

Romanian Family Health Initiative

A Comprehensive Reproductive Health Curriculum

Antenatal and Postnatal Care – A Training Curriculum for Family Doctors



USAID
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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 rehydration 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 has been developed for improving the competence of health professionals in the delivery of antenatal and postnatal care services.

Although these services has been provided routinely for many years by the general practitioners, in collaboration with Obstetric–Gynecology specialists, there is concern, however, regarding the effectiveness and quality of these services, as well as the lack of demand for these services. In general, the quality of antenatal and postnatal care has been described as weak in terms of the thoroughness of screening, accuracy and timeliness of client charting, adequacy of client education, and treatment and/or referral of identified problems. Lack of demand is seen in the fact that women often do not seek prenatal consultations early enough in pregnancy, nor follow a schedule of consultations that would enable them to benefit maximally from the screening and preventive care that these services are intended to provide.

The training proposed by this manual aims to fill the gap between the actual performance and the desired performance described in the existing/available documents of the MoH and relevant documents of World Health Organization.

We hope that through using the manual to train general practitioners, it will contribute to ensure quality of services and to decrease maternal mortality and morbidity in Romania.

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About the manual

This manual is intended to be used for training General Practitioners in Romania (Family Doctors) in antenatal and postnatal care, and also for improving their interpersonal communication skills appropriate to these services. It might be used as 3-day training, or as a specific 1-day training activity for each issue (Antenatal Care, Postnatal Care, and Counseling), based on the specific training needs identified in each district/area.

It provides necessary instructions and materials to guide trainers in the organization, implementation and evaluation of training activities.

The manual:

- Promotes a learner-centered, participatory approach to training.
- Leads learners through the core concepts of adult learning.
- Develops and models concepts and skills essential to effective participatory training.
- Guides learners through the implementation and evaluation of selected training sessions in reproductive health.
- Offers learners the opportunity to practice their skills in interpersonal communication and the implementation of group education sessions in reproductive health.

By the end of the workshop, participants will:

- Have a better orientation on the Ministry of Health protocols governing the delivery of antenatal and postnatal consultations.
- Describe essential components of antenatal and postnatal physical examinations
- Explain how to make a diagnosis/case classification of maternal-fetal health status.
- Explain common care, information, education and counseling for pregnant and postpartum clients and infants
- Record client data and follow-up plans
- Describe the importance of counseling in the context of antenatal and postnatal consultations.
- Demonstrate skills in active listening when conducting antenatal and postnatal consultations

The document is organized into three sections:

Section 1 outlines the methodology of antenatal consultations, as per protocols developed by the Romanian MoH, including principles of care, education and counseling of pregnant women.

Section 2 provides an overview on the postpartum visits, including the principles of care, information and education needed for both mother and infant.

Section 3 addresses interpersonal communication skills necessary for doctors to effectively communicate with women during pregnancy and postpartum period.

Each session 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 to implement the training sessions as they are designed, including verifying and preparing needed materials and logistics before each session.



**Romanian Family Health
Initiative**

Partnership funded by USAID



ANTENATAL CARE
A ONE-DAY TRAINING CURRICULUM FOR
FAMILY DOCTORS

February 2004

Session 1: Introduction

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

1. Introduce themselves to the group.
2. Describe the role of family doctors in the provision of antenatal care
3. Explain the workshop objectives
4. Name group norms which will help facilitate a productive workshop

Methods: Discussion

Time: 30 min.

Materials:

Flip chart:

- Group norms

Handout:

- Workshop Goal, Objectives & Schedule

Flip chart stand and paper

Markers

Masking tape

Name tags

Note pads

Pens

Folders

Instructions:

***NB to trainers:** The following guidelines for the introductory session apply to situations in which the trainers and participants are together for the first time for orientation to reproductive health issues.*

I. Introductions (10 min)

Welcome participants to the workshop. Thank them for responding positively to the workshop invitation.

Introduce the trainers briefly.

Ask participants to look around the room. Ask how many of them already know everyone in the room. (Likely, no one will already know everyone.) Tell them that the group will be together for what is planned to be a positive and productive day for everyone and that they will be learning together and learning from each other. Invite participants to introduce themselves and to display their name tags so that everyone can see them.

[*Note to trainer: This introductory session helps to “break the ice” within the group, and helps participants to become comfortable with the group.*]

II. Role of Family Doctors in Antenatal Care (10 min)

Introduction to the new MOH strategy of involving Family Doctors in providing antenatal care:

- Review briefly with the group the following MCH statistics for Romania:
 - Maternal mortality rate: 34/100,000 (of which 16.8/100,000 was due to abortion and 17.2/100,000 was due to obstetrical complications), compared with a range of 12 (Poland) to 31 (Albania) for surrounding countries (data available in 2002);
 - Infant mortality rate: 18.4/1000, compared with 13 for Eastern Europe (2002);
 - 58% of pregnant women registered in the first trimester of pregnancy (2001)
- Explain that:
 - The MOH is concerned with improving access to high quality reproductive health services for women in an effort to improve their health and that of their children.
 - Two important strategies adopted by the MOH for the improvement of access to high quality reproductive health services are 1) the participation of Family Doctors in the delivery of these services, and 2) the establishment of protocols for the delivery of these services by Family Doctors.
 - Protocols for prenatal care have been developed by the MOH and ICMC; based on these, RFHI developed some tools, easy to be used by the family doctors for their day-by-day work. The RFHI documents reflect the strategy of MOH for improving the antenatal care.
 - The purpose of this workshop is to share with participants (Family Doctors) 1) the role they are anticipated to play in the provision of antenatal services, and 2) the protocols that are to guide the delivery of these services by family doctors.

III. Workshop Objectives & Schedule (5 min)

Distribute the handout *Workshop Goal, Objectives and Schedule* and review it with the group. Explain that the day’s program is designed to:

- Review with participants the new prenatal care protocols, and
- Discuss/clarify anything in either document that is not clear to participants, in order to facilitate 1) their understanding of, and respect for, the protocols, and 2) their competent delivery of antenatal services.

Encourage participants to ask questions, and to share ideas/knowledge, as appropriate to facilitate their learning.

IV. Group Norms & Logistics (5 minutes)

Explain that group norms are important to creating a positive learning environment. Everyone's understanding of, and agreement to, group norms helps to facilitate participation and learning.

Post the flip chart *Group norms*. Ask participants to read the list and to indicate their commitment to respect these norms in order to facilitate everyone's participation and learning.

Indicate the location of toilets/washrooms.

Handout

WORKSHOP GOAL

To orient Family Doctors to Ministry of Health protocols governing the delivery of prenatal consultations.

WORKSHOP OBJECTIVES

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

1. Describe normal and abnormal anatomical and physiological changes during pregnancy.
2. Describe essential content of clients' social and health histories in the context of the first antenatal consultation.
3. Describe essential components of antenatal physical examinations, to include:
 - General examination
 - OB examination
 - Laboratory/paraclinic examinations
4. Explain how to make a diagnosis/case classification of maternal-fetal health status.
5. Explain common care, information, education and counseling for pregnant clients
6. Record client data and follow-up plans

WORKSHOP SCHEDULE

| | |
|--------------|--|
| 8:30-9:00 | Session 1: Welcome & Introductions |
| 9:00-9:30 | Session 2: Anatomical & Physiological Changes During Pregnancy |
| 9:30-10:15 | Session 3: Client History |
| 10:15-10:30 | Break |
| 10:30- 11:30 | Session 4: Physical Examination |
| 11:30-12:15 | Session 5: Laboratory/Paraclinical examinations |
| 12:15-1:15 | Lunch |
| 1:15-2:00 | Session 6: Diagnosis/Case Classification |
| 2:00-2:45 | Session 7: Client Education & Follow-up |
| 2:45-3:00 | Session 8: Record Management |
| 3:00-3:15 | Break |
| 3:15-5:00 | Case studies |

Flipchart

NORMS THAT FACILITATE A PRODUCTIVE WORKSHOP

- Respect the workshop schedule
- Respect and encourage everyone's participation
- Listen to others; do not interrupt
- Respect confidentiality of what others share
- Everyone is responsible for their own learning
- No smoking in the training room
- No mobile phone conversations in training room
- Everyone stick to the subject

Session 2: Anatomical and Physiological Changes during Pregnancy

Objectives:

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

5. Describe at least 5 normal physiological changes that occur in a woman during pregnancy.
6. Describe at least 3 normal changes in the uterus and in the breast during pregnancy.
7. Name at least 4 common discomforts during pregnancy.
8. Describe at least 10 indications of a high-risk pregnancy and what to do in each case.

Methods: Discussion

Time: 30 min.

Materials:

Handouts:

- Anatomical and Physiological Changes During Pregnancy

Instructions:

I-II. Normal Changes During Pregnancy (10 min)

Introduce the session by suggesting that the group review normal changes, as well as discomforts and complications, during pregnancy in preparation for discussions of the rationale for and process of conducting the various components of prenatal care consultations.

Distribute the handout *Anatomical and Physiological Changes During Pregnancy* and ask volunteers to read it. Allow for questions and comments.

III. Common Discomforts in Pregnancy (5 min)

Ask the group to name other discomforts of pregnancy (not already mentioned in the previous exercise), their causes and what to do to alleviate them.

- Heartburn and acid indigestion
- Constipation, hemorrhoids
- Swelling of the feet
- Low back pain
- Varicose veins (especially in the lower legs)

IV. High-risk Pregnancies (15 min)

Review with participants the factors which contribute to high-risk pregnancies and the table with Copland score (indicate them annexes 6 and 7).

ANATOMICAL AND PHYSIOLOGICAL CHANGES DURING PREGNANCY

- Reproductive organs and breasts
 - Uterine enlargement:
 - 12 weeks: (normal range) uterus can be palpated at level of symphysis pubis
 - 20 weeks: (normal range) uterus can be palpated at umbilicus
 - 36 weeks: (normal range) uterus can be palpated beneath mother's ribs
 - Vaginal discharge –an increase in vaginal discharge is a common physiological change in pregnancy
 - Breast changes
 - Increase in size and nodularity
 - Increased size, erection and leaking of colostrums from nipples
 - Dilated sebaceous glands and increased in pigmentation of areola
- Heart and circulation
 - Cardiac output increases by 30-50% by 6 weeks and peaks at 16-28 weeks, causing the heart rate at rest to rise from a normal of around 70 beats/minute to 80-90 (a medium growth of 15-20 beats/minute compared with non-pregnant status of the woman).
 - After 30 weeks, cardiac output may decrease slightly as the uterus presses on the veins carrying blood from the legs.
 - During labor, cardiac output increases an additional 30%
- Lungs
 - Faster and deeper breaths as more oxygen needed for mother and fetus
- Kidneys
 - Filter 30-50% more blood, reaching maximum at 16-24 weeks until immediately before delivery. Frequency of need to urinate increases when the woman is lying down, particularly on her side.
- Skin
 - Melasma (mask of pregnancy) on the forehead and cheeks
 - Darker line on abdomen from umbilicus downward
 - Small spiderlike blood vessels above the waist and in lower legs
- Digestive system
 - Nausea (“morning sickness”), especially during 2nd-3rd months of pregnancy
 - Constipation from uterus pushing on rectum and lower part of large intestine
- Endocrine system
 - Hormones (especially HCG) produced by placenta prevent ovaries from producing eggs and stimulate ovaries to continue producing high levels of estrogen and progesterone needed to maintain pregnancy.

Session 3: Client History

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

1. Name the 10 components of antenatal consultations
2. Name at least 10 elements of data to obtain about a client's social history in the context of a antenatal consultation
3. Name 4 categories of data to obtain from a pregnant client regarding her general medical history.
4. Describe 8 types of data to obtain from a pregnant client regarding her past pregnancies.
5. Name at least 6 questions to ask a client in the case of a suspected but unconfirmed pregnancy
6. Explain at least 2 situations in which it is appropriate to perform:
 - A pregnancy test
 - A physical examination
7. Name 4 types of data to obtain from the client in the case of a confirmed pregnancy

Methods: Discussion

Time: 45 min.

Materials:

Flip charts:

- Components of Antenatal Consultations

Handouts:

- Standards for Antenatal Care
- Client history

Instructions:

I. Components of antenatal consultations (10 min)

Distribute the handout *Standards for Antenatal Care*. Ask volunteers to read them aloud to the group. Ask participants if they have any questions or comments regarding the standards. Respond to questions as appropriate.

Post the flipchart *Components of Antenatal Consultations*.

Distribute the materials: *Antenatal Care Visit: Protocol for Family Doctors with Annexes*. Explain that the remainder of the day will focus on a review of the components of antenatal consultations.

II. Client social history (5 min)

Suggest to the group that quality health care begins well before beginning to take the client history (which is generally the first “technical” component of a consultation). It begins with an appropriately prepared consultation room and with warmly welcoming the client. When a client is received warmly in a clean and organized consultation room, she is likely to have more confidence in all that follows.

Review with the group the first two components of the *Antenatal Care Visit: Protocol for Family Doctors* (Preparation for examination and Welcome client). Emphasize the importance of these two elements to the establishment of positive rapport with the client.

Review with the group the elements of the client social history, including the purpose of the information sought from the client.

III-IV. General Medical History (15 min)

Review with the group the four components of a medical history (physiological data, pathological data, obstetric history and family history), as per the handout *Client history*

Clarify terms/concepts as necessary (for example, under the heading “Pathologic data” what is considered to be a heart or blood pressure, liver or renal disease problem in the context of pregnancy)

V-VII. Actual Pregnancy History (15 min)

Review with the group questions to ask to determine if a woman is pregnant (in the case of suspected but unconfirmed pregnancy), as per Annex 2 *Interview for Suspected Pregnancy*.

Review situations in which it is appropriate to perform a pregnancy test or a pelvic examination, including why the doctor would do one or another.

Ask for volunteers to read the kinds of data a doctor would ask about in the case of a confirmed pregnancy. Ask the group to comment on the rationale for asking these questions.

Flipchart

COMPONENTS OF ANTENATAL CONSULTATIONS

1. Prepare for examination
2. Welcome client
3. Take client's history
4. Perform physical examination
5. Laboratory/paraclinic examinations
6. Assess maternal-fetal health status and make diagnosis/case classification
7. Share assessment and diagnoses with client
8. Provide care, information and recommendations/advice
9. Plan follow-up care with client
10. Record data and follow-up plan

STANDARDS FOR ANTENATAL CARE

The following standards shall apply to all family doctors, OB-GYN doctors and midwives, whether they work in the private or in the public sector.

- All pregnant women shall be considered to be insured for the purposes of receiving prenatal care. As a consequence:
 - health personnel shall not refuse service to a pregnant woman presenting for a prenatal consultation and registration
 - prenatal care shall be free of charge regardless of the insured status of the woman.
- Pregnant women shall have priority to consultation in the Family Doctors' cabinets.
- The first prenatal visit and registration of the pregnant woman shall be done in the first trimester of the pregnancy (first 14 weeks of amenorrhea).

Family doctor and his/her nurse will offer pro-active counseling about the importance of antenatal care to every woman at reproductive age, when they are providing other services (like periodical check, prenuptial certificate release etc.)

- Registration shall be done by the family doctor at the request of the pregnant woman or the community nurse.
- The gestational age is expressed in weeks of amenorrhea, starting with the beginning date (first day) of the last menstrual period
 - First trimester: until 14th week of amenorrhea
 - Second trimester: between 15th and 28th weeks
 - Third trimester: starting with the 29th week, until delivery
- The following schedule of visits shall apply to consultations during the antenatal period:

MOH: The minimum number of prenatal consultations for a woman with no to minimum risk is 8(9):

 - First trimester: 1 visit
 - Second trimester: 3 visits (one visit per month) in normal pregnancies or more in moderate-risk pregnancy
 - Third trimester: 4-5 visits (1 visit every 2-3 weeks) in normal pregnancies or one often (1-2 weeks) for moderate-risk pregnancies
- The following elements shall apply to initial visit:
 - Diagnosis of pregnancy
 - Establish gestational age, and calculate the estimated date of birth
 - Medical and obstetrical history of the woman

- Physical examination
 - Paraclinic/laboratory tests
 - Evaluation of obstetrical risk (Cooiland score for pregnancies at risk)
 - Assessment of socio-economic, cultural and biological factors as existing or potential risks factors for pregnancy
 - Case classification
 - Sharing of results of assessment with client, and any measures to be taken
 - Client counseling regarding nutrition, rest, exercise during pregnancy, travel, clothes, sexual activity, alarm signs, prevention of spontaneous abortion/premature labor
 - Implement prophylactic and therapeutic interventions
 - Referrals as necessary for further diagnoses and/or treatments
 - Planning subsequent visits
 - Documentation of findings, assessments, care and advice provided, and recommended follow-up plan; and completion of medical documents: Pregnancy evidence register, medical file of the client (Annex for Pregnancy and Postpartum period) and Client's Pregnancy book.
- The following elements shall apply to all subsequent visits:
 - Assessment of progress of pregnancy and maternal-fetal status; and of existing or potential risks
 - Physical examination, including evaluation of obstetrical risk
 - Sharing of results of assessment with the client, and any measures to be taken
 - Client counseling regarding nutrition, rest, exercise etc during pregnancy, and prevention of anemia, abortion and premature labor
 - Implement prophylactic and therapeutic interventions
 - Referrals as necessary for further diagnoses and/or treatment
 - Documentation of findings, assessments, care and advice provided, and recommended follow-up plan; and completion of medical documents
- Pregnant women with no risk or minimum risk shall be supervised by the family doctor during the first 28 weeks of pregnancy, and then by both the family doctor and an OB-GYN specialist doctor, in collaboration
 - If the family doctor detects moderate obstetrical risk to a woman during the first prenatal visit, he shall refer her to the OB-GYN specialist for monitoring and supervision of her pregnancy, in collaboration with other specialists as needed, starting from the first trimester of pregnancy/date of registration.
 - Pregnant women at high risk shall be referred from the beginning to the OB-GYN specialist for registration and monitoring and/or supervising in hospital, as needed
 - If the family doctor is not able to make the case classification, he/she shall refer pregnant woman to the OB-GYN specialist or other specialist doctors, in order to establish diagnosis and receive adequate treatment.

CLIENT HISTORY

Obtain following data from client:

Social history

- Name and address
- Age
- Address
- Marital status
- Educational level; Profession
- Working conditions (type, noxes, physical efforts)
- Living conditions (housing, sanitary conditions), economic resources of family
- Use of alcohol or other social drugs
- Smoking
- Spouse's age and health status
- Conflicts in family or at work

Client's Medical history

- **Physiologic data**
 - First menstruation (menarche)
 - Menstrual features
- **Pathologic data**
 - Heart problems
 - High blood pressure
 - Liver problems
 - Renal disease, chronic renal failure
 - Epilepsy
 - High blood sugar or diabetes
 - Severe anemia
 - Allergy
 - STIs, including HIV
 - Rubella
 - Tuberculosis
 - Hospitalization and surgeries
 - Medication (prescription or OTC)
- **Obstetric history**
 - Past pregnancies:
 - Number of full-term babies
 - Number of pre-term babies
 - Number of pregnancies ending in spontaneous or induced abortion
 - Number of living children
 - Date of last live birth
 - Pregnancies obtained by Assisted Humane Reproductive Techniques

- Weight of each baby at delivery and Apgar scores
- Current health conditions of children
- Any problems with previous pregnancies or deliveries:
 - high blood pressure
 - seizures
 - bleeding or hemorrhage
 - infection
 - high blood sugar or diabetes
 - cesarean section, forceps
 - stillbirths and neonatal deaths
 - labor and birth-related data
 - babies born with a deformity
 - twins
- **Family-history**
 - Any genetic diseases, malformations (on either side of the family). If so, refer client for genetic examination
 - Family-related diseases (high blood pressure, diabetes, obesity, psychiatric illnesses etc)

Actual pregnancy history.

- In case of suspected but unconfirmed pregnancy (very early pregnancy):
 - Ask some questions, in order to establish the possibility of a pregnancy (see Annex 2 *Interview for Suspected Pregnancy*)
 - If client answers do not confirm pregnancy,
 - Perform pregnancy test (5 weeks after LMP)
 - OR
 - Perform physical examination (6 weeks after LMP)
- In cases in which pregnancy is confirmed, inquire about:
 - Date of last menstrual period (LMP)
 - Any problems with this pregnancy:
 - Unusual fatigue
 - Prolonged nausea and vomiting
 - Sudden sharp continuous abdominal pains
 - Fever and chills
 - Severe continuous headache
 - Unusual changes in vision
 - Pain or burning on urination
 - Vaginal itching or unusual discharge
 - Leaking of fluid from vagina
 - Vaginal bleeding
 - Pain, redness, tenderness of calves
 - Swelling of face and hands
 - Constipation
 - Client's diet:
 - Diet history (24 hour recall)
 - Appetite changes (e.g. food cravings, loss of appetite)

Session 4: Physical examination

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

1. Explain 3 principles to respect in the conduct of an antenatal physical examination
2. Name the components of a general physical examination in the context of an antenatal consultation
3. Name essential measurements to take during antenatal consultations
4. Name the components of an obstetrical examination in the context of an antenatal consultation
5. For each of the above components, describe the elements to be examined.
6. Explain the following:
 - Steps/techniques for using a speculum or vaginal valve
 - What to look for in the inspection of the cervix
 - How to obtain specimens for laboratory testing
 - What to look for in the inspection of vaginal walls/floor
 - Steps/techniques for doing a bimanual examination.

Methods: Document review, discussion

Time: 60 min.

Materials:

Handouts:

- Checklist for conducting prenatal consultations

Instructions

I. Principles for Conducting Antenatal Examinations (5 min)

Review with the group the general principles for performing physical examinations, and ask them the purpose for respecting these principles.

- Observation of the client often gives clues about her physical as well as her mental health
- Explaining all procedures in simple terms while performing them
- Asking questions both educates the client about her health and encourages her to share concerns and to ask questions.

II-V. General Physical Examination & Obstetrical Examination (55 min)

Review with the group *Antenatal Care Visit: Protocol for Family Doctors*, section 4, *Perform Physical Examination*. For each examination and/or measurement, discuss 1) “normal ranges”, and 2) criteria under which the Family Doctor should refer the client to an OB-GYN specialist.

Project the video film/CD *Pregnant Woman’s Examination*.

Review each examination, emphasizing 1) how to do it, and 2) what to look for. Indicate the Annexes: *Obstetrical Examination*, *Expected Fundal Height during Normal Pregnancy*, and *Leopold's Maneuvers*.

Give each participant a CD or a video tape, based on their preference.

For practicing *Leopold's Maneuvers*, as well as genital examination, participants will be invited to attend the clinical sessions organized by District Public Health Authorities/Colleges of Physicians and Society for Education on Contraception and Sexuality (the NGO key-partner of JSI Romania for implementing RFHI).

Session 5: Laboratory/Paraclinical Examinations

Objectives:

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

1. Explain common laboratory tests and investigations to be performed for pregnant women in the first, second, and third trimesters of pregnancy
2. Explain actions to be taken based on a the range of results possible from the above laboratory tests and investigations

Methods: Discussion

Time: 45 min.

Materials:

Handout:

- Antenatal Care Visit: Protocol for Family Doctors

Instructions:

I. Common Laboratory Tests & Investigations (30 min)

Referring to the handout *Antenatal Care Visit: Protocol for Family Doctors*, section 5, *Laboratory/Paraclinic Examinations*, review with the group 1) mandatory investigations, 2) routine investigations, and 3) supplemental investigations, including reasons for/conditions under which routine and supplemental investigations should be done.

Discuss procedures for having investigations done, including facilities within the district for such testing/investigations.

II. Actions to be Taken Based on Test Results (15 min)

Review with the group possible test results, and the actions a family doctor should take in each case.

Session 6: Diagnosis/Case Classification

Objectives:

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

1. Confirm a pregnancy based on the estimated date of conception (EDC) and physical findings
2. Explain how to calculate the estimated date of birth (EDB) using the 280-day rule.
3. Explain how to evaluate the progress of pregnancy based on EDC, EDB and physical findings.
4. Explain how to evaluate maternal well-being based on historical and physical findings for presence or absence of risk factors and of actual problems.
5. Explain how to evaluate fetal well-being based on historical and physical findings for presence or absence of problems.
6. Explain the case classification system used to determine when clients should be referred to Ob-Gyn specialists

Methods: Discussion

Time: 45 min.

Materials:

Documents:

- Antenatal Care Visit: Protocol for Family Doctors
- Pregnancy Diagnosis & Estimated Date of Birth
- Case study: Maternal & Fetal Well-being

Instructions

I-II. Confirmation of Pregnancy & Calculation of Estimated Date of Birth (10 min)

Using the *Antenatal Care Visit: Protocol for Family Doctors*, section 6 *Assess maternal-fetal status and make diagnosis/case classification* as a guide, review with the group the calculation used for:

- Estimated date of conception (EDC)
- Estimated date of birth (EDB)

Discuss procedures to follow:

- To determine consistency between EDC with physical findings
- When EDC is not consistent with physical findings

Indicate also the Annex 4 *Expected Fundal Height*.

III. Evaluation of Progress of Pregnancy (15 min)

Discuss procedures to follow in order to determine consistency between EDC, EDB and physical findings at different stages of a pregnancy.

IV-V. Evaluation of Maternal & Fetal Well-being (10 min)

Distribute the case study *Maternal & Fetal Well-being*. Review it with the group, asking:

- What kinds of things they need to be aware of from the historical and physical findings
- What they consider to be the maternal, and fetal, health status based on their evaluation of the findings

VI. Case Classification (10 min)

Review with the group the basis for case classification, including:

- The relative importance of possible risk factors
- The classification of low, moderate and high medical or obstetrical risk.

Session 7: Client Education & Follow-up

Objectives:

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

1. Describe information useful to pregnant clients in each of the following areas:
 - Normal body changes
 - Coping with common discomforts
 - Nutritional needs and how to meet them
 - Avoidance of potentially harmful practices (smoking, alcohol, medication, drugs)
 - Avoidance of exposure to X-ray
 - Prevention of infectious diseases
 - Need for rest and moderate exercise
 - Personal hygiene
 - Sexual intercourse
 - Work and domestic activities
 - Traveling
 - Signs and complications and what to do
 - Symptoms and prevention of abortion
 - Labor symptoms and prevention of premature labor
 - Breast feeding
2. Describe six situations in which special counseling may be necessary
3. Describe the dosage and client instructions for iron and folate supplementation during pregnancy
4. Describe the anti-tetanus immunization schedule (3rd trimester)
5. Describe prophylactic measures against childhood rickets (3rd trimester)
6. Describe the components of follow-up care
7. Explain how to introduce to clients:
 - The availability of family planning services following delivery
 - The benefits of breastfeeding

Methods: Discussion

Time: 45 min.

Materials:

Documents:

- Antenatal Care Visit: Protocol for Family Doctors
- Annexes 8, 8a-8g

Instructions

I. Information Useful to Pregnant Clients (15 min)

Review with the group the elements of information and recommendations for pregnant women, using Annexes 8, 8a, 8c-8g.

II. Special Counseling (5 min)

Using the Annex 8b, review with the group the situations in which special counseling may be required, emphasizing essential information they should share with clients.

III-V. Preventive & Treatment Measures (10 min)

Discuss with the group:

- Dosages and timing for iron, folic acid and calcium supplements; prophylaxis for child rickets; and anti-tetanus immunizations
- Treatment for anemia and urinary infections.

Indicate to participants Annex 9.

VI. Follow-up Care (5 min)

Review with the group section 9 of *Antenatal Care Visit: Protocol for Family Doctors, Plan Follow-up Care with Client*.

VII-VIII. Family Planning & Breastfeeding (10 min)

Indicate and review it with the group Annex 8d *Breastfeeding Counseling during Pregnancy*; emphasize the importance of counseling during pregnancy, not only after delivery.

Review with the group the contraceptive methods most appropriate for breastfeeding and non-breastfeeding mothers, based on information from Annex 8e *Birth Spacing and Family Planning*.

Session 8: Record Management

Objectives:

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

9. Explain the protocol for the registration of findings, assessments, diagnoses, care, information and follow-up plan
10. Explain the use of the client data and follow-up plan by the doctor and by the client.

Methods: Discussion

Time: 30 min.

Materials:

Handouts:

- Copies of Annex for Pregnant and Post-partum Woman
- Copies of “Pregnant woman’s Book”
- Cue Cards

Distribute each participant the following *Cue Cards*:

- Antenatal Consultation in the First Trimester of Pregnancy
- Antenatal Consultation in the Second Trimester of Pregnancy
- Antenatal Consultation in the Third Trimester of Pregnancy
- First Antenatal Consultation in the Second Trimester of Pregnancy
- First Antenatal Consultation in the Third Trimester of Pregnancy

Explains that each cue card indicate to Family Doctor how to conduct antenatal consultations and to complete the Annex for Pregnant and Post-partum Woman.

Session 9: Case Studies

Objectives: By the end of the session, participants will be able to:

1. Apply knowledge they have gained from the workshop to the analysis of a range of pregnancy cases.
2. Recommend appropriate actions based on the analysis of their cases.

Method: Case study

Time: 75 minutes

Materials:

Handouts:

- Case studies (4-5), representing a variety of pregnancy-related problems likely to confront family doctors

Instructions

I-II. Analysis of, and recommendations regarding, pregnancy cases (75 min)

Divide the group into small groups of 5 participants per group. Distribute copies of a single case study to all groups. Give the groups 10 minutes to analyze their cases and decide the course of action they would take (according to the questions posed in the case study).

Ask the small groups to rejoin the large group. Lead a discussion of the groups' analyses of the case and their recommended actions (10-15 minutes)

Repeat the above small and large group analysis and discussion with additional cases as time permits.

ANTENATAL CARE VISIT

| No | Examination component | First Trim. | Second Trim. | Third Trim. |
|----|---|-------------|---------------------|---------------------|
| 1 | Prepare for examination - Ensure availability of technical conditions/equipment for antenatal consultations (see Annex 1: ANC Room Preparation) <i>If some examinations, procedures or investigations can not be realized in the family doctor's cabinet, because of the lack of equipment or technical conditions, this shall be specified in the medical documents and client shall be referred to a facility where she can obtain necessary services</i> - Review previous medical record - Wash hands with soap and water, dry with clean cloth or air dry | | | |
| 2 | Welcome client - Greet client & introduce yourself (<i>if not already known to client</i>) - Offer a seat to client and ensure privacy - If woman is escorted by her partner, invite him to discussion, after receiving woman's consent - Explain purpose and procedures of visit | | | |
| 3 | Take client's history <i>Social (personal) history</i> - Obtain following data: Name, address, phone, age, marital status, educational level/profession of client - Working (type of work, toxic substances, physical effort) and living conditions - Smoking, use of alcohol, drugs (<i>if Yes, specify</i>) - Spouse's age and health status - Conflicts in family or at work - Evaluate the socio-economic status of the family <i>Medical history</i> | | X If first visit | X If first visit |

| | | X If first visit | X If first visit |
|--|--|------------------------|------------------------|
| <p><u>Physiologic data</u></p> <ul style="list-style-type: none"> - First menstruation (menarche), menstrual features <p><u>Pathologic data</u> – <i>if possible, validate by client's medical record</i></p> <ul style="list-style-type: none"> - Previous or actual health problems: heart, blood pressure, liver, renal disease, chronic renal failure, diabetes, epilepsy, severe anemia, allergy - Infectious diseases, including STIs/HIV - Blood transfusions, antibodies - Hospitalization and surgery - Current medication (prescription or OTC) –<i>specify</i> <p><u>Obstetric history</u> – <i>if possible validate by client's medical record</i></p> <ul style="list-style-type: none"> - Past pregnancies: number and date of births (full-term babies, pre-term babies, weigh of each child and Apgar scores), abortion (spontaneous or induced), or other outcomes of pregnancies (ectopic, still births); pregnancies obtain by assisted humane reproductive techniques - Any problems with previous pregnancies or deliveries - Special perinatal (fetal, newborn) complications and events - Breastfeeding of babies - Living children and current condition of children <p><u>Family history</u></p> <ul style="list-style-type: none"> - Gemelarity/twins - Genetic disease, malformations (on either side of family). If so, refer client for genetic examination - Family-related diseases (high blood pressure, diabetes, obesity, psychiatric illnesses) | | | |
| <i>Actual pregnancy history</i> | | | |
| In case of suspected but unconfirmed pregnancy (very early pregnancy) | | | |
| <ul style="list-style-type: none"> ▪ ask questions, in order to determine if woman is pregnant or not (see Annex 2: <i>Interview Questions For Suspected Pregnancy</i>) ▪ if client's answers do not confirm pregnancy, perform a pregnancy test (5 weeks after LMP) or a pelvic examination (6weeks after LMP) | | | |
| In case of confirmed pregnancy, inquire about: | | | |
| <ul style="list-style-type: none"> ▪ Date of last menstrual period (LMP) | | X If first visit | X If first visit |
| <ul style="list-style-type: none"> ▪ Any problems with actual pregnancy <ul style="list-style-type: none"> - Unusual fatigue - Prolonged nausea and frequent vomiting - Sudden sharp, continuous abdominal pains - Fever or chills - Severe headache - Unusual change in vision - Pain or burning on urination - Vaginal itching or unusual discharge - Leaking of fluid from vagina - Vaginal bleeding - Pain, redness, tenderness of calves - Swelling of face and hands or calves - Constipation | | | |
| <ul style="list-style-type: none"> ▪ Diet history (24 hour recall), appetite changes | | | |
| <ul style="list-style-type: none"> ▪ Date of first felt active fetal movements (after 16 weeks) | | | X If first visit |

| | | | | |
|----------|--|--|------------------------|------------------------|
| | <ul style="list-style-type: none"> ▪ Fetal movements in last 24 hours | | | |
| | <ul style="list-style-type: none"> ▪ Signs of abortion <ul style="list-style-type: none"> - Increased pelvic pressure - Uterine contraction - Loss of mucus plug - Bloody mucus - Amniotic fluid loss | | | |
| | <ul style="list-style-type: none"> ▪ Signs of (premature) labor <ul style="list-style-type: none"> - Increased pelvic pressure - Uterine contraction - Loss of mucus plug - Bloody mucus - Amniotic fluid loss | | | |
| | Ask client about her respect for recommendations given in previous consultations | | | |
| 4 | Perform physical examination | | | |
| | <p><i>In general/principles:</i></p> <ul style="list-style-type: none"> -Observe client's level of energy, emotional tone and posture -Explain all procedures in simple terms while performing them -Ask questions of clarification about client's health, as appropriate, while conducting examination | | | |
| | <i>General examination</i> – check for signs of: | | | |
| | - anemia | | | |
| | - edema | | | |
| | - varicose veins | | | |
| | Heart auscultation, heart rate | | | |
| | Measure Blood Pressure (<i>at each visit</i>) <i>If BP \geq140/90 mm Hg, client has high risk</i> | | | |
| | Perform Roll-over Test (between 28 and 32 weeks) <i>Measure BP at every 5 minutes, with client lied on left side on the bed, at least 15 minutes; then, measure BP after 1 and 5 minutes, with client lie on the back. If diastolic BP is growing with \geq 20 mmHg, test is positive and client at risk of eclampsia. Refer for special examination</i> | | | |
| | Measure height <i>Height < 1,55 cm is a risk factor</i> | | X If first visit | X If first visit |
| | Measure weight (<i>at each visit</i>) <i>Initial weigh <45 kg is a risk factor</i> <i>Normal weigh gain during pregnancy is about 40-40.5 kg and is progressive, uniform. Any sudden weigh gain, more than 15-20 kg or less than 8 kg is abnormal and put client at risk</i> | | | |
| | <i>Perform obstetrical examination</i> (see Annex 3: <i>Obstetrical Examination</i>) | | | |
| | Breast examination Ask client to undress the upper half of her body. | | | |

