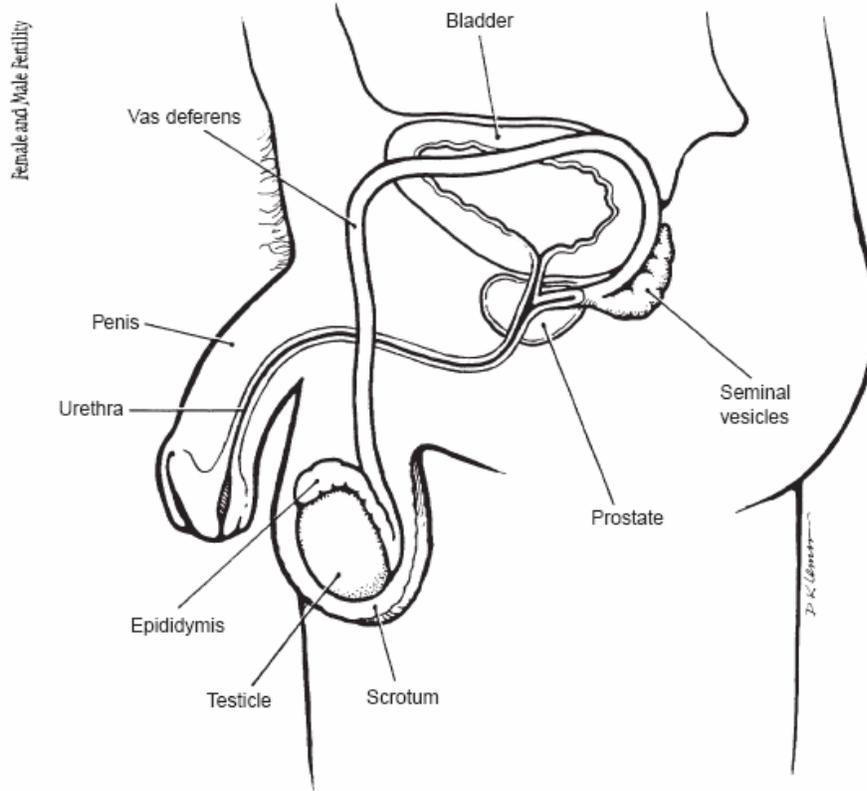
Millions of sperm cells are deposited in the vagina during sexual intercourse. After the male ejaculates (“comes”) in the vagina, ejaculated sperm swim up through the cervix into the uterus, and reach the Fallopian tubes seeking an egg. If a mature egg is present, fertilization can take place. Although thousands of sperm may be present, only one sperm cell can penetrate the egg. Sperm can fertilize an egg up to seven days after intercourse. The fertilized egg moves from the Fallopian tube into the uterus (womb) where it will grow.

**Implantation** occurs when the fertilized egg attaches to the lining of the uterus. When this happens, the lining remains throughout pregnancy, so menstruation stops.

When the **fertilized egg** attaches to the lining of the uterus, a thick and spongy organ called the **placenta** is formed. One side of the placenta is attached to the inside wall of the womb. The other side is attached to the **umbilical cord**, which connects the placenta to the growing baby, called the “fetus”. He/she gets blood supply from the mother's body through the placenta. **A bag of water** surrounds the fetus and protects it from jerks, bumps and external injuries.

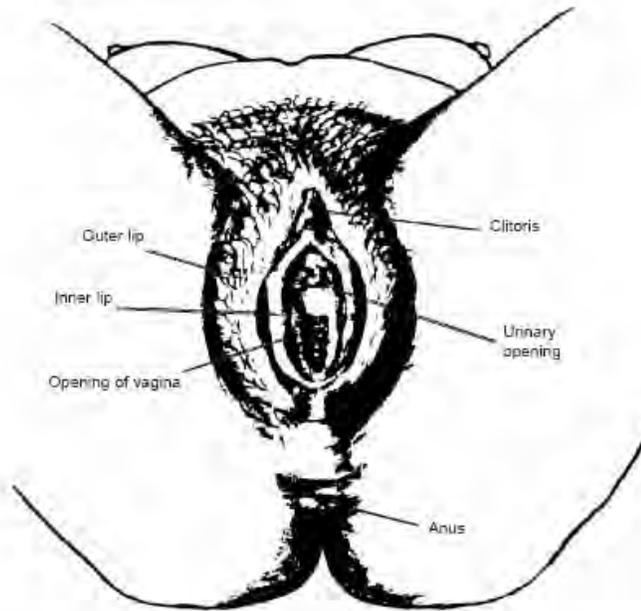
In approximately nine months, the fertilized egg develops into a fully formed human baby, who is now ready to be born and is about three kilos in weight. It then comes out of the mother's body by the process of childbirth.

**Male Reproductive System**

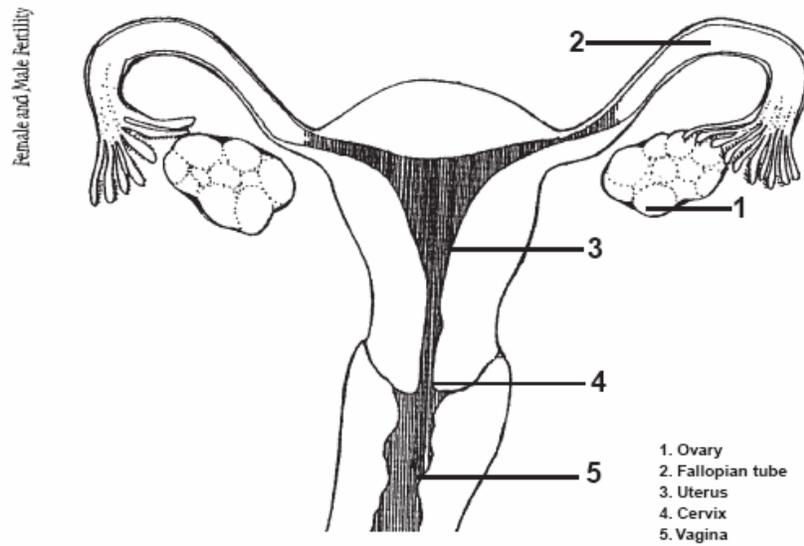


**Female Reproductive System—External Genitalia**

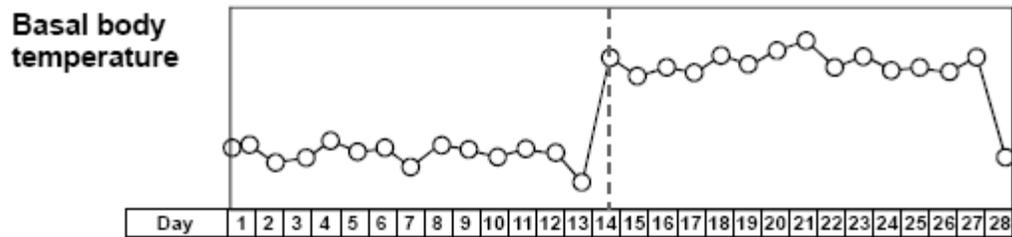
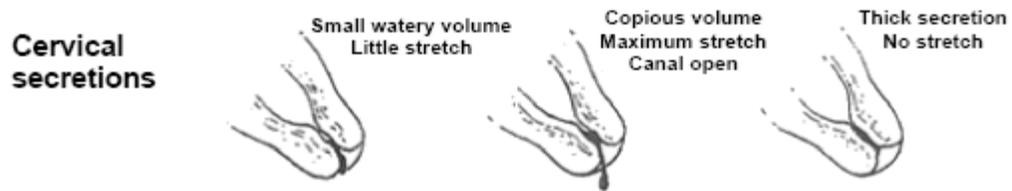
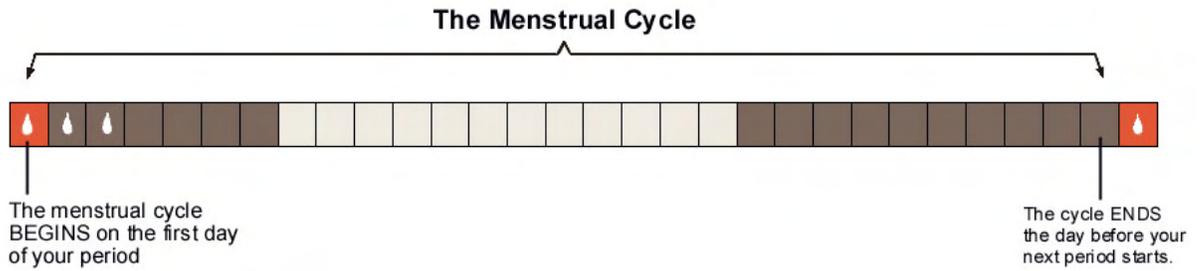
Female and Male Fertility



**Female Reproductive System—Internal Genitalia**



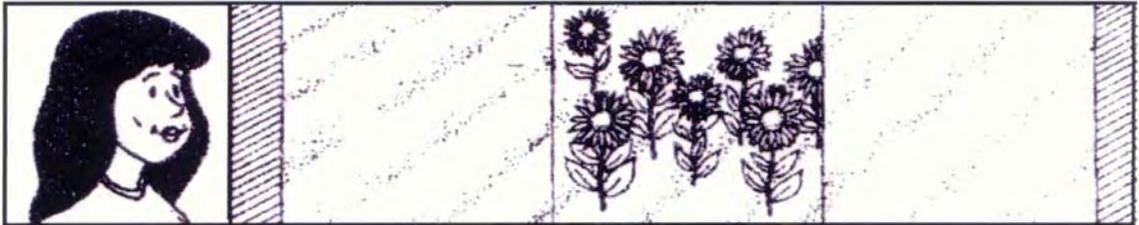
Participant document



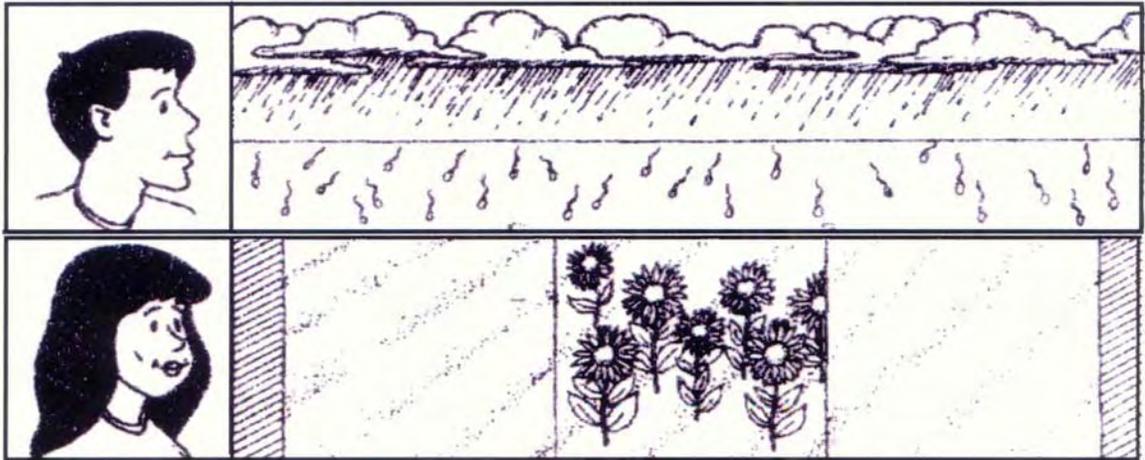
## MALE AND FEMALE FERTILITY



- A man is fertile every day, from puberty through very old age.



- A woman is fertile from puberty until menopause, but only during a few days each menstrual cycle.



- Combined fertility means that a woman can become pregnant if the couple has sexual intercourse during the fertile days of her menstrual cycle.
- A couple's combined fertility can be compared to planting during different seasons.
  - Planting during a wet season, followed by sun, will result in growth. That is, pregnancy can occur during a woman's "wet" or fertile days.
  - Planting during a dry season will not result in growth. That is, pregnancy does not result during a woman's "dry" or infertile days.
- To use fertility awareness information to prevent pregnancy, people need to see a trained provider.

## **SESSION 4: FAMILY PLANNING METHODS**

**OBJECTIVES:** By the end of the session, participants should be able to:

1. Define what is “contraception”
2. Explain the risk of using contraceptive methods versus the risk of not using family planning
3. Describe available family planning methods (available with, or without, medical prescription):
  - How they work
  - Advantages and disadvantages
  - Where to get them
  - When to go to a provider
4. Dispel rumors and myths about family planning methods

**TRAINING METHODS:** Presentation, Discussions, Demonstration, Brainstorming

**TIME:** 6 hours

**MATERIALS:**

- Samples of contraceptives
- Condoms
- Bananas

Flip charts/overheads:

- Family Planning Methods

Trainer documents:

- Traditional Contraceptive Methods
- Natural Family Planning Methods (presentation)
- Steps for Effective Use of Condoms (cards)
- Male Condom (presentation)
- Vaginal Methods (presentation)
- Combined Oral Contraceptives (COCs) (presentation)
- Progestagen-Only Pill (presentation)
- Injectable Contraceptive (presentation)
- Intra-Uterine Device (presentation)
- Voluntary Surgical Contraception (presentation)

Participant documents:

- Methods of Contraception - Fact sheets

## **INSTRUCTIONS:**

### **I-II. CONTRACEPTION (20 minutes)**

Ask participants:

- What do the terms “conception” and “contraception” mean?

Conception: to conceive or to become pregnant.

Contraception (contra = against, ception = conception): way of preventing pregnancy or conception.

- What are the necessary conditions for conception?

The following conditions are necessary for a woman to conceive or to become pregnant:

- Release of an egg (ovum) from one of the woman’s ovaries
- Open fallopian tubes
- Presence of sperm in male seminal fluid
- Sperm being deposited in vagina
- Sperm’s entry into the uterus through the cervix
- Adequate numbers and mobility of sperm in order to reach the ovum in the fallopian tube.
- Inner lining of the uterus soft and spongy (which requires a normal balance of female hormones) to allow the fertilized ovum to attach to it where it can grow into a baby.

Explain that pregnancy can be avoided or prevented if any of the above conditions is changed.

Ask:

- What are contraceptives?

Any obstacle or any condition which does not allow the ovum and the sperm to meet will prevent pregnancy.

Explain that any methods used for this purpose are called family planning methods or contraceptives.

Ask participants what methods they know. Note their responses on the flipchart.

[**Note:** probably some traditional methods will be listed].

Explain that, for many years, people used a variety of unscientific ways to avoid pregnancy, and these are called **traditional methods**. Since that time, other scientifically based methods have been developed and these methods are called **modern contraceptive methods**.

In Romania, until 1989 many couples used traditional methods, because modern methods were not available; some people continued to use them into the 1990s and after, despite their low effectiveness and even dangerous effects on health.

Explain briefly the traditional methods listed by participants or add those if necessary, using the trainer document *Traditional Contraceptive Methods* as a basis.

Post the flipchart *Family Planning Methods*. Explain that world wide, more and more couples are using modern methods of family planning.

Emphasize that approximately half of the population is still using traditional methods or no method. This has resulted in a high number of unintended/unplanned pregnancies, which has led to a high rate of abortion.

Emphasize that the increased use of contraception has led to an important decrease in the abortion rate, and thus in maternal mortality.

Ask participants:

- How many women have you heard of whose death was due to using a modern contraceptive method?

Answers will vary. The number will likely be low.

- Before 1989, how many women did you hear about who died during or following an abortion (which was commonly used because of the lack of contraception)?

Answers will vary. The number will likely be higher.

Explain that:

- Many more women have died because of abortion compared with women who have died due to using modern contraception.
- Modern contraceptives are one of the most studied categories of medicines produced by the pharmaceutical industry and because of this their side effects are very low, much less than the natural risks which may occur during women's pregnancies.

Emphasize that the risks associated with the lack of contraception (unwanted pregnancies, often terminated through abortion), are much more important than the risk of using modern methods of contraception.

### **III-IV. AVAILABLE FAMILY PLANNING METHODS**

#### **a) NATURAL FAMILY PLANNING METHODS (40 minutes)**

Referring to the process of fertilization and conception discussed in previous session, ask participants:

- What are the situations in which a woman cannot become pregnant, from puberty until menopause?

- |  |
|--|
| <ul style="list-style-type: none"><li>• When she is already pregnant</li><li>• When she is breastfeeding a baby (and respecting the conditions of LAM)</li><li>• When she is in the infertile stage of her menstrual cycle</li></ul> |
|--|

Explain that:

- During a woman's menstrual cycle, there are stages when she is fertile (around the time an egg/ovum is released from one of her ovaries) and she can become pregnant if she has intercourse with a man
- There are other stages of the menstrual cycle (well before, and well after, the time when an egg/ovum is released) when she is infertile and will not become pregnant if she has intercourse with a man
- There are several Natural Family Planning Methods based on a woman's having intercourse only during the infertile stages of her menstrual cycle. By using a natural family planning method, pregnancy is prevented in a natural way without using any artificial interference.

Distribute the participant document *Lactational Amenorrhea Method (LAM) - Fact Sheet* and ask volunteers to read it. Answer participants' questions as necessary.

Make a brief presentation of the natural family planning methods based on fertility awareness, using the information from the trainer document *Natural Family Planning Methods*.

Inform participants that SDM will be discussed in more detail in the next session.

Summarize the Fertility Awareness Methods:

- For all methods based on fertility awareness, the couple needs to choose a method for identifying the fertile period during each menstrual cycle.
- Then, the couple needs to make a decision about their sexual behavior during the woman's fertile period and respect this decision. They could choose:
  - Abstinence: not to have sexual intercourse during the fertile days (periodic abstinence)
  - A barrier method (condom, spermicides)
  - Coitus Interruptus or Withdrawal Method.
- The effectiveness of fertility awareness methods varies more than for other methods, depending on variables such as consistency of use, regularity of menstrual cycles, and user-related factors. Fertility awareness methods have a typical pregnancy rate of about 20% in the first year; consistent and correct use can reduce the pregnancy rate to 2%.

- Fertility awareness methods may be appropriate for women:
  - Who will not or cannot use other methods for personal or religious reasons
  - Who have conditions that are a precaution for hormonal or other methods
  - For whom using a more effective method is not crucial (the woman can accept a pregnancy)

## **b) BARRIER METHODS (60 minutes)**

Introduce barrier methods by explaining that we will focus on male condoms and spermicides. Although there are other barrier methods (female condoms, diaphragms, vaginal sponges and cervical caps), they are mentioned for interest, but not in detail since they are not currently available. Training must prepare health mediators to assist persons in the community to understand available methods.

### **1. Male condom (50 minutes)**

Hold up a male condom and ask participants what it is. Give the condom to the first participant on your right side and ask about her feelings, reactions towards this method; after the first person has expressed her point of view, she will pass it on to the neighbor on her right and so on until all participants have had the opportunity to state their opinions regarding the condom.

[**Note:** Pay attention to the trainees' non-verbal messages during this exercise; it helps you to identify their attitudes towards the condom].

Distribute to each participant a card containing a “step” in the effective use of condoms (use the Trainer document *Steps for effective use of condom – cards*).

Ask participants to get up from their chairs and to arrange themselves in a circle representing the logical steps for using a condom.

[**Note:** If the number of trainees does not correspond to the number of cards, you might ask them to work in small groups; each group receives a set of cards and they will place the cards in the proper order within their group. At the end of the exercise, each group will present their results and participants will compare them with the results of the other groups.]

At the end of the exercise, demonstrate the use of the condom, following the participants' indications. Lead participants through a discussion correcting the steps and then do the demonstration based on the correct sequence of steps, using the trainer document *Condom Demonstration* (and a banana, if available).

Pair off participants. Provide packets of condoms to each pair and ask them to practice demonstrating the correct use of condoms. During practice, one participant should act as a mediator and the other as a person from the community. Then they should switch roles.

During the exercise move around the room and ensure that all participants are working. Observe the quality of their demonstrations. (Do not forget that some of them may directly experience the condom for the first time in their lives).

Indicate the page in the manual where they can find the indications for correct use of condoms.

Discuss the importance of storing condoms correctly.

Tips for Condom Care:

- Store condoms in a cool, dark place. Heat, light, and humidity can damage condoms. If properly stored, condoms will stay good for about five years.
- Always check the expiration date on the condom package. Do not use condoms whose expiration date has already passed. Also check the quality of the condom: if it is dry and stiff, do not use it.
- Take care when handling condoms. Fingernails can tear them.
- Do not unroll condoms before using them. You may weaken them, and an unrolled condom is difficult to put on.

Ask participants:

- What are the advantages and disadvantages of condoms?

Note their responses on a flipchart paper, dividing them into two columns: advantages and disadvantages. Review the elements proposed by the participants, offering additional information and corrections if necessary. Use the trainer document *Barrier Methods: Male Condom* as a basis for conducting the discussion.

Ask participants about myths and rumors they have heard about condoms. As one person mentions a myth or rumor, invite other participants to provide explanations to dispel the myths/rumors. Ensure that logical explanations are offered in response to incorrect information, misconceptions, and myths regarding the condom.

Emphasize the importance of double protection against unwanted pregnancy as well as against STIs and stress that the condom is the only method which ensures double protection.

## **2. Vaginal methods (10 minutes)**

Make a brief presentation on spermicides (the only vaginal method available), using the information from the trainer document *Barrier Methods: Vaginal methods*.

Explain the correct use of spermicides, which usually are bought directly from pharmacies and used without any medical instruction.

Indicate the page in the manual where the vaginal methods are described.

## c) **HORMONAL METHODS** (70 minutes)

### **Introduction** (5 minutes)

Explain that:

- There are several hormonal methods of contraception, using very small quantities of artificial forms of hormones, similar to the natural hormones produced by women's ovaries.
- These methods act in two ways:
  - Women using these methods do not ovulate (release an egg/ovum prepared for fertilization)
  - The hormones cause other small changes in women's genital organs, which prevent pregnancy from occurring, without any significant effect on their health.

List the hormonal methods on the flipchart.

- Combined oral contraceptives (pills)
- Progestagen-only pills (mini-pills)
- Combined injectable contraceptives
- Progestagen-only injectable contraceptives
- Subdermal implants
- Vaginal ring

Underline the available methods in Romania and inform participants that you will refer only to them.

### **1. Combined oral contraceptives (COCs) or pills** (40 minutes)

**[Note to the trainer:** It is very important to know the participants' level of knowledge about hormonal methods, because there are many myths about these methods in the community, and these myths influence women not to use these methods. Mediators have an important role in dispelling rumors and myths in order to encourage women to use modern contraceptive methods].

Ask participants:

- What do you know about the pill: good things? bad things? myths/rumors you have heard about the pill?

Write their answers on the flipchart and discuss each.

Make a short presentation, using the trainer document *Combined Oral Contraceptives (COCs)* as a basis.

**[Note:** A pre-prepared flipchart may be used to explain the method].

Refer to the *Myths and Facts about Pill* during your presentation, in order to dispel the myths mentioned by participants.

Distribute the participant document *Methods of Contraception: Combined Oral Contraceptives (COCs) - Fact Sheets* and pair participants. Ask them to simulate a discussion between a mediator and a woman in the community, the mediator having the role of communicating to the woman basic information about the pill based on the *Fact Sheet*. After two minutes, ask them to switch roles.

Explain that:

- Pills may have some side effects that women should be made aware of. Ask participants to name possible side effects of the pill. Correct any misinformation, and be sure the points in their fact sheet/cue card are covered.
- These minor side effects are generally not signs or symptoms of serious illness and they usually stop after the body becomes accustomed to the pill, which takes about 2-3 months. Some women never experience these side effects.
- If minor side effects continue beyond 2-3 months and/or are intolerable, the woman should consider using another method. She should visit the doctor who prescribed her the pill or another family planning provider.

Explain that while the pills are an extremely effective method of family planning, there are some situations or conditions in which women should not use the pill. Emphasize that it is recommended for women to ask advice from a trained health provider (such as a Family Doctor) if they are interest in using COCs.

## **2. Progestagen-only pills (POP) or mini-pills (10 minutes)**

Briefly describe the method, emphasizing the differences between this method and COCs. Use the trainer document *Progestagen-Only Pill* for your presentation.

[**Note:** A pre-prepared flipchart may be used to explain the method].

Explain that POPs are generally provided to breastfeeding women. Used correctly, they are as effective as COCs in non-breastfeeding women. However, the effectiveness of POPs is dependent upon the woman taking the pill at the same time every day. It is important for the woman to understand that missing even one pill can render the method ineffective for that cycle of pills.

## **3. Injectable Contraceptives (15 minutes)**

Explain what injectables contraceptives are and that you will present the injectable contraceptive available in Romania, which is known as Depo-Provera. Distribute a few samples of Depo-Provera and allow participants 1-2 minutes to examine them.

Explain that:

- Depo-Provera is a very effective and safe injectable contraceptive for women.
- It works for a three-month period.
- It may have some minor effects and if those appear, they may last as long as 6-8 months after the woman's last injection.

- After stopping the injection, it usually takes 6-10 months to become pregnant (reversibility of the method is delayed).
- Because of these side-effects some women give up using injectable contraceptives which are one of the most effective methods of family planning. Emphasize that these side effects are not signs of sickness.
- There are also some situations or conditions in which women should not use the method. Thus, it is necessary for women to seek the services of a trained health provider (such as a Family Doctor) if they are interested in using injectable contraceptives.

[**Note:** A pre-prepared flipchart may be used to explain the method].

#### **d) INTRA-UTERINE DEVICE (IUD) (20 minutes)**

Explain that usually in rural communities, the health providers (family doctors) distribute only condoms, pills and injectables. Other long-term family planning methods are available in Family Planning clinics, hospitals and private clinics, and they must be promoted.

Ask the group to name the methods for which women must be referred to a clinic, health center or hospital. List them on the flipchart

- |   |
|---|
| <ul style="list-style-type: none"> <li>• IUDs</li> <li>• Voluntary surgical contraception             <ul style="list-style-type: none"> <li>- Vasectomy</li> <li>- Tubal ligation</li> </ul> </li> </ul> |
|---|

Show packets of IUDs to the participants. Let them see how small the IUD is in comparison to the uterine cavity of the women where it is placed.

Explain that:

- An IUD is a small plastic device (which may contain copper or progesterone hormone) that is placed in the uterus of a non-pregnant woman where it acts as an effective long-term but reversible contraceptive.
- The most commonly used IUD is a Copper T. The Copper T looks like the letter “T”. The stem of “T” is wound with copper wire. Two thin nylon threads are attached to its lower end and lie in the vagina. The threads are very important for a woman using an IUD: they allow her to check after each menstrual period to verify that the IUD is still in place, and they allow a medical doctor to remove the IUD from the uterus when necessary.

Briefly explain the method using the trainer document *Intra-Uterine Device (presentation)* as a basis.

[**Note:** A pre-prepared flipchart may be used to explain the method].

Explain that Family Doctors usually know where to refer women for IUD insertion.

Emphasize that although insertion of an IUD is a minor procedure, it is performed only by medical doctors (Ob-Gyn specialists) who are authorized and trained to insert an IUD. Although the mediator is never directly involved in IUD insertion, she should know about the process in order to educate women.

Discuss with mediators the myths and rumors they have heard about IUDs and respond to any doubts participants may have.

#### e) **VOLUNTARY SURGICAL CONTRACEPTION** (20 minutes)

Explain that the other long-term methods are surgical contraceptive methods which are available on a voluntary basis to men and/or women who do not want any more children.

Emphasize that these are **permanent, irreversible** methods and mediators should inform people very clearly about this point. They are safe and relatively free of side effects. Once the couple completes the size of their family, the man or woman may opt for permanent contraception.

Explain that there are two types of VSC:

- Female Sterilization or Tubal Ligation for women
- Male Sterilization or Vasectomy for men
- Both are minor operations, generally performed by injecting local anesthesia at the site of operation. Vasectomies are relatively simpler, safer, and less expensive than tubal ligation.

Using the trainer document *Voluntary Surgical Contraception*, briefly present the main aspects of the two methods, for women and for men.

Emphasize that:

- Before choosing this method, men and women must be informed about the permanency of the method.
- Persons must decide to undergo the surgical procedure voluntarily (i.e. without any force or coercion) after a complete understanding of the relevant facts of the procedure. A consent form is used to document the individual's agreement. Although there is no requirement for a spouse's consent, a joint decision usually will mean a more satisfied client and fewer complaints to health providers following the procedure. So both partners should be counseled about VSC.
- Attempts to reverse vasectomy or tubal ligation are rarely successful. Therefore, couples who are considering VSC should be certain that they do not wish to have any more children.

Ask participants which persons can undergo VSC. Listen to their answers and then reinforce the correct answer.

Who can undergo VSC:
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- One who is fully informed and is absolutely certain that s/he wants no more children
- Women who have a health condition which makes pregnancy very risky.

Discuss the myths and rumors in relation to tubal ligation and vasectomy and how to dispel them.

#### **f) EMERGENCY CONTRACEPTION (10 minutes)**

Explain that for different reasons, people sometimes have “unprotected sex”. Ask participants to define situations in which unprotected sex is more likely to happen. List the answers on the flipchart.

- Woman has sexual intercourse without contraception (unplanned intercourse)
- Woman has sex against her will
- Woman uses a contraceptive method but it fails:
  - the condom breaks
  - the IUD has been expelled
  - the woman vomits within an hour of taking her pill
- The woman has incorrectly used the contraceptive method:
  - she has forgotten to take the pill
  - she has delayed her follow-up visit for a new dose of injectable contraceptive
  - she has done a vaginal douche within less than 6 hours after using spermicidal jelly, etc.

Explain that in any of these situations, another type of contraceptive is available, named emergency contraception.

Emphasize that this type of contraception should not be used on a routine or a regular basis (“in place of family planning methods”), but only in emergency situations (when unprotected sex has occurred and the woman wants to avoid pregnancy).

There are two types of emergency contraception:

- The woman can use pills with a high dose of hormones up to 3 days after unprotected intercourse.
- The woman can ask for an IUD insertion up to 5 days after unprotected intercourse.

Both methods prevent the pregnancy from occurring. Neither method acts on an egg already attached in the uterus (they are not methods of abortion).

Add that frequent use of the hormonal method is not recommended due to the high level of hormones contained in this type of contraception compared to the regular use of oral contraceptives. If a woman repeatedly requests emergency contraception, she needs a family planning method and she should be encouraged to choose one.

If an IUD was chosen for emergency contraception, the woman can keep it as a regular, long-term method of family planning.

## **SUMMARY**

At the end of this session, emphasize that:

- All contraceptive methods presented are available to any person in Romania, no matter his/her status in relation with the House of Health Insurance. Access to Family Planning is a basic right for all human beings.
- Family Doctors and specialists working in Family Planning clinics are trained and authorized to provide these methods to the population.
- Mediators have only the role to inform people about the existing methods, to emphasize the advantages of practicing family planning and to support the population in their communities to visit health providers who can offer contraception to their clients.

All mediators will receive a list of trained Family Planning providers in their districts.

Participants will have the opportunity to practice the provision of information about family planning methods in the last day of the workshop, when they will have to prepare and demonstrate in front of the group a group education session.

The next session will cover another method, Standard Days Method, which they can discuss with people in their community; and they can provide a tool (Cycle Beads) to help people to understand and practice this method.

## **TRADITIONAL CONTRACEPTIVE METHODS**

Coitus Interruptus or Withdrawal Method in which the man interrupts intercourse by pulling out or withdrawing his penis from his partner's vagina before he ejaculates so that semen is not deposited inside her body. The effectiveness of this method depends on the man's willingness and ability to withdraw before ejaculation.

Vaginal (post coital) douching consists of placing water into the vagina (with a vaginal irrigator or douche) immediately after intercourse in order to eliminate the sperm from the vagina. Effectiveness of the method is very low because the sperm pass into the uterus (through the cervical opening) in a very short time (approximately 30-60 seconds).

Using "sperm-killer" substances is an old method, used without any scientific basis. People used different common substances (like salt, lemon juice, vinegar) in order to kill the sperm and avoid pregnancy. Some of these substances work, destroying the sperm, but they also destroy the human tissues, especially the woman's vaginal and cervical lining.

Only modern, adapted products (spermicides) are recommended for this purpose.

## **FAMILY PLANNING METHODS**

### **NATURAL FAMILY PLANNING METHODS**

- Lactational Amenorrhea Method
- Fertility Awareness Methods
  - Rhythm (or Calendar) Method
  - Cervical Mucus Method (Billings Method)
  - Basal Body Temperature Method
  - Symptothermal method
- Standard Days Method (Cycle Beads)

### **BARRIER METHODS**

- Male Condom
- Vaginal methods
  - Diaphragm with spermicide
  - Spermicides (only vaginal method widely available in Romania)
  - Cervical cap
  - Female Condom (femidome)

### **HORMONAL METHODS**

- Combined hormonal contraceptives:
  - Combined Oral Contraceptives (pills)
  - Combined injectable contraceptives
- Progestagen only contraceptives
  - Progestagen-Only Pills PNP/ POP
  - Progestagen-Only Injectable Contraceptives
  - Hormonal implants
  - Vaginal Ring

### **INTRA-UTERINE DEVICE (IUD)**

- Copper IUD
- Progestin IUD

### **VOLUNTARY SURGICAL CONTRACEPTION**

- Male / Vasectomy
- Female / Tubal Ligation

### **EMERGENCY CONTRACEPTION**

- Pills
- IUD

## **NATURAL FAMILY PLANNING METHODS (presentation)**

### **LACTATIONAL AMENORRHEA METHOD (LAM)**

LAM (Lactation = breastfeeding. Amenorrhea = absence of menses. M=method) is a family planning method for breastfeeding mothers which provides natural protection against pregnancy for up to 6 months after birth.

#### ***Mechanism of Action***

Lactational Amenorrhea Method can be used by breastfeeding women and is based on the physiological infertility during this time, demonstrated by the absence of menses. Women's fertility is reduced because they do not ovulate. Without ovulation, fertilization and pregnancy cannot take place.

#### ***Effectiveness***

If using the LAM perfectly, only 1 woman out of 200 women will get pregnant in the first 6 months after childbirth. As commonly used, 2 women out of 100 may become pregnant in the first 6 months.

In order for LAM to be effective, the woman must meet the following criteria:

- She is less than six months postpartum
- She is amenorrheic (she has had no menstrual periods)
- She is fully and regularly breastfeeding, without giving the baby any other food

The woman should start another contraceptive method before any of the three criteria expire. A woman needs an alternative method before 6 weeks postpartum to begin immediately if she should menstruate or reduce breastfeeding intensity.

#### ***Advantages***

- Can be used immediately after delivery
- Is very convenient for the mother who breastfeeds during the first 6 months after delivery
- Requires no prescription
- Has no side effects or precautions
- Is economical (free of charge)
- Requires no chemical substances or mechanical devices
- Helps protect the infant from diarrhea and other infectious diseases

#### ***Disadvantages/Limitations***

- Can be used only during the postpartum period
- May be difficult for woman to maintain a pattern of fully or almost fully breastfeeding
- Provides no protection against STD/HIV
- In HIV-positive mothers, the babies have the risk of infection through breastfeeding

## **FERTILITY AWARENESS METHODS**

Fertility Awareness Methods are methods that rely on various techniques to identify a woman's fertile days (the days in which she can become pregnant). In using these methods, a woman monitors the various changes and signs that occur in her body during each menstrual cycle, which may indicate when she is fertile and when she is not (the "safe" days to have sex). By avoiding intercourse on "unsafe" days, a woman may avoid pregnancy. These methods have varying degrees of reliability. Each method requires careful instruction and a high level of motivation and commitment on the part of the couple in order to be used successfully.

### ***Mechanism of Action***

The **Rhythm (or Calendar) Method**, one of the oldest and most widely practiced fertility awareness methods worldwide, requires the woman to calculate the fertile days of her cycle. She keeps a strict record of the length of her last six cycles (counting the first day of bleeding as the first day of a new cycle) and then uses a simple formula to identify her fertile days. She counts the number of days in the shortest cycle, and subtracts 18, using the answer to estimate the first day of fertility in a cycle. The woman then determines the number of days in her longest cycle, subtracts 11, and uses the answer to estimate the last day of fertility in a cycle.

**The Basal Body Temperature (BTT) Method** requires the woman to take her own temperature every morning on awaking and record it on a chart over several months to determine her time of ovulation. A drop in the BBT sometimes precedes ovulation by 12 to 24 hours and rises immediately after ovulation, staying elevated slightly (0.2 to 0.5 degrees C) until her next menstrual period.

To use the **Cervical Mucus Method (Billings Method)**, the woman monitors and records on a daily basis the changes in her cervical mucus discharge. Typically, there is little mucus discharge for a few days following menstruation. Then the mucus becomes sticky/pasty or crumbly/slightly yellow or white. As ovulation nears, the mucus becomes slippery, white, clear and wetter. Following ovulation, the mucus becomes sticky/pasty again.

**The Symptothermal Method** combines several techniques to predict ovulation. The woman monitors her cervical mucus (as in the Billings Method) and her temperature changes (as in the BBT method), including other signs of ovulation, like breast tenderness, back pain, abdominal pain, and light intermenstrual bleeding. She must abstain from the first sign of wet cervical mucus until her body temperature has remained elevated for three days after the peak day (the last day of clear, slippery mucus) or until the fourth day after the thin mucus is no longer observed, whichever is later.

### ***Effectiveness***

Fertility awareness methods have a typical pregnancy rate of about 20% in the first year. Depending on variables such as consistency of use, regularity of menstrual cycles, and user-related factors, consistent and correct use can reduce the pregnancy rate to 2%. When used in combination with a barrier method, effectiveness is increased.

### ***Advantages***

- No or low cost
- No chemical products/no physical side effects

- Immediately reversible
- Acceptable to many religious faiths
- Responsibility for family planning is shared by both partners

*Disadvantages*

- Requires considerable instruction
- Requires high level of responsibility: women must keep daily records
- Couples must cooperate in order to avoid sexual relations during fertile days (about 10-15 days each month), unless a barrier method is used at that time
- Women with irregular menstrual periods may be unable to use rhythm or BBT methods
- Does not protect against STDs/HIV
- Effectiveness is low at common usage of the methods
- Women with modifications in health status or illnesses (fever, vaginal infections) may be unable to recognize the signs of fertile, and infertile, stages of their menstrual cycles

**STEPS FOR CONDOM USE (cards)**

<b>Pinch the tip of the condom to leave <math>\frac{1}{2}</math> centimeter of space at the tip of the condom</b>	<b>Sexual intercourse</b>	<b>Open the condom package</b>
<b>Pull the foreskin back</b>	<b>Verify the condition of the condom</b>	<b>Carefully remove the condom from the package</b>
<b>Throw the condom in the garbage can</b>	<b>Withdraw the penis before it becomes flaccid</b>	<b>Place the unrolled condom on the tip of the penis</b>
<b>Bend the penis and carefully remove the condom</b>	<b>Check the expiration date on the condom package</b>	<b>Hold the condom rim at the base of the penis</b>
<b>Hold the condom with the rolled side up</b>	<b>Tie a knot at the end of the condom</b>	<b>Unroll the condom all the way to the base of the penis</b>

## **MALE CONDOM (presentation)**

The condom is a thin, latex rubber sheath placed on the erect penis before penetration into the vagina, forming a mechanical barrier between the penis and the vagina. Some condoms are covered with a lubricant or with spermicidal substances.

### ***Mechanism of Action***

The condom protects against unwanted pregnancy and against STIs by covering the erect penis during intercourse. The male seminal fluid (or semen), containing sperm and (sometimes) disease-causing organisms, are caught in the condom and do not pass through it.

### ***Effectiveness***

Condoms can be very effective when used consistently and correctly. Using a condom with vaginal spermicide increases its effectiveness.

### ***Advantages***

#### **Contraceptive benefits:**

- Easy to use
- Easy to obtain
- Inexpensive
- Safe and effective
- Allows the man to share responsibility for family planning
- Convenient when need for short-term contraception is required
- Can be easily used by breastfeeding mothers as it does not affect lactation

#### **Non-contraceptive benefits or other advantages of condom:**

- Provides protection against STIs & HIV/AIDS to both partners
- Helps protect against cancer of the cervix, which can be caused by STIs
- Helps some men with premature ejaculation maintain an erection because of the rim around the base of the penis
- Protects women from pelvic inflammatory disease (PID) and its complications like infertility due to the blockage of fallopian tubes

### ***Disadvantages***

- Must be used at the time of intercourse (interferes with sexual intercourse)
- Some men complain of decrease in sexual pleasure
- Slipping off, tearing, spillage of sperm can occur especially among inexperienced users
- User must be highly motivated to use condoms consistently and correctly
- Deteriorates quickly when storage conditions are poor
- Some people may be embarrassed to purchase the condoms, to discuss them with their partner or to use them.

### ***Side Effects of Condoms***

- Rare allergy to rubber (latex)

### *Correct Use of Condom*

- Check the manufacture date and the expiry date on the package when you buy condoms.
- Use a new condom every time, with every act of intercourse.
- Open the condom package
- Carefully remove the condom from the package
- Before the penis touches the partner, place the condom on the erect penis or have the partner do it.
  - Hold the condom with the rolled side up
  - Pull the foreskin back
  - Pinch the tip of the condom in order to leave a half centimeter of empty space at the tip of the condom
  - Put the unrolled condom on the tip of the penis
  - Completely unroll the condom all the way to the base of the penis
- If you want additional lubrication, contraceptive foam or spit may be used. **Do not** use petroleum jelly or other oils as they can cause deterioration of the rubber.
- Sexual intercourse
- After ejaculation, hold the condom rim to the base of the penis so it will not slip off
- Withdraw the penis as soon as possible, because if the erection is lost, the condom can slip off and semen can spill into the vagina
- Bend the penis and carefully remove the condom
- Tie a knot at the end of the condom
- Throw the condom in the garbage can (avoid throwing the condom in the toilet, where the condom floats); do not throw it in places that can easily be reached by children who can play with it, exposing themselves to infection risks.

If the condom breaks:

- A spermicide may be immediately applied in the vagina.
- Washing the vagina and the penis with water and soap will reduce the risks of STI occurrence.
- In order to prevent pregnancy, the woman may request emergency contraception.

*Tips for Condom Care:*

- Store condoms in a cool, dark place, protected from sunlight. Heat, light, and humidity can damage condoms. If properly stored, condoms will stay good for about five years.
- If the package is damaged, do not use the condom.
- Take care when handling condoms. Fingernails can tear them.
- Do not unroll condoms before using them. You may weaken them, and an unrolled condom is difficult to put on.

