

A handbook for building skills

# **Counselling for Maternal and Newborn Health**

Adaptation Guide

**WHO**  
**July 2008**

# TABLE OF CONTENTS

<b>ACKNOWLEDGEMENTS</b> .....	<b>III</b>
<b>ABBREVIATIONS</b> .....	<b>IV</b>
<b>1. INTRODUCTION</b> .....	<b>1</b>
<b>2. ABOUT THE MNH COUNSELLING HANDBOOK</b> .....	<b>2</b>
<b>2.1 BACKGROUND</b> .....	<b>2</b>
<b>2.2 DEVELOPMENT</b> .....	<b>2</b>
<b>2.3 CONTENT</b> .....	<b>3</b>
<b>2.4 KEY PRINCIPLES</b> .....	<b>4</b>
<b>2.5 INTENDED USERS</b> .....	<b>5</b>
<b>3. ADAPTATION PROCESS</b> .....	<b>5</b>
<b>3.1 ASSESSING THE NEED TO ADAPT</b> .....	<b>5</b>
<b>3.2 PROCESS OF ADAPTATION</b> .....	<b>7</b>
3.2.1 <i>Appoint an Adaptation Committee</i> .....	<b>7</b>
3.2.2 <i>Develop the Terms of Reference</i> .....	<b>8</b>
3.2.3 <i>Review the MNH Counselling Handbook</i> .....	<b>8</b>
3.2.4 <i>Adaptation</i> .....	<b>9</b>
3.2.5 <i>Align with National Policies</i> .....	<b>9</b>
<b>4. TRANSLATION</b> .....	<b>10</b>
<b>5. SUGGESTED ADAPTATIONS</b> .....	<b>10</b>
<b>5.1 LINKS WITH PCPNC</b> .....	<b>10</b>
<b>5.2 CONSIDERATIONS FOR ADAPTATION</b> .....	<b>12</b>
<b>5.3 CULTURAL CONSIDERATIONS</b> .....	<b>13</b>
5.3.1 <i>Counselling Skills (Session 3)</i> .....	<b>13</b>
5.3.2 <i>Factors influencing the Counselling Session (Session 4)</i> .....	<b>13</b>
5.3.3 <i>Support during Labour (Session 10)</i> .....	<b>14</b>
5.3.4 <i>Death and Bereavement (Session 15)</i> .....	<b>15</b>
<b>5.4 ILLUSTRATIONS</b> .....	<b>15</b>
<b>5.5 LOCAL TERMINOLOGY AND CONCEPTS</b> .....	<b>16</b>
5.6.1 <i>Post-Abortion Care (Session 9)</i> .....	<b>17</b>
5.6.2 <i>Women and Violence (Session 16)</i> .....	<b>17</b>
<b>5.7 CONSISTENCY WITH NATIONAL PROTOCOLS AND GUIDELINES</b> .....	<b>17</b>
5.7.1 <i>Counselling Paradigms (Sessions 2-5)</i> .....	<b>18</b>
5.7.2 <i>General Care (Session 6)</i> .....	<b>18</b>
5.7.3 <i>Birth and Emergency Planning (Session 7)</i> .....	<b>18</b>
5.7.4 <i>Family Planning Counselling (Session 12)</i> .....	<b>19</b>
5.7.5 <i>Breastfeeding (Session 13)</i> .....	<b>19</b>
5.7.6 <i>Women with HIV/AIDS (Session 14)</i> .....	<b>20</b>
<b>5.8 PRIORITY MATERNAL AND NEWBORN HEALTH ISSUES NOT ADDRESSED</b> .....	<b>20</b>
5.8.1 <i>Female Genital Mutilation (FGM)</i> .....	<b>20</b>
5.8.2 <i>Obstetric Fistulae</i> .....	<b>21</b>
5.8.3 <i>Malaria</i> .....	<b>22</b>
5.8.4 <i>Adolescents and Women with Special Needs</i> .....	<b>22</b>
<b>6. BUILDING CONSENSUS FOR ADAPTATION</b> .....	<b>23</b>
<b>7. FIELD TESTING</b> .....	<b>23</b>
<b>8. IMPLEMENTATION</b> .....	<b>24</b>