| | | | |
|---|--|------------------------|--|
| <ul style="list-style-type: none"> ▪ With client's arms by her side, inspect breasts for: <ul style="list-style-type: none"> - Size, shape and symmetry - Shape of the nipples - Coloration/pigmentation of areola - Secretion of colostrum from nipples - Color, consistency, amount of other discharge from nipples ▪ As client lifts her arms above head, inspect breasts for retraction or dimpling ▪ With client's hands on hips, inspect breasts for retraction or dimpling ▪ With client lying on her back with 1) left arm, then 2) right arm over her head, palpate the left, then right breast and axilla, noting any masses or enlarged lymph nodes <p><i>NB: Normal changes in pregnancy include:</i></p> <ul style="list-style-type: none"> ✓ Increased size and nodularity of breasts ✓ Increased size, erection and leaking of colostrum from nipples ✓ Dilated sebaceous glands and increased pigmentation of areola <p>Ask client to cover/dress.</p> | | | |
| <p>Abdomen Ask client to empty her bladder and to undress. Assist her to sit on examination table/bed.</p> | | | |
| Inspect abdomen for size and contour | | | |
| Palpate abdomen for tenderness, masses, liver or spleen enlargement | | | |
| <p>Measure external pelvimetry <i>NB: Normal sizes are:</i> Bi-spinal diameter = 24 cm Bi-crest diameter = 28 cm Bi-trochanterian diameter = 32 cm Antero-posterior diameter = 20 cm</p> | | X If first visit | X If first visit |
| Inspect Michaelis lozenge – observe symmetry | | X If first visit | X If first visit |
| Measure fundal height (after 12 th week) – (see Annex 4: <i>Expected Fundal Height During Normal Pregnancy</i>) | | | |
| Measure abdominal circumference with tape | | | |
| Palpate uterus for: fetal lie, position, presentation and for active fetal movements (from 16 weeks) | | | |
| Perform Leopold maneuvers (see Annex 5: <i>Leopold's Maneuvers</i>) | | | |
| Measure fetal heart rate (with Pinard stethoscope, after 18 th week). Note intensity, rhythm (normal frequency: 120-160/minute) and auscultation area | | | |
| <p>Genital examination Assist client into position for pelvic examination and drape client for privacy. Remove hand jewelry. Put on gloves without contaminating them.</p> | | | |
| <p><u>External genital area</u> - Inspect perineum for scarring from laceration or episiotomy - Gently separate labia majora and inspect labia minora, clitoris, urethral opening and vaginal opening for color, lesions, growths, fissures and discharge - Milk urethra and Skene's ducts to exclude pus or bloody discharge</p> | | X If first visit | If first visit, refer to Ob- Gyn |

| | | | | |
|----------|---|--|---------------------|--|
| | <p><u>Pelvic (vaginal) exam</u></p> <ul style="list-style-type: none"> - Select correct size of speculum or vaginal valves for client - Show speculum or vaginal valves to client and explain how it will be used and will feel - Explain to client how to relax during insertion of speculum and examination - Encourage client to indicate if procedure too uncomfortable - Lubricate speculum or vaginal valves with water or lubricating jelly (if no specimen are to be obtain) - Hold speculum obliquely, part labia with other hand, and insert speculum gently, avoiding urethra and clitoris; Turn speculum and open blades to expose cervix OR insert first the posterior vaginal valve vertically, then turn it 90° and after then insert the anterior valve and gently push to expose cervix - Inspect cervix - Obtain specimens if necessary and equipment in place - Inspect vaginal walls/floor - Close and remove speculum gently in oblique position - Put used speculum/valves in designated container for decontamination | | X If first visit | If first visit in 3 rd trimester, refer to Ob-Gyn |
| | <p><u>Bimanual examination</u></p> <ul style="list-style-type: none"> - Explain examination to client - Encourage client to indicate if procedure uncomfortable - Insert two fingers into vagina, spread them and exert downward pressure. - Ask client to cough gently, and observe for: involuntary loss of urine, cystocele, rectocele - Draw two fingers together, ask client to tighten up vaginal muscles and check of muscle tone - Sweep vaginal walls with two fingers and feel for growths and masses - Locate cervix and feel for: <ul style="list-style-type: none"> ▪ Size, shape and position ▪ Consistency ▪ Smoothness ▪ Dilatation and regularity of os ▪ Mobility ▪ Tenderness (observe client's face) - Use both hands to palpate uterus for: <ul style="list-style-type: none"> ▪ Size, shape and consistency ▪ Smoothness ▪ Mobility ▪ Tenderness (observe client's face) - Use both hands to palpate adnexa for: <ul style="list-style-type: none"> ▪ Size, shape and position ▪ Consistency ▪ Masses ▪ Tenderness (observe client's face) - Remove fingers smoothly, remove gloves and dispose of them in designated decontamination solution - Ask client to get up and to get dressed - Wash hands with soap and water and air dry or dry them with a clean cloth | | X If first visit | If first visit in 3 rd trimester, refer to Ob-Gyn |
| | Refer for internal pelvimetry * (*performed by Ob-Gyn specialist) | | | |
| 5 | Laboratory/paraclinic examinations | | | |
| | <i>Mandatory investigations</i> | | | |
| | Hb, Ht | | X If first visit | |
| | - If Hb<11g/dl or Ht<33%, start iron supplementary therapy, even in the first trimester | | | |

| | | | | |
|----------|---|--|---------------------|---------------------|
| | Blood type and Rh factor - If woman is Rh negative, test partner's Rh factor. If partner is Rh positive, take blood samples from pregnant woman for antibody dosage - If woman's blood type is O I and partner's is A II, B III or AB IV, take blood samples from pregnant woman for antibody dosage | | X If first visit | X If first visit |
| | Ac for blood incompatibility (<i>as needed</i>) | | | |
| | Glycemia | | X If first visit | X If first visit |
| | Urine analysis - If a rise number of leukocytes is identified, bacterial exam of urine shall be recommended | | | |
| | RBW (VDRL, THPA)* | | | |
| | HIV test* (<i>after specific counseling and obtaining of informed consent</i>) * See Annex 8e: Counseling on HIV Testing | | X If first visit | X If first visit |
| | <i>Routine investigations</i> | | | |
| | Bacterial exam of vaginal discharge - Any infection shall be treated and this exam will be repeated any time when vaginal discharge or clinical signs occur in a pregnant woman | | | |
| | Pap smear - If woman has a result belonging to classes C III – C V, it is mandatory to refer her to the Ob-Gyn specialist for investigations | | X If first visit | |
| | Ultrasound examination <ul style="list-style-type: none"> ▪ During first trimester (at 10-14 weeks) is important for: determination/confirmation of gestational age; confirmation of embryo's life; and detection of multiple pregnancy, molar pregnancy and ectopic pregnancy ▪ In 2nd trimester is important for: <ul style="list-style-type: none"> - Fetal morphology (22-26 weeks of gestation) - Suspicion of multiple pregnancy - Early detection of low-inserted placenta - Early detection of slow rate of fetal development ▪ In 3rd trimester is useful for: <ul style="list-style-type: none"> - Appreciation of fetal development and estimated date of delivery - Detection of slow rate of fetal development - Detection of chronic fetal distress - Appreciation of maturation of the placenta and quantity of amniotic fluid | | | |
| | <i>Supplementary investigations</i> | | | |
| | Stomatological exam | | | |
| | Bacterial exam of urine - If a rise in number of leukocytes was identified by urine analysis | | | |
| | Hepatitis serology (Ag HBS, Ag HVC) | | | |
| | STI – Chlamydia, Mycoplasma | | | |
| | Toxoplasmosis*, Cytomegalovirus, Rubella* | | | |
| | Induced Hyperglycemia - For pregnant women having a history of diabetes in their family or of births with macrosomal/overweight fetus | | X If first visit | X If first visit |
| | Assessing the 21 trisomy risk (Down syndrome) - If pregnant woman aged over 35 or has suggestive history – refer for amniocentesis or triple testing: AFP-alpha-fetoprotein, HCG-human corionic gonadotrophine and estriol (between 14 th and 20 th week) | | | |
| 6 | Assess maternal-fetal health status and make diagnosis/case classification | | | |

Antenatal Care

Protocol for Family Doctor

| | | | | |
|----------|--|--|------------------------|------------------------|
| | <p>Diagnose pregnancy</p> <ul style="list-style-type: none"> - Calculate estimated date of conception (EDC) based on date of last normal menstrual period and calculate the estimated date of birth (EDB), using 280-day rule (LMP+280 days) - Compare calculated EDC with physical findings - Decide if there is consistency between calculated EDC and physical findings and, if necessary, recommend ultrasound examination and/or refer to Ob-Gyn specialist (if not already done for the first obstetrical exam) - Confirm if client is pregnant and, if yes, that progress of pregnancy is normal based on above evaluations | | | |
| | <p>Evaluate progress of pregnancy</p> <ul style="list-style-type: none"> - Compare calculated EDC and EDB (using 280-day rule) with physical findings - Compare physical findings with findings from previous visit(s) - Decide if there is consistency between EDC, EDB and physical findings at each visit, including the present; and whether observed growth is consistent with expected growth - Decide if progress of pregnancy is normal based on above evaluations - Asses the risk for abortion/premature labor | | | |
| | <p>Maternal well-being</p> <ul style="list-style-type: none"> - Evaluate historical and physical findings for presence or absence of problems, noting: <ul style="list-style-type: none"> ▪ Psycho-emotional response to pregnancy ▪ Common discomforts ▪ Life-threatening complications - Evaluate historical and physical findings for presence or absence of risk factors - Decide if maternal health status is normal based on above evaluations, and if not, appropriately manage and/or refer for further evaluation or care | | | |
| | <p>Fetal well-being</p> <ul style="list-style-type: none"> - Evaluate historical and physical findings for presence or absence of problems - Decide if fetal health status is normal based on above evaluations; and if not, prepare to discuss treatment or referral with client | | | |
| | <p>Case classification</p> <p>Risk factors shall be written down at the first visit, following the order of their importance (see Annex 6: <i>Risk Factors in Pregnancy</i>) and the risk score shall be determined (see Annex 7: <i>Cooplant Score</i>)</p> <ul style="list-style-type: none"> - Absent/Low risk: to be monitored by family doctor during first 2 trimesters - Moderate medical or obstetrical risk: to be referred to Ob-Gyn in an ambulatory facility from early pregnancy and so noted in woman’s pregnancy book and medical letter shall be send to Ob-Gyn specialist - High risk: to be referred from the beginning to Ob-Gyn specialist for registration and monitoring and/or admission into the hospital, as needed - If the family doctor is not able to make the case classification, he/she shall refer pregnant woman to the OB-GYN specialist or other specialist doctors, in order to establish diagnosis. | | X If first visit | X If first visit |
| | <p>Review case-classification and modify it, if new risk factors occurred</p> | | | |
| 7 | <p>Share assessment and diagnoses with client</p> <ul style="list-style-type: none"> - Inform client of the assessments and diagnosis - If any abnormalities are discovered <ul style="list-style-type: none"> ▪ ask client if she is aware of these ▪ explain possible causes ▪ inform clients about next steps - Encourage client to share reactions to information provided | | | |
| 8 | <p>Provide care, information and recommendations/advice</p> <p>Provide information, depend upon client need (see Annexes 8-8f):</p> <p>Normal body changes</p> | | | |

| | | | |
|---|--|--|--|
| Coping with common discomforts | | | |
| Nutritional needs and how to meet them | | | |
| Need for rest and moderate exercises | | | |
| Avoidance of potentially harmful practices | | | |
| Avoidance of X-ray exposure | | | |
| Prevention of infectious diseases | | | |
| Personal hygiene | | | |
| Sexual intercourse | | | |
| Prevention of domestic violence | | | |
| Work and domestic activities | | | |
| Traveling | | | |
| Signs of complications and what to do | | | |
| Symptoms and prevention of abortion | | | |
| Labor symptoms and prevention of premature delivery | | | |
| List of hospitals (phone, address) and information about when to go to hospital | | | |
| Special Counseling | | | |
| HIV test | | | |
| Social counseling –refer, if needed | | | |
| In case of accidental exposure to X-rays <i>Exposure during first trimester- termination of pregnancy is recommended because of the high risk of fetal malformations</i> | | | |
| <i>In the 2nd or 3rd trimester- special counseling is needed and pregnant woman shall be referred for a checking to a facility where early detection of malformation is possible</i> | | | |
| Infections during pregnancy* <i>If infections occur before the 28th week, special counseling is needed and option of termination of pregnancy shall be discussed:</i> | | | |
| <ul style="list-style-type: none"> • Toxoplasmosis • Cytomegalovirus • Rubella <i>After 28th week, pregnant women shall be admitted into hospital for treatment</i> | | | |
| Counseling for delivery - Birth-related psychological preparation - Respiratory exercises for delivery - Preparations for new baby, anticipated changes in family roles and responsibilities | | | |
| Breastfeeding counseling | | | |
| Preventive measures (see Annex 9: Preventive Measures) | | | |
| Prevention of anemia – provide iron (30-60 mg Fe/day) and folic acid (1 mg/day) | | | |
| Calcium supplement (1,000-1,200 mg/day) - only if milk intake and derived products is not possible or insufficient | | | |
| Prophylaxis for child rickets - give vitamin D2 or D3 per os, 500-1,000 U.I./day (depending on season and individual situation of pregnant woman) - OR 4,000-5,000 U.I/week - OR 200,000 U.I. per os, single dose (32-36 weeks), in special situations, when daily/weekly administration is not possible | | | |

| | | | | |
|-----------|--|--|--|--|
| | <p>Anti-tetanus immunization</p> <ul style="list-style-type: none"> ▪ If client was not vaccine/not sure about it <u>and</u> she is at first pregnancy, she will receive 1 dose of vaccine (VTA or DT) 0.5 ml, at 34 weeks, + 1 dose at 38 weeks; she will receive 1 revaccination after 6-12 months from first dose, and 2nd revaccination after 5 years with similar dose ▪ If client was previous immunized, she will receive a revaccination dose of VTA or DT 0.5 ml at 34 weeks ▪ If client is at 2nd, 3rd pregnancy or more and she was immunized, she need a new revaccination only if >10 years past from last immunization | | | |
| | <p>Treatment or interventions</p> | | | |
| | <ul style="list-style-type: none"> - Treat anemia if Hb \leq11 g/dl or Ht <33% (120-180 mg Fe/day + folic acid 5 mg/day + vitamin C) - Treat megaloblastic anemia with higher doses of folic acid - Treat urinary infections - Treat or refer problems, as necessary | | | |
| 9 | <p>Plan follow-up care with client</p> | | | |
| | <ul style="list-style-type: none"> - Discuss follow-up treatments as appropriate - Ask client to repeat instructions - Encourage client to ask questions - Describe sequences and importance of routine antenatal care - Schedule plan for next visits - Encourage client to bring her partner to visits if she desires - Set the date for the next consultation (give client date and time) and ask her to sign in the medical records - Encourage client to come sooner, if needed | | | |
| 10 | <p>Record data and follow-up plan</p> | | | |
| | <ul style="list-style-type: none"> - Note all findings, assessments, diagnosis, care and information, and plan for follow-up on “Pregnancy Annex” and clients’ “Pregnancy Book” - Give client her pregnancy book with return date indicated on it - Teach client how to use information from pregnancy book and advise her to take it to each health service she requires - Record important findings, diagnosis and preventive measures into the special “Register for pregnant women” | | | |

To be applied/done always



To be applied/done if needed



Not necessary/recommended to be done



abc – To be noted into medical records

abc – Do not record / protocol description

Antenatal Care: Room Preparation

Before beginning an antenatal consultation, ensure that the following are available and in adequate condition

- Adequate light
- Examination table with clean drapes and examination table paper (to be changed prior to each consultation)
- Gloves (new or reusable which have been high-level disinfected)
- BP cuff, stethoscope
- Watch
- Tape measure
- Scale and height measure
- Pelvimeter
- Specula or vaginal valves (high-level disinfected)
- Decontamination solutions and container
- Laboratory equipment (if available and indicated)

Interview Questions for Suspected Pregnancy

In case of suspected but unconfirmed pregnancy (very early pregnancy) ask the following questions:

- *Do you think you are pregnant now? What signs indicate that you might be pregnant?*
 - Absence of a period
 - Breast tenderness and nipple sensitivity (may be felt as early as 1-2 weeks after fertilization)
 - Fatigue, nausea and urinary frequency (may be felt as early as 2 weeks after fertilization, more intensely at 6 weeks of pregnancy, and disappear at 18-20 of pregnancy).

- *Have you had intercourse since your last menses?*

- *Have you been using a contraceptive method?*
Note reliability of method and correct and consistent use of the method by the client

- *When did your last menstrual period begin?*
Client not likely pregnant if she is within the first 7 days after start of her menses, (e.g. day 1-7)

- *Was your last menstrual period normal? If not:*
 - *How would you describe it?* (Bleeding, spotting, or lower abdominal pain may signal ectopic pregnancy or threatened spontaneous abortion)
 - *What date did your previous menstrual period begin?* (An unusually light or mistimed period may mean fertilization occurred before the LMP, and for this reason, the date of the previous menstrual period should be determined.)

- *When did you were pregnant last time?*
Client not likely pregnant if she is:
 - Within first 7 days post abortion
 - Within 4 weeks postpartum and not breast feeding
 - Fully breast feeding, less than 6 months postpartum and has no menstrual bleeding

If client answers do not confirm pregnancy

- Perform pregnancy test (5 weeks after LMP)
- OR
- Perform physical examination (6 weeks after LMP)

Obstetrical Examination

- **Breasts**
 - With client's arms by her side, inspect breasts for:
 - Size, shape and symmetry
 - Coloration/pigmentation
 - Secretion of colostrum from nipples
 - Color, consistency, amount of other discharge from nipples
 - As client lifts her arms above head, inspect breasts for retraction or dimpling
 - With client's hands on hips, inspect breasts for retraction or dimpling
 - With client lying on her back with 1) left arm, then 2) right arm over her head, palpate the left, then right, breast and axilla, noting any masses or enlarged lymph nodes

NB: Normal changes in pregnancy include:

 - ✓ Increased size and nodularity of breasts
 - ✓ Increased size, erection and leaking of colostrum from nipples
 - ✓ Dilated sebaceous glands and increased pigmentation of areola.

- **Abdomen**
 - Inspect abdomen for size and contour
 - Measure external pelvimetry

Note that normal sizes in first trimester are:

 - Bi-spinal diameter = 24 cm
 - Bi-crest diameter = 28 cm
 - Bi-trohanterian diameter = 32 cm
 - Antero-posterior diameter = 20 cm
 - Inspect Michaelis lozenge
 - Palpate all 4 quadrants of abdomen for:
 - Tenderness
 - Masses
 - Liver or spleen enlargement

- **External genital area**
 - Inspect perineum for scarring from laceration or episiotomy
 - Gently separate labia majora and inspect labia minora, clitoris, urethral opening and vaginal opening for color, lesions, growths, fissures, and discharge
 - Milk urethra and Skene's ducts to exclude pus or bloody discharge

- **Pelvic/vaginal examination**
 - Select correct size of speculum or vaginal valves for client
 - Show speculum or vaginal valves to client and explain how it will be used and will feel
 - Explain to client how to relax during insertion of speculum and examination
 - Encourage client to indicate if procedure too uncomfortable
 - Lubricate speculum or vaginal valves with water or lubricating jelly (depending on taking samples or not)

- Hold speculum obliquely, part labia with other hand, and insert speculum gently, avoiding urethra and clitoris
- Turn speculum and open blades to expose cervix or insert first the posterior vaginal valva vertically, then turn it 90 degrees and after then insert the anterior valva and expose cervix
- Inspect cervix for:
 - Color
 - Size, shape and position
 - Dilatation of os
 - Ectopy
 - Redness or inflammation
 - Bleeding
 - Lesions, erosion or ulcers
 - Growths or masses
 - Polyps or cysts
 - Discharge (color, consistency, amount)
- Obtain specimens if necessary
- Inspect vaginal walls/floor for:
 - Color
 - Redness or inflammation
 - Bleeding
 - Lesions and ulcers
 - Growths or masses
 - Discharge (color, consistency, amount)
- Close and remove speculum gently in oblique position
- Put used speculum in designated container for decontamination
- **Bi-manual examination**
 - Explain examination to client
 - Encourage client to indicate if procedure uncomfortable
 - Insert two fingers into vagina, spread them and exert downward pressure. Ask client to cough gently, and observe for: involuntary loss of urine, cystocele, rectocele
 - Draw two fingers together, ask client to tighten up vaginal muscles and check for muscle tone
 - Sweep vaginal walls with two fingers and feel for growths and masses
 - Locate cervix and feel for:
 - Size, shape and position
 - Consistency
 - Smoothness
 - Dilatation of os
 - Regularity of os
 - Mobility
 - Tenderness (observe client's face)
 - Use both hands to palpate uterus for:
 - Size, shape and consistency

Note that the uterus gains in volume and it is compared during the first trimester to citric fruits (tangerine at 4 weeks, orange at 8 weeks, grapefruit at 12 weeks).

The shape is globular at the beginning of pregnancy, then the uterus becomes egg-shaped, with a soft consistency (Bonnaire sign) and occupies the vaginal sac bottom (Noble sign)

If the uterus is difficult to estimate, because of its position (retroversion), early pregnancy, or abundance of adipose tissue, it is recommended to perform another pelvic exam after 10-14 days or a ultrasound exam

- Smoothness
- Mobility
- Tenderness (observe client's face)
- Use both hands to palpate adnexa for:
 - Size, shape and position
 - Consistency
 - Masses
 - Tenderness (observe client's face)
- Remove fingers smoothly, remove gloves and dispose of them in designated decontamination solution
- Ask client to get up and to get dressed
- Wash hands with soap and water and air dry or dry them with a clean cloth

Expected Fundal Height during Normal Pregnancy

| Gestational age (weeks) | Expected Fundal Height |
|-------------------------|--|
| Less than 12 | Not Detectable by Abdominal Palpation |
| 12 | Just above the pubic bone |
| 16 | Halfway between the pubic bone and the umbilicus |
| 20 -22 | At the umbilicus |
| 23 | 23 cm |
| 24 | 24 cm |
| 25 | 25 cm |
| 26 | 26 cm |
| 27 | 27 cm |
| 28 | 28 cm |
| 29 | 29 cm |
| 30 | 30 cm |
| 31 | 31 cm |
| 32 | 32 cm |
| 33 | 33 cm |
| 34 | 34 cm |
| 35 | 35 cm |
| 36 | 36 cm |
| 37 | 36 - 37 cm |
| 38 | 35 - 37 cm |
| 39 | 35 - 36 cm |
| 40 | 34 – 36 cm |

If the uterine height measurement between 20 – 36 weeks is more than 2 cm different (larger or smaller) than expected, look for:

- wrong dates
- abnormalities of the baby
- too much or too little amniotic fluid
- twins
- a very large or very small baby
- abnormal presentation.

If you suspect that the uterine growth is not normal, refer the woman for evaluation to Ob-Gyn specialist.

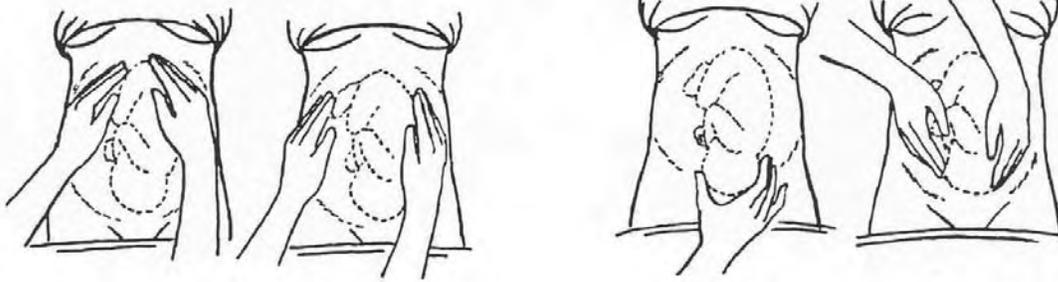
After 36 weeks, the baby's head may be descending into the pelvis and therefore the measurements may seem less. You can confirm descent by abdominal exam. When measuring the uterus, each provider must use the same technique.

Leopold's Maneuvers

Palpation of the uterus using Leopold's maneuvers (in 3rd trimester)

- Help the client to get comfortable lying on her back on the examination bed. Her knees should be bent and her feet planted on the surface of the bed.
- Start by standing beside the bed and turn to face slightly towards the woman's head. If you are right-handed, stand beside the woman's right hand (as she is lying down); if you are left-handed, stand beside the woman's left hand.
- Perform the maneuvers.
 - **Step 1:** Use your two hands to feel what part of the baby is in the uterine fundus (the upper part of the uterus). Place the palms of both hands over the top of the uterus and use your finger tips to feel the uterine contents.
 - **Step 2:** Slide your hands down both sides of the uterus and try to feel where the baby's back is located – this is the side which feels smoother. The side where the baby is kicking your hand is his front, not his back.
 - **Step 3:** Use one hand to feel what part of the baby is in the lower uterus just above the top of the pubic bone. Try to grasp the presenting part of the baby between your thumb and fingers and see if it feels hard, round and bony (the head).
 - **Step 4:** Turn and face towards the woman's feet now. Start at the top of the uterus and slide your hands, fingertips leading, down the sides of the uterus to feel for descent of the baby's presenting part. Has it dropped below the top of the pubic bone?
- As you perform these maneuvers, look for and feel the movement of the baby.
- Observe whether or not the woman has any pain.
- There is no real clinical significance to the position of the baby prior to 36 weeks. Doing Leopold's maneuvers prior to 36 weeks helps the provider locate the fetal heart and is an opportunity for the provider to tell the mother more about her baby. Be sure to talk with the mother and reassure her about your findings. The fetal head should be down after 36 weeks; if not, the client should be referred to Ob-Gyn specialist.

Leopold's Maneuvers:



- Step 1:** Feel what part of the baby is in the upper uterus
- Step 2:** Feel for the baby's back
- Step 3:** Feel what part of the baby is in the lower uterus
- Step 4:** Feel for descent of baby's presenting part

Factors Contributing to High-risk Pregnancies

Maternal risk factors:

- Age < 18 or >35 years of age (especially first baby over age 35)
- Greater than 4 pregnancies
- First baby over age 35
- Less than 2 years between births
- Weight < 45 kg
- Height < 155 cm
- Victim of domestic abuse

Previous obstetric risk factors:

- Genital undergrowth (infantilism)
- Cicatricial uterus (after Cesarean section or other interventions, like myomectomy, plastic surgery)
- Genital tumors
- Plastic surgery on reproductive tract
- Treatment for sterility
- Perineal long-term damage
- Ectopic pregnancy
- Miscarriages
- Abortions
- Pre-term delivery
- Late delivery (beyond 42 weeks)
- Previous pathologic pregnancies:
 - Hemorrhage
 - High BP, pre-eclampsia or eclampsia
 - Infections
- Previous complicated deliveries:
 - Retained placenta
 - Prolonged or obstructed labor
 - Hemorrhage
 - Operative delivery (forceps, vacuum extraction or Cesarean)
- Stillbirth or neonatal death
- Infant born with anomalies or with birth trauma
- Birthweight of last baby <2500g or > 4500g

Pathology in actual pregnancy:

- Pregnancy-induced hypertension
- Pre-eclampsia or eclampsia
- Vaginal bleeding
- High uterine tonus, contractions

- Cervico - istmic incontinence
- Blood type or Rh incompatibility
- Multiple gestation
- Cessation or reduction of fetal movements
- Hydramnios
- Transverse or breech position – after 36 weeks
- Previous cesarean section – after 36 weeks
- Baby/uterus $\lt \gt$ for gestational age
- Premature labor
- No fetal movement/FHT after 20 weeks
- Chronic fetal distress
- “In utero” fetal death (stillbirth)
- Distocia / Obstructed labor

Medical conditions which might affect pregnancy (previous or associated with actual pregnancy):

- Cardiac disease
- Hypertension (systolic blood pressure $\gt 130$ mm Hg, diastolic blood pressure $\gt 90$ mm Hg)
- Hemathologic conditions or diseases (severe or moderate anemia, Thalassemia or other)
- Venous thrombophlebitis
- Pulmonary disease
- Diabetes
- Cancer
- Hepatitis
- Urinary tract infection or kidney disease
- Epilepsy
- Mental illness
- Eye/ophthalmologic pathology
- Allergy
- STI or HIV positive
- Tuberculosis
- Malnutrition
- Chronic intoxication (Pb, Hg, alcohol, smoking, drugs, neuroleptic medicines)

Social risk factors:

- Poverty
- Low literacy
- Hard physical labor
- No family or social support (lives alone, isolated from family members, father of baby not involved), unmarried woman
- Unwanted pregnancy

COOPLAND SCORE FOR HIGH RISK PREGNANCIES

| Obstetrical History | | Medical and Surgical History | History of Actual Pregnancy |
|---|--------------|---------------------------------|-----------------------------|
| Age | ≤ 161 | Gynecologic interventions.....1 | Bleeding < 20 weeks.1 |
| | 16-350 | Chronic renal diseases.....1 | ≥ 20 weeks.....3 |
| | ≥35 2 | Gestational diabetes | Anemia (<10g%)1 |
| Parity | 01 | Class A1 | Prolonged pregnancy.....1 |
| | 1-40 | Class B or >3 | Hypertension2 |
| | > 52 | Cardiac diseases.....3 | Premature delivery.....2 |
| ≥ Abortions or infertility treatment....1 | | Others1-3 | Polihidramnios2 |
| Postpartum bleeding1 | | (depending on importance) | Fetal hypotrophie.....3 |
| Baby > 4000 g1 | | | Multiple pregnancy.....3 |
| < 2500 g1 | | | Distocic presentation.....3 |
| Pregnancy-induced hypertension2 | | | Izoimmunization3 |
| C-section.....2 | | | |
| Prolonged labour.....2 | | | |
| Sub-Total | | | |
| Total Score | | | |

Low risk 0 – 2
Medium risk 3 – 6
High risk ≥ 7

Counseling during Pregnancy and Postpartum

During pregnancy, all women need special attention and care.

All antenatal/postnatal consultations should be based on **general principles of good care**:

Communication with the pregnant woman (and her partner)

- Make the woman (and her partner) feel welcome.
- Be friendly, respectful and non-judgmental at all times.
- Use simple and clear language.
- Encourage her to ask questions
- Ask questions, and provide information, related to her needs and concerns
- Support her in understanding her options and making decisions
- During examinations and procedures seek her permission and explain what you are doing
- Share with the woman important information gathered during the visit, including the clinical findings, laboratory tests and treatments
- Verify that she understands emergency signs, treatment instructions and when and where to return (by asking her to explain or demonstrate instructions).

Privacy and confidentiality

- Ensure a private place for examinations and protect the client from being viewed by other people (conduct examinations behind a curtain, screen, or wall)
- Ensure that your conversations cannot be overheard
- Make sure you have the woman's consent before discussing any of her information with her partner or family member
- Never discuss confidential information with other providers or outside the facility, except the cases when other specialized examinations are needed
- Ensure that medical records are kept locked away, with limited access (providers only).

Recommendations, preventive care and treatments

When giving a treatment or prescribing preventive measures to be followed:

- Explain what the treatment is and why it should be given
- Explain that the treatment will not harm her or her baby, and that not taking it it may be more dangerous
- Give clear and helpful advice on how to take the drug regularly (exp.: take 1 tablet 3 times a day, thus 1 every 8 hours, in the morning, afternoon and evening, with some water and after a meal, for "x" days)
- Explain possible side effects of the treatment and that they are not serious and tell the woman how to manage them
- Advise the woman to return if she has any problem and/or concerns about the treatment
- Explore any barriers she or her family may have about using the treatment
- Discuss the importance of procuring the prescribed amount of medicines. Help her to think about how she will be able to purchase them, if needed.

When you prescribe a treatment for the baby:

- Explain how the treatment is given to the baby

- Demonstrate the procedure
- Watch her as she does the first treatment.

Emotional support

May be needed in some special situations. When giving emotional support to a woman with special needs it is particularly important to remember the following:

- Create a comfortable environment
 - be aware of your attitude
 - be open and approachable
 - use a gentle, reassuring tone of voice
- Guarantee confidentiality and privacy
 - communicate directly and clearly about confidentiality (tell the woman that you will not discuss with anyone about her situation)
 - if the woman is escorted by her partner or another family member, ask her if she would like to include him/them in the examination and discussion; make sure you seek her consent, and that you have time and space to talk privately, if needed
 - make sure that the examination area allows privacy
- Convey respect
 - do not be judgmental
 - be understanding of her situation
 - overcome your own discomfort with her situation (if you cannot, recognize it, and refer her to an appropriate service provider)
- Give simple, direct answers in clear language
- Verify that she understands your questions, advice and explanations
- Provide information according to her situation which she can use to make decisions
- Be a good listener
 - be patient; women with special needs may need more time to tell you their problem or make decisions
 - pay attention to her as she speaks
- Encourage follow-up visits.

Client Education

During pregnancy, women need information, and often counseling, to help them to make decisions about behaviors that are important for a healthy pregnancy.

- Providers should offer clients information and/or counseling on the following topics, depending upon client need:
 - Normal body changes
 - Coping with common discomforts
 - Nutritional needs and how to meet them
 - Need for rest and moderate exercise
 - Work and domestic activities
 - Avoidance of potentially harmful practices (smoking, alcohol, medication, drugs)
 - Avoidance/prevention of domestic violence
 - Avoidance of X-ray exposure
 - Prevention of infectious diseases
 - Personal hygiene and avoidance of douching or placing anything in vagina
 - Sexual intercourse
 - Traveling during pregnancy
 - Signs of complications and what to do
 - Labor symptoms and prevention of premature labor

These topics are addressed below.

- Women also have other special counseling needs. These are addressed in the following annexes:
 - Annex 8b: Special counseling needs during pregnancy
 - HIV positive women
 - Pregnant adolescents
 - Single/unmarried mothers
 - Women living with violence
 - Women with unwanted pregnancies
 - Annex 8c: Dietary needs of pregnant women
 - Annex 8d: Breastfeeding
 - Annex 8e: Family planning and birth spacing
 - Annex 8f : HIV testing
 - Annex 8g : Birth-related psychological preparation/counseling for delivery

Normal body changes and how to cope with them

- Reproductive organs and breasts
 - Uterus enlargement during pregnancy
 - 12 weeks: uterus can be felt at level of symphysis pubis
 - 20 weeks: uterus can be felt at umbilicus
 - 36 weeks: uterus can be felt beneath ribs
 - Vaginal discharge –an increase in vaginal discharge is a common physiological change in pregnancy, especially toward the end of pregnancy. It may be clear or yellow.
The woman should be informed that if vaginal discharge is associated with itching, soreness, a different odor or with pain, an infection could be the cause and she will

need to address to her FD for investigation and adequate treatment. If the discharge is white and lumpy with itching and burning, she may have a yeast infection (which is common in pregnancy) and uncomfortable but not dangerous). Providers should recommend correct and consistent use of condoms in all cases in which a STI is diagnosed or a risk of STIs is identified.

- Breast changes
 - Increase in size and nodularity
 - Increased size, erection and leaking of colostrums from nipples
 - Dilated sebaceous glands and increased in pigmentation of areola

If a pregnant woman has invaginated (or inverted) nipples, she should be advised to massage them during pregnancy, in order to prepare them for breastfeeding.
- Heart rate and circulation –are modified during pregnancy
 - Heart rate is raised from a normal of around 70 beats/minute to 80-90.
 - Uterus presses on the veins carrying blood from the legs, so swelling of the feet and varicose veins may appear.

The woman should be informed that these are common symptoms of pregnancy, especially in the afternoon or in hot weather and that they will not cause harm to her or her baby. Compression stockings and avoiding standing for long periods of time can improve the symptoms. It may help if the woman puts her feet up for a few minutes every 2 to 3 hours.