## Condom Demonstration

1. Explain to the person/couple the importance of:
  - Using condoms for protection from genital tract infections, including STIs, (as well as for prevention of pregnancy if this is the person's/couple's contraceptive choice).
  - Using a new condom every time, with every act of intercourse
  - Checking the manufacture date and the expiration date on the package when buying condoms
  - Placing the condom on the erect penis before any sexual contact (for both contraceptive protection and/or for the prevention of STIs as some semen may be released during foreplay).
  - Not using vaseline, cooking oil or grease to lubricate the condom as any of these will weaken the condom quickly and allow it to break during intercourse. Most condoms are already lubricated. If not, one should use a contraceptive jelly or foam, or spit, for lubrication.
2. Verify the expiration date on the condom package and show the person/couple how to verify it. Tell the person/couple not to use condoms if the expiration date has passed.
3. Verify the integrity of the package. Tell the person/couple:
  - If the package is already open, the condom may not be in good condition.
  - Not to leave condoms for long periods of time in warm places (for example, in automobile glove boxes in the summer heat nor in men's wallets in the back pocket).
4. Open the package gently where indicated. Explain that it is important not to damage the condom when opening the package. Remove the condom.
5. Verify the integrity of the condom. Explain that if the condom is dry and stiff or like paper, it should not be used.
6. Show the person/couple how to verify that the condom is right side out (so that it can be unrolled easily down the penis): hold the condom with the rolled side up/out.
7. With one hand, grasp the tip of the condom and with the other hand guide its application on the model. Explain the importance of pinching the tip of the condom to be sure that there is no air in the tip and thus to leave room for the semen during ejaculation. Explain that if there is air in the tip of the condom, the condom may break during ejaculation or the air may push the semen up the sides of the condom, causing leakage and loss of protection.
8. Unroll the condom to the base of the model.

9. Explain the importance of withdrawing the penis soon after ejaculation before the penis becomes soft and semen leaks out of the condom, or the condom slips off the penis.
10. Explain the importance of holding the condom rim to the base of the penis during withdrawal of the penis in order to prevent the condom from slipping off. Demonstrate this step.
11. Remove the condom from the model by carefully pushing the condom toward the end of the model representing the tip of the penis. Explain that simply rolling the condom down the penis may allow semen to spill out.
12. Make a node/knot at the top of the condom to keep its contents from spilling.
13. Explain the importance of throwing the condom where children will not find it.

### **Myths and Facts about Condom**

**Myth:** The condom will not fit properly.

**Fact:** One size fits all.

**Myth:** The condom will break.

**Fact:** Condoms are very strong. They rarely break, especially if care is taken to use them correctly.

**Myth:** The condom will decrease sexual pleasure.

**Fact:** Condoms are made of extremely thin rubber. Although sex with a condom does not feel exactly like sex without it, it is just as enjoyable for most people. The security of knowing the woman will not get pregnant while using a condom can actually improve the couple's sexual pleasure. *(You may invite participants to palpate the tip of their nose with one of their fingers and then with another finger covered with a condom. Ask: can you feel your nose through the condom? Emphasize that a slight reduction in tactile sensations can extend the duration of the sexual intercourse, most of the couples considering this as an advantage.)*

**Myth:** Condoms usually cause allergy.

**Fact:** Allergy to condoms is very rarely seen.

**Myth:** Condoms are harmful if used over many years.

**Fact:** They are extremely safe and protect both partners from STIs including HIV/AIDS, pelvic inflammatory disease (PID) and cancer of cervix in women. So regular use of condoms is recommended.

## **VAGINAL METHODS (presentation)**

Vaginal methods are used by the woman. They are placed in the vagina before sexual intercourse.

Spermicides are the only vaginal methods of contraception available in Romania.

### ***Mechanism of Action***

Spermicides (tablets, gels, foams and creams) destroy sperm so that they cannot reach the egg/ovum to fertilize it.

### ***Effectiveness***

The effectiveness of spermicides depends upon its correct and consistent use, as well as on the type of spermicide.

### ***Reversibility***

Immediate.

### ***Side Effects***

- Irritations in women as well as in men (especially if used more than once a day)
- Local allergic reactions (rare)

### ***Instructions for user***

- Woman may start using spermicides whenever she wants.
- Spermicide is introduced deep into the vagina, close to the cervix, with the aid of the fingers or an applicator (in the case of cream, foam and gel).
- It can be introduced within a maximum of 1 hour before intercourse. If tablets are used, it is necessary to wait 10 minutes after the insertion before having intercourse in order for the tablets to be dissolved in the vagina.
- If sexual intercourse takes place more than once, a new dose of spermicide is needed before each act of intercourse
- Vaginal douches are not allowed until **at least 6 hours** after the last act of sexual intercourse.

## **COMBINED ORAL CONTRACEPTIVES (presentation)**

Combined Oral Contraceptives (COCs), also known as contraceptive pills or birth control pills or oral contraceptives, contain two synthetic hormones similar to the female sexual hormones: estrogen and progesterone.

### ***Presentation forms***

COCs come in packets of:

- 21 pills, all of which contain hormones (active pills)
- 28 pills, out of which the first 21 contain hormones (active pills) and the remaining 7 pills do not contain hormones (inactive pills, continuity pills); these usually have another color or another size than the active pills, in order to be easily recognizable.

### ***How they work***

COCs work by preventing the release of the egg from the ovary (block ovulation). Without an egg to be fertilized, a woman cannot become pregnant.

### ***Effectiveness***

If they are used correctly and continuously, COCs are very effective: only 1 pregnancy in 100 women within the first year of usage. As they are commonly used, however, 6-8 women out of 100 women using COCs will get pregnant within the first year of using this method.

### ***Advantages***

- Are safe, effective, and easy to use
- Can be used by women of all ages, from puberty to menopause
- Do not interfere with sex
- Women can become pregnant rapidly after stopping the pill (method is immediately reversible)
- May be beneficial for the woman's health:
  - Lead to lighter, regular periods with less cramping
  - Reduce acne
  - Decrease the risk of cancer of the female reproductive organs, and other genital problems (pelvic inflammatory disease, ectopic pregnancy).

### ***Disadvantages***

- Have some side effects
- Must be taken every day
- Do not protect against STIs/HIV
- Cannot be used by certain categories of women or in some specific situations (breastfeeding, chronic illnesses, smokers over 35 years)

### ***Possible Side Effects***

Most women experience no side effects. Occasionally, they may experience:

- Nausea
- Unexpected bleeding or spotting
- Breast tenderness
- Headaches or dizziness
- Increase appetite and weight gain.

### **Myths and Facts about the Pill**

**Myth:** The pill causes cancer.

**Fact:** Scientists have done many studies with women using the pill. These studies do not show that the pill causes cancer. In fact, they show that the pill can help protect women from some kinds of cancer, such as ovarian or uterine cancer.

**Myth:** The pill causes deformed babies and multiple births (twins, triplets).

**Fact:** There is no difference between women who use the pill and those who do not, in the number of deformed babies they have or in the number of multiple births, even if they conceive while on the pill.

**Myth:** If a woman uses the pill, she will have trouble getting pregnant again when she stops using the pill.

**Fact:** In the majority of women, pregnancy occurs soon after they stop using the pill. Experts believe that the small number of women who have trouble getting pregnant after taking the pill would have experienced this trouble even if they had never taken the pill.

**Myth:** The pill will build up in the body.

**Fact:** Contraceptive pills dissolve in a woman's stomach, just like other medicines and food she eats and do not build up in the body.

## **PROGESTAGEN-ONLY PILLS (presentation)**

Progestagen-Only Pills (POPs), also known as mini-pills, contain only one synthetic hormone similar to the progesterone hormone produced by the woman's ovaries. The amount contained in each mini-pill is very low.

### ***How they work***

POPs work by:

- Thickening the cervical mucus, making it difficult for sperm to pass through.
- Blocking ovulation

### ***Effectiveness***

If they are used correctly and continuously, POPs are very effective for breastfeeding women: only 1 pregnancy in 100 women within the first year of usage. As they are commonly used, 2 women out of 100 breastfeeding women using POPs get pregnant within the first year of usage.

In non-breastfeeding women, the effectiveness is lower.

### ***Advantages***

- Are safe, effective, especially in breastfeeding women.
- Contain only one hormone, in a smaller quantity than the COCs.
- Can be used by women who cannot use COCs because of the estrogen.
- Do not interfere with sexual intercourse.
- Woman can become pregnant rapidly after stopping the pill (method is immediately reversible).
- May be beneficial for the woman's health:
  - Reduces the risk of benign breast disease
  - Decreases the risk of cancer of the female reproductive organs, and other genital problems (uterine fibroma).
  - May reduce the cramps and bleeding during menstrual periods.

### ***Disadvantages***

- Have some side effects.
- Must be taken every day at exactly the same hour.
- Do not protect against STIs/HIV.

### ***Possible Side Effects***

Most women experience no side effects. Occasionally, they may experience:

- Changes in menstrual bleeding (irregular menstrual periods or absence of periods)
- Unexpected bleeding or spotting between periods
- Breast tenderness
- Acne
- Increase appetite and weight gain.

## **INJECTABLE CONTRACEPTIVE – DEPO-PROVERA (presentation)**

### ***How Depo-Provera Works***

Depo-Provera works the same way as pills:

- It suppresses ovulation
- It creates a thick cervical mucus plug
- It thins out the inner lining of the uterus (endometrium)

### ***Effectiveness***

They are very effective: only 1 pregnancy in 300 women using the injectable in the first year.

### ***Advantages***

- Is a safe, very effective, long lasting method
- Is easy to use (only 4 injections per year) and offers privacy to the user
- Can be used by women who cannot use COCs, including breastfeeding women
- Does not interfere with sex life
- Has health benefits:
  - Reduces menstrual bleeding and thus prevents anemia
  - Decreases the risk of endometrial cancer, acute pelvic inflammatory disease and ectopic pregnancy

### ***Disadvantages***

- Has some side effects.
- Must be provided every 3 months by a health professional.
- It usually takes 6-10 months to become pregnant after stopping the injection
- Cannot be withdrawn from body after injection is given
- Does not protect against STIs/HIV.

### ***Possible Side Effects***

Most women experience:

- Changes in menstrual bleeding (prolonged or heavy bleeding, irregular menstrual periods or absence of periods for many months)
- Unexpected bleeding or spotting between periods

Occasionally, they may experience:

- Headache, dizziness, and mood changes
- Breast tenderness
- Acne
- Increase appetite and weight gain.

## **INTRA-UTERINE DEVICE (presentation)**

The IUD is a small plastic device (which may contain copper or progesterone hormone) that is placed in the uterus of a non-pregnant woman, where it acts as an effective, long-term, but reversible contraceptive.

The most commonly used IUD is a Copper T. The Copper T looks like the letter “T”. The stem of “T” is wound with copper wire. Effective life of the Copper-T 380 is ten years, meaning that once inserted in the women’s uterus, it can prevent pregnancy for ten years. Two thin nylon threads /strings are attached to its lower end and lie in the vagina. The threads are used in checking the IUD and in its removal.

### ***How it Works***

- The IUD prevents sperm from reaching the ovum as copper decreases their mobility.
- It prevents the eggs from being fertilized.

### ***Effectiveness***

The IUD is high effective: only 1 pregnancy in 125 women using the IUD in the first year

### ***Advantages***

- Is a safe, effective, long lasting method (up to 10 years)
- Is easy to use (once it is inserted, the woman has nothing else to do or to remember, except checking the strings regularly)
- Can be removed at any time by a trained health provider, according to the woman’s wishes or for medical reasons
- Immediate return to fertility upon removal
- Does not interfere with sexual intercourse
- Does not affect breastfeeding
- Has no interaction with medicines the woman may be taking
- After the initial follow-up visit, the woman needs to return to clinic only if there are any problems
- No supplies needed by the woman.

### ***Disadvantages/Limitations***

- May have some side effects
- Must be inserted and removed by a trained health professional
- Pelvic examination required and screening for RTIs/STIs recommended before insertion
- May induce changes in menstrual cycle pattern (Cooper IUDs)
- Women using IUDs need to check the strings regularly
- Does not protect against STIs, including AIDS (in fact it increases the risk of STIs in women with multiple partners or whose only constant partner has multiple sexual partners)

### *Possible Side Effects*

Most women experience no side effects. Occasionally, they may experience:

- During the first **3 to 5 days** after insertion
  - Mild cramps
  - Bleeding or spotting
- During the **first three months**:
  - Longer and heavier periods
  - Increased cramps during periods
  - Bleeding or spotting between periods

### **Myths and Facts about IUD**

**Myth:** The IUD can travel from the uterus to other places in the woman's body, such as the belly or heart.

**Fact:** The IUD usually stays in the uterus until a trained person removes it. If it comes out by itself, it usually comes out through the vagina. An IUD is too big to travel to the heart. Rarely, an IUD may puncture the wall of the uterus and rest in the abdomen beside the uterus.

**Myths:** The IUD causes discomfort and harm to the male partner during intercourse.

**Fact:** The male partner may sometimes "feel" the strings but they do not cause him discomfort or harm him. If the couple wants, the string may be trimmed accordingly. If the male partner feels the hard part of IUD, the woman should go for a check-up as the IUD might be coming out.

**Myth:** The IUD prevents pregnancy by destroying a fertilized egg.

**Fact:** IUDs work by preventing fertilization and not by destroying a fertilized egg (it is not an abortive method).

**Myth:** IUDs usually do not "suit" women and cause them harm.

**Fact:** IUDs are inserted after correctly checking/screening the woman for conditions that may cause health problems. Therefore, they usually do not cause health problems and are very well tolerated by most women.

## **VOLUNTARY SURGICAL CONTRACEPTION (presentation)**

### **FEMALE SURGICAL STERILIZATION or TUBAL LIGATION**

#### ***How Tubal Ligation Works***

This method involves blocking the fallopian tubes by cutting and tying or applying clips, rings, or bands. The sperm cannot travel beyond the blocked area and cannot reach the female egg or ovum, so there is no fertilization.

#### ***Effectiveness***

Is very high and depends on the surgical technique: less than 1 pregnancy per 200 women during the first year of use.

#### ***Common Immediate Side Effects***

- Pain at the operation site
- Fever after the operation
- Bleeding from the skin near the operation site

### **MALE SURGICAL STERILIZATION or VASECTOMY**

Is one of the safest, simplest, and most effective methods of contraception. The two Vas Deferens are tied at two places and cut.

#### ***How Vasectomy Works***

Sperm is produced in the man's testes. The two tubes (vas deferens) that carry sperm from both the testes to the urethra in the penis are cut and blocked. After the minor operation, the sperm produced in the testes cannot travel beyond the blocked ends of the vas deferens and can no longer enter the male seminal fluid (semen). However, the semen becomes sterile, or completely free of sperm, only after 20 ejaculations. Condoms or another contraceptive method should be used until then.

Vasectomy is not castration, where testes are removed. With vasectomy, the function of testes (sperm and male hormone production) is not affected; both continue to be produced. Sperm are reabsorbed by the body. The male hormones circulate via the blood vessels which are not effected by the vasectomy. The male hormones stimulate the man to have erections, sex drive, feelings, and ejaculations as before. A man may even feel his sex drive increase since he no longer has to worry about getting his partner pregnant. The amount, smell, appearance, and thickness of semen after the vasectomy appear the same as before.

#### ***Effectiveness***

It is one of the most effective methods of contraception. It is more effective than COCs, IUDs or condoms. The failure rate is less than 1 pregnancy in 200 women in the first year.

The most common cause of pregnancy after vasectomy is failure to use a contraceptive during the first 20 ejaculations or for 3 months after surgery.

### ***Common Immediate Side Effects***

- Pain at incision site
- Minor swelling of scrotum
- Bleeding or collection of blood (hematoma) in the scrotum
- Bruising or discoloration around incision site.

### **Advantages of VSC**

- Highly effective
- Effective immediately
- Permanent
- Does not interfere with intercourse
- Good for women for whom pregnancy would pose a serious health risk
- Simple surgery usually done under local anesthesia
- No long-term side effects
- No change in sexual function (no effect on hormone production by ovaries or testes)

### **Disadvantages/Limitations of VSC**

- Must be considered permanent (not reversible)
- Woman/man may regret later
- Small risk of complications (during anesthesia or intervention)
- Requires trained physician (gynecology specialist or surgeon)
- Does not protect against STIs and HIV/AIDS

## **Myths and Facts**

### **Myths and Facts about Tubal Ligation**

**Myth:** After tubal ligation a woman becomes less interested in sex.

**Fact:** Tubal ligation does not affect normal sexual function in any way. The woman's body continues to produce female hormones, and the woman's sex drive is not changed. The hormones pass through the blood vessels, which are not affected by the tubal ligation. Many women enjoy sex even more because they are not worried about getting pregnant

**Myth:** Tubal ligation causes early menopause.

**Fact:** Tubal ligation does not affect menopause in any way. A woman continues having her monthly periods after tubal ligation, since she still has her uterus and ovaries and still produces the normal female hormones.

**Myth:** Tubal ligation makes a woman weak and she can no longer perform her day-to-day work.

**Fact:** Tubal ligation is a very small operation and has no ill effects on the woman's health. In fact, her health improves as she does not bear any more children. She can perform her day-to-day work without any problem.

## **Myths and Facts about Vasectomy**

**Myth:** A vasectomy is a big operation that reduces the person's strength and ability to work.

**Fact:** A vasectomy is a very small operation and has no ill effects on the health of the person. After a vasectomy, the man can resume normal activity after 2-3 days.

**Myth:** A vasectomy makes the man impotent and he cannot have a normal sex life.

**Fact:** A vasectomy does not affect the sexual performance of the man in any way because the testes continue to produce the male hormone as before and with a vasectomy, only the tubes carrying the sperm from the testes to the penis are blocked. The hormones pass through the blood vessels, which are not affected by the vasectomy.

**Myth:** After the vasectomy, there will be no sexual fluid (semen) during intercourse.

**Fact:** After a vasectomy, the semen remains the same as before in terms of amount, smell, appearance and thickness. The only difference is that it does not contain sperm.

**Myth:** A vasectomy causes the testes to shrink.

**Fact:** A vasectomy does not effect the size of the testes in any way.

## METHODS OF CONTRACEPTION – FACT SHEETS

### **Lactational Amenorrhea Method (LAM)**

Explain the following to the woman:

#### **When LAM Can Be Used**

- Her menstrual period has not returned.
- She is breastfeeding her baby exclusively at least every 4 hours during the day and at least every 6 hours at night, and her baby receives very little or no other food besides breast milk.
- The baby is less than six months old.
- If all the above conditions are met, then LAM can be used. A longer term family planning method should be decided upon and started before LAM is no longer effective.

#### **When LAM Cannot Be Used**

When any one or more of the following are true:

- Baby reaches six months of age.
- Menstrual bleeding begins.
- The baby is receiving supplemental foods.

#### **How to Make Breastfeeding Effective**

- Breastfeed on demand, day and night, and feed from both breasts.
- Avoid intervals of more than four hours between any daytime feeds and more than six hours between any nighttime feeds.
- Breastfeed exclusively or nearly exclusively for about six months.
- Do not use pacifiers, nipples, or bottles.
- Express breastmilk if separated from the baby.
- Do not give the baby other liquids. If the baby is thirsty, the mother should drink more.

#### **LAM Does Not Protect Against STIs/HIV**

To protect against STIs/HIV and provide further protection against pregnancy, use a condom for every act of intercourse.

#### **Reasons to Return to Provider**

- Anytime there is a problem with the method.
- If you condoms or other contraceptive method.
- Either partner thinks s/he may have been exposed to a STI.

## **Male Condom**

Show the client the condom and explain/demonstrate the following:

### **How to Use a Condom**

- Check the expiration date on the condom package.
- Open the package carefully so the condom doesn't tear.
- Do not unroll the condom before putting it on.
- Place the unrolled condom on the tip of the erect penis.
- Hold the tip of the condom with the thumb and forefinger.
- Unroll the condom until it covers the penis.
- Leave enough space at the tip of the condom for the semen.
- After ejaculation, hold the rim of the condom and pull the penis out of the vagina before it becomes soft.
- Burn or bury the condom, do not flush it down the toilet.

### **Condom Care**

- Do not apply oil-based lubricants (like baby oil, cooking oil, petroleum jelly/Vaseline), because they could destroy the condom. It is safe to use clean water, saliva, or water-based lubricants.
- Store condoms in a cool, dry place. Do not carry them near the body, because heat could destroy them.
- Use each condom only once.
- Do not use a condom from a broken package, or if the condom is dry, sticky, or the color has changed.
- Take care to dispose of used condoms properly.

### **Possible Side Effects**

Most people experience no side effects.

Occasionally, they may experience an allergic reaction, which causes:

- Itching
- Burning
- Swelling

### **Reasons to Return to Provider**

- Anytime there is a problem (condom breaks or unhappy with method).
- A re-supply is needed (never run out completely before returning).
- Either partner thinks s/he may have been exposed to a STI.

**Have the Client Repeat this Information Back to You and Demonstrate Proper Condom Use.**

## **Combined Oral Contraceptives (COCs)**

Show the woman the pill packet and explain that the method is provided by a doctor.

### **How to Use the Pills**

- Take first pill on the first day of your menstrual period or any of the next four days.
- Take one pill every day, at the same time of day. Keep pills in a place that is easy to remember such as near where you brush your teeth every night.
- 28-day packet: Upon finishing a packet, begin a new one the following day.
- 21-day packet: Upon finishing a packet, wait seven days and then begin a new one. To remember when to start up again, mark it on a calendar.

### **Missed Pills – What to Do**

Missed pills may result in pregnancy.

- If one pill is missed, take it as soon as you remember. Take the next pill at the regular time.
- If two or more pills are missed, ask the doctor how to proceed.
- Use a backup method for a week.

### **Possible Side Effects**

Most women experience no side effects.

Occasionally, they may experience some of the following side effects

- Nausea
- Unexpected bleeding or spotting
- Breast tenderness
- Headaches or dizziness
- Increase appetite and weight gain

### **The Pill Does Not Protect Against STIs/HIV**

To protect against STIs/HIV and provide further protection against pregnancy, use a condom during every act of intercourse.

### **Reasons to Return to Provider**

- Chest pain or shortness of breath
- Severe headaches (with blurred vision)
- Anytime there is a problem with the method.
- Either partner thinks s/he may have been exposed to a STI.
- A re-supply of COCs or condoms is needed (never run out completely before returning).

## **Progestagen-Only Pills (POPs)**

Show the woman the pill packet and explain that the method is provided by a doctor.

### **How to Use POPs**

- Start by taking first mini-pill on the first day of your menstrual period.
- If you recently delivered, you can start taking mini-pills at 6 weeks after delivery or at any time if you are reasonably sure that you are not pregnant again.
- Take one mini-pill every day, at the same hour of the day, without any break (take the first pill from the new packet on the very next day after you have finished your last packet).
- Keep your pills in a place that is easy to remember such as near where you brush your teeth every night.

### **Missed POPs – What to Do**

Missed mini-pills may result in pregnancy.

- If you are breastfeeding and you missed one pill, you are still protected
- If you are breastfeeding, but your periods returned after delivery, OR if you are not breastfeeding and more than 3 hours passed from the time you are taking the pills ask the doctor how to proceed. Take the next pills each day as usual.
- You should use condoms or spermicides or avoid sexual intercourse for the next 3 days.

### **Possible Side Effects**

Most women experience no side effects.

Occasionally, they may experience some of the following side effects

- Changes in menstrual bleeding (irregular menstrual periods or absence of periods)
- Unexpected bleeding or spotting between periods
- Breast tenderness
- Acne
- Increase appetite and weight gain.

### **The Pill Does Not Protect Against STIs/HIV**

To protect against STIs/HIV and provide further protection against pregnancy, use a condom during every act of intercourse.

### **Reasons to Return to Provider**

- Extremely heavy bleeding (twice as long or as much as usual)
- Bad headaches that start or become worse after starting to take POPs
- Missed period after several regular cycles
- Anytime there is a problem with the method
- Either partner thinks s/he may have been exposed to a STI.
- A resupply of POPs or condoms is needed (never run out completely before returning).

## **DMPA Injectable Contraceptive**

Show the woman the vial of DMPA and explain that the method is provided by a doctor.

### **How to Use DMPA**

- DMPA is given by injection every three months.
- Identify a way to remember to return in three months (e.g. write it down on a calendar).
- Never be more than two weeks late for a repeat injection.
- Do not press the injection place.

### **Missed Injection – What to do**

- If the injection is given after day seven of the cycle, a backup method should be used for 24 hours.
- If unable to come at the appointed time, it is possible to come up to four weeks early for the second injection, or up to two weeks late.

### **Possible Side Effects**

Most women experience no side effects.

Occasionally, they may experience some of the following side effects:

- Irregular spotting
- Prolonged light to moderate bleeding
- Bleeding that becomes lighter, less frequent, or stops altogether
- Weight gain or headaches

### **DMPA Does Not Protect Against STIs/HIV**

To protect against STIs/HIV and provide further protection against pregnancy, use a condom during every act of intercourse.

### **Reasons to Return to Provider**

- Heavy vaginal bleeding
- Excessive weight gain
- Headaches
- Anytime there is a problem with the method.
- Another three-month injection or a re-supply of condoms is needed (never run out completely before returning).
- Either partner thinks s/he may have been exposed to a STI.

## **Intrauterine Device (IUD)**

Show the woman the IUD and explain that the method is provided by a gynecologist.

### **How to Use the IUD**

- The IUD is inserted into the uterus and can stay there for up to 10 years.
- Follow-up is not required after the first three to six week checkup (unless there is a problem or national guidelines specify other protocols).
- After every menstrual period, check to see if strings are in place. If they are missing, are shorter or are longer, see the medical doctor.

### **Possible Side Effects**

Most women experience no side effects.

Occasionally, they may experience some of the following side effects:

- Cramping
- Pain during and immediately after insertion
- An increase in vaginal discharge
- An infection
- Heavier and/or longer periods, which normally decrease during the first and second years.

### **The IUD Does Not Protect Against STIs/HIV**

To protect against STIs/HIV and provide further protection against pregnancy, use a condom during every act of intercourse.

### **Reasons to Return to Provider**

- Abnormal bleeding or discharge\*
- Pain (abdominal or pain with intercourse)\*
- Fever\*
- Period is late or missing period\*
- Strings are missing, are shorter, or are longer\*
- Anytime there is a problem with the method.
- A re-supply of condoms is needed (never run out completely before returning).
- Either partner thinks s/he may have been exposed to a STI\*

\*Immediately contact health care provider or clinic if you develop any of these problems.

## Voluntary Surgical Contraception

Explain that VSC is provided by high-trained health professionals in hospitals.

### Who Can Use VSC

- A man or a woman who is fully informed and is absolutely certain that s/he wants no more children
- Women who have a health condition which makes pregnancy very risky.

These are **permanent, irreversible** methods. They are safe and relatively free of side effects. Once the couple completes the size of its family, the man or the woman may opt for permanent contraception.

### Types of VSC

- Female Sterilization or Tubal Ligation for women
- Male Sterilization or Vasectomy for men

Both are minor operations, generally performed by injecting local anesthesia at the site of operation. Vasectomies are relatively simpler, safer, and less expensive than tubal ligation.

### Effectiveness

Is very high and depends on the surgical technique: less than 1 pregnancy per 200 women during the first year of use.

### Common Immediate Side Effects

- Pain at incision site
- Minor swelling near operation site
- Bruising or discoloration around incision site.
- Bleeding or collection of blood (hematoma) in the scrotum (vasectomy)

## **Emergency Contraception Pills (ECPs)**

Explain the woman that ECPs are provided by health professionals.

### **How to Use ECPs**

- Swallow the tablets provided by health professionals as soon as possible after unprotected sex. Do not delay treatment unnecessarily as effectiveness decreases over time.
- Swallow the second dose 12 hours after the first dose.
- Important: ECPs can be used for up to five days (120 hours) after the occurrence of unprotected sex.
- If vomiting occurs within one hour after either dose, repeat the dose. If vomiting is severe, go to the doctor.
- To reduce nausea, take the tablets after eating or before going to bed.

### **Possible Side Effects**

Most women experience no side effects.

Occasionally, they may experience the following side effects:

- Nausea
- Vomiting
- Headaches or dizziness
- Cramping
- Breast tenderness

Side effects generally do not last for more than 24 hours.

### **What to Expect After Using ECPs**

There will not be any immediate signs showing whether the ECPs worked.

The menstrual period should come on time (or a few days early or late).

### **Reasons to Return to Provider**

- Period is more than a week later than expected.
- Any other cause for concern.

Encourage the woman to visit a family planning provider who will offer her contraceptive counselling and, if she chooses, a method of contraception. Explain that condoms must also be used with the method, in order to protect against STIs/HIV.

## **SESSION 5: STANDARD DAYS METHOD (SDM)**

**OBJECTIVES:** By the end of the session, the participants should be able to:

1. Demonstrate thorough knowledge about the SDM.
2. Demonstrate how to assess women interested in using the SDM.
3. Demonstrate how to use Cycle Beads and the various SDM job aids (Cycle Beads, Cue Card, Provider Calendar, and Provider Job Aids for Initial and Follow-Up Visits).

**TRAINING METHODS:** Presentation, brainstorming, case study, demonstration, role-play

**TIME:** 2 hours 15 min (or less for promoters)

### **MATERIALS:**

- Cycle Beads

#### Trainer documents:

- Standard Days Method (presentation)
- Case Studies (answers)
- Role-plays scenarios

#### Participant documents:

- Cue Card SDM
- Calendar
- Case Studies
- Initial Visit Screening Checklist for SDM
- Follow-up Visit Checklist
- Frequent Asked Questions about SDM

## **INSTRUCTIONS:**

### **I. DESCRIPTION OF SDM (15 minutes)**

Give Cycle Beads to each participant. Allow them 1 minute to observe the Cycle Beads. Referring to the previous session about menstrual cycle and fertility, ask participants:

- What do you think each beads represents?

Every bead represents a day from the menstrual cycle.

- Why the beads have different colors?

They represent different days of the menstrual cycle: the red bead means that menstruation started, the brown beads indicate the unfertile days and the white beads indicate the fertile days.

Using the trainer's document *Standard Days Method*, make a short presentation of the method.

[**Note:** keep the presentation as simple as possible, without too many details that could overloaded participants]

- How many beads do you have?

32 beads

- What this might mean?

Women having menstrual cycles longer than 32 days cannot use the SDM/Cycle Beads.

Invite participants to observe that a dark brown bead is on each cycle and ask them to count the number of beads between the first day (menstruation) and this bead. Ask:

- How many beads there are before the dark brown bead?

26 beads

- What this might mean?

Women having menstrual cycles shorter than 26 days cannot use the SDM/Cycle Beads.

Explain how the beads are used:

- On the first day of your period, move the ring to the red bead. Also mark that day on your calendar.
- Every morning move the ring to the next bead. Always move the ring in the direction of the arrow, from narrow to wide end. Move the ring even on days when you have your period.
- If you forget whether you moved the ring, check in your calendar when your period began. Count the days since your period began and move the ring the same number of beads starting with the RED bead.
- When the ring is on a BROWN bead you can have sexual intercourse. These are days when pregnancy is very unlikely.
- When the ring is on a WHITE bead day, avoid unprotected sex. These are days when you can get pregnant if you have unprotected sex.
- The day your next period starts, move the ring to the RED bead again. Skip over any remaining beads. Your period signals that a new cycle has started.
- Contact your provider if you start your period before you put the ring on the DARK BROWN bead. Also contact your provider if you have not started your period by the day after you put the ring on the last BROWN bead. In these situations it is possible that this method may not be appropriate for you.

[**Note:** demonstrate CycleBeads using while you explain these, and invite participants to do the same]

Explain that the movement of the ring could be a little difficult at the beginning, but in time this will be easier.

Distribute participants the Cue-card *Standard Days Method (Cycle Beads)*. Check if they have any questions and explain that this job-aid will help them to conduct discussion with clients in their communities, using the drawings to explain the method.

**Summarize:**

- CycleBeads are based on a natural family planning method called the Standard Days Method (SDM). This method is more than 95% effective when used correctly.
- A woman can use this method if her cycles last between 26 and 32 days. To use it effectively, the couple needs to avoid unprotected intercourse on days when the woman can get pregnant.

**II. EVALUTION OF CLIENTS FOR SDM USING (20 minutes)**

Ask participants:

- Who can use this method?

Note their answers on the flipchart

*Possible answers:*

- Women who have the cycles between 26 and 32 days
- Couples who jointly decided to avoid a pregnancy
- Couples able to avoid intercourse for 12 days (during the fertile period)
- Couples at no risk for sexually transmitted infections

If the list provided with participants' inputs is not including all the above criteria, add them on the list and explain their importance. Emphasize that the method addresses to a couple and is very important to ask woman questions which will help her to think about method appropriateness for her and her partner.

Underline “cycles between 26 and 32 days” on the list. Remind participants what menstrual cycles means.

Demonstrate how one can determine if the client's menstrual cycle length is 26 to 32 days, using a list of questions and a calendar:

[**Note to the trainer:** prepare in advance a flipchart with one month calendar with big figures, visible to all participants]

Ask the following questions:

- Do your periods usually come when you expect them?
- When was the first day of your most recent period? (note the day in the calendar on the flipchart)

- When do you expect your next period? (note this day, too)
- *Calculate cycle length* —

If the woman cannot remember the date her period started, ask:

- Do your periods usually come when you expect them?
- Do your periods usually come about a month apart?

— *Estimate whether her cycle is between 26 and 32 days long* —

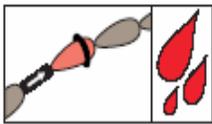
Divide the group in small groups of 2 or 3. Give each small group a case study (see participants material *Case Studies*) and a calendar. Invite them to determine if the woman from their case study can use SDM. Give them 5 minutes for this task.

One representative of each group will present the case and their answer in front of the large group. Conduct a discussion about each situation, using the answer mentioned in the trainer's document *Case Studies (answers)*. Review the eligibility criteria with participants, if needed.

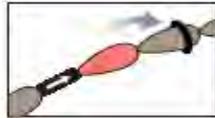
## CYCLE BEADS

- CycleBeads are based on a natural family planning method called the Standard Days Method (SDM). This method is more than 95% effective when used correctly.
- CycleBeads help a woman know on which days she can get pregnant. Using CycleBeads a woman keeps track of her days to know when to avoid unprotected intercourse in order to prevent a pregnancy.
- CycleBeads represent the menstrual cycle. The menstrual cycle begins on the first day of the period (menstrual bleeding) and ends the day before the next period. Each bead is a day of the cycle. The RED bead marks the first day of the period. The WHITE beads represent days when a woman CAN GET PREGNANT. The BROWN beads represent days when pregnancy is unlikely.
- A woman can use this method if her cycles last between 26 and 32 days. To use it effectively, the couple needs to avoid unprotected intercourse on days when the woman can get pregnant.

### INSTRUCTIONS FOR USE



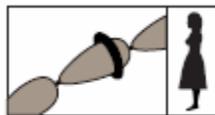
On the first day of your period, move the ring to the red bead. Also mark that day on your calendar.



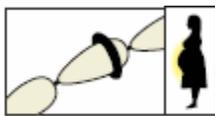
Every morning move the ring to the next bead. Always move the ring in the direction of the arrow, from narrow to wide end. Move the ring even on days when you have your period.



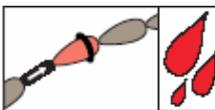
If you forget whether you moved the ring, check in your calendar when your period began. Count the days since your period began and move the ring the same number of beads starting with the RED bead.



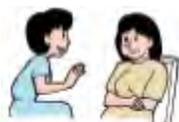
When the ring is on a BROWN bead you can have sexual intercourse. These are days when pregnancy is very unlikely.



When the ring is on a WHITE bead day, avoid unprotected sex. These are days when you can get pregnant if you have unprotected sex.



The day your next period starts, move the ring to the RED bead again. Skip over any remaining beads. Your period signals that a new cycle has started.



Contact your provider if you start your period before you put the ring on the DARK BROWN bead. Also contact your provider if you have not started your period by the day after you put the ring on the last BROWN bead. In these situations it is possible that this method may not be appropriate for you.

**CASE STUDIES (statements)**

**Case 1**

Elena is 25 year old. She ususally gets her menstrual period every month at about the same day of the month. Sometimes it comes a day or two late. The first day of her last period was October 24. she expects her next period to start on November 22.

Please determine:

- What is her cycle length?
- If today is November 1<sup>st</sup>, what day of her cycle is she on today?
- Can the SDM work for her today?

**Case 2**

Maria is 45 years old. The first day of her last menstrual cycle was November 6. She is not sure when the next period will be. Sometimes it comes in about three weeks; sometimes two or three months go by and she still doesn't get her period. Her cycles used to be regular, but now she never knows when her next period will come.

Please determine:

- What is her cycle length?
- If today is November 23, what day of her cycle is she on today?
- Can the SDM work for her today?

**Case 3**

Ann is 30 years old. She uses a calendar to mark when she gets her period and brought her calendar to show you. Her last menstrual period started on November 7. The one before started on October 3. The cycle before that started August 29.

Please determine:

- How long were Ann's last two cycles?
- Can the SDM work for her today?

**Case 4**

Monica has been breastfeeding her daughter for the past 18 months. For the past year, she has had her period every month at about the same time. Her last period started November 5 and she expects her next period the first week of December, probably December 2 or 3.

Please determine:

- What is her cycle length?
- Can the SDM work for her today?

**Case 5**

Christina gave birth to her baby two months ago and she is interested in the SDM. She plans to breastfeed for at least a year. She has not gotten her period yet.

Please determine:

- What is her cycle length?
- Can the SDM work for her today?

**Case 6**

Jane stopped using birth control pills two months ago. Her period returned right away and seems to be normal, just like it was before she took the pill. The first day of her last menstrual period was October 25. She expects her next period to start on November 22. She knows that her period before that started on September 25, because that was her wedding anniversary. The period before that was regular too- it came at the same time it always does.

Please determine:

- What is her cycle length?
- Can the SDM work for her today?

**CASE STUDIES (answers)**

**Case 1**

Elena is 25 year old. She ususally gets her menstrual period every month at about the same day of the month. Sometimes it comes a day or two late. The first day of her last period was October 24. she expects her next period to start on November 22.

Please determine:

- What is her cycle length? **29 days**
- If today is November 1<sup>st</sup>, what day of her cycle is she on today? **She is on the day 9 of her cycle.**
- Can the SDM work for her today? **Yes**

**Case 2**

Maria is 45 years old. The first day of her last menstrual cycle was November 6. She is not sure when the next period will be. Sometimes it comes in about three weeks; sometimes two or three months go by and she still doesn't get her period. Her cycles used to be regular, but now she never knows when her next period will come.

Please determine:

- What is her cycle length? **Unknown**
- If today is November 23, what day of her cycle is she on today? **She is on the day 18 of her cycle.**
- Can the SDM work for her today? **No. Offer other method or refer her to Family planning services.**

**Case 3**

Ann is 30 years old. She uses a calendar to mark when she gets her period and brought her calendar to show you. Her last menstrual period started on November 7. The one before started on October 3. The cycle before that started August 29.

Please determine:

- How long were Ann's last two cycles? **35 days**
- Can the SDM work for her today? **No. Offer other method or refer her to Family planning services.**

**Case 4**

Monica has been breastfeeding her daughter for the past 18 months. For the past year, she has had her period every month at about the same time. Her last period started November 5 and she expects her next period the first week of December, probably December 2 or 3.

Please determine:

- What is her cycle length? **About 27 to 28 days.**
- Can the SDM work for her today? **Yes, ask questions and use the calendar to check to see if the last three menstrual cycles have been 26 to 32 in length.**

### Case 5

Christina gave birth to her baby two months ago and she is interested in the SDM. She plans to breastfeed for at least a year. She has not gotten her period yet.

Please determine:

- What is her cycle length? **Unknown**
- Can the SDM work for her today? **No, not today. Offer other method or refer her to Family planning services. She can be reassessed once she has had three complete menstrual cycles postpartum.**
- 

### Case 6

Jane stopped using birth control pills two months ago. Her period returned right away and seems to be normal, just like it was before she took the pill. The first day of her last menstrual period was October 25. She expects her next period to start on November 22. She knows that her period before that started on September 25, because that was her wedding anniversary. The period before that was regular too- it came at the same time it always does.

Please determine:

- What is her cycle length? **28 days**
- Can the SDM work for her today? **Yes, her menstrual cycles were between 26 and 32 days before using the pill.**

## Participant document

### **WHO CAN USE SDM?**

The majority of women can use the SDM.

A woman can use the SDM if:

1. She has regular menstrual cycles between 26 and 32 days long; and
2. She and her partner can avoid unprotected intercourse on days when she can get pregnant.

This method is appropriate for women who meet the criteria mentioned previously, EXCEPT:

- Postpartum or breastfeeding women until they have had three menstrual cycles (i.e. four consecutive periods), and
- Their most recent cycle was between 26 and 32 days long.

Users of the 3-month contraceptive injection, until 3 months have passed since the last injection and their most recent cycle was between 26 and 32 days long.

There are no restrictions for using the SDM among women who recently have used oral contraceptives, one-month injection, implant, or emergency contraception. These women can use the SDM if their cycles prior to using these methods lasted between 26 and 32 days.

Women who recently used an IUD can use the SDM if their cycles while using the IUD were between 26 and 32 days long. Use of the IUD does not affect cycle length.

Women who recently experienced an abortion or a miscarriage also can use the SDM if their cycles prior to becoming pregnant lasted between 26 and 32 days.

## Standard Days Method Provider Job Aid – Initial Visit

### Assessment Criteria for Selecting the Method

#### Can the SDM work for the woman?

NO	Does the woman have regular cycles between 26 and 32 days long?	YES
NO	Do her periods usually come when she expects them?	YES
NO	If she is postpartum or breastfeeding, has her menses returned and has she had at least three consecutive cycles? Was her last cycle between 26 and 32 days long?	YES
NO	If she was using the 3-month contraceptive injection, have three months passed since the last injection? Was her last cycle between 26 and 32 days long?	YES
NO	If she was using oral contraceptives, the implant, the 1-month injection, or emergency contraception, were her cycles prior to using any of these methods between 26 and 32 days long? Was her last cycle between 26 and 32 days long?	YES
NO	If she had an IUD, did her cycles last between 26 and 32 days while using the IUD ?	YES
NO	If she recently had a miscarriage or an abortion, did her cycles last between 26 and 32 days before getting pregnant?	YES
NO	Has she decided that the method is appropriate for her and her partner?	YES

#### Can the SDM work for the couple?

NO	Do both partners want to avoid pregnancy at this time?	YES
NO	Do both partners think they can avoid unprotected sexual intercourse on days when the woman can get pregnant?	YES
NO	Are both partners not at risk for sexually transmitted infections?	YES

▲

**If the answer is NO to any of the above questions, the SDM is not appropriate for the woman and her partner.**

▲

**If the answer to the above questions is YES, the SDM is appropriate for the woman and her partner.**

## HOW TO USE “INITIAL VISIT” SCREENING CHECKLIST

A woman can use the method if her cycles are between 26 and 32 days long and if she and her partner can avoid unprotected sex during the fertile days. This screening checklist will help providers determine if the woman and couple meet the method eligibility criteria. It begins with questions pertaining to the woman and then moves on to questions pertaining to the couple.