8.1 PRODUCTION, DISTRIBUTION AND DISSEMINATION .....	24
8.2 INTRODUCING THE MNH COUNSELLING HANDBOOK .....	24
8.3 ENSURING MNH COUNSELLING HANDBOOK'S USE .....	25
8.4 TRAINING AND SUPERVISION .....	26
<b>9. MONITORING AND EVALUATION .....</b>	<b>26</b>
<b>10. ADAPTATION BIBLIOGRAPHY .....</b>	<b>28</b>
<b>11. OTHER REFERENCES .....</b>	<b>28</b>
<b>ANNEX 1.....</b>	<b>31</b>
<b>ANNEX 2.....</b>	<b>33</b>
<b>ANNEX 3.....</b>	<b>40</b>
<b>ANNEX 4.....</b>	<b>50</b>
<i>Box 1 MNH COUNSELLING HANDBOOK'S OBJECTIVES .....</i>	<i>1</i>
<i>Box 2 MNH COUNSELLING HANDBOOK'S TOPICS .....</i>	<i>3</i>
<i>Box 3 TRANSLATION TIPS.....</i>	<i>10</i>
<i>TABLE 1 PCPNC LINKS TO ADAPTATION GUIDE &amp; MNH COUNSELLING HANDBOOK .....</i>	<i>11</i>
<i>TABLE 2 SUMMARY TABLE: CONSIDERATIONS FOR ADAPTATION .....</i>	<i>12</i>
<i>TABLE 3 POTENTIAL LANGUAGE BARRIERS.....</i>	<i>16</i>
<i>TABLE 4 EVALUATING THE MNH COUNSELLING HANDBOOK .....</i>	<i>27</i>
<i>FIGURE 1 SCHEMATIC OVERVIEW OF THE COUNSELLING PROCESS .....</i>	<i>4</i>
<i>FIGURE 2 FLOW DIAGRAM: SUGGESTED ADAPTATION PROCESS .....</i>	<i>7</i>

## **Acknowledgements**

This Adaptation Guide for "**Counselling for Maternal and Newborn Health: A handbook for building skills**" was written by Hannah Ashwood-Smith, with technical support from Annie Portela (World Health Organization Department of Making Pregnancy Safer (WHO/MPS)).

Valuable inputs were received from Yolande Coombes, independent consultant and Margareta Larsson, Ornella Lincetto, Matthews Matthai, Juliana Yartey, and Jelka Zupan of the WHO/MPS Department. In addition, Heather Brown provided input on the sections about sexuality, and Nasr Abdallah of Sudan provided comments regarding cultural considerations. The first draft was edited by Pat Coppard and Barbara Ashwood-Smith. The final draft was edited by Anayda Portela and Karen Mulweye, WHO/MPS.

MPS/WHO gratefully acknowledges the contribution of the teams who conducted the field reviews for the "**Counselling for Maternal and Newborn Health: A handbook for building skills**" (MNH Counselling Handbook) in Malawi, Indonesia, Sudan and the Philippines. Many of the suggested recommendations in this document draw from this body of work. The enthusiasm, motivation and commitment of the Skilled Attendants interviewed were paramount to the development of the MNH Counselling Handbook and to this technical adaptation guide.

## Abbreviations

<b>AIDS</b>	Acquired immunodeficiency syndrome
<b>ANC</b>	Antenatal care
<b>ARV</b>	Antiretroviral drug
<b>BEOC</b>	Basic emergency obstetric care
<b>CEOC</b>	Comprehensive emergency obstetric care
<b>FGM</b>	Female genital mutilation
<b>FP</b>	Family Planning
<b>HIV</b>	Human immunodeficiency virus
<b>IEC</b>	Information, education and communication department
<b>IUD</b>	Intrauterine Device
<b>LAM</b>	Lactational Amenorrhoea Method
<b>MCH</b>	Maternal and child health
<b>MPS</b>	Making Pregnancy Safer
<b>MNH</b>	Maternal and Newborn Health
<b>PCPNC</b>	Pregnancy, Childbirth, Postpartum and Newborn Care: A Guide for Essential Practice
<b>PLPWA</b>	People Living Positively with AIDS
<b>PMTCT</b>	Prevention of mother-to-child transmission
<b>SAs</b>	Skilled Attendants
<b>STIs</b>	Sexually transmitted infection
<b>TB</b>	Tuberculosis
<b>TBAs</b>	Traditional Birth Attendants
<b>WHO</b>	World Health Organization

## 1. Introduction

The World Health Organization (WHO) developed a clinical guide entitled “Pregnancy, Childbirth, Postpartum and Newborn Care: A guide for essential practice” (PCPNC). The aim of the PCPNC is to provide evidence-based recommendations to guide health care professionals in the management of women during pregnancy, childbirth, postpartum and post-abortion periods, and newborns during the first week of life, including management of endemic diseases like malaria, HIV/AIDS, TB and anaemia. All recommendations are for Skilled Attendants (SAs) who work at the primary level of care, in health facilities or in the community. While the PCPNC serves as a guide for clinical decision-making and includes recommendations on the information to share with women and their families, little guidance is included on how to effectively communicate and counsel.