It may be a risk sign, however, if the feet are swollen when the woman wakes up in the morning, if the swelling is severe or if it comes on suddenly. Swelling of the hands and face is also a risk sign. Women should be advised to seek medical help if pain, redness or exacerbated swelling appear.
- Lungs
 - Faster and deeper breaths are noticed during pregnancy, as more oxygen is needed for 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. If the mother is also weak and tired, or short of breath all the time, it may be a sign of heart problems, anemia, poor diet, infection or depression. The woman will be advised to seek help in these cases.
- Kidneys
 - 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, particularly when the woman is lying on her side, because the growing uterus presses on the bladder and leaves less room for it to hold urine.
 - If the woman notices burning on urination, she should seek medical help (in order to receive adequate treatment in case of a urinary infection). *Urinary tract infections* often have the following symptoms: frequent urination, pain or burning when urinating, rise in body temperature. UTIs can increase the risk of miscarriage, fetal death in the uterus and preterm labour. The woman should increase the amount of fluid she drinks and seek medical care.
- Skin
 - Melasma (mask of pregnancy) on the forehead and cheeks
 - Darker line on abdomen from umbilicus downward
 - Small spiderlike blood vessels above the waist and in lower legs

The woman should be informed that these are common symptoms of pregnancy and they will disappear after delivery.

- Digestive system
 - Nausea (“morning sickness”), especially during 2nd-3rd months of pregnancy. The woman should be informed that in most cases nausea will resolve spontaneously within 16-20 weeks of gestation. If needed, some interventions may be recommended, as long as they appear to be effective in reducing symptoms: ginger, acu/ pressupuncture or medication (antiemetics, antihistamines).
 - Constipation caused by the uterus pushing on the rectum and lower part of large intestine. The woman should be informed about this effect. It may help to eat more fruits and vegetables, and whole grains (brown rice and whole wheat); to drink more water; and to get more exercise.
 - 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. If clinical symptoms remain troublesome, anti-hemorrhoid creams may be prescribed.
 - Heartburn. The woman should be offered information regarding lifestyle and diet modification (increase intake of milk and milk products). If symptoms still remain after these interventions, antacids may be prescribed.

Coping with common discomforts

- Feelings and emotions

Pregnancy can cause strong emotions (crying, laughing, depression, anger, irritability) and fears. They are normal but should not be ignored simply because the woman is pregnant.
- Physical aches and pains
 - *Baby’s kicks hurt the mother or the baby stops kicking.* A baby’s kick during the last weeks of pregnancy may be uncomfortable but it is not harmful. The woman should feel kicks every day by the 6th or 7th month. If the baby stops kicking for several hours, it is okay. But if the mother feels no movement for more than a day and a night, there may be a problem. She should see a doctor immediately.
 - *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. However, if the cramps are regular or constant, are very strong or painful, or if the woman also has spotting or bleeding, it may be a sign of miscarriage/spontaneous abortion. The woman may need medical help immediately.
 - *Aches and pains of the joints.* A pregnant woman’s joints, especially her hips, may get loose and uncomfortable. This is not dangerous and will get better after the birth. However, she should seek medical advice if any of the following occur: red, swollen joints; severe pain; signs of anemia with joint pain; or weakness.
 - *Back pain.* The weight of the baby, the uterus, and the waters put strain on the woman’s bones and muscles. Hard work can also cause back pain. The woman

should be informed that this is a common symptom of pregnancy and it may be alleviated by gymnastics (single or group special classes for pregnant women), swimming and exercises in water, and massage. It is helpful if family members can massage the mother's back, and assist her with heavy work.

- *Leg cramps.* Leg cramps are common, especially at night. Flexing the foot upward will stop the pain. She may then gently stroke her leg to help it relax. To prevent cramps, she should not point her toes when stretching, and she should eat more calcium.
 - *Difficulty getting up and down.* It is usually best if the pregnant woman does not lie flat on her back. The weight of the uterus presses on the large blood vessels that bring food and oxygen to the baby. If the mother wants to be on her back, she should put something behind her back so she is not lying completely flat. She may also be more comfortable if she puts her feet up. To sit up, she should roll to the side and push herself up with one of her hands.
 - *Headaches.* Headaches are common and usually harmless in pregnancy. In the case of migraine headaches (strong headaches, often on one side of the head), she should avoid migraine medicine (ergotamine) as it may cause premature labor and/or harm the baby; she may take acetaminophen or paracetamol. Headaches with swelling, dizziness or high blood pressure may be a sign of pre-eclampsia.
- Feeling hot and sweaty
Very common and harmless if there are no other signs of risk.

Nutritional needs and how to meet them

Pregnant women should be counseled on nutritional needs during pregnancy; a greater amount and variety of healthy foods, such as meat, fish, oils, nuts, seeds, cereals, beans, vegetables, cheese, milk, should be recommended (see also Annex 8c: *Dietary Recommendations for Pregnant Woman*).

Special attention should be given to the nutritional needs of very thin women and adolescents. Talking with family members (partner, mother, mother-in-law) and involving them in ensuring a healthy food regimen for the pregnant woman may be very useful.

Nutritional supplements:

Iron supplementation should be offered routinely to all pregnant women, starting with 14-24 weeks of gestation (see also *Preventive measures*).

The following information should be offered regarding iron supplements:

- iron is essential for health during pregnancy and after delivery
 - tablets should be administered daily, until 3 months after delivery
 - minimum daily dose is 60 mg (1 tablet) and may be raised if anemia occurs
 - side effects are possible; these are normal and do not affect either the mother's or the baby's health
 - how to manage side effects - if black stools occur →this is normal, don't worry
 - if constipated →drink more water
 - if nausea →take tablets after food or at night
 - iron supplies should be stored safely, in a dry place, where children cannot reach them
- At each antenatal visit supplies should be checked and re-supplied if needed.

Folic acid – women should be informed that supplementation with folic acid before conception and up to 12 weeks gestation reduces the risk of having a baby with neural tube defects; supplementation after the 14th week of gestation is necessary to prevent anemia (together with iron).

Vitamins

Vitamin D administration is recommended during the third trimester of pregnancy, for the prevention of rickets in the child.

The pregnant woman should be informed that vitamin A supplementation (>700 micrograms/day) might be teratogenic and therefore should be avoided; consumption of foods which contain high levels of vitamin A, such as liver and liver products, should also be avoided.

Other supplementation of vitamins is not necessary during pregnancy if women have a healthy, diversified diet.

Calcium supplementation is not necessary, unless the intake of milk and milk products is very low, or because of insufficient alimentation or digestive intolerance to them.

Need for rest and moderate exercise

Exercise makes a woman's body stronger. During pregnancy, exercise helps her body prepare for labour and delivery. Exercise can also make her feel better and more full of energy. Easy exercises and walking have a positive effect on labour and should be encouraged until the time of birth.

Women should be informed that moderate exercise can be started and/or continued during pregnancy without adverse outcomes. Potentially dangerous activities, like contact sports, high-impact sports, falls, scuba diving or sports that may involve risk of abdominal trauma, should be avoided.

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. 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 should be informed of their legal rights and benefits related to maternity. The majority of women can continue working. Family Doctors (with the support of the specialist in Occupational Medicine) shall identify cases at increased risk through occupational exposure and 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 be strongly advised to avoid harmful practices, like smoking (even passive smoking) and drinking alcohol during pregnancy, because of the adverse effects on fetal development and health.

- Avoid smoking, drinking alcohol or using 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. Cessation interventions (like advice/counseling by physician, group sessions, and behavioral therapy) may be proposed. Women who are unable to quit smoking should be encourage to reduce smoking
 - When a pregnant woman drinks, her baby drinks with her. Alcohol can cause deformations and mental problems.

Pregnant women who use alcohol should be advised to limit alcohol consumption to no more than one standard unit/day (a measure of spirits, one glass of wine, one beer).

- 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/medication abuse 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 (when the risk of not taking the medicine is greater than the risk of taking it). If she thinks she needs medicine, it is important to find out whether a particular medicine is safe for her baby. Pregnant women should be informed that few OTC medicines are safe to take in pregnancy and they should be advised to use any medication as little as possible.
- 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

Healthcare professionals need to be aware to the symptoms or signs of domestic violence (unexplained bruises, injuries) and women should be given an opportunity to disclose domestic violence in a secure environment.

At the PHC level/FDs' cabinets posters, leaflets and other materials (that condemn violence and give information) should be displayed. It is an easy way to inform women in need of this type of specialized assistance and to indicate interest for this issue and willingness of health professionals to help them.

If domestic violence is identified in a pregnant woman, she should be referred for special counseling to a specialized service (see Annex 8b: *Special Counseling Needs During Pregnancy*).

Avoidance of X-ray exposure

Women should be informed that X-ray exposure, especially in the first trimester of pregnancy, is dangerous for fetal development and it 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.

If a pregnant woman was accidentally exposed to X-rays, she needs special counseling and specific interventions, depending upon gestational age at the moment of exposure.

- if exposure occurs in the first trimester of pregnancy, termination of pregnancy is strongly recommended because of the high risk of fetal malformation and stillbirth
- if exposure occurs in the second and third trimesters, special counseling is needed, and testing in a specialized facility is recommended for early detection of fetal malformations

Prevention of infectious diseases

Women should be informed about the importance of avoiding infectious diseases during pregnancy, because of their potentially dangerous effect on the fetus, resulting in death sometimes.

In general, it is important for pregnant women to avoid being near people who are ill.

Pregnant women should be advised to avoid very populated areas in order to prevent infection from respiratory diseases. During winter, anti-influenza vaccine is recommended. It is particularly important for pregnant women 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:

- Listerioza may be prevented by:
 - drinking only pasteurized or UHT milk
 - not eating special types of cheese, like Camembert and Brie; hard cheese or cottage and processed cheese have no associated risk
 - not eating pate (liver product)
 - not eating uncooked/undercooked meals or ready-prepared meals (meals prepared ahead, e.g. cafeteria-style)
- Salmonella may be prevented by:
 - avoiding raw or partially cooked eggs or food that may contain Salmonella (e.g. mayonnaise)
 - avoiding raw or partially cooked meat, especially poultry.

Correct and consistent use of condoms should be recommended for reducing STI risk.

If an infection with Listeria, Cytomegalovirus, Toxoplasma, Rubella, Treponema Pallidum, HIV or other STI is detected during pregnancy, the woman should receive special counseling and be referred to a specialized service.

- If the infection occurs before the 28th week of pregnancy, special counseling is needed and the option of termination of pregnancy shall be discussed because of the risk of fetal malformation.
- If infection occurs after the 28th week of pregnancy, special treatment will be provided in the hospital.

Personal hygiene

Maintaining good personal hygiene helps to prevent infections and to stay healthy in pregnancy. The mother should bathe with clean water every day, including washing the outside of her genitals gently with clean water. She should also clean her teeth with a soft brush after every meal. Avoidance of hot water baths should be recommended.

Avoidance of douching and placing any substances in vagina should be strongly recommended, in order to avoid abortion or premature labour (unless the Ob-Gyn specialist is recommending something else).

The woman's clothes and shoes should be as comfortable as possible.

Sexual intercourse

Women should be informed that sexual intercourse in pregnancy is not known to be associated with any adverse effects, although there are specialists who 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 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 chance that he has an STD, HIV or other illness, he should always use a condom during sex with his wife. If sex is uncomfortable, the couple may try different positions or other ways to share their affection, to be close and each other.

Traveling during pregnancy

Pregnant women should be informed that long air travel is associated with an increase risk of venous thrombosis.

Car travel is no more risky for pregnant women than for the general population. Women should be informed about the correct use of a seatbelt (three-point seatbelts' above and below the bump, not over it) and be advised to wear it.

If women plan to travel abroad, they should discuss vaccinations and travel insurance with health professionals.

Signs of complications and what to do

Pregnant women should be informed about **danger signs** in pregnancy and advised to go to the hospital or health center immediately, day or night, if any of them appear:

- vaginal bleeding
- convulsions
- severe headaches with blurred vision
- severe abdominal pain
- fast or difficult breathing
- fever and weakness

They should be also informed about other **alarm signs**, which indicate that they are to go to the hospital or health center as soon as possible:

- fever
- abdominal pain
- water breaks and not in labour after 6 hours
- illness/bad general health status
- swollen fingers, face and/or legs
- pain, redness, swelling of the calves

Symptoms and prevention of abortion

If the woman has any of the following symptoms, she should consult her doctor immediately:

- o Cramps or abdominal pains in the first 3 months that get stronger or come more often (possibility of miscarriage/spontaneous abortion)
- o Strong constant abdominal or side pain in the first 3 months (possibility of tubal pregnancy)
- o Constant abdominal pain in late pregnancy (possible detached placenta)
- o Constant pain in lower abdomen that goes to the side or back and does not get better with rest, massage or exercise (possible bladder or kidney infection)

Labor symptoms and prevention of premature labor

Pregnant women should be advised to avoid long trips, extreme physical efforts, and prolonged standing during the third trimester of pregnancy, in order to prevent premature labor.

They should be also informed about labor symptoms and to go to the hospital as soon as possible if any of the following appear:

- o Loss of mucus plug
- o Bloody mucus discharge
- o Rupture of amniotic sac/amniotic fluid loss
- o Increased pelvic pressure and/or painful uterine contractions every 20 minutes or less.

Special Counseling Needs during Pregnancy

Some pregnant women may have special needs for emotional support and specific counseling:

- HIV positive women
- Pregnant adolescents
- Single/unmarried mothers
- Women living with violence
- Women with unwanted pregnancies

In these situations you may need to refer the woman to another level of care or to support groups. If neither are available/accessible in the geographical area or if the woman does not seek additional help, your counseling, emotional support and willingness to listen will help her.

- Provide a safe and non-judgmental environment in which the woman can talk about her problems, concerns and/or feelings
- Be sensitive, and empathize with her concerns and fears
- Help her to assess her situation and decide which is the best option for her, for her unborn baby and for her sexual partner (if appropriate). Support her choice.
- Connect her with support services, including peer support groups led by social workers, community workers, and/or social assistance

Special considerations for working with HIV positive women

Pregnant women who are HIV positive benefit greatly from the support provided by specially trained personnel. However, if a trained counselor is not available, counsel pregnant women who are HIV positive concerning:

Additional care

- Determine how much the family and companions know about her situation, and respect this confidentiality
- Help her to find ways to involve her partner and/or her family in sharing responsibilities, or to identify a person from the community to help her
- Discuss with her how to provide care for other children, if any
- Use universal precaution as for all women
- Advise her on the importance of good nutrition
- Advise her that she is more prone to infections and should seek medical help as soon as possible if she has: fever, persistent diarrhea, cold and cough, burning urination, vaginal itching/discharge, weight loss, skin infections, and/or four-smelling lochia (after delivery)
- Review the birth plan and advise her to deliver in an appropriate facility
- Counsel her/refer her for antiretroviral therapy

Prevention of mother-to-child transmission of HIV

Confirm/provide information on mother-to-child transmission, infant feeding, treatment, safer sex, and family planning. Help the woman to absorb the information and apply it in her own case.

- Inform her that she has an up to 40% risk of transmitting HIV infection to her unborn baby if no measures are taken
- Explain that the drugs taken during pregnancy may decrease dramatically this risk and that she must attend antenatal visits regularly and respect the indications for treatment
- Explain the risk of HIV transmission through breastfeeding and other possible risks from not breastfeeding
 - 3 out of 20 babies born to known HIV positive mothers will be infected by breastfeeding
 - The risk may be reduced if the baby is breastfed exclusively using good technique, so that the breasts stay healthy
 - Mastitis and nipple fissures increase the risk that the baby will be infected
 - The risk of not breastfeeding may be much higher in some cases because replacement feeding carries risks of diarrhea and malnutrition
 - Mixed feeding may also increase the risk of HIV transmission and diarrhea
- Help her to assess her situation and decide which is the best feeding option for her, and support her choice
- If she chooses breastfeeding, provide information and advice about:
 - How to ensure good attachment and suckling to prevent mastitis and nipple damage
 - The importance of returning immediately if she has any symptoms or signs of problems with her breasts or if the baby has any difficulty feeding
 - The importance of regular visits to assess breastfeeding and the condition of her breasts
- If she chooses replacement feeding:
 - Teach the mother how to prepare formula
 - Teach the mother how to feed the baby by cup and then by bottle
 - Explain the risks of replacement feeding and how to avoid them
 - Advise the mother to seek care if: the baby does not grow well, has diarrhea, or has other danger signs
 - Ensure regular follow-up visits for growth monitoring

Safer sex

Counsel the woman that the best protection is obtained by:

- Correct and consistent use of condoms during every sexual act
- Choosing sexual activities that do not allow semen, fluid from the vagina, or blood to enter the mouth, anus or vagina, or to touch the skin of the partner where there is an open cut or sore.

Family Planning

- Explain to the woman that future pregnancies can have significant health risks for her and her baby (miscarriage, preterm labour, stillbirth, low birth weight, ectopic pregnancy)
- If she wants more children, advise her to wait at least 2 or 3 years between pregnancies
- Counsel the woman about the correct and consistent use of condoms (including with an HIV positive partner)
- Explain that another family planning method can be used for additional protection against pregnancy. Help her to choose a method. Be aware that not all methods are appropriate for HIV positive women:

- LAM may not be a suitable method
- IUD use is recommended only if other methods are not available or acceptable
- Fertility awareness methods may be difficult if the woman is on treatment, due to changes in menstrual cycle and elevated temperature
- If the woman is taking medication for tuberculosis (rifampicin), she usually cannot use hormonal methods.

Special considerations for working with pregnant adolescents

When interacting with an adolescent, married or not, it is particularly important to remember the following:

- Do not be judgmental. Be aware of your own discomfort with adolescent sexuality
- Understand her difficulties in communicating about topics related to sexuality (fears of parents and other adults; fear of disapproval, social stigma)
- Support her and ask if she has any particular concerns:
 - Does she live with her parents? Can she confide in them? Does she live as a couple? Is she in a long-term relationship? Has she been subject to violence or coercion?
 - Determine who knows about this pregnancy
 - Support her concerns related to puberty, social acceptance, peer pressure, social stigma and violence.
- Help the adolescent to consider her options and to make decisions which best suit her needs:
 - Birth planning: -she needs to understand why delivery in a hospital is important; and she may need help in making her arrangements
 - STIs /HIV prevention –she needs to understand that is important for her and her baby’s health that she use a condom in all sexual relations, if she or her partner are at risk of STI/HIV. She may need advice on how to discuss condom use with her partner.
 - Spacing of the next pregnancy – it is highly recommended that future pregnancies be spaced at least 2 or 3 years apart. She needs to decide if and when a second pregnancy is desired. Be active in providing family planning counseling and advice, and help her to choose a contraceptive method (any contraceptive method can be safely use by healthy adolescents).

Special considerations for working with single/unmarried mothers

Single/unmarried mothers often face challenges that women in stable relationships do not. Often, the greatest challenges are having sole responsibility for the physical care and emotional needs of the child, along with the financial needs of both herself and her child. Society often sees single parenthood in one of several ways:

- The woman is a victim who is struggling with little money or support.
- The woman is tough and independent. She is single by choice.
- The woman “deserves” to be pregnant. It is “punishment” for her unacceptable behavior.

Faced with a single woman who is pregnant, the service provider needs to counsel her (using open questions) to help her think through her situation, her alternatives and the pros and cons of each alternative, so that she can come to a decision which she feels most comfortable with. The following questions may be of assistance:

- What has been the reaction of your partner, your family?

- Who will support you?
- Where will you live?
- How will you cope financially?
- Will the baby's father help at all?
- What do you think it will be like in a year, two years, five years from now?
- Who will help you in later stages of pregnancy with practical arrangements?
- Can you take the place of two parents?
- Are you emotionally strong enough?
- What will you have to give up?

Special considerations for working with women living with violence

Violence against women by their intimate partners affects women's physical and mental health. While you may not have been trained to deal with this problem, women may disclose violence to you, or you may see unexplained bruises and injuries which make you suspect that she has been abused. The following are some recommendations on how to respond to, and support, these women:

- Provide a space where the woman can speak to you in privacy, where her partner cannot hear. Do all you can to guarantee confidentiality and reassure her on this.
- Gently encourage her to tell you what is happening. Ask indirect questions to help her speak.
- Listen her in a sympathetic manner (listening can often be a great support). Do not blame her or make jokes of the situation. If she defends her partner, reassure her that she does not deserve to be abused in any way.
- Help her to assess her present situation, to identify options for immediate safety for herself and for her children as needed (e.g. can she stay with her parents or friends? Does she have any money or could she borrow from someone?)
- Explore her options and possibilities. Provide her information on social services, shelters, NGOs.
- Offer her an opportunity to see you again in case that she will need more time to take decisions.
- Display posters, leaflets and other information that condemn violence in the waiting room, indicating in this way your willingness to support these women and to provide information on support groups.

Special considerations for working with women with unwanted pregnancies

A woman may consider a pregnancy to be unwanted for a variety of reasons:

- She already has all the children she wants and/or can care for
- A pregnancy is a danger to her health or her life; or the child is likely to have serious birth defects
- She has no partner to help support the child
- She wants to continue her education
- She does not want to have children
- She got pregnant after being forced to have sex

A woman with an unwanted pregnancy may or may not have been using contraception.

- If she used contraception, she may or may not have been using it correctly. If she used it incorrectly, it could have been because:
 - She didn't understand the instructions
 - She was ambivalent about using the particular method
 - She was distracted by other problems or priorities
- If she didn't use contraception, it may have been because:
 - She didn't have physical or financial access to it
 - She didn't think she would get pregnant
 - She is not "allowed" by her partner to make contraceptive decisions
 - She lacks the self esteem to assert herself and ask for it
 - She didn't plan to have sex (she was coerced)
 - She finds it difficult, if not impossible, to discuss sexuality and contraception with her partner
 - She got pregnant for deeper psychological reasons that caused her, albeit accidentally, to get pregnant for unconscious needs: to have someone to love her, to exert control in a relationship, to punish her partner or family
 - Her judgment was impaired by alcohol or drugs

Different women view an unwanted pregnancy with varying degrees of ambivalence or frustration. The same woman may, from time to time, experience varying degrees of ambivalence about her unwanted pregnancy, depending upon factors surrounding her getting pregnant as well as other factors including her level of security – job, relationship, living situation and long term aspirations.

In taking the woman's history during the first antenatal consultation, it is important to ask her how she feels about the pregnancy. Most pregnancies are received by the woman, her partner and her family with happiness and celebration. However, service providers should not assume that every pregnancy is automatically a wanted pregnancy. Faced with a client who indicates that she has an unwanted pregnancy, the service provider needs counsel her (using open questions) to help her think through the pros and cons of her situation, her alternatives and the pros and cons of each alternative, so that she can come to a decision which she feels most comfortable with.

Dietary Needs of Pregnant Women

A pregnant woman should eat a variety of foods from each of the major food groups. The following is a guide for a healthy pregnancy diet:

| Food | Number of Servings per day | Examples/Serving size |
|--|----------------------------|--|
| Dairy Products | 4 | Milk (skim, low fat or whole): 1 glass (220 ml) Hard cheese: (size of matchbox) Cottage cheese: ½ cup Yogurt: ½ cup |
| Lean Meat, fish, fowl, beans, tofu, nuts, eggs | 3 | Meat/fish/fowl: (size of palm) Cooked beans or tofu: ½ cup Eggs: 2 |
| Vegetables (variety) | 3 | Green leafy vegetables: 1 cup Cooked yellow or green vegetables: ½ cup Tomato: 1 medium |
| Fruits (variety; include at least one citrus) | 3 | Juice: 160 ml Melon: ½ small Berries: 1 cup Grapes: 10 Grapefruit: ½ Fruit: 1 medium Cooked or chopped fruit: ½ cup |
| Grains, cereals, breads, potatoes, pasta, rice | 4 | Bread: 1 slice Crackers: 4-6 Cooked cereal: ½ cup Cooked rice or pasta: ½ cup Pizza: 1 slice Cold cereal: 2/3 cup Large roll: 1/2 ,etc |

This diet provides approximately 2,200 – 2,500 calories per day, which provides the nutrition for both mother and baby. Weight gain will average about 12 – 15 kg during the pregnancy. Most will be lost after delivery, although a reserve of about 3 Kg is ideal for breastfeeding. If a woman is unusually active, very undernourished before pregnancy, or a young adolescent (who is still growing herself) – additional servings may be needed.

Pregnancy is not a time to try to lose weight. Women who are obese may gain less weight during pregnancy, since the recommended diet for pregnancy often contains less calories than the high caloric foods she normally eats (ie. high in simple sugars and fats).

If salt is added to food, it should be iodized. In general, pregnant women should not use a lot of additional salt.

Coffee and tea should be avoided, as they reduce absorption of iron and folic acid. A pregnant woman should have at least 4-6 glasses of water a day in addition to other liquids.

Vegetables should either be raw or cooked lightly. Over-cooking destroys essential vitamins.

Pregnant women are usually very receptive to advice on nutrition, as they want to stay healthy and have a healthy baby.

Counseling for Breastfeeding during Antenatal Visits

During antenatal consultations, the advantages of breastfeeding should be presented to pregnant women/future parents. Future mothers should be encouraged to breast feed their babies for the many reasons presented below.

The current bottle-feeding fashion has no health advantages, and has only spread because of the success of intensive marketing efforts made by the formula manufacturing companies. It is only an alternative for the rare cases when breast feeding the baby is impossible.

Pregnant women should know that:

- Babies should start breastfeeding within 1 hour of birth. They should not have any other food or drink before they start to breastfeed
- Babies should be exclusively breastfed for the first 6 months of life. During this period, breast milk provides all the nutrients and liquid that a baby needs.
- There are many advantages of breastfeeding, both to the baby and to the mother:

Advantages of Breastfeeding

| <i>Advantages for the Baby</i> | <i>Advantages for the Mother</i> |
|--|---|
| <ul style="list-style-type: none"> • Perfectly formulated to meet infant's nutritional needs • Non-allergenic • Contains antibodies which protect the infant from infections despite his immature immune system • Helps prevent neonatal jaundice • Easily digestible and efficiently used by the baby's body • Promotes mother-infant attachment • Promotes healthy infant development | <ul style="list-style-type: none"> • Reduces postpartum blood loss, helps prevent anemia • Promotes uterine involution • Promotes mother-infant attachment • Inexpensive, easy to feed • Always ready, always fresh, always clean, always the right temperature • Helps mother lose weight gained in pregnancy • Helps space pregnancies • Reduces the risk of ovarian cancer, may reduce the risk of breast cancer |

During the antenatal visits in the first two trimesters of pregnancy breasts will be examined for inverted nipples. If this is the case, pregnant women should be advised to massage their breasts each day and to either 1) gently pinch and pull the nipples or 2) take their breasts in their hands and then pull back toward the chest. This will make the nipple stand out. Gently rubbing the breasts and nipples with a rough towel may also be useful.

Starting with the 6th month of pregnancy, lactational secretion is possible. If it happens, the pregnant woman should be advised to empty her breasts by pressing on them, from the external area to the areola, in order to avoid the blocking of the galactophore canals.

Suggestions for successful breastfeeding (to be given to pregnant women in the third trimester of pregnancy):

- Start breastfeeding within 1 hour of birth
- The baby's sucking stimulates milk production. The more the baby feeds, the more milk will be produced.
- The first milk (colostrum) is very important for the baby because it is nutritious and it has antibodies which help the baby to stay healthy.
- For the first 6 months of life, the baby needs only breast milk, day and night as often as he/she wants. No other foods or liquids should be given. Breast milk contains all the water and nutrients that a baby's body needs.

“Baby-Friendly Hospital Initiative” – Ten steps to support exclusive breastfeeding

Every facility providing maternity services and care for newborn infants should:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers to initiate breastfeeding within an hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation even if they are separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless *medically* indicated.
7. Practice rooming-in – allow mothers and infants to remain together – 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

Physiology of Breastfeeding

Prolactin – When the baby suckles at the breast, sensory impulses go from the nipple to the brain. In response, the anterior pituitary gland at the base of the brain secretes prolactin into the blood stream. The blood carries the prolactin to the breast, where it causes the milk secreting cells to produce milk.

Most of the prolactin is in the blood about 30 minutes after the feed, so it makes the breast produce milk for the NEXT feed. 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 own baby.

Most women can produce more milk than their babies need or can take. Most women can produce enough milk to feed at least two babies, if they are both allowed to suckle freely.

More prolactin is produced at night, so breastfeeding at night is especially helpful for establishing and keeping up the milk supply.

Prolactin makes a mother feel relaxed, and sometimes sleepy; so she usually rests well, even if she breastfeeds at night.

Oxytocin – When the baby suckles, sensory impulses go from the nipple to the brain. In response, the posterior pituitary gland at the base of the brain secretes oxytocin into the blood stream.

The blood carries the oxytocin to the breast, where it causes the muscle cells around the alveoli to contract. This makes the milk that has collected in the alveoli flow along the ducts to the lactiferous sinuses. Sometimes the milk flows to the outside. This is the oxytocin reflex or the milk ejection reflex or the let-down reflex.

Oxytocin is produced more quickly than prolactin. It makes the milk in the breast flow for THIS feed. Oxytocin can start working before a baby suckles, when a mother learns to expect a feed.

If the oxytocin reflex does not work well, the baby may have difficulty in getting milk, because it is not flowing out. This can occur even if the breasts are producing plenty of milk.

Oxytocin also is the hormone that 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.

Helping and Hindering the Oxytocin Reflex – The let-down reflex is easily affected by a mother's thoughts and feelings and sensations. Good feelings, such as love, confidence, happiness and pride, can help the reflex work and the milk to flow. Sensations such as touching, hearing or seeing her baby can also help the reflex.

Bad feelings, such as pain, worry, fear or doubt, can hinder the reflex and stop her milk from flowing. Fortunately, this effect is usually temporary.

Signs of an active let-down reflex 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.

Inhibitor in Breastmilk – There is a substance in breastmilk that can reduce or inhibit milk production. If a lot of milk is left in a breast, the inhibitor stops the cells from secreting any more milk.

This helps protect the breast from the harmful effects of being too full. If the breastmilk is removed, by suckling or by expression, the inhibitor is also removed. Then the breast makes more milk.

Thus for many reasons, the baby's frequent suckling is vital to successful lactation. However, he must also suckle in the right way.

Counseling on Birth Spacing and Family Planning

During *antenatal consultations*, pregnant women should be advised of the importance of birth spacing and family planning after the delivery of their babies.

Counseling women/couples on the importance of FP

- Explain that, after birth, if a woman has sex and is not exclusively breastfeeding, she can become pregnant as soon as 4 weeks after delivery. Therefore it is important to start thinking early on about what family planning method she/the couple will use.
 - Ask the woman/couple about plans for having more children. If she/they want more children, advise that waiting at least 2-3 years between pregnancies is healthier for both mother and child.
 - Exactly when a woman/couple should start using a contraceptive method after delivery will vary depending upon whether the woman is breastfeeding or not.
 - Counsel her for family planning or make arrangements for her to see a FP provider.
- Advise on the correct and consistent use of condoms for dual protection. Promote condoms especially if the woman is at risk for STI or HIV.
- For HIV-positive women:
 - Explain that future pregnancies can have significant health risks for the mother and her baby
 - Advise the woman on the correct and consistent use of condoms
 - Offer/refer for special counseling, including for FP (not all methods are appropriate for HIV-positive women).

Special considerations for FP counseling during pregnancy (third trimester)

- If the woman/couple chooses female sterilization:
 - This can be performed immediately postpartum if there is no sign of infection (ideally within 7 days, or delay for 6 weeks)
 - Plan for delivery in a hospital where the personnel is trained to carry out the procedure
 - Ensure counseling and informed consent prior to labour and delivery.
- If the woman/couple chooses an IUD:
 - IUDs can be inserted immediately postpartum if there is no sign of infection (up to 48 hours, or delay 4 weeks)
 - Plan for delivery in a hospital where the personnel is trained to insert the IUD postpartum.
- If her partner decides to have a vasectomy this can be performed at any time.