### Women with menstrual cycles between 26 and 32 days long

The first section begins with questions that help the provider and the woman determine if she has regular cycles between 26 and 32 days long.

**1. Does the woman have regular cycles between 26 and 32 days?** This question is designed to help the provider determine if the woman has cycles within the range recommended for SDM users. The woman’s cycle length includes all days between the first day of her last period and the day *before* she expects her next period. Using a calendar the provider calculates the woman’s cycle length by marking the first day of her most recent period and the day she expects her next period. The provider then counts the days to establish the woman’s cycle length.

#### ***Recommended Questions:***

- How often do you get your periods?
- Do your periods usually come when you expect them?
- When was the first day of your most recent period?
- When do you expect your next period to start?
- Do your periods ever come earlier or later than you expect them?

All women will have some variability with their menstrual cycles. This question helps the provider determine if the woman frequently has shorter or longer periods. If the woman has more than more than one cycle out of the 26 to 32-day range per year, she should consider another method.

**If the woman does not remember the date her period started,** estimate if her cycle is between 26 and 32 days long by asking:

- Do your periods come about a month apart?
- Do your periods come when you expect them?

She must answer yes to both questions for the provider to establish that her cycles are between 26 and 32 days long. Having periods about a month apart is a good indicator that her cycles are within the appropriate range.

### Women under special circumstances

Providers should determine if the woman recently had a pregnancy, currently is breastfeeding or using/has recently used a hormonal method of family planning, as these circumstances may affect cycle length. If any of these circumstances apply, ask her the questions pertaining to her special circumstance.

**2. If she is postpartum or breastfeeding, has she had 4 periods (3 consecutive cycles) since her baby was born? Was her last cycle between 26 and 32 days?** These questions are designed to help the provider determine if a postpartum or breastfeeding woman is having regular menstrual cycles. She can start using the SDM only if she has had at least four normal periods (3 consecutive menstrual cycles), and her last cycle was within the 26 to 32-day range.

***Recommended questions for postpartum or breastfeeding women:***

- How old is your youngest child?
- Are you currently breastfeeding?
- Has your period returned?
- How many periods have you had since your baby was born?
- Were your last 2 periods about a month apart?

**3. If she recently used the 3-month contraceptive injection, have three months passed since her last shot? Has her period returned? Was her last cycle between 26 and 32 days?**

Since the three-month injection frequently causes changes in the woman's menstrual cycle, it is important for the service provider to ensure that the woman has stopped using the method and three months have passed since her last injection. It is also important to determine whether her most recent menstrual cycle was between 26 and 32 days.

***Recommended questions for previous users of the 3-month injection:***

- When did you have the last injection?
- When were you supposed to get your next injection?
- Since your last injection, have you had your period?
- Was your most recent cycle between 26 and 32 days long? Before using the injection, did your periods start when you expected them?

**4. If she recently used the contraceptive pill, patch, 1-month contraceptive injection, implant, hormonal IUD, ring or emergency contraception, were her cycles between 26 and 32 days prior to using any of these methods?**

This question is designed to determine if the woman regularly had menstrual cycles between 26 and 32 days before using these hormonal methods. If a woman is still taking the pill at the time she receives counseling on the SDM, she should be advised to finish her current pack of pills and to begin using the SDM on the day she starts her next period. If a woman is still using other hormonal method, she is also advised to begin using the SDM on the day she starts her next period.

**5. If she was using a non-hormonal IUD, has it been removed? Were her cycles between 26 and 32 days while using this IUD? Was her last cycle between 26 and 32 days?**

This question is designed to ensure that a previous IUD user has had it removed and that her cycles were between 26 and 32 days while she was using it. If a woman still has the IUD at the time she gets information on the SDM, she should be advised to **wait** until it has been removed. After the IUD has been removed, she can begin using the SDM immediately if she remembers the first day of her last period. However, if she does not remember this date, she should begin using the SDM on the day her next period starts.

**6. If she recently had a miscarriage or an abortion, were her cycles between 26 and 32 days before getting pregnant?**

This question is designed to determine if the client's menstrual cycles prior to getting pregnant were between 26 and 32 days. If yes, the woman can begin using the SDM on the day her next period starts.

***Recommended questions for a woman with a recent miscarriage or abortion:***

- Before you were pregnant, did your periods come when you expected them?
- Has any bleeding related to the loss of your pregnancy stopped?
- Have you started having your period again?

**Couples who can avoid unprotected sex during the fertile days**

This section of the checklist is designed to identify and explain issues related to the couple relationship and how to assess whether they can use the method effectively. In general, it is designed to help the provider determine if the method is appropriate for the couple based on relationship issues and the degree of communication that exists, whether there is any risk of STIs, and how likely they are to be able to manage the woman's fertile days.

**7. Do both partners want to avoid pregnancy at this time?**

This question is important to confirm that both partners do not want a pregnancy at this time and whether both partners would agree to use the method and be motivated to avoid unprotected sex. A conflict between partners regarding pregnancy intentions would make it very difficult for the couple to avoid unprotected sex on the white bead days, an essential requirement of the SDM. If the couple does not have open communication regarding pregnancy intentions, or does not agree on pregnancy avoidance, then the SDM may be a difficult method for them to use.

***Recommended question:***

- Are you able to discuss openly and freely with your partner whether you want to have children?
- Have you agreed that it is important to both of you not to get pregnant right now?
- Have you discussed using a family planning method?

**8. Do both partners think they can avoid unprotected sex on days when the woman can get pregnant?**

This question is designed to help the user and provider identify whether the couple might have problems avoiding unprotected sex. The question is also meant to identify whether the woman is able to tell her partner on any given day whether or not she wants to have sex and whether her partner respects and supports that decision.

***Recommended questions:***

- How do you think your partner would feel about avoiding unprotected sex on the white-bead days?
- What about you?

- What will you and your partner do to prevent pregnancy during the fertile days?
- Can you think of situations when avoiding sex might create a problem in your relationship?
- What has your partner's reaction been in the past when you haven't wanted to have sex?
- Have both of you talked about what you will do to prevent pregnancy during the fertile (white bead) days?
- How might you and your partner let each other know on which days you can have sex?
- What problems do you think you both may have using this method?

**9. Are both partners free of risk for sexually transmitted infections?**

This question is designed to determine if the woman perceives that there may be a risk of sexually transmitted infection (STI) and to inform her that the SDM does not protect against HIV/AIDS or STIs. In circumstances where either partner has sex with more than one person, there may be a risk.

***Recommended questions:***

- People who have sex with more than one person are at risk for getting a sexually transmitted infection. Since you have been involved with your current partner, have either of you been diagnosed with a sexually transmitted infection?
- How likely is it that either of you might be at risk of getting a sexually transmitted infection?

**10. When can a woman who meets the eligibility criteria start using the SDM?**

If she has decided to use the SDM, help her determine when she can begin using the method.

- Women who remember the date of their last period can start using the method immediately by placing the ring on the correct bead. For a woman who is past cycle day 7 when she starts the SDM, tell her she may already be pregnant if she has had unprotected sex this cycle.
- Women who don't remember the start date of their last period can begin using the SDM on the first day of their next period. They should use another method until they can start the SDM.
- Women who are post-partum or breastfeeding should wait until they have four periods and the last one is between 26 to 32 days long to start using the SDM.
- Women who have recently used the 3-month injection should wait until 3 months have passed since the last shot and her last cycle is between 26 to 32 days long.
- Women who have recently stopped the pill or any other hormonal method, and women who have had a miscarriage, abortion, or used emergency contraception can start the SDM on the first day of their next period. These women should use a back-up method until they're able to start using the SDM.

## **FREQUENT ASKED QUESTIONS**

### **What if a woman forgets whether or not she has moved the ring on her CycleBeads?**

We recommend that a woman who uses CycleBeads also use a calendar to mark the first day of her cycle – the day her period starts. That way, if she is not sure whether or not she has moved the ring on any particular day, or whether it may have been moved accidentally, she can check her calendar. To confirm that the ring is on the correct bead, she counts from the day she started her period up until today, and then counts the same number of beads. The ring should be on the corresponding bead on her CycleBeads.

### **How do couples normally manage the 12-day fertile time?**

Couples have used different strategies for managing the fertile time. The method allows users to be aware of the days during the menstrual cycle when there is a possibility of pregnancy. Couples who use the SDM may choose to manage their fertile days in different ways. Some couples prefer to avoid intercourse completely during the fertile days. Other couples prefer to use condoms or other barrier methods during the fertile days. The most important element, however, to managing the fertile period is open communication between both partners.

### **What if the woman thinks that she might be pregnant?**

If the woman thinks she might be pregnant or if 42 days or more have passed since her last period started, she should be referred for a pregnancy test. If the pregnancy test is negative and this is the first time that her cycle is out of the 26-32 day range, she may continue to use the method with caution. She should return if she has a delayed period again. If the test is positive, offer her appropriate counseling and refer the woman for prenatal care.

### **What if the woman reports bleeding between periods?**

In case of minor spotting, inform the woman that this is probably a normal sign of impending ovulation, rather than a sign of a health problem. Otherwise, counsel her according to the service delivery guidelines or refer her for an assessment for unusual vaginal bleeding.

## **FOLLOW-UP VISIT CHECKLIST**

### **Who can continue using the SDM?**

This section of the checklist is designed to help providers determine whether the woman continues to have cycles between 26 and 32 days.

#### **1. Have her menstrual cycles been between 26 and 32 days?**

This question is designed to help the service provider determine if the woman continues to have cycles within the recommended range for SDM users. Check the woman's calendar to see if she has had any cycles shorter than 26 days or longer than 32 days. All women will have some variability with their menstrual cycles. If she has had only one cycle out of the 26 to 32 day range, inform her that she may still use the method. However, she should be careful and pay close attention to the length of her cycle. If the woman has more than one cycle out of the 26 to 32 day range per year, recommend that she considers another method.

##### *Recommended Questions:*

- Was your last period a normal period for you?
- Has your period ever started before placing the ring on the dark brown bead?
- Have you ever put the ring on the last brown bead and not gotten your period by the next day?
- Have you had any bleeding in between your periods?

In case of minor spotting, inform the woman that this is a normal sign of impending ovulation, rather than a sign of a health problem. Otherwise counsel her according to service delivery guidelines or refer her for an assessment for unusual vaginal bleeding.

#### **2. Was her most recent cycle still between 26 and 32 days?**

This question is designed to remind the provider to calculate the user's cycle length again to ensure that it is still within the 26 to 32 day range. It is recommended that the provider use the calendar to calculate her cycle length by marking the first day of her most recent period on the calendar and the day she expects her next period. The provider then counts the days to determine the woman's cycle length.

##### *Recommended Questions:*

- When was the first day of your most recent period?
- When you do expect your next period?

### **Does the SDM still work for the couple?**

This section of the screening checklist is designed to identify and explain issues related to the couple's relationship and how to assess whether they are using the method effectively.

#### **3. Do both partners still want to avoid pregnancy at this time?**

This question is important to confirm that both partners still do not want a pregnancy and that both partners still agree to use the method.

*Recommended question:*

- Are you and your partner still in agreement about not wanting a pregnancy at this time?
- Have you and your partner had any conflicts about your desire to avoid pregnancy since starting SDM?
- How have you handled the conflict?

**4. Is the couple able to avoid unprotected sex on days when the woman can get pregnant (white-bead days)?** This question is designed to help identify whether the couple is having problems avoiding unprotected sex. The question is also meant to identify whether the woman has been able to tell her partner on any given day whether or not she wants to have sex, and whether this has become a source of conflict in the relationship.

*Recommended questions:*

- How are you and your partner doing with the method?
- Have you and your partner talked about the need to avoid unprotected sex on days when you can get pregnant?
- Have you come to an agreement on what to do during those days?
- What are you and your partner doing to prevent pregnancy during the fertile days?
- Is this working for you? Do you think that this is working for your partner?
- Who is responsible for keeping track of which days you can have sex, and which days you must avoid unprotected sex? How do you and your partner communicate with each other about which days you can have sex?
- Are you having any problems with the method?

**5. Are both partners without risk of sexually transmitted infections?**

This question is designed to determine if the woman still perceives that there is no risk of sexually transmitted infection (STI) and to remind her that the SDM will not protect against HIV/AIDS or STIs. In circumstances where either partner has sex with more than one person, there may be a risk.

*Recommended questions:*

- People who have sex with more than one person risk getting a sexually transmitted infection and the SDM does not protect you against these infections. Since you have been using SDM, have either you or your partner been diagnosed with a sexually transmitted infection?
- Do you still believe that you and your partner are not at risk of contracting a sexually transmitted infection?

**6. Are both partners satisfied with the method and do they want to continue using it?**

This question is to determine if the users are satisfied with the method and whether the couple intends to continue using it.

*Recommended questions:*

- Are you and your partner satisfied with the method?

- What do you like about it?
- Is there something that you or your partner doesn't like about the method? Have you discussed this with your partner? Have you been able to resolve the issue, or would you like to consider another method?

### **7. Is the couple able to use CycleBeads correctly?**

This question is designed to remind the provider to determine if the woman is using CycleBeads correctly and to ask her some general questions about how she uses the beads.

#### *Recommended questions:*

- Can you explain to me how you are using your beads?
- Which are the days you can get pregnant?
- When do you normally move the ring on your CycleBeads?
- Where do you keep your CycleBeads?
- Have you been able to remember to move the ring?
- What do you do if you forget to move the ring?
- Does your partner help you move or remember to move the ring?

## **SESSION 6: SAFE MOTHERHOOD – PREGNANCY AND PRENATAL CARE**

**OBJECTIVES:** By the end of the session, the participants should be able to:

1. Explain health services related to “Safe Motherhood” and their importance in reducing maternal mortality
2. Describe the role of health mediators in promoting Safe Motherhood in their communities
3. Describe normal changes that occur in a woman’s body during pregnancy.
4. Name common discomforts during pregnancy.
5. Explain essential components of prenatal care and the purpose of prenatal visits
6. Name the prescribed schedule for prenatal visits and situations when women need to seek emergency medical care
7. Explain the importance of hospital delivery, including preparations and when to go

**TRAINING METHODS:** Discussion, Mini-lecture, Small Group Work, Case Study

**TIME:** 3 hours

### **MATERIALS:**

#### Flipcharts:

- Facts about women’s lives

#### Trainer documents:

- Normal Body Changes During Pregnancy
- Coping with Common Discomforts
- Myths and Facts Regarding Pregnancy (and slips of paper containing myths)
- Needs of Pregnant Women
- Case Studies

#### Participant documents:

- Coping with Common Discomforts
- Safe Motherhood Services / The Role of Health Mediators in Safe Motherhood
- Needs of Pregnant Women

### **INSTRUCTIONS:**

#### **I-II. INTRODUCTION: SAFE MOTHERHOOD (15 minutes)**

Introduce the session by asking the group what they understand by the concept “Safe Motherhood”. Correct and/or complete their ideas as necessary.

- Women stay healthy throughout pregnancy and give birth to normal, healthy babies.
- Women are protected from complications during pregnancy, childbirth and after childbirth.
- Women have safe deliveries
- Newborns receive good care after birth.

Post and review the flipchart *Facts About Women's Lives*. Explain that these data are available for the entire world.

Explain that:

- Although pregnancy and childbirth are normal in the life of a woman, many women die from complications.
- Few people, including women themselves, understand the risks involved in bearing children.
- The most common cause of death of women of childbearing age is complications of pregnancy and childbirth; this is called maternal mortality.
- In Romania, maternal mortality (the number of women who die as a result of complications of pregnancy and childbirth) is one of the highest in Europe. This high maternal mortality rate is an indication that the health of women during pregnancy, delivery and after delivery is neglected. Most of these deaths can be prevented through education, health programs, good nutrition and the use of prenatal and obstetric health services.

Ask participants:

- Do you know of cases of women who died as a result of problems of the pregnancy or during delivery?
- What are the most frequent causes of maternal deaths you have heard about?

Listen carefully to their answers and emphasize that complications can develop in perfectly healthy women. Every pregnancy carries some risk even if earlier pregnancies have ended normally.

Ask participants:

- What can be done in order to prevent maternal mortality?

The answers will vary with participants' knowledge
--

Distribute the handout *Safe Motherhood Services / The Role of Health Mediators in Safe Motherhood* and ask volunteers to read and comment it.

### **III-IV. CHANGES AND COMMON DISCOMFORTS DURING PREGNANCY (45 minutes)**

Explain that a woman undergoes many physical and emotional changes during pregnancy. Physical changes occur as her body prepares to meet the needs of the baby during pregnancy, birth, and breastfeeding.

Ask participants:

- What are the first signs of pregnancy?

- The woman misses her period (often is the first sign)
- 'Morning sickness' (nausea or feeling you are going to vomit, especially in the morning).
- Sleepiness, tiredness, dizziness
- Modified appetite, food cravings
- The breasts get bigger or feel tender
- She may have to urinate more often

Discuss with the group why a mediator should know the common signs and symptoms of pregnancy, and what their role could be in this regard:

- The mediator could identify pregnant women in the community by asking the following questions to women she suspects of being pregnant:
  - Have you missed your period? When did your last menstrual period begin?
  - Do you experience nausea, vomiting, loss/increase of appetite or food cravings?
  - Do you feel tired, or sleepy or dizzy?
  - Do you feel heaviness, pain or tingling in your breasts?
  - Do you have frequent urination?If most of the answers are 'yes', she will know that the woman is most probably in the early stage of pregnancy.
- If the woman's situation is uncertain, the mediator could explain what a pregnancy test is, where it can be obtained, and how it can be done at home.

Then ask participants:

- What are the signs in the later stages of pregnancy?

**Mid-term Stage or Second Trimester:**

- Enlargement of the abdomen and palpable uterus
- Women begin to feel fetal movements
- Women generally feel better during this period

**Late Stage or Third Trimester:**

- Uterus becomes very big in size and fetal parts and movements are felt
- Fetus becomes viable, that is, capable of an independent existence
- Breast changes are more pronounced and there may be some milk-secretion
- Frequent urination
- Difficulty in sleeping, walking

Using the trainer document *Normal Body Changes During Pregnancy*, briefly explain the normal changes during pregnancy.

Indicate the pages in the Roma Health Mediator's Manual containing this information.

Invite participants to share common discomforts they encountered during their pregnancies.

- Morning sickness
- Heartburn and acid indigestion
- Constipation, hemorrhoids
- Frequent urination
- Shortness of breath
- Swollen feet
- Low back pain
- Other

Explain that:

- Many women experience one or more of these common discomforts during pregnancy
- Providing prompt care to relieve discomfort will prevent problems that are more serious.

Distribute the participant document *Coping with Common Discomforts* and ask volunteers to read it. Lead a discussion about how mediators could:

- Help a pregnant woman to deal with the common discomforts
- Identify situations when women need to seek medical help from their family doctor

## **V-VI. PRENATAL CARE (45 minutes)**

Explain that:

- We have discussed symptoms and common discomforts of pregnancy, and some of the ways health mediators can help women during their pregnancies. An important part of a health mediator's role is to encourage women who are pregnant to go to their doctors for prenatal care.
- Pregnancy is a natural phenomenon and not an illness. It is a very special time in a woman's life when she has special needs because of the growing fetus in her womb. It is important for health professionals (family doctor, gynecologist, nurse) to look after the health of the mother throughout pregnancy, for both her and her baby's benefit.

Ask participants to enumerate the needs of a pregnant woman.

- Nutritious food
- Enough rest, sleep, and relaxation
- Good personal hygiene

- Comfortable clothing and footwear
- Prevention of infectious diseases
- Avoidance of potentially harmful practices
- Sexual intercourse
- Emotional support
- Regular visits to the doctor for checkups

Write down the answers on a flipchart. Use the trainer document *Needs of Pregnant Women* to complete the list if needed.

Organize the following activity (which will assist mediators in recognizing and responding to common myths regarding pregnancy):

- Pair off the participants.
- Distribute to each pair one slip of paper containing one of the most common myths regarding the needs during pregnancy, prepared before the session starts (see trainer document *Myths and Facts Regarding Pregnancy*).
- Ask each pair to discuss among themselves and to decide whether the statement is a fact or a myth. Give them about 2 minutes for discussion.
- One person from each pair will read out the statement written on the slip of paper and tell whether the pair agrees or disagrees with the statement and why.
- Ask participants to explain how to respond to each myth. Use the “facts” paragraph in the trainer document *Myths and Facts Regarding Pregnancy* as a guide for helping participants to formulate their responses. Use the trainer document *Needs of Pregnant Women* to complete the explanations as needed.

Discuss with participants how they can help a pregnant woman to take care of herself and her baby during pregnancy. Emphasize that the mediator can play a vital role in educating the pregnant woman, her husband, and other family members about a pregnant woman’s special needs and how to fulfill them.

- The mediator can explain:
  - What to eat
  - How to get enough rest and sleep
  - The importance of maintaining personal hygiene and infection prevention
  - What work (exercise) she should do and what work to avoid.
  - The importance of wearing comfortable clothing and footwear
  - Avoidance of potentially harmful practices
  - The importance of emotional support from the entire family
- The mediator can play a substantial role in:
  - Maintaining the emotional health of the pregnant woman by actively listening to her and re-assuring her.
  - Countering myths and misconceptions regarding a woman’s needs and care during pregnancy.
  - Informing her about 'alarm signs' and when she needs to go immediately to a health centre.
- The mediator can explain to the woman and her family:

- The importance of regular antenatal check-ups, and encourage her to go to the doctor for antenatal check-ups. (The family may not know the benefits of antenatal care and may see no reason to go, especially if the pregnant woman has no complaint.)
- That during the antenatal visits, the pregnant woman should be able to obtain the following services:
  - An examination to make sure that she is generally healthy and that the fetus is growing well
  - Tablets of iron, folic acid and vitamins to prevent anemia
  - Tetanus immunization to safeguard her and the baby against tetanus.
  - Treatment and medical advice for ailments during pregnancy.
  - Counseling on how to prepare for safe delivery, how to breastfeed the baby, and how to space or avoid future pregnancies (effective contraception after childbirth).
  - The doctor's assessment of her likelihood of having a normal delivery (by the position of the baby in her womb, the size of her pelvis, etc.)

Ask participants:

- When does a pregnant woman need to go to the doctor for the first time during her pregnancy?
- How often should a pregnant woman go to the doctor for regular consultations?

Listen to their answers and make corrections if necessary.

- The first consultation should take place in the **first trimester** of pregnancy. Usually, during the first visit the family doctor checks the woman's health status, takes a medical history and recommends some tests. Sometimes it is necessary to perform a pregnancy test or an ultrasound exam to confirm the pregnancy.
- During the **second trimester** of pregnancy, a monthly visit is generally adequate for monitoring the mother's and baby's health status, for recommending preventive measures and for providing special counseling, depending on the mother's needs.
- In the **third trimester** of pregnancy, more consultations are necessary (every two or three weeks) because most of the complications appear during this stage of pregnancy, and most women need more counseling for birth preparation.

- Besides the regular visits to the doctor, what other situations might signal a need for medical help?

Answers will vary. Probably alarm signs and emergencies will be mentioned

Emphasize that:

- Although most of a woman's needs can be cared for by herself and her family at home, she needs to be seen by the doctor as soon as possible if any of the following alarm signs appear:
  - Fever

- Abdominal pain
  - Weakness, tiredness, and pale skin
  - Illness/bad general health status
  - Swollen fingers, face and/or legs
  - Pain, redness, swelling of the calves
  - Water breaks and not in labour after 6 hours
- If any of the following emergencies arises, the woman should be taken to a hospital immediately, day or night, because the lives of the mother and child cannot be saved at home.
    - Vaginal bleeding
    - Convulsions
    - Severe headaches with blurred vision
    - Severe abdominal pain
    - Fast or difficult breathing
    - High fever and weakness
    - Regular labor pains beginning more than 3 weeks before the baby is expected
  - An emergency:
    - May occur any time suddenly without warning
    - Is life threatening
    - Requires urgent action
  - The patient must be taken to a hospital without delay.
  - If the pregnancy goes beyond 9 months (the baby is not born within 2 weeks after the full 9 months of pregnancy), the woman should go to her doctor.

## VII. PREPARATIONS FOR DELIVERY (60 minutes)

Explain that:

- One of the most frequent questions during a pregnancy is “When is the baby due?”
- Usually a normal pregnancy last 9 months or 40 weeks, counted from the first day of the last period. After 38 weeks of pregnancy, the birth may come at any time.
- A woman can calculate the probable date of birth by adding 7 days to the last period, and then adding 9 months. Example: if a woman had her last period on January 22, she adds 7 days, which means January 29; then she counts 9 months and finds that her likely date for delivery is October 29.

Emphasize that this date is an estimation, not a certain or fixed date.

Ask participants:

- How would someone know that the end of pregnancy is near?

A few days before labor begins, usually **the baby moves lower** in the womb. This lets

the mother breathe more easily, but she may need to urinate more often because of pressure on the bladder. (In the first birth, these signs can appear up to 4 weeks before delivery.)

➤ What are the signs of labor?

- Loss of mucus plug
- Blood with mucous comes out of the vagina.
- A gush of water comes out of the vagina (rupture of amniotic sac or “bag of water” breaks)
- Increased pelvic pressure and painful regular contractions of the womb, every 20 minutes or less.

Pregnant women should be advised to go to the hospital as soon as possible if any of these signs of labor appear.

Explain the term ‘labor’ and describe the three stages of normal labor:.

- Labor is the process by which a woman delivers her baby into the world.
- The **first stage** of labor starts with regular contractions of the womb, which become stronger and stronger and the intervals between contractions become less. The baby is pushed downwards with each contraction and thus pressure is applied regularly on the cervix (mouth of the uterus or womb) so that it opens up and finally the baby moves down into the vagina (birth canal) and the mother feels she has to push. Usually labor lasts 10 to 20 hours or more when it is the mother's first birth, and from 7 to 10 hours in a woman who has already had the first baby. This varies a lot. During the first stage of labor, the mother should not try to hurry the birth. It is natural for this stage to go slowly. The mother should not try to push or bear down. She should change positions often or get up and walk about from time to time. She should not lie flat on her back for a long time. If the mother is frightened or in great pain, she needs to take deep, slow, regular breaths during each contraction, and breathe normally between them. This will help control the pain and calm her. Reassure the mother that the strong pains are normal and that they help to push her baby out.
- The **second stage**, in which the child is born, lasts from the dropping of the baby into the vagina (birth canal) until the baby passes through the vagina and goes out from the mother's body. Sometimes this begins when the bag of water breaks. It is often easier than the first stage and usually does not take longer than 1 hour. During the contractions the mother bears down (pushes) with all her strength. Between contractions, she may seem very tired and half-asleep.
- The **third stage** begins when the baby has been born and lasts until the placenta (afterbirth) comes out. Usually, the placenta is detached from the wall of the uterus and comes out by itself 5 minutes to an hour after the baby. The uterus contracts further to minimize blood-flow and becomes tight.

Discuss with participants how they can help a pregnant woman to have a safe delivery.

- During pregnancy, the mediator can ask the pregnant woman where she plans to have the baby. Sometimes births take place at home, without any medical assistance (attended by an untrained person); sometimes both the mother and the baby are fine and healthy, but home deliveries are dangerous because a serious problem may arise at any time and trained medical help is not available.
- The mediator can discuss with the pregnant woman and her family about the need to prepare in advance for childbirth.

Ask participants:

- What preparations should a family make for safe delivery?

- The family should know the signs of labor and of emergencies.
- They should also know the address and location of the nearest hospital
- They should make arrangements for suitable transport (jeep, tractor or a bullock-cart), so that the woman can be transported to the hospital in case an ambulance is not available. Some money should be kept aside for this purpose.
- The family members must be prepared to donate blood if required by the woman during any emergency.
- Every pregnant woman should have the following things ready to take with her to the hospital (by the last month of pregnancy):
  - Soap and clean towels
  - Tooth brush and paste
  - Clean cotton or hygienic tampons
  - Clean clothes for mother and baby

List their answers on the flipchart.

Ask participants:

- How many families do you think consider these preparations?
- What happens when they have to go to the hospital in a hurry?

Few families consider these preparations. As a consequence,

- When an emergency arises, people panic and lose precious time identifying an appropriate solution; they are unable to find solutions in a timely manner.
- People discover the importance of the “small” things the women needs, which may require additional visits to the hospital and more expenses for the childbirth.

Divide participants in small groups of 4-5 persons and give to each group a case study (see trainer document *Case Studies*). Ask the groups to study their case studies and to respond to the following questions: (10 minutes)

- What is the woman’s current situation?
- What did she and/or other family members do that led to this situation?

- What should she and/or other family members have done differently?
- If you were aware of her situation (before it became too late), what should/could/would you have done?

One representative of each group will present their conclusions in front of their colleagues. Ask the other participants if they have questions, comments or a different approach.

Using the solutions/proposals identified by participants, summarize the session. Emphasize that, despite the fact that women have been giving birth to children for thousands of years and despite the fact that the science is advancing all the time, still there are cases when women and/or children are dying during pregnancy and delivery.

Emphasize that maternal mortality it would be lower if:

- Women had good health and nutrition before getting pregnant (they are biologically prepared for the pregnancy)
- Pregnant women received antenatal care on regular basis, went to hospital for delivery, and received postnatal follow-up
- Women had all the necessary information about the normal changes during pregnancy and postpartum period and how to stay healthy
- Women and their families sought emergency care immediately when a pregnancy-related problem occurred.

Review with the group the flip chart *The Role of Health Mediators in Safe Motherhood*

Flipchart

## **FACTS ABOUT WOMEN'S LIVES**

**Every minute** (throughout the world):

**380 women become pregnant**

**190 women face an unplanned or unwanted pregnancy**

**110 women experience a pregnancy-related complication**

**40 women have an abortion**

**1 woman dies**

## **SAFE MOTHERHOOD SERVICES / THE ROLE OF HEALTH MEDIATORS IN SAFE MOTHERHOOD**

### **Safe Motherhood Services**

The following services help to make motherhood safer. They should be readily available through a network of linked community health care providers, clinics and hospitals. These integrated services should include:

- Community education on reproductive health and safe motherhood;
- Antenatal care and counseling, including the promotion of proper maternal nutrition;
- Skilled assistance during childbirth;
- Care for obstetric complications, including emergencies;
- Postpartum care;
- Management of abortion complications, post abortion care;
- Family planning counseling, information and services.

### **The Role of Health Mediators in Safe Motherhood**

The mediators' role is to:

- Educate pregnant women and their families about a pregnant woman's special needs
- Inform their communities about existing maternal and child health services and about women's rights to benefit from antenatal care free-of-charge
- Encourage pregnant women to go to the doctor for regular antenatal check-ups
- Inform pregnant women and their families about "alarm signs" during pregnancy, and when they need to ask for medical care without delay
- Inform pregnant women and their families about the signs of labor and about the advantages of delivery in a hospital, assisted by qualified health personnel
- Discuss with pregnant women and their families about the need to prepare in advance for childbirth.

## NORMAL BODY CHANGES DURING PREGNANCY

- **Weight** increases constantly during pregnancy, approximately 1 kg/month until the 7<sup>th</sup> month of pregnancy, and then approximately 0.5 kg/week until delivery.
- **Reproductive organs**
  - Uterus (womb) increases in size during pregnancy, starting by the sixth week of pregnancy
    - 12 weeks: uterus can be felt at the level of the symphysis pubis
    - 20 weeks: uterus can be felt at the umbilicus
    - 36 weeks: uterus can be felt beneath the ribs
  - Vaginal discharge –an increase in vaginal discharge is common in pregnancy, especially toward the end of pregnancy. It may be clear or yellow.
- **Breast** – some of the earliest changes caused by pregnancy are in the breast, which prepares to feed the newborn.
  - Breasts become enlarged, tender and feel heavier by the first weeks of pregnancy
  - Dilated sebaceous glands and increased pigmentation of the areola (the dark skin around the nipples) appear during the first trimester
  - Nipples increase size, become erect and leak colostrum
- **Skin**
  - Melasma (mask of pregnancy) on the forehead and cheeks
  - Darker line on abdomen from umbilicus downward
  - Small spider-like blood vessels above the waist and in the lower legs

These common symptoms of pregnancy disappear after delivery.
- **Heart rate and circulation** –are modified during pregnancy
  - Heart rate is raised from a normal of around 70 beats/minute to 80-90 and the amount of blood increases by about 30% in order to meet the rapidly increasing needs of the baby.
  - Uterus presses on the veins carrying blood from the legs, causing swelling of the feet; and varicose veins may appear. These are common symptoms of pregnancy, especially in the afternoon or in hot weather, and they will not harm the woman or her baby.
- **Lungs and respiration**
  - Breathing becomes faster and deeper during pregnancy as more oxygen is needed for the mother and fetus.
  - *Shortness of breath* usually occurs because the baby crowds the mother's lungs and she has less capacity to breathe, especially in the third trimester of pregnancy.
- **Kidneys and urination**
  - Kidneys have increased activity during pregnancy, as they filter more blood for the mother and fetus.

- Frequent urination. The need to urinate often is normal, especially in the first and last months of pregnancy (because the growing uterus presses on the bladder and leaves less room for it to hold urine).
- **Digestive system**
  - Nausea (“morning sickness”) is often one of the first sign of pregnancy and is present especially during the 2<sup>nd</sup>-3<sup>rd</sup> months of pregnancy.  
The doctor may recommend some interventions for reducing symptoms.
  - Constipation is caused by the uterus pushing on the rectum and lower part of large intestine.
  - Hemorrhoids (a type of swollen veins around the anus) may burn, hurt or itch; and may bleed when the woman defecates, especially if she is constipated. Sitting in a cool bath, and avoiding constipation by diet modification, can both help.
  - Heartburn is a common symptom, especially in the last months of pregnancy. The woman should be informed on lifestyle and diet modification. (See document *Needs of Pregnant Women*)

## **COPING WITH COMMON DISCOMFORTS**

### **Morning Sickness**

Avoid oily or spicy foods.

Eat frequent small meals.

Eat a light snack before rising in the morning and before going to sleep at night.

- Go to the doctor if severe nausea with frequent vomiting occurs.

### **Heartburn**

Eat frequent light meals.

Avoid spicy foods.

Do not lie down immediately after a meal.

- If symptoms remain after these interventions, the doctor may prescribe some medication.

### **Constipation**

Proper diet can usually relieve constipation.

Eat plenty of fruits, vegetables, and whole grains and drink plenty of water (6-8 glasses per day).

- If clinical symptoms remain troublesome, go to the doctor for a prescription.

### **Frequent Urination**

Drink plenty of water.

- If you notice burning on urination, seek medical help (in order to receive adequate treatment in case of a urinary infection).

### **Vaginal discharge**

Maintain proper hygiene of the genital area.

Wear hygienic tampons.

- If vaginal discharge is associated with itching, soreness or with pain, or it has a different odor or a bad smell, you may have an infection. Go to the doctor for diagnosis and treatment.

### **Shortness of Breath**

Walk slowly and rest frequently during the day.

Rest and/or sleep with your head slightly raised on a pillow.

- If the shortness of breath is present all the time and/or is associated with weakness and fatigue, it may be a sign of a problem. Go to the doctor!

### **Swollen feet**

Avoid standing for long periods.

Put your feet up for a few minutes every 2 to 3 hours.

Compression stockings can improve the symptoms.

- If the feet are swollen when you wake up in the morning, if the swelling is severe or if it comes on suddenly, it may be a risk sign. Go to the doctor as soon as possible.

### **Backache**

Practice daily exercise, such as walking, swimming and exercises in water, or gymnastics (single or special group classes for pregnant women).

Maintain good posture.

Massage your lower back (ask family members to massage your back)

Avoid lifting heavy loads if possible. Ask family members to assist you with heavy work.

### **Leg cramps**

Leg cramps are common, especially at night.

Flex the foot upward to stop the pain. You may gently stroke your leg to help it relax.

To prevent cramps, 1) do not point your toes when stretching, and 2) eat more foods that contain calcium (milk, curd, cottage cheese).

### **Headaches**

Headaches are common and usually harmless in pregnancy.

- In the case of migraine headaches (strong headaches, often on one side of the head), or headaches with swelling or dizziness, go to the doctor immediately! It may be a sign of pre-eclampsia.

### **Feeling hot and sweaty**

Very common and harmless if there are no other signs of risk.

### **Sudden pain in the side of the lower abdomen**

A sudden movement may cause a sharp pain in the tissues/ligaments holding the uterus in place. It is not dangerous and will stop in a few minutes.

### **Cramps in early pregnancy**

It is normal to have mild cramps (like those of menstruation) from time to time during the first 3 months of pregnancy. These cramps happen because the uterus is growing.

- If the cramps are regular or constant, are very strong or painful, or if you also have spotting or bleeding, it may be a sign of miscarriage/spontaneous abortion. You need medical help immediately!

### **Aches and pains of the joints**

The joints, especially hips, may get loose and uncomfortable. This is not dangerous and will get better after the birth.

- Seek medical advice if any of the following occur: red, swollen joints; severe pain; or weakness.

Items marked with **red bullets** need special attention: pregnant women should go to the doctor without delay!

## MYTHS AND FACTS REGARDING PREGNANCY

**Myth:** A pregnant woman should eat a lot of food, to cover her needs and the baby's needs.

**Fact:** A pregnant woman needs to eat nutritious food for the healthy growth of the baby. The quality of food is important, not the quantity.

**Myth:** A pregnant woman may continue performing heavy physical labor.

**Fact:** Too much heavy work (working in the fields or lifting and carrying heavy loads) can cause problems such as miscarriage, premature delivery or underweight babies. Therefore, pregnant women should avoid heavy physical labor.

**Myth:** A pregnant woman should avoid doing any work.

**Fact:** A pregnant woman should do normal housework, unless advised not to by the doctor, as it is a form of daily exercise that will keep her healthy and her muscles toned.

**Myth:** A pregnant woman does not need to go for antenatal check-up if she does not have any complaint or health problem

**Fact:** Even if she has no complaint, it is very important for her to go for antenatal check ups so the doctor can monitor the progress of her pregnancy, identify and treat any problems, and counsel her regarding her health needs during pregnancy.

**Myth:** A pregnant woman should remain in the house as much as possible.

**Fact:** Pregnancy is not an illness. Like other people, a pregnant woman can also go out. In fact, remaining indoors may deprive her from getting fresh air, exercise, recreation, essential antenatal check-ups, etc. However, she should avoid jerks and heavy strain if traveling by a vehicle. Walking for some distance is a good exercise for her.

**Myth:** A man and his family members can do nothing to help a pregnant woman.

**Fact:** They can give her a lot of emotional support and ensure essential care for her by providing her with nutritious food, sharing her workload, taking her for regular health check-ups, etc.

**Myth:** A pregnant woman should abstain from having sex.

**Fact:** The sexual desire during pregnancy varies: some women do not want much sex when they are pregnant, others want more sex than usual; both feelings are normal. Having sex, and not having sex, are okay for the woman and her baby. Sexual intercourse in pregnancy is not known to be associated with any adverse effects, although some specialists recommend avoiding vaginal intercourse during the last trimester of pregnancy.

**Note to trainer:** *Before each workshop prepare copies of this material and cut slips of paper containing only the myths.*

## **NEEDS OF PREGNANT WOMEN**

### **Nutritional needs and how to meet them**

Pregnant women should eat a variety of healthy foods, such as meat, fish, oils, nuts, seeds, cereals, beans, vegetables, cheese, and milk.

Daily diet should consist of:

- Body-building foods such as milk, curd, cottage cheese, pulses, green peas, lentils, red beans, peanuts, egg, meat and fish
- Energy-giving foods such as rice, potatoes, bread, cereals
- Some fats, oil, butter or margarine
- Body-protecting foods such as green leafy vegetables, beans, tomatoes, carrots, cabbage and a variety of fruits

General advice for pregnant woman:

- Eat whatever local food is available and eat small quantities at frequent intervals for good digestion.
- Avoid spicy and oily food and eat your dinner at least one hour before going to bed.
- Vegetables should be either raw or cooked lightly. Over-cooking destroys essential vitamins.
- In general, try to avoid salt; if salt is added to food, it should be iodized
- Avoid coffee, tea, and caffeinated drinks (Pepsi, Coca-Cola). Drink natural juices if possible. You need at least 4-6 glasses of water a day in addition to other liquids.
- Good nutrition during pregnancy helps to initiate good lactation after the birth of the baby.
- Do not fast or abstain from food during pregnancy.
- Do not be the last one in the family to eat.
- A walk after dinner helps to digest the food and avoid heartburn at night.

Talking with family members (husband, mother, mother-in-law) and involving them in ensuring a healthy food regimen for the pregnant woman may be very useful. Since a woman has special dietary needs during pregnancy, family members should cut expenses on less essential things to ensure an adequate supply of food. A kitchen garden could be cultivated by the father.

### **Need for rest and moderate exercise**

Exercise makes a woman's body stronger. During pregnancy, exercise helps her body prepare for labor and delivery. Exercise can also make her feel better and more full of energy. Easy exercises, walking, and swimming, have a positive effect on labor and should be encouraged until the time of birth.

Sleep and rest are also important for a pregnant woman, helping her stay healthy and resist illness. During pregnancy, some women need more sleep or rest than before. It is good for a pregnant woman to take a few minutes every 1 or 2 hours to sit, rest and put her feet up.

### **Work and domestic activities**

Pregnant women have legal rights and benefits related to maternity.

The majority of women can continue working. Family Doctors may propose temporary changes in work assignments during pregnancy.

Pregnant women should be advised to avoid hard work, lifting or carrying heavy objects, and standing-up for long periods of time.

### **Avoidance of potentially harmful practices**

Pregnant women should avoid harmful practices like smoking (including passive smoking: breathing smoke from other people's cigarettes) and drinking alcohol during pregnancy because of the adverse effects on fetal development and health.

- Avoid smoking, drinking alcohol and drugs.
  - When a pregnant woman smokes, her baby smokes with her. Her blood vessels get smaller which makes it hard for her blood to carry food and oxygen to her baby. The benefits of quitting smoking at any of the stages of pregnancy should be emphasized.
  - When a pregnant woman drinks, her baby drinks with her. Alcohol can cause deformations and mental problems.
  - When a pregnant woman takes drugs, her baby takes them too. Her baby may be born sick, dead or addicted to the drug. For drug use, women should be referred to specialized services.
- A pregnant woman should avoid taking medicines whenever possible. Medicines should be taken only when there is a good reason and only with medical prescription from the doctor. Only few medicines are safe to be taken in pregnancy.
- Avoid contact with poisonous chemicals (pesticides, herbicides, workplace chemicals and anything that has strong fumes). Poisonous chemicals can cause infertility, illness, miscarriage, or a dead or deformed baby.