During *postpartum visits*, all women should be counseled on family planning so that they can consider their alternatives and make an informed choice. They should be informed of 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 woman

- Can be used immediately after delivery:
 - Lactational amenorrhoea method (LAM)
 - Condoms
 - Spermicides
 - Female sterilization (within 7 days or at least 6 weeks after childbirth)
 - IUD (within 48 hours or at least 4 weeks postpartum)
- At 6 weeks postpartum:
 - Progestogen-only pills
 - Progestogen injectable contraceptives
 - Diaphragm
- At 6 months postpartum:
 - Combined oral contraceptives
 - Fertility awareness methods

Method options for non-breastfeeding woman

- Can be used immediately after delivery:
 - Condoms
 - Progestogen-only pills
 - Progestogen injectable contraceptives
 - Spermicides
 - Female sterilization (within 7 days or at least 6 weeks after childbirth)
 - IUD (within 48 hours or at least 4 weeks postpartum)
- At least 3 weeks postpartum:
 - Combined oral contraceptives
 - Diaphragm
 - Fertility awareness methods

FAMILY PLANNING METHODS FOR POST PARTUM WOMEN

The following table lists the most common Family Planning methods used & available in Romania. The table should provide a quick reference for service providers when counseling women/couples during pregnancy and the post partum period.

| METHOD | ADVANTAGES | DISADVANTAGES | ELIGIBILITY | WHEN TO START | INSTRUCTIONS | RETURN VISIT | COMMENTS |
|---|---|---|---|---|--|---|---|
| LACTATIONAL AMENORRHEA METHOD (LAM) | <ul style="list-style-type: none"> * Effectively prevents pregnancy for 6 months. * Encourage the best breastfeeding patterns. * Ensures that the baby gets needed nutrients and is protected from many diseases. * No direct cost for FP or feeding of the baby. * Convenient * No side effects * Promotes close mother/ child relationship * May reduce risk of breast cancer | <ul style="list-style-type: none"> * Temporary method (effectiveness after 6 months is not certain). * May be difficult or inconvenient for some women to breastfeed frequently (e.g. working women) * No protection from STIs/HIV * May not be advisable for HIV positive women. | <ul style="list-style-type: none"> * All women who: <ul style="list-style-type: none"> -exclusive breastfeed their babies often, both day and night - baby < 6 months old -menses have not returned. Possible exception: those women who are HIV positive. When HIV positive, the risks must be considered against the benefits. | As soon as possible after birth | <ul style="list-style-type: none"> *Breastfeed often: at least 8-10 times a day and once during the night. *Offer no other liquids or food to the baby until 6 months. *Initiate another FP method: <ul style="list-style-type: none"> - at 6 months, even if still breastfeeding. - if menses return - if no longer breastfeeding exclusively a baby < 6months old. | At 6 months after birth, or sooner if menses return or no longer breastfeeding exclusively. | After 6 months of LAM, a woman should be encouraged to continue to breastfeed until the baby is 1 –2 years old. |
| PROGESTIN - ONLY CONTRACEPTIVE PILLS (Exluton) | <ul style="list-style-type: none"> * Very effective during breastfeeding * No effect on milk secretion * May prevent endometrial and ovarian cancer * Safe – serious problems are very rare. | <ul style="list-style-type: none"> * May cause irregular bleeding/spotting, menstrual changes or prolonged amenorrhea after birth. * No protection for STIs/HIV | <ul style="list-style-type: none"> * Immediately after delivery (non-breastfeeding women) * During breastfeeding * Can be used by smokers and by women with other medical conditions | <ul style="list-style-type: none"> * Anytime after 6 weeks post partum if breastfeeding; * Any time in the first 4 weeks post partum if not breastfeeding. * After 4 weeks, any time it is reasonably certain that the | <ul style="list-style-type: none"> * Take 1 pill daily at the same time each day; no breaks between packages of pills. * If taking a pill later than 2 hours or missing pills, use another method in addition during the | <ul style="list-style-type: none"> * Before her supply of pills runs out (every 3months); * Scheduled visit is not necessary. * If woman has problems or concerns with the pills | <ul style="list-style-type: none"> * Although not needed during LAM, will provide extra protection if desired. * Excellent choice for breastfeeding women not relying on LAM. |

| METHOD | ADVANTAGES | DISADVANTAGES | ELIGIBILITY | WHEN TO START | INSTRUCTIONS | RETURN VISIT | COMMENTS |
|---|--|---|--|--|---|---|---|
| | | | except with history of breast cancer, vascular blood clots, or taking medicines for seizures | woman is not pregnant | next 2 days. * Spotting, irregular or lack of menses are possible. | | |
| DMPA INJECTABLE CONTRACEPTIVE (DEPO-PROVERA) | <ul style="list-style-type: none"> *Very effective & safe *Private – others can not tell a woman is using it. * Convenient, easy to use * Helps prevent endometrial cancer | <ul style="list-style-type: none"> * Return of fertility can be delayed few months after stopping use of DMPA. * Changes in menstrual bleeding (spotting, heavy bleeding, lack of menses). * May cause side effects * Does not protect from STI/HIV | <ul style="list-style-type: none"> *Women of any age *Breastfeeding women * Women who smoke * Not to be taken by women with history of heart disease, vascular blood clots, severe diabetes, breast cancer, BP over 160/100. | <ul style="list-style-type: none"> * Any time after 6 weeks post partum if (nearly) fully breastfeeding *Any time within 6 weeks post partum if not breastfeeding * Women who are not breastfeeding anymore may begin DMPA immediately or any other time it is reasonably certain that they are not pregnant. | <ul style="list-style-type: none"> * To be effective, a new injection must be given every 3 months. * If more than 2 weeks late for next injection, avoid sex or use another method until next injection. * Irregular menses or lack of menses are likely during the first months. | <ul style="list-style-type: none"> *Every 3 months. * If woman has problems or concerns. | <ul style="list-style-type: none"> *Although not needed during LAM, will provide extra protection if desired. * Excellent choice for breastfeeding women not relying on LAM *Use disposable syringes & needles if available. |
| LOW DOSE COMBINED ORAL CONTRACEPTIVE PILLS (COC) | <ul style="list-style-type: none"> *Very effective when used correctly. * Lighter menses and fewer cramps * May prevent endometrial and ovarian cancer * Safe – serious problems are rare. | <ul style="list-style-type: none"> * May affect the quality and quantity of milk * Common side effects (nausea, spotting, lack of menses, mild headache) * No protection against STIs/HIV. | <ul style="list-style-type: none"> *Women of any age * Women who smoke if under 35 years * Not to be taken by women with BP 140/90 or higher on 2 readings. * Not to be taken by women with history of heart disease, vascular blood clots, severe diabetes, breast cancer, migraines, current | <ul style="list-style-type: none"> * 3-6 weeks after birth if not breastfeeding. * 6 months postpartum if breastfeeding; *A woman who stopped breastfeeding may begin on any of the first 7 days after menses begins or any other time it is reasonably certain that she is not pregnant. | <ul style="list-style-type: none"> * Take 1 pill at same time each day. * When finishing one packet of 21 pills, wait 7 days before starting the next packet; * When finishing one packet of 28 pills, take the first pill from the next packet on the very next day. * Extra protection may be needed in the following cases (missing pills, | <ul style="list-style-type: none"> *Before her supply of pills runs out (every 3 months) * If woman has problems or concerns with the pills | <ul style="list-style-type: none"> Not recommended for breastfeeding women during the first 6 months after childbirth. |

| METHOD | ADVANTAGES | DISADVANTAGES | ELIGIBILITY | WHEN TO START | INSTRUCTIONS | RETURN VISIT | COMMENTS |
|----------------------------------|---|--|---|---|---|--|--|
| | | | gall bladder disease, taking medicines for seizures, over 35 years and smoke. | | vomiting, diarrhea, taking medicines) * Minor side effects are possible at the beginning of using COC: nausea, mild headache, tender breasts, spotting between periods; usually they become less or stop within 3 months. * Return immediately to clinic if any of the following occur: severe pain in belly, chest or legs; bad headaches; brief loss of vision, seeing flashing lights; brief trouble speaking or moving an arm or leg; jaundice. | | |
| INTRAUTERINE DEVICE (IUD) | *Very effective *Convenient, easy to use, long term method *No hormonal side effects (Cooper IUD) *Improve menstrual bleeding (Progesterone-releasing IUD) | * May cause heavier menses & more cramps * Medical procedure, including pelvic exam, needed to insert IUD * Requires specially trained providers to insert and remove it *Does not protect from STIs/HIV, | *Women of all ages * Not advised for women at high risk for STI * Not for women with unexplained vaginal bleeding until condition has been evaluated and treated * Not for women with history of | * Within 48 hours after childbirth or after 4 weeks post partum *May be inserted any time after 4weeks if it is reasonably sure that the woman is not pregnant and has a healthy uterus. *May be inserted any time during the | * Check for IUD strings after each menses or once a month. * Heavier menses, spotting between menses and more cramps are possible (in the case of Cooper IUD) in the first months after insertion. | * 3 to 6 weeks after insertion (not during a menses). No further scheduled visits required until IUD needs to be replaced (usually several years) * If the strings of the IUD cannot be felt or seem shorter. | * Insert only if certain there is no pregnancy *If a health facility does not have a trained provider, the woman should be referred. *Not a good method for women with recent STIs or at risk of STIs. |

| METHOD | ADVANTAGES | DISADVANTAGES | ELIGIBILITY | WHEN TO START | INSTRUCTIONS | RETURN VISIT | COMMENTS |
|--------------------|---|--|--|--|--|---|---|
| | | <p>may even increase the risk of PID following STIs.</p> <ul style="list-style-type: none"> * May be expelled without woman knowing (more likely if inserted soon after birth) *Needs to be checked by the client, by putting her fingers into vagina | cervical, endometrial or ovarian cancer. | menstrual cycle, although may be easiest and less uncomfortable during menstruation. | | <ul style="list-style-type: none"> * If missed menstrual period and/or abdominal pain, abnormal vaginal bleeding. * If woman has any problems or concerns. *If woman thinks she might have an STI. | <ul style="list-style-type: none"> * Woman should be taught to check for IUD strings * Provide woman with a written record of the type of IUD, date of insertion and date for removal/ re-insertion |
| CONDOMS | <ul style="list-style-type: none"> *Prevents pregnancy and STIs/HIV if used correctly and consistently *Can be used during pregnancy, or during oral or anal sex to prevent STIs. *Can be used with other FP methods *Do not need a health provider to initiate *Enable men to take responsibilities. * No hormonal side effects. | <ul style="list-style-type: none"> * Man's cooperation is needed. *May be hard for women to negotiate male condom use *Occasionally cause irritation from latex or lubricants * May interfere with spontaneous sex *Must be stored in a dark place, away from heat. *May break during use. | Anyone, if not allergic to latex | Prior to every sexual exposure | <ul style="list-style-type: none"> * Do not use with oil lubricants (water based lubricants are fine; many condoms come already lubricated) * Store away from light and heat * Condoms should only be used once and then disposed of. | <ul style="list-style-type: none"> *If condom breaks and might need emergency contraception. * If client has problems or concerns * If need additional supply of condoms | <p>Provide clients with adequate supply of condoms, especially if client unable or unlikely to purchase them away from the health facility (give 36 condoms every 3 months).</p> <p>*Client should be taught through demonstration how to use correctly</p> |
| SPERMICIDES | <ul style="list-style-type: none"> * Woman-controlled method. *Offer contraception just when needed. | <ul style="list-style-type: none"> *May cause irritation to woman or her partner. *May be considered | *All women of any age | *Any time after childbirth | <ul style="list-style-type: none"> * Must be used correctly and consistently each time. * Insert the spermicide | <ul style="list-style-type: none"> *When needing a new supply if unable to purchase *If woman has | *Nonmedical providers may safely offer spermicides to all |

| METHOD | ADVANTAGES | DISADVANTAGES | ELIGIBILITY | WHEN TO START | INSTRUCTIONS | RETURN VISIT | COMMENTS |
|--|---|--|---|---|--|---|--|
| | <ul style="list-style-type: none"> * May help to prevent some STIs, PID, and possibly cervical cancer. *No hormonal side effects, no effect on breastfeeding *No need of a trained provider to initiate * Can be inserted up to 1 hour before sex | “messy” | | | <ul style="list-style-type: none"> deep into vagina before each time you have sexual intercourse (up to 1 hour before intercourse, depending on the type of the spermicide used) * Avoid vaginal douching for at least 6 hours after sex * Store in a cool, dry place | problems or concerns | women. *Woman should be instructed how to use correctly |
| VOLUNTARY SURGICAL STERILIZATION Female sterilization /Tubal ligation | <ul style="list-style-type: none"> * Provides permanent contraception for women who do not want more children *Very effective immediately. | <ul style="list-style-type: none"> *The woman has to be decided before she goes into labor *Possible, but very rarely complication. * Requires specially trained providers. * Reversal surgery is difficult, expensive, and not guaranteed. * No protection against STIs/HIV. | <ul style="list-style-type: none"> * No medical condition prevents a woman from using VSC. Some conditions and circumstances call for delay, referral, or caution with the method. | <ul style="list-style-type: none"> * Minilaparotomy can be performed immediately after a woman gives birth, or within the next 7 days after delivery, during her hospitalization, or any other time after 6 weeks postpartum. * Tubal ligation/section can be performed during the intervention for Caesarian Section | <ul style="list-style-type: none"> *Rest 2-3days after the intervention. *Keep the incision clean and dry. *Take pain-relief medicines if needed. *Do not have sex for at least 1 week. (All these conditions are in place after delivery) | <ul style="list-style-type: none"> *A follow-up visit after 1-2 weeks for removing stitches, if necessary. *If fever, pus or bleeding from the wound, pain, heat, swelling or redness of the wound appears. *If pregnancy is suspected (especially ectopic pregnancy). | Requires special counseling and proper informed consent. |
| VOLUNTARY SURGICAL STERILIZATION Male sterilization /Vasectomy | <ul style="list-style-type: none"> * Provides permanent contraception for men who will not want more children * Very effective | <ul style="list-style-type: none"> * Possible pain and short-term complications. * Not effective immediately. At least 20 ejaculations or 3 months interval | <ul style="list-style-type: none"> * No medical condition prevents a man to use SVC. Some conditions and circumstances call for delay, referral, or caution | <ul style="list-style-type: none"> * Anytime, after special counseling. * Vasectomy can be performed during the pregnancy period in couples who received proper counseling | <ul style="list-style-type: none"> * Rest 2days after the intervention. * Keep the incision clean and dry. * Take pain-relief medicines if needed. * Use condoms or | <ul style="list-style-type: none"> *A follow-up visit within 7 days is recommended, to check for any complications, remove the stitches, if necessary. | Requires special counseling and proper informed consent. |

| METHOD | ADVANTAGES | DISADVANTAGES | ELIGIBILITY | WHEN TO START | INSTRUCTIONS | RETURN VISIT | COMMENTS |
|--------|------------|---|------------------|-------------------------------------|--|---|----------|
| | | is needed. * Requires special trained providers. * Reversal surgery is difficult, expensive, and not guaranteed. * No protection against STIs/HIV. | with the method. | and have decided to use the method. | another contraceptive method for at least the next 20 ejaculations or 3 months after the procedure, whichever comes first. | *The client should return immediately if there is fever, pus or bleeding from the wound; or if pain, heat, swelling or redness of the wound appears. * A man may want to have a semen analysis after vasectomy to check that his vasectomy is working. | |

Counseling on HIV Testing

It is recommended that all pregnant women be tested for HIV. A special trained person should provide the pre- and post HIV test counseling. Primary health care professionals can contribute to the reduction of the incidence of HIV infection by doing the following:

- Provide key information on HIV to all women at their first antenatal visit. Explain how HIV is transmitted and the advantages of knowing the HIV status in pregnancy.
- Explain about voluntary counseling and testing (VCT) services, and benefits of involving and testing the male partner(s).
- Explain the significance of the test result.
- For HIV positive women (see Annex 8b: *Special counseling needs during pregnancy*)
 - provide additional care during pregnancy and postpartum
 - give any particular support that the client may need
 - counsel her regarding ways to prevent mother-to-child transmission
- Counsel all women on correct and consistent use of condoms during and after pregnancy.

Provide key information on HIV

- Explain what HIV is. Emphasize that a person infected with HIV may not feel sick at first, but slowly the immune system is destroyed and the person becomes ill and unable to fight infections. He/she can give the virus to others.
- How HIV can be transmitted:
 - Via exchange of body fluids (semen, vaginal fluid, blood) during unprotected sexual intercourse
 - Via HIV-infected blood transfusions or contaminated instruments and needles
 - Via contaminated cutting instruments or needles (drug abuse, tattoos)
 - From an infected mother to her child during: pregnancy, delivery and postpartum through breastfeeding.
- A special blood test is done to find out if a person is infected with HIV.

Advantage of knowing the HIV status in pregnancy

The woman can:

- Get appropriate medical care and interventions to treat and/or to prevent HIV-associated illnesses
- Reduce the risk of transmission of infection to the baby
 - by taking antiretroviral (ARV) drugs in pregnancy and during labour
 - by adapting infant feeding practices. The mother will need to decide whether to breastfeed or do replacement feeding, taking into account the advantages and disadvantages of each alternative. If the mother decides to breastfeed her baby, she needs to know: how to avoid infection and to take care of her breasts in order to minimize the risk of transmission; or how to express her milk and feed the baby by cup. If she chooses not to breastfeed her baby, she needs special instruction on replacement feeding.
 - by adapting birth plan and delivery practices. It is recommended that an HIV positive woman delivers in a hospital with special equipment and trained staff, and that she

receive an ARV (Nevirapine) at the beginning of labour, in order to reduce the risk of transmission of HIV infection to her baby. The baby will receive a dose of Nevirapine after birth.

- Protect her sexual partner(s) from infection by using condoms
- Make a choice about future pregnancies.

Voluntary counseling and testing (VCT) services

- VCT is used to determine the HIV status of a person
- Testing is voluntary and is based on informed consent (the person has the right to refuse it, after counseling)
- VCT provides an opportunity to learn, and to confront, one's HIV status in a confidential environment
- VCT includes pre-test counseling, blood testing and post-test counseling.

If VCT is available in your setting and you are trained to do VCT, provide it.

If VCT is not available, inform the woman about:

- where to go/the address of VCT center in your area
- how the test is performed
- how confidentiality is maintained
- when and how results are given
- the fact that VCT services are free-of-charge for pregnant women.

Benefits of involving and testing the male partner(s)

In many families and communities men still are the decision-makers. Involving them will:

- have a positive impact on the increasing acceptance of condom use and practice of safer sex to avoid infections or unwanted pregnancy
- help to increase support to their female partners
- help to decrease the risk of suspicion and violence
- encourage the woman to motivate her partner to be tested.

Significance of test result

Usually the woman will have been counseled at the VCT center; she may need further counseling and support from her current doctor. Ask the woman if she is willing to disclose the result. Reassure her on confidentiality and its legal limits.

- If the result is positive, explain that:
 - a positive test means that she is carrying the infection and she has possibility of transmitting the infection to her sexual partner, during sexual intercourse
 - she also has the possibility of transmitting the infection to her unborn child, during pregnancy, delivery and breastfeeding
 - without any intervention the infection is transmitted from HIV positive mothers only to a limited number of babies (5 out of 20 babies born to HIV positive mothers will be infected during pregnancy and delivery and another 3 may be infected during breastfeeding)
 - the initiation of the preventive treatment (ARV) during pregnancy will decrease the risk of the baby becoming infected
- If the result is negative:

- explain to the woman that a negative result can mean either she is not infected with HIV, or that she is infected but has not yet made antibodies against the virus; repeated test can be offered after 3 months
- counsel her on the importance of staying negative
- If the woman does not disclose the result to you (the family doctor):
 - assure her that you keep the result confidential if she were to disclose it
 - reinforce the importance of testing and the benefits of knowing the result.

Counsel on correct and consistent use of condoms

Safer sex = any sexual practice that reduces the risk of transmitting HIV and STIs from one person to another.

- The best protection is obtain by:
 - Correct and consistent use of condoms during every sexual act
 - Choosing sexual activities that do not allow semen, fluid from the vagina, or blood to enter the month, anus or vagina, or to touch the skin of the partner where there is an open cut or sore.
- If the woman is HIV positive:
 - Explain that she can transmit the infection to her partner. They should use a condom during every sexual act
 - Explain the importance of avoiding reinfection during pregnancy and breastfeeding. The risk of infection to the baby is higher if the mother is re-infected
 - If her partner's status is unknown, counsel her on the benefits of testing the partner
- If the woman is HIV-negative or result is unknown:
 - Explain that she is at risk of HIV and that is important to remain negative during pregnancy and breastfeeding. The risk of infecting the bay is higher if the mother is newly infected
 - If her partner's status is unknown, counsel her on the benefits of testing her partner
 - Make sure that she knows how to use condoms and where to get them.

Counseling for Delivery

Many women, especially if it is their first pregnancy, are insufficiently prepared for the important event: the birth of their child. Primary health care professionals can have a very important role in preparing women for childbirth. During antenatal visits, they can counsel clients, provide them easy-to-understand information about labour and the delivery process, and respond to their concerns and fears.

Hospital delivery shall be recommended to all pregnant women

- Explain why birth in a facility is recommended
 - any complication can develop during delivery
 - complications are not always predictable
 - a hospital has staff, equipment, supplies and drugs available to provide the best care if needed

- Discuss with the client how to prepare/Review the arrangements for delivery
 - How she will get to the hospital? Will she have to pay for transport?
 - Will she need to pay for services at the facility? How will she pay?
 - Can she start saving money straight away?
 - Who will go with her for support?
 - Who will help to care for her home and other children while she is away?

- Discuss when to go to the hospital
 - if the woman lives near the facility, she should go at the first signs of labour
 - if she lives far from the facility, she should go 2-3 weeks before the EDB and stay either at the maternity (especially women with high obstetrical risk) or with family or friends near the facility
 - advise her to ask for help from the community, if needed.

- Discuss what to bring
 - her “Pregnancy Book”
 - clean cloths
 - sanitary pads for her and for the baby
 - food and water if she needs to wait near the facility

Advise on labour signs

Advise the woman to go to the facility or contact a helping person if:

- she has a bloody sticky discharge
- she has painful contractions every 20 minutes or less
- her water has broken.

Preventive Measures during Pregnancy

Prevention of anemia

Provide iron and folic acid, starting with 3rd month of pregnancy (latest 24th week) until delivery and during breastfeeding.

- **Iron** supplementation should be offered routinely to all pregnant women, starting with 14-24 weeks of gestation.
 - The necessary dose for prevention of anemia during pregnancy is (30) 60 mg Fe/day. If Hb<11g/dl or Ht<33%, start iron supplementary therapy, even in the first trimester.
 - The therapeutic doses are higher: at least 60-120 mg Fe/day or even more (180 mg Fe/day) and shall be associated with folic acid (1-5 mg/day) and vitamin C for increasing intestinal absorption.
 - Advise the woman on how to take the tablets: with meals or at night, if once daily. Tell her about possible side effects: constipation, nausea, black stools. Explain that these effects are not serious and they will not affect the mother's nor the child's health status.
 - At each visit check to see if the client is taking iron and folate tablets correctly and regularly. Verify that the client has a sufficient supply. Provide more tablets if necessary.
 - Advise the client to store tablets safely: in a dry place, where children cannot get them.
- **Folic acid** supplements are recommended together with iron for prevention of anemia.

The preventive dose is 0.4-1 mg/day and it may be higher (1-5 mg/day) in case of anemia and in case of women at risk of megaloblastic anemia (multipara, short intervals between multiple pregnancies, repeated urinary infections with Esch. Colli, insufficient alimentation).

Prophylaxis for child rickets

During the third trimester pregnant women shall receive supplements of vitamin D, and eventually calcium supplements.

- **Vitamin D**
Give vitamin D2 or D3 per os:
 - 500-1,000 U.I./day (depending on season and individual situation of pregnant woman)
 - OR 4,000-5,000 U.I/week
 - OR 200,000 U.I. per os, single dose (32-36 weeks), in special situations, when daily/weekly administration is not possible

- **Calcium** supplementation (1,000-1,200 mg/day) is necessary only if milk intake and derived products is not possible or insufficient.

Prevention of tetanos

Administrate anti-tetanic vaccine

- If the client has not previously been vaccinated, or is not sure about it, and she is in her first pregnancy, she will receive 1 dose of vaccine (VTA or DT) 0.5 ml, at 34 weeks, + 1 dose at 38 weeks; she will receive 1 revaccination after 6-12 months from first dose, and 2nd revaccination after 5 years with similar dose
- If the client was previous immunized, she will receive a revaccination dose of VTA or DT 0.5 ml at 34 weeks
- If the client is in her 2nd, 3rd pregnancy or more and she was immunized, she needs a new revaccination only if it has been >10 years since her last immunization.

ANTENATAL CARE CHECKLIST

| No | Examination component | First Trim. | Second Trim. | Third Trim. |
|----|---|-------------|--------------|-------------|
| 1 | Prepare for examination | | | |
| 2 | Welcome client | | | |
| 3 | Take client's history | | | |
| | Social history | | | |
| | Medical history: physiologic and pathologic data, obstetric history, family history | | | |
| | Actual pregnancy history | | | |
| 4 | Perform physical examination | | | |
| | <i>General examination</i> – check for signs of: | | | |
| | - anemia | | | |
| | - edema | | | |
| | - varicose veins | | | |
| | Observe general status (physical and psychological) | | | |
| | Heart auscultation, heart rate | | | |
| | Blood Pressure measurement | | | |
| | Roll-over Test | | | |
| | Height | | | |
| | Weight | | | |
| | <i>Obstetrical examination</i> | | | |
| | Breast | | | |
| | - inspection, palpation of breasts | | | |
| | - nipples | | | |
| | Abdomen | | | |
| | - inspection, palpation | | | |
| | - external pelvimetry | | | |
| | - fundal height | | | |
| | - abdominal circumference | | | |
| | - fetal heart auscultation | | | |
| | - active fetal movements | | | |
| | - Leopold maneuvers | | | |
| | Genital examination | | | |
| | External genital area | | | |
| | Pelvic (vaginal) exam | | | |
| | Bimanual examination | | | |
| | Refer for internal pelvimetry (*performed by Ob-Gyn) | | | |
| 5 | Laboratory/paraclinic examinations | | | |
| | <i>Mandatory investigations</i> | | | |
| | Hb, Ht | | | |
| | Blood type and Rh factor | | | |
| | Ac for blood incompatibility | | | |
| | Glycemia | | | |
| | Urine analysis | | | |

| | | | | |
|-----------|---|--|--|--|
| | RBW (VDRL, THPA) | | | |
| | HIV test | | | |
| | <i>Routine investigations</i> | | | |
| | Bacterial exam of vaginal discharge | | | |
| | Pap smear | | | |
| | Ultrasound examination | | | |
| | <i>Supplementary investigations</i> | | | |
| | Stomatologic consultation | | | |
| | Bacterial exam of urine | | | |
| | Hepatitis serology (Ag HBS, Ag HVC) | | | |
| | STI – Chlamydia, Mycoplasma | | | |
| | Toxoplasma, Cytomegalovirus, Rubella | | | |
| | Induced Hyperglycemia | | | |
| | Assessing the 21 trisomy risk (Down syndrome) | | | |
| 6 | Assess maternal-fetal health status and make diagnosis/case classification | | | |
| | Diagnose pregnancy | | | |
| | Evaluate progress of pregnancy | | | |
| | Maternal well-being | | | |
| | Fetal well-being | | | |
| | Case classification | | | |
| 7 | Share assessment and diagnoses with client | | | |
| 8 | Provide care, information and recommendations/advice | | | |
| | Provide information, depend upon client need (see table 2) | | | |
| | Special Counseling | | | |
| | HIV test | | | |
| | Social counseling | | | |
| | In case of accidental exposure to X-rays | | | |
| | Counseling for delivery | | | |
| | Breastfeeding counseling | | | |
| | Preventive measures (see protocol) | | | |
| | Prevent anemia | | | |
| | Calcium supplement | | | |
| | Prophylaxis for child rickets –vitamin D2 or D3 | | | |
| | Anti-tetanic immunization | | | |
| | Treatment or interventions | | | |
| 9 | Plan follow-up care with client | | | |
| 10 | Record data and follow-up plan | | | |

To be always applied/done

To be applied/done if needed

Not recommended/not necessary to be done



**Romanian Family Health
Initiative**

Partnership funded by USAID



POSTNATAL CARE
A ONE-DAY TRAINING CURRICULUM
FOR FAMILY DOCTORS

February 2004

Session 1: Introduction

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

1. Introduce themselves to the group.
2. Describe the role of family doctors in the provision of prenatal care
3. Explain the workshop objectives
4. Name group norms which will help facilitate a productive workshop

Methods: Discussion

Time: 30 min.

Materials:

Flip chart:

- Group norms

Document:

- Workshop goal, objectives & schedule

Flip chart stand and paper

Markers

Masking tape

Name tags

Note pads

Pens

Folders

Instructions

***NB to trainers:** The following guidelines for the introductory session apply to situations in which the trainers and participants are together for the first time for orientation to reproductive health issues. If the group has been together previously for an orientation to prenatal care, trainers may need only to review the workshop objectives and schedule as well as group norms.*

I. Introductions (10 min)

Welcome participants to the workshop. Thank them for responding positively to the workshop invitation.

Introduce the trainers briefly.

Ask participants to look around the room. Ask how many of them already know everyone in the room. (Likely, no one will already know everyone.) Tell them that the group will be together for what is planned to be a positive and productive day for everyone and that they will be learning together and learning from each other. Invite participants to introduce themselves and to display their name tags so that everyone can see them.

[**Note to trainer:** This introductory session helps to “break the ice” within the group, and helps participants to become comfortable with the group.]

II. Role of Family Doctors in Postnatal Care (10 min)

Introduction to the new MOH strategy of involving Family Doctors in providing postnatal care:

- Review briefly with the group the following MCH statistics for Romania:
 - Maternal mortality rate: 34/100,000 (of which 16.8/100,000 was due to abortion and 17.2/100,000 was due to obstetrical complications), compared with a range of 12 (Poland) to 31 (Albania) for surrounding countries (data unavailable for the whole of Eastern Europe, 2002)
 - Infant mortality rate: 18.4/1000, compared with 13 for Eastern Europe (2002)
 - 58% of pregnant women registered in the first trimester of pregnancy (2001)

- Explain that:
 - The MOH is concerned with improving access to high quality reproductive health services for women in an effort to improve their health and that of their children.
 - Two important strategies adopted by the MOH for the improvement of access to high quality reproductive health services are 1) the participation of Family Doctors in the delivery of these services, and 2) the establishment of standards and protocols for the delivery of these services by Family Doctors.
 - Standards and protocols for postnatal care have been developed by the MOH
 - The purpose of this workshop is to share with participants (Family Doctors) 1) the role they are anticipated to play in the provision of postnatal services, and 2) the standards and protocols that are to guide the delivery of these services by family doctors.

III. Workshop Objectives & Schedule (5 min)

Distribute the handout *Workshop Goal, Objectives and Schedule* and review it with the group. Explain that the day’s program is designed to:

- Review with participants the new postnatal care standards and protocols, and
- Discuss/clarify anything in either document that is not clear to participants, in order to facilitate 1) their understanding of, and respect for, the standards and protocols, and 2) their competent delivery of postnatal services.

Encourage participants to ask questions, and to share ideas/knowledge, as appropriate to facilitate their learning.

IV. Group Norms & Logistics (5 minutes)

Explain that group norms are important to creating a positive learning environment. Everyone's understanding of, and agreement to, group norms helps to facilitate participation and learning.

Post the flip chart *Group norms*. Ask participants to read the list and to indicate their commitment to respecting these norms in order to facilitate everyone's participation and learning.

Indicate the location of toilets/washrooms.

Handout

WORKSHOP GOAL

To orient Family Doctors to Ministry of Health standards and protocols governing the delivery of postnatal consultations.

WORKSHOP OBJECTIVES

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

1. Describe normal and abnormal anatomical and physiological changes in women at different stages of the postpartum period (6 weeks).
2. Describe essential content of women' health history in the context of postnatal consultations.
3. Describe essential components of postnatal physical examinations of women, to include:
 - General examination
 - OB examination
4. Explain how to make a diagnosis/case classification of maternal health status during the postpartum period (6 weeks).
5. Explain essential care, information, education and counseling for women during the postpartum period (6 weeks).
6. Describe essential content of a newborn's/infant's health history
7. Describe essential components of physical examinations of newborns/infants.
8. Explain how to make a diagnosis/case classification of the health status of newborns/infants.
9. Explain essential information, education and counseling for the mother/family regarding the care of newborns/infants,
10. Explain the new MOH system for documenting postpartum care and follow-up of mothers and infants.

WORKSHOP SCHEDULE

| | | |
|-------|--------------|--|
| 9h00 | Session 1: | Welcome and introductions (if group has not already met) |
| 9h30 | Session 2: | Normal Postpartum Changes |
| 9h45 | Session 3: | Health History (mother) |
| 10h15 | Coffee break | |
| 10h30 | Session 4: | Physical Examination (mother) |
| 11h15 | Session 5: | Diagnosis/Case Classification (mother) |
| 11h45 | Session 6: | Information and Education (mother) |
| 12h45 | Lunch | |
| 13h30 | Session 7: | Health History (infant) |
| 14h00 | Session 8: | Physical Examination (infant) |
| 14h30 | Session 9: | Diagnosis/Case Classification (infant) |
| 14h45 | Session 10 | Information and Education (infant) |
| 15h45 | Coffee break | |
| 16h00 | Session 11: | Record Management |
| 16h15 | Session 12: | Case studies |
| 17h30 | End of day | |

Flipchart

NORMS THAT FACILITATES A PRODUCTIVE WORKSHOP

- Respect the workshop schedule
- Respect and encourage everyone's participation
- Listen to others; do not interrupt
- Respect confidentiality of what others share
- Everyone is responsible for their own learning
- No smoking in the training room
- No mobile phone conversations in training room
- Everyone stick to the subject

Session 2: Normal Changes in the Postpartum Period

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

1. Describe normal changes in the reproductive organs during the postpartum period.
2. Describe normal changes in the breast during lactation

Methods: Discussion

Time: 15 minutes

Materials:

- *Physiological Changes During the Postpartum Period*

Instructions

I-II. Normal Changes in the Reproductive Organs During the Postpartum Period (15 minutes)

Introduce the session by suggesting that a review of normal changes, and discomforts and potential problems, in the reproductive organs during the postpartum period will help orient discussions of the rationale, and procedures, for conducting postnatal consultations.

Distribute the document *Physiological Changes During the Postpartum Period* and ask volunteers to read it. Allow for questions and comments.

Session 3: Postpartum Health History (Mother)

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

1. Name 7 essential components postnatal consultations for women
2. Explain the significance of each of the components of a woman's obstetrical history in the context of the first postnatal consultation
3. Explain the relevance of each of the components of a postpartum history to the monitoring of a mother's health.

Methods: Discussion

Time: 30 minutes

Materials:

Documents:

- Standards for Postnatal Care
- Postnatal Care (Mother): Protocol for Family Doctors
- Checklist for Conducting Postnatal Consultations (mother)

Instructions

I. Components of Postnatal Consultations (mother) (10 minutes)

Distribute the document *Standards for Postnatal Care*. Ask volunteers to read the standards aloud to the group. Ask participants if they have any questions or comments regarding the standards. Respond to questions as appropriate.

Distribute the documents *Postnatal Care (mother): Protocol for Family Doctors* and *Checklist for Conducting Postnatal Consultations (mother)*. Explain that the remainder of the morning will focus on a review of the components of postnatal consultations for mothers.

II. Obstetrical History (10 minutes)

Review briefly with the group the first two components of the *Postnatal Care (mother): Protocol for Family Doctors* (Preparation for examination and Welcome client). Emphasize the importance of these two components to the establishment of positive rapport with the client.

Review with the group the items under Obstetrical History, asking volunteers to comment on the relevance of the different items.

III. Postpartum History (10 minutes)

Review with the group the components of a postpartum history, emphasizing what the Family Doctor should look for and how he/she would use various findings.

Session 4: Postpartum Physical Examination (Mother)

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

1. Explain 3 principles to respect in the conduct of a postnatal physical examination.
2. Name 6 elements of a general physical examination in the context of a postnatal consultation, and when each of them should be done
3. Name at least 3 measurements to do during the postnatal examination
4. Explain what to look for when conducting a breast examination during the postpartum period
5. Explain what to look for when examining the abdomen and extremities during the postpartum period
6. Explain what to look for in:
 - Examining the external genitalia
 - Conducting a speculum examination
 - Conducting a bi-manual examination

Methods: Document review, discussion

Time: 45 minutes

Materials:

Documents:

- Postnatal Care (Mother): Protocol for Family Doctors
- Checklist for Conducting Postnatal Visits

Instructions

1. Principles of conducting postnatal examinations (2 minutes)

Review with the group the general principles for performing physical examinations, and ask them the purpose for respecting these principles.

- Observation of the client often gives clues about her physical as well as her mental health
- Explaining procedures and asking questions both educates the client about her health and encourages her to share concerns and to ask questions.

II-V. General Physical Examination & Obstetrical Examination (38 min)

Review with the group the document *Postnatal Care (Mother): Protocol for Family Doctors*, section 4, *Perform Physical Examination*. For each examination and/or measurement, discuss 1) when the examination should be done, 2) “normal ranges” for findings, and 3) criteria under which the Family Doctor should refer the client to an OB-GYN specialist.

VI. Examination of External Genitalia; and Pelvic Examinations: Speculum & Bimanual (15 min)

Review each examination, as per the protocol, emphasizing 1) how to do it, and 2) what to look for.

Session 5: Diagnosis/Case Classification (Mother)

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

1. Explain how to assess the progress of uterine involution
2. Explain how to evaluate historical and physical findings in postnatal clients for the presence or absence of problems.

Methods: Discussion

Time: 30 minutes

Materials:

Documents:

- Postnatal Care (Mother): Protocol for Family Doctors
- Checklist for Conducting Postnatal Visits

Instructions

Assessment of progress of involution (10 minutes)

Using the documents *Postnatal Care (Mother): Protocol for Family Doctors*, review with the group the process for assessing progress of uterine involution.

Evaluation of historical and physical findings (20 minutes)

Refer to the discussion in Session 2 of normal changes in a mother after delivery (including uterine involution, lactation and vaginal discharge).

Discuss with the group the procedure for making a diagnosis/case classification based on a woman's obstetrical and postpartum history and her physical findings.

Review with the group postpartum problems that should be referred to an Ob-Gyn and/or to a hospital.

Session 6: Information & Education (Mother)

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

1. Explain principles that apply to sharing assessments and diagnoses with clients.
2. Describe information useful to clients in each of the following areas:
 - Normal uterine involution
 - Normal emotional response to birth
 - Changes in family relationships
 - Getting enough sleep and rest
 - Special postpartum exercises to strengthen abdominal muscles
 - Personal hygiene and perineal care
 - Initiation of lactation; breastfeeding; and breast care
 - Benefits of breastfeeding
 - Breastfeeding techniques and positions
 - Importance of feeding baby colostrum (for baby's health and for uterine involution)
 - Common problems with breastfeeding (difficulties with let-down reflex, perceived low milk supply, plugged ducts, inverted/flat nipples) and appropriate treatment and care
 - Nutritional needs of breastfeeding mothers and how to meet these needs
 - Expression of breast milk
 - Use of drugs during lactation
 - Self breast examination (Teach client to do own examination)
 - Sexuality:
 - Resumption of intercourse
 - Return to fertility and menses in breastfeeding and non-breastfeeding women
 - Protection from pregnancy and STIs
 - Appropriate family planning methods. Provide contraceptive method of choice, as appropriate.
 - Common discomforts and how to cope with them (perineal pain, breast engorgement, constipation, hemorrhoids and varicose veins)
 - Signs of complications (chills and fever; severe headache; visual changes; severe abdominal pain; constant or increasing vaginal bleeding; clots or passing of tissue; foul-smelling vaginal discharge; severe perineal pain or pressure; infrequent, scanty or painful urination; severe pain with hard lump in breast; severe lower leg pain)
 - Client instructions for iron and folate supplementation (provide supplements)
 - Tetanus toxoid immunization schedule. (Give vaccine according to schedule.)
 - Prophylactic measures in case of Rh incompatibility.
 - Sequence and importance of routine postnatal care
3. Explain the management, and referral process, for further evaluation of care of women with abnormalities and complications
4. Explain types of family planning services appropriate following delivery, and timing considerations for each.

Methods: Document review, discussion

Time: 60 minutes

Materials:

Documents:

- Postnatal Care Visit: Protocol for Family Doctors
- Checklist for Conducting Postnatal Visits
- Postnatal Education and Follow-up (mothers)
- Breastfeeding

Instructions

I. Sharing Assessments and Diagnoses With Clients (5 minutes)

Discuss with the group principles for sharing assessments and diagnoses with clients, including:

- Looking at the client
- Speaking to the client in a calm, quiet and reassuring manner
- Using terminology that the client can easily understand
- Asking the client about any symptoms she may have that relate to an identified abnormality or problem
- Asking what the client already knows about the identified abnormality or problem (in order to 1) build upon what she already knows, and 2) be able to respond to any misinformation that she might have)
- Asking what more the client would like to know
- Providing sufficient information to enable the client to understand her situation, the recommended course of action and what to expect
- Encouraging the client to share her reactions to the diagnosis and information provided (probing gently as needed)
- Listening and expressing understanding and acceptance of clients' feelings about her situation

II. Information Useful to Postpartum Clients (50 minutes)

Distribute the documents *Postnatal Education and Follow-up (mothers)* and *Breastfeeding*. Review with the group the information and recommendations. Encourage questions and discussion in order to clarify points as needed.

III. Management and Referral for Problems (5 minutes)

Describe the management, and referral process, for further evaluation of care of women with abnormalities and complications within the district.

IV. Family Planning Services

Distribute the handout with FP methods suitable for women in postpartum period (breastfeeding and non-breastfeeding women).

Session 7: Health History (Infant)

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

1. Name at least 6 essential components of a newborn health history in the context of a first postnatal consultation.
2. Name components of a general physical examination of a newborn/infant.

Methods: Discussion

Time: 30 minutes

Materials:

Documents:

- Postnatal Care (Infant): Protocol for Family Doctors
- Checklist for Conducting Postnatal Visits (newborn)

Instructions

I. Components of Infant Postnatal Consultation (5 minutes)

Distribute the documents *Postnatal Care (Infant): Protocol for Family Doctors* and *Checklist for Conducting Postnatal Visits (newborn)*. Review the components of the protocol for postnatal infant care.

II-III. Components of Newborn Health History (25 minutes)

Review with the group items under Obstetrical History and Postpartum History (for both newborns and follow-up weekly visits), asking for volunteers to comment on the relevance of the various items to the monitoring of infant health status.

Session 8: Physical Examination (Infant)

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

1. Explain 4 principles to respect in the conduct of a newborn's/infant's physical examination.
2. Explain the purpose, and normal range, of essential measurements taken during a newborn's/infant's examination.
3. Explain the purpose of, and procedure for conducting, each of the components of a general physical examination of a newborn/infant.

Methods: Discussion

Time: 30 minutes

Materials:

Documents:

- Postnatal Care (infant): Protocol for Family Doctors
- Checklist for Conducting Postnatal Visits

Instructions

I. Principles of Conducting Newborn Examinations (5 minutes)

Review with the group the general principles for conducting physical examinations of infants, asking volunteers the relevance of each principle to the monitoring of the infant's health.

II. Essential Measurements and Vital Signs (5 minutes)

Review with the group the essential measurements and vital signs to be taken during a postnatal consultation for an infant, including the "normal" range of measurements in all cases. Emphasize the significance of measurements above, and below, the normal range.

III. Physical Examination of a Newborn/Infant (20 minutes)

Review with the group the remaining components of section 4 of *Postnatal Care (infant): Protocol for Family Doctors*. For each aspect of the physical examination, discuss 1) the purpose of the particular exam, 2) procedure for conducting the exam, and 3) "normal" findings. Encourage questions and comment in order to clarify all points.

Session 9: Diagnosis/Case Classification (Infant)

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

1. Explain how to assess an infant's gestational age and growth based on health history and physical examination
2. Explain how to evaluate historical and physical findings in newborns for presence or absence of problems and risk factors

Methods: Discussion

Time: 15 minutes

Materials:

Documents:

- Postnatal Care (Infant): Protocol for Family Doctors
- Checklist for Conducting Postnatal Visits (infant)

Instructions

I. Assessment of Gestational Age and Growth (7 minutes)

Review with the group the essential signs of neuromuscular and physical maturity. Discuss elements of the health history and physical examination that are used to help determine an infant's gestational age and growth.

II. Evaluation of Findings for Presence or Absence of Problems and Risk Factors (8 minutes)

Review with the group elements of a health history and physical examination used for assessing the presence or absence of problems and risk factors. Discuss the procedure for making a diagnosis/case classification based on the evaluation of findings.

Session 10: Information & Education (Infant)

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

5. Explain principles that apply to sharing assessments and diagnoses with mothers of infants.
6. Describe information useful to mothers in each of the following areas:
 - Normal behavior and physical changes in the newborn (e.g. sleep and wake patterns, bowel and bladder patterns, growth)
 - Nutritional needs of the newborn, how to meet these, including assistance with breastfeeding, if indicated
 - Importance of maintaining baby's body temperature
 - Signs of potentially serious problems:
 - Not feeding as well as usual
 - Sleeps most of the time
 - Vomits or spits up a lot
 - Watery, dark green stools
 - Skin feels hot or cold
 - Breathes too fast (>60 breaths per minute) or with difficulty
 - Skin and eyes are yellow
 - a. Care of newborn's umbilical cord
 - b. Benefits of continued breastfeeding for baby
 - c. Sequence and importance of routine follow-up visits for baby
7. Describe the following preventive health measures:
 - a. Immunizations: importance and schedules (DTP, Hepatitis B, Polio)
8. Explain the management, and referral process, for further evaluation or care of babies with abnormalities and complications

Methods: Discussion

Time: 60 minutes

Materials:

Documents:

- Postnatal Care (Infant): Protocol for Family Doctors
- Checklist for Conducting Postnatal Visits
- Postnatal Education and Follow-up (Infant)

Instructions

I. Principles of Sharing Findings With Clients (5 minutes)

Refer the group to the principles discussed earlier for sharing assessments and diagnoses with clients:

- Look at the client
- Speak to the client in a calm, quiet and reassuring manner
- Use terminology that the client can easily understand

- Ask the client about any symptoms she may have that relate to an identified abnormality or problem
- Ask what the client already knows about the identified abnormality or problem (in order to 1) build upon what she already knows, and 2) be able to respond to any misinformation that she might have)
- Ask what more the client would like to know
- Provide sufficient information to enable the client to understand her situation, the recommended course of action and what to expect
- Encourage the client to share her reactions to the diagnosis and information provided (probing gently as needed)
- Listen and express understanding and acceptance of clients' feelings about her situation

III. Information Useful to Mothers about Their Newborns/Infants (40 minutes)

Distribute the document *Postnatal Education and Follow-up (infants)*. Review with the group the information and recommendations. Encourage questions and discussion in order to clarify points as needed.

IV. Preventive Measures (10 minutes)

Review the following preventive measures:

- a. Ophthalmia neonatorum
 - i. organisms responsible for ophthalmia neonatorum (conjunctivitis)
 - ii. how the infection is transmitted
 - iii. consequences of non-treatment
 - iv. prophylactic treatment of the infection
- b. Care of newborn's umbilical cord
- c. Immunizations

IV. Management and Referral for Problems (5 minutes)

Describe the management, and referral process, for further evaluation of care of infants with abnormalities and complications within the district.

Session 11: Record management

Objectives: By the end of the session, participants will be able to:

1. Explain how to record all assessments, diagnoses, findings, care and information provided and follow-up plan in clients' medical files.
2. Organize client records to facilitate access for future consultations.

Methods: Discussion

Time: 15 minutes

Materials:

Documents:

- Postnatal Care Visit: Protocol for Family Doctors
- Checklist for Conducting Postnatal Visits

Instructions

I. Recording of Essential Information (10 minutes)

Review with the group information necessary to record in the infant's file in order to provide continuity of care to the individual.

II. Organization of Charts (5 minutes)

Discuss with the group mechanisms for the efficient organization of client files (in order to facilitate access to them in a timely manner).

Session 12: Case Studies

Objectives: By the end of the session, participants will be able to:

1. Apply knowledge they have gained from the workshop to the analysis of a range of postpartum cases.
2. Recommend appropriate actions based on the analysis of their cases.

Method: Case study

Time: 75 minutes

Materials:

Handouts:

- Case studies (4-5), representing a variety of postpartum-related problems likely to confront family doctors

Instructions

I-II. Analysis of, and Recommendations Regarding, Postpartum Cases (75 min)

Divide the group into small groups of 5 participants per group. Distribute copies of a single case study to all groups. Give the groups 10 minutes to analyze their cases and decide the course of action they would take (according to the questions posed in the case study).

Ask the small groups to rejoin the large group. Lead a discussion of the groups' analyses of the case and their recommended actions (10-15 minutes)

Repeat the above small and large group analysis and discussion with additional cases as time permits.

POSTNATAL CARE VISIT

Mother care

| No | Examination component | 24 hr 1 st wk | 3 rd week | 6 th week |
|----------|--|-----------------------------|-------------------------|-------------------------|
| 1 | Prepare for examination | | | |
| | <ul style="list-style-type: none"> • Ensure availability of and arrange equipment (see Annex for necessary equipment for postnatal consultations) | | | |
| | <ul style="list-style-type: none"> • Review previous medical record | | | |
| | <ul style="list-style-type: none"> • Wash hands with soap and water, dry with clean cloth or air dry | | | |
| 2 | Welcome client | | | |
| | <ul style="list-style-type: none"> • Greet client & introduce yourself (if not already known to client) | | | |
| | <ul style="list-style-type: none"> • Offer a seat to client and ensure privacy • If woman is escorted by her partner, invite him to discussion, after receiving woman's consent | | | |
| | <ul style="list-style-type: none"> • Explain purpose and procedures of visit | | | |
| 3 | Obtain postpartum history | | | |
| | <i>Obstetrical and medical history</i> | | | |
| | <ul style="list-style-type: none"> • Date of birth • Duration of labor and birth • Type of birth (spontaneous or cesarean) • Episiotomy | | | |
| | <ul style="list-style-type: none"> • Problems during pregnancy, labor, birth and immediate postpartum: <ul style="list-style-type: none"> ○ Prolonged rupture of membranes ○ Prolonged or obstructed labor ○ High blood pressure ○ Seizures or convulsions ○ Excessive bleeding/hemorrhage ○ Severe infection (chills and fever) ○ Other serious health conditions | | | |
| | <i>Postpartum history</i> | | | |
| | <ul style="list-style-type: none"> • General well-being; <ul style="list-style-type: none"> ○ Emotional state (client's perception of: labor and birth experience; baby's well-being; ability to care for baby; adjustment of family to baby, to one another) ○ Rest and sleep patterns ○ Activity level (frequency, duration and ease of walking) ○ Appetite and fluid intake; diet history (24-hour recall) ○ Bladder and bowel function (frequency, amount and ease) | | | |
| | <ul style="list-style-type: none"> • Breastfeeding (frequency, duration per session; discomfort or problems; perceived satisfaction of self and baby; care of breasts; if stopped, why) | | | |
| | <ul style="list-style-type: none"> • Signs of involution <ul style="list-style-type: none"> ○ Uterus (position, firmness) ○ Lochia (duration, sequence of color, amount, consistency) ○ Resumption of menses (date, duration, amount) | | | |
| | <ul style="list-style-type: none"> • Sexual intercourse <ul style="list-style-type: none"> ○ When resumed and frequency ○ Level of physical and emotional comfort | | | |
| | <ul style="list-style-type: none"> • Contraception <ul style="list-style-type: none"> ○ Use of contraception (if not, why) ○ Method used or desired ○ Satisfaction with method, if using ○ Need for STI protection | | | |

| | | | | |
|----------|---|--|--|--|
| | <ul style="list-style-type: none"> • Other problems since birth: <ul style="list-style-type: none"> ○ Excessive fatigue ○ Severe breast tenderness, engorgement, cracked or bleeding nipples ○ Continued perineal pain ○ Fever and chills ○ Lower abdominal pain, severe cramping ○ Foul-smelling vaginal discharge ○ Excessive vaginal bleeding or clots ○ Pain or burning on urination ○ Urinary incontinence ○ Constipation ○ Hemorrhoids ○ Pain, redness or tenderness of lower legs ○ Other | | | |
| 4 | Perform physical examination | | | |
| | <i>In general:</i> | | | |
| | <ul style="list-style-type: none"> • Observe client’s level of energy, emotional tone and posture throughout exam • Explain all procedures in simple terms while performing them • Ask questions of clarification about client’s health, as appropriate, while conducting examination | | | |
| | <i>Laboratory tests and vital signs</i> | | | |
| | <ul style="list-style-type: none"> • Measure weight • Measure BP and heart rate | | | |
| | <i>Breast examination</i> | | | |
| | <ul style="list-style-type: none"> • Ask client to undress, and offer her a drape for privacy • With client’s arms by her side, inspect breasts for: <ul style="list-style-type: none"> ○ Size, shape and symmetry ○ Secretion of milk ○ Color, consistency, amount of other discharge from nipples ○ Cracking or blistering of the nipples ○ Presence or absence of engorgement (enlarged, shiny, reddened, dilated veins) ○ Presence or absence of abscess • With client lying down and raising left, then right, arm over her head, palpate breasts and axilla noting: <ul style="list-style-type: none"> ○ Masses ○ Filling with milk (degree of firmness of breast) ○ Presence or absence of engorgement (breasts warm and hard) ○ Presence or absence of abscess ○ Enlarged lymph nodes | | | |
| | <i>Abdomen</i> | | | |
| | <ul style="list-style-type: none"> • Ask client to lie on back; inspect abdomen for: <ul style="list-style-type: none"> ○ Healing of Cesarean scar, if present: <ul style="list-style-type: none"> ▪ Presence or absence of wound separation ▪ Presence or absence of pus ○ Contour <ul style="list-style-type: none"> ▪ Presence or absence of bladder distension ▪ Presence or absence of uterine displacement • Palpate all four quadrants of abdomen for: <ul style="list-style-type: none"> ○ Presence or absence of uterus above pubis ○ Presence or absence of bladder above pubis ○ Masses ○ Tenderness | | | |

| | | | |
|--|--|--|--|
| <ul style="list-style-type: none"> • Palpate uterus for: <ul style="list-style-type: none"> ○ Size ○ Location (in relation to mid-line and umbilicus) ○ Consistency (firmness) ○ Tenderness (observe client’s face) | | | |
| <i>Extremities</i> | | | |
| <ul style="list-style-type: none"> • Inspect legs: <ul style="list-style-type: none"> ○ Entire leg for varicose veins ○ Lower leg for areas of redness ○ Low leg, ankles and feet for edema | | | |
| <ul style="list-style-type: none"> • Palpate legs for tenderness or heat | | | |
| <ul style="list-style-type: none"> • Dorsiflex each foot to check for presence or absence of lower leg pain | | | |
| <ul style="list-style-type: none"> • Test patellar reflex (deep tendon) for hyper- or hypo-activity | | | |
| <i>Pelvic: external genitalia</i> | | | |
| <ul style="list-style-type: none"> • Assist client into position for examination and drape for privacy | | | |
| <ul style="list-style-type: none"> • Put on gloves without contaminating them | | | |
| <ul style="list-style-type: none"> • Inspect perineum for: <ul style="list-style-type: none"> ○ Trauma ○ Healing of episiotomy ○ Scarring from laceration or episiotomy ○ Varicose veins (of vulva and anus) | | | |
| <ul style="list-style-type: none"> • Gently separate labia majora and inspect labia minora then clitoris, urethral opening and vaginal opening for: <ul style="list-style-type: none"> ○ Color ○ Redness or irritation ○ Ulcers or lesions ○ Growths ○ Fissures or fistulae ○ Adhesions ○ Vaginal discharge: <ul style="list-style-type: none"> ▪ Color ▪ Amount ▪ Consistency (presence or absence of clots or tissue fragments) | | | |
| <ul style="list-style-type: none"> • Milk urethra and Skene’s ducts to exclude pus or blood discharge | | | |
| <ul style="list-style-type: none"> • Palpate Bartholin’s glands for <ul style="list-style-type: none"> ○ Swelling ○ Masses or cysts | | | |
| <i>Pelvic: speculum examination</i> | | | |
| <ul style="list-style-type: none"> • Select correct size speculum for client | | | |
| <ul style="list-style-type: none"> • Explain procedure to client <ul style="list-style-type: none"> ○ Show speculum to client and explain how it will be used and will feel ○ Explain to client how to relax during insertion of speculum and examination ○ Encourage client to indicate if procedure too uncomfortable | | | |
| <ul style="list-style-type: none"> • Insert speculum <ul style="list-style-type: none"> ○ Lubricate speculum with water or lubricating jelly ○ Hold speculum obliquely, part labia with other hand, and insert speculum gently, avoiding urethra and clitoris ○ Turn speculum and open blades to expose cervix | | | |

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| | <ul style="list-style-type: none"> • Inspect cervix for: <ul style="list-style-type: none"> ○ Color ○ Size, shape and position ○ Dilatation of os ○ Ectopy ○ Redness or inflammation ○ Bleeding ○ Lesions, erosion or ulcers ○ Growths or masses ○ Polyps or cysts ○ Discharge (color, consistency, amount) | | | |
| | <ul style="list-style-type: none"> • Obtain specimens if necessary | | | |
| | <ul style="list-style-type: none"> • Inspect vaginal walls/floor for: <ul style="list-style-type: none"> ○ Color ○ Redness or inflammation ○ Bleeding ○ Lesions and ulcers ○ Growths or masses ○ Scarring (from episiotomy) ○ Discharge (color, consistency, amount) | | | |
| | <ul style="list-style-type: none"> • Close and remove speculum gently in oblique position | | | |
| | <ul style="list-style-type: none"> • Put used speculum in designated container for decontamination | | | |
| | <i>Pelvic: bimanual examination</i> | | | |
| | <ul style="list-style-type: none"> • Explain examination to client and encourage her to indicate if procedure uncomfortable | | | |
| | <ul style="list-style-type: none"> • Insert two fingers into vagina, spread them and exert downward pressure. Ask client to cough gently, and observe for: involuntary loss of urine, cystocele, rectocele | | | |
| | <ul style="list-style-type: none"> • Draw two fingers together, ask client to tighten vaginal muscles, and check for muscle tone | | | |
| | <ul style="list-style-type: none"> • Sweep vaginal walls with two fingers and feel for growths and masses | | | |
| | <ul style="list-style-type: none"> • Locate cervix and feel for: <ul style="list-style-type: none"> ○ Size, shape and position ○ Consistency ○ Dilatation of os ○ Regularity of os ○ Mobility ○ Tenderness (observe client's face) | | | |
| | <ul style="list-style-type: none"> • Use both hands to palpate uterus for: <ul style="list-style-type: none"> ○ Size, shape and consistency ○ Smoothness ○ Mobility ○ Tenderness (observe client's face) | | | |
| | <ul style="list-style-type: none"> • Use both hands to palpate adnexa for: <ul style="list-style-type: none"> ○ Size and shape ○ Masses ○ Tenderness (observe client's face) | | | |
| | <ul style="list-style-type: none"> • Remove fingers smoothly, remove gloves and dispose of them in designated decontamination solution | | | |
| | <ul style="list-style-type: none"> • Ask client to get up and to get dressed | | | |
| | <ul style="list-style-type: none"> • Wash hands with soap and water and air dry or dry them with a clean cloth | | | |
| 5 | Assess progress of involution and maternal health status, and make diagnosis | | | |

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|----------|---|--|--|--|
| | <ul style="list-style-type: none"> • Progress of involution <ul style="list-style-type: none"> ○ Compare uterine location, size and consistency; and vaginal discharge color, amount and consistency with expected characteristics for number of days postpartum ○ Decide if there is consistency between actual findings and expected characteristics ○ Decide if involution is normal based on above evaluation, and if not, appropriately manage or refer for further evaluation | | | |
| | <ul style="list-style-type: none"> • Maternal well-being <ul style="list-style-type: none"> ○ Evaluate historical and physical findings for presence or absence of problems: <ul style="list-style-type: none"> ▪ Psycho-emotional response to postpartum ▪ Common discomforts ▪ Life-threatening complications; if any, manage immediately ▪ Risk factors ○ Decide if maternal health status is normal based on above evaluations, and if not, consult or refer for further evaluation | | | |
| 6 | Share assessment and diagnoses with client | | | |
| | <ul style="list-style-type: none"> • Inform client, in reassuring manner, of the assessments and diagnoses, including: <ul style="list-style-type: none"> ○ Progress of involution ○ Her health status • If any abnormalities are discovered: <ul style="list-style-type: none"> ○ Ask client if she is aware of these ○ Explain possible causes ○ Inform client about next steps in addressing identified abnormalities • Encourage client to share reactions to information provided, gently probing as necessary | | | |
| 7 | Provide care, information and recommendations/advice | | | |
| | <ul style="list-style-type: none"> • Provide information (see annex for details) about the following: <ul style="list-style-type: none"> ○ Normal postpartum involution ○ Normal emotional response to birth ○ Changes in family relationships ○ Getting enough sleep and rest ○ Special postpartum exercises to strengthen abdominal muscles ○ Nutritional needs for breastfeeding and how to meet these needs ○ Personal hygiene and perinatal care | | | |
| | <ul style="list-style-type: none"> ○ Initiation of lactation, breastfeeding and breast care <ul style="list-style-type: none"> ▪ Importance of breastfeeding baby (both for baby’s health and for uterine involution) ▪ Breastfeeding techniques and positions ▪ Treatment/care of common problems/ how to cope, as indicated (difficulties with let-down reflex, perceived low milk supply, plugged ducts, inverted/flat nipples) ▪ Expression of breast milk ▪ Use of drugs during lactation ▪ Self breast examination (Teach client to do own examination) | | | |
| | <ul style="list-style-type: none"> ○ Sexuality: <ul style="list-style-type: none"> ▪ Resumption of intercourse ▪ Return to fertility and menses in breastfeeding and non-breastfeeding women ▪ Protection from pregnancy and STIs ▪ Appropriate family planning methods. Provide contraceptive method of choice, as appropriate. | | | |

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| | <ul style="list-style-type: none"> ○ Common discomforts and how to cope with them (perineal pain, breast engorgement, constipation, hemorrhoids and varicose veins) | | | |
| | <ul style="list-style-type: none"> ○ Signs of complications (chills and fever; severe headache; visual changes; severe abdominal pain; constant or increasing vaginal bleeding; clots or passing of tissue; foul-smelling vaginal discharge; severe perineal pain or pressure; infrequent, scanty or painful urination; severe pain with hard lump in breast; severe lower leg pain) | | | |
| | <ul style="list-style-type: none"> ○ Continued iron and folate supplements (provide supplements) | | | |
| | <ul style="list-style-type: none"> ○ Importance of follow-up visits | | | |
| | <ul style="list-style-type: none"> ● Offer client reassurance and encouragement | | | |
| | <ul style="list-style-type: none"> ● Answer client questions | | | |
| | <ul style="list-style-type: none"> ● Treat or refer other problems as necessary and appropriate. | | | |
| 8 | Plan follow-up care with client | | | |
| | <ul style="list-style-type: none"> ● Discuss with client instructions related to preventive measures and treatments, if any ● Ask client to repeat instructions, if any ● Encourage client to ask questions ● Describe timing and importance of follow-up visits, and time/date of next visit ● Schedule next visit and give client time/date of visit ● Advise client to contact clinic for questions or concerns as needed ● Encourage client to include partner in postpartum visits if desired | | | |
| 9 | Record findings, assessments, diagnoses, care provided and follow-up plan | | | |
| | <ul style="list-style-type: none"> ● Record all findings, assessments, diagnosis, care provided, and plans for follow-up on “Annex” and client’s “Pregnancy Book” postpartum record. ● Give client her “Pregnancy Book” with postpartum record with follow-up date recorded in it ● File client’s record | | | |

To be applied/done always

To be applied/done if needed

Not necessary to be done

POSTNATAL CARE
Infant care

| No | Examination component | 24 hr | 2 nd w k | 3 | 4 | 5 | 6 |
|----------|--|-------|---------------------|---|---|---|---|
| 1 | Prepare for health history and physical examination | | | | | | |
| | <ul style="list-style-type: none"> Ensure availability of technical conditions/equipment for necessary equipment for postnatal consultations: adequate light, examination table, stethoscope, watch, tape measure, infant scale, gestational age assessment and growth charts. | | | | | | |
| | <ul style="list-style-type: none"> Review delivery and newborn records for: <ul style="list-style-type: none"> Date and time of birth Duration of labor Type of birth (spontaneous, forceps or cesarean) Apgar scores Gestational age by dates Gestational age by examination (if done) Maternal antenatal and natal problems Maternal use of drugs/medications which might affect newborn | | | | | | |
| | <ul style="list-style-type: none"> Wash hands with soap and water, dry with clean cloth or air dry | | | | | | |
| 2 | Welcome client | | | | | | |
| | <ul style="list-style-type: none"> Greet client & introduce yourself (if not already known to client) Offer a seat to client and ensure privacy Explain purpose and procedures of visit | | | | | | |
| 3 | Obtain health history from client | | | | | | |
| | <i>Relevant Obstetrical History</i> | | | | | | |
| | Review newborn health history with client for following information if records available. Obtain the following health history from client if records unavailable: | | | | | | |
| | <ul style="list-style-type: none"> Date and time of birth | | | | | | |
| | <ul style="list-style-type: none"> Duration of labor and birth | | | | | | |
| | <ul style="list-style-type: none"> Type of birth (spontaneous, forceps or cesarean) | | | | | | |
| | <ul style="list-style-type: none"> Whether baby breathed spontaneously at birth or needed assistance | | | | | | |
| | <ul style="list-style-type: none"> Whether baby was full-term at birth | | | | | | |
| | <ul style="list-style-type: none"> Date and time of last visit | | | | | | |
| | <ul style="list-style-type: none"> Whether any problems or abnormalities were noted at birth | | | | | | |
| | <ul style="list-style-type: none"> Weight and length of baby at birth (if known) | | | | | | |
| | <i>Postpartum history</i> | | | | | | |
| | <u>Newborn</u> - Ask client about the following: | | | | | | |
| | <ul style="list-style-type: none"> Client's feelings about the baby's sex and appearance | | | | | | |
| | <ul style="list-style-type: none"> Baby's activity, sleep and crying patterns | | | | | | |
| | <ul style="list-style-type: none"> Suckling and feeding pattern/perceived satisfaction of both mother and infant | | | | | | |
| | <ul style="list-style-type: none"> Baby's bladder and bowel function | | | | | | |
| | <ul style="list-style-type: none"> Condition/care of baby's umbilical cord | | | | | | |
| | <ul style="list-style-type: none"> Immunizations received (e.g. BCG) | | | | | | |

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|--|--|--|--|--|--|--|
| <ul style="list-style-type: none"> • Signs of potentially serious problems: <ul style="list-style-type: none"> ○ Not feeding well ○ Sleeps most of the time ○ Vomits or spits up a lot ○ Watery, dark green stools ○ Skin feels hot or cold ○ Breathes too fast (>60 breaths per minute) or with difficulty ○ Skin and eyes are yellow | | | | | | |
| <p><u>Weekly health history</u> – Ask client about:</p> <ul style="list-style-type: none"> • Baby’s general health | | | | | | |
| <ul style="list-style-type: none"> • Baby’s activity, sleep and crying patterns | | | | | | |
| <ul style="list-style-type: none"> • Suckling and feeding pattern (perceived satisfaction of mother and baby) | | | | | | |
| <ul style="list-style-type: none"> • If baby is growing and gaining weight | | | | | | |
| <ul style="list-style-type: none"> • Baby’s bladder and bowel patterns | | | | | | |
| <ul style="list-style-type: none"> • Signs of any potentially serious problems: <ul style="list-style-type: none"> ○ Not feeding as well as usual ○ Sleeps most of the time ○ Vomits or spits up a lot ○ Watery, dark green stools ○ Skin feels hot or cold ○ Breathes too fast (>60 breaths per minute) or with difficulty ○ Skin and eyes are yellow | | | | | | |
| <ul style="list-style-type: none"> • Other concerns about the baby | | | | | | |
| <p>4 Perform physical examination</p> | | | | | | |
| <p><i>In general:</i></p> | | | | | | |
| <ul style="list-style-type: none"> • Observe baby’s general appearance throughout examination, noting: <ul style="list-style-type: none"> ○ Posture in supine position ○ Body proportions and symmetry ○ Skin color, texture, markings, veining, rashes ○ Spontaneous activity ○ Cry (frequency and pitch) ○ Respiratory effort | | | | | | |
| <ul style="list-style-type: none"> • Explain procedures to client while performing them on baby | | | | | | |
| <ul style="list-style-type: none"> • Ask questions of clarification about baby’s health, as appropriate, while conducting examination | | | | | | |
| <ul style="list-style-type: none"> • Calm baby as needed | | | | | | |
| <p><i>Vital signs and body measurements</i></p> | | | | | | |
| <ul style="list-style-type: none"> • Ask client to place baby on examination table and to undress baby | | | | | | |
| <ul style="list-style-type: none"> • Measure heart rate/rhythm/sounds; respiratory rate/rhythm/sounds; temperature | | | | | | |
| <ul style="list-style-type: none"> • Measure weight, length and head circumference | | | | | | |
| <p><i>Head and neck</i></p> | | | | | | |
| <ul style="list-style-type: none"> • Inspect head for: <ul style="list-style-type: none"> ○ Symmetry ○ Fontanels (extent of closure, depression or bulging) | | | | | | |

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|--|--|--|--|--|--|--|
| <ul style="list-style-type: none"> • Inspect eyes for: <ul style="list-style-type: none"> ○ Reaction of pupils to light ○ Red reflex ○ Blink reflex ○ Corneal reflex ○ Opaqueness ○ Coordination and movement ○ Shape ○ Color of sclera ○ Discharge (yellowish or greenish) | | | | | | |
| <ul style="list-style-type: none"> • Inspect nose for patency (observe nursing) | | | | | | |
| <ul style="list-style-type: none"> • Inspect ears for: <ul style="list-style-type: none"> ○ Presence or absence of canal ○ Position in relation to eyes ○ Baby’s reaction to loud noise | | | | | | |
| <ul style="list-style-type: none"> • Inspect mouth for presence or absence of: <ul style="list-style-type: none"> ○ cleft lip or palate ○ white deposits (Candida) | | | | | | |
| <ul style="list-style-type: none"> • Elicit suckling and rooting reflexes (observe adequacy of breastfeeding) | | | | | | |
| <ul style="list-style-type: none"> • Elicit range of motion of head/neck | | | | | | |
| <i>Chest</i> | | | | | | |
| <ul style="list-style-type: none"> • Inspect breasts for: <ul style="list-style-type: none"> ○ Engorgement ○ Discharge from nipples ○ Size of areolae | | | | | | |
| <i>Abdomen</i> | | | | | | |
| <ul style="list-style-type: none"> • Inspect abdomen for: <ul style="list-style-type: none"> ○ Size ○ Shape or contour ○ Healing of umbilicus (color, dryness) | | | | | | |
| <ul style="list-style-type: none"> • Palpate abdomen for: <ul style="list-style-type: none"> ○ hernias (umbilical or inguinal) ○ liver or spleen enlargement | | | | | | |
| <i>Extremities</i> | | | | | | |
| <ul style="list-style-type: none"> • Inspect arms, hands, and digits for: <ul style="list-style-type: none"> ○ Symmetry of shape and length ○ Formation (presence or absence of deformity) ○ Palmar creases ○ Color (e.g. pale or blue nailbeds) | | | | | | |
| <ul style="list-style-type: none"> • Determine range of motion and muscle tone of arms, hands and digits | | | | | | |
| <ul style="list-style-type: none"> • Inspect legs, feet and digits for: <ul style="list-style-type: none"> ○ Symmetry of shape and length ○ Formation (presence or absence of deformity) ○ Color (e.g. pale or blue nailbeds) | | | | | | |
| <ul style="list-style-type: none"> • Determine range of motion and muscle tone of legs, feet and digits | | | | | | |
| <i>External genitalia</i> | | | | | | |
| <ul style="list-style-type: none"> • Put on gloves without contaminating them | | | | | | |
| <ul style="list-style-type: none"> • If female baby, inspect vulva to determine presence of: <ul style="list-style-type: none"> ○ Edema of labia majora ○ Prominence of labia minora and clitoris ○ Redness or irritation ○ Character of vaginal discharge ○ Patency of urethral meatus (observe urination) | | | | | | |

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| | <ul style="list-style-type: none"> If male baby, inspect penis, then gently retract foreskin to determine presence of: <ul style="list-style-type: none"> Redness or irritation Urethral discharge Position and patency of urethral meatus (observe urination) | | | | | | |
| | Inspect anus for patency. | | | | | | |
| | If bowel movement occurs, note stool for: <ul style="list-style-type: none"> Color Consistency Volume Odor | | | | | | |
| | <ul style="list-style-type: none"> Remove gloves and dispose of them in designated decontamination solution | | | | | | |
| | <ul style="list-style-type: none"> Back: lift baby up and inspect spine for mobility and formation | | | | | | |
| | <ul style="list-style-type: none"> Other reflexes: <ul style="list-style-type: none"> Elicit walking/stepping reflex (4 weeks) Elicit Moro reflex (4-8 weeks) | | | | | | |
| | <ul style="list-style-type: none"> Ask client to dress her baby | | | | | | |
| | <ul style="list-style-type: none"> Wash hands with soap and water, air dry or dry with clean cloth | | | | | | |
| 5 | Assess infant's gestational age, growth and health status, and make diagnosis | | | | | | |
| | <ul style="list-style-type: none"> <u>Newborn</u> gestational weight for age <ul style="list-style-type: none"> Evaluate signs of neuromuscular and physical maturity and calculate gestational age using the gestational age chart Plot newborn's weight, length and head circumference on a growth chart denoting the 10th, 50th and 90th percentile Decide if newborn's weight for gestational age is small, average or large | | | | | | |
| | <ul style="list-style-type: none"> <u>Infant</u> growth <ul style="list-style-type: none"> Evaluate infant's weight, length and head circumference in comparison with expected measures for age (for Europe) Decide if infant's growth pattern is within normal range based on European/Romanian growth standards | | | | | | |
| | <ul style="list-style-type: none"> Newborn/infant well-being <ul style="list-style-type: none"> Evaluate historical and physical findings for presence or absence of: <ul style="list-style-type: none"> Problems Risk factors Decide if newborn's/infant's health status is normal based on above evaluations, and if not, consult and/or refer for further evaluation | | | | | | |
| 6 | Share assessments and diagnoses of infant's health status with client | | | | | | |
| | <ul style="list-style-type: none"> Inform client, in reassuring manner, of the assessments and diagnoses of her newborn's/infant's health status | | | | | | |
| | <ul style="list-style-type: none"> If any abnormalities are discovered: <ul style="list-style-type: none"> Explain possible causes of the abnormalities Inform client about next steps in addressing identified abnormalities | | | | | | |
| | <ul style="list-style-type: none"> Encourage client to share reactions to information provided, gently probing as necessary | | | | | | |
| 7 | Provide care to infant and important information to client | | | | | | |
| | <i>Education and counseling</i> | | | | | | |

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| | <ul style="list-style-type: none"> • Explore client’s need for, and provide information about: <ul style="list-style-type: none"> ○ Normal behavior and physical changes in the newborn/infant (sleep and wake patterns, bowel and bladder patterns, growth) ○ Nutritional needs of the newborn/infant, how to meet these, including assistance with breastfeeding if indicated ○ Importance of maintaining baby’s body temperature ○ Providing for baby’s safety ○ Signs of potentially serious problems: <ul style="list-style-type: none"> ▪ Not feeding as well as usual ▪ Sleeps most of the time ▪ Vomits or spits up a lot ▪ Watery, dark green stools ▪ Skin feels hot or cold ▪ Breathes too fast (>60 breaths per minute) or with difficulty ▪ Skin and eyes are yellow ○ Other relevant issues as indicated | | | | | | |
| | <ul style="list-style-type: none"> • Help client to make decisions which positively affect her baby’s health | | | | | | |
| | Preventive measures | | | | | | |
| | <ul style="list-style-type: none"> • Discuss and demonstrate care for newborn’s umbilical cord | | | | | | |
| | <ul style="list-style-type: none"> • Discuss benefits of continued breastfeeding | | | | | | |
| | Treatment or intervention | | | | | | |
| | <ul style="list-style-type: none"> • Treat and refer newborn problems as necessary and appropriate | | | | | | |
| 8 | Plan follow-up care for infant in collaboration with client | | | | | | |
| | <ul style="list-style-type: none"> • Discuss with client follow-up treatments or preventive measures and associated instructions, if any | | | | | | |
| | <ul style="list-style-type: none"> • Ask client to repeat instructions for follow-up treatments or preventive measures, if any | | | | | | |
| | <ul style="list-style-type: none"> • Encourage client to ask questions | | | | | | |
| | <ul style="list-style-type: none"> • Discuss with client the timing and importance of well-baby check-ups, and time/date of next visit | | | | | | |
| | <ul style="list-style-type: none"> • Schedule next visit and give client time/date of visit | | | | | | |
| | <ul style="list-style-type: none"> • Encourage client to bring the father to next visit if she desires | | | | | | |
| 9 | Record findings, assessments, diagnoses, care provided to infant and follow-up plan | | | | | | |
| | <ul style="list-style-type: none"> • Record all findings, assessments, diagnoses, care provided, and plans for follow-up on health record | | | | | | |
| | <ul style="list-style-type: none"> • Give client a copy of baby’s health record with follow-up date recorded in it (if indicated and where possible) | | | | | | |
| | <ul style="list-style-type: none"> • File baby’s health record | | | | | | |

To be applied/done always



To be applied/done if needed



Not necessary to be done



Handout

Counseling for Breastfeeding during Postnatal Visits

During the postnatal visits, mothers/parents should be reminded of the advantages of breastfeeding. Mothers should be encouraged to breast feed their babies for as long as possible. Help the mother whenever she wants, and especially if she is a first time or adolescent mother.