### **Avoidance/prevention of domestic violence**

If domestic violence is identified in a pregnant woman, she should be referred for special counseling to a specialized service.

### **Avoidance of X-ray exposure**

X-ray exposure, especially in the first trimester of pregnancy, is dangerous for fetal development and may cause lethal malformations and stillbirths, and that it should therefore be avoided during pregnancy. A pregnant woman should always advise health personnel of her pregnancy if the need for X-rays is discussed.

### **Prevention of infectious diseases**

Women avoid infectious diseases during pregnancy, because of their potentially dangerous effect on the fetus, sometimes resulting in death.

Pregnant women should avoid very populated areas in order to prevent infection from respiratory diseases. It is particularly important to stay away from anyone with measles, especially rubella. If a woman gets rubella during the first 3 months of pregnancy, the baby may be stillborn, born deaf or may be born with a heart problem.

Pregnant women should be offered information on how to reduce the risk of some digestive infections by:

- drinking only pasteurized milk
- not eating blue cheese, pate (liver product), uncooked meals
- avoiding raw or partially cooked eggs (e.g. mayonnaise) or meat, especially poultry.

Correct and consistent use of condoms should be recommended for reducing STI risk. If an STI is detected during pregnancy, the woman should be referred to a specialized service.

### **Personal hygiene**

Maintaining good personal hygiene helps to prevent infections and to stay healthy in pregnancy. The pregnant woman should:

- Bathe with clean water every day, including washing the outside of her genitals gently with clean water.
- Avoid hot water baths
- Avoid douching or placing any substances in vagina
- Clean her teeth with a soft brush after every meal.

The woman's clothes and shoes should be as comfortable as possible.

### **Sexual intercourse**

Sexual intercourse in pregnancy is not known to be associated with any adverse effects, although some specialists recommend avoidance of vaginal intercourse during the last trimester of pregnancy. Some women do not want much sex when they are pregnant. Others want more sex than usual. Both feelings are normal. Having sex, and not having sex, are okay for the woman and her baby. If sex is uncomfortable, the couple may try different positions or other ways to share their affection and to be close to each other.

If the woman has sex, it is important that anything put in her vagina (the man's penis or his fingers) be clean in order to avoid infection. If there is any risk for STIs, including HIV, the couple should always use a condom during sex.

### **Emotional support**

Pregnancy can make women very emotional. Some women laugh or cry for no apparent reason. Some feel depressed, angry, or irritable. Odd laughing, crying and other sudden mood changes or strong feelings are normal. They usually pass quickly. However, do not ignore a woman's feelings simply because she is pregnant. Her feelings are real.

Many women worry when they are pregnant, especially about the baby's health and about giving birth. A woman's worries about other problems in her life may also become stronger when she is pregnant. Such worries are normal.

Women with these feelings need emotional support, like someone to listen to their worries and encourage them to feel positive and hopeful. They may also need help to solve the problems they are having in their lives, like problems with their partners, money, drugs or alcohol, or other issues.

## **CASE STUDIES**

Elena is a 26-year old woman who has 5 children and lives in the countryside. She is six months pregnant and she has visited the family doctor in the village only once. He told her that she should come back after she has had some laboratory tests and he advised her to quit smoking. Elena had neither time nor money to spend on traveling to town for analysis and she continued to smoke as she did during her previous pregnancies. Now she is not feeling very well but she does not want to return to the family doctor because she is afraid that he will reprimand her for not respecting her scheduled visits and for continuing to smoke.

Mira is a 20-year old woman and is four months pregnant for the first time. She and the family members (her husband and mother-in-law) have ignored her needs related to her pregnancy. Mira does not know anything about her special needs. She has not attended a clinic for a check-up. Her life is like everybody else's and nothing has changed: she continues to do her housework, to carry water from the fountain and to take care of the garden just like before her pregnancy. Several days ago, she started to have some pains in her belly. Her mother-in-law calmed her telling that is normal, especially during the first pregnancy. Two hours ago, Mira started to bleed.

Gheorghe's wife, Andreea, became pregnant for the fourth time at 34-years of age. Like previous times, both husband and wife thought that there was nothing to worry about, as the new baby would arrive without any problem in due course like the others: without any intervention from any doctor. She noticed a persistent headache during the last month but didn't pay much attention because she knew that all pregnant women have some discomfort during pregnancies. Andreea died during the 8th month of pregnancy.

Maria is a 20-year and she is giving birth to her second baby. She delivered her first baby at the hospital, everything was well, and she gave birth in only a few hours. This time, the water broke during the night and her husband called the traditional birth attendant early in the morning to assist Maria. She delivered a healthy baby and everything looked fine, but after 1 hour she had not yet eliminated the placenta. The traditional birth attendant gave her to drink (a plant infusion) but nothing changed. After another hour, they called the ambulance. At 3 hours after the childbirth, Maria arrived to the hospital, loosing blood. The doctors gave her a blood transfusion but unfortunately, Maria died in 30 minutes.

## SESSION 7: POSTPARTUM CARE

**OBJECTIVES:** By the end of the session, the participants should be able to:

1. Describe normal changes during the postpartum period
2. Explain the purpose of postpartum visits
3. Name the prescribed schedule for postpartum visits
4. Explain the importance of birth-spacing and post-partum contraception

**TRAINING METHODS:** Discussion, Role-play

**TIME:** 60 minutes

**MATERIALS:**

Trainer documents:

- Normal Changes During the Postpartum Period
- Women's Needs During the Postpartum Period

Participant document:

- Counseling on Birth Spacing and Family Planning

## INSTRUCTIONS

### I. NORMAL CHANGES DURING THE POSTPARTUM PERIOD (15 minutes)

Introduce the session by referring to the last session and the fact that how a woman takes care of herself and the care she receives while pregnant are both extremely important to the eventual outcome of the pregnancy. Add that the postpartum period, and the care the mother receives during this time, is also very important to both the mother's health as well as the health of her newborn baby. Explain that this session will focus on postpartum care for the mother and that the following two sessions will focus on newborn care and breastfeeding.

Describe the **post-partum period**: the period of six weeks or forty days after delivery. This is a time:

- In which the woman's body returns to its normal state
- When the woman adjusts to a new way of life with the newborn.
- Of rest and recovery after pregnancy and childbirth.

Ask participants:

- What changes take place in the woman's body after delivery?

Complete the list, if necessary, and explain the changes briefly, using the trainer document *Normal Changes During the Postpartum Period*.

## II-IV. POSTPARTUM VISITS (45 minutes)

Ask participants if they visit families or mothers with newborns and, if so, what they do during these visits.

Likely answers: they make sure that all is going well with the mother and baby.

Ask participants:

- What are the needs of a woman during the postpartum period?

Woman's needs during the postpartum period (refer to the trainer document *Women's Needs During the Postpartum Period* for additional details)

- Rest
- Work, physical activities, exercises
- Diet
- Extra iron and folic acid
- Cleanliness
- Resumption of intercourse
- Avoidance of potentially harmful practices: smoking, alcohol, drugs and medicines
- Emotional support

- When you visit women during the postpartum period, what are the questions you ask them?

- How are you feeling?
- Do you have any pain in your lower abdomen?
- Do you still have vaginal discharge?
- Are you able to breastfeed the baby properly?
- Do you have any pain, heaviness or swelling in your breasts?
- Are you eating well?
- Are you passing urine and stools without difficulty?
- Do you have any fever?
- How is the baby doing?
- Is s/he breastfeeding properly?

Ask two volunteers to conduct a role-play in front of the group as a way of demonstrating: 1) issues a mediator should discuss with a young mother during the postpartum period, and 2) how the mediator should talk to a young mother. One of the volunteers will play the role of a young inexperienced mother sitting with her "baby"; the other will play the mediator. Allow them 10 minutes to demonstrate the discussion and then thank them.

Ask "the mother":

- How did you feel?
- What did “the mediator” do to help you to discuss your needs and concerns?
- What else could she do to make it easier for you to discuss your situation?

Ask “the mediator”:

- How did you feel?
- It was hard or easy for you to talk with the young mother?
- Think about your responses during the conversation. Do you think you heard and understood all that the woman wanted to say (including what was behind what she said)?
- How can you be more prepared to respond in difficult situations?

Ask other participants to analyze the woman’s needs revealed during the role-play. Bring to the group’s attention any myths or misinformation that came out in the discussion during the role-play.

Discuss the potential role of mediators in visiting the mother and baby after delivery: postpartum visits provide an excellent opportunity for the mediator to answer questions the woman may have about breastfeeding, sexual relations, family planning, baby immunization or other topics. Even if the woman has no questions, this is a good time to inform her about the importance of postpartum visits to her family doctor.

Describe the prescribed schedule for postpartum visits with the family doctor:

- In principle, the postpartum woman and the baby should receive (at home) the **first visit** of the family doctor within 24 hours following their release from the hospital. However, this does not always happen (especially if the woman was not monitored by the doctor during the pregnancy or if she changed her address). The mediator could facilitate access to a health provider for both mother and child (including informing the family doctor of the birth of the baby).
- Health **check-ups** are highly recommended within six weeks of delivery, for both mother and child.
- Ideally, the woman should visit a health center or be visited by a family doctor at home at 3 weeks and/or 6 weeks postpartum.

Explain that after the birth of the baby, it is important for the woman to know that if she has sex and is not exclusively breastfeeding, she can become pregnant as soon as 4 weeks after delivery. Therefore, it is important for her to start thinking early on about what family planning method she/the couple will use.

The mediator can help the woman think about this issue by:

- Asking the woman/couple about her/their plans for having more children. If she/they want more children, advise them that waiting at least 2-3 years between pregnancies is healthier for both mother and child.
- Explaining that exactly when a woman/couple should start using a contraceptive method after delivery will depend upon whether the woman is breastfeeding or not.
- Providing information about the availability of family planning services, and make arrangements for her to see a family planning provider if she is interested.

Suggest that another important topic to be discussed with women during the postpartum period is the correct and consistent use of condoms for dual protection. The mediator can promote condoms, especially if the woman is at risk for STI or HIV.

### **Summary**

Summarize the mediator's important role in educating the mother and family members about her special needs and about newborn care.

- The mediator can explain:
  - What to eat
  - How to get enough rest and sleep
  - The importance of maintaining personal hygiene and infection prevention
  - The importance of breastfeeding
  - The importance of postpartum contraception and birth-spacing
  - Avoidance of potentially harmful practices
  - The importance of emotional support from the entire family
- The mediator can play a substantial role in:
  - Providing emotional support to the postpartum woman by actively listening to her and re-assuring her.
  - Countering myths and misconceptions regarding her needs and care during postpartum period.
  - Informing her about 'alarm signs' (for her and the baby) and when she needs to seek medical help.
- The mediator can explain to the woman and her family:
  - The importance of check-ups after delivery and encourage her to go to the doctor.
  - The services the mother and baby should receive during postpartum checkups:
    - An examination to make sure that she is generally healthy and that the baby is growing well
    - Breastfeeding counseling and support
    - Iron and vitamins supplements
    - Contraceptive counseling and contraceptives supplies if necessary
    - Immunizations for the baby, as per schedule

Indicate pages in the Roma Health Mediator Manual where participants found this information.

## NORMAL CHANGES DURING THE POSTPARUM PERIOD

### Physical Changes

A woman's body will never be exactly as it was before pregnancy. Some changes in the reproductive system are ever lasting changes. Body shape and weight come back to normal sooner if she breastfeeds her baby for a longer period of time.

**Body weight** starts to be lost immediately after delivery; a woman loses about 5-7 kilos during delivery and continues to lose weight in the following months, especially if she is breastfeeding her baby.

### **Reproductive organs:**

- **Uterus** shrinks and sheds its linings

Immediately after delivery, the uterus is still quite large and can be felt in the lower abdomen as a hard and round mass. It soon begins to get smaller in size due to contractions. These may be painful (like periods) for the first couple of days. Breastfeeding helps the uterus to contract properly: it reduces the amount of fluid that comes out after delivery and it helps the uterus to recover its shape and size.

- **Vaginal secretion** decreases and changes.

Fluids coming out of the uterus and passing through vagina are called lochia. This is bright red immediately after delivery because it contains mostly blood for the first few days. Gradually its color changes to dark brown and then to pale cream. The amount of discharge becomes smaller over time and then completely stops, usually by the end of the fourth week.

- **Changes in the breast**

After childbirth, the breasts start producing milk. The milk secretion is established properly within a couple of days, especially if the baby is put to the breast within an hour of delivery and suckles regularly. The first milk, called colostrum, is thick and yellowish and is very good for the baby. Soon it becomes thin and white.

- **Return of menstruation**

The time it takes for menstrual periods to return following childbirth may vary from one pregnancy and delivery to another. If a woman breastfeeds exclusively, without giving her baby any other milk, her periods may not return for six or more months after delivery. If she is not breastfeeding, menstruation usually begins 4-6 weeks after delivery.

**Abdomen** returns gradually to its normal size.

Other changes that occurred during pregnancy (**respiratory, blood, renal** systems) disappear several days after childbirth.

The **skin** darkness (on face, breast, abdomen) lasts for a few weeks or months.

### Emotional Changes

As childbirth is a deeply emotional experience, it often affects the mood and behavior of the woman. She may feel happy and relaxed one minute and anxious, depressed, or tearful the next. She needs support, understanding and reassurance from her husband, other family members and friends.

## **WOMEN'S NEEDS DURING THE POSTPARTUM PERIOD**

**Rest:** After childbirth, which is a great physical effort, the woman needs to rest so that she can become strong and healthy again.

**Work, physical activities, exercises:** In the first 2-3 days after childbirth, it's good for the woman to rest and to move only for basic needs and for breastfeeding. Gradually, she will start to do usually activities, avoiding hard work; probably she will need support from family, relatives and/or friends.

Women may start physical exercises for perineal (pelvic) muscles the day after delivery, increasing the number of times she contracts them each day,. She may also practice exercises for abdominal muscles. The doctor will advise her how to do this.

**Better diet:** A new mother needs the same healthy foods she needed when she was pregnant. If she is breastfeeding her baby, she should eat more body-building foods such as beans, pulses, milk, eggs, and meat. She should also eat more protective foods such as green vegetables and fruits. She should drink plenty of fluids. She should drink at least one glass of milk a day, if possible. She should drink a glass of fluid every time she breastfeeds her baby (6-8 glasses per day).

**Extra iron and folic acid:** A lactating woman needs more iron and folic acid than most diets can provide. Iron and folic acid prevent anemia. A woman taking supplemental iron will have black stools. This causes no harm. Tell her to expect dark stools.

**Cleanliness:** During this period, the woman is very prone to infections and needs to be safeguarded against them. A clean room with fresh air and sunshine, clean bed and bedding, and clean clothes are required. Use of clean cloth or sanitary napkin is essential. Daily baths are needed to keep her body, especially the external genitalia and breasts, clean.

**Resumption of intercourse:** Abstinence from sex or use of condoms helps in protecting her from infection during this period; once a woman's lochia (postpartum vaginal discharge) has ceased to flow and once she is comfortable doing so (i.e. any lacerations she may have sustained have healed), she may resume intercourse as desired. If she does not meet the LAM criteria, she should be sure to use an appropriate contraceptive method.

### **Avoidance of potentially harmful practices**

As in the case of pregnancy, women should be strongly advised to avoid harmful practices like smoking (even passive smoking) and drinking alcohol because of the adverse effects on fetal development and health.

- Avoid smoking

When a postpartum woman smokes, her baby smokes with her, because the nicotine is present in her milk. If she smokes while caring for her baby, the baby

passively smokes with her by inhaling cigarette smoke. Nicotine is a poison that can harm the baby. Beside, the unpleasant smell will confuse the baby, who will not recognize anymore his/her mother by smelling her.

- Avoid drinking alcohol

It is a tradition to offer beer to a breastfeeding woman. . The quantity of alcohol present in the milk of a new mother who consumes alcohol is huge for a newborn baby and it may cause his intoxication or even death. Women should be strongly advised not to drink alcohol; they should instead drink plenty of fruit juice or clean water.

- Avoid taking medicines whenever possible.

Medicines should be taken only when there is a good reason and only with medical prescription from the doctor, because they are entering the mother's milk and can cause intoxications to the baby.

**Emotional support:** The postpartum period is an emotionally demanding period for the mother and she needs a lot of family support and understanding from her husband.

## COUNSELING ON BIRTH SPACING AND FAMILY PLANNING

During *postpartum visits*, all women should be informed about family planning so that they can consider their alternatives and make an informed choice. They should be informed about the following:

### **A breastfeeding woman is protected from pregnancy only if:**

- She is no more than 6 months postpartum, and
- She is breastfeeding exclusively (8 or more times a day, including at least once at night; no daytime feeding more than 4 hours apart and no night feedings more than 6 hours apart; no complementary foods or fluids), and
- Her menstrual periods have not returned.

A breastfeeding woman can also choose other methods, either to use alone or together with LAM.

### **Method options for breastfeeding women**

- **Can be used immediately after delivery:**
  - Lactational amenorrhoea method (LAM)
  - Condoms
  - Spermicides
  - Female sterilization
  - IUD
- At 6 weeks postpartum:
  - Progestogen-only pills
  - Progestogen injectable contraceptives
- At 6 months postpartum:
  - Combined oral contraceptives
  - Fertility awareness methods (if menstruation return after delivery)

### **Method options for non-breastfeeding woman**

- **Can be used immediately after delivery:**
  - Condoms
  - Progestogen-only pills
  - Progestogen injectable contraceptives
  - Spermicides
  - Female sterilization
  - IUD
- At least 3 weeks postpartum:
  - Combined oral contraceptives
  - Fertility awareness methods (if menstruation return after delivery)

## **SESSION 8: NEWBORN CARE**

**OBJECTIVES:** By the end of the session, the participants should be able to:

1. Identify normal behavior and physical characteristics of a newborn
2. Describe the basic care of newborns
3. Identify signs of potentially serious problems in newborns and what to do in case they occur

**TRAINING METHODS:** Presentation, Discussion, Demonstration

**TIME:** 60 minutes

**MATERIALS:**

- Baby doll
- Cotton swabs (for cleaning baby's eyes), baby oil or cream, towels, diapers

Trainer document:

- Essential Newborn Care
- Later Care of the Infant

Participant document:

- Later Care of the Infant

## **INSTRUCTIONS**

### **I-II. NORMAL NEWBORN BABIES AND THEIR CARE (45 minutes)**

Introduction: In previous sessions, we focused mostly on the woman's health during pregnancy and after childbirth. Now we will turn our attention to the health of the newborn (babies during the first 28 days of their lives).

Briefly describe the physical appearance and normal behavior of the newborn baby.

- The eyes may be uncoordinated and appear slightly crossed for the first several weeks.
- The stump of the umbilical cord is very moist at birth; it dries slowly until it falls off in a week to ten days.
- The baby's genitals may appear swollen for the first several days.
- Some babies may have slightly swollen breasts; some baby girls may bleed a little from their vaginas (like a small period). This is an effect of the hormones from the mother and will disappear in a few days.
- Newborns have two small soft spots on the top of the head (fontanelles) that will slowly close during the first year.
- Some babies are covered with fine hair that falls off during the first few months.
- Some babies are covered with a creamy white substance (vernix) when they born. This is not a sign of any problem.
- Many babies have small pimples covering their faces and bodies. These slowly go away during the first few days or weeks.

Explain why newborns need a lot of care:

- Newborns (babies during the first month of life) need a lot of care in order to better adapt to the external environment.
- Throughout the fetal stage, the baby lies inside the mother's womb, which is warm and secure and performs important functions for the fetus: circulation, provision of nutrients and passage of waste products through the mother's body.
- Immediately after birth, the newborn baby has to perform all these functions independently. It breathes for the first time and gives a loud cry. Some babies have difficulty breathing. The newborn's body does not have the ability to regulate its body temperature or to fight infections.
- The first 28 days of life are crucial for the baby. Most infants who die during this period do so due to difficulty in breathing, hypothermia (lowered body temperature) and infections. Low-birth weight babies are at a higher risk of dying and need more specialized care.

Ask participants:

- What do you consider to be the basic needs of a newborn?

- To be kept warm
- To be fed
- To sleep
- To be clean
- To feel comfortable
- To be loved and safe

- How many of you have had children?

Hopefully, most of the participants have children.

- What did you do when your baby cried? What questions did you ask yourself?

- When did I feed him last?
- Should I check the diaper?
- Does he need to burp?
- Does he need to sleep?
- Is he cold/too warm?
- Is there too much noise/are there too many people around him?

Ask 2-3 volunteers to demonstrate the essential care of a newborn (how to maintain hygiene, changing diapers, bathing, preparing for sleep). Use a baby doll and common objects (towel, cotton swabs, soap, baby oil or cream etc.) for making the demonstration as real as possible.

Using the trainer document *Essential Newborn Care* as a basis, conduct a discussion on this issue, based on the following questions:

- How should the cord stump be cared for?
- What can a mother do in order to prevent her baby from having gas pains?
- How should the baby's eyes be cleaned?
- How should a baby be held during his bath?
- What is the order in which the mother should bathe different parts of the baby's body?
- After the bath, what common things should a mother do?
- What can a mother do to help her baby sleep well?

Correct misinformation as necessary.

Review the essentials of newborn care with the group

- Ask as second volunteer to demonstrate these principles of care
- Ask the group for feedback regarding the volunteer's demonstration of the principles of newborn care
- Review once more the principles if necessary.

Indicate the pages in the Roma Health Mediators' Manual where newborn care is described.

### **III. MONITORING THE NEWBORN'S HEALTH STATUS (15 minutes)**

Ask participants what their purpose is in visiting families with newborns.

The answer will probably be that their purpose is to make sure that all is going well with the baby and his mother.

Ask participants:

- How do you know that a baby is doing well?
- What questions should you ask the mother/family about the newborn?

- How your baby is doing?
- Is he breastfeeding properly?
- How frequently is he passing urine and stools?
- What do the stools look like (color, consistency)?
- Does there seem to be any problem with him?
- How is the umbilical cord stump? Is there any blood or discharge from it?

Emphasize that:

- Beside routine weekly visits of the family doctor and/or the nurse, the mediator should check to see if a newborn is well and facilitate access to a family doctor for both mother and child if necessary
- Visiting families with babies is an excellent opportunity for the mediator to answer questions the mother may have about breastfeeding and about the baby's development, immunizations and/or other topics.
- Even if the mother has no questions, this is a proper time to inform her about the importance of medical supervision, and to recommend that she contact the family doctor to enroll the newborn on his list of patients.
- Another important aspect is the identification of potentially serious problems in newborns and what to do in case they occur.  
Explain that a newborn's life may be endangered by serious complications such as:
  - **Poor condition of the baby** (especially in pre-term, small for date babies).  
Some signs of poor condition of the baby. The newborn:
    - Has trouble in breathing
    - Breathes faster than 60 breaths per minute
    - Is limp and weak
    - Does not have normal color
    - Is cold to the touch
  - **Jaundice.** Normally babies may have signs of jaundice during the first two weeks of life when their eyes and skin become yellowish. This resolves itself without any medicines. However, if the jaundice does not resolve soon and the baby looks ill and does not feed properly, it could be a serious complication.
  - **Sepsis.** If the cord-stump is infected, the baby may develop sepsis (infection). If the baby shows any of the following signs, he may have a blood infection and he should be taken immediately at the nearest hospital. The baby:
    - Does not feed as well as usual
    - Sleeps most of the time
    - Vomits or spits up a lot
    - Has green watery stools
    - Skin feels hot or cold
    - Breathes too fast or too slow

Sometimes complications may occur rapidly; this is why is important to recognize alarm signs and to take the baby to a hospital or call the family doctor immediately if they occur.

Indicate the pages in the Roma Health Mediator Manual where these alarm signs are described.

Make a very briefly presentation of the trainer/participant document *Later Care of the Infant*. Ask participants if they have any question. Distribute the participant documents.

**Summarize** the mediator's important role in educating mothers and family members about the newborn care.

- The mediator can educate mothers/parents about:
  - The basic needs of a newborn
  - The essential care of a newborn
  - The importance of breastfeeding (which will be covered in the following session)
- The mediator can play a substantial role in:
  - Maintaining the emotional support of the mother
  - Helping mothers correct mistakes in newborn feeding and care
  - Informing families about the 'alarm signs' and when to seek medical help.
  - Encouraging mothers to take their babies to the family doctor on a regular basis
  - Monitoring the baby's health status and for preventive services (such as immunizations).

## ESSENTIAL NEWBORN CARE

### Care of Cord

The area around the cord stump should be kept clean and dry. It will dry and fall off by itself with 7-10 days.

Advice for the mother:

- Fold the diaper so that it is below the stump.
- Do not put herbs or other substances on the cord as they may cause severe infection like tetanus and kill the baby.
- If there is redness around the cord, a bad smell or discharge from it, take the baby to the health centre or call the family doctor at home.

### Breastfeeding on Demand

- All newborns must be kept with their mothers and put to the breast soon after birth.
- Breastfeeding the baby soon after birth and on demand (suckling him whenever he wants and for as long as he wants) has important advantages:
  - Breast milk 'comes in' sooner
  - Baby gains weight faster
  - Fewer difficulties such as breast engorgement
  - Breastfeeding is more easily established
  - Exclusive breastfeeding for six months saves lives of many babies by preventing malnutrition and infections like diarrhea and pneumonia.

### Gas Pains (Colic)

If a baby starts to cry and pull his legs up soon after he starts to suck, he may have gas — too much air in the belly. Some babies swallow air when they breastfeed. It may help to let the baby burp:

- Lay the baby on your shoulder and rub or pat his back, or
- Lay the baby across your knees and rub or pat his back, or
- Sit the baby up leaning forward and rub or pat his back.

Sometimes a baby seems to get gas pains when the mother eats certain foods or spices. The mother can try eating food without spices, or stop eating a food that may be causing gas for 2 or 3 days (if she is getting enough nutrition from other foods). There is no particular food that should be avoided, because each baby is different.

Gas pains usually stop when the baby is about 4 months old.

### Eye Care

Clean each eye with a separate clean moist cloth or cotton swab, beginning from external part of the eye to the nose. Do not put any drops in the baby's eyes.

## **Bathing Newborns**

Newborns need to be clean and warm as they are not able to control their body temperature. Usually, after each feeding, the baby wets his diaper and needs to be changed. Fortunately, “pampers” keep the baby’s skin drier and healthier than the classic cotton diapers.

Babies need to be bathed every day:

- Babies should be bathed in the evening. This helps to relax the baby and helps him to feed and sleep better.
- The temperature of the water must be around 36-38 degrees Celsius.
- The baby needs to be supported and carefully supervised during the bath in order to avoid his swallowing water.
- Baby soap should be used for cleaning the baby’s skin.
- Immediately after the bath, the skin should be dried gently with a cotton towel (without rubbing it), and a baby oil or cream should be used for moistening the baby’s skin.

## **Sleep**

The baby needs to sleep most of the time during the first days after his birth. Then, gradually he will need fewer hours for sleep, as other activities will occupy him.

- Create from the beginning a routine for a regular sleep
- Do not force the baby to sleep if he does not need it.

## **Checking the Newborn’s Weight**

The baby’s weight should be checked and recorded regularly. Health professionals (family doctors and nurses) do this during the regular check-ups of the baby. Mothers and/or mediators may use spring-balances at home for measuring the baby’s weight.

## **LATER CARE OF THE INFANT**

If the baby is breastfeeding exclusively and continues to gain weight there is no worry. As long as mother eats well herself, she will have enough milk. However, after six months, breast milk alone is not enough for the baby and semi-solids must be introduced along with breast milk. This is called weaning. The principles related to weaning of the baby:

- Give semi-solids
- Continue breastfeeding and give semi-solids after breastfeeding
- Introduce one food at a time
- Start with 1-2 teaspoons full and increase the quantity of food gradually
- Feed frequently
- Mash all foods

If a baby suffers from diarrhea, i.e., it passes many loose, watery stools per day, he should be given oral re-hydration solution in order to make up for the water and important salts lost in stools. The doctor will recommend and supervise the treatment.

Infants need to be protected against the following diseases that are the most common causes of death and disability in children: tuberculosis, diphtheria, polio, whooping cough, tetanus and measles.

All babies should be fully immunized against all these diseases within the first year of their lives. Vaccines are available from family doctors at the PHC level. Every mother should get her baby immunized.

Parents should be aware that the baby may cry, or develop fever or a small sore after an immunization injection. These are normal after-effects and should not be a cause for alarm nor for refusing to immunize babies. The baby should be given plenty of food and liquids, preferably breast milk. If the problem seems serious or lasts more than three days, the baby should be seen by the doctor.

<b>Immunization Schedule for Infants</b>		
<b>AGE</b>	<b>VACCINE</b>	<b>DISEASE</b>
At birth	BCG Hepatitis B	Tuberculosis Hepatitis B
2 months	DTP Polio Hepatitis B (second dose)	Diphtheria, whooping cough (pertussis), tetanus Poliomyelitis Hepatitis B
4 months	DTP(second dose) Polio (second dose)	Diphtheria, whooping cough (pertussis), tetanus Poliomyelitis
6 months	DTP (third dose) Polio (third dose) Hepatitis B (third dose)	Diphtheria, whooping cough (pertussis), tetanus Poliomyelitis Hepatitis B
12 months	DTP (rappel I) Polio (rappel I)	Diphtheria, whooping cough (pertussis), tetanus Poliomyelitis
13 months	MMR	Measles, Mumps, Rubella
2yr ½	DTP (rappel II) Polio (rappel II)	Diphtheria, whooping cough (pertussis), tetanus Poliomyelitis

## **SESSION 9: BREASTFEEDING**

**OBJECTIVES:** By the end of the session, the participants should be able to:

1. Describe how breast milk is produced
2. Name the benefits of breastfeeding for infants and for mothers
3. Describe essential principles of breastfeeding (when to begin, frequency, duration, exclusivity)
4. Identify essential techniques and positions for successful breastfeeding
5. Name common problems with breastfeeding and what to do in case they occur
6. Explain common myths about breastfeeding and the role of mediators in overcoming these myths.

**TRAINING METHODS:** Presentation, Discussion, Demonstration, Small Groups

**TIME:** 1 hour 45 minutes

**MATERIALS:**

- Baby doll (for demonstration)
- Breast model

Flipcharts/Overheads

- Benefits of Breastfeeding
- Baby's Attachment to the Breast

Trainer documents:

- How Breast Milk is Produced
- Benefits of Breastfeeding
- Answers to Frequently Asked Questions
- Myths about Breastfeeding

Participant documents:

- Principles of Breastfeeding
- Care of the Breasts during Breastfeeding
- Common Problems during Breastfeeding

## **INSTRUCTIONS**

### **I-II. PRODUCTION OF BREAST MILK AND BENEFITS OF BREASTFEEDING (15 minutes)**

#### **Introduction**

Refer participants to the previous session and what was said about breastfeeding:

- Breast milk is the perfect food for a baby
- Breastfeeding is so important that it would be the topic of a separate session

Explain that in order to best help mothers breastfeed successfully, we need to understand:

- How breast milk is produced and what influences its production

- The importance, and the benefits, of breastfeeding
- Principles of breastfeeding
- Essential techniques and positions for successful breastfeeding
- Common problems that may arise and what to do in case they occur
- Common myths about breastfeeding and how to best respond to them

### **Production of breast milk**

Explain that:

- Inside the breast are millions of very small sacs which produce milk under the control of a hormone produced in the brain. Muscles surrounding these sacs contract and squeeze the milk out through small tubes which carry milk from the sacs to the outside, through the nipple. The sacs and tubes are surrounded by fat and other tissue which give the breast its shape, and which make most of the difference between large and small breasts. Small breasts and large breasts both contain about the same amount of small sacs and tubes and can both make plenty of milk.
- When the baby suckles at the breast, impulses go from the nipple to the mother's brain which stimulates the small sacs to produce milk. If the baby suckles more, the mother will produce more milk for the next feed. If the baby suckles less, the mother will produce less milk for the next feed. The amount of milk produced is adjusted by the mother's body to meet the needs of her baby.
- The hormone that causes the muscles around the sacs to contract and milk to flow through the tubes also causes a mother's uterus to contract after delivery. This helps to reduce bleeding, but it sometimes causes uterine pain and a rush of blood during a feed for the first few days. The pains can be quite strong. It is important to tell the mother about this so that she does not worry. It is good for the healing of her body after delivery and will stop in a few days.
- The production of milk in the mother's breast is affected by her thoughts, feelings and sensations. Positive thoughts and feelings (such as love, confidence, happiness and pride) and sensations (such as touching and hearing or seeing her baby) can help the milk to flow. Bad feelings (such as pain, worry, fear or doubt) can stop her milk from flowing. Fortunately, this effect is usually temporary.
- Signs of good milk production may include: tingling sensation in the breasts just before or during a feed; milk flowing or dripping from the breasts; painful uterine contractions, sometimes with a rush of blood, during feeds in the first week; and slow deep sucks and swallowing by the baby as he feeds.

### **Importance and benefits of breastfeeding:**

Explain that:

- Babies who are breastfed are healthier, grow stronger, and are less likely to die

- Every child should be exclusively breastfed for at least a few months of life. Infants who are not breastfed are twice as likely to die as those who are.
- The current bottle-feeding fashion has no health advantages over breastfeeding, and has spread only because of the success of intensive marketing efforts made by the companies who produce baby formulas
- Health workers should make every effort to help mothers to achieve successful lactation

Post the flipchart *Benefits of Breastfeeding* and review the benefits with the group. Refer to the trainer document: *Benefits of Breastfeeding* for further details.

Indicate pages in the Roma Health Mediator Manual where this information can be found.

## II. PRINCIPLES OF BREASTFEEDING (15 minutes)

Distribute the handout *Principles of Breastfeeding*. Ask volunteers to read the statements.

Ask participants:

- In your communities, are these principles generally applied?

The answers will vary.

- What can you do to encourage more mothers to follow these principles?

- Inform/Educate mothers about:
  - The benefits of breastfeeding
  - The principles of breastfeeding (when to begin, frequency, duration, exclusivity)
  - Techniques and positions for breastfeeding
  - How to maintain lactation
  - How to maintain proper hygiene of the breasts
  - How to resolve common problems of breastfeeding
- Correct misinformation and myths encountered in the community

## III. TECHNIQUES AND POSITIONS FOR SUCCESSFUL BREASTFEEDING (40 minutes)

Ask participants:

- What kind of mothers need more help with breastfeeding?

- new mothers who are breastfeeding for the first time

- mothers who have difficulty with breastfeeding
- mothers who bottle fed previously but now want to breastfeed

➤ How could a mediator help a mother with breastfeeding?

- Talk with her quietly and with patience
- Ask the mother how she feels and how breastfeeding is going.
- Try to see the mother when she is feeding her baby, and quietly watch what is happening.
- If the mother is having difficulty, help her with positioning her baby correctly
- Give her relevant information and make sure that she understands it.
- Answer the mother's questions.
- Explain simply and clearly what she needs to know.

### **Baby's position**

Explain that positioning the baby properly at the breast is necessary so that the baby can suckle effectively.

Emphasize the following points when helping mothers:

- *Always observe a mother breastfeeding before you help her.*  
Take time to see what she does, so that you can understand her situation clearly. Do not rush to make her do something different.
- *Give a mother help only if she has difficulty.*  
Some mothers breastfeed babies satisfactorily in positions that would be difficult for others. Do not try to change a baby's position if he is getting breast milk effectively and his mother is comfortable.
- *Let the mother do as much as possible herself.*  
Be careful not to 'take over' from her. Explain to her what to do. If possible, demonstrate on your own body to show her what you mean.
- *Make sure that she understands what you do so that she can do it herself.*  
Your aim is to help her to position her own baby. It does not help if you can get a baby to suckle and his mother cannot.

Inform participants that you will demonstrate, with the help of a volunteer, several techniques and positions for successful breastfeeding, as well as some common mistakes and how to correct them. Invite them to observe, ask questions and comment as appropriate.

**[Note to the trainer:** Before the demonstrations, ask a participant to help you with the demonstration. Explain that you want her to play the role of a mother who needs help to position her baby. Ask her to decide on a name for herself and her "baby" (the doll). Find a cloth to cover the table, and some pillows if these are appropriate in the community. Arrange chairs, a footstool, and a bed, or a table that can be used for a bed to demonstrate breastfeeding lying down.]

**1. Demonstrate how to help a mother who is sitting**

Ask the participant who is helping you to sit on the chair or bed that you have arranged. [Note: She should hold the doll across her body in a common, but poor, position: loosely, supporting only his head, with his body away from hers, so that she has to lean forward to get her breast into his mouth]

Follow these steps:

- Greet the 'mother' (by her name) and ask her baby's name. Ask her how she is and ask one or two open questions about how breastfeeding is going. She replies that breastfeeding is painful.
- Ask her if you may see how (baby's name) breastfeeds, and ask her to put him to her breast as she usually does. Observe her breastfeeding for a few minutes.
- Explain what might help and ask if she would like you to show her. Say something encouraging, like: "He really wants your breast milk, doesn't he?" Then say: "Breastfeeding might be less painful if (baby's name) took more of your breast in his mouth when he suckles. Would you like me to show you how?" If she agrees, you can start to help her.
- Make sure that the 'mother' is sitting in a comfortable, relaxed position.
  - A low seat is usually best, if possible one that supports the mother's back. If the seat is rather high, find a stool for her to put her feet on. Be careful not to make her knees so high that her baby is too high for her breast. If she is sitting in bed, pillows may help (if appropriate in the community).
  - If she is sitting on the floor, make sure that her back is supported. If she supports her baby on her knee, help her to hold the baby high enough so that she does not lean forward to put him onto her breast.
- Sit down yourself, so that you also are comfortable and relaxed, in a convenient position to help. You cannot help a mother satisfactorily if you are in an uncomfortable position yourself.
- Explain to the 'mother' how to hold her baby. Show her what to do if necessary.
- Make sure that you make these **four key points** clear:
  1. The baby's head and body should be in a straight line (a baby cannot suckle or swallow easily if his neck is twisted or bent).
  2. His face should face the breast, with his nose opposite the nipple (The baby's whole body should almost face his mother's body. He should be turned away just enough to be able to look at her face. This is the best position for him to take the breast, because most nipples point slightly downward).
  3. The mother should hold the baby's body close to hers.
  4. The mother is looking at the baby while breastfeeding him. If her baby is newborn, she should support his bottom, and not just his head and shoulders.
- Show the mother how to support her breast with her hand and to offer it to her baby:
  - She should rest her fingers on her chest wall under her breast, so that her first finger forms a support at the base of the breast.
  - She can use her thumb to press the top of her breast slightly. This can improve the shape of the breast so that it is easier for her baby to attach well. She should not hold her breast too near to the nipple.

If a mother has large and low breasts, support may help her milk to flow, because it makes it easier for the baby to take the part of the breast with the tubes into his mouth.

- Explain how she should touch her baby's lips with her nipple, so that he opens his mouth.
- Explain that she should wait until her baby's mouth is open wide before moving him to her breast. His mouth needs to be open wide to take a large mouthful of breast. It is important to use the baby's reflexes, so that he opens his mouth wide to take the breast himself. You cannot force a baby to suckle.
- Explain or show her how to move her baby to her breast quickly when he is opening his mouth wide:
  - Bring your baby to your breast. Do not move yourself to your baby.
  - Aim your baby's lower lip below your nipple, so that his chin will touch your breast.
- Notice how the mother responds. (The participant playing the “mother” should say, "Oh, that feels better!", and look happier.)  
*Explain to participants:*
  - If you improve a baby's poor suckling position, a mother sometimes spontaneously says that it feels better.
- You may need to work with the mother again, until breastfeeding is going well. If she is having difficulty in one position, try to help her to find a different position that is more comfortable for her (for example, in one of the positions described below).

## 2. **Demonstrate other ways for a mother who is sitting**

You can do this demonstration more briefly than the previous one. It is not necessary to repeat every step in detail.

Follow these steps:

- Help the “mother” to hold her baby in the underarm position.
- Ensure that the “mother” remembers and practices the above **four key points**. She may need to support the baby with pillows at her side.

*Explain to participants:*

- The baby's head rests in the mother's hand, but *she does not push it to the breast*.
- The underarm position is useful:
  - If she is having difficulty attaching her baby across the front;
  - To treat a blocked duct;
  - If a mother prefers it.
- Show the ‘mother’ how to hold her baby with the arm opposite to the breast.
- Ensure that she remembers and practices the above **four key points**. If she needs to support her breast, she can use the hand on the same side as the breast.

*Explain to participants:*

- The mother's forearm supports the baby's body.
- Her hand supports the baby's head, at the level of his ears or lower. She does not push at the back of the baby's head.
- This way of holding a baby is useful:
  - for very small babies;

- for sick or disabled babies.

### 3. Demonstrate how to help a mother who is lying down

Ask the participant who is helping you to demonstrate breastfeeding lying down.

[**Note:** She should lie down propped on one elbow, with the doll far from her body, loosely held on the bed]

Follow these steps:

- Help the “mother” to lie down in a comfortable, relaxed position.  
*Explain to participants:*
  - To be relaxed, the mother needs to lie down on her side in a position in which she can sleep.
  - Being propped on one elbow is not relaxing for most mothers.
  - If she has pillows, a pillow under her head and another under her breast may help.
- Show her how to hold her baby.
- Ensure that the “mother” remembers and practices the above **four key points**. She can support her baby with her lower arm. She can support her breast if necessary with her upper arm. If she does not support her breast, she can hold her baby with her upper arm.  
*Explain to participants:*
  - A common reason for difficulty attaching when lying down is that the baby is too high, and he has to bend his neck forward in order to reach the nipple.
  - Breastfeeding lying down is useful:
    - when a mother wants to sleep, so that she can breastfeed without getting up;
    - soon after a Caesarian section, when lying on her back or side may help her to breastfeed her baby more comfortably.

### 4. Demonstrate some common mistakes

[**Note:** You can give these demonstrations quickly, holding a doll and a model breast yourself]

Explain that there are some ways a mother holds her baby, which make it difficult for him to attach to her breast and suckle effectively.

Give the demonstration (follow these steps):

- Use a doll to show these ways of holding a baby:
    - too high (for example, sitting with your knees very high);
    - too low (for example, with the baby unsupported, so you have to lean forward);
    - too far to the side (for example, putting a small baby too far out in the ‘crook’ of the arm, instead of on the forearm. This can happen if the mother holds her baby’s bottom in the hand on the same side as the breast he is feeding from).
- Explain to participants:*
- If a mother holds her baby in these ways, his mouth will not be opposite her nipple.
  - It will be difficult for him to take the breast into his mouth.
  - On your own clothed body, or on a model, show these ways of holding a breast:

- holding the breast with fingers and thumb close to the areola;
- pinching up the nipple or areola between your thumb and fingers, and trying to push the nipple into a baby's mouth;
- holding the breast in the `scissor' or `cigarette' hold (index finger above and middle finger below the nipple).