Suggestions for successful breastfeeding:

- Encourage breastfeeding on demand, day and night, as long as the baby wants
 - A baby needs to feed day and night, 8 or more times in 24 hours; only on the first day after birth may a full-term baby sleep many hours after a good feed
 - A small baby should be encouraged to feed, day and night, at least 8 times in 24 hours
- Explain how the milk's appearance changes: milk in the first days is thick and yellow, then it becomes thinner and whiter. Both are good for the baby.
- Encourage exclusive breastfeeding, at least in the first 6 months
- Encourage skin-to-skin contact since it makes breastfeeding easier.
- Explain that breastfeeding will become easier if the baby suckles and stimulates the breast him/herself and when the baby becomes bigger.
- Tell mothers to let the baby release the breast, then to offer the second one
- Tell mothers that if they must be absent, they should express breast milk and let somebody else to feed the expressed milk to the baby by cup
- Counsel mothers to:
 - not force the baby to take the breast
 - not interrupt feeding before the baby wants to stop
 - not give newborn infants any food or drink other than breast milk, unless *medically* indicated
 - not give artificial teats or pacifiers to breastfeeding infants.
 - That while breastfeeding, the mother should:
 - drink plenty of clean, safe water
 - eat more and healthier foods
 - rest a few hours in the afternoon and a minimum of 6 hours at night
 - avoid medication (only when needed and by prescription)

Teach mothers correct positioning and attachment for breastfeeding

- Show the mother how to hold her baby. She should:
 - make sure the baby's head and body are in a straight line
 - make sure the baby is facing the breast, the baby's nose is opposite her nipple
 - hold the baby's body close to her body
 - support the baby's whole body, not just the neck and shoulders
- Show the mother how to help her baby to attach. She should:
 - touch her baby's lips with her nipple
 - wait until her baby's mouth is opened wide
 - move her baby quickly onto her breast, aiming the baby's lower lip well below the nipple (the baby needs to take more than just the nipple into his mouth; if the baby takes only the nipple into his mouth, his tongue will not compress the lactiferous

sinuses, milk will not flow well, and the mother's nipple is likely to become sore and damaged).

- Show the mother how to look for signs of good attachment and effective suckling (slow, deep sucks, sometimes pausing). If the attachment is not good, advise her to try again. Then reassess.
- If the mother experiences breast engorgement, advise her to express a small amount of breast milk before starting breastfeeding to soften the nipple area so that it is easier for the baby to attach to.

Teach mothers how to maintain proper hygiene of the breasts during breastfeeding:

- Teach the mother to clean her breasts before and after each breastfeeding.
 - She should not use anything except clean water to cleanse her 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.
- Teach the mother to use both breasts at each feeding during establishment of lactation. She should alternate which breast to give first.
- Instruct the mother to use different feeding positions to prevent nipple damage.

Give special support to breastfeed the small baby (pre-term and/or with low birth weight)

- Reassure the mother that she can breastfeed her small baby and she has enough milk.
- Explain that her milk is the best food for such a small baby. Feeding is more important for him/her than for a big baby. A small baby does not feed as well as a big baby in the first days because s/he:
 - may tire easily and suck weakly at first
 - may suckle for shorter periods before resting
 - may fall asleep during feeding
 - may have long pauses between suckling and may feed longer
 - does not always wake up for feeds.
- Encourage the mother to feed the baby every 2-3 hours and to wake the baby for feeding, even if he/she does not wake up alone, 2 hours after the last feed.
- Tell the mother to keep the baby longer at the breast and to allow long pauses or long, slow feeds, if needed. Do not interrupt feeds if the baby is still trying.
- If the baby is not suckling well and long enough, counsel the mother to:
 - express breast milk into the baby's mouth
 - express breast milk and feed the baby by cup
- In this case, teach the mother to observe swallowing.

Give special support to breastfeed twins

- Reassure the mother that she has enough milk for two babies.
- Encourage her that twins may take longer to establish breastfeeding since they are frequently born pre-term and/or with low birth weight.
- Encourage the mother to start feeding one baby at a time until breastfeeding is well established.
- Help the mother find the best method to feed the twins:

- if one is weaker, encourage her to make sure that the weaker twin gets enough milk
- if necessary, she can express milk for him/her and feed him/her by cup after initial breastfeeding
- alternate the side each baby is offered each day.

Give special support to the mother who is not yet breastfeeding (mother or baby ill, or baby too small to suckle)

- Teach the mother to express breast milk. Help her if necessary.
- Teach the mother to use the milk to feed the baby by cup.
- If mother and baby are separated, inform her about the baby's condition daily/twice daily if possible.
- Encourage the mother to breastfeed when she or the baby recovers.

Give special support to the mother who is not breastfeeding at all

- Inform the mother that the breasts may be uncomfortable for a while.
- Encourage the mother to:
 - Avoid stimulating her breasts.
 - Support her breasts with a well-fitting bra or cloth. Do not bind the breasts tightly as this may increase her discomfort.
 - Apply a compress. Warmth is comfortable for some women, others prefer a cold compress to reduce swelling.
 - Relieve pain with analgesics, such as ibuprofen or paracetamol, or use plant products such as teas made from herbs, or raw cabbage leaves placed directly on the breast to reduce pain and swelling.
- Teach the mother to express enough milk to relieve discomfort. Expressing can be done a few times a day when the breasts are overfull.
- Advise the mother to seek care if her breasts become painful, swollen, or red, or if she feels ill or has a temperature greater than 38 C.

Give special support if the baby does not have a mother

- Give (a source of) donated breast milk or commercial formula by cup.
- Teach the person who takes care of the baby how to prepare milk and feed the baby.
- Follow up carefully.

Signs that baby is receiving an adequate amount of milk

- Baby is satisfied with the feed.
- Weight loss is less than 10% in the first week of life.
- Baby gains at least 160 g in the following weeks or a minimum 300 g in the first month.
- Baby wets every day as frequently as is feeding.
- Baby's stool is light brown or yellow.

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/she wants.
- The environment supports breastfeeding.

Correct Positions during Breastfeeding

Good Positioning

Poor Positioning

How does the mother hold her baby?

- a. Baby's body close, facing breast
Face to face attention from mother

- b. Baby's body away from mother
neck twisted
No mother baby eye contact



Alternative positions:



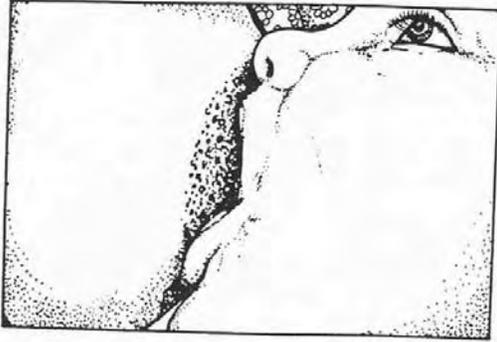
The mother finds relief from nipple pain by using an alternative position such as the watermelon (or football) hold – as shown above. In this position, the baby lies on a pillow by her side (the same side where s/he is nursing) with his or her body and legs tucked back under her arm as she cradles his head in her hand.

Another alternative position that may provide relief is for the baby to suckle as s/he lies next to the mother on the bed where she is lying. (Shown below)

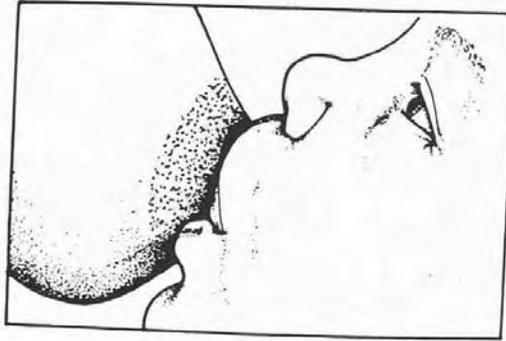


Attachment of the Baby during Breastfeeding

a. A baby well attached to his mother's breast



b. A baby poorly attached to his mother's breast



There are 4 points of good attachment:

1. Chin close to breast
2. Mouth wide open
3. Lower lip everted
4. Mouth is beyond the nipple and attached to the areola. (More areola will be noted above than below the mouth).

Results of Poor Attachment

Poor attachment will cause:

- sore nipples, nipple cracks or fissures
- poor let-down reflex
- breast engorgement
- fussy, crying baby, baby wanting to feed very frequently because he is unsatisfied
- poor weight gain
- possible refusal to suck because baby is frustrated
- low milk production because the breasts are not properly emptied

FAMILY PLANNING METHODS FOR POST PARTUM WOMEN

The following table lists the most common Family Planning methods used & available in Romania. The table should provide a quick reference for service providers when counseling women/couples during pregnancy and the post partum period.

| METHOD | ADVANTAGES | DISADVANTAGES | ELIGIBILITY | WHEN TO START | INSTRUCTIONS | RETURN VISIT | COMMENTS |
|---|---|---|---|---|--|--|---|
| LACTATIONAL AMENORRHEA METHOD (LAM) | <ul style="list-style-type: none"> * Effectively prevents pregnancy for 6 months. * Encourage the best breastfeeding patterns. * Ensures that the baby gets needed nutrients and is protected from many diseases. * No direct cost for FP or feeding of the baby. * Convenient * No side effects * Promotes close mother/ child relationship * May reduce risk of breast cancer | <ul style="list-style-type: none"> * Temporary method (effectiveness after 6 months is not certain). * May be difficult or inconvenient for some women to breastfeed frequently (e.g. working women) * No protection from STIs/HIV * May not be advisable for HIV positive women. | <ul style="list-style-type: none"> * All women who: <ul style="list-style-type: none"> -exclusive breastfeed their babies often, both day and night - baby < 6 months old -menses have not returned. Possible exception: those women who are HIV positive. When HIV positive, the risks must be considered against the benefits. | As soon as possible after birth | <ul style="list-style-type: none"> * Breastfeed often: at least 8-10 times a day and once during the night. * Offer no other liquids or food to the baby until 6 months. * Initiate another FP method: <ul style="list-style-type: none"> - at 6 months, even if still breastfeeding. - if menses return - if no longer breastfeeding exclusively a baby < 6 months old. | At 6 months after birth, or sooner if menses return or no longer breastfeeding exclusively. | After 6 months of LAM, a woman should be encouraged to continue to breastfeed until the baby is 1 –2 years old. |
| PROGESTIN - ONLY CONTRACEPTIVE PILLS (Exluton) | <ul style="list-style-type: none"> * Very effective during breastfeeding * No effect on milk secretion * May prevent endometrial and ovarian cancer * Safe – serious problems are very rare. | <ul style="list-style-type: none"> * May cause irregular bleeding/spotting, menstrual changes or prolonged amenorrhea after birth. * No protection for STIs/HIV | <ul style="list-style-type: none"> * Immediately after delivery (non-breastfeeding women) * During breastfeeding * Can be used by smokers and by women with other medical conditions except with history of breast cancer, vascular blood clots, or taking medicines for seizures | <ul style="list-style-type: none"> * Anytime after 6 weeks post partum if breastfeeding; * Any time in the first 4 weeks post partum if not breastfeeding. * After 4 weeks, any time it is reasonably certain that the woman is not pregnant | <ul style="list-style-type: none"> * Take 1 pill daily at the same time each day; no breaks between packages of pills. * If taking a pill later than 2 hours or missing pills, use another method in addition during the next 2 days. * Spotting, irregular or lack of menses are possible. | <ul style="list-style-type: none"> * Before her supply of pills runs out (every 3 months); * Scheduled visit is not necessary. * If woman has problems or concerns with the pills | <ul style="list-style-type: none"> * Although not needed during LAM, will provide extra protection if desired. * Excellent choice for breastfeeding women not relying on LAM. |
| DMPA INJECTABLE | <ul style="list-style-type: none"> * Very effective & safe * Private – others can | <ul style="list-style-type: none"> * Return of fertility can be delayed few | <ul style="list-style-type: none"> * Women of any age * Breastfeeding | * Any time after 6 weeks post partum if | * To be effective, a new injection must be | <ul style="list-style-type: none"> * Every 3 months. * If woman has | * Although not needed during |

| METHOD | ADVANTAGES | DISADVANTAGES | ELIGIBILITY | WHEN TO START | INSTRUCTIONS | RETURN VISIT | COMMENTS |
|---|---|--|---|---|--|--|--|
| CONTRACEPTIVE (DEPO-PROVERA) | <p>not tell a woman is using it.</p> <ul style="list-style-type: none"> * Convenient, easy to use * Helps prevent endometrial cancer | <p>months after stopping use of DMPA.</p> <ul style="list-style-type: none"> * Changes in menstrual bleeding (spotting, heavy bleeding, lack of menses). * May cause side effects * Does not protect from STI/HIV | <p>women</p> <ul style="list-style-type: none"> * Women who smoke * Not to be taken by women with history of heart disease, vascular blood clots, severe diabetes, breast cancer, BP over 160/100. | <p>(nearly) fully breastfeeding</p> <ul style="list-style-type: none"> * Any time within 6 weeks post partum if not breastfeeding * Women who are not breastfeeding anymore may begin DMPA immediately or any other time it is reasonably certain that they are not pregnant. | <p>given every 3 months.</p> <ul style="list-style-type: none"> * If more than 2 weeks late for next injection, avoid sex or use another method until next injection. * Irregular menses or lack of menses are likely during the first months. | <p>problems or concerns.</p> | <p>LAM, will provide extra protection if desired.</p> <ul style="list-style-type: none"> * Excellent choice for breastfeeding women not relying on LAM * Use disposable syringes & needles if available. |
| LOW DOSE COMBINED ORAL CONTRACEPTIVE PILLS (COC) | <ul style="list-style-type: none"> * Very effective when used correctly. * Lighter menses and fewer cramps * May prevent endometrial and ovarian cancer * Safe – serious problems are rare. | <ul style="list-style-type: none"> * May affect the quality and quantity of milk * Common side effects (nausea, spotting, lack of menses, mild headache) * No protection against STIs/HIV. | <ul style="list-style-type: none"> * Women of any age * Women who smoke if under 35 years * Not to be taken by women with BP 140/90 or higher on 2 readings. * Not to be taken by women with history of heart disease, vascular blood clots, severe diabetes, breast cancer, migraines, current gall bladder disease, taking medicines for seizures, over 35 years and smoke. | <ul style="list-style-type: none"> * 3-6 weeks after birth if not breastfeeding. * 6 months postpartum if breastfeeding; * A woman who stopped breastfeeding may begin on any of the first 7 days after menses begins or any other time it is reasonably certain that she is not pregnant. | <ul style="list-style-type: none"> * Take 1 pill at same time each day. * When finishing one packet of 21 pills, wait 7 days before starting the next packet; * When finishing one packet of 28 pills, take the first pill from the next packet on the very next day. * Extra protection may be needed in the following cases (missing pills, vomiting, diarrhea, taking medicines) * Minor side effects are possible at the beginning of using COC: nausea, mild headache, tender breasts, spotting between periods; usually they become less or stop within 3 months. * return immediately to clinic if any of the | <ul style="list-style-type: none"> * Before her supply of pills runs out (every 3 months) * If woman has problems or concerns with the pills | <p>Not recommended for breastfeeding women during the first 6 months after childbirth.</p> |

| METHOD | ADVANTAGES | DISADVANTAGES | ELIGIBILITY | WHEN TO START | INSTRUCTIONS | RETURN VISIT | COMMENTS |
|----------------------------------|---|--|--|--|---|---|---|
| | | | | | following occur: severe pain in belly, chest or legs; bad headaches; brief loss of vision, seeing flashing lights; brief trouble speaking or moving an arm or leg; jaundice. | | |
| INTRAUTERINE DEVICE (IUD) | <ul style="list-style-type: none"> *Very effective *Convenient, easy to use, long term method *No hormonal side effects (Cooper IUD) *Improve menstrual bleeding (Progesterone-releasing IUD) | <ul style="list-style-type: none"> * May cause heavier menses & more cramps * Medical procedure, including pelvic exam, needed to insert IUD * Requires specially trained providers to insert and remove it *Does not protect from STIs/HIV, may even increase the risk of PID following STIs. * May be expelled without woman knowing (more likely if inserted soon after birth) *Needs to be checked by the client, by putting her fingers into vagina | <ul style="list-style-type: none"> *Women of all ages * Not advised for women at high risk for STI * Not for women with unexplained vaginal bleeding until condition has been evaluated and treated * Not for women with history of cervical, endometrial or ovarian cancer. | <ul style="list-style-type: none"> * Within 48 hours after childbirth or after 4 weeks post partum *May be inserted any time after 4weeks if it is reasonably sure that the woman is not pregnant and has a healthy uterus. *May be inserted any time during the menstrual cycle, although may be easiest and less uncomfortable during menstruation. | <ul style="list-style-type: none"> * Check for IUD strings after each menses or once a month. * Heavier menses, spotting between menses and more cramps are possible (in the case of Cooper IUD) in the first months after insertion. | <ul style="list-style-type: none"> * 3 to 6 weeks after insertion (not during a menses). No further scheduled visits required until IUD needs to be replaced (usually several years) * If the strings of the IUD cannot be felt or seem shorter. * If missed menstrual period and/or abdominal pain, abnormal vaginal bleeding. * If woman has any problems or concerns. *If woman thinks she might have an STI. | <ul style="list-style-type: none"> * Insert only if certain there is no pregnancy *If a health facility does not have a trained provider, the woman should be referred. *Not a good method for women with recent STIs or at risk of STIs. * Woman should be taught to check for IUD strings * Provide woman with a written record of the type of IUD, date of insertion and date for removal/ re-insertion |
| CONDOMS | <ul style="list-style-type: none"> *Prevents pregnancy and STIs/HIV if used correctly and consistently *Can be used during pregnancy, or during oral or anal sex to | <ul style="list-style-type: none"> * Man's cooperation is needed. *May be hard for women to negotiate male condom use *Occasionally cause irritation from latex | Anyone, if not allergic to latex | Prior to every sexual exposure | <ul style="list-style-type: none"> * Do not use with oil lubricants (water based lubricants are fine; many condoms come already lubricated) * Store away from | <ul style="list-style-type: none"> *If condom breaks and might need emergency contraception. * If client has problems or concerns | Provide clients with adequate supply of condoms, especially if client unable or unlikely to purchase them away from the health facility (give |

| METHOD | ADVANTAGES | DISADVANTAGES | ELIGIBILITY | WHEN TO START | INSTRUCTIONS | RETURN VISIT | COMMENTS |
|--|---|--|---|---|--|---|--|
| | prevent STIs. *Can be used with other FP methods *Do not need a health provider to initiate *Enable men to take responsibilities. * No hormonal side effects. | or lubricants * May interfere with spontaneous sex *Must be stored in a dark place, away from heat. *May break during use. | | | light and heat * Condoms should only be used once and then disposed of. | * If need additional supply of condoms | 36 condoms every 3 months). *Client should be taught through demonstration how to use correctly |
| SPERMICIDES | * Woman-controlled method. *Offer contraception just when needed. * May help to prevent some STIs, PID, and possibly cervical cancer. *No hormonal side effects, no effect on breastfeeding *No need of a trained provider to initiate * Can be inserted up to 1 hour before sex | *May cause irritation to woman or her partner. *May be considered “messy” | *All women of any age | *Any time after childbirth | * Must be used correctly and consistently each time. * Insert the spermicide deep into vagina before each time you have sexual intercourse * Avoid vaginal douching for at least 6 hours after sex * Store in a cool, dry place | *When needing a new supply if unable to purchase *If woman has problems or concerns | *Nonmedical providers may safely offer spermicides to all women. *Woman should be instructed how to use correctly |
| VOLUNTARY SURGICAL STERILIZATION Female sterilization /Tubal ligation | * Provides permanent contraception for women who do not want more children *Very effective immediately. | *The woman has to be decided before she goes into labor *Possible, but very rarely complication. * Requires specially trained providers. * Reversal surgery is difficult, expensive, and not guaranteed. * No protection against STIs/HIV. | * No medical condition prevents a woman from using VSC. Some conditions and circumstances call for delay, referral, or caution with the method. | * Minilaparotomy can be performed immediately after a woman gives birth, or within the next 7 days after delivery, during her hospitalization, or any other time after 6 weeks postpartum. * Tubal ligation/section can be performed during the intervention for Caesarian Section | *Rest 2-3days after the intervention. *Keep the incision clean and dry. *Take pain-relief medicines if needed. *Do not have sex for at least 1 week. (All these conditions are in place after delivery) | *A follow-up visit after 1-2 weeks for removing stitches, if necessary. *If fever, pus or bleeding from the wound, pain, heat, swelling or redness of the wound appears. *If pregnancy is suspected (especially ectopic pregnancy). | Requires special counseling and proper informed consent. |
| VOLUNTARY SURGICAL STERILIZATION | * Provides permanent contraception for men who will not want | * Possible pain and short-term complications. | * No medical condition prevents a man to use SVC. | * Anytime, after special counseling. * Vasectomy can be | * Rest 2days after the intervention. * Keep the incision | *A follow-up visit within 7 days is recommended, to | Requires special counseling and proper informed |

| METHOD | ADVANTAGES | DISADVANTAGES | ELIGIBILITY | WHEN TO START | INSTRUCTIONS | RETURN VISIT | COMMENTS |
|--------------------------------------|-----------------------------------|--|---|---|--|--|----------|
| Male sterilization /Vasectomy | more children * Very effective | * Not effective immediately. At least 20 ejaculations or 3 months interval is needed. * Requires special trained providers. * Reversal surgery is difficult, expensive, and not guaranteed. * No protection against STIs/HIV. | Some conditions and circumstances call for delay, referral, or caution with the method. | performed during the pregnancy period in couples who received proper counseling and have decided to use the method. | clean and dry. * Take pain-relief medicines if needed. * Use condoms or another contraceptive method for at least the next 20 ejaculations or 3 months after the procedure, whichever comes first. | check for any complications, remove the stitches, if necessary. *The client should return immediately if there is fever, pus or bleeding from the wound; or if pain, heat, swelling or redness of the wound appears. * A man may want to have a semen analysis after vasectomy to check that his vasectomy is working. | consent. |

POSTNATAL CONSULTATIONS

All standards and protocols shall be applied by all family doctors whether they work in the private or in the public sector.

Standards:

- All women shall be considered to be insured for the purposes of receiving postnatal care. As a consequence:
 - health personnel shall provide services to all women and newborns babies in postnatal period
 - postnatal care shall be free of charge regardless of the insured status of the woman.
- Post-partum women and newborn babies shall have priority to consultation in the Family Doctors' cabinets.
- The following schedule of visits shall apply to consultations during the postnatal period:
 - First postnatal visit will be done by the Family doctor within 24 hours following hospital release after delivery and will evaluate the woman and her newborn at their home
 - Every week after hospital release, family doctor and nurse shall monitor the woman and her newborn
 - 3 weeks following delivery Family doctor or Ob-Gyn specialist shall provide a consultation to woman
 - 6 weeks following delivery Family doctor or Ob-Gyn specialist shall provide a consultation to woman, including contraception
- The following elements shall apply to all postnatal visits as per the protocols for initial and subsequent visits:
 - Assessment of maternal health status; and of existing or potential risks
 1. Emotional state
 2. Activity level
 3. Rest and sleep patterns
 4. Appetite and fluid intake
 5. Bladder and bowel function
 6. Experience with breastfeeding
 7. Signs of involution (uterus, lochia)
 8. Discomfort or pain
 9. Concerns or questions
 10. Sexual activity anticipated before next visit, including need for contraception and for STI protection
 - Assessment of newborn's health status, and make diagnosis
 1. General appearance (posture, body proportions, symmetry, skin, spontaneous activity, crying, respiratory effort)
 2. Vital signs and body measurements (heart rate/rhythm/sounds; respiratory rate/ rhythm/sounds; temperature, weight, length and head circumference)
 3. Elicit reflexes

Postnatal Standards

- Sharing of results of assessment with mother/parents, and any measures to be taken
- Provide care to newborn, as needed
- Counseling regarding nutrition, rest, exercises, taking care, alarm signs
- Referrals as necessary for further diagnoses and/or treatments
- Documentation of findings, assessments, care and advice provided, and recommended follow-up plan

FIRST POSTPARTUM CONSULTATION
(at home)

1. **Prepare for postpartum history and physical examination**
 - Introduce yourself (if not already known to client)
 - Explain purpose and procedures of visit
 - Ensure availability of and arrange conditions and equipment for consultation
 - Review client's antenatal and immediate postpartum records
2. **Obtain postpartum history**
 - Review relevant obstetrical and medical history
 - Date of child-birth
 - Duration of labor and birth
 - Type of birth (natural/spontaneous or cesarean)
 - Episiotomy
 - Other problems during labor, birth and immediate postpartum:
 - Postpartum history
 - Obtain following information from client:
 - Emotional state (e.g. client's perception of: labor and birth experience; baby's well-being; ability to care for baby)
 - Rest and sleep patterns
 - Activity level (e.g. walking frequency, duration and ease)
 - Appetite and fluid intake
 - Bladder and bowel function (e.g. frequency, amount and ease)
 - Experience with breastfeeding (e.g. frequency, duration per session; discomfort or problems; perceived satisfaction of self and baby)
 - Signs of involution
 - Uterus (e.g. position, firmness)
 - Lochia (e.g. color, amount, consistency) , appreciated by inspection of the hygienic tampons)
 - Discomfort or pain
 - Concerns or questions
3. **Perform physical examination**
 - Observe client's level of energy, emotional tone and posture throughout examination
 - Measure and notes:
 - weight (if possible, or asked about her weight before hospital release)
 - BP and heart rate
 - temperature
 - Extremities
 - Inspect legs for varicose veins, areas of redness, and edema
 - Palpate legs for tenderness or heat
 - Dorsiflex each foot to check for presence or absence of lower leg pain
 - Test patellar reflex (deep tendon) for hyper- or hypo-activity
 - Breasts
 - With client's arms by her side, inspect breasts for:
 - Secretion of colostrum/milk from nipples
 - Cracking of nipples
 - Presence or absence of engorgement (e.g. enlarged, shiny, reddened, dilated veins)
 - Presence or absence of abscess

Postnatal Care

- With client's left, then right, arm over head, palpate left, then right, breast and axilla noting:
 - Filling with milk/colostrum (e.g. degree of firmness)
 - Presence or absence of engorgement (e.g. warm and hard)
 - Presence or absence of abscess
 - Enlarged lymph nodes
- Abdomen
 - Inspect abdomen for:
 - Healing of Cesarean scar
 - Contour
 - Presence or absence of bladder distention
 - Presence or absence of uterine displacement
 - Palpate uterus for: size, location (in relation to mid-line and umbilicus), consistency (firmness), tenderness (observe client's face)
- Pelvic: external genitalia
 - Inspect vulva, perineum and rectum for: trauma, healing of episiotomy, varicose veins (of vulva and anus), vaginal discharge (color, amount, consistency -e.g. presence or absence of clots or tissue fragments)
- 4. **Assess progress of involution and maternal health status, and make diagnosis**
 - Progress of involution
 - Compare uterine location, size and consistency; and vaginal discharge color, amount and consistency with expected characteristics
 - Decide if there is consistency between actual findings and expected characteristics
 - Decide if involution is normal based on above evaluation, and if not, appropriately manage or refer for further evaluation
 - Maternal well-being
 - Evaluate historical and physical findings for presence or absence of problems or risk factors
 - Decide if maternal health status is normal based on above evaluations, and if not, consult or refer for further evaluation
- 5. **Share assessment and diagnosis with client**
 - Inform client, in reassuring manner, of assessments and diagnoses
 - If any abnormalities discovered, explain possible causes and inform client of next steps in addressing identified abnormalities
 - Encourage client to share reactions to information, gently probing as necessary
- 6. **Provide care, information and counseling to client**
 - Provide information about:
 - Normal postpartum involution
 - Normal emotional response to birth
 - Changes in family relationships
 - Getting enough sleep and rest
 - Nutritional needs for breastfeeding and how to meet these needs
 - Personal hygiene and perineal care
 - Initiation of lactation, breastfeeding and breast care
 - Breastfeeding techniques and positions
 - Treatment/care of common problems (difficulties with let-down reflex, perceived low milk supply, plugged ducts, inverted/flat nipples)
 - Use of drugs during lactation
 - Expression of breast milk

Postnatal Care

- Sexuality, resumption of intercourse, return to fertility and menses
 - Common discomforts and how to cope with them (e.g. perineal pain, breast engorgement, constipation, hemorrhoids and varicose veins)
 - Signs of complications (e.g. chills and fever; severe headache; visual changes; severe abdominal pain; constant or increasing vaginal bleeding; clots or passing of tissue; foul-smelling vaginal discharge; severe perineal pain or pressure; infrequent, scanty or painful urination; severe pain with hard lump in breast; severe lower leg pain)
 - Importance of follow-up visits
 - Discuss continued iron and folate supplements during breastfeeding
 - Discusses tetanus toxoid immunization schedule
 - Treat or refer other problems as necessary and appropriate
7. **Plan follow-up care with client**
- Discuss with client instructions related to preventive measures and treatments, if any
 - Ask client to repeat instructions, if any
 - Encourage client to ask questions
 - Discuss timing and importance of follow-up visits, and time/date of next visit
 - Schedule next visit and give client time/date of visit
 - Encourage client to include partner in postpartum visits if desired
8. **Record findings, assessments, diagnoses, care provided and follow-up plan**
- Record all findings, assessments, diagnoses and care provided and plans for follow-up on postpartum record
 - Give client a copy of her postpartum record with follow-up visit date recorded
 - File client's postpartum record

FOURTH WEEK POSTPARTUM CONSULTATION
(In clinic/Family Doctor's cabinet)

PROTOCOL: Postpartum visit (mother)

1. Prepare for 4th week maternal postpartum history and physical examination

- Ensure availability of and arrange:
 - Adequate light
 - Examination table
 - BP cuff, stethoscope, watch, scale, vaginal valves or specula
 - Gloves (new or reusable which have been high-level disinfected)
 - Laboratory equipment (if available and indicated)
 - Decontamination solutions and container
- Review client's antenatal, delivery, and immediate postpartum records for:
 - Normal progress of pregnancy, labor and delivery, and early postpartum involution/recovery
 - Postpartum common discomforts
 - Postpartum problems/life-threatening complications
 - Postpartum risk factors
- Wash hands with soap and water, air dry or dry with clean cloth.
- Welcome client
 - Greet client (& introduce yourself if first contact with client)
 - Offer a seat to client and ensure privacy
 - If woman is escorted by her partner/family member, invite him to discussion, after receiving woman's consent
 - Explain purpose and procedures of visit

2. Obtain 4th week maternal postpartum history

- Relevant obstetric and medical history (if not done already/first contact with the client)
 - Review/Obtain the following information:
 - Date of birth
 - Duration of labor and birth
 - Type of birth (natural/spontaneous or cesarean)
 - Other problems during pregnancy, birth and immediate postpartum:
 - High blood pressure
 - Seizures or convulsions
 - Anemia
 - Excessive bleeding/hemorrhage
 - Severe infection (chills and fever)
 - High blood sugar or diabetes
 - Other serious health conditions
- Postpartum history
 - Obtain the following information:
 - General well-being:
 - Rest and sleep
 - Activity and exercise
 - Perceived ability to care for baby
 - Adjustment of family to baby, to one another
 - Diet history (24 hour recall)

Postnatal Care

- Breastfeeding (if stopped, when and why)
 - Frequency, duration per session
 - Perceived satisfaction of self and baby
 - Care of breasts
- Symptoms of involution
 - Lochia (e.g. duration, sequence of color)
 - Resumption of menses (date, duration and amount)
- Resumption of sexual intercourse
 - If resumed, when resumed and how many times
 - Level of physical and emotional comfort
 - STI risk
- Contraception
 - Use of contraception (if not using, why)
 - Method now using or desired
 - Satisfaction with that method, if using
- Any problems since birth with:
 - Excessive fatigue
 - Severe breast tenderness, engorgement, cracked or bleeding nipples
 - Difficulty breastfeeding
 - Continuing perineal pain
 - Fever and chills
 - Lower abdominal pain, severe cramping
 - Foul-smelling vaginal discharge
 - Excessive vaginal bleeding or clots
 - Pain or burning on urination
 - Urinary incontinence
 - Constipation
 - Hemorrhoids
 - Pain, redness or tenderness of lower legs
 - Any other problems

3. Perform 4th week maternal postpartum physical examination

- General approach to examination
 - Observe client's level of energy, emotional tone and posture throughout examination
 - Explain all procedures in simple terms while performing them
 - Ask questions of clarification about client's health, as appropriate, while conducting examination
- Vital signs
 - Measure weight
 - Measure BP and heart rate
 - Measure temperature
- Extremities
 - Inspect legs:
 - Entire leg for varicose veins
 - Lower leg for areas of redness
 - Lower leg, ankles and feet for edema
 - Palpate legs for tenderness or heat
 - Dorsiflex each foot to check for presence or absence of lower leg pain
 - Test patellar reflex (deep tendon) for hyper- or hypo-activity

Postnatal Care

- Breasts
 - Ask client to remove clothes, and offer drape for privacy
 - With client's arms by her side, inspect breasts for:
 - Size, shape and symmetry
 - Presence or absence of engorgement
 - Presence or absence of abscess
 - Secretion of milk from nipples
 - Color, consistency, amount of other discharge from nipples (e.g. bleeding)
 - Fissures or blistering of nipples
 - As client raises her arms above her head, inspect breasts for retraction and dimpling
 - With client's hands on hips, inspect breasts for retraction and dimpling
 - With client lying and left, then right, arm over head, palpate left, then right, breast and axilla, noting:
 - Masses
 - Enlarged lymph nodes
 - Presence or absence of engorgement
 - Presence or absence of abscess
- Abdomen
 - Ask client to lie on back on examination table
 - Inspect abdomen for:
 - Scars (if recent surgery, for healing)
 - Size and contour
 - Palpate all four quadrants of abdomen for:
 - Presence or absence of uterus above pubis
 - Presence or absence of bladder above pubis
 - Masses
 - Tenderness
- Pelvic: external genitalia
 - Assist client into position for pelvic examination, and drape client for privacy
 - Put on gloves without contaminating them
 - Inspect perineum for scarring from laceration or episiotomy
 - Gently separate labia majora and inspect labia minora then clitoris, urethral opening and vaginal opening for:
 - Color
 - Redness or irritation
 - Ulcers or lesions
 - Growths
 - Fissures or fistulae
 - Adhesions
 - Discharge (color, consistency, amount)
 - Milk urethra and Skene's ducts to exclude pus or bloody discharge
 - Palpate Bartholin's glands for:
 - Swelling
 - Masses or cysts
- Pelvic: speculum/vaginal valves examination
 - Select correct size speculum/vaginal valves for client
 - Show speculum to client and explain how it will be used and will feel
 - Explain to client how to relax during insertion of speculum and examination
 - Encourage client to indicate if procedure too uncomfortable

Postnatal Care

- Lubricate speculum with water or lubricating jelly
- Hold speculum obliquely, part labia with other hand, and insert speculum gently, avoiding urethra and clitoris; Turn speculum and open blades to expose cervix
- OR insert first the posterior vaginal valva obliquely, then turn it 90° and after then insert the anterior valva and expose cervix
- Inspect cervix for:
 - Color
 - Size, shape and position
 - Dilatation of os
 - Ectopy
 - Redness or inflammation
 - Bleeding
 - Lesions, erosion or ulcers
 - Growths or masses
 - Polyps or cysts
 - Discharge (color, consistency, amount)
 - Sutures
- Obtain specimens if necessary (for bacteriologic exam)
- Inspect vaginal walls/floor for:
 - Color
 - Redness or inflammation
 - Bleeding
 - Lesions and ulcers
 - Growths or masses
 - Scarring (from episiotomy)
 - Discharge (color, consistency, amount)
- Close and remove speculum gently in oblique position
- Put used speculum in designated container for decontamination
- Pelvic: bimanual examination
- Bi-manual examination
 - Explain examination to client
 - Encourage client to indicate if procedure uncomfortable
 - Insert two fingers into vagina, spread them and exert downward pressure. Ask client to cough gently, and observe for: involuntary loss of urine, cystocele, rectocele
 - Draw two fingers together, ask client to tighten up vaginal muscles and check of muscle tone
 - Sweep vaginal walls with two fingers and feel for growths and masses
 - Locate cervix and feel for:
 - Size, shape and position
 - Consistency
 - Dilatation of os
 - Regularity of os
 - Mobility
 - Tenderness (observe client's face)
 - Use both hands to palpate uterus for:
 - Size, shape and consistency
 - Smoothness
 - Mobility

Postnatal Care

- Tenderness (observe client's face)
 - Use both hands to palpate adnexa for:
 - Size and shape
 - Masses
 - Tenderness (observe client's face)
 - Remove fingers smoothly, remove gloves and dispose of them in designated decontamination solution
 - Ask client to get up and to get dressed
 - Wash hands with soap and water and air dry or dry them with a clean cloth
4. **Assess progress of involution and maternal health status, and make diagnoses**
- Progress of uterine involution
 - Compare uterine size and consistency with that expected for number of days postpartum
 - Decide if actual and expected uterine size and consistency are as expected for number of days postpartum
 - Decide if involution is normal
 - Maternal well-being
 - Evaluate historical and physical findings for presence and absence of problems
 - Psycho-emotional response to postpartum
 - Common discomforts
 - Life-threatening complications
 - Evaluate historical and physical findings for presence and absence of risk factors
 - Decide if maternal health status is normal based on above evaluations.
5. **Share assessment and diagnoses with client**
- Inform client, in reassuring manner, of assessments and diagnoses, including:
 - Progress of involution
 - Her own health status
 - If any abnormalities discovered in any areas mentioned,
 - Ask client if she is aware of these
 - Explain possible causes
 - Inform client of next steps in addressing these
6. **Provide care, information and counseling to client**
- Education and counseling
 - Explore client's need for, and provides information about:
 - Getting enough sleep and rest
 - Special postpartum exercises to strengthen abdominal muscles
 - Special exercises for perineal muscular tonus
 - Continued nutritional needs and how to meet them
 - Common problems with breastfeeding and how to cope, as indicated
 - Return to fertility in breastfeeding or non-breastfeeding women, as indicated
 - The importance of birth-spacing
 - Other relevant issues, as indicated
 - Helps client make decisions which positively affect her health and well-being
 - Preventive measures
 - Discuss and provide continued iron and folate supplementation

Postnatal Care

- Teach client to take care of her breast during breastfeeding and to perform self-breast examination
- Discuss and provide contraceptive method of choice, as appropriate
- Treatment or intervention
 - Treat or refer problems, as necessary and appropriate

7. **Plan follow-up care with client**

- Discuss with client follow-up treatment and relevant instructions, if any
- Ask client to repeat instructions for follow-up treatment(s), if any
- Encourage client to ask questions
- Advise client to contact clinic for questions or concerns

8. **Record findings, assessments, diagnoses, care provided and follow-up plan**

- Record all findings, assessments, diagnoses and care provided and plans for follow-up on postpartum record
- Give client a copy of her postpartum record with follow-up visit date recorded
- File client's postpartum record

PROTOCOL: FIRST POSTPARTUM VISIT (baby)

1. Prepare for newborn health history and physical examination

- Explain purpose and procedures of baby's examination
- Ensure availability of and arrange:
 - Adequate light
 - A place for examination
 - Stethoscope, watch, tape measure, infant scale, gestational age assessment and growth charts
 - Sterile gloves
- Review delivery and newborn records for:
 - Date and time of birth
 - Duration of labor
 - Type of birth (natural/spontaneous, forceps or other obstetrical maneuvers or cesarean section), Apgar scores
 - Gestational age by dates
 - Gestational age by examination (if done)
 - Maternal antenatal and natal problems
 - Maternal use of drugs/medications which might affect newborn
- Wash hands with soap and water and dry with clean cloth.

2. Obtain newborn health history from client

- Relevant obstetric history
 - Obtain newborn health history from client for following information (if records not available):
 - Date and time of birth
 - Duration of labor and birth
 - Type of birth (natural/spontaneous, forceps or other obstetrical maneuvers or cesarean section)
 - Whether baby breathed spontaneously at birth or needed assistance
 - Whether baby was full-term at birth
 - Whether any problems or abnormalities were noted at birth
 - Weight and length of baby at birth (if known)
- Postpartum history
 - Ask client about the following:
 - Her feelings about the baby's sex and appearance
 - Baby's activity, sleep and crying patterns
 - Suckling and feeding pattern/perceived satisfaction of both mother and infant
 - Baby's bladder and bowel function
 - Condition/care of baby's umbilical cord
 - Immunization received (e.g. BCG, Hepatitis B)
 - Signs of any potentially serious problem
 - Not feeding well
 - Sleeps most of the time
 - Vomits or spits up a lot
 - Watery, dark green stools
 - Skin feels hot or cold
 - Breathes too fast (>60 breaths per minute) or with difficulty
 - Skin and eyes are yellow

- Other concerns about the baby

3. **Perform physical examination**

- General approach to examination
 - Observe baby's general appearance, noting:
 - Posture in supine position
 - Body proportions and symmetry
 - Skin color, texture, markings, veining
 - Spontaneous activity
 - Cry (frequency and pitch)
 - Respiratory effort
 - Explain procedures to client while performing them on baby
 - Ask questions of clarification, as needed, while conducting examination
 - Calm baby as needed
- Vital signs and body measurements
 - Ask client to place baby on examination place and to undress baby; help her to undress the baby and explain how to do it, if needed
 - Measure heart rate/rhythm/sounds; respiratory rate/ rhythm/sounds; temperature
 - Measure weight, length and head circumference
- Head and neck
 - Inspect eyes for:
 - Reaction of pupils to light
 - Blink reflex
 - Corneal reflex
 - Opaqueness
 - Coordination and movement
 - Shape
 - Color of sclera
 - Discharge
 - Inspect nose for patency
 - Inspect ears for:
 - Presence or absence of canal
 - Position in relation to eyes
 - Baby's reaction to loud noise
 - Inspect mouth for presence or absence of cleft lip or palate
 - Elicit sucking reflexes (observe adequacy of breastfeeding)
- Chest
 - Inspect breasts for:
 - Engorgement
 - Discharge from nipples
 - Size of areolae
- Abdomen
 - Inspect abdomen for:
 - Size
 - Shape or contour
 - Healing of umbilicus (e.g. color, dryness)
 - Palpate abdomen for presence or absence of hernias (umbilical or inguinal)
- Extremities
 - Inspect arms, hands, digits for:

- Symmetry of shape and length
 - Formation (presence or absence of deformity)
 - Palmar creases
 - Color (e.g. pale or blue nailbeds)
 - Determine range of motion and muscle tone
 - Inspect legs/feet/digits for:
 - Symmetry of shape and length
 - Formation (presence or absence of deformity)
 - Color (e.g. pale or blue nailbeds)
 - Determine range of motion and muscle tone and check for hip dislocation
 - External genitalia
 - Put on gloves without contaminating them
 - If female baby, inspect vulva to determine presence of:
 - Edema of labia majora
 - Prominence of labia minora and clitoris
 - Redness or irritation
 - Character of vaginal discharge
 - Patency of urethral meatus (observe urination)
 - If male baby:
 - Inspect penis, then gently retract foreskin to determine presence of:
 - Redness or irritation
 - Urethral discharge
 - Position and patency of urethral meatus (observe urination)
 - Palpate scrotum to determine descent of testes
 - Inspect anus for patency. If bown movement occurs, note stool for:
 - Color
 - Consistency
 - Volume
 - Odor
 - Remove gloves and dispose them in their package
 - Ask client to dress her baby; help her and explain how to do it, if needed
 - Wash hands with soap and water, air dry or dry with clean cloth
4. **Assess newborn's gestational age and health status, and make diagnoses**
- Newborn gestational weight for age
 - Evaluate signs of neuromuscular and physical maturity and calculate gestational age using the gestational age chart
 - Plot newborn's weight, length and head circumference on a growth chart denoting the 10th, 50th, and 90th percentile.
 - Decide if the newborn's weight for gestational age is small, average or large.
 - Newborn well-being
 - Evaluate historical and physical findings for presence or absence of health problems
 - Evaluate historical and physical findings for presence or absence of risk factors
 - Decide if newborn's health status is normal based on above evaluations, and if not, consult and/or refer for further evaluation
5. **Share assessments and diagnoses of newborn's health status with client**
- Inform client, in a reassuring manner, of the assessments and diagnoses of her newborn's health status.

- If any abnormalities are found:
 - Explain possible causes of the abnormalities
 - Inform client about next steps in addressing them
- Encourage client to share reactions to information provided, probing gently as necessary

6. **Provide care to newborn and important information to client**

- Education and counseling
 - Explore client's need for, and provide information about:
 - Normal behavior and physical changes in the newborn (e.g. sleep and wake patterns, bowel and bladder patterns, growth)
 - Nutritional needs of the newborn, how to meet these, including assistance with breastfeeding, if indicated
 - Importance of maintaining baby's body temperature
 - Review signs of potentially serious problems:
 - Not feeding as well as usual
 - Sleeps most of the time
 - Vomits or spits up a lot
 - Watery, dark green stools
 - Skin feels hot or cold
 - Breathes too fast (>60 breaths per minute) or with difficulty
 - Skin and eyes are yellow
 - Other relevant issues, as indicated
 - Help client to make decisions which positively affect her baby's health
- Preventive measures
 - Discuss ophthalmia neonatorum and provide prophylactic treatment to newborn's eyes (if not previously done)
 - Discuss and demonstrate care for newborn's umbilical cord
 - Discuss BCG immunization (where indicated, usually is done in the hospital)
 - Discuss benefits of continued breastfeeding
- Treatment or intervention
 - Treat and refer newborn problems, as necessary and appropriate

7. **Plan follow-up care to newborn in collaboration with client**

- Discuss with client follow-up treatments or preventive measures and associated instructions, if any
- Ask client to repeat instructions for follow-up treatments or preventive measures, if any
- Encourage client to ask questions
- Discuss with client the timing and importance of newborn follow-up care
- Discuss possible dates for next visits (weekly until 6 weeks postpartum)
- Schedule follow-up visit and give client time and date.
- Encourage client to be assisted by her partner to next visit if she desires and possible
- Encourage mother and family to announce clinic, if any problem occur

8. **Record all findings, assessments, diagnoses, care provided to newborn and follow-up plan**

Newborn care - Protocol

- Record all findings, assessments, diagnoses, care provided and plans for follow-up on newborn's health record
- Give client a copy of baby's health record with return date noted on it (if indicated and where possible)
- Teach client how to interpret and use information on baby's record
- File baby's health record (registration shall be done after first visit to a newborn baby by the Family Doctor on his/her list of patients)

**WEEKLY POSTPARTUM VISITS (baby)
(at home)**

PROTOCOL

1. Prepare for weekly physical examination of infant

- Greet family/mother (& introduce yourself if first contact with client)
- Explain purpose and procedures of visit
- Ensure availability of and arrange:
 - Adequate light
 - Clean examination place/table
 - Soap, water and clean hand towel
 - Pen light, stethoscope, watch, tape measure, infant scale, growth charts
 - Review delivery record and initial newborn physical examination records
- Wash hands with soap and water, dry with clean cloth.

2. Obtain weekly infant health history from client

- Review newborn health history:
 - Date and time of birth
 - Date and time of last visit
 - Whether any problems or abnormalities were noted from that time
 - Weight and length of baby at last visit (if known)
- Weekly history
 - Ask client about:
 - Baby's general health
 - Baby's activity, sleep and crying patterns
 - Suckling and feeding pattern (perceived satisfaction of both mother and baby)
 - If baby is growing and gaining weight
 - Baby's bladder and bowel patterns
 - Healing of umbilical cord
 - Signs of any potentially serious problems
 - Not feeding as well as usual
 - Sleeps most of the time
 - Vomits or spits up a lot
 - Watery, dark green stools
 - Skin feels hot or cold
 - Breathes too fast (>60 breaths per minute) or with difficulty
 - Skin and eyes are yellow
 - Other concerns about the baby since last visit

3. Perform weekly physical examination of infant

- General approach to examination
 - Observe baby's general appearance throughout, noting:
 - Posture, in supine position
 - Body proportions and symmetry
 - Skin color, texture, markings, rashes
 - Spontaneous activity
 - Cry (frequency and pitch)
 - Respiratory effort

Newborn care - Protocol

- Explain to client procedures as they are performed on baby
- Ask questions for clarification while conducting examination
- Calm baby as needed
- Vital signs and body measurements
 - Ask client to place baby on examination place and to undress baby
 - Measure heart rate/rhythm/sounds
 - Measure temperature
 - Measure weight, length and head circumference
- Head and neck:
 - Inspect head for:
 - Symmetry
 - Fontanels (extent of closure, depression or bulging)
 - Inspect eyes for:
 - Reaction of pupils to light
 - Red reflex
 - Blink reflex
 - Corneal reflex
 - Opaqueness
 - Coordination and movement
 - Shape
 - Color of sclera
 - Discharge (e.g. yellowish or greenish)
 - Inspect nose for patency (observe nursing)
 - Inspect ears for baby's reaction to loud noise
 - Inspect mouth and tongue for presence of white deposits (Candida)
 - Elicit rooting and sucking reflexes
 - Elicit range of motion of head/neck
- Abdomen
 - Inspect abdomen for:
 - Size
 - Shape or contour
 - Healed umbilicus
 - Palpate abdomen for:
 - Hernia (umbilical and inguinal)
 - Liver or spleen enlargement
- Extremities
 - Inspect arms/hands/digits for:
 - Color (e.g. pale or blue nailbeds)
 - Determine range of motion and muscle tone
 - Inspect legs/feet/digits for:
 - Color (e.g. pale or blue nailbeds)
 - Determine range of motion and muscle tone and check for hip dislocation
- External genitalia
 - Put on gloves without contaminating them
 - If female baby, inspect vulva, then gently separate labia to determine presence of:
 - Redness or irritation
 - Vaginal discharge
 - Patency of urethral meatus (observe urination)
 - If male baby:

- Inspect penis, then gently retract foreskin to determine presence of:
 - Redness or irritation
 - Urethral discharge
 - Position and patency of urethral meatus (observe urination)
- Palpate scrotum to determine descent of testes
- Inspect anus for patency. If bown movement occurs, note stool for:
 - Color
 - Consistency
 - Volume
 - Odor
- Remove gloves and dispose of them in their package
- Back
 - Lift baby up and inspect spine for mobility and formation
- Other (reflexes)
 - Elicit walking/stepping reflex (1 month)
 - Elicit Moro reflex (2-4 months)
 - Ask client to dress her baby
 - Wash hands with soap and water, dry with clean cloth

4. Assess infant's growth and health status, and make diagnoses

- Infant growth
 - Evaluate infant's weight, length and head circumference in comparison with expected measures for age
 - Decide if infant's growth pattern is within normal range based on European/Romanian growth standards.
- Infant well-being
 - Evaluate historical and physical findings for presence or absence of health problems and risk factors
 - Decide if infant's health status is normal based on above evaluations.

5. Share assessments and diagnoses of infant's health with client

- Inform client, in a reassuring manner, of assessments and diagnoses of her infant's health status
- If any abnormalities are found:
 - Explain possible causes of the abnormalities
 - Inform client about next steps in addressing them
- Encourage client to share reactions to information provided, probing gently as necessary

6. Provide care to infant in collaboration with client

- Education and counseling
 - Explore client's need for, and provide information about:
 - Normal behavior and physical changes in the baby (e.g. sleep and wake patterns, bowel and bladder patterns, growth)
 - Nutritional needs of the baby and how to meet these needs
 - Importance of maintaining baby's body temperature
 - Providing for baby's safety
 - Review signs of potentially serious problems:
 - Not feeding as well as usual
 - Sleeps most of the time

Newborn care - Protocol

- Vomits or spits up a lot
 - Watery, dark green stools
 - Skin feels hot or cold
 - Breathes too fast (>60 breaths per minute) or with difficulty
 - Skin and eyes are yellow
 - Other relevant issues, as indicated
 - Help client to make decisions which positively affect her baby's health
 - Preventive measures
 - Discuss infant growth monitoring
 - Discuss immunizations and schedules (e.g. DPT, Hepatitis B, Polio). Give vaccines according to immunization protocol
 - Treatment or intervention
 - Treat and refer newborn problems, as necessary and appropriate
7. **Plan follow-up care to newborn in collaboration with client**
- Discuss with client follow-up treatments or preventive measures and associated instructions, if any
 - Ask client to repeat instructions for follow-up treatments or preventive measures, if any (e.g. scheduled immunizations)
 - Encourage client to ask questions
 - Discuss with client importance of well-baby check-ups.
 - Discuss possible dates for next well-baby check-up
 - Schedule follow-up visit and give client time and date.
 - Encourage client to be assisted by her partner to next visit if she desires
8. **Record all findings, assessments, diagnoses, care provided to newborn and follow-up plan**
- Record all findings, assessments, diagnoses, care provided and plans for follow-up on health record
 - Give client a copy of baby's health record with return date noted on it (if indicated and where possible)
 - Teach client how to interpret and use information on baby's record
 - File baby's health record



**Romanian Family Health
Initiative**

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COUNSELING SESSIONS FOR ANTENATAL & POSTNATAL CARE

A ONE-DAY TRAINING FOR FAMILY DOCTORS

February 2004

SESSION GUIDE 1: INTRODUCTION

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

1. Give the names the trainer and other participants wish to be called during the workshop
2. Explain the objectives of the workshop
3. Name at least four group norms the group will adhere to in order to facilitate a productive workshop
4. Name at least four principles for giving and receiving feedback

METHODS: Discussion

TIME: 30 minutes

MATERIALS:

Flip charts:

- Group norms
- Feedback

Handouts:

- Workshop goal, general objectives and schedule
- Feedback

Flip chart stand and paper

Photo copy paper

Markers

Masking tape

Note pads

Pens

Folders

INSTRUCTIONS:

***NB to trainers:** The following guidelines for the introductory session apply to situations in which the trainers and participants are together for the first time. If the group has been together previously for an orientation to pre/postnatal care, trainers may need only to review the workshop objectives and schedule as well as group norms.*

I. INTRODUCTIONS (15 minutes)

Welcome participants to the workshop. Thank them for responding positively to the workshop invitation.

Introduce the trainers briefly.

Ask participants to look around the room. Ask how many of them already know everyone in the room. (Likely, no one will already know everyone.) Tell them that the group will be together for what is planned to be a positive and productive day for

everyone and that they will be learning together and learning from each other. Invite participants to introduce themselves and to display their name tags so that everyone can see them.

[Note to trainer: This introductory session helps to “break the ice” within the group, and helps participants to become comfortable with the group.]

II. WORKSHOP GOAL, OBJECTIVES & SCHEDULE (5 minutes)

Distribute the handout *Workshop Goal, Objectives and Schedule* and review it with the group. Explain that the day’s program is designed to introduce participants to certain principles and techniques of communication that are useful when conducting antenatal and postnatal consultations.

Encourage participants to ask questions, and to share ideas/knowledge, as appropriate to facilitate their learning.

III. GROUP NORMS & LOGISTICS (10 minutes)

Explain that group norms are important to creating a positive learning environment. Everyone’s understanding of, and agreement to, group norms helps to facilitate participation and learning.

Post the flip chart *Group norms*. Ask participants to read the list and to indicate their commitment to respecting these norms in order to facilitate everyone’s participation and learning.

Indicate the location of toilets/washrooms.

IV. FEEDBACK (15 minutes)

Suggest to the group that a norm that has not been discussed but is of particular importance to this workshop concerns how to give feedback to each other. Explain that during the workshop, participants will participate in role plays to enable them to practice certain counseling skills. During these role plays, they will have the opportunity to apply their skills both as service providers as well as observers of their colleagues; and they will be asked to share their feedback with their colleagues regarding their use of certain counseling techniques.

Lead a discussion on:

- The characteristics and effects of negative feedback on participation and learning:
 - Is generally evaluative
 - Communicates lack of respect for the person to whom the feedback is directed

- Often makes the receiver feel bad, resentful, guilty; may lower his/her self-esteem
 - May lead to a negative reaction, a resistance to hearing and/or applying what is said
- The principles of positive and constructive feedback:
 - Provides information the individual can use to make his/her own evaluation.
 - Begins by putting oneself in the shoes of the other person and asking “How can I formulate what I have to say in a way that will be most useful to this person?”

Distribute the handout *Feedback* and ask volunteers to read it.

Post the flip chart *Feedback* as a guide for participants to follow during the workshop.

Ask the group to practice the principles of giving and receiving feedback when indicated throughout the workshop.

Flip chart

GROUP NORMS

- Respect the workshop schedule
- Respect and encourage others' participation
- Do not interrupt
- Listen to others
- Respect confidentiality of what others share
- Do not make personal attacks
- Everyone is responsible for their own learning
- No smoking in the training room
- No mobile phone conversations in training room
- Everyone stick to the subject

Handout

WORKSHOP GOAL, OBJECTIVES AND SCHEDULE

Workshop goal: To improve the counseling skills of family doctors in the context of antenatal and postnatal consultations

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

1. Describe the importance of counseling in the context of antenatal and postnatal consultations.
2. Demonstrate skills in active listening when conducting antenatal and postnatal consultations

Workshop schedule:

8h00 Session 1: Introduction

8h45 Session 2: Basic Principles of Counseling

10h30 Break

10h45 Session 3: Techniques of Counseling: Active Listening. Part 1: Introduction, Passive Listening

12h00 Lunch

13h00 Session 4: Techniques of Counseling: Active Listening. Part 2: Paraphrasing

14h15 Session 5: Techniques of Counseling: Active Listening. Part 3: Clarifying questions, Practice

17h15 Closing

Flipchart

FEEDBACK

Feedback is more effective when:

1. It is specific rather than general.
2. It concerns the attitude or behavior of the person and not the person him/herself.
3. It takes into consideration the needs of the person receiving feedback.
4. It is directed toward an attitude or behavior the person can change.
5. It is wanted and not imposed.
6. It is an exchange of ideas and information rather than advice.
7. It is given at the right moment.
8. It includes the quantity of information the receiver can use and not the quantity we want to give.
9. It concerns what was said or done and not why it was.
10. It is verified to assure that it was clear.
11. It is positive and constructive, and not negative.
12. The receiver listens without defending his/her behavior.

FEEDBACK

Feedback is communication to a person or group about the effect of their attitude or behavior on another person. It consists of the perceptions, feelings and reactions of the person giving the feedback. It is not critical or evaluative but rather descriptive. Feedback provides information which the individual can use to make his/her own evaluation. If he/she is not evaluated, he/she will feel less need to react defensively.

Feedback is more effective when:

1. It is specific rather than general. Instead of saying a person is “authoritarian”, it would be more useful to say: “When you just made that decision, you didn’t listen to what others had to say and I felt as though I was forced to agree with you.”
2. It concerns the attitude or behavior of the person and not the person him/herself. It is more useful to tell the person that he/she “talked more than anyone else during the meeting” rather than saying he/she is a “loudmouth”.
3. It takes into consideration the needs of the person receiving feedback. Feedback can become destructive when it only serves our own needs and does not consider the needs of the receiver. Feedback is for helping others, not for hurting them.
4. It is directed toward an attitude or behavior the person can change. Feedback about physical characteristics the person cannot control only hurts and frustrates.
5. It is wanted and not imposed. Feedback will be more useful if the receiver has asked for it.
6. It is an exchange of ideas and information rather than advice. In exchanging information and ideas, we leave the person the liberty to draw their own conclusions and make their own decisions, according to their goals, needs, etc. When we offer advice, we tell people what they should do which assumes that they lack the liberty to decide themselves.
7. It is given at the right moment. In general, feedback should be given as soon as possible after the action in question (depending upon the receptivity of the receiver). Feedback may provoke several kinds of emotional reactions. The most effective feedback, given at the wrong moment, could do more harm than good.
8. It includes the quantity of information the receiver can use and not the quantity we want to give. If the person is overwhelmed by feedback, his/her ability to use it will be less. When we give more feedback than necessary, it is probably to satisfy our own needs rather than to help the other person.

9. It concerns what was said or done and not why it was. The “why” takes us from what we observed to assumptions about the motives or intentions of the person. Pretending to understand the motives or intentions of the receiver usually only serves to alienate him/her and create suspicion and distrust which does not facilitate learning or change. It is presumptuous to assume we know why someone said or did something. If we are uncertain as to a person’s motives or intentions, this uncertainty may be our feedback.
10. It is verified to assure that it was clear, that the person understood our feedback. To do this, one can ask the other person to repeat the feedback in their own words.
11. It is positive and constructive, and not negative. Negative feedback hurts while the purpose of feedback is to help the receiver to change his/her behavior.
12. The receiver listens without defending his/her behavior. When someone is giving feedback (and respecting the above rules for giving feedback), the receiver may only listen, except if there is something he/she does not understand: then he/she may ask for clarification. When we begin to defend ourselves, usually we cease to hear what is being said.

SESSION GUIDE 2: BASIC PRINCIPLES OF COUNSELING

Objectives: By the end of the session, participants will be able to:

1. Describe the purpose of counseling in the context of antenatal and postnatal care.
2. Explain 4 types of factors that influence human behavior
3. Explain the process of decision-making
4. Explain the concept 'informed choice'
5. Define the term 'counseling'
6. Explain how counseling can facilitate the processes of decision making and behavior change
7. Explain at least 5 principles to respect when counseling clients regarding antenatal and/or postnatal care

Methods: Mini-lecture, discussion

Time: 1 hour 45 minutes

Materials:

Flip chart:

- Advice (definition)

Handouts:

- Factors That Influence Human Behavior
- Decision-making Process
- Basic Counseling Concepts
- Benefits of Counseling; Consequences of the Lack of Counseling

Trainer document:

- Story: Factors That Influence Human Behavior

INSTRUCTIONS

I. COUNSELING IN THE CONTEXT OF ANTENATAL & POSTNATAL CONSULTATIONS (15 minutes)

Introduce the session by asking participants to think about on clients they see in ANC & PNC consultations, and on the needs and concerns of these clients beyond physical examinations, diagnoses and prescriptions. Ask the group:

- What kinds of concerns do clients express?
- What kinds of needs do you observe that may not be expressed by clients?
- How do you see your role as a clinician in terms of responding to these concerns and needs?

Common concerns of ANC/PNC clients:

- “Will I have a healthy baby?”
- “Will I have a girl or a boy?”
- “How can I avoid infections/stay healthy during pregnancy?”

- “Should I go to the doctor? How will I know when I need to seek help? How often should I go to the doctor? Why should I go to the doctor?”
- “Should I go for lab tests? Where?”
- “Should I avoid sex/travel/medication/cigarettes/alcohol/immunizations during pregnancy?”
- ”How will my delivery be? Will I have pain?”

Common informational needs of ANC/PNC clients:

- Information about proper nutrition and care during pregnancy
- Information about danger signs during pregnancy and in the postpartum period (for both mother and baby), and what to do if they occur
- Information about the importance of breastfeeding
- Information about birth spacing
- Information about mother-to-child transmission of HIV and the importance of knowing one’s HIV status

Role of clinicians in responding to client needs and concerns:

- Help clients express their concerns and listen carefully to what they say
- Inquire about their knowledge of the above types of information in order to know what they already know and what they need further clarification on
- Provide clients with basic information related to the above concerns and needs in a way which responds to their concerns and in language which they can understand

Explain to the group that the above issues are the kinds of things we normally address in counseling women during ANC & PNC consultations. The purpose of this workshop is to introduce participants to some concepts and skills of counseling which will be useful in counseling women in the context of ANC & PNC consultations.

II. FACTORS THAT INFLUENCE HUMAN BEHAVIOR (30 minutes)

Introduce the concept of influencing client behavior by asking participants to note individually on a piece of paper:

- Situations in which they received advice but did not to follow it. Ask them to think particularly of situations in which they were in the role of client/patient and did not follow advice given them by a doctor (or other health worker)
- Why they did not follow this advice.
- What, if anything, would have made them more likely to follow the advice that was given to them.

Ask participants to form small groups of three. Ask groups to discuss their responses to the above questions.

In the large group, ask 6-8 participants to share their experiences. Note on a flip chart the various reasons participants give for why they did not follow advice given to them

Suggest that the experiences shared by participants provide interesting examples of:

- Factors that influence our behavior as clients
- Why clients may not always follow our advice.

Explain that you are going to tell a story about an antenatal client, including:

- Health conditions she faced with her pregnancy when she sought prenatal care
- The advice she was given by her family doctor
- The factors that influenced her behavior.

NB: Use the *Trainer document: Story: Factors That Influence Human Behavior* and modify factors as necessary to reflect local cultural, social and enabling factors, and possible problems of perception.

In the large group, ask participants to identify factors that influenced the client's behavior and choices, including the various reasons why the client did not follow the doctor's advice. Note responses on a flip chart.

Post the flip chart *Advice* and ask a volunteer to read it.

Advice: Face-to-face communication in which the service provider tries to solve client's problem by proposing the solution to the client.

Advice generally communicates the message: "You are not capable of resolving this so I will have to do it for you".

Refer to the small group discussions of reasons why participants didn't follow doctors' advice, and to the story of Andrea. Ask the group:

- What are some common consequences of such "forced" decisions (based on advice without discussion)?

- Advice may reinforce the client's dependency on the health worker
- Clients do not act on/implement such decisions
- Clients do not accept responsibility for such decisions and may even blame the health worker for any negative consequences of the decisions.

Distribute the handout *Factors That Influence Human Behavior*. Ask volunteers to read it and to refer to the examples given by participants, and those cited in the story, as appropriate.

III-IV. DECISION-MAKING PROCESS AND INFORMED CHOICE (30 min)

Explain to the group that when we make decisions, we all go through a somewhat similar process. The different factors which we just discussed are an important part of this process.

In order to introduce the process of decision-making, ask the following questions concerning participants' attendance at the workshop:

- How did you receive the information about this workshop?

- I was told to come
- I learned that this training would take place and I asked 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

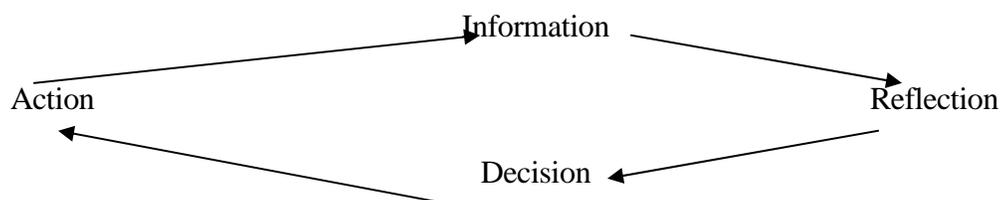
- What did you do in order to prepare to attend the workshop?

- Delegated my activities to someone else
- Made sure that someone could take my place during my absence
- Made provisions for the family before leaving home

- What questions did you ask yourself?

- 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 (about what they needed to do before leaving home, and about the conditions of the workshop)

Decision step: Participants made a decision to attend, based on information they received about the workshop, and on other priorities.

Action step: Is expressed by the fact that participants are present at the workshop.

Ask the following questions in order to apply the decision-making process to the context of antenatal and postnatal consultations.

- If we apply this decision-making process to communication with a client in the context of an antenatal or postnatal consultation, what happens at the step Reflection?

The client:

- Weighs the pros and cons of what the service provider tells her, and her situation and options, based on:
 - what she knows (including the information she has received)
 - other factors:
 - cultural, social and enabling factors
 - perceptions
 - other priorities
- Asks herself questions
- Anticipates the consequences of her decision

- What is the importance of the step *Information* on the step *Reflection*?

Providing clients with information appropriate to their situation, and communicated it to them in a way they can easily understand, enables them to reflect on/use the information make **informed choices** (voluntary choices/decisions based on information regarding one's health, behaviors and treatment options).

- What can/should a health worker do to ensure that the information he/she provides is relevant to the clients' needs and concerns, and to any cultural, social and/or enabling factors that might influence the client's decision?

- Imagine the needs and concerns of the client based on your experience as a health worker
- Help the client express herself and listen carefully
- Adapt information to the needs and concerns of the client; give complete, precise, and clear information, using language easily understood by the client
- Encourage her questions and reactions (in order to better understand, and respond to, her concerns and needs)
- Give the client time to reflect on the information before making a decision
- Ensure follow-up to reduce the risk of problems once the decision is put into action

- Do we usually respect the decision-making process?

No. Often we give minimal information and expect clients to do what we think is medically best for them (as expressed in 'you should . . . , ought to . . .' etc) which often results in the reactions discussed earlier in this session.

V-VII. COUNSELING (30 minutes)

Distribute the handout *Basic Counseling Concepts* and ask a volunteer to read the section on counseling.

Counseling: Face-to-face communication in which the health worker helps a client:

- to better understand her problem/situation
- to identify possible solutions appropriate to her situation
- to make informed decisions/choices
- to assume responsibility for her problems and choices/decisions

The health worker does this by:

- *Asking open questions* that help the client assess her situation, weigh her options, and identify and apply solutions
- *Providing information* to assist the client in this process so that she can make her own decision and then act on it.

Counseling 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.”