*Explain to participants:*

- Holding the breast in these ways makes it difficult for a baby to attach and suckle effectively.
- The `scissor hold' can block milk flow.
- Demonstrate holding the breast back from the baby's nose with a finger.

*Explain to participants:*

- This is not necessary, and can pull the nipple out of the baby's mouth.
- A baby can breathe quite well without the breast being held back.

Explain that there are also common mistakes that health workers make when they help mothers.

Give the demonstration:

- Ask the participant to help you again. She should hold a doll in the same way as for the first demonstration. She should also hold a model breast in place as if the doll is trying to suckle.
- Take hold of the model breast in one hand and the doll in the other and push them together.

*Explain to participants:*

- When we try to put the baby to the breast, instead of helping the mother to put him on herself, she does not learn how to position her baby herself and she does not gain confidence.
- Hold the doll at the back of his head, and demonstrate trying to push him onto the breast.

*Explain to participants:*

- If you put pressure on the back of a baby's head, he may react by pushing his head back. Our natural reaction is then to push the baby onto the breast more strongly. This will likely cause the baby to fight back, and may cause him to refuse to breastfeed.

Ask participants if they have any questions, and try to answer them.

### **Attachment to the breast**

Explain that the baby needs to open his mouth wide and take more than just the nipple into his mouth. He actually needs to take much of the areola into his mouth, and to suck the milk by compressing the areola with his tongue.

If the baby takes only the nipple into his mouth, his tongue will not compress the tubes, milk will not flow well, and the mother's nipple is likely to become sore and damaged.

Some women have very large areolas, so you may not see a lot of areola outside the baby's mouth even though he is well attached. Compare how much areola you can see above and below the baby's mouth. When the baby is well attached, you will see more areola above his mouth than below it.

There are **4 points of good attachment**. The baby's:

1. Chin is close to the breast
2. Mouth is wide open
3. Lower lip is turned outwards
4. Mouth is beyond the nipple and attached to the areola. (More areola will be noted above than below the mouth).

Post the flipchart/project the overhead *Baby's Attachment to the Breast*.

Ask participants:

- What signs of good attachment do you see?

- The baby's chin is touching the breast.
- His mouth is wide open.
- His lower lip is turned outwards.
- His cheeks are round, or flattened, against his mother's breast.
- There is more areola above the baby's mouth than below it.
- The breast looks rounded during a feed.

- How can you tell if a baby is suckling effectively?

- The baby is taking slow deep sucks.
- His sucks become deeper and slower (after the few quick sucks at the beginning of the feed)
- You can see and/or hear the baby swallowing.
- The baby gulps as he swallows. Gulps are very loud swallowing sounds, when a lot of fluid is being swallowed at once. This is a sign that a baby is getting a lot of milk. It sometimes means that his mother has an oversupply, and her baby is getting too much milk too fast. Oversupply is sometimes the cause of breastfeeding difficulties.

- What signs of poor attachment do you see?

- The baby's chin is not touching the breast
- His mouth is not wide open (especially important with a large breast).
- His lips are pointing forwards (his lower lip is turned in).
- His cheeks are tense or pulled in as he suckles.
- There is more areola below the baby's mouth than above it, or the same amount above and below.
- The breast looks stretched or pulled during a feed.

➤ How can you tell if a baby is not suckling effectively?

- The baby takes quick shallow sucks all the time.
- The baby makes smacking sounds as he sucks.

➤ What are the consequences of poor attachment?

Correct participant responses if necessary.

Poor attachment will cause:

- Sore and cracked nipples, either across the tip of the nipple or around its base
- Poor reflex to the mother, leading to poor milk production
- Breast engorgement
- Fussy, crying baby who wants to feed very frequently because he is unsatisfied
- Poor weight gain
- Possibly refusal to suck because baby is frustrated
- Low milk production because the breasts are not properly emptied.

The eventual result may be breastfeeding failure.

Emphasize that the mother needs to know how to check if the baby seem satisfied. She should look for these signs:

- The baby releases the breast himself.
- He/she looking satisfied and sleepy. This shows that he has had all that he wants from that side. He may or may not want the other side too.

If the mother takes her baby off her breast quickly as soon as he pauses, because she thinks he has finished or because she wants to make sure that he suckles from the other side as well, the baby may not have gotten enough hind milk and he may want to feed again soon.

The exact length of time is not important. Feeds normally vary very much in length. However:

- If breastfeeds are very long (more than about half an hour) or very short (less than about 4 minutes) it may mean that there is a problem.
- In the first few days, or with a low-birth-weight baby, breastfeeds may be very long and this is normal

It is also important to ask the mother how breastfeeding feels to her:

- If it is comfortable and pleasant, her baby is probably well attached.
- If it is uncomfortable or painful, the baby is probably not well attached.

Summarize:

Breastfeeding will be successful in most cases if:

- The mother feels good about herself.
- The baby is well attached to the breast so that he suckles effectively.

- The baby suckles as often and for as long as he wants.
- The environment supports breastfeeding.

#### IV. COMMON PROBLEMS DURING BREASTFEEDING (15 minutes)

Briefly present the most frequent problems (common breast conditions which sometimes cause difficulties) in breastfeeding:

- Sore or cracked nipples
- Breast engorgement
- Blocked ducts (tubes)
- Painful breasts
- Breast infections (mastitis and abscess)

Emphasize that diagnosis and management of these breast conditions are important both to relieve the mother, and to enable breastfeeding to continue.

Distribute the participant document *Common Problems during Breastfeeding*, and ask volunteers to read it. Distribute participant document *Care of the Breasts during Breastfeeding* and ask volunteers to read it.

Allow participants to ask questions and try to answer them, using the trainer document *Answers to Frequently Asked Breastfeeding Questions*, as a basis.

#### V. MEDIATOR'S ROLE IN PROMOTING BREASTFEEDING (20 minutes)

Divide participants into small groups. Give them slips of paper with a myth written on each slip (see trainer document *Myths about Breastfeeding*). Ask them to discuss each myth and fact. One person from each group will present the group's response to their myth. Correct and/or complete their responses as necessary

Generate a discussion about the mediators' roles in promoting exclusive breastfeeding and supporting mothers with breastfeeding. Ensure that the mediator's role includes the following:

- Antenatal preparation for breastfeeding
  - With mothers in groups:*
    - Explain benefits of breastfeeding
    - Give simple relevant information on how to breastfeed
    - Explain what happens after delivery
    - Discuss mothers' questions
  - With each mother individually*
    - Ask if she has any questions or worries
    - Build her confidence, and explain that you will help her
- Education of young mothers

- Ask about previous breastfeeding experience
- Discuss (as appropriate):
  - When to start breastfeeding and to continue as long as possible (ideally until the baby is two years-old)
  - Basic principles of breastfeeding
  - Correct position during breastfeeding
  - Care of the breasts during breastfeeding
  - Common discomforts and how to deal with them
  - Nutritional needs of the mother, her health and fertility
- Check/observe breastfeeding position and technique, and offer suggestions if necessary
- Provide emotional support as necessary
  - Express empathy and understanding of a mother's feelings when talking to her.
  - Express confidence in the mother to make her feel good and build her confidence
- Involve the whole family in newborn care and in supporting the mother

### **Conclusions:**

Mediators should ensure that the following messages are communicated to the community (to mothers and women of reproductive age, and to families expecting a child)

- Begin breastfeeding immediately after delivery. During the first three days, it is especially important to feed the baby with colostrum, the thick yellowish fluid which is rich in antibodies, proteins, and vitamins.
- Feed frequently, both day and night, whenever the baby is hungry.
- Feed from both breasts.
- Feed at least every four hours, more frequently in the early weeks.
- Breastfeed exclusively for the first four-six months.
- When semi-solid foods are introduced, breastfeed first and then give supplemental food.
- Do not use pacifiers/nipples/bottles.
- Express breast milk if separated from the baby.
- Continue to breastfeed even when the mother or baby is sick.
- Maintain a nutritionally sound diet for the mother and satisfy her own hunger/thirst (and identify what local foods constitute a good diet).
- Is not necessary to give baby water/teas. If the baby appears thirsty, it is best for mother to drink water, so that she will produce more milk.
- Continue to breastfeed for as long as possible (up to two years).

## **BENEFITS OF BREASTFEEDING**

### **For the Baby:**

- Breast milk
  - Has what the baby needs
  - Changes as the baby matures
  - Is easy to digest.
  - Is clean.
  - Is at the right temperature.
  - Protects the baby against certain illnesses and infections
- Breastfeeding makes the baby feels warm and secure

### **For the Mother:**

- Suckling by the baby helps the mother's uterus to contract to its normal shape and size
- Breastfeeding:
  - Reduces the bleeding after delivery
  - Helps the mother to lose fat
  - Forms a bond of love with the baby.
  - Is convenient
  - Protects the mother from pregnancy

## **BENEFITS OF BREASTFEEDING**

### **For the Baby:**

- Breast milk is the best and most natural food for a baby. Breast milk:
  - Has a better balance of what the baby needs than does any other milk, whether fresh, canned, or powdered.
  - Changes as the baby matures to meet the baby's complete nutritional needs and to nourish him/her properly.
  - Is easy to digest.
  - Is clean. When other foods are given, especially by bottle feeding, it is very hard to keep bottles and other utensils clean enough to prevent the baby from getting diarrhea and other sicknesses.
  - Is always at the right temperature.
  - Contains substances (antibodies) which protect the baby against certain illnesses and infections (diarrhea and respiratory infections), especially during the first six months.
- Infants who are breastfed are more healthy than those who receive artificial milk.
- During breastfeeding, the baby feels warm and secure and a bond of love is formed with the mother.
- Suckling helps the jaws and tooth development of the baby.

### **For the Mother:**

- Suckling of the nipples by the baby helps the mother's uterus to contract and to come to its normal shape and size after delivery.
- Breastfeeding:
  - Reduces the bleeding after delivery due to proper uterine contraction.
  - Helps the mother to lose the extra fat put on during pregnancy.
  - Makes the mother feel emotionally satisfied and her self-image is enhanced. A bond of love is formed with the baby.
  - Is convenient as breast milk is immediately available at the right temperature and is free of cost.
  - Protects the mother from becoming pregnant soon.
  - Protects mothers from breasts and ovarian cancers, and from osteoporosis.

## **PRINCIPLES OF BREASTFEEDING**

Breastfeeding should be the norm for all mothers. Assume that every mother will and can successfully breastfeed; reassure her that she is capable of producing plenty of milk for her baby. Young mothers who are having their first baby are more likely to need information, support and help.

The mother should give her breast to the baby as soon as possible, within the hour(s) after he is born, when he seems to be ready. This initial feeding provides colostrum for the baby, which has very valuable antibodies to protect the baby from infections.

A baby shows he is ready to feed in several ways. He may:

- Be wakeful and restless
- Make small noises
- Make hand-to-mouth movements or sucking movements
- Suck his fingers or fist
- Root for the breast (i.e. when his cheek is stroked, he turns his head to the side that is stroked and opens his mouth.)

For the first few days the mother's breasts usually produce very little milk. This is normal. She should continue to nurse her baby often—at least every two hours. The baby's sucking will help her produce more milk.

Encourage mothers to hold their babies naked against their skin (skin-to-skin contact) and to cover both with the same blanket.

A mother needs to have her baby near her so that she can see and touch and respond to him. This helps her body to prepare for a breastfeed, and it helps her breast milk to flow. If a mother is frequently separated from her baby between feeds, the reflex may not work as well. In more and more maternities, mothers are staying in the same room with their babies (room-in system), which allows mothers to feed their babies on demand.

The mother should feed her baby entirely on demand: she should suckle him whenever he wants and for as long as he wants. The advantages of breastfeeding on demand are:

- Breast milk 'comes in' sooner
- The baby gains weight faster
- There are fewer difficulties such as breast engorgement
- Breastfeeding is more easily established

Do not discourage the woman if she wishes to practice *bedding-in* (keeping the baby in bed with her). This makes it easier for her to breastfeed at night.

If the weather is hot, the mother should drink plenty of fluids, and not worry about the baby. The breast milk contains all the water and nutrients that a baby's body needs.

It is very normal for breast fed babies to feed at least every three hours. Mothers should not attempt to make their babies follow a schedule until lactation is very well established, certainly not before six weeks.

Mothers should not use anything except clean water to cleanse their breasts. Even soap can have an astringent (drying) effect and contribute to sore, cracked nipples. Rubbing a small amount of breast milk or colostrum on the nipples, will help to prevent and/or heal sore nipples.

**BABY'S ATTACHMENT TO THE BREAST**



*A baby well attached  
to his mother's breast*



*A baby poorly attached  
to his mother's breast*

## **CARE OF THE BREASTS DURING BREASTFEEDING**

Taking good care of the breasts is important for the health of both the mother and her baby. The baby should begin to breast feed soon after it is born.

Normally, the breasts make as much milk as the baby needs. If the baby empties them, they begin to make more. If the baby does not empty them, soon they make less.

When a baby gets sick and stops sucking, after a few days the mother's breasts stop making milk. So when the baby can suck again, and needs a full amount of milk, there may not be enough. For this reason, when a baby is sick and unable to take much milk, it is important that the mother keep producing lots of milk by milking her breasts with her hands.

To milk the breasts by hand, the woman takes hold of the breast way back, then moves her hands forward, squeezing. To squeeze the milk out, she must press behind the nipple. She can then give the milk to the baby by spoon or dropper.

Another important reason to milk the breast if the baby stops sucking, is that this keeps the breasts from getting too full. When they are too full, they are painful. A breast that is painful is more likely to develop an abscess. In addition, the baby may have trouble sucking when the breast is very full.

Regular bathing will help to keep the mother's breasts clean. It is not necessary to clean her breasts and nipples each time she breastfeeds her baby. She should **not** use soap to clean her breasts, as this may cause cracking of the skin, sore nipples, and infection.

## COMMON PROBLEMS DURING BREASTFEEDING

### **Sore or Cracked Nipples**

Sore or cracked nipples develop when the baby sucks only the nipple instead of taking the nipple and part of the breast when he is breastfeeding.

#### *Recommendations:*

It is important to keep breastfeeding the baby even if it hurts. To avoid sore nipples, breast feed often, for as long as the baby wants to suck, and be sure the baby is taking as much of the breast into his mouth as he can. It also helps to change the baby's position each time he nurses.

If only one nipple is sore, let the baby suck on the other side first, then let the baby suck from the sore nipple. After the baby is finished, squeeze out a little milk and rub the milk over the sore nipple. Let the milk dry before covering the nipple. The milk will help the nipple heal. If the nipple oozes a lot of blood or pus, milk the breast by hand until the nipple is healed.

### **Breast Engorgement**

Breast engorgement occurs when the breasts are overfull, partly with milk and partly with increased tissue fluid and blood, which interferes with the flow of milk. Engorged breasts are very painful, edematous, tight (especially the nipple), shiny, and may look red; milk is NOT flowing; and the woman may have a fever for 24 hours.

#### *Recommendations:*

- It is essential to remove milk from the breasts, otherwise mastitis will develop, an abscess may form, and milk production will decrease. Do NOT “rest” the breast.
- If the baby is able to suckle, feed frequently, helping the baby with positioning.
- If the baby is not able to suckle, express milk by hand or by pump. Sometimes expressing a little milk will soften the breast enough so that baby can suckle.
- Before feeding:
  - Put warm compresses on the breast or take a warm shower
  - Massage the neck and back
  - Lightly massage the breast
  - Stimulate the nipple skin
  - Relax
- To reduce edema after breastfeeding, put cold compress on the breasts.

### **Painful Breasts**

Pain in the breast can be caused by a sore nipple or by breasts that get very full and hard. The pain will often go away in a day or two if the baby breastfeeds frequently and the mother rests in bed and drinks lots of liquids. Usually, no medication is needed but it is recommended for the woman to see the doctor.

## **Blocked Duct**

Blocked ducts occur when the milk is not removed from part of a breast. Sometimes this is because the duct to that part of the breast is blocked by thickened milk. The symptoms are a tender lump and often localized redness of the skin over the lump. The woman has no fever and feels well. Contributing causes include: infrequent or short breastfeeds (mother very busy, baby sleeping at night, changed routine, mother stressed), poor drainage of part or all of the breast (ineffective sucking, pressure from tight clothes, pressure from fingers during feeds, large breast draining poorly), damaged breast tissue (trauma to the breast).

### *Recommendations:*

The most important thing is to improve drainage from the affected part of the breast.

Advise:

- Frequent breastfeeds,
- Gentle massage of affected area towards the nipple,
- Warm compresses to the affected area.

It may help to vary the baby's feeding position.

## **Breast Infection (Mastitis) and Abscess**

Painful breasts and sore or cracked nipples can lead to an infection or abscess (pocket of pus).

### *Signs*

- Part of the breast becomes hot, red, swollen, and very painful
- Fever or chills
- Lymph nodes in the arm-pit are often sore and swollen
- A severe abscess sometimes bursts and drains pus.

### *Treatment*

- Keep breastfeeding frequently, or milk the breast by hand, whichever is less painful.
- Rest and drink lots of liquids.
- Use hot compresses on the sore breast for 15 minutes before each feeding. Use cold compresses on the sore breast between feedings to reduce pain.
- Go to the doctor for treatment.

### *Prevention*

Keep the nipples from cracking and don't let the breasts get overfull.

## ANSWERS TO FREQUENTLY ASKED QUESTIONS

**Q:** Doesn't rooming-in expose newborns to more risk of infection?

**A:** No. There is lower incidence of neonatal infections with rooming-in than with traditional newborn nurseries. Newborns are most likely to be infected unknowingly by the medical personnel who handle them, especially if hand washing facilities are not very adequate. It is very important for healthcare workers to wash their hands between contacts with patients. In addition, newborns receive high doses of protective antibodies from the colostrum they receive by suckling frequently with their mothers.

**Q:** What should we do if the baby is crying a lot before the milk comes in?

**A:** This problem is much less likely to occur if breastfeeding is initiated early, if mother and baby are not separated at all, if the baby is attaching properly to the breast, and if the mother is encouraged to let the baby suckle whenever he wants, for as long as he wants. Of course, it is important that the mother gets plenty of fluids to drink, especially if she has bled a lot. As long as she is not dehydrated, if the baby is allowed to suckle as much as he wants, and if he is attaching properly to the breast, the crying will soon cease. Do NOT give any supplements; this would only make the problem worse.

**Q:** What if the mother says she doesn't have enough milk?

**A:** To help a mother increase her milk supply, she should:

- Drink plenty of liquids
- Make sure that the baby is attaching well to the breast at each feed
- Keep the baby with her at all times, allowing him to suckle freely, especially at night
- Allow him to nurse whenever he is interested, for as long as he wants
- Try to give both breasts at each feed
- Avoid giving the baby any supplements – these would only further suppress the milk production.

**Q:** If the weather is very hot, doesn't the baby need to be given some water?

**A:** The baby does not need supplementary water even when the weather is hot, as long as his mother is getting plenty to drink. Encourage her to drink a lot of water and to give the baby free access to the breast, so that his suckling will stimulate her breasts to produce more milk to keep him hydrated.

**Q:** Is it true that breastfeeding prevents pregnancy?

**A:** Exclusive breastfeeding can protect a woman from becoming pregnant by suppressing ovulation for the first six months of the baby's life, as long as certain conditions are met:

- The baby is 6 months old or less
- The baby is given nothing except breast milk, day and night
- The woman has not had a menstrual period since delivery.

**Q:** When should I start giving my baby supplementary foods?

**A:** Until 6 months of age, exclusive breastfeeding is best. When the baby is 6 months old, it is time to start giving him supplementary foods, such as cereals, fruits, fruit juice, etc. Continue breastfeeding in combination with supplementary foods for as long as possible, at least two years is good. Do not give formula, and do not use feeding bottles. The baby can be weaned gradually directly from the breast to the cup.

**Q:** What is proper nutritional advice for nursing mothers?

**A:** It is important for nursing mothers to eat a healthy and varied diet with plenty of protein, calcium, iron and vitamins so that they can produce plenty of milk without putting their own health at risk. They should continue taking iron supplements for three months after delivery. They should consume dairy products (milk, cheese, yogurt) every day. They should drink plenty of water and avoid alcohol and cigarettes. Many mothers find that nursing an infant helps them regain their pre-pregnancy figure quickly.

## MYTHS ABOUT BREASTFEEDING

**Myth:** "You have to drink a lot of milk to produce more milk."

**Fact:** It is not true. Any type of food and fluids taken in by the mother in adequate quantity is sufficient to produce milk. The production of breast milk is not dependent on the milk intake by the mother. The baby's suckling on the breast is also important, "more suckling- more milk."

**Myth:** "Small breasts will not produce enough milk."

**Fact:** Being able to breastfeed successfully does not depend on the size of the woman's breast. The size of the breasts depends upon the fatty tissue layer under the skin. Special sacs in the breast, which are present in all women, produce breast milk.

**Myth:** "You have to stop eating certain foods during breastfeeding."

**Fact:** The woman can continue eating most of her favorite foods during breastfeeding. Though some people report problems with different food, many others don't have any problems with the same kind of food. If the woman is worried about a particular food, she may eat a small amount each time and see whether it causes any problem to her baby. If it really bothers her baby every time she eats it, she should quit eating this food.

**Myth:** "Working with cold water will affect the milk supply."

**Fact:** This is not true. Some people believe that it may cause cold to the baby but it does not.

**Myth:** "If you were not able to breastfeed your first baby, you won't be able to breastfeed successfully this time."

**Fact:** Mothers can be successful in breastfeeding their babies even if they were not able to breastfeed the first baby, so it is important to be confident.

**Myth:** "Mother's milk 'comes in' after three days."

**Fact:** One may say that it actually starts flowing freely by the third day but the yellowish milk (colostrum) starts coming out as early as baby starts suckling and it is sufficient for baby's demands for the first three days.

**Myth:** It is not practical to fully breastfeed the baby.

**Fact:** Once the mother has clearly understood the benefit for her baby and herself and she is determined to fully breastfeed her baby, it is not difficult to do so.

**Myth:** If the mother fully or nearly fully breastfeeds her baby, she will become very weak and malnourished.

**Fact:** If the mother clearly understands the dictum "*feed the mother to feed the baby*" and takes a well balanced diet, she will remain healthy and successfully breastfeed her baby.

**Myth:** Most of the mothers do not have sufficient milk to fully breastfeed their babies.

**Fact:** Milk production is directly related to suckling of the breast by the infant. Mothers should not lose heart but should continue putting their babies to the breast for frequent suckling so that milk production is optimal. They should eat well to assist in milk production.

**Myth:** Exclusive breastfeeding is not sufficient for a baby's growth during the first 6 months and supplementation is required earlier.

**Fact:** Exclusive breastfeeding for the first six months provides sufficient nutrition, supplying all the needs of the infant for the first six months. It also complements the infant's immature immune system.

## SESSION 10: SEXUALLY TRANSMITTED INFECTIONS

**OBJECTIVES:** By the end of the session, the participants should be able to:

1. Explain how STIs are transmitted from one person to another
2. Describe how sexually active people can reduce their risk of contracting STIs, including HIV
3. Discuss basic facts about HIV transmission, prevention and testing

**TRAINING METHODS:** Card game, Discussion, Presentation, Exercise

**TIME:** 1 hour 30 minutes

### **MATERIALS:**

Index Cards (one for each participant)

Papers with words “Myth” and “Truth”

#### Trainer documents:

- Myths and Truths About HIV/AIDS (statements)
- HIV/AIDS: What is True? What is False? (Sample Discussion Points)

#### Participant documents:

- Ways to Significantly Reduce the Risk of Sexually Transmitted Infections
- How Is HIV/AIDS Spread?

## **INSTRUCTIONS:**

### **I. STI TRANSMISSION (20 minutes)**

[**Note:** The following activity is a good icebreaker, at the beginning of the session, to get the group involved in discussion of STIs/HIV.]

Prepare index cards so that one index card has a small letter *h*, one card has a small letter *g*, one card has a small letter *c*, and one card says “Do not accept signatures.” The rest of the cards are blank.

Inform participants that they will play a game.

#### Exercise instructions:

1. Give each participant an index card. A few of the cards will be slightly different. (One card has the letter *h*, one card has the letter *g*, and one card has the letter *c*, and one card says “Do not shake hands with anyone.” The rest of the cards are blank.). Do not tell participants that a few of the cards will be slightly different.
2. Quietly remind the person with the card that says “Do not shake hands with anyone” to kindly refrain from shaking hands during the exercise. Then, in a loud voice, ask participants to stand and move about the room and shake hands with three different people in various parts of the room.

Ask that each time they shake hands with someone, they ask that person to sign their card. Ask that they return to their seats after everyone has shaken hands with three different participants.

3. First, ask the person with the index card *h* to stand. Then, ask the person with index card *g* to stand. Then, ask the person with index card *c* to stand. Next, ask everyone who shook hands with these three people to also stand.

Then, ask anyone who is still sitting if they shook hands with any of the people who are now standing. Continue to ask this question until everyone who shook hands with a standing person is also standing. This will be most if not all the class.

4. Ask the group to imagine that the *h* card represented a person with HIV, the *g* card represented a person with Gonorrhea, and the *c* card represented a person with Chlamydia. These are all sexually transmitted diseases. Ask participants to imagine that the handshake represented unprotected sex. If this was the case, all of the standing people could have been infected with one of these diseases. Emphasize that this shows how easily STIs can spread in a community. Remind participants that STIs are *NOT* spread by shaking hands, but by intimate sexual contact.

5. Ask everyone to sit down. Then, ask the person who did NOT shake anyone's hand to stand up. Remind the group that each person has the right to refuse to shake hands with another participant, just as each person has the right to refuse a sexual encounter that may put them at risk of being infected by a sexually transmitted infection.

Discover what participants know about STIs by asking the following key questions. Correct misinformation and provide additional information if needed.

- Since shaking hands does not spread sexually transmitted infections (STIs), how are they spread?

By having vaginal, anal, and/or oral sex with an infected person.

- What do you understand by sexually transmitted infections or STIs?

STIs are infections of the reproductive organs. They are transmitted through sexual intercourse with an infected person.

- What STIs do you know?

Syphilis, Gonorrhea, Chlamydia, Herpes, HPV, Hepatitis B and C, HIV infection, Candida

Specify that:

- All STIs are spread through genital secretions (both in male in female) when a person has unprotected sexual intercourse with an infected partner

- The sexual act can be vaginal, anal, or oral (the vagina, penis, rectum, and mouth provide the ideal environment through which STI germs can invade the body)
- In some cases, STIs are transmitted via genital-to-genital contact but without penetration.
- Some STIs are spread also by others body fluids, like blood and mother's milk.

➤ Can you tell if a person has a STI by looking at them?

Usually you cannot tell. Some STIs have symptoms. Others have no symptoms or the symptoms may not show up for a long time.

For example, a person infected with HIV, the virus that causes AIDS, may look perfectly healthy for many years but can still infect others with the virus.

➤ If a person with a STI does have symptoms, what might he or she notice?

- A strange discharge or smell from the penis or vagina
- Pain or burning while urinating
- Pain during sex
- Itching or pain on or near the genitals
- Sores, blisters, rashes, swelling, or growths around the genitals which may hurt or may not hurt
- Swollen and painful lymph glands in the groin
- Changes in menstrual bleeding, e.g. very little bleeding or heavy bleeding (in women)

Remind participants of the characteristics of a normal vaginal secretion in different stages of the menstrual cycle, and explain that it is important to learn how to differentiate between normal and abnormal vaginal discharge.

- **Normal vaginal discharge** consists of clear mucus discharge from the cervix which increases in quantity and becomes thin and slimy at the time ovulation, or at mid-cycle. The clear fluid from the walls of the vagina increases more during sexual excitement and emotional stress. It has normal body odor.
- **Abnormal discharge** has unpleasant smell, unusual color and consistency and it usually causes irritation and soreness and soreness in genital area.

Summarize STI transmission with the following points:

- Anyone can get a STI if they have sex with an infected person, as the exercise demonstrated. It doesn't matter who they are.
  - Caring and loving people, clean and educated people, very wealthy people can all get STIs.
  - Both men and women can get STIs.
  - A person can get an STI even after a single unprotected sexual act with an infected partner. The more a person has sexual intercourse with one or more infected partners, the more likely he/she is to get infected.
  - No one is immune to STIs

- Reproductive tract infections are more common in women because of their body structure and functions (like menstruation, pregnancy and childbirth). They are much more vulnerable to the entry and growth of disease-germs.
- Not all reproductive tract infections are STIs.
  - There are many types of infections and inflammations of the reproductive tract exhibiting different symptoms in men and women.
  - They may be caused by different organisms/germs that enter the reproductive tract, or by organisms which normally live in the reproductive tract when these expand in numbers. The reproductive tract can get infected by:
    - Poor general health due to poor diet, lack of sleep, and life stresses which lower the body's resistance to infection
    - Poor genital hygiene, which promotes infections (unclean underwear, failure to change or remove pads, wiping from rear to front after passing stools)
    - Use of some soaps, perfumes and deodorants which irritate tender skin
    - Some medicines (antibiotics) that kill normal bacteria that protect the vagina's health
    - Sexual intercourse with an infected person
    - Trauma (e.g. from delivery, sexual intercourse or use of chemicals, etc.)
    - Unhygienic practices of health-care providers (e.g. unhygienic delivery or abortion practices, insertion of contaminated IUD).
- One cannot recognize a person having a STI just by looking at him/her as s/he may look normal
  - STIs may not produce any signs/symptoms, particularly in women
  - People having a STI without symptoms may not know that they are infected, and they act as carriers, or may spread the infection to others.

By incorporating STI prevention, early detection and referral messages into all types of education, mediators can raise awareness and help community members to take responsibility to protect themselves from these types of infections.

## II. REDUCING THE RISK OF STIs (30 minutes)

Suggest that we have just learned how STIs are transmitted and some of the symptoms of STI infection. Now we will discuss how people can reduce their risk of becoming infected with an STI or infecting others. Ask:

- What should you do if you have symptoms or think you may have been infected with an STI?

- See a health provider.
- Don't have sex again until you are checked.
- Follow the medical recommendation and treatment. Many STIs can be cured if the person is treated right away.
- Remember that some STIs do not have symptoms. Yet, they can still make you very

sick and spread to others.

- How can a person avoid getting a STI?

He/she doesn't have sex.

Explain that most of the people choose to have sex. In this case:

- How can sexually active people significantly reduce the risk of STIs?

- Use condoms every time they have sex
- Have sex with only one person who is disease free and who has sex only with him/her (be faithful)
- Do not have sex if he/she or his/her partner has an infection in the reproductive system. Wait until after the infection has been fully treated
- Do not use unclean injection needles or have sex with someone who uses them.

- What other ways can sexually active people reduce the risk of STIs?

- Reduce the number of sexual partners
- Find ways to be sexual that do not include penetrative sex
- Communicate with their partners about STIs and the risk of infection
- Discuss with partner(s) about past sexual partners, needle drug use, and untested transfusions
- Get regular checkups
- Monitor their bodies for signs of infection or for changes
- See a health professional if they notice a change that is not typical, or if they think they may have been infected with a STI
- Do not abuse drugs or alcohol. These substances can cloud the judgment and make it harder to protect reproductive health
- Make sure blood has been screened for disease before receiving a transfusion
- Believe they have the right to keep themselves healthy.

- Why is it important to detect early and to treat infections?

Without treatment, STIs can lead to serious complications such as:

- Infertility in men and women
- Eight to ten times increased risk of getting HIV/AIDS, if exposed to a STI
- Increased risk of cervical cancer
- Risky pregnancy, e.g., miscarriage, still births or infants born with birth defects, including brain damage
- During birth, the newborn can get severe eye infection from mother's birth-canal and can become blind.

Distribute the participant document *Ways to Significantly Reduce the Risk of Sexually Transmitted Infections*.

Close this part of the session with the following points:

- All STIs can be prevented
  - We have the right and responsibility to keep ourselves healthy and to reduce the risk of STIs. Sometimes people:
    - Do not know that they are at risk of getting a sexually transmitted infection.
    - Find it hard to advocate for themselves or follow the practices that can keep them healthy.
    - Avoid telling their partners, even if they know they have a sexually transmitted infection.
  - As we become more comfortable talking about STI risks with our partners and discussing how to keep each other healthy, it becomes easier to engage in behaviors that significantly reduce the risk of infection.
- Most STIs can be treated. Early detection and treatment can significantly decrease serious complications, including infertility in both men and women.
- Mediators can offer opportunities for community members to think about, discuss, and practice the communication skills they need to better advocate for their own reproductive health and reduce the risk of infection. For example, they can help people to:
  - Improve their prevention practices
  - Monitor their health and behavior on a regular basis
  - Educate others about prevention of STIs, and about the importance of early detection and treatment for preventing serious complications
  - Request services if symptoms of STIs are noticed or if there is a chance of infection

Inform people that they can choose an appropriate family planning method depending upon whether they are at risk or are suffering from STIs or not (for example, IUD should not be inserted in a woman with an STI or PID; condoms may be used in association with other contraceptive method if any risk of STIs is suspected).

### **III. HIV/AIDS (40 minutes)**

Briefly explain what HIV/AIDS is:

- AIDS (Acquired Immune Deficiency Syndrome) is a fatal and dangerous disease. It is spreading at an alarming rate all over the world. Besides sexual intercourse, it can be spread by sharing needles or sharp tools with an infected person, blood transfusion or organ donation from an HIV positive person, and from mother-to-child during pregnancy, birth or breastfeeding.
- A virus known as Human Immunodeficiency Virus (HIV) causes the disease. Once HIV enters the body of a healthy person (by any one of its modes of transmission), it multiplies and slowly destroys the immune system of the body by entering the blood

cells (which fight against infections) and destroying them. The HIV infected person may look normal for 2-10 years while the immune system is breaking down slowly.

- Once the immune system is destroyed the person is likely to get a variety of diseases, as her/his body cannot fight against any infections. This condition is called AIDS. With AIDS, symptoms of many diseases appear and that is why it is called a syndrome (group of symptoms). AIDS has no treatment and is always fatal, but it can be prevented.

Explain the difference between HIV, HIV infection and AIDS.

- **HIV** is the virus that causes the disease by destroying the ability of the human body to fight against any infections.
- **HIV infection** is the condition when the virus is present in the body. The HIV infected person has no symptoms and s/he may look healthy for 2-10 years but **s/he can spread HIV** to other people.
- **AIDS** is the late stage of the HIV infection when symptoms appear. It leads to death. HIV is present in the blood and other body fluids of the infected person.

Prepare a list of myths and misconceptions about HIV/AIDS that are common in the community. The trainer document *Myths and Truths about HIV/AIDS* may be used for this; however, it is best to use myths that are common in the Roma communities. Make enough slips of paper so that each participant has at least one statement.

Make a sign that says “Myth” and a sign that says “Truth”. Post the signs on opposite ends of the room. You will also need many little pieces of masking tape for this activity.

Explain to participants that they will be involved in an activity which is intended to dispel myths, and provide accurate information about HIV/AIDS.

- Pass out a slip of paper to each participant. Tell participants the statement on the paper is either true or false. If the statement is true, ask participants to tape the statement to the wall under the sign that says “Truth”. If their statement is false, ask them to tape the statement to the wall under the sign that says “Myth”.
- Once all the statements are taped to the wall, review each of the statements with the entire group. Together, confirm whether each statement is a truth or a myth. (If there are any errors, move the statement and tape it under the correct sign.) Provide additional information and answer questions, using the trainer document *HIV/AIDS: What is True? What is False? (Sample Discussion Points)* as a basis.

Distribute the participant document “*How Is HIV/AIDS Spread?*” and discuss it, if appropriate.

Ask participants:

- What messages would you pass on in the community regarding protection against HIV/AIDS?

Emphasize that HIV/AIDS can be **prevented but it cannot be cured**.

- Have a mutually faithful relationship with one sexual partner who is uninfected
- Use condoms every time you have sex with anyone whose HIV status you are not sure of, or if you are not sure of your own
- Avoid injections with infected syringes or needles
- Do not share hypodermic needles, other needles, or razors
- Be sure that instruments used to pierce the skin are sterilized
- Do not have sex with someone who uses unclean needles
- Avoid blood transfusions if possible by keeping healthy and avoiding anemia caused by malnutrition, repeated pregnancies, etc. If a transfusion is required, blood should be tested for HIV before the transfusion.
- If there is a possible risk of transmission, be tested early to prevent further spread
- Keep yourself healthy, disease-free and clean
- Get STIs treated as early as possible

Summarize the activity with the following main points:

- Anyone can get HIV/AIDS if they are exposed to the blood, semen, or vaginal fluid of an infected person. Most often, this happens due to unprotected sex or sharing of hypodermic needles. Often there are no outward signs that a person has been infected with HIV.
- To protect yourself against HIV/AIDS, abstain from sex or only have sex with an uninfected partner. Using a condom every time you have sex can protect you and your partner from getting and spreading HIV/AIDS. Also, do not share hypodermic needles, other needles, or razors. And, do not have sex with someone who uses unclean needles.
- It is important for mediators to know what community members already know and believe about HIV/AIDS. Then, they can tailor educational messages to meet the needs of the people they serve.

## **WAYS TO SIGNIFICANTLY REDUCE THE RISK OF SEXUALLY TRANSMITTED INFECTIONS**

- Make sure you and your partner are not infected. Only have sex with one faithful, uninfected partner.
- Decide not to have sex. Or, do not have penetrative sex.
- Use condoms correctly every time you have sex.
- Do not use unclean injection needles or receive transfusions of infected blood. And, do not have sex with someone who does.
- Do not have sex if you or your partner has an infection in the reproductive system. Wait until after the infection has been fully treated

### **More ways to reduce the risk of STIs**

- Reduce the number of sexual partners you have.
- Choose to be in a mutually monogamous relationship.
- Wait until you are older to begin having sex (or wait until you are older to get married).
- Find ways to be sexual that do not include penetrative sex.
- Get regular checkups.
- Believe you have the right and responsibility to keep yourself healthy.
- Use a family planning method that also protects against STIs (condom).
- Communicate with your partner(s) about STIs and the risk of infection
- Discuss with your partner about past sexual partners, needle drug use, and untested transfusions.
- Advocate for yourself. Do not feel pressured into having sex or pressured to engage in unsafe sex practices.
- Do not pressure others to have sex or engage in unsafe sex practices.
- For women, do not douche and do not put unclean substances (herbs, drying agents, etc.) into the vagina.
- Do not abuse drugs or alcohol. These substances can cloud your judgment and make it harder to protect your reproductive health.
- Monitor your body for signs of infection or for changes that are not typical for you.
- See a health professional if you notice a change that is not typical for you, or if you think you may have been infected with a STI.

**MYTHS AND TRUTHS ABOUT HIV/AIDS  
(Statements)**

- ✚ HIV is the virus that causes AIDS.
- ✚ Condoms are not very effective in preventing HIV.
- ✚ Abstaining from every kind of sex (oral, anal, and vaginal) can protect you against HIV/AIDS.
- ✚ A pregnant woman can pass the HIV virus to her unborn child.
- ✚ You can get HIV by shaking hands with an infected person.
- ✚ You can get HIV by sharing toilet facilities with someone who is infected.
- ✚ Only homosexual couples need to worry about getting HIV/AIDS.
- ✚ You can get HIV by having unprotected sex with a person who is infected.
- ✚ You can get HIV by eating food prepared by a person who has the infection.
- ✚ The virus that causes AIDS is also spread by insect bites.
- ✚ You can get HIV/AIDS if an infected person coughs or sneezes on you.
- ✚ A person can get HIV by using dirty injection needles, other needles, or razors.
- ✚ You can usually tell if a person has HIV by looking at them.
- ✚ A person who looks and feels healthy can be carrying the HIV virus and still infect others.
- ✚ A blood test can determine whether you have HIV.
- ✚ HIV can be cured if diagnosed early.
- ✚ Anyone can get AIDS if they are exposed to the blood, vaginal fluid, or semen of an infected person

**HIV/AIDS: WHAT IS TRUE? WHAT IS FALSE?  
Sample Discussion Points**

**HIV is the virus that causes AIDS. (TRUE)**

HIV (human immune deficiency virus) causes people to become sick with infections that would normally not affect them. AIDS (acquired immune deficiency syndrome) is the last phase of the HIV infection, when an infected person becomes very sick.

**Condoms are not very effective in preventing HIV. (FALSE)**

Next to abstinence, condoms are the most effective way to prevent the transmission of HIV and other sexually transmitted infections. To be effective in preventing HIV transmission, condoms should be used correctly every time the couple has sex. This includes oral, anal, and vaginal sex. Condoms also prevent pregnancy.

**Abstaining from every kind of sex (oral, anal, and vaginal) can protect you against HIV/AIDS. (TRUE)**

Abstaining from any kind of sex can protect you from HIV/AIDS. Abstinence also protects against pregnancy.

**A pregnant woman can pass the HIV virus to her unborn child. (TRUE)**

Fifteen to thirty percent of babies born to women with HIV are also infected. A baby can be infected during pregnancy, delivery, and through breastfeeding. The use of certain drugs during pregnancy can reduce the risk of infection to babies.

**You can get HIV by shaking hands with an infected person. (FALSE)**

A person does not get HIV by shaking hands. The infection is spread through the exchange of body fluids (blood, semen, or vaginal fluids). Having oral, anal, or vaginal sex with an infected person spreads HIV. Using a hypodermic needle or other needle that was used by an infected person also spreads it. You can also get HIV by having sex with someone who shares needles. If a pregnant woman has HIV, she can infect her baby during pregnancy, delivery, and through breastfeeding.

**You can get HIV by sharing toilet facilities with someone who is infected. (FALSE)**

You cannot get HIV in this way. (See previous answer.)

**Only homosexual couples need to worry about getting HIV/AIDS. (FALSE)**

Anyone who has sex with an infected person, or shares needles with an infected person, can get HIV. It does not matter whether the individuals are homosexual or heterosexual.

**You can get HIV by having unprotected sex with a person who is infected. (TRUE)**

Body fluids are exchanged during sex. Semen, vaginal fluid, and sometimes blood are mixed and the infection can spread. Using a male or female condom keeps the body fluids of one person from mixing with the body fluids of another person.

Condoms provide “dual protection.” They prevent pregnancy and reduce the risk of getting HIV/AIDS or other sexually transmitted infections.

**You can get HIV by eating food prepared by a person who has the infection. (FALSE)**

HIV/AIDS is not spread this way. (See previous answer.)

**The virus that causes AIDS is also spread by insect bites. (FALSE)**

HIV/AIDS is not spread this way. (See previous answer.)

**You can get HIV/AIDS if an infected person coughs or sneezes on you. (FALSE)**

HIV/AIDS is not spread this way. (See previous answer.)