Refer the group to the discussion on their personal experiences as clients and their reactions to the advice they received (and did not follow). Ask a volunteer to read the section *Advice*.

Advice: face-to-face communication in which the health worker tries to solve client's problem by proposing the solution to the client.

Advice generally communicates the message: "You are not capable of resolving this so I will have to do it for you".

Refer the group to the discussion of decision making and helping people to make informed decisions. Ask a volunteer to read the section *Informed Choice* from the handout *Basic Counseling Concepts*.

Informed choice: a voluntary choice/decision based on information regarding behaviors and treatment relevant to the choice/decision.

In order to make an informed choice, the client needs to:

- Be made aware of her (and her fetus' or newborn's) health status and potential problems
- Be made aware of the options available and the possible advantages and disadvantages of each option, including possible side effects of proposed interventions and the risks of not doing anything
- Know how to apply recommended preventive measures and/or treatments safely and effectively

Role of counseling in ensuring an informed choice: assist the client to consider all aspects of her problem and options in order to choose what suits her best.

Distribute the handout *Benefits of Counseling; Consequences of the Lack of Counseling*. Suggest to the group that this document can help us think about the effect of the quality of counseling we provide in the context of antenatal and postnatal consultations, as well as in the case of other reproductive health services.

In order to place the counseling process in the context of an antenatal or postnatal consultation, ask participants:

- What are the steps of an antenatal and/or postnatal consultation (from the client's arrival to her departure)?
- How and where does counseling fit into these consultations?

Steps in a consultation:

- Reception
- Interview
- Exam
- Diagnosis
- Discussion of findings with client
- Follow-up

Counseling is done at all steps, especially at step 5: *Discussion of findings with client*

Ask the group:

- Do clients typically have sufficient information to make informed choices regarding antenatal and postnatal needs and care?

No. Clients come to clinics with a range of information, and misinformation, regarding pregnancy, delivery, postnatal health and newborn health. The health worker can never assume that they have sufficient information upon their arrival in the clinic to be able to make an informed choice about their health and care.

- What kinds of information do clients need in order to make informed choices?

- Special needs of a woman's body during pregnancy and how to provide for them
- Special needs of a woman during delivery
- Special needs of a woman's body during the postpartum period, especially for breastfeeding mothers, and how to provide for them
- Special needs of newborns, and how to provide for them.

Discuss with the group the "contradiction" between Informed Choice (which implies that the client needs to have "all" available information in order to make an informed decision) and the recognition that when clients are given too much information, they may be overwhelmed and find it difficult to retain the information that is important to both their health and the choices they need to make. Emphasize the importance of: giving essential

information (what the client needs to know in order to make her decision); and not overwhelming the client with too much information.

Handout

**BENEFITS OF COUNSELING
CONSEQUENCES OF THE LACK OF COUNSELING**

Benefits of counseling:

For the **client**:

- resolution of the problem
- satisfaction with the result/solution
- increased skill and self-confidence in decision-making
- better choices
- better coping with minor side effects of prescribed treatments
- greater respect for follow-up visits
- less influenced by rumors and myths

For the **clinic**:

- positive reputation of the clinic; satisfied clients promote the services and refer other clients
- fewer unscheduled visits for time-consuming minor complaints
- builds trust and respect between client and provider

Some consequences of a lack of counseling

For the **client**:

- non-resolution of the problem (ex: client does not follow advice)
- lack of satisfaction with the result/solution
- increased dependence on the service provider
- no learning (in terms of decision-making)

For the **clinic**:

- rumors and misconceptions
- increased number of client dropouts
- negative reputation of the clinic
- frequent revisits: staff spends much time treating and re-treating problems

Handout

FACTORS THAT INFLUENCE HUMAN BEHAVIOR

Factors which influence human behavior in general and which must be considered in helping certain clients make informed choices:

Cultural factors:

Customs: behaviors/practices that are shared by, or common/normal to, a group of people

Traditions: behaviors/practices that have been carried out/maintained for a long time and are passed down from parents to children

Beliefs: religion

Social factors: influences of other people (spouse, parents/ relatives, friends, religious leaders etc).

A person may judge a proposed behavior favorably but may perceive that those important to him/her do not want him/her to change. (example: a woman may want to practice FP but knows her husband would not approve)

A person may have an unfavorable attitude towards the behavior but be pressured by those around him/her to perform it. (example: an adolescent girl may not wish to have sex but feel pressured into it by her boyfriend)

Whether a person's own judgment can overcome the influence of those around him/her depends upon the person's strength of will and susceptibility to pressure.

Perception: subjective process in which people attempt to understand and interpret messages. It is influenced by:

- The client's familiarity with, and understanding of, language and terminology used
- The credibility of the health worker in the eyes of the client
- The clarity of visual aids used to explain the message
- The quantity of information given

Enabling factors: factors which facilitate, or inhibit, certain behavior changes (for example the time, money, and/or skills necessary to implement certain behavior changes, treatments etc; the accessibility & quality of antenatal and postnatal services)

Examples of beliefs people may have that may influence their decisions to seek or not to seek antenatal care:

- The causes of MCH problems
- The benefits of antenatal care
- One's personal susceptibility to health problems resulting from pregnancies
- “Normal” versus “risky” 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 her life)
- The credibility of the communication source (clients' perceptions of the competence and caring or commitment of the service provider)
- The prestige/status of seeking antenatal care versus feeling strong and capable of taking care of oneself

It is difficult to change those beliefs that:

- Are based on a person's direct experience unless you can explain the basis for their experience; and explain and demonstrate the rationale for, and safety of, the proposed change (ex: complications of pregnancy and/or childbirth despite a client's regular antenatal visits and applying all recommended behavior changes and prescribed treatments)
- Are part of wider, and strongly held, belief systems (religion or tradition) Examples: Catholic beliefs about artificial FP; Islamic belief in polygamy; prestige or other reasons for having many children)
- Have been held since childhood or have been acquired from trusted persons.

A client's readiness to change her behavior is strongly influenced by:

- Influences of other people (social factors described above)
 - Whether a client 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 and/or her fetus/infant 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

BASIC COUNSELING CONCEPTS

Difference between counseling and advising:

Counseling: face-to-face communication in which the health worker helps a client to better understand her problem, situation &/or feelings so that she can make her own decision and act on it.

Counseling 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 communication in which the health worker tries to solve client's problem by proposing the solution to the client.

Advice generally communicates the message: "You are not capable of resolving this so I will have to do it for you".

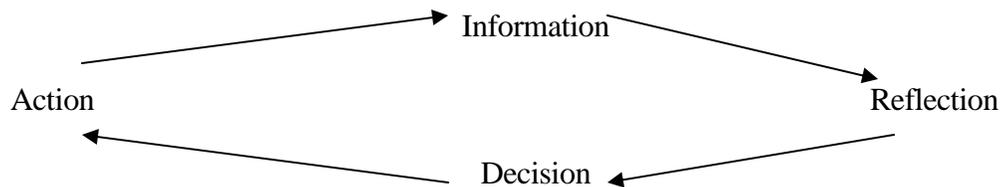
Informed choice: a voluntary choice or decision based on knowledge of all information relevant to the choice or decision. In order to make an informed choice, the client needs to:

- Be made aware of her (and her fetus' or newborn's) health status and potential problems
- Be made aware of the options available and the possible advantages and disadvantages of each option, including possible side effects of proposed interventions and the risks of not doing anything
- Know how to apply recommended preventive measures and/or treatments safely and effectively

Role of counseling in ensuring an informed choice: assist the client to consider all aspects of her problem and options in order to choose what suits her best.

DECISION-MAKING PROCESS

1. The decision-making process is facilitated by adequate and accurate information. In the diagram below, the health worker helps the client reflect on information (about her situation, problem or needs) and provides the client additional information as necessary. This information must be appropriate to the client's needs; be complete, precise, and clear; and be understood by the client.
2. The client 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 client makes a decision.
4. The client acts on her decision.



To facilitate the client's decision-making process, the health worker needs to:

1. imagine the needs of the client based on your experience with other clients
2. help the client express herself and listen carefully
3. adapt information to the needs/concerns of clients; give complete, precise, and clear information, using language easily understood by the client
4. encourage her questions & reactions (in order to better understand, and respond to, her concerns and needs)
5. give clients time to reflect on the information before making a decision
6. ensure follow-up to reduce the risk of problems once the decision is put into action

Health workers do not always respect the decision-making process, and instead give minimal information and expect clients to do what we think is medically best for them (as expressed by 'you should . . . , ought to . . .' etc). As a result, clients often do not act at all or they make decisions without adequate thought and without conviction. In the end, clients may not accept responsibility for such decisions and may even blame the health worker for any negative consequences of the decision.

FACTORS INFLUENCING HUMAN BEHAVIOR (story)

This is the story of Andrea, an antenatal client in one of our clinics. Andrea is 35 years old. She is married and has two children. She and her husband have a small farm. Her diet is largely potatoes and corn. During her two pregnancies, Andrea had very high blood pressure. Her family doctor has strongly recommended that she avoid another pregnancy.

Andrea is now 30 weeks into her third pregnancy and has come to your clinic. Upon examining her, you diagnose: anemia and pregnancy-induced hypertension. You begin advising Andrea regarding what she needs to do to protect her health and the health of her fetus. You advise her to:

- Take magnesium sulfate (or other anti-hypertensives) for her pre-eclampsia
- Take iron and folic acid for her anemia
- Eat more green leafy vegetables, fresh fruits, meat and dairy products for her anemia
- Rest and avoid heavy lifting and work
- Plan to deliver her baby at the regional hospital

As you talk with Andrea, you learn that:

- She has never taken any drugs
 - Her family doesn't believe in taking them
 - She feels that since she survived the first two pregnancies, she doesn't see why you insist on all of the changes this time.
 - She has friends who have had bad experiences with drugs and so she refuses to take them
- Her diet is based on what is available on the farm
- She feels she must help her husband with the farming
- She is not understanding many of the words you use nor the diagrams you are showing her
- For Andrea, the risks of pregnancy are “normal” (“everyone” goes through this)
- She confuses what you say about iron tablets and magnesium sulfate
- She seems to understand the importance of her delivering in a regional hospital until you discuss the cost and distance she would have to travel to the hospital

What factors are influencing Andrea's behavior and consideration of choices?

SESSION GUIDE 3: TECHNIQUES OF COUNSELING: ACTIVE LISTENING

Part 1: Introduction; & Passive listening

Objectives: By the end of the session, each participant will be able to:

1. Describe at least 4 behaviors that indicate that one person is actively listening to another.
2. Define active listening.
3. Explain the importance of active listening in the provision of antenatal and postnatal services.
4. Name 3 components of active listening.
5. Define passive listening.
6. Describe the purpose of passive listening in antenatal and postnatal counseling.
7. Demonstrate passive listening.

Methods: discussion, exercises

Time: 1 hour 15 minutes

Materials:

Handout:

- Self-evaluation grid for listening skills

INSTRUCTIONS:

I-IV. INTRODUCTION (30 min)

As an introduction to active listening, invite participants to complete a **self-evaluation grid** as a way of assessing their individual active listening skills. Suggest that they can keep it and refer to it from time to time as a way of reflecting on changes in their skills.

Refer to the last session and suggest that service providers can improve the effectiveness of communication in the delivery of health services by listening carefully to clients, and by facilitating clients' expression of needs, concerns, etc. Ask participants:

- 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 listener has understood what the person wanted to say
- serves as feedback, allowing the person to reflect on what they had said (listening to their problem paraphrased as it was understood by the listener/counselor)

Clarifying questions posed by the health worker help the client to consider all aspects of her problem & 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 or the wall.

He/She interrupts and gives advice before I've explained all of my problem

- How do you feel when you try to explain a problem to someone and they do not listen?

Frustrated, inferior, inadequate etc

- What is active listening? What does "active listening" suggest to you?

A communication technique used for the purpose of helping people to diagnose and resolve their problem themselves in consultation with a "helper". The "helper": 1) uses a variety of short responses, 2) paraphrases what the person says, and 3) poses questions in order to help the person reflect on his/her problem and alternatives, and to find a solution to his/her own problem. It 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 the delivery of antenatal and postnatal services?

Clients may have questions, concerns and problems that influence their ability to properly monitor their pregnancies. 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 the initial statements, questions or responses of a client, in order to be able to better respond to these concerns.

Steps in learning active listening

Explain that active listening is made up of three techniques:

- Passive listening
- Paraphrase
- Clarifying questions

Briefly explain what each of these means.

Add that:

- The following 4 steps facilitate the learning of active listening skills

- You will demonstrate each step and all participants will have the opportunity to practice each step
- This is only an introduction. Mastery of the techniques requires their continued application.
 1. Passive listening
 2. Paraphrasing
 3. Asking clarifying questions
 4. Integration of the 3 components

V-VII. PASSIVE LISTENING (45 minutes)

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 an antenatal or postnatal client and explains a problem, need or concern. The other individual (a trainer) takes the role of the service provider, responding with non-verbal and one-word responses to encourage the client to continue to explain her concern. (1 minute)

Ask the group:

- What did the service provider do?
- What jests did he/she use?
- What did he/she communicate to the client?
- What was the effect on the client?

Divide participants into groups of 3. In each group, participants decide who will be a) service provider, b) client, and c) observer for the first role play. (All participants will play all roles by the end of the practice.)

Review with the group the role of the observer: to give positive and constructive feedback to the service provider on his mastery of passive listening skills. Refer the group to the list of rules for giving, and for receiving, feedback.

Choice of subject. Give all participants 2 minutes to individually choose a problem/case they wish to use when they play the role of client or give to each “client” a case study prepared in advance (to avoid being distracted by the need to choose during the role plays). The problem/case should be a problem posed by a former antenatal or postnatal client.

1st role play. In each group, the client explains her problem to the service provider who practices passive listening (1 minute). The observer pays attention to the behavior of the service provider in order to be able to give feedback.

N.B. For all role plays, it is important that the trainer monitor the time according to the instructions 1) to respect the time allowed for the session, and 2) to put participants more at ease. Some people may be uncomfortable about role playing, especially at the beginning. Limiting the amount of time reduces this discomfort.

Discussion/feedback in small groups (2 minutes)

In each group, in turn, the 1) service provider, 2) client, and 3) observer gives feedback to service provider concerning the service provider's use of passive listening

2nd role play. In each group, participants change roles as follows:

- service providers become observers
- observers become clients
- clients become service providers

In each group, the client explains her problem to the service provider who practices passive listening (1 minute). The observer pays attention to the behavior of the service provider in order to be able to give feedback.

Discussion/feedback in small groups (2 minutes)

In each group, in turn, the 1) service provider, 2) client, & 3) observer gives feedback to service provider concerning the service provider's use of passive listening

3rd role play. In each group, participants change roles as follows:

- service providers become observers
- observers become clients
- clients become service providers

In each group, the client explains her problem to the service provider who practices passive listening (1 minute). The observer pays attention to the behavior of the service provider in order to be able to give feedback.

Discussion/feedback in small groups (2 minutes)

In each group, in turn, the 1) service provider, 2) client, & 3) observer gives feedback to service provider concerning the service provider's use of passive listening

Summary - large group discussion

Discussion questions.

1. To clients

- How did you feel when you were explaining your problem?

- Did you have the impression you were being listened to? What were the signs of non-verbal communication which gave you this impression?

2. To service providers

- How did you feel practicing passive listening with your client?

They may respond that it was difficult to pay attention, that they were tempted to ask questions &/or give advice.

3. To observers

- What did you observe? (Emphasize the application of the technique and its effect on clients.)

4. To everyone

- Why is silence sometimes so difficult to tolerate?

People want to give their opinion, advice

- What is the purpose of passive listening?

- The service provider, by learning to tolerate silence, pays more attention to what the client says
- Passive listening:
 - gives responsibility to the client to explain his/her concerns, needs, problems; ask questions
 - demonstrates to the client that the service provider is listening
 - prevents the service provider from imposing his/her ideas

- What are the limitations?

It can make people uneasy; the service provider must eventually intervene more actively.

- How was the feedback? Were the rules respected?

Handout

ACTIVE LISTENING Self-evaluation grid

Instructions: Read each sentence carefully and check in the indicated column the frequency with which you demonstrate the particular behavior.

| Behaviors | Rarely | Sometimes | Often | Very Often |
|--|---------------|------------------|--------------|-------------------|
| 1. I focus on the purpose of what I am going to say. | | | | |
| 2. I indicate verbally during a conversation that I am listening. | | | | |
| 3. I try to have an idea of what the other person is feeling (uncertainty, anger, worry etc) | | | | |
| 4. I focus on what the person is trying to tell me & on the details I will need to know. | | | | |
| 5. I ask for explanation of words I don't understand | | | | |
| 6. I remind myself that a word can be interpreted in many different ways. | | | | |
| 7. I know what words and phrases make people react negatively. | | | | |
| 8. I note what is said in order to remind myself of the important details. | | | | |
| 9. I repeat what one tells me to be sure that I have understood the message. | | | | |
| 10. If there is noise (other people talking nearby etc) while I am in consultation with a client, I do not allow myself to be distracted | | | | |
| 11. I try to remind myself that each person is an individual faced with a unique situation. | | | | |
| 12. I try to put myself in the place of the person talking. | | | | |
| 13. I try to listen without judging and criticizing | | | | |
| 14. I do not interrupt the person talking unless necessary. | | | | |
| 15. I try to remind myself that every comment is an occasion to improve my work. | | | | |
| 16. I try to improve my skills in listening to my patients carefully . | | | | |

SESSION GUIDE 4: TECHNIQUES OF COUNSELING: ACTIVE LISTENING

Part 2: Paraphrase

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

1. Describe paraphrasing as a component of active listening
2. Describe the purpose of paraphrasing in the context of antenatal and postnatal consultations
3. Demonstrate the use of paraphrasing

Methods: Demonstration, role play

Time: 1 hour

Materials:

INSTRUCTIONS

I-II. INTRODUCTION (5 minutes)

Refer to last session and the fact that passive listening is 1 of 3 components of active listening; the second is paraphrasing. Ask:

- What one does 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 service provider's understanding of what the client says
- To help the service provider refrain from interrupting the client and giving advice
- To encourage the client to continue to explain her problem

III. PARAPHRASING PRACTICE (30 minutes)

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 client and explains a problem, need or concern. The other individual (a trainer) takes the role of the service provider, paraphrasing what the client says and encourages the client to continue to explain his/her concern. (2 minutes)

Ask the group:

- What did the service provider do?

- How did paraphrasing contribute to communication between the service provider and the client?

- The service provider verified he/she understood what the client said (and where he/she misunderstood, the client was able to clarify what she said/meant)
- The service provider encouraged the client to continue to explain her problem
- The service provider did not interrupt the client with advice nor solutions to her problem

N.B. Paraphrasing requires that one listen carefully without focusing on other things, without being distracted.

Divide participants into groups of 3. If participants are still with their groups from the previous role plays, ask them to change places in order to benefit from experiences with other people. To facilitate changing places, ask participants to do as follows:

- Participants who were service providers in the last role play get up and join another group.
- Participants who were clients in the last role play get up and join another group (a group where they have not already worked with the service provider).

In each group, participants decide who will be a) service provider, b) client, and c) observer for the first role play. (All participants will play all roles by the end of the practice.) Precise the role of the observer (what to observe, to be focused on) and the fact that he must observe not necessary the content of the consultation, but the interaction between the client and the service provider and give feedback to the provider.

Choice of subject. Give participants 2 minutes to individually choose a problem/case they wish to use when they play the role of client or give to each “client” a case study prepared in advance (to avoid being distracted by the need to choose during the role plays). The problem/case should be a problem posed by an antenatal or postnatal client. Participants can use the same problems as for the last role plays as the members of the groups have changed.

1st role play. In each group, the client explains her problem, 1-2 phrases at a time to allow the service provider to practice. The service provider paraphrases what the client said. (2 minutes). The observer pays attention to the behavior of the service provider in order to be able to give feedback.

- If the service provider does not accurately reflect what the client said, the client repeats what she said until the service provider paraphrases correctly.
- If the service provider begins to give advice, the observer reminds him/her of his/her role during this activity.

N.B. For all role plays, it is important that the trainer monitor the time according to the instructions 1) to respect the time allowed for the session, and 2) to put participants more at

ease. Some people may be uncomfortable about role playing, especially at the beginning. Limiting the amount of time reduces this discomfort.

Discussion/feedback in small groups (2 minutes)

In each group, in turn, the 1) service provider, 2) client, and 3) observer gives feedback to service provider concerning the service provider's use of paraphrasing, its effectiveness and any difficulties experienced.

2nd role play. In each group, participants change roles as follows:

- service providers become observers
- observers become clients
- clients become service providers

In each group, the client explains her problem, 1-2 phrases at a time to allow the service provider to practice. The service provider paraphrases what the client said (2 minutes). The observer pays attention to the behavior of the service provider in order to be able to give feedback.

- If the service provider does not accurately reflect what the client said, the client repeats what she said until the service provider paraphrases correctly.
- If the service provider begins to give advice, the observer reminds him/her of his/her role during this activity.

Discussion/feedback in small groups (2 minutes)

In each group, in turn, the 1) service provider, 2) client, & 3) observer gives feedback to service provider concerning the service provider's use of paraphrasing, its effectiveness and any difficulties experienced.

3rd role play. In each group, participants change roles as follows:

- service providers become observers
- observers become clients
- clients become service providers

In each group, the client explains her problem, 1-2 phrases at a time to allow the service provider to practice. The service provider paraphrases what the client said (2 minutes). The observer pays attention to the behavior of the service provider in order to be able to give feedback.

- If the service provider does not accurately reflect what the client said, the client repeats what she said until the service provider paraphrases correctly.
- If the service provider begins to give advice, the observer reminds him/her of his/her role during this activity.

Discussion/feedback in small groups (2 minutes)

In each group, in turn, the 1) service provider, 2) client, & 3) observer gives feedback to service provider concerning the service provider's use of paraphrasing, its effectiveness and any difficulties experienced.

SUMMARY (10 min)

Ask the group:

- Was this activity easy? Difficult? How? In what sense?
- Did you have problems paraphrasing correctly? Why?

If yes, generally because:

- It's a new technique
- One is distracted
- The tendency to want to intervene (which is more familiar to health professionals, used to take medical histories)
- A pre-occupation with one's own response to what the client said.

- In what way can paraphrasing be useful in the context of an antenatal or postnatal consultation?

- Paraphrasing allows the service provider to:
 - verify if he/she has understood what the client said
 - pay attention to worries and other pre-occupations of the client which may prevent her from taking necessary precautions
- Paraphrasing confirms for the client that the service provider has heard and understood what she has said

Ask participants:

- In what way can paraphrasing used by the client be useful in the context of a consultation?

- confirms for the service provider that the client has understood the information given
- gives the service provider the chance to clarify information/instructions which may not have been clear

- Are there limitations to using paraphrasing in antenatal and postnatal consultations?

Only as in the case of passive listening: it is not in and of itself enough to carry out a consultation. Questions & dialogue are also important.

SESSION GUIDE 5: TECHNIQUES OF COUNSELING: ACTIVE LISTENING

Part 3: Clarifying Questions

Objectives: By the end of the session, each participant will be able to:

1. Explain the difference between closed and open questions.
2. Define clarifying questions.
3. Give at least 3 reasons why one should use open questions in counseling.
4. Demonstrate the use of open questions.
5. Explain two principles to respect when responding to rumors raised by clients or others.
6. Demonstrate active listening skills in a role play situation.

Methods: discussion, exercises

Time: 3 hours

Materials:

Flip charts:

- Role play discussion questions
- Principles of Using Clarifying Questions

Handouts:

- Role play discussion questions
- Principles of Using Clarifying Questions
- Principles of Counseling

INSTRUCTIONS:

I-IV. CLARIFYING QUESTIONS (1 hour)

Ask the group:

- What are some of the reasons we ask clients questions during an antenatal or postnatal consultation?

- To evaluate client health
- To evaluate client knowledge
- To help the client to weigh her options
- To help the client make a decision
- To help the client act after having made the decision

- What are some questions you ask clients during an antenatal or postnatal consultation?

Note examples (6 - 8) 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

Explain that:

- Closed questions can be:
 - Neutral: one can answer with a "yes", "no" or a fact. These questions are used most often to obtain certain facts (general information about the client during the intake interview). (Examples: How old are you? Are you married? How many children do you have?)
 - Directed: suggest to the client the "correct" response (and in this sense they can be a form of manipulation). Often these questions:
 - are statements which end with a question mark
 - have an element of "Isn't that right?"
(Example: "You will want to breastfeed your baby won't you?")
- Closed directed questions should be used with caution in counseling (principally for gaining basic information).
- Clarifying questions are open questions that the service provider uses to help the client to reflect and to make her own decision. They:
 - Ask for more information/specifics
 - Help the client identify possible alternatives & weigh the pros & cons of each
 - Help the client reflect on her situation, on her feelings & 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 an antenatal or postnatal counseling example). (2 minutes)

Ask the group:

- What did you observe?
- In what ways did open questions contribute to communication between the service provider and the client?

The use of open questions facilitated communication between the health worker and the client:

- Regarding the evaluation of:
 - the health of the client
 - the client's knowledge
 - the client's feelings and concerns regarding her pregnancy/baby
- Which helped the client:
 - Identify more alternatives for action and weigh her options (by anticipating the

possible consequences of each of the actions)

- make a decision based on this analysis
- act after having made the decision

Divide participants into groups of 3. In each group, participants decide who will be a) service provider, b) client, and c) observer for the first role play. (All participants will play all roles by the end of the practice.)

Choice of subject. Give participants 2 minutes to choose a problem/case they wish to use when they play the role of client (to avoid being distracted by the need to choose during the role plays). The problem/case should be a problem posed by an antenatal or postnatal client. It should have an element of worry or anxiety to it. It can be the same as for previous roles plays.

1st role play (2 minutes)

In each group, the client introduces her problem. The service provider asks open questions in order to help the client assess her problem, consider alternatives and find a solution. The observer pays attention to the quality of questions posed by the service provider in order to be able to give feedback. If the service provider begins to give advice etc, the observer reminds him/her of the task.

N.B. For all role plays, it is important to control time according to the instructions 1) to respect the time allowed for the session, and 2) to put participants more at ease. Some people may be uncomfortable about role playing, especially at the beginning. Limiting the amount of time reduces this discomfort.

Discussion/feedback in small groups (2 minutes). In each group, in turn, the 1) service provider, 2) client, & 3) observer gives feedback to service provider concerning the service provider's use of, and problems with, open questions.

2nd role play. In each group, participants change roles as follows:

- service providers become observers
- observers become clients
- clients become service providers

In each group, the client explains her problem, 1-2 phrases at a time. The service provider asks open questions about what the client said, including focusing on the emotions, feelings etc he/she perceives as being behind the message as appropriate. (2 minutes). The observer pays attention to the behavior of the service provider in order to be able to give feedback. If the service provider begins to give advice, the observer must remind him/her of his/her role during this activity.

Discussion/feedback in small groups (2 minutes)

In each group, in turn, the 1) service provider, 2) client, and 3) observer gives feedback to service provider concerning the service provider's use of open questions, their effectiveness and any difficulties experienced.

3rd role play. In each group, participants change roles as follows:

- service providers become observers
- observers become clients
- clients become service providers

In each group, the client explains her problem, 1-2 phrases at a time. The service provider asks open questions about what the client said, including focusing on the emotions, feelings etc he/she perceives as being behind the message as appropriate. (2 minutes). The observer pays attention to the behavior of the service provider in order to be able to give feedback. If the service provider begins to give advice, the observer must remind him/her of his/her role during this activity.

Discussion/feedback in small groups (2 minutes). In each group, in turn, the 1) service provider, 2) client, and 3) observer gives feedback to service provider concerning the service provider's use of open questions, their effectiveness and any difficulties experienced.

SUMMARY (large group discussion)

Ask the group:

- Was it easy or difficult to formulate open and relevant questions that helped the client reflect on her situation and choices? In what way?

If one has a habit of asking closed questions, it takes some effort to formulate open and useful questions.

Post the flip chart *Principles of Using Clarifying Questions* and review them with the group:

V. RESPONDING TO RUMORS (20 minutes)

Ask the group:

- In the communities where you are working do you encounter rumors regarding pregnancy, delivery and newborn care? How are you facing them?
- 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 information is important to people but it is not clear, and
- there is nobody who can clarify the information
- the source is considered to be credible

Presentation of information to clients - exercise

To demonstrate principles of presentation of information to clients (and how it can sometimes lead to rumors) invite the group to participate in the following exercise:

Ask for 4 volunteers who will leave the room and a fifth to come to the front of the room.

Ask the participant (5th 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 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?

- | |
|---|
| <ul style="list-style-type: none">• 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

➤ How was the information organized?

There was no logical order

➤ What was the main message?

The "discussion of sexual behaviors & 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 antenatal and postnatal counseling?

- Very little information is retained by clients
- Information which is poorly communicated and poorly understood by clients is a fertile source of rumors

➤ To help clients to remember important information that we have communicated to them about antenatal or postnatal care, what must we do?

- Limit ourselves to key information according to client needs
- Repeat key information several times during the consultation
- 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 client knows already
- Ask the client to repeat the message to verify what she understood and retained

- How can we best respond when faced with rumors raised by clients?

In certain situations, it may be appropriate to present directly the truth regarding the particular issue (for example, when the client seems fairly sure that the issue he/she has raised is a rumor).

In most situations, 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 client.

VI. INTEGRATION OF ACTIVE LISTENING COMPONENTS (1 hour 40 minutes)

Invite participants to practice integrating their skills of passive listening, paraphrasing and asking clarifying questions by participating in role plays based on cases prepared by the trainers. There will be three to six role plays so that each participant will have the opportunity to play the part of service provider, client and observer at least once (and possibly twice, time permitting).

Divide the group into groups of 3. In each group, there is a service provider, client and observer. Give a prepared role play case to the client who reads it (silently to him/herself) to prepare his/her role. (The same role play situation should be given to all groups so that the large group discussion following the role plays can focus on common issues.)

Give the groups 15 minutes to conduct their role plays.

Stop the role plays and give the groups 5 minutes for feedback within their groups (beginning with the service provider, followed by the client & the observer). Participants use the flip chart/hand out *Role Play Discussion Questions* as a basis for giving feedback.

Ask participants to change roles within the groups and conduct a second, then a third, role play, as indicated in the instructions above. Each time, give the client of each group a new role (the same role play situation to be used by all groups).

Following the first series of role plays, lead a discussion on the experience of counseling using Active Listening skills. The group discusses any problems they have experienced as well as the application of this counseling technique to the conduct of antenatal and postnatal consultations.

- How well did participants apply these skills?
- What problems did they encounter?
- How useful did they find the approach to antenatal and postnatal counseling?

Distribute the handout *Principles of Counseling*. Ask volunteers to read the principles. Invite the group to make any comments they may have regarding the various principles. Emphasize what every statement means: 1) from the provider perspective and 2) from the client perspective.

Suggest to the group that:

- the *Counseling check list* plus the role play questions can be used to continue to monitor the application of one's counseling skills to the delivery of antenatal and postnatal services.
- Continuing practice with clients in their clinics will enable them to further master their skills.

Proceed to the evaluation of the workshop, including asking participants to complete a written evaluation if desired.

PRINCIPLES OF USING CLARIFYING QUESTIONS

1. Do not ask open questions too early in the interview. The service provider should have listened sufficiently to the client (using passive listening, paraphrasing and closed questions) to have gained the client's trust and be able to ask relevant and useful questions.
2. The service provider must be able to have the client's confidence in order for the interview to be productive.
3. Clarifying questions should not serve as an interrogation but rather assist the client to reflect on her situation.
4. Clarifying questions should not begin with "Why . . .?" Questions that begin with "Why" tend to put people on the defensive and create reasons and excuses when there were none.

ROLE PLAY DISCUSSION QUESTIONS

Questions for health workers

1. What did you do to put the client at ease, to gain her confidence?
2. What did you do to help the client talk about her problem, to clarify information about her problem?
3. Were you able to respond to concerns of the client? If yes, how? If no, why not?
4. What additional services or assistance might this client still need?
5. Were there any blockages during your interaction with the client (problems of communication, client's reaction to you and/or something you asked or said, lack of information etc)? What did you do to resolve any problems between you and the client? What might you have done differently?

Questions for clients

1. How did you feel at the beginning of your interaction with the health worker?
2. Did the health worker put you at ease? How? If not, why not?
3. Did the health worker help you? How? If not, why not?
4. What more might the health worker have done to help you?
5. Did the health worker give you correct and appropriate information in a way that you could understand?
6. Did you sense any judgments on the part of the health worker? Give examples.

Questions for observers

1. Did the health worker:
 - introduce him/herself to the client?
 - define his/her role (what the client could expect from him/her)?
 - encourage the client to discuss any problems or concerns she had?
 - give advice? (give an example)
 - pass judgments or moralize?
 - demonstrate respect for the client?
 - allow the client time to think about (or reflect on) her situation?
 - verify the client's understanding of important points?
 - demonstrate confidence in his/her skills, & in the client's abilities to deal with her problem?
 - lack certain information? (give examples)
 - offer to see the client again if the client wishes?
2. Was the information given by the health worker correct and complete?
3. Did the session end in a positive manner?
4. Other points/observations not already covered?

PRINCIPLES OF COUNSELING

1. Establish a relationship of trust with the client. Use a warm tone of voice, avoid criticisms and judgments. Listen carefully to what the client says and pay attention to any feelings or messages behind what is said. Respect confidentiality.
2. Ensure a logical sequence to the counseling.
3. Limit closed questions (with 'yes'/'no' answers) which do not facilitate communication.
4. Gather information about the client's needs, expectations of the consultation and concerns (through open questions). Draw out information which may help the client in making and carrying out her decision. Decisions regarding changes in behaviors may be easy but the development of habits necessary to sustain the behavior changes may be difficult.
5. Pay attention to problems and concerns expressed by the client; do not ignore nor negate them. Such acknowledgement contributes to a trusting relationship and allows the service provider to gain information which may be important in the client's choice of actions and in instructions given to the client.
6. Be positive in the diagnosis of problems. For example, if the client has problems forgetting to take a medication, instead of asking "Why did you forget to take your medication?" a more positive response would be "Let's see what you did when you took these medication correctly. Since you were taking them correctly, you can do it again."
7. Recognize that certain clients who are ill at ease may unconsciously test the service provider to see if he/she accepts them before revealing their problems or concerns, or asking questions. If the client becomes defensive, it may mean that she feels threatened or ill at ease. This may be because the health worker has not shown respect for the client or doesn't accept her; or because the health worker is ill at ease.
8. Provide concrete, correct, objective information.
9. Support and encourage the client:
 - be aware that this prenatal consultation may be a new experience for the client (she may be pregnant for the first time, or she may not have sought prenatal services during previous pregnancies)
 - be patient and encourage questions; take the time necessary to assist the client with her decision

- verify that you have responded to all the client's questions and concerns, and that she has understood all the necessary information.
10. Identify possible obstacles related to the client's ability to act on her decisions (via open questions about the client's social situation, her partner's or other family member knowledge and preferences regarding the situation in question etc). If there are obstacles which are not discussed and resolved, they may prevent the client from taking necessary actions.
 11. Use language the client can understand.
 12. Correct rumors by questioning the client to see where the rumor comes from and helping her to see the lack of logic herself.
 13. Respect the client's privacy and do not judge her behavior
 14. Respect the client's confidentiality: in the process of counseling and in maintenance of client records
 15. Use visual aids to help clients better understand the explanations you are giving
 16. Pay close attention to the client's non-verbal communication
 17. Speak simply and minimize unnecessary explanations. Emphasize information essential to the client's needs and/or requests.
 18. Develop one idea at a time. Define terms before developing entire concepts.
 19. Establish a rapport between new ideas and the client's existing knowledge and/or experience, associate the unknown with the known
 20. Repeat important and/or difficult information and concepts (using examples)
 21. Do not try to convince the client of your point of view nor give her solutions to her problems (except for clinical/medical advice)