**A person can get HIV by using dirty injection needles, other needles, or razors, (TRUE)**

Blood with HIV in it may be left on the needle or razor, and passed on to the next user.

**You can usually tell if a person has HIV by looking at him/her. (FALSE)**

A person with HIV may look and feel healthy for a very long time. However, even if an infected person appears healthy, he or she can still pass the HIV infection to others through unprotected sex or by sharing dirty needles or syringes. Many people with HIV do not even know they are infected.

**A person who looks and feels healthy can be carrying the HIV virus and still infect others. (TRUE)**

Many people with HIV do not even know they have this infection. (See previous answer.)

**A blood test can determine whether you have HIV. (TRUE)**

A simple blood test can determine whether a person is infected with HIV. The test looks for HIV antibodies. If there are HIV antibodies in the blood, the person is HIV positive. However, once a person is infected with HIV it can take up to 6 months for the HIV antibodies to appear in the blood. This means an infected person can spread HIV to others even before the test shows that the person is HIV positive (having an HIV negative result).

**HIV can be cured if diagnosed early. (FALSE)**

There is presently no cure for HIV/AIDS. Some people with HIV get sick and die sooner than others. Some people have lived with the infection for more than 10 years. Although HIV/AIDS cannot be cured at this time, it can be prevented. To prevent HIV/AIDS follow the safer sex practices described in previous answers.

**Anyone can get AIDS if they are exposed to the blood, vaginal fluid, or semen of an infected person (TRUE)**

(See previous answers.)

### **HOW IS HIV/AIDS SPREAD?**

- From unprotected sex with an infected person (the most common route of transmission).
- From an infected mother to her baby during pregnancy, birth, and through breastfeeding
- From sharing dirty needles and razor blades
- From transfusion of infected blood

### **HOW HIV/AIDS IS NOT SPREAD?**

- Talking
- Playing together
- Sneezing or coughing
- Hugging
- Touching
- Shaking hands or holding hands
- Kissing
- Boiling water or cooking food
- Sharing toilet facilities
- Sharing meals
- Insect bites

## SESSION 11: INFERTILITY

**OBJECTIVES:** By the end of the session, the participants should be able to:

1. Name common causes of infertility
2. Describe general measures for reducing the risks of infertility and for investigation of a infertile couple

**TRAINING METHODS:** Discussion, Presentation

**TIME:** 30 minutes

**MATERIALS:**

Trainer document

- Causes of Infertility

### INSTRUCTIONS:

#### I. INFERTILITY – DEFINITION, CAUSES (15 minutes)

Refer to the last session and the fact that untreated STIs can lead to problems of infertility. Ask participants:

- When you hear someone say that a man, or a woman or a couple is infertile, what do you think that means?

That the person, or couple, has difficulty having (or is unable to have) a child.

- In general, who is responsible for not being able to have a pregnancy/a child?

Either the man or the woman, or both of them, may be unable to do their part in order to create a pregnancy/have a child.

Explain that:

- Often the woman is blamed when she does not become pregnant. Even if the couple gets medical help, sometimes doctors will check only the woman for fertility problems. But just as often the man is the one who is infertile. Neither men nor women should be blamed for infertility. And both need support during this difficult time. For a couple that wants to have children, infertility can bring sadness, anger, or shame.
- A couple is said to be infertile if the woman has not gotten pregnant after having normal sexual intercourse two-three times a week, without using any method of contraception, for at least one year. In general, 80% of couples who are trying to have a baby can achieve a pregnancy within a year, and up to 90% within 18 months of trying.
- Infertility has many causes. Some causes of infertility are preventable.

- Sexually transmitted infections can leave scars inside a man's or woman's reproductive parts that prevent pregnancy from occurring.
- Illnesses such as diabetes, tuberculosis, and mumps can cause infertility.
- Dangerous chemicals from pesticides, cleaning products, or factories can get into the air, water, or food. These chemicals can make it difficult for a woman to get pregnant, or can harm the growing baby.
- Smoking, drinking a lot of alcohol or using drugs can all harm fertility.
- There are other causes of infertility that are not preventable.

Make a short presentation of the causes of infertility, using the trainer document *Causes of Infertility* as a basis. Emphasize that infertility is a problem involving two people. On average, the cause lies with the man 40% of the time and with the woman 40% of the time; and in 20% of the cases, both man and woman contribute to the problem.

## II. REDUCING THE RISK OF INFERTILITY (15 minutes)

Ask participants:

- What health practices do people need to follow to protect their own fertility and general health?

- Maintain good health by eating nutritious meals, keeping good personal hygiene, and getting sufficient sleep.
- Avoid behaviors that can harm physical and mental health like drugs, alcohol, excess stress, or violence.
- Know and watch for the signs of a possible reproductive health problem. (These signs may include pain or burning with urination, unusual discharge or smell from the penis or vagina, pain during sexual intercourse or sores, rashes, itching, burning or pain around the genital area)
- Seek health and other services for regular checkups. Also seek services if an unusual change is noticed, or you have questions or concerns.
- Follow recommended treatment, if prescribed.

- What are the general investigations for infertility?

- Monitor the signs of ovulation (cervical secretion, basal body temperature)
- Physical exam for both partners
- Semen analysis
- Other investigations for checking woman's fertility (tubal permeability, uterine structure)

- What can mediators do to help people to reduce the risk of, or to face, infertility problems?

Mediators can discuss with people common causes of fertility problems and risk

reduction; and assist people if necessary to seek/receive infertility services (investigations and/or treatment).

For example, they can:

- Inform people:
  - About the importance of prevention of STIs, and about the importance of early detection and treatment
  - About the importance of requesting services if symptoms of STIs are noticed or if there is a chance of infection, and following treatment for preventing serious complications such as infertility
  - About the importance of quitting smoking, drinking alcohol and using drugs
  - About the importance of avoiding physical factors which can lead to infertility (high temperature, contact with chemicals)
  - That infertility problems involve the couple (the woman and the man), not just one person.
- When infertility is suspected, support people seeking investigations which may be done by the family doctor and which involve both partners, not only the woman.

Indicate to participants the pages in the Roma Health Mediator Manual containing information about infertility.

## CAUSES OF INFERTILITY

### *Causes of Infertility in Men*

Anything which affects the production of sperm or the transportation of sperm into the woman's vagina could lead to infertility:

- Poor quality of semen, especially low number of sperm or sperm that cannot move, can be induced by different causes:
  - Physical factors
    - Excessive heat due to tight underwear, working for long periods at high temperature (near ovens or furnaces)
    - Chemicals
    - Direct injury of the testes
    - Excessive smoking and drinking
    - Drug use (marijuana, heroin, cocaine)
    - Certain diseases (diabetes, thyroid disease)
  - Infections of the testes (mumps infection after puberty)
  - Failure of the testes to descend from the abdomen at an early age
  - Abnormally small testes.
- Inability to deposit sperm in the vagina
  - Blocked passage (semen cannot come out of the testes)
    - Complication of sexually transmitted diseases, especially gonorrhea and Chlamydia
    - Tuberculosis
  - Impotence
    - Emotional, psychological factors
    - Physical stress

### *Causes of Infertility in Women*

Anything which affects the release of eggs from the ovaries (ovulation), the permeability of the fallopian tube, the structure and the function of the womb, could lead to infertility:

- Failure to ovulate: represents approximately 20% of the causes of infertility in women; there are many factors which can lead to failure of ovulation
  - Hormonal disturbances
  - Ovaries dysfunctions and abnormalities
  - Physical factors
    - Chemicals
    - Excessive smoking and drinking
    - Drug use (marijuana, heroin, cocaine)

- Woman's age over 35 years
- Tubal blockage – the most common cause of infertility in women
  - Complication of sexually transmitted diseases, particularly Gonorrhoea and Chlamydia
  - Infections of the reproductive organs following abortion
- Abnormalities of the uterus

## **SESSION 12: BREAST AND CERVICAL CANCER**

**OBJECTIVES:** By the end of the session, the participants should be able to:

1. Discuss ways to help women recognize what is normal in the appearance and feel of their breasts and identify when to seek health care services.
2. Name possible signs of, and the common test for, cervical cancer.

**TRAINING METHODS:** Discussion, Presentation

**TIME:** 45 minutes

**MATERIALS:**

Participant document

- Breast Self-Exam

### **INSTRUCTIONS:**

#### **I. BREAST CANCER (30 minutes)**

Introduce the session by informing participants that:

- Breast and cervical cancers are fairly common in women, and are always dangerous.
- Successful treatment depends on spotting the first sign of possible cancer and getting medical care soon. Surgery is usually necessary.

Ask participants:

- What are the signs of breast cancer?

- The woman may notice a lump somewhere on the breast. The lump grows slowly. At first it usually does not hurt or get hot. Later it may hurt.
- The breast may have an abnormal dent or dimple, or many tiny pits like the skin of an orange.
- There may be large but painless lymph nodes in the armpit.

Explain the importance of regular self-examination of the breasts performed by the woman, and of periodic check-ups performed by a trained health provider.

**[Note to Trainers:** Beliefs and attitudes about privacy and about touching the body can influence a person's desire and ability to conduct a breast self-exam. For these reasons it is important to explore with participants taboos, myths, and beliefs about looking at and touching the body that may be common in their communities.]

Emphasize that every woman should learn how to examine her own breasts for possible signs of cancer. She should do it once a month, preferably after her menstrual period has stopped.

Determine what participants already know about the breast self-exam. Ask:

- Have you done breast self-exams yourselves? What has been your experience?
- Is it acceptable in your communities for women to examine their breasts?
- How do you feel about helping women to recognize what is normal and healthy in their own breasts?
- What are some ways in which you might approach discussing breast cancer in your communities?

Distribute the participant document *Breast Self-Exam*. Referring to the diagrams in the document, describe the correct technique for conducting the self-exam of the breast. Discuss the purpose of the exam, and when, where, and how to do it. Ask participants to explain how they would do the self-exam themselves (or teach others to do the exam). Correct any misinformation and provide additional information, if needed.

Explain what to do if an unusual change is noticed:

- What might the change look and feel like?
- In their community, where might a person go for health services?
- About how much would it cost?

Discuss ways to teach women about self-exams and about the recognition of healthy breasts and potential problems. Ask:

- What key messages would you emphasize when:
  - ✓ Talking with women in your community about breast cancer?
  - ✓ Encouraging women to conduct a self-exam on a regular basis? What would you teach them about this exam?
- What are some of the barriers or difficulties to teaching and motivating people to practice self exams?
- How might you and women in your community overcome these possible difficulties?

Indicate to participants the pages in the Roma Health Mediator's Manual where they can find additional information about breast cancer.

Close with the following points.

- It is important for women to recognize what is normal and healthy in their own breasts.
- Detecting a sign of a problem does not always mean the person has a health problem. Instead, it means she should be checked by a trained health provider. The health provider can then determine whether there is a health problem and recommend treatment early on, if indicated.

- For health problems like cancer or a reproductive tract infection, it is important to get treated right away. Often early treatment can cure a disease before it becomes more serious or life threatening.
- For diseases that cannot be cured, there are often treatments that slow down the progression of the disease or lessen the severity of symptoms.
- When teaching women about breast self-exams, it is important to assess what they know and believe about the self-exam. To do this, find out:
  - Whether women have ever done a self-exam before
  - How they feel about touching themselves
  - Whether the fear of detecting a problem is an obstacle to self-observation

Then, tailor your educational session to meet the needs of the particular individual or group you are teaching.

## II. CERVICAL CANCER (15 minutes)

Explain that:

- The uterus (womb), like others organs in the body, can be afflicted with cancer. The cervix is the most frequently affected.
- In general, cervical cancer is found in older women (over age 40), although it can occur in younger women, sometimes even less than 30 years of age.
- Although any woman can develop cervical cancer, some women are more likely to develop it than others:
  - Women who have had certain sexually transmitted infections (such as warts, genital herpes)
  - Women who have begun sexual activity very young (under the age of 17)
  - Women who have delivered their first child under the age of 20
  - Women who have had multiple partners.
- The diagnosis of cervical cancer is relatively easy to do and the disease can be detected in very early stages which allows timely treatment and cure.
- Cervical cancer may be prevented by regular check-ups and screening examination (Pap test) which can be performed even at the primary health level of care. If possible, women should have examinations and screening tests every 2-3 years even they are having no problem and are feeling fine.

Ask participants:

- What are the signs that could indicate a dangerous problem with the reproductive organs (including genital cancer)?

- Unexplained, prolonged, frequent bleeding from the vagina
- Pain during sexual intercourse
- Constant pain in the pelvis
- Bleeding starting again after the woman's menstrual periods have stopped for a year or more (menopause)

- Unusual, gradually growing lump in the belly

Emphasize that cancers do not show symptoms until the disease is very far advanced; by then it might be difficult or even impossible to be treated effectively. The only way to avoid this situation is to have regular screening tests.

## BREAST SELF-EXAM

### Check Your Breasts Once a Month

For menstruating women, check your breasts after your period stops. If you have reached menopause and no longer menstruate, pick a day that is easy to remember (like the first day of the month).

### Look at Your Breasts in the Mirror

1. Stand in front of a mirror, with your arms at your side, and look at your breasts.
2. Lift your arms over your head and look at your breasts.
3. With your elbows raised, hold your wrists together just below the chin. Press firmly on your arms and look at your breasts.



In each of these positions, look for any changes in the size or shape of your breasts. Look at the skin also. Does it pucker or dimple? Has the texture of the skin changed?

### Check Each Breast Completely

4. Lie flat on your back. Put a pillow under the shoulder of the breast that you are checking. Lift your arm on this side and place that hand behind your head. Then, start checking the breast with your other hand. Begin checking in your armpit, feeling for any grainy or firm lumps. To feel for lumps or changes, use the finger pads of your middle fingers and make three little circles. With the first circle, press gently. With the next two circles, feel a little deeper in the same position. Then move your fingers down slightly, without lifting them, and make three more little circles. Continue making little circles as you move your hand up and down the entire breast area. Make sure you check the entire breast. Since you have breast tissue that wraps around the side of your chest, remember to check that area, too. Some women prefer to start at the nipple and work outward in a circular motion until the entire breast is checked. Others check from the nipple out to the edge of the breast, and back to the nipple, like the spokes on a wheel. The important thing is to check every part of the breast. Check the same way each month and remember how your breasts feel from month to month.

5. To check the other breast, place the pillow under your other shoulder and follow the same instructions.
6. Then, while standing up gently squeeze the nipple and check to see if any clear or bloody fluids come out. You may want to do the breast self-exam again, while bathing, because it can be easier to feel changes when the skin is wet and soapy.



**If you feel a lump, see fluid leave the nipple (unless breastfeeding), or notice any other changes in your breasts, see a health provider right away.**

Finding a change may not mean there is a problem. However, if a health problem is developing, it is best to get treatment early on.

Source: Adapted from the Family Planning Health Project Dominican Republic, 1996

## **SESSION 13: BASIC CONCEPTS OF COMMUNICATION FOR BEHAVIOR CHANGE**

**OBJECTIVES:** By the end of the session, the participants should be able to:

1. Define “Communication for Behavior Change” in the context of the role of Roma mediators in reproductive health
2. Explain the importance of initiating discussions of reproductive health with women in the community
3. Explain 4 types of factors that influence people’s reproductive health behavior
4. Describe the process of behavior change
5. Explain the process of decision-making
6. Explain how interpersonal and group communication can facilitate the processes of decision-making and behavior change in reproductive health

**TRAINING METHODS:** Lecture, Discussion

**TIME:** 2 hours

### **MATERIALS:**

#### Flip charts:

- Session 13 objectives
- Communication for Behavior Change (definition)
- Behavior Change Continuum
- Decision-making Process
- Problem-solving Process

#### Participant documents:

- Communication for Behavior Change (definition)
- The Influence of Personal Beliefs on Behavior
- Behavior Change Continuum
- Decision-making Process
- Problem-solving Process

#### Trainer document:

- Story: Factors That Influence Human Behavior

## **INSTRUCTIONS**

Post the flip chart *Session 13 objectives* and ask volunteers to read them.

### **I. COMMUNICATION FOR BEHAVIOR CHANGE (15 minutes)**

Introduce the session by suggesting that we’ve just updated our knowledge of important aspects of reproductive health. During the rest of the workshop, we will discuss concepts and practice skills which will help us improve the way in which we discuss reproductive health problems, practices and services with women in our communities.

Ask the group:

- How do women in your community decide when it is necessary to go see a family doctor? What are some situations or conditions in which they would go see a family doctor?

- When they are sick or injured
- When they suffer an accident
- When they are pregnant
- When they need a medical leave certificate or an act for social service (for getting unemployment social support)

Explain that in terms of reproductive health:

- Most often women are not injured nor severely ill although they may become severely ill if they do not care for their health properly or seek appropriate services in a timely manner.
- The decision to adopt certain practices and/or to use certain health services is a very personal one.
- The ways in which we talk with women about reproductive health influences our effectiveness in helping them to make and implement decisions which will improve their health.

Post the flip chart *Communication for Behavior Change*. Ask volunteers to read it. Ask the group:

- What is the difference between 1) communication aimed at helping women to change their behavior, and 2) advice?
- What messages do communication for behavior change, and advice, “communicate” to women?

**Communication for behavior change** (in the context of the activities of Roma Health Mediators): Face-to-face or group communication in which the mediator helps a woman (or women) to better understand her/their problems, situations and/or feelings, and to identify and apply solutions that are appropriate to her/their situation/s. The mediator does this by:

- Introducing a reproductive health topic that she thinks will be important/relevant to the woman/group; or asking questions about the woman’s/women’s health concerns
- Asking open questions that help the woman/women assess her/their situation, consider her/their options, and identify and apply solutions
- Providing information to assist the woman/women to better understand her/their situation and to consider options so that she/they can make her/their own decisions and then act on them.

Communication for behavior change generally communicates the message: “The problem and decision are yours and I have confidence that you are capable of resolving the problem by making the decision that is best for you.”

**Advice:** Face-to-face or group communication in which the mediator tries to solve woman’s/women’s problem/s, identify her/their solution and/or make the woman’s/women’s decisions by giving her opinion and/or proposing the solution to the woman/women.

Advice generally communicates the message: "You are not capable of resolving this so I will have to do it for you". It makes the woman/women dependent on the mediator.

- What is the purpose of talking with women in your communities about reproductive health?

To enable the women to:

- Make decisions and adopt behaviors that will improve their reproductive health, based on a consideration of their situations and their alternatives
- Assume responsibility for their problems and decisions.

Add that our communication with women must therefore 1) help them to understand their situations, and 2) provide them with information they can use to decide to change certain behaviors.

Refer the group to an example: family planning. Ask the following questions, one at a time:

- What is the purpose of talking with women about family planning? What do you hope to accomplish?
- What should women consider, and what do they need to know, in order to make decisions about practicing family planning?
- What is your role in talking with women about family planning?

Purpose: To enable women to make voluntary decisions about whether or not to practice family planning and how, based on their knowledge of information relevant to their decision.

In order to make decisions about practicing family planning, it is helpful for women to know:

- The risks of not practicing family planning (using effective family planning methods)
  - Risks of getting pregnant (and the woman's feelings about whether or not she wants to have a child)
  - Risks of abortion (if the woman gets pregnant and decides not to keep the pregnancy/have the child)
  - Risks associated with pregnancy and childbirth versus the risks associated with contraceptive use
- The family planning methods available (at the nearest source of family planning services)
- The (major) advantages and disadvantages of the available methods
- Possible side effects of the available methods
- Generally how to use available methods that are of interest them

The role of the mediator in talking with women about family planning:

- Ask questions about the woman's/women's reproductive health intentions, values, beliefs etc
- Provide information relevant to the woman's/women's situation, interests, values, and beliefs.

**Note:** Indicate to participants that we will discuss later in this session types of information to discuss with women depending upon their degree of interest in family planning (as an example of one component of reproductive health). (See IV. Process of Behavior Change)

## II. INITIATING DISCUSSIONS OF REPRODUCTIVE HEALTH (15 minutes)

Ask the group:

- Do women who might need reproductive health services always seek them? What are some of the reasons why they do not seek services?

- They may feel that they have other more important priorities
- They may not have thought much about their situations and health risks
- They may be embarrassed, or they may not know how to bring up their concerns to anyone
- There may be conflicts between some of their family's customs, traditions and/or beliefs and their own behavior
- They may have fears about certain services or health personnel

- Should mediators initiate discussions with women about reproductive health if women do not ask? Why? Why not?

Mediators should ask women of reproductive age about their reproductive health situations and concerns if there is any indication that they might need services but are not using them. By initiating such discussions, the mediator can help women to think about their health and their children's health and about any needs, questions and/or concerns they might have. Making women aware of the mediator's readiness to help them may make it easier for some women to talk about their needs/concerns.

Refer to the family planning example and ask:

- What is the role of the mediator in situations in which:
  - ✓ Women of reproductive age are not using contraception?
  - ✓ Women of reproductive age are not using effective methods of contraception, or are not using effective methods of contraception effectively?

- With women of reproductive age who are not using contraception, ask questions about their reproductive intentions:
  - Whether they plan to have more children
  - What they wish to be the spacing between their pregnancies/children
  - The number of children they wish to have
  - Whether they are currently using contraception or are interested in using contraception to help them plan the number and spacing of their children
- With women of reproductive age who are not using effective methods of contraception, or who are using effective contraceptive methods but are using them incorrectly, review with them:
  - Their reproductive health intentions
  - The risks of using the methods they are using in the ways they are using them

Ask:

- How do you feel about asking women about their reproductive health needs and/or concerns without their requesting information or services?

Some mediators may feel reluctant to initiate discussions of women's reproductive health needs, thinking that it would be an invasion of a woman's privacy, and that women would be embarrassed or offended.

- How can you overcome your reluctance and/or respond to a woman's embarrassment if it occurs?

Clarify with the woman, or with women in a group situation, that your purpose is only to assist her/them to consider needs and concerns, and to obtain services if desired, and that the choice is hers/theirs; and that you are available to help with information and/or to obtain services if needed.

### III. FACTORS THAT INFLUENCE HUMAN BEHAVIOR (20 minutes)

Tell a story about a woman and the decisions she faced concerning her reproductive health and her seeking services. (see trainer document: *Story: Factors That Influence Human Behavior*)

In the large group, ask participants to identify factors that influenced the woman's behavior and choices. As participants name various factors, draw a flower (with four petals labeled cultural, social, perception and enabling) on a flip chart and fill in the petals with the factors, according to the four categories.

Explain that in order to assist individuals to change certain behaviors and/or to seek certain reproductive health services, we need to understand what kinds of things might influence their behavior:

- Cultural factors, including:
  - Customs within the Roma community
  - Traditions that are passed down from parents to children
  - Religious beliefs
- Social factors: influences of other people (spouse, parents/relatives, friends, religious leaders)
- People's perception (their understanding and interpretation of messages). A person's perception is influenced by:
  - Their understanding of language and terminology used
  - Their understanding of any visual aids used to explain the message
  - The quantity of information given

- **Enabling factors:** factors which facilitate/make easier, or inhibit/make more difficult, certain behavior changes (for example the time, money and skills necessary to practice certain reproductive health behaviors; the accessibility and quality of health services, etc)

Distribute the participant document *The Influence of Personal Beliefs on Behavior*. Ask volunteers to read and comment on the application of the various influences on the reproductive health behavior of women.

#### **IV. PROCESS OF BEHAVIOR CHANGE (20 minutes)**

Introduce the concept of behavior change by asking participants:

- Based on our discussion of factors that influence women's reproductive health behavior, should your approach to discussing reproductive health be the same with all women? If not, why not?

No. The situation, needs and concerns of each woman determines what issues need to be addressed and how they need to be addressed.

Explain that there are a variety of theories about how people change their behavior, and that you are going to present one of these theories that is relevant to the way in which people often change their reproductive health behavior. Post the flip chart *Behavior Change Continuum* and distribute the participant document *Behavior Change Continuum*. Using family planning as an example, lead a discussion of a woman's behavior at each level, including an appropriate approach to communicating with the woman at each stage of the behavior change process in order to facilitate the woman's decision-making. Ask volunteers to read and comment the text of their participant documents. Clarify any points that are unclear.

#### **V. DECISION-MAKING PROCESS (30 minutes)**

Refer to:

- The previous discussion on the purpose of communication for behavior change: to assist women to make decisions based on an awareness of their situations and relevant information; and to act on these decisions.
- The discussion on behavior change and the fact that individual women may be at different stages in terms of deciding to change certain reproductive health behaviors.

Explain that in the process of changing our behavior, we all go through a series of steps in making decisions to change.

Ask the following questions concerning participants' attendance at the workshop, in order to introduce the process of decision-making:

- How did you receive the information about this workshop?

- I was told to come
- I learned that this training would take place and I was asked if I wished to attend
- I received official notification that I was to attend

➤ Did you decide to come as soon as you received the information?

Responses will vary depending upon the individual

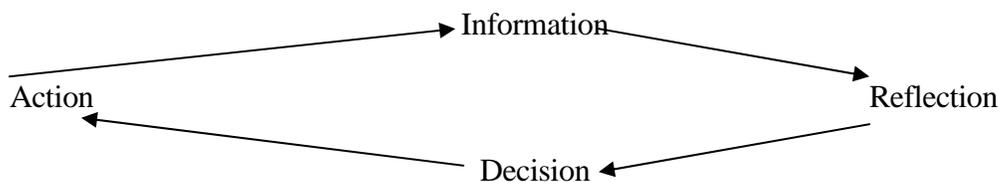
➤ What did you do in order to prepare to attend the workshop?

- Found someone who could continue certain of my activities during my absence
- Made provisions for my family before leaving home

➤ What questions did you ask yourself?

- Why was I asked to attend this training?
- What will be the content and/or the process of training?
- Where will the training take place?
- Who will be the trainers?
- Who will the other participants be?

Outline on flip chart paper the **decision-making process**, referring to the above questions and participant responses:



*Information step:* Participants received information about the workshop

*Reflection step:* Participants reflected (thought about whether or not they wanted to attend the workshop, about what they needed to do before leaving home, and about the conditions of the workshop)

*Decision & Action steps:* Are expressed by the fact that participants are present at the workshop

Ask the following questions in order to bring out the importance of respecting the decision-making process in the context of communicating with women about reproductive health.

➤ If we think of this decision-making process in terms of talking about reproductive health with women in our communities, what happens at the Reflection step?

Women:

- Weigh the pros and cons of their situation
- Anticipate the consequences of their decision

- Ask themselves questions
- Consider the alternatives

➤ What is the importance of the step Information on the step Reflection?

Information provided must:

- Be relevant to the women's interests and needs
- Be complete, precise, and clear; and be understood by the women

➤ What can/should a mediator do to facilitate the decision-making process for women?

- Imagine the needs/interests of women in our communities based on our experience in working with them
- Help women express their needs, concerns and questions, as well as their reactions to what we tell them; and listen carefully
- Adapt information to the needs/interests of individuals; encourage their questions and reactions (in order to better understand, and respond to, their concerns and needs)
- Give women time to reflect on the information before making a decision

➤ Do we usually respect the decision-making process when we try to help women solve their health needs and concerns?

No. Often we give information and expect women to decide immediately what they wish to do (as expressed in 'you should . . . , you ought to . . .' etc)

➤ What are the consequences of such rushed/forced decisions?

Either the woman doesn't act at all or she makes a decision without adequate thought and without conviction. Often, the woman does not follow through with/implement such decisions. Sometime the woman carries out her decision but does not accept responsibility for any problems associated with the decision and may even blame the mediator for any negative consequences of the decision.

➤ What should be the role of the mediator in communicating with women in the context of this process of decision-making?

- Give complete, precise, objective and clear information
- Ask questions to help women to reflect on the information and on their choices
- Follow-up with women to reduce the risk of problems once the decision is put into action

Explain that sometimes a woman presents herself as having a problem (for example an unwanted pregnancy, indecision about whether or not to use contraception, a relationship problem etc). In such cases, it may be difficult to know how to help her to resolve the problem in a way that is best for her. A simple problem-solving model is a useful tool to guide the mediator in helping the woman.

Post the flip chart *Problem-solving Process* and review it with the group.

Distribute the participant document *Problem-solving Process*.

## **VI. FACILITATING BEHAVIOR CHANGE THROUGH INTERPERSONAL AND GROUP COMMUNICATION (15 minutes)**

Remind the group of the topics covered in this session:

- Concept of communication for behavior change
- Factors that influence human behavior
- Behavior Change Continuum
- Decision-making process
- Problem-solving model

Ask the group:

- How can you use/apply these concepts to your role in helping women in your communities to improve their reproductive health?

Mediators need to be aware of not only reproductive principles, practices and services covered earlier in the training but also of:

- Our purpose in communicating with women about these principles, practices and services
- All of the kinds of things that influence women's reproductive health behaviors and decisions
- The different ways that we can help women to consider changes in their behavior
- Our need for patience in, and commitment to, helping women to improve their reproductive health

## Flip chart

### **COMMUNICATION FOR BEHAVIOR CHANGE** (in the context of the role of mediators)

#### *What it is:*

Face-to-face or group communication in which the mediator helps a woman, or women, to:

- Better understand her/their problems, situations and/or feelings, and
- Identify and apply solutions that are appropriate to the woman's/women's situations.

#### *What the mediator does:*

- Asks open questions to help the woman/women assess her/their situations, consider her/their options, and identify and apply solutions
- Provides information to assist the woman/women to make her/their own decisions and then act on them.

#### *Generally communicates the message:*

“The problem and decision are yours and I have confidence that you are capable of resolving the problem by making the decision that is best for you.”

## **Advice**

#### *What it is:*

Face-to-face or group communication in which the mediator tries to solve woman's/women's problem, identify the woman's/women's solutions, and/or make the woman's/women's decisions by giving her opinion and/or proposing the solution to the woman/women.

#### *Generally communicates the message:*

“You are not capable of resolving this so I will have to do it for you”. It makes the woman /women dependent on the mediator, and in some cases leads to rebellion, and rejection of the advice, by the woman.

## **FACTORS INFLUENCING HUMAN BEHAVIOR (story)**

This is the story of Andrea, a woman in one of our communities. Andrea is 35 years old. She is married and has four children. During the last two pregnancies, Andrea had very high blood pressure. The family doctor has strongly recommended that she avoid another pregnancy. Until now, her husband “protected” her (they used withdrawal). Andrea is tired of using this method; she worries that one day, it will fail and she will get pregnant again. At the same time, Andrea has many concerns about modern methods of contraception.

Andrea has come to you because one of her neighbors said that you are very kind and that you could help her.

Andrea’s preference is for using the Standard Days Method of family planning because:

- She is afraid of the possible side effects of hormonal methods because:
  - A friend who was using the pill has gained a lot of weight.
  - Her sister used the injectable and then did not have her periods
- She does not want an IUD because
  - Some people in her church said that the IUD kills the baby when it first begins to grow, and Andrea does not want to sin
  - A friend told her of a woman who ended up with the IUD in her abdomen
- Her husband warns her of cancer every time she mentions contraception but she is not sure which method causes cancer
- Her husband refuses to use condoms

When you counsel Andrea about the methods of contraception, your concerns are to:

- Help her understand the methods,
- Respond to misinformation that she has,
- Help her identify her alternatives and to weigh the pros and cons of each alternative
- Encourage her to visit the Family Doctor and to adopt an effective method which is suitable to her

As you talk with Andrea, you notice that:

- She is not understanding many of the words you use nor the pictures you are showing her
- For Andrea, the risks of pregnancy are “normal” (“everyone” goes through this) whereas the risks of using contraception can be more dangerous
- She confuses what you say about barrier methods versus hormonal methods
- She expresses some interest in sterilization until you discuss the cost and distance she would have to travel to the hospital where it could be done
- She feels that the Standard Days Method would cost her the least in terms of money and time

**What factors are influencing Andrea’s family planning behavior and consideration of alternatives?**

## Participant document

### **THE INFLUENCE OF PERSONAL BELIEFS ON BEHAVIOR**

**Factors which influence human behavior** in general and which must be considered in helping women to change certain behaviors:

*Cultural factors:*

- Norms or customs
- Traditions
- Beliefs

*Social factors:* influences of other people (spouse, parents/relatives, friends, religious leaders, traditional healers etc).

A woman may judge a proposed behavior favorably but may perceive that people important to her do not want her to change. (example: she may want to practice family planning but knows her husband would not approve)

A woman may have an unfavorable attitude towards the behavior but be pressured by those around her to perform it. (example: an adolescent girl may not wish to have sex but feel pressured into it by her boyfriend)

**Note:** Whether a woman's own judgment can overcome the influence of those around her often depends also upon her strength of will and on her susceptibility to pressure.

*Perception:* subjective process in which people attempt to understand and interpret messages. It is influenced by:

- One's familiarity with, and understanding of, language and terminology used
- The clarity of visual aids used to explain the message
- The quantity of information given

*Enabling factors:* factors which facilitate/make easier, or inhibit/make more difficult, certain behavior changes (for example the time, money and skills necessary to practice certain reproductive health behaviors; the accessibility and quality of health services, etc)

**Examples of beliefs people may have that may influence their decisions to practice or not practice family planning. Beliefs about:**

- The causes of maternal and child health problems
- The effort involved in practicing family planning
- The benefits of using family planning
- The consequences of many and/or closely-spaced pregnancies

- One's personal susceptibility to health problems resulting from many and/or closely-spaced pregnancies
- “Normal” versus “risky” in terms of the number and spacing of pregnancies
- What other persons think you should do (for example one's husband, mother-in-law)
- The possibility of change (beliefs about what happens being God’s will versus the individual having some control over his/her life)
- The credibility of the communication source (women's perceptions of the competence and caring or commitment of the mediator)
- The prestige/status of practicing family planning versus having many children

It is difficult to change those beliefs that:

- Are based on a person's direct (and negative) experience unless you can explain the basis for their experience, and explain and demonstrate the rationale for and safety of the proposed change. (example: It may be difficult for a woman to accept to use an IUD if she or someone she knows has experienced perforation of the uterus by an IUD)
- Are part of wider, and strongly held, belief systems (religion or tradition) Examples: Catholic beliefs about artificial family planning; Islamic belief in polygamy; prestige or other reasons for having many children)
- Have been held since childhood or have been acquired from trusted persons (parents, religious leaders).

A woman's readiness to change behavior is strongly influenced by:

- Influences of other people (social factors):
  - A woman may judge a proposed behavior favorably but may perceive that those important to her do not want her to change (example: a woman may want to practice family planning but knows her husband would not approve)
  - A woman may have an unfavorable attitude towards the behavior but be pressured by those around her to perform it (example: an adolescent girl may not wish to have sex but feel pressured into it by her boyfriend)

**Note:** Whether a woman’s own judgment can overcome the influence of those around her depends upon her strength of will and susceptibility to pressure.

- Beliefs that:
  - She is susceptible (that the health problem could affect her rather than just 'other people')
  - The health problem is serious/could lead to serious consequences if action is not taken
  - The health problem can be prevented by the prescribed actions and that the benefits of taking action would outweigh the disadvantages

Flip chart

**BEHAVIOR CHANGE CONTINUUM**

7 stages

7. I am willing to demonstrate or propose the solution to others.



6. I am ready to try to change/the proposed action.



5. I see the problem and I am interested in learning more about it.



4. There is a problem but I am afraid of changing because of fear of possible negative consequences.



3. There is a problem but I am not convinced of the proposed solutions.



2. There may be a problem but it is not my responsibility. (It is the responsibility of God, of government, of someone else.)



1. There is no problem. (I am satisfied with the way things are & see no reason to change.)

## Participant document

### **BEHAVIOR CHANGE CONTINUUM** (modified from Tools for Community Participation, L. Srinivasan)

#### 7 stages

7. I am willing to demonstrate or propose the solution to others.  
↑
6. I am ready to try to change/the proposed action.  
↑
5. I see the problem and I am interested in learning more about it.  
↑
4. There is a problem but I am afraid of changing because of fear of possible negative consequences.  
↑
3. There is a problem but I am not convinced of the proposed solutions.  
↑
2. There may be a problem but it is not my responsibility. (It is the responsibility of God, of government, of someone else.)  
↑
1. There is no problem. (I am satisfied with the way things are & see no reason to change.)

#### What strategies or messages might be most effective at each stage of resistance to behavior change?

The same approach will not be effective at all levels.

- At stages 5 - 7, people are more ready to accept and apply information; given them the information they need in order to act.
- At stages 1 - 4, it is important to bring out people's opinions, and better understand their attitudes, concerns and beliefs, in order to adapt reproductive health messages to their needs and pre-occupations.

(continued on next page)

## Possible interventions at each stage of behavior change (or resistance to behavior change)

### Stage 1: *There is no problem.*

Provide an example of a similar reproductive health problem in this or a nearby community. Engage the woman in discussion in order to help her to become more aware of the problem.

#### Possible discussion questions:

1. What problem does this person have?
2. Do you know anyone this has happened to/who has had this problem?
3. Has it ever been a problem for you? In what way? What did you, or could you, do about it?

### Stage 2: *There may be a problem but it is not my responsibility. (It is the responsibility of God, of government, of someone else.)*

Use proverbs and analogies to help people identify why the situation is a problem.

#### Possible discussion questions:

1. Why is this (the situation presented) a problem?
2. What do you know about this problem?

### Stages 3 & 4: *There is a problem but:*

*a. I am not convinced of the proposed solutions.*

*b. I am afraid of changing because of fear of possible negative consequences.*

Brainstorm with the woman/women to identify all possible solutions & pros & cons of each.

#### Possible discussion questions:

1. What are the different alternatives for coping with/overcoming this problem?
2. Which alternatives seem most realistic, the most feasible for you?
3. What more would you like to know about "x" alternative?

### Stages 5 & 6: *I see the problem and would like to learn more about it; I am ready to try to change.*

Discuss family planning methods and services in order to provide the necessary information so that individual can act.

#### Possible discussion questions:

1. What do you know about the different methods of contraception? "x" method?
2. What do you think about the different methods of contraception? "x" method?

Ask these 2 questions in relation to each method in order to assess the level of knowledge, attitudes, preferences and rumors.

### Stage 7: *I am willing to demonstrate or propose the solution to others.*

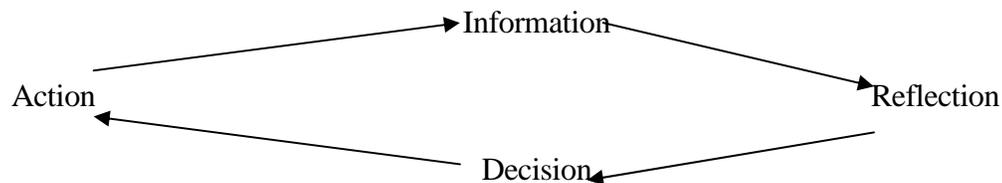
Ensure follow-up. Support the individual in her family planning decisions.

#### Possible discussion questions:

1. How has your experience been with "x" family planning method? Have you had any problems?
2. What can we do to help others to benefit from family planning ?

## DECISION-MAKING PROCESS

1. The decision-making process is facilitated by adequate and accurate information. In the diagram below, the mediator helps the woman to reflect on her situation, problem or needs, and provides the woman information as necessary. This information must be appropriate to the woman's needs. It must be complete, precise, and clear; and be understood by the woman.
2. The woman reflects on the information about her situation, feelings, alternatives etc. She weighs the pros and cons of the situation, anticipates the consequences of her decision, asks herself questions, considers the alternatives.
3. The woman makes a decision.
4. The woman acts on her decision.



To facilitate the woman's decision-making process, the mediator needs to:

1. Imagine the needs of the woman (based on the mediator's experience with other women)
2. Help the woman to express herself and listen carefully
3. Adapt information to the needs/interests of the woman; encourage her questions and reactions (in order to better understand, and respond to, her concerns and needs)
4. Give the woman time to reflect on the information before making a decision
5. Ensure follow-up to reduce the risk of problems once the decision is put into action

When mediators do not respect the decision-making process, and instead give information and expect women to decide immediately what they wish to do (as expressed by 'you should . . . , ought to . . .' etc), often women do not act at all or they make decisions without adequate thought and without conviction. They may not accept responsibility for the decision and may even blame the mediator for any negative consequences of the decision.

### **PROBLEM-SOLVING PROCESS**

- ❖ The woman identifies the problem (including causes and effects of the problem)
  
- ❖ The woman identifies possible alternatives for dealing with the problem
  
- ❖ The woman identifies possible consequences of each alternative (pros and cons of each alternative)
  
- ❖ The woman identifies the best alternative or solution for her, based on knowledge of all the alternatives and possible consequences of each alternative
  
- ❖ The woman implements her solution

At each stage of this process, the very important role of the mediator is to ask open and neutral questions and to provide information (as necessary) to help the woman reflect upon her situation (problem, alternatives and consequences of alternatives) in order to come to the best decision for her and to implement it. Because the problem is the woman's problem, she will have to live with the solution she chooses (including the consequences of the solution).

## **SESSION 14: INTERPERSONAL COMMUNICATION**

**OBJECTIVES:** By the end of the session, the participants should be able to:

1. Identify verbal responses that can block communication with women in the community.
2. Identify non-verbal obstacles to communication with women in the community.
3. Name conditions that favor positive communication with women in the community.
4. Describe behaviors that indicate that one person is actively listening to another.
5. Define active listening.
6. Explain the importance of active listening in communication for behavior change.
7. Define the 3 components of active listening: passive listening, paraphrasing and clarifying/open questions.
8. Explain factors that influence what they are willing to reveal about themselves.
9. Explain the application of these factors to the behavior of women in the community in discussions of reproductive health.
10. Explain principles to respect when responding to rumors raised by women in the community.
11. Describe approaches to the initiation of discussions of reproductive health issues with women in a variety of situations
12. Demonstrate interpersonal communication skills appropriate to promoting changes in reproductive health behaviors.

**TRAINING METHODS:** Exercise, Discussion, Role play

**TIME:** 5 hours

### **MATERIALS:**

#### Flip charts:

- Session 14 objectives
- Obstacles to Communication
- Principles for Improving Communication in Reproductive Health

#### Participant documents:

- Obstacles to Communication
- 
- Active Listening
- Examples of Questions Useful in Reproductive Health
- Principles for Improving Communication in Reproductive Health
- Role play Discussion Questions

#### Trainer document:

- Statements: Obstacles to Communication
- Role plays: 2 series of 3 each

## **INSTRUCTIONS**

Post the flip chart *Session 14 objectives* and ask volunteers to read them.

### **I-II. OBSTACLES TO COMMUNICATION (40 minutes)**

Introduce the session by suggesting to the group that the role of mediators in communicating with women in the community about reproductive health is primarily to share information with women for the purpose of helping them to adopt certain behaviors and/or to use certain reproductive health services.

- In this session on interpersonal communication, we will begin by focusing on what happens when we communicate with people, including some of the obstacles to communication and how to avoid or overcome them.
- Following this, we will focus on how to initiate discussions of reproductive health with women in a variety of situations.
- Finally, we will practice initiating discussions of reproductive health with women and responding to reproductive health concerns raised by women, using communication skills that will make our work more effective.

Invite the group to participate in an exercise that will help them examine some of the ways in which they communicate.

- Present, one at a time, several reproductive health-related situations, ending each situation with a statement or question by the woman the mediator is talking with (see Trainer document: *Statements: Obstacles to Communication*).
- Ask participants to listen to each situation and to note on a piece of paper what they would say (their immediate verbal response) to the woman. Emphasize that participants should respond spontaneously (as they would if they were in a discussion with the woman). (Give participants 1-2 minutes to respond to each woman's statement.)
- After you have presented all of the statements, and participants have noted their responses on paper, ask participants to put their papers aside.
- Using the flip chart *Obstacles to Communication*, present, one by one, certain obstacles to communication that we as mediators may use (unconsciously), including examples of each obstacle.
- As you present each obstacle, ask participants:
  - What would be your reaction if a mediator were to respond to you like this?

**[Note to trainer:** When you come to the obstacle “sympathy” on the flip chart, it is important to help participants distinguish between “sympathy” (sometimes defined as pity or sorrow for the woman because of her problems) and “empathy” (putting yourself in the woman’s situation and helping her to solve her problem)]

- Ask participants to:
  - Take their papers (on which they wrote their responses to women earlier in the exercise)
  - Review individually the responses they gave to women in the exercise

- Note next to each of their responses to the woman any of the types of obstacles just presented (in other words, note if any of their responses to these women could be classified as obstacles to communication).
- Ask several volunteers to share examples of their responses.

### Summary

Assist the group to summarize their learning, using the following questions:

- How did you feel:
  - ✓ Responding to these women?
  - ✓ Reviewing your responses to see how you had responded to the women and their possible reactions?
- Think about your reactions and responses during the exercise and about why you responded as you did. Do you think you heard and understood all that the woman wanted to say (including what was behind what she said) and if not, why?
- If you were to hear these statements again, would you react differently?
- Do you get a second chance to respond more appropriately to a woman if you have responded inappropriately the first time?

Maybe yes, maybe no. In general, the mediator's first response has an impact, positive or negative depending upon the response, on the woman's perception of her. If the mediator responded poorly, she may be able to re-establish a more positive relationship with the woman by apologizing for her response and responding more appropriately afterward.

- How can you be more prepared to respond in such difficult situations?

- By recognizing that the problem presented by the woman belongs to her.
- By applying the problem-solving model (discussed in Session 13), and remembering that our job is to help the woman to work through this process by asking questions and providing information as needed.

Explain that:

- All of the responses are normal. We have learned to respond in these ways, usually with the intent of helping the person.
- There are occasions when certain of these responses are appropriate.
- These responses may block communication, however, when they hurt the individual or cause resistance or hostility toward us or to what we are trying to explain.

- Certain responses communicate a lack of acceptance of the person or a desire to change or control them. Certain imply that the person is incapable of making a decision and deny the person the responsibility for their problem and solution.

Ask the group:

- What usually happens in a conversation:
  - You speak . . . . I listen
  - I speak . . . . . you listen

**or**

  - You speak . . . . .
  - I listen – evaluate – listen – plan – listen – prepare what I’m going to say – speak (at the first chance I get to interrupt you).

Explain that, in fact, we often evaluate what others say before trying to understand them; in so doing, we risk drawing false conclusions.

Distribute the participant document *Obstacles to Communication*. Ask volunteers to read and comment the additional obstacles on page 3.

### **III. CONDITIONS THAT FAVOR POSITIVE COMMUNICATION (15 minutes)**

Ask the group:

- What kind of conditions do we need to create in order to make it easier for a woman to discuss freely her situation (problems, concerns, feelings)?

We need to create a relationship of mutual trust and respect:

- Establish a positive and constructive rapport with the woman
- Try to understand the woman’s situation and feelings, and any problems she may have in talking about her situation
- Be willing and able to accept and respect the woman without judging her
- Be ready and willing to help
- Be objective in interacting with the woman
- Pay attention to the relationship between what we say verbally and our non-verbal messages. (The woman’s perception of our non-verbal behavior is often more important than what we say verbally.)
- Ask for feedback from the woman if we are unsure of whether or not we are understanding each other or whether information we are giving her is helpful; respect the woman’s feedback; and respond constructively to it.
- Use language (words, expressions) that are understood by the woman

Explain to the group that the following sessions will focus on creating the conditions, and using communication skills, that facilitate positive communication with women in our communities.

#### IV-VII. ACTIVE LISTENING (20 minutes)

Ask the group:

- How do you know when someone is actively listening to you?

**Non-verbal communication:** eye contact, leaning forward, nodding.

**Brief responses** which demonstrate interest and encourage the person to continue to talk: uh-huh, oh, I see, etc.

**Reformulation of what I said** in his/her own words. This:

- Verifies that the other person has understood what I said
- Serves as feedback, allowing the other person to reflect on what they said (listening to their problem paraphrased as I understood it)

**Clarifying/Open questions:**

- When posed by the other person, such questions indicate to me that he/she is listening.
- When used by me (the mediator) in interpersonal communication for behavior change with women in the community, such questions help the woman consider all aspects of her problem and better assess the alternatives and solutions.

- How do you know when someone is only partly listening to you?

He/She does other things at the same time (writes, reads, visits with others)

He/She looks at the floor, at the wall, or out the window.

He/She interrupts and gives advice before I've explained all of my problem

He/She fidgets, giving an impression of impatience, boredom or distraction.

- How do you feel when you try to explain a problem to someone and they do not listen?

Frustrated, inferior, inadequate etc

Ask participants:

- What is active listening?

A communication technique used by “helpers” to help people to analyze and resolve their problems themselves. The “helper”:

- 1) uses a variety of short responses,
- 2) paraphrases /reformulates what the person said, and

3) poses open questions in order to help the person reflect on his/her problem and alternatives, and to find a solution to his/her own problem. Active listening communicates acceptance of the person in that the “helper” does not communicate judgments nor solutions. It facilitates decision-making by the individual.

- In what way is active listening important to interpersonal communication in reproductive health?

Women may have questions, concerns and problems that influence their ability to adopt certain practices that would benefit their health and the health of their young children. They may pose informational questions which in fact represent rumors, beliefs, anxieties or disagreement with a partner. Active listening is useful to help bring out what may be behind a woman’s initial statements, questions or responses, in order to be able to better respond to these concerns and to anything that may prevent her from making a positive change in behavior.

### **Steps in learning active listening**

Explain that active listening is made up of three techniques:

- Passive listening
- Paraphrase
- Open questions

Add that:

- You will demonstrate each step
- At the end of the session, all participants will have an opportunity to practice Active Listening when they participate in role plays of interpersonal communication.
- This is only an introduction. Mastery of the techniques requires continued practice.

Refer to the first component of active listening; passive listening. Ask the group:

- What do you do when you listen to someone passively? Why?

Listen without speaking in order to hear and understand what the other person is saying

Invite participants to observe a demonstration of passive listening (done by 2 trainers or a trainer and a participant). One individual (a trainer or a participant) takes the role of a woman in the community and explains a problem, need or concern. The other individual (a trainer) takes the role of the mediator, responding with non-verbal and one-word responses (“Yes”, “I see”, “Mm-mm”, “Right”, “OK”, “Uh-huh”, nodding etc, and maintaining eye contact) to encourage the woman to continue to explain her concern. (1 minute)

Ask the group:

- What did the mediator do?  
➤ What jests did she use?

- What did she communicate to the woman?
- What was the effect on the woman?

The mediator's eye contact, short responses and jests, and the fact that she did not interrupt the woman, encouraged the woman to continue explaining her problem.

Refer to the second component of active listening; paraphrasing. Ask:

- What does one do when one paraphrases what a person said?

Reformulates what the person said in their own words, including perception of feelings behind the message (expressed by tone of voice, facial expression, body language)

- What is the purpose of paraphrasing?

- To verify the mediator's understanding of what woman said
- To help the mediator refrain from interrupting the woman and giving advice
- To encourage the woman to continue to explain her problem

Invite participants to observe a demonstration of paraphrasing (done by 2 trainers or a trainer and a participant). One individual (a trainer or a participant) takes the role of a woman in the community and explains a problem, need or concern. The other individual (a trainer) takes the role of a mediator, paraphrasing what the woman says and encouraging the woman to continue to explain her concern. (2 minutes)

Ask the group:

- What did the mediator do?
- How did paraphrasing contribute to communication between the mediator and the woman?

- The mediator verified that she understood what the woman said (and where she misunderstood, the woman was able to clarify what she said/meant)
- The mediator encouraged the woman to continue to explain her problem
- The mediator did not interrupt the woman with advice nor solutions to her problem

**Note:** Paraphrasing requires that one listen carefully without focusing on other things, without being distracted.

## VIII-IX. OPEN QUESTIONS (40 minutes)

Explain that in discussions of reproductive health, we need to ask women certain questions in order give them appropriate information. Sometimes, we have the impression that women do not respond truthfully to the questions we ask. There may be several reasons for

this. It may be difficult for us to know what questions make women uncomfortable or when women trust us enough to discuss certain things. Women may question when to respond or not. We will do an exercise which will help us reflect on some conditions which favor, or do not favor, sharing certain personal information.

Ask participants to take a piece of paper and to make a list as follows:

6. Strangers \_\_\_\_\_
5. Acquaintances \_\_\_\_\_
4. Friends \_\_\_\_\_
3. Intimate friends \_\_\_\_\_
2. Myself \_\_\_\_\_
1. Denial/repression \_\_\_\_\_

**Note:** Explain that “1” represents those things we cannot even admit to ourselves, that we repress or deny.

Post the flip chart "*To whom would you tell . . . ?*" Read each question, and ask participants to write a key word of the question next to the category of people with whom she would be most likely to share her answer to the question. Emphasize that participant responses are private and that participants will not be asked to share them. (Participants give only one answer to each question. They may, however, put more than one answer on a line.)

### **Questions:**

#### **TO WHOM WOULD YOU TELL:**

1. How much money you earn?
2. That you thought you caught an STI?
3. That you thought you were infected with HIV?
4. That you have had an induced abortion ?
5. The last time you had sexual relations (the date)?
6. That you thought you had a tumor (breast, uterine)?
7. That you abandoned your child?
8. What made you cry the last time?
9. That you, or your partner, was having sex outside of marriage?
10. That you have considered suicide (killing yourself)?

[**Note:** key words are underlined]

After participants have responded to all the questions (put a key word from each question on one of the lines), ask the following discussion questions (and note on a flip chart the total number of participants who put responses on lines 5-6; on lines 2-3; and on line 1).

- How many people put 7 - 10 responses:
  - ✓ On the first two lines (strangers & acquaintances)?
  - ✓ On lines 3 and 2 (intimate friends and self)?
- How many people put at least one response on line 1 (things we cannot admit even to ourselves)?
- Was it difficult sometimes to decide which line would be the most appropriate (that is, with whom you would most likely share your response)?

- Did you want to put conditions on sharing some of this information? If so, what kinds of conditions?

That the person I shared the information with:

- Would not ridicule me
- Would not laugh at me
- Would take me seriously
- Would not share my problem with others
- Is competent and interested in helping me

- What is the relationship between this exercise and your roles in discussing reproductive health with women in your communities?
- How are you perceived by women in your communities: as a stranger, acquaintance, friend, or intimate friend (the first time you initiate a discussion of reproductive health with them)?
- What is the effect of the rapport you have with women in your community on your ability to help them resolve reproductive health problems?

Like us, all women reflect about these same conditions:

- We tend to put conditions on the disclosure of certain information (for example: Why is the person asking? How are they going to use the information?)
- It may be difficult for us to determine particular conditions in which we feel comfortable to share certain aspects of our lives with others.
- We may share intimate information with a stranger if we know we will never see the person again. It may be difficult, however, to share such information with a stranger, acquaintance or friend who we might see again or with someone who is in contact with other members of the community.

Initially, as mediators we may be seen as strangers, acquaintances or casual friends by some women in our communities.

Depending upon women's level of comfort with a question, and with us, they may respond with the truth, or with what they perceive as the "appropriate" response, or something else.

Our ability to create a positive rapport and a feeling of trust with women in our communities is essential to effective communication with them, and to our ability to help them.

- If we need to ask questions that may be threatening, or questions that may create fear and/or anxiety in women, what can we do to put them at ease/to gain their trust?

- Create an atmosphere in which language, beliefs, anxieties and behavior are not judged/ridiculed.
- Explain the reasons why we ask certain questions.
- Always consider the rapport/trust we need to establish in order to ask certain

personal questions.

- Recognize that when we ask certain questions, especially concerning attitudes and feelings, what is important is that the woman begins to think about her response. Whether or not she decides to share her response may not be important.

Ask the group:

- What are some of the reasons we ask women questions during discussions of reproductive health?

- To understand reproductive health practices of women
- To assess women's knowledge of recommended reproductive health practices
- To help women make decisions
- To help women to anticipate consequences if certain decisions are made
- To help woman act after having made decisions

- What are some questions you might ask a woman about reproductive health?

Note several examples on a flip chart. Most will likely be closed questions. Ensure there are at least 2 open questions.

- What kinds of responses can one give to these questions?

Often a "yes", "no" or a fact. The response to a question indicates the kind of question asked:

- closed question: only 1 answer is possible
- open question: several answers are possible

Draw attention to the open questions and the fact that they serve to:

- Ask for more information/specifics
- Help the woman identify possible alternatives and weigh the pros and cons of each
- Help the woman reflect on her situation, on her feelings and values, on her behavior
- Give more structure to the discussion.

**Demonstration of the use of open questions.** Two trainers demonstrate the use of open questions (using a reproductive health example). (2 minutes)

Ask the group:

- What did you observe?
- In what ways did open questions contribute to communication between the mediator and the woman in the community?

Open questions help the mediator:

- To understand reproductive health practices of women
- To assess women's knowledge of recommended reproductive health practices

Open questions help women:

- To assess their situations and alternatives, and to make decisions
- To anticipate consequences if certain decisions are made
- To act after having made decisions

Refer participants to the participant document *Examples of Questions Useful in Reproductive Health* and review them with the group.

Post the flip chart *Principles for Improving Communication in Reproductive Health*. Ask volunteers to read and comment on each idea.

## **X. RESPONDING TO RUMORS (25 min)**

Ask the group:

- What are some rumors that circulate regarding reproductive health?

Note these rumors on a flip chart.

- How would you define the term "rumor"? Where do rumors come from?

Rumors are unconfirmed stories that are passed from one person to another. In general, rumors arise when:

- An issue or a piece of information is important to people but it is not clear, and
- There is nobody who can clarify the information, and/or
- The source is considered to be credible

### **Presentation of information to women in the community- exercise**

To demonstrate how the presentation of information to women may contribute to rumors, invite the group to participate in the following exercise:

Ask for 4 volunteers to leave the room and a fifth to come to the front of the room.

Ask the participant (5<sup>th</sup> volunteer who remained in the room) to listen carefully while you read the following message because the participant will have to repeat it to one of the volunteers who has left the room.

After having read the message, invite one of the volunteers to return to the room. The first volunteer repeats the message to the second.

One by one, the volunteers return to the room: the second volunteer repeats the message to the third, the third to the fourth, and the fourth to the fifth. The fifth volunteer repeats the message to the group. When they have finished, read the original message in order to compare it with the message of the last volunteer.

### Message

"I have just met a very interesting group of people which I am going to describe to you. You must pay close attention because you will have to repeat this message to one of your friends who is not here at this moment.

In this group, three people were from here and three came from other countries. Two of those who are from here were dressed Scandinavian style, in sports clothes, while the pretty young woman wore a traditional Asian dress. They preferred different kinds of foods: Italian, Chinese and Mexican.

The foreigners were of different nationalities. A woman came from a country west of ours and a man came from a Nordic country. All the Europeans spoke a mixture of English, French, German and Swedish, and discussed sexual behaviors and values of their respective countries".

### Summary

Ask the following questions:

- What happened to the message as it was repeated by each of the participants?

- It was shortened
- It was modified/distorted
- Important elements were left out

- Why?

- The message was too complicated
- The message was too long
- There was too much detail
- The person who received the message was not given time to ask questions nor allowed to verify the message with the sender by repeating it to her

- How was the information organized?

There was no logical order

- What was the main message?

The "discussion of sexual behaviors and values of the respective countries"

- Where was the main message placed in the conversation? How many people were able to repeat it?

At the end of the text; no one was able to repeat it

- Were there other obstacles?

The person who was listening:

- Paid more attention to the other person's non-verbal communication than to the verbal
- Gave the impression of listening while in reality he was thinking of something else
- Reacted to certain words

➤ What are the consequences of this kind of communication in reproductive health?

- Very little information is retained by women
- Information which is poorly communicated and poorly understood by women is a fertile source of rumors

Review with the group:

- Principles to help women to remember important information that we have communicated to them about reproductive health:
  - Limit ourselves to key information according to the woman's needs
  - Repeat key information several times during the discussion
  - Limit the details to the essential
  - Begin with important information and repeat it at the end of the discussion for emphasis
  - When possible, link information to something the woman knows already
  - Encourage the woman to ask questions if any part of the message is unclear to her
  - Ask the woman to repeat the message to verify what she understood and retained
- How to best respond when faced with rumors raised by women:
  - In certain situations, it may be appropriate to present directly the truth regarding the particular issue (for example, when the woman seems fairly sure that the issue she has raised is a rumor).
  - In most situations, however, it is important to find out what may be behind the rumor (for example, misinformation, a negative experience, poorly understood explanations, values, beliefs etc). When a person raises a rumor, listen carefully and try to discern the source of the rumor. This will enable you to be more certain that your response will be valid and respond to the concerns of the woman.

## **XI. INITIATING DISCUSSIONS OF REPRODUCTIVE HEALTH ISSUES (40 minutes)**

Refer to earlier parts of this session in which we discussed 1) obstacles to interpersonal communication, and 2) certain techniques to avoid these obstacles and to be more helpful to women in discussions of reproductive health. Suggest that there are two ways/situations in which a mediator may engage in a discussion of reproductive health with a woman:

- 1) *the woman comes to the mediator with a problem which she wants the mediator to help her with.* In this case, the mediator uses her knowledge of reproductive health and her skills in active listening to try to help the woman resolve her problem.
- 2) *the mediator initiates a discussion about reproductive health with a woman based on the mediator's impression of the woman's situation and possible benefits from changing certain of her behaviors.* In this case, the mediator initiates a discussion with the woman, based on the mediator's knowledge and/or observations of the woman's situation.

Explain that, for the moment, we will consider approaches we can use to initiate discussions of reproductive health with women in our communities.

Ask the group:

- Based on what you have learned about reproductive health, and what you know about reproductive health practices in your communities, in what kinds of situations would you initiate a discussion about reproductive health with a woman in your community?

In relationship to my knowledge and/or observation that:

- The woman is pregnant
- The woman has a newborn/infant
- The woman has recently had an abortion
- The woman has had many abortions in the past
- The woman has several children and has problems taking care of them

- For what purpose would you initiate such a discussion?

In order to find out the woman's:

- Perception of her situation (healthy, problematic, etc)
- Reproductive health practices
- Feelings about her situation
- Knowledge of important principles that apply to her situation and if she is applying them; and if not, to see how we can help her to:
  - Become more knowledgeable
  - Change her behavior in ways that are healthier for her and for her children.

Remind participants of the earlier discussions of the processes of:

- 1) behavior change, and 2) decision-making, and the fact that some women may decide to change their behavior relatively quickly while others may take years to change, or may never change.
- Problem solving, and the fact that the individual is responsible for her behavior (although her situation may be complicated by other factors as well) and that the role of the mediator is to help her if she wants to change/solve her problem, and to provide information and other assistance to help her.

Divide the group into 5 small groups. Ask each group to discuss and prepare to present to the large group, their approach to initiating discussion with women in their community concerning one of the following reproductive health situations:

- The woman is pregnant
- The woman has a newborn/infant
- The woman has recently had an abortion
- The woman has had many abortions in the past
- The woman has several children and has problems taking care of them

- The woman is pregnant:
  - Acknowledge that this must be a happy event (or ask if it is a happy event if it appears that it might not be)
  - Ask how many weeks/months she is pregnant
  - Ask how she feels her pregnancy is progressing. Any problems, concerns?
  - Ask about her knowledge and practice of eating, resting and exercising during pregnancy
  - Ask about her knowledge of recommended prenatal visits and the purpose of these visits
  - Ask about her attendance at prenatal visits
- The woman has a newborn/infant
  - Acknowledge that this must be a happy event (or ask if it is a happy event if it appears that it might not be)
  - Ask about the age and health of the infant; and about the eating, behavior and sleeping patterns of the baby
  - Ask if the baby has received its vaccinations (according to its age)
  - Ask if the woman is breastfeeding (including frequency, satisfaction, problems etc)
  - Ask about her knowledge of the sequence and importance of routine:
    - follow-up visits for baby
    - postnatal visits for herself
  - Ask about her attendance at postnatal visits, and her infant's attendance at follow-up visits
- The woman has recently had an abortion
  - If it seems appropriate to the woman, ask questions to help her identify reasons or circumstances behind her unintended pregnancy and to assess whether these events could lead to another unintended pregnancy
  - Ask questions regarding her thoughts about her future behavior and possible need for contraception (and STI prevention) according to her situation, in order to prevent future unwanted pregnancies
- The woman has had many abortions in the past
  - If it seems appropriate to the woman, ask questions about her feelings about the fact that she has had multiple abortions (any feelings of sadness or loss, concerns about the effects on her from multiple abortions)
  - Ask questions regarding her thoughts about her future behavior and possible need for contraception (and STI prevention) according to her situation, in order to prevent future unwanted pregnancies
- The woman has several children and has problems taking care of them

- Ask about the children; acknowledge any problems expressed by the woman
- Ask if the woman hopes/plans to have other children
  - If the response is yes, ask open questions about the concerns/problems she expressed earlier in order to help her reflect on the reality of her situation
  - If the response is no, ask open questions about what she would like to do to prevent future pregnancies, what she knows about family planning etc

Emphasize the importance of providing the woman relevant and clear information throughout the discussion, as appropriate to her responses to the questions asked.

## **XII. INTEGRATION OF ACTIVE LISTENING COMPONENTS (2 hours)**

**[Notes to trainers:** You will need to have six role plays (three for Series 1 and three for Series 2), enabling all participants to play the role of mediator once in each series.

- Series 1 role plays focus on initiating discussions of reproductive health with a woman. Note that there will be three of these role plays so that each participant will have the opportunity to play the part of mediator, woman in the community and observer
- Series 2 should be based on difficult cases that women in the community may raise with mediators. Note that there will be three of these role plays so that each participant will have the opportunity to play the part of mediator, community woman and observer.

Role play cases should include the following information:

- Woman's age
- Number of pregnancies
- Number of abortions (if applicable to the situation)
- Number of children
- Details about the particular reproductive health situation
  - Woman's situation with respect to the particular reproductive health issue (example: Pregnant, eating poorly, does heavy physical labor on the farm, has not gone for prenatal visits because she does not want to be examined)
  - Woman's feelings about her situation (for example about her pregnancy)
  - Woman's knowledge of reproductive principles that apply to her situation
  - Woman's reproductive health practices relative to her situation]

Invite participants to practice integrating their skills of:

- initiation of discussions of reproductive health
- active listening (passive listening, paraphrasing and asking open questions)
- sharing reproductive health information with women

Post the flip chart and distribute the participant document *Role Play Discussion Questions*. Review the questions with the group. Explain that these questions will be useful to them in observing the role plays and in sharing feedback at the end of the role plays.

Refer the group to the flip chart *Feedback* (introduced the first day of training) and remind them of the importance of respecting the rules for giving and receiving feedback.

**Series 1:** Divide the group into small groups of 3. In each group, for the **first role play** there is a mediator, a woman in the community and an observer. Give a prepared role play case to the woman who reads it (silently to herself) to prepare her role. Inform the entire group only that this role play concerns a woman who (is pregnant, has a new baby etc – whatever the reproductive health issue is for this particular role play).

**Note:** The same role play situation should be given to all groups so that the large group discussion following each role play can focus on common issues.

**Note:** In order to make the classroom practice as real as possible, the mediator should only know in advance the reproductive health issue being addressed.

**Note:** During the role plays, trainers should move around the room and observe the groups:

- Taking note of particular skills of mediators, and problems they encounter, to be raised in the large group discussion following the role plays
  - Ensuring that all groups are actively engaged in the role plays
- 
- ❑ Give the groups 10 minutes to conduct their role plays.
  - ❑ Stop the role plays and give the small groups 2 minutes to share feedback within their groups (beginning with the mediator, followed by the woman and then the observer). Participants use the flip chart/participant document *Role Play Discussion Questions* as the basis for giving feedback.
  - ❑ Discuss in the large group participants' observations, what they learned from applying communication skills in the role play, and any observations they have about how best to conduct similar discussions in their communities (8 minutes).
  - ❑ Ask participants to change roles within the groups and conduct a **second role play**, as indicated in the instructions above. Give the (new) woman of each group a new role (the same role play situation to be used by all groups); and inform the large group only of the reproductive health issue being addressed in this role play.
  - ❑ Give the groups 10 minutes to conduct their role plays
  - ❑ Stop the role plays and give the groups 2 minutes to share feedback within their groups (beginning with the mediator, followed by the woman and then the observer). Participants use the flip chart/participant document *Role Play Discussion Questions* as the basis for giving feedback.
  - ❑ Discuss in the large group participants' observations, what they learned from applying communication skills in the role play, and any observations they have about how best to conduct similar discussions in their communities (8 minutes).
  - ❑ Ask participants to change roles within the groups and conduct a **third role play**, as indicated in the instructions above. Give the (new) woman of each group a new role (the same role play situation to be used by all groups); and inform the large group only of the reproductive health issue being addressed in this role play.

- ❑ Give the groups 10 minutes to conduct their role plays
- ❑ Stop the role plays and give the groups 2 minutes to share feedback within their groups (beginning with the mediator, followed by the woman and then the observer). Participants use the flip chart/participant document *Role Play Discussion Questions* as the basis for giving feedback
- ❑ Discuss in the large group participants' observations, what they learned from applying communication skills in the role play, and any observations they have about how best to conduct similar discussions in their communities (8 minutes).

Ask participants:

- What problems did you encounter in initiating discussions of reproductive health in these situations?
- How useful did you find the role plays in practicing your skills?

**Series 2.** Ask participants to change groups. To do this most efficiently, ask everyone who was the mediator in the last role play to get up and join another group. Then ask everyone who was a woman from the community in the last role play to get up and join another group (a group with participants she has not yet worked with).

**Note:** The same role play situation should be given to all groups as in the first series of role plays, so that the large group discussion following each role play can focus on common issues.

**Note:** In order to make the classroom practice as real as possible in these situations, the mediator should not know anything about the role play case in advance.

**Note:** During the role plays, trainers should move around the room and observe the groups:

- Taking note of particular skills of “mediators”, and problems they encounter, to be raised in the large group discussion following the role plays
- Ensuring that all groups are actively engaged in the role plays

- ❑ In each group, there is a mediator, a woman from the community and an observer. ***First role play.*** Give a prepared role play case to the woman who reads it (silently to herself) to prepare her role.
- ❑ Give the groups 10 minutes to conduct their role plays.
- ❑ Stop the role plays and give the groups 2 minutes to share feedback within their groups (beginning with the mediator, followed by the woman and then the observer). Participants use the flip chart/participant document *Role Play Discussion Questions* as the basis for giving feedback
- ❑ Discuss in the large group participants' observations, what they learned from applying communication skills in the role play, and any observations they have about how best to apply these skills in their communities (8 minutes).

- ❑ Ask participants to change roles within the groups and conduct a ***second role play***, as indicated in the instructions above. Give the (new) woman of each group a new role (the same role play situation to be used by all groups).
- ❑ Give the groups 10 minutes to conduct their role plays
- ❑ Stop the role plays and give the groups 2 minutes to share feedback within their groups (beginning with the mediator, followed by the woman and then the observer). Participants use the flip chart/participant document *Role Play Discussion Questions* as the basis for giving feedback.
- ❑ Discuss in the large group participants' observations, what they learned from applying communication skills in the role play, and any observations they have about how best to apply these skills in their communities (8 minutes).
- ❑ Ask participants to change roles within the groups and conduct a ***third role play***, as indicated in the instructions above. Give the (new) woman of each group a new role (the same role play situation to be used by all groups).
- ❑ Give the groups 10 minutes to conduct their role plays
- ❑ Stop the role plays and give the groups 2 minutes to share feedback within their groups (beginning with the mediator, followed by the woman and then the observer). Participants use the flip chart/participant document *Role Play Discussion Questions* as the basis for giving feedback.
- ❑ Discuss in the large group participants' observations, what they learned from applying communication skills in the role play, and any observations they have about how best to apply these skills in their communities (8 minutes).

Suggest to the group that the *Role Play Discussion Questions* can be used to continue to monitor the application of one's communication skills to discussions of reproductive health.

**STATEMENTS : OBSTACLES TO COMMUNICATION**

1. A woman who has 8 children. She nearly died from hemorrhage during her last delivery. It is doubtful she would be able to survive another pregnancy. You ask her if she is interested in family planning. She responds: "I don't believe in family planning. Those things make you sick. I don't need it."
2. A woman with 2 children (ages 2 years, and 5 months) has been using contraceptive pills for the past 4 months. Her husband has just found her pills and thus learned that she is on contraception. He is completely opposed to contraception and has forbid her to continue taking the pills. She tells you: "I don't want more children right now. I don't agree with the position of my husband but I cannot continue if he doesn't want it."
3. A woman 21 years old with one child. She wants to know where she can get a tubal ligation because she doesn't want any more children. When you try to discuss other family planning methods with her, she responds: "I don't want to hear about other methods. I told you that I don't want any more children. And for that reason, I want to be sterilized."
4. A single girl, 17 years old, who has been having sex for the last 2 years. She is now in the second month of pregnancy. She has already had one induced abortion and she intends to abort this pregnancy as well. When you try to discuss family planning with her, she responds: "I will not need it. I'm not going to have sex any more before I get married."

## Flip chart

### **OBSTACLES TO COMMUNICATION**

1. Ordering  
Telling the woman to do something, without explanation or alternatives.
  
2. Threatening, warning  
Telling the woman the negative consequences that will happen if she acts a certain way
  
3. Advising, giving solutions, moralizing  
Telling the woman how to solve her problem.
  
4. Judging, criticizing, disagreeing, blaming  
Making a negative judgment or evaluation of the woman.
  
5. Labeling, stereotyping  
Putting the woman into a category to shame her.
  
6. Interpreting, analyzing, diagnosing  
Telling the woman what her motives are, analyzing what she is doing or saying.
  
7. Sympathizing  
Trying to make the woman feel better, talking her out of her feelings; trying to make her feelings go away.
  
8. Distracting, humoring, diverting  
Drawing the woman away from her problem (possibly because mediator doesn't know how to deal with it): changing the subject etc.

## Participant document

### **OBSTACLES TO COMMUNICATION**

1. Ordering  
Telling the woman to do something, without explanation or alternatives.  
*Examples:*  
"I don't care what other people say. You have to ..... "  
"Listen to me!"  
*Possible feelings generated by these responses:*
  - Fear
  - Resentment, anger
  - Sense that my feelings and needs are not important
  
2. Threatening, warning  
Telling the woman the negative consequences that will happen if she acts a certain way  
*Examples:*  
"If you do that, you'll be sorry."  
*Possible feelings generated by these responses:*
  - Fear
  - Resentment
  
3. Advising, giving solutions, moralizing  
Telling the woman how to solve her problem.  
*Examples:*  
"If I were you, I would ....."  
"You shouldn't act like that"  
"You ought to ....."  
*Possible feelings generated by these responses:*
  - Resistance, defensiveness
  - Guilt
  - Feeling of inferiority
  
4. Judging, criticizing, disagreeing, blaming  
Making a negative judgment or evaluation of the woman.  
*Examples:*  
"You're wrong about that! I couldn't disagree with you more."  
"You aren't even making an effort."  
"You didn't understand anything of what I said."  
*Possible feelings generated by these responses:*
  - Sense of inferiority
  - Defensiveness
  
5. Labeling, stereotyping  
Putting the woman into a category to shame her.  
*Examples:*

"You're acting like a child."

"You women/Roma are all alike."

*Possible feelings generated by these responses:*

- Sense of inferiority

6. Interpreting, analyzing, diagnosing

Telling the woman what her motives are, analyzing what she is doing or saying.

*Examples:*

"You don't really believe that!"

"You're just trying to avoid the problem."

"You're just saying that to bug me."

*Possible feelings generated by these responses:*

- If correct, embarrassment
- If incorrect, hostility and anger.

7. Sympathizing

Trying to make the woman feel better, talking her out of her feelings; trying to make her feelings go away.

*Examples:*

"You'll feel different tomorrow."

"All women go through this sometime."

"Don't worry, things will work out."

"I used to feel like that, too."

*Possible feelings generated by these responses:*

- Frustration, feeling that the mediator doesn't understand.
- Sense that the person's feelings are not important.

8. Distracting, humoring, diverting

Drawing the woman away from her problem (possibly because mediator doesn't know how to deal with it): changing the subject etc.

*Examples:*

"We've been through all of this before."

"That reminds me of . . . . <diversion>"

*Possible feelings generated by these responses:*

- Rejection
- Frustration and hurt

## **Other possible obstacles to hearing what others say**

The mediator:

- Misinterprets what the woman says and thinks the woman is criticizing her.
- Prepares her response at the same time she listens to the woman.
- Listens selectively (based on her experience with other women). We limit our understanding of what people say by ignoring details according to our values and therefore our interpretations of what was said.
- Pays more attention to all that is not correct, or to that with which she doesn't agree, in what the woman says.
- Identifies with something the woman said and begins to relive her own experiences.

Other obstacles to communication:

- Differences in values, education, class, vocabulary between the mediator and the woman may make it difficult for one to understand the other. Mediators may misinterpret their roles in communication for behavior change, and:
  - Transform a dialogue into a monolog
  - Not show respect towards the woman
- The attitude that mediators have better ideas than community women
- Extreme appearance (of the woman or the mediator)
- The woman's problem is shocking
- The mediator, or the woman, is distracted by other pre-occupations
- The mediator's response is not what the woman needed or wanted to hear
- The environment is not conducive to communication (noisy, distracting, no privacy); the woman is self-conscious to discuss problems because of the possibility of other people listening
- The woman feels uncomfortable because she does not trust the mediator
- The mediator does not understand the woman's problem and gives advice or information that is irrelevant or impossible to apply
- Too much information is given: the woman only remembers part of what was said, especially if she was worried or anxious
- People who do not know each other or otherwise lack confidence in each other sometimes have difficulty hearing each other
- Women in the community may:
  - Fear expressing their ideas
  - Believe that their problems would not be of interest to mediators
- Previous experience – if previous encounters/communication did not lead to a change in behavior, the mediator may assume that future communication with this woman, or “women like her”, would be the same.
- The woman's sense of insecurity or inferiority may lead her to interpret the mediator's questions as accusations, and the woman's answers turn into justifications
- The woman's perception of the mediator as incompetent (in terms of what the mediator says and how she says it)
- The woman's interest in the subject, other preoccupations and/or attitude toward the mediator. If the woman is anxious or nervous, she may easily become defensive and misinterpret what is said (including perceiving threats which are not there)

## ACTIVE LISTENING

Active listening is a communication technique used by “helpers” to help people to analyze and resolve their problems themselves. The “helper”: 1) uses silence and a variety of short responses, 2) paraphrases what the person says, and 3) poses questions, in order to help the person reflect on her problem and alternatives, and to find a solution to her own problem. Active listening communicates acceptance of the person in that the “helper” does not communicate judgments nor solutions. It facilitates decision-making by the individual.

### ***Active listening is useful in discussions of reproductive health:***

Women may have questions, concerns and problems that influence their ability to adopt healthy reproductive health practices, including using reproductive health services. They may pose informational questions which in fact represent rumors, beliefs, anxieties or disagreement with a partner. Active listening is useful to help bring out what may be behind a woman’s initial statements, questions or responses in order to be able to better respond to these concerns and to anything that may prevent her from adopting healthy behaviors and appropriately using reproductive health services.

#### **1. *Passive listening***

- By learning to tolerate silence, the mediator pays more attention to what the woman says
- The purpose of passive listening:
  - Give responsibility to the woman to explain her concerns, needs, and/or problems; and to ask questions
  - Demonstrate to the woman that the mediator is listening
  - Prevent the mediator from imposing her ideas

#### **2. *Paraphrasing***

- Paraphrasing is the reformulation of what the person said in their own words, including the mediator’s perception of feelings behind the message (expressed by tone of voice, facial expression, body language)
- The purpose of paraphrasing:
  - To verify the mediator's understanding of what the woman says
  - To help the mediator refrain from interrupting the woman and giving advice
  - To encourage the woman to continue to explain her problem

#### **3. *Open questions***

- Open questions are used to help the woman to reflect and to make her own decision. They serve to:
  - Ask for more information/ detail
  - Help the woman identify possible alternatives and weigh the pros and cons of each alternative
  - Help the woman reflect on her situation, on her feelings and values, on her behavior

- Give more structure to the discussion.

## Participant document

### **EXAMPLES OF QUESTIONS USEFUL IN REPRODUCTIVE HEALTH**

The following questions may help to verify your understanding of a woman's concerns, problems and/or questions; and to give you clues about the presence of misinformation, about attitudes and expectations, and about the nature and meaning of the woman's concerns.

**Note:** It is sometimes useful to preface a question but stating that *“I need to ask you a question or two to help me know how best to answer your concern”*

- What do you know about the LAM?
- What is your husband's opinion on the family planning method you use?
- What type of problems are you having?
- Which family planning methods would you like to know about?
- Can you describe for me some of the signs and symptoms of STIs?
- Tell me more about \_\_\_\_\_
- Would you tell me a little more about \_\_\_\_\_
- I'd be interested in knowing \_\_\_\_\_
- How did you feel about \_\_\_\_\_
- Would you explain \_\_\_\_\_
- I'm not certain I understand \_\_\_\_\_
- Would you explain that in more detail \_\_\_\_\_
- What do you mean by \_\_\_\_\_
- Perhaps you could clarify \_\_\_\_\_
- What was there about \_\_\_\_\_ that appealed to you?
- What prompted your decision to \_\_\_\_\_
- How did you happen to \_\_\_\_\_
- To what do you attribute \_\_\_\_\_

When you have provided answers to a request for information, you may verify the woman's understanding by asking:

- Is that what you were asking me?
- Do you want to ask me more about this?

If you do not know the answer to a question posed by a woman, acknowledge that you do not know, that you are not able to be of help

- I don't know the answer to your questions (followed by)
  - Let's see if we can find the answer together
  - Perhaps I can put you in touch with someone who can help you

Participant document

**PRINCIPLES FOR IMPROVING COMMUNICATION IN REPRODUCTIVE HEALTH**

- Listen carefully to the woman (to ensure your understanding of what she says & what may be behind what she says; to bring out her needs, problems, concerns, values and choices)
  
- Speak simply and minimize unnecessary explanations.
  
- Establish a rapport between new ideas and the woman's existing knowledge and/or experience, associate the unknown with the known
  
- Repeat important and/or difficult information & concepts (using examples)
  
- Emphasize the essential
  
- Be careful about trying to convince the woman of your point of view or giving her solutions to her problems

## **ROLE PLAY: QUESTIONS FOR DISCUSSION**

### **Questions for mediators**

1. What did you do to put the woman at ease, to gain her confidence?
2. How did you encourage the woman to talk about her problem and/or clarify information regarding her problem?
3. Did you respond to the preoccupations of the woman? If yes, how? If no, why not?
4. Were there any obstacles in the communication? If so, what did you do to resolve them? What might you have done differently?

### **Questions for community members/women**

1. How did you feel at the beginning of your interaction with the mediator?
2. Did the mediator gain your confidence? How? If not, why not?
3. Was the mediator interested in your situation/problems? Did she help you? How? If not, why not?
4. What more could the mediator have done to help you?
5. Did the mediator give you clear and relevant information in a manner in which you could understand?
6. Did you feel that the mediator was judging you in any way? If so, in what ways?

### **Questions for observers**

1. Did the mediator:
  - Help the woman talk about her concerns, knowledge and practices regarding the particular reproductive health topic?
  - Apply the techniques of active listening (passive listening, paraphrase, clarifying questions)?
  - Make judgments or moralize? If so, give examples.
2. How would you describe the quality of information given to the woman?
  - Was the information clear to her?
  - Were the mediator's explanations simple, correct, complete etc? Did the mediator lack certain information? Which information?
3. Did the mediator verify the woman's understanding of information given to her?
4. Did the interaction end in a positive manner?

## ROLE PLAYS (samples)

### **Series 1: Initiating discussions of reproductive health**

#### Role play 1:

Age:

Marital status: married

Number of children: 4

Date of last delivery: 5 years ago

Breast feeding: no

Problem:

#### Role play 2:

#### Role play 3:

### **Series 2: Difficult cases that women in the community may raise with mediators**

#### Role play 1:

Age: 30

Marital status: married

Number of children: 4

Date of last delivery: 5 years ago

Breast feeding: no

Problem: Your husband has been out of work for two years. You are the sole source of income for the family. You recently got pregnant while using an IUD. You want an abortion because 1) you fear being fired if your boss finds out you are pregnant, and you will have no other source of income, and 2) you cannot imagine having another child to care for. Your husband wants you to have the baby. You do not know what to do.

#### Role play 2:

#### Role play 3:

## **SESSION 15: GROUP EDUCATION SESSIONS – GENERAL CONCEPTS**

**OBJECTIVES:** By the end of the session, participants should be able to:

1. Explain 6 stages in the communication process for promoting behavior change.
2. Describe 6 steps in planning group education sessions.
3. Describe how to use group discussion as a teaching method for small groups.
4. Explain the importance of visual aids in educational sessions.
5. Name at least 3 principles for the selection and use of visual aids.

**TRAINING METHODS:** discussion

**TIME:** 2 hours

### **MATERIALS:**

Flip charts:

- Session 15 objectives
- Continuum in the Effectiveness of Educational Activities
- Preparation of Group Education Sessions

Participant documents:

- Continuum in the Effectiveness of Educational Activities
- Preparation of Group Education Sessions
- Facilitating Group Discussion
- Checklist for the Facilitation of Educational Sessions
- Principles of Using Visual Aids

Trainer documents:

- Anteater description
- Anteater (picture)
- Old lady/young lady (picture)

## **INSTRUCTIONS**

Post the flip chart *Session 15 objectives* and ask volunteers to read them.

### **I. STAGES IN THE COMMUNICATION PROCESS FOR BEHAVIOR CHANGE (20 minutes)**

Introduce the session by explaining that:

- Group education sessions are a second method which mediators can use to communicate with women about reproductive health issues
- In this session, we will discuss principles to follow in preparing and conducting group educational sessions.

Ask the group:

- What should be the ultimate objective of educational sessions on reproductive health that you will conduct with groups of women?

To help women adopt healthy behaviors/practices concerning pregnancy, delivery, family planning, and early childhood care, including nutrition; such healthy behaviors/practices include the appropriate use of reproductive health services.

Explain that once we have defined the overall objectives of our educational sessions, it is important to consider how to reach these objectives.

Post the flip chart *Continuum in the Effectiveness of Educational Activities* and present the different stages in order to help participants appreciate the importance of the preparation of educational sessions. Emphasize that the effectiveness of educational activities may be limited (to any point of the continuum) by the effectiveness of the preparation and/or the facilitation of the session.

In order for educational activities to be effective:

A. Reaching the intended audience

The mediator must identify the target population and develop the session based on their *needs and characteristics*.

It is not very productive to:

- Focus on desired/positive behaviors that the group already practices consistently, except to validate and/or reinforce them
- Suggest behaviors/practices that are difficult or impossible to implement or are totally unacceptable to the group

B. Attracting the audience's attention

The educational session must attract people's attention so they will make the effort to listen/participate. In order for this to happen:

- The topic must be of interest
- The manner in which the mediator facilitates the session must be interesting to the group.

C. Understanding the message (perception)

People must be able to understand the message as it was intended. This depends upon their ability to:

- Understand the language, terminology and/or pictures used
- Absorb the volume of information presented

Thus, the language, terminology and pictures used, and the volume of information presented, must be appropriate to the characteristics of the group.

D. Promoting change (acceptance)

People must believe and accept the message. The acceptance of new information/ideas depends in part on:

- The degree to which the information, ideas and/or proposed behavior changes correspond to, or conflict with, people's existing beliefs regarding the particular subject/behavior

- How long people have held these beliefs (beliefs that have been acquired more recently are generally easier to change than beliefs that have been held in the family, community and/or culture for a long time)
- How easily and immediately the effects the proposed change can be demonstrated

E. Producing a change in behavior

- The message must target the beliefs which have the most influence on the person's attitude toward the proposed behavior change
- The person must be able to overcome any opposing pressures from family or others important to him/her
- Enabling factors (money, time, skills, health services etc) must be adequate to facilitate the change

F. Improvement in health

Behaviors being promoted must lead to health improvements.

Distribute the participant document *Continuum in the Effectiveness of Educational Activities*.

## II. STEPS IN PLANNING GROUP EDUCATION SESSIONS (20 minutes)

Ask participants:

- Where on the continuum that we just discussed are your objectives for educational sessions you will be doing with women in your communities?
  - ✓ That you reach your intended audience?
  - ✓ That women listen and participate in your sessions?
  - ✓ That women understand your messages?
  - ✓ That women believe and accept your messages?
  - ✓ That women change their behavior as a result of participation in your sessions?
  - ✓ That women's health improves as a result of their behavior change?

**Note:** It is assumed that the mediators' objectives are to help women change certain behaviors which will lead to improvement in their health and in the health of their children

- What do you need to do to prepare an effective session (one which meets your objectives)?

Introduce a practical structure for planning educational sessions, based on the following six questions.

1. **Who is my public/target group?** What kind of group am I going to speak with?

- What do they already know about the subject?
- What expectations/interests might they have on the chosen subject?

- How many women will likely be present?
2. **What are my objectives?** What do I want the group to know or be able to do as a result of my session? This determines the key message of my presentation.

Ask the group:

- Why is it important for you to know what you want the group to know or be able to do as a result of your session?

What you want them to know or be able to do as a result of your session:

- Defines the main themes to be discussed during the session.
- Influences the choice of methods to be used to facilitate learning during the session. (For example, if you want women to learn new ways to prepare more nutritious foods for babies, you might want to do a demonstration of preparation of these foods)
- Influences the choice of visual aids you may use
- Is necessary in order to evaluate the effectiveness of the session

3. **Where will the session take place? How long will it last?**

Ask:

- What factors influence the choice of location and the length of time of the session?

- Availability of space and seats for the size of group you anticipate (Can the space be organized so that women are comfortable and can see each other?)
- How much time women will be able to spend
- How much time I will be able to spend

4. **What method of facilitation/teaching will I use?** What kinds of questions will I ask to facilitate participation and learning?

Ask:

- What factors influence the choice of teaching/facilitation method?

- The objectives of the session
- The characteristics of target group (and what they are comfortable with)
- The time and place
- The methods the facilitator is capable of using effectively

Explain that:

- In general, more effective teaching methods:
  - Provide opportunity for discussion, feedback and participation

- Involve simulations, role play and problem-solving exercises
- Use pictures that can promote discussion
- Emphasize reflection, critical thinking and problem-solving skills rather than the acquisition of specific knowledge
- Require small groups (20 people maximum)
- Require a facilitator rather than a teacher or 'expert'
- Group discussion is a very common and effective method for conducting educational sessions.

Emphasize the importance of preparing open questions to be used to:

- Introduce the subject
- Open the discussion
- Help participants think about their experience and knowledge about the subject
- Help participants consider their feelings about, and reactions to, proposed behavior changes (the pros and cons of possible changes)

### 5. What visual aids are available and appropriate?

Ask the group:

- What kind of visual aids have we used since the beginning of this training?

- |  |
|--|
| <ul style="list-style-type: none"> <li>● Written documents</li> <li>● Flip charts</li> </ul> |
|--|

- What are other visual aids one could use?

- |  |
|--|
| <ul style="list-style-type: none"> <li>● Pictures</li> <li>● Models</li> <li>● Real objects</li> </ul> |
|--|

- What is a visual aid?

Anything visual which helps people learn
--

Propose the following exercise to demonstrate the importance of visual aids in group education.

Ask participants to take out a piece of paper and pencil.

Ask participants to design an animal according to a dictionary description you read to them. (See the trainer document *Anteater description*.) Read the description twice slowly and clearly. (Do not read the instructions too many times or some participants may copy the text which defeats the purpose of the exercise.)

Do not be concerned if participants are confused. Ask them to do their best according to the instructions. Ask participants to reflect upon their reactions to the activity as they are doing it.

Give participants several minutes at the end to complete their designs.

Ask participants:

- What are your impressions concerning the activity? Was it easy? Difficult? Why?

Difficult:

- I didn't understand the instructions
- There was not enough information

Ask several people to guess the type of animal they have drawn. Show the picture of the anteater. Re-read the description and indicate each part of the body as it is mentioned.

Ask participants:

- What have you learned from this activity concerning visual aids? What lesson can you draw concerning learning new information expressed a) in words, and b) in pictures?

- Visual aids are often necessary for understanding new information.
- A good visual aid attracts the attention of the group

- Could you describe an IUD or a condom to people who have never heard of them, without a visual aid?
- What happens when people do not understand what you tell them?

Often people do not understand what is said and this misunderstanding leads to rumors. Sometimes, even with a visual aid (a real object), the terminology we use is an obstacle to the people's understanding.

Give each participant a copy of a picture of a young/old lady. Do NOT tell them what is in the picture. Ask them to study the picture for a minute without talking, then to share with the group what they see in the picture.

Ask the following questions:

- What do you see?

Responses will vary.

*Hopefully, at least one person will see a young, or an old, lady.*

- How many people see:
  - ✓ a young lady?
  - ✓ an old lady?
  - ✓ something else?
- Why is it that we are not all seeing the same thing in the same picture?

- We have differences in experience, different perceptions
- The picture is confusing

- What can we learn from this experience?

- If the visual aid is confusing for whatever reason, it is not appropriate/ effective
- One must always test visual aids with a representative target group in order to be sure that they are seen and understood as they were intended

- What influences what we see in a picture?

- our surroundings
- our experience

- What must we do to make visual aids as effective as possible?

- avoid distortions in size and distracting details
- show complete objects, especially parts of the body
- show objects from familiar angles
- use signs and symbols that are understood by the target audience
- in using visual aids, draw a relationship between the picture and the experience of the target group
- use real objects whenever possible
- make sure that the visual aid is
  - easy to see and understand
  - attractive

Distribute the participant document *Principles of Using Visual Aids*. Ask volunteers to read it.

Ask:

- What factors influence the choice of visual aid?

It must be:

- Appropriate to the topic and to the group
- Adapted to the teaching/facilitation method used
- Available (including necessary equipment)
- Portable

- Sufficiently interesting to attract and maintain group attention
- Adapted to the location

Emphasize the importance of:

- Collecting and organizing visual aids in advance
- Practicing using the visual aids in advance (if necessary)

6. **How can I evaluate the effectiveness of my session?** Short term? Long term?

Short term, by:

- The number of people and level of participation/expressed interest
- The quality of responses to questions posed

Long term, by:

- Changes in people's behavior

Add that:

- During the session, the mediator can:
  - Observe the group to see if the subject interests them and if they understand the message.
  - Ask open questions to assess what women have learned/what the message meant to them.
  - Ask a member of the group to resume what has been said.
- After the session, the mediator should:
  - Note if the number of people attending future sessions increases.
  - Note if people seek additional information
  - Ask herself if the group does what she anticipated in her objective for the session.
  - Ask herself: "How can I improve?"

### **III. USING GROUP DISCUSSION (40 minutes)**

Explain that participants will prepare and facilitate group education sessions, using group discussion as their method.

Explain that you are going to demonstrate how to conduct an educational session using group discussion (15 minutes).

**[Note to trainer:**

- The following example of a group discussion is simply an outline. When you demonstrate such a discussion with the participants, you will very likely ask additional relevant questions; and the group may well ask interesting questions and/or add other information that is not included in this brief outline.
- As indicated in the principles for preparing an educational session, the questions listed under "3" below represent the main themes of the message and serve to:

- Introduce the subject
- Invite the participation of the group
- Provide structure to the discussion in order to achieve the objectives of the session
- It will improve your demonstration (and you will model what you are teaching) if you can use visual aids. Be sure to respect the principles for using them.]

Lead a group discussion, using visual aids (if possible) and asking open questions. Ask the group to assume the roles of a group of mothers of infants 6-12 months of age.

1. Welcome the group and introduce yourself.
2. Introduce the subject (prevention and treatment of early childhood malnutrition). Suggest that this is a subject that is of concern to women who have young babies. Invite the group to participate actively in the discussion.

**[Note to trainer:** For the purposes of demonstrating the facilitation of a group education session, you may decide to designate a different target population of women and a different reproductive health topic.]

3. Facilitate the group discussion, using the following key questions (or similar questions and/or introduction as appropriate):
  - The health of our babies and children is important to us as mothers, and their nutrition is very important to their health. What is the best food we can give our babies/infants?

Breast milk
-------------

- At what time (age of the baby) do you begin giving other foods to your baby? What do you give them?

Responses will vary. <b>Note:</b> assume that several people say they wean their babies early (at 3-4 months) and give them rice and thin porridge.
--

- What happens to babies if they only eat rice and porridge?

Often they get sick
---------------------

- What are the signs that tell you they are sick?

After some time, their hair becomes lighter; their tummies, arms, legs and feet swell; their skin may begin to crack and peel, especially at the joints; they are weak and very unhappy
---

- Does this happen to all babies?

No

- Why is it that some babies get this sickness and others do not?

Some breastfeed longer, and their mothers give them all kinds of foods (fruit, meat and vegetables) in addition to breast milk, and they do not get this sickness.

- At what age should babies start eating other foods (while continuing to breastfeed)?  
What should they eat?

At 6 months, they should begin eating small amounts of:

- fruit juice and/or soft fruits
- light porridge, enriched progressively with one or more of the following, according to the child's age and the family's possibilities:
  - Oil
  - Milk
  - Dried fish (powdered)
  - Egg (raw egg cooked into the porridge)
  - Well-cooked and mashed beans

- What can you do to treat your child if s/he has this sickness?

Depending upon what the baby is already eating, add oil to his/her porridge, and begin adding the other foods.

- Who would like to summarize what we need to feed our babies so that they are healthy and grow well?

- Give them only breast milk until they are 6 months of age
- At 6 months, they should begin eating small amounts of:
  - fruit juice and/or soft fruits
  - light porridge, enriched progressively with one or more of the following, according to the child's age and the family's possibilities:
    - Oil,
    - Milk
    - Dried fish (powdered)
    - Egg (raw egg cooked into the porridge)
    - Well-cooked and mashed beans
- Progressively, as the baby gets teeth, give him more of the foods the family eats, being careful not to give him very spicy foods
- Continue to give the baby breast milk until the age of 1-2 years if possible

Ask the following questions about the use of group discussion as an educational method

- What did the mediator do to put the group at ease, make people feel comfortable?

Introduced herself and welcomed the group

- What did she do to encourage group participation?

She introduced the subject and suggested that it is a subject of concern to the group, and invited their active participation.

Instead of telling the group about the subject, she asked them questions in order to help them benefit from their own knowledge and experience, and in order to adapt the discussion to their knowledge and experience. She corrected some information and added new information as necessary.

- What steps did she follow?

- Introduced the subject
- Asked questions concerning the participants' knowledge and experience related to the subject
  - Added new elements of information (not too many)
  - Led a discussion of these new elements
  - Summarized the ideas expressed by the group
  - Posed questions about the application of what the group learned to their personal lives

Emphasize that a group discussion is more participative and productive when the group is limited to 15-20 people. When the group is larger, the method tends to become 'lecture' as it is more difficult to engage everyone's participation.

- What were the objectives of the session? Were they achieved?

At the end of the session, the group should be able to:

- Explain the consequences to children when mothers only give babies rice and thin porridge
- Explain when to begin supplemental feeding
- Name the first foods a mother should begin adding to a baby's diet and explain how to prepare them

### **Choice of subject for a group discussion**

Ask the group:

- What are some reproductive health topics that might be important to women in your communities?

- Pregnancy
  - 
  -
- Delivery
  - 
  -
- Breastfeeding
  - 
  -
- Family planning
  - 
  -

➤ Let us use family planning as an example. For what purpose would you conduct educational sessions on family planning?

Depending upon the level of information the group already has, and the motivation of the group toward family planning:

- To make the group more aware of:
  - The importance of family planning to the health of mothers and children
  - The availability of family planning services
- To inform the group of the family planning methods available

➤ Depending upon the purpose, what might be the key messages?

- The relationship between maternal and child health and child spacing
- Contraceptive methods

Explain that for practical work in class and in the community, participants will base the objectives, content and process of the educational session on their knowledge of common practices in the community. They will limit their sessions to 15-20 minutes.

Distribute the participant documents: *Facilitating Group Discussion* and *Checklist for the Facilitation of Educational Sessions*. Ask volunteers to read them. Discuss any points that are not clear, and any questions participants may have. Explain that these guidelines may help participants in their preparation and presentations; and that the group will use the *Checklist* to give the presenter feedback following each presentation.

## Participant document

### **CONTINUUM IN THE EFFECTIVENESS OF EDUCATIONAL ACTIVITIES**

In order for educational activities to be effective:

A. Reaching the intended audience

The mediator must identify the target population and develop the session based on their *needs and characteristics*.

It is not very productive to:

- Focus on desired/positive behaviors that the group already practices consistently, except to validate and/or reinforce them
- Suggest behaviors/practices that are difficult or impossible to implement or are totally unacceptable to the group

B. Attracting the audience's attention

The educational session must attract people's attention so they will make the effort to listen/participate. In order for this to happen:

- The topic must be of interest
- The manner in which the mediator facilitates the session must be interesting to the group.

C. Understanding the message (perception)

People must be able to understand the message as it was intended. This depends upon their ability to:

- Understand the language, terminology and/or pictures used
- Absorb the volume of information presented

Thus, the language, terminology and pictures used, and the volume of information presented, must be appropriate to the characteristics of the group.

D. Promoting change (acceptance)

People must believe and accept the message. The acceptance of new information/ideas depends in part on:

- The degree to which the information, ideas and/or proposed behavior changes correspond to, or conflict with, people's existing beliefs related to the particular subject
- How long related beliefs have been held (beliefs that have been acquired more recently are generally easier to change than beliefs that have been held in the family, community and/or culture for a long time)
- How easily and immediately the effects the proposed change can be demonstrated

E. Producing a change in behavior

- The message must target the beliefs which have the most influence on the person's attitude toward the proposed behavior change

- The person must be able to overcome any opposing pressures from family or others important to him/her
- Enabling factors (money, time, skills, health services etc) must be adequate to facilitate the change

F. Improvement in health

Behaviors being promoted must lead to health improvements.

Flip chart

**CONTINUUM IN THE EFFECTIVENESS OF EDUCATIONAL ACTIVITIES**

In order for educational activities to be effective, they must:

- A. Reach the intended audience
- B. Attract the audience's attention
- C. Be easily understanding by the audience (perception)
- D. Promote change (acceptance)
- E. Produce a change in behavior
- F. Improve people's health

## PREPARATION OF GROUP EDUCATION SESSIONS

The following questions may help the mediator in the preparation of educational sessions.

1. **Who** is my public/target group? What kind of group am I going to speak to?
  - a) What do they already know about the subject?
  - b) What expectations/interests might they have on the chosen subject?
  - c) How many people will likely be present?
  
2. What are my **objectives**? What do I want the group to know or be able to do at the end of my session? Educational session objectives are important:
  - a) they specify knowledge and/or behavior expected of participants as a result of the session
  - b) they influence the choice of teaching methods
  - c) they influence the choice of visual aids
  - d) they are necessary for evaluation of the session
  
3. **Where** will the session take place? **How long** will it last?  
Factors which influence the choice of location and the length of time of the session:
  - a) Could the session best be held indoors or outdoors (in terms of weather, available space, number of people likely to attend etc)
  - b) How can I make the space comfortable for participants?
  - c) How much time will people be able to spend?
  - d) How much time will I be able to spend?
  
4. What **method** of facilitation will I use? What kinds of questions will I ask to facilitate participation and learning?  
  
Factors which influence the choice of facilitation methods:
  - a) objectives of the session
  - b) characteristics of target group
  - c) time and place
  - d) methods the animator is capable of using effectively

In general, more effective teaching methods:

- provide opportunity for discussion, feedback and participation
- involve simulations, role play and problem-solving exercises
- use pictures that can promote discussion
- emphasize reflection, critical thinking and problem-solving skills rather than the acquisition of specific knowledge
- require small groups (20 people maximum)
- require a facilitator rather than a teacher or 'expert'

Common teaching/animation methods:

- demonstration
- group discussion
- story telling

5. What **visual aids** will be appropriate for my group education sessions? Choices might include:

- real objects
- flip chart
- pictures
- wall signs

Factors which influence the choice of visual aid. The visual aid must be:

- adapted to the teaching/facilitation method used
- available (including necessary equipment)
- portable
- sufficiently interesting to attract and maintain group attention
- adapted to the location

6. How can I **evaluate** the effectiveness of my session?

- During the session:
  - Observe the audience to see if the subject interests them and if they understand the message.
  - Ask open questions to assess what they have learned/what the message meant to them.
  - Ask a member of the group to resume what has been said.
- After the session:
  - See if the number of people attending future sessions increases.
  - See if people come to you after the session for more information
  - Ask yourself if the group does what you had anticipated in your objective for the session.
  - Ask yourself: "How can I improve?"

Flip chart

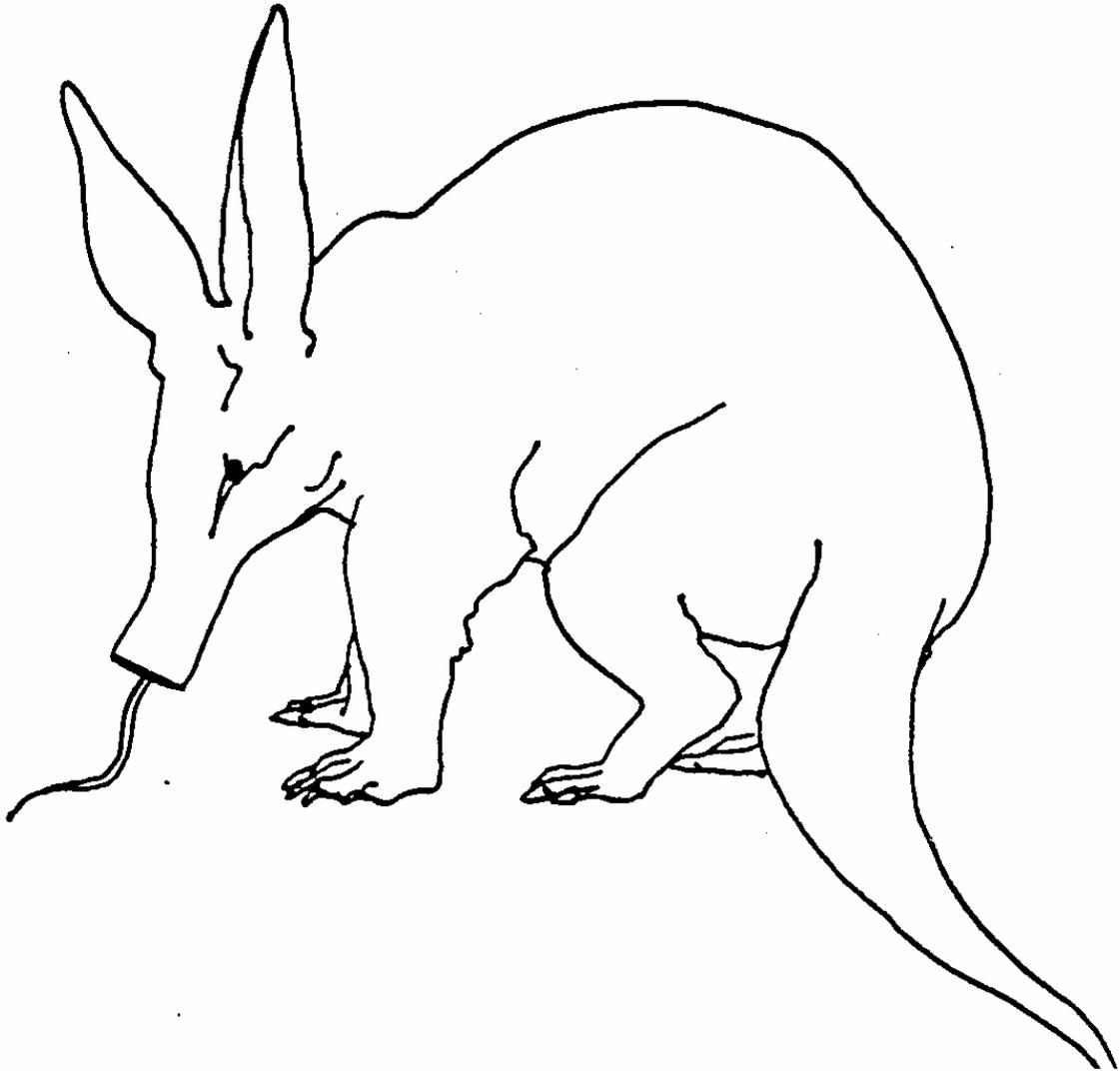
**PREPARATION OF GROUP EDUCATION SESSIONS**

The following questions may help the mediator in the preparation of educational sessions.

1. **Who** is my public/target group? What kind of group am I going to speak to?
2. What are my **objectives**? What do I want the group to know or be able to do as a result of my session?
3. **Where** will the session take place? **How long** will it last?
4. What **method** of facilitation will I use? What kinds of questions will I ask to facilitate participation and learning?
5. What **visual aids** will be appropriate for my group education sessions?
6. How can I **evaluate** the effectiveness of my session?

## **DESCRIPTION OF ANTEATER**

"The body is stout, and the back arched. The limbs are short and stout, and armed with strong blunt claws. The ears are long. The long bushy tail is large near the body, but tapers near the end. The elongated head sits on a short thick neck, and at the end of the snout is a disc in which the nostrils open. The mouth is small and tubular, with a very long thin tongue."





Participant document:

## **PRINCIPLES FOR USING VISUAL AIDS**

1. Prepare visual aids in advance
  - Avoid distortions in size and distracting details
  - Show complete objects, especially parts of the body
  - Show objects from familiar angles
  - Use signs and symbols that are understood by the target audience
  - In using visual aids, draw a relationship between the picture and the experience of the target group
  - Use real objects whenever possible
  - Make sure that the visual aid is
    - Easy to see and understand
    - Attractive
2. Ensure that everyone can see the visual aid
3. Display each visual aid long enough so that all participants can see
4. If the visual aid has several components, point out the different elements.
5. Explain important details that may not be familiar to the group.
6. Pass the visual aid around the group if appropriate (for example in the case of a discussion of contraceptive methods with a small group)
7. Maintain eye contact with the group while showing a visual aid
8. Practice using visual aids before using them in front of a group

## **FACILITATING GROUP DISCUSSION**

1. Limit the number of women participating to 20 maximum.
2. Gather the group in a comfortable place.
3. Seat women in a circle if possible so everyone is equal and can see and hear each other.
4. Invite the group at the beginning to take part in the discussion. Emphasize that you will not be doing all the talking.
5. Maintain eye contact with the group. Look at everyone in the group. Focusing only on the one or two people who answer most of the questions discourages others.
6. Pay attention to your facial expressions, body movements and gests.
7. Be aware of tics (repetition of certain words, wringing of hands, pacing of feet) which may distract the group.
8. Begin with easy questions, with what you think people will be more free to talk about. This builds people's confidence.
9. Ask an open question. When someone answers, comment on their response or ask others to comment ("Do you agree? What reactions do you have to this? Are there other points of view? What do you think about that? What has been your experience?" etc)
10. If you ask a question and no one answers, ask it again, using slightly different words.
11. Don't give up if answers are slow in coming. It may take people time to warm up to this form of learning.
12. Always respond with enthusiasm to any answer. Recognize people who answer even if the answer is wrong: " Thank you for your thoughts", "That's interesting", "Good for you for speaking up", for example.
13. If someone asks you a question, direct the question back to the group: "That's a very good question. Does anyone have any thoughts about that?" for example.
14. In the case of real objects or models as visual aids, pass them around so everyone can see.

15. Continue to ask open questions in relationship to the topic in order to encourage everyone to participate.
16. Encourage people to listen to the person who is talking.
17. Follow the discussion closely. Do not let it deviate from the subject. If important points are not mentioned, mention them yourself.
18. Keep discussions short (15 - 20 minutes maximum) and leave people wishing for more. After an hour or so, people become bored and lose interest.
19. Practice with colleagues, family or friends until you gain experience and confidence. Ask them questions you plan to ask the group to find out what their response is.

### Summary

1. Ask members of the group to resume the important points of the discussion.
2. Ask group members what they learned during the session that is relevant to them and/or can help them.
3. Suggest that group members continue to discuss the subject with family and friends later. If the message had meaning to them, encourage them to act on it.

### Evaluation

Evaluate the effectiveness of the session by your observations of the level of interest, questions asked and answers given by participants; and by subsequent interest and requests for additional information.

## Participant document

### **CHECKLIST FOR THE FACILITATION OF EDUCATIONAL SESSIONS**

1. Develop session objectives and prepare content and methodology for the animation of the session according to target group characteristics
2. Prepare the environment (so that women are comfortable and can see each other – preferably in a circle)
3. Organize materials ahead of time
4. Introduce yourself to the group
5. Introduce the topic to the group
6. Use the chosen educational methodology according to the principles that apply to it
7. Attract group interest in the topic (by using examples and asking questions that are relevant to the group and to their experience)
8. Use clear language appropriate to the level of the group
9. Use an audible tone/level of voice
10. Demonstrate knowledge of the topic
11. Use appropriate visual aids
12. Use visual aids appropriately
13. Respond clearly and appropriately to participant questions
14. Encourage group participation in the session
15. Ask open questions to stimulate reflection and participation
16. Evaluate the effectiveness of the session
17. Thank the group for their participation
18. Inform the group of the next topic and venue

## **Additional Questions for the Evaluation of Educational Sessions**

1. What were the objectives of the session?
2. What was the level of interest of the group?
3. Did the group learn what the mediator anticipated? (Were the objectives achieved?)
  - How did the mediator know whether or not the group understood? What evidence did she have?
4. Did the mediator ensure active and effective participation of the group?
  - What did she do to:
    - help the group relate the subject discussed to their beliefs and practices?
    - encourage the group to express attitudes about, or reaction to, the subject of the session?
  - Were most of the questions open or closed?
  - Did she encourage women to identify related problems, issues and/or solutions themselves (rather than pointing them out herself)?
5. During the session, were there certain actions, information or responses to questions which a participant could have done/provided instead of the mediator?
6. Were there other (open) questions which the mediator might have posed to get more group response/participation? (Give examples)
7. Were the visual aids effective? How do you know? If they were not effective, was it because of the materials or the way in which they were used?
8. Did the organization of the session (placement of chairs) facilitate participation?
9. What was the most positive aspect of the session?
10. If the mediator was to conduct the session again, what should she do differently? What could improve this session? How? Why?

**Possible questions for facilitating group discussion on a given health problem:**

1. What is the problem/health condition called?
2. What has been your experience with this problem/issue?
3. Do you know others (friends of family) who have experienced this problem?
4. What causes this problem or condition? Why does it occur?
5. What do people do/can they do to prevent it?
  - How effective/successful are these practices? How do you know?
  - Which of these practices are/can be harmful? How do you know?
6. What do people do/can they do to treat/cure it?
7. What happens if you don't treat this problem?
8. Do you know many people who have this problem?
9. What do you do when this health problem/condition occurs? Why?
10. Where do you go if you need help with this problem?

## SESSION 16: PREPARATION OF GROUP EDUCATION SESSIONS

**OBJECTIVES:** By the end of the session, participants should be able to:

1. Prepare a group education session according to the principles taught.

**TRAINING METHOD:** practical work

**TIME:** 2 hours

**MATERIALS:**

Visual aids

whatever visual aids are available and appropriate for the chosen themes for educational sessions

### INSTRUCTIONS

#### I. PREPARATION OF GROUP EDUCATION SESSIONS (2 hours)

Remind participants that:

- In planning their sessions, they need to consider the 6 steps in planning group education sessions. Refer them to the participant document *Preparation of Group Education Sessions*
- Their sessions need to be based upon one or several objectives (what the mediator wants the women to know and/or be able to do as a result of the session)
- They need to develop a sequence of key questions to ask during the session in order to:
  - Introduce the topic and open the discussion. The questions should:
    - Be about the topic
    - Relate it to the women's experience
    - Elicit the women's interest in the topic
  - Facilitate and structure the discussion
  - Achieve the objectives of the session

Remind participants to consult the two documents: *Facilitating Group Discussion* and *Checklist for the Facilitation of Educational Sessions* as they prepare their sessions.

Prepare a flip chart of topics to choose from for the group educational sessions. Ask participants to sign up (in groups of 2) for the topics they wish to facilitate, ensuring that all topics will be presented.

Participants prepare to facilitate the sessions they signed up for, using group discussion as a method of facilitation.

Circulate among the small groups as participants work:

- Ask questions as necessary to ensure that they are progressing and that the content and process they are planning to use are appropriate
- Respond to any questions participants have about the task

**Note:** It is important that all participants have the opportunity to participate in the facilitation of a group educational session. It is essential for them to practice their skills in a learning environment where they can receive positive and constructive feedback which will help them to improve their skills.

- If there are 10-14 participants in the workshop, it may be most appropriate to conduct all presentations in one large group so that the “group” is large enough to reflect the situations in which they will conduct group sessions in the community. In this case, the members of each small group will need to decide how to co-facilitate their session, making sure that:
  - They are NOT both in front of the group, talking at the same time
  - Each one has an opportunity to practice her skills
  
- If the group is large (16-18 participants), it may be most appropriate to conduct the presentations in two groups. In this case, participants will prepare their sessions in pairs. Then, for the facilitation of their sessions, the large group will be divided into two groups so that one person from each pair will be in one group and the other person will be in the second group. This will:
  - Enable everyone to have the opportunity to practice facilitating a session (and to receive feedback)
  - Enable all participants to have sole responsibility for leading a session (reflecting the reality in their communities as well as the fact that only one person should talk with, and respond to, the group at a time).
  - Provide an efficient use of time and greater learning for participants. Participating in the facilitation of 8-9 sessions, one after the other, is tedious. After several presentations, trainers and participants get tired and cease to focus on the quality of the sessions and giving feedback to the facilitators of the sessions. In this case, participant learning is minimal and the activity loses its value.

One trainer should go with each group in order to monitor the timing of the presentations /sessions, and facilitate the feedback at the end of the presentations/sessions.

## **SESSION 17: FACILITATION OF GROUP EDUCATION SESSIONS**

**OBJECTIVES:** By the end of the session, the participants should be able to:

1. Facilitate educational sessions in reproductive health, respecting the principles of the preparation of sessions and using group discussion as a method of facilitating the educational session.
2. Evaluate informally the effectiveness of their educational sessions

**TRAINING METHOD:** classroom practice

**TIME:** 2.5 hours

**MATERIALS:**

### **INSTRUCTIONS**

#### **I-II. IMPLEMENTATION OF SESSIONS (2.5 hours)**

[**Note:** the time needed for this session will depend upon the number of participants in the workshop. The trainers should plan on approximately 30 minutes for each presentation (including approximately 2 minutes for each group to organize their materials if needed, 15 minutes maximum for the session, and 10-15 minutes for feedback)].

Ask participants to facilitate their sessions, respecting the principles taught and time limits (15 minutes).

During the facilitation of each session, ask all other participants to:

- Participate as women in the community. (The facilitators should indicate the target population of women.)
- Be aware of the items on the *Checklist for the Facilitation of Educational Sessions* (distributed earlier) in order to be able to give their colleague (the facilitator) positive and constructive feedback at the end of her session.

At the end of the each educational session facilitated by a participant, lead a feedback session. Begin by asking the facilitator of the session to share her impressions of the session (to give her own feedback regarding the session). Then ask other participants to share their feedback (respecting the rules for giving positive and constructive feedback). Facilitate a discussion of problems encountered, and any questions participants have about facilitating sessions in the community.

Validate participants' experience and remind them that with experience, they will continue to improve their skills in conducting group education sessions.

## **SESSION 18: EVALUATION OF THE TRAINING**

**OBJECTIVES:** By the end of the session, the participants should be able to:

1. Assess their knowledge of reproductive health concepts and communication concepts and skills, and compare it with their knowledge prior to the workshop
2. Evaluate the effectiveness of the training

**TRAINING METHODS:** Post test, Self-assessment questionnaire, discussion

**TIME:** 1 hour 30 minutes

### **MATERIALS:**

Participant documents:

- Post test
- Training evaluation form

## **INSTRUCTIONS**

### **I. POST TEST (30 min)**

Summarize the reproductive health workshop by referring to the general objectives of the workshop and its focus on the improvement of mediators' knowledge and skills in communicating reproductive health information to people in their communities.

Refer to the pretest participants took on the first day of training. Emphasize that the post test will enable participants to be used to evaluate the effectiveness of the training program.

Distribute the post test and ask participants to complete it. Allow them 30 minutes to complete the post-test.

Collect the tests. Correct them while participants complete the training evaluation form (II. Evaluation of the Training).

### **II. EVALUATION OF THE TRAINING (30 min)**

Explain to participants that their evaluation of the training (their impressions, reactions and ideas) are very important to the evaluation process, and will help the trainers in improving training in the future.

Distribute the workshop evaluation form and ask participants to complete it.

Once everyone has completed and returned the evaluation form, ask the group if they have any feedback they wish to share and/or discuss in the group.

Return the pre/post tests and share with the group the high, mean and low test scores. Review with the group any questions that may have been missed by many participants. Ask participants if they wish to discuss any other questions on the test.

Proceed to final end-of-training activities that have been planned:

- Distribution of certificates
- Any plans for follow-up with health mediators

**HEALTH MEDIATOR TRAINING IN REPRODUCTIVE HEALTH  
PRE/POST-TEST**

**True/False Questions**

For each of the following phrases, put a T in the space indicated at the left of the statement if the phrase is true or an F if it is false. Each correct response is worth one point.

- \_\_\_\_\_1. Mothers younger than 18 and older than 35 are at greater risk of prenatal complications and pregnancy-related death than are mothers between the ages of 18 and 35.
- \_\_\_\_\_2. Most adults know how to use condoms effectively.
- \_\_\_\_\_3. Vaseline and cooking oil should not be used to lubricate a condom
- \_\_\_\_\_4. A pregnant woman does not need to go for antenatal check-up if she does not have any complaint or health problem
- \_\_\_\_\_5. The condom is the only family planning method that also protects individuals from sexually transmitted infections.
- \_\_\_\_\_6. Health check-ups are recommended within six weeks of delivery, for both mother and child.
- \_\_\_\_\_7. Reproductive tract infections are more common in women than in men
- \_\_\_\_\_8. Reproductive tract infections are most commonly caused by sexually transmitted infections
- \_\_\_\_\_9. Untreated STI lead to a greatly increased risk of getting HIV/AIDS
- \_\_\_\_\_10. In Romania, maternal mortality (the number of women who die as a result of complications of pregnancy and childbirth) is one of the highest in Europe

### Multiple Choice Questions

Each of the following questions is followed by a certain number of possible responses. For each question, choose the best response/s, according to the number of correct responses indicated in the trunk of the question. Indicate your response by circling the appropriate letter/s next to your choice/s. Each correct response is worth one point. If you circle more than the requested number of responses to a question, you will receive no points for the question.

1. Which of the following is not a criteria for using Lactational Ammenorhea Method as a family planning method (one correct answer):
  - a. The mother must be less than four months postpartum
  - b. The mother must breastfeed the baby regularly at least every four hours during the day and at least every six hours at night and the baby must not receive any other foods
  - c. The mother has had no menstrual periods
  
2. Which of the following statements about breastfeeding is not true? (3 correct answers)
  - a. The hormone that causes milk to flow through a mother's breasts also causes a mother's uterus to contract after delivery
  - b. For the first several weeks postpartum, mothers generally produce the same amount of milk regardless of how often they breastfeed
  - c. The uterine pain and a rush of blood during a feed for the first few days is good for the healing of the woman's uterus
  - d. A breastfeeding baby needs to take much of the areola into his mouth
  - e. If a baby is sucking effectively, he makes smacking sounds when he sucks
  - f. During the first three days, it is especially important to feed the baby the thick yellowish fluid called colostrum
  - g. When semi-solid foods are introduced, it is important to give them first so that the baby develops a taste for them and then breastfeed.
  
3. Which of the following are characteristics of infection in a newborn? The baby: (4 correct responses)
  - a. Is hungry all of the time
  - b. Does not want to sleep
  - c. Vomits or spits up a lot
  - d. Has green watery stools
  - e. Skin feels hot or cold
  - d. Breathes too fast or too slow
  - e. Has colic
  
4. Which of the following statements are true about HIV/AIDS? (2 correct responses)
  - a. Condoms are not very effective in preventing HIV transmission
  - b. A pregnant woman can pass the HIV virus to her unborn child
  - c. A person can get HIV by using dirty injection needles, other needles, or razors
  - d. HIV can be cured if diagnosed early

### Matching questions

Below are two lists: 1) contraceptive methods, and 2) characteristics of contraceptive methods. Read the characteristics “a” through “j”. For each item, identify the method of contraception to which it applies. Put the letter of the item (a, b, c, d, e, f, g, h, i, or j) in the space next to the contraceptive method to which it applies. Note that each item may only be used once. Please write clearly.

#### Contraceptive methods

- \_\_\_\_\_ Combined Oral Contraceptives (pill)
- \_\_\_\_\_ Condoms
- \_\_\_\_\_ Sterilization
- \_\_\_\_\_ Lactational Amenorrhea Method
- \_\_\_\_\_ Progestagen-only Contraceptives (pill)
- \_\_\_\_\_ Spermicide
- \_\_\_\_\_ Natural Family Planning Methods
- \_\_\_\_\_ IUDs
- \_\_\_\_\_ Injectable
- \_\_\_\_\_ Emergency contraceptives

#### Characteristics of contraceptive methods:

- a. Can only be used by breastfeeding mothers under certain conditions
- b. Effectiveness is low as the method is commonly used
- c. Provides protection against STIs & HIV/AIDS to both partners
- d. Destroys sperm so that they cannot reach the egg/ovum to fertilize it
- e. Often causes irregular menstrual periods or absence of periods
- f. The method involves blocking the fallopian tubes (in a woman) or the vas deferens (in a man)
- g. Often leads to lighter, regular periods with less cramping
- h. It usually takes 6-10 months to become pregnant after stopping the method
- i. The method should not be used on a regular basis
- j. Is a safe, effective, long lasting method (up to 10 years)

**EVALUATION OF THE TRAINING OF TRAINERS WORKSHOP  
PROPOSED EVALUATION FORM**

You have just participated in a workshop for Roma Health Mediators in reproductive health. Please respond to the following questions which will allow us to evaluate this training and improve future training.

I. Achievement of the objectives.

Listed below are the general objectives of the training. For each general objective, please indicate 1) to what degree you feel it was achieved, circling the number that best responds to your point of view; and 2) if an objective was not entirely achieved, why you felt it was not (for example, a problem of time, inadequate explanation, lack of practice, inappropriate training method, or other reasons that you perceive).

**Well achieved   Achieved   Not achieved**

- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. Explain basic concepts of Reproductive Health and Family Planning to persons in their communities  | 1 | 2 | 3 | 4 | 5 |
| 2. Describe in simple terms the anatomy and physiology of human reproduction  | 1 | 2 | 3 | 4 | 5 |
| 3. Explain family planning methods to persons in their communities  | 1 | 2 | 3 | 4 | 5 |
| 4. Promote Safe Motherhood (including prenatal and postnatal care) with members of their communities  | 1 | 2 | 3 | 4 | 5 |
| 5. Promote the optimal care of newborns with members of their communities   | 1 | 2 | 3 | 4 | 5 |
| 6. Promote breastfeeding of newborns/infants in their communities   | 1 | 2 | 3 | 4 | 5 |
| 7. Describe to community members measures for reducing other reproductive health-related risks (STIs, HIV, abortion, infertility, and breast and cervical cancer) | 1 | 2 | 3 | 4 | 5 |
| 8. Conduct group education sessions on reproductive health issues in their communities  | 1 | 2 | 3 | 4 | 5 |



III. Open questions

1. What aspects of the training were the most important and/or useful for you? Why?
  
  
  
  
  
  
  
  
  
  
2. What aspects of the training were the least important and/or useful for you? Why?
  
  
  
  
  
  
  
  
  
  
3. On what subjects do you have need for more information and or practice in order to improve your competence in communicating with women in your community about reproductive health?
  
  
  
  
  
  
  
  
  
  
4. Are there other subjects that should have been included in this training? Which ones?
  
  
  
  
  
  
  
  
  
  
5. What modifications (changes) would you suggest in the organization of a future training of mediators in reproductive health?