Many countries have documented weak communication and counselling skills in health workers as a major deterrent to health service use (Nicholas et al, 1991; Jacobsen, 1991; Ashwood-Smith et al, 2000). Evidence-based information provided to practitioners and training strategies to strengthen their clinical skills need to be complemented by strategies geared towards improving their inter-personal and inter-cultural skills. Studies examining quality of care factors in maternity facilities have identified improving communication and counselling skills as a priority for improving access to, and utilization of, *quality* maternal and newborn health (MNH) services (WHO, 2003; Hulton et al, 2000; Jacobsen, 1991; Ashwood-Smith et al, 2000). Improved interpersonal communication and intercultural competence of health care workers result in greater client satisfaction levels, higher compliance with treatments, more accurate diagnoses, positive outcomes, enhanced perceptions of quality of care, and overall increased service use (WHO, 2003; Brown et al, 1995; Young Mi Kim et al, 2001).

It is therefore important to consider how to support SAs in providing the many recommendations for women and their families included in the PCPNC: With this goal in mind, the Making Pregnancy Safer Department (MPS) of the WHO developed “A handbook for building skills: counselling for maternal and newborn health” for SAs. The main aim of this practical Handbook (herein referred to as the MNH Counselling Handbook), and companion to the PCPNC, is to strengthen SAs’ counselling and communication skills, helping them to effectively convey to women, families and communities the key issues surrounding pregnancy, childbirth, postpartum and postnatal care highlighted in the PCPNC. Box 1 describes the MNH Counselling Handbook’s primary objectives.

### Box 1 MNH Counselling Handbook’s Objectives

#### **MNH Counselling Handbook’s Objectives:**

The SA should learn how to:

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

The MNH Counselling Handbook can be utilized as it stands, or tailored to meet a country's specific needs. The present document serves as a technical adaptation guide for the MNH Counselling Handbook, developed to help programme managers, policy makers and reproductive health specialists analyse the MNH Counselling Handbook, exploring potential areas for change. It describes the key principles, purpose and objectives of the generic MNH Counselling Handbook. It explores a methodology for countries to adapt its content to suit their local country's context. It covers recommendations, drawn in part from WHO documents on technical adaptations (WHO, 2007; WHO, 2005; Church, 2006) and includes specific examples extracted from the field reviews conducted in four countries in Africa and Asia. The final section of the guide contains the bibliography and references (annexes 1 and 2) for the MNH Counselling Handbook, an overview of the methodology and samples of tools (used in the field reviews) that may assist in the adaptation process and field testing (annex 3), and a summary of recommendations from the field reviews (annex 4).

## 2. About the MNH Counselling Handbook

### 2.1 Background

This generic MNH Counselling Handbook is designed to support SAs in developing effective counselling and communication skills in maternal and newborn health. It can be used in conjunction with the PCPNC, but also on its own, as fundamental information from the PCPNC has been integrated into the Handbook, including Section M, Information and Counselling sheets, which summarize the key information to share with women and their families during pregnancy, labour and birth, and in the postnatal and post-abortion periods.

The nature of the MNH Counselling Handbook is open and flexible, with a strong emphasis on skills building. In the past, SAs have frequently focused on one-way provision of information rather than two-way shared dialogue. The main mandate of this Handbook is to provide key counselling skills to the SAs so they can assist women and their families to make informed decisions to improve maternal and newborn health. Women are more likely to improve their health status if they have a full understanding and ownership in the decision-making process (Portela & Santarelli, 2003).

The MNH Counselling Handbook is chiefly designed to be used by groups of SAs with the help of a facilitator. Ideally, the facilitator should be someone with a counselling background who can guide and motivate the SAs as they work through the Handbook. It can also be used by individuals who can get together with other SAs for discussions and activities where needed. It relies on a self-directed learning approach, allowing SAs to work at their own pace, drawing on their past counselling experience. The way it is used will be determined by each country's context, and the SAs' preference.

### 2.2 Development

The MNH Counselling Handbook was developed through a participatory process that incorporated the views and expertise of a wide number of international stakeholders, both in developed and developing countries. It has been field tested with the intended users in three countries<sup>1</sup> (Indonesia, the Philippines, and Sudan) through a review process that included group discussions, in-depth interviews, observation techniques (groups of SAs working through specific topic

---

<sup>1</sup>The content was also reviewed with community midwives in Malawi during an early stage of development.

sessions), and questionnaires. The findings from these methods were compiled and presented at a workshop which took place in each country at the end of the review process, to generate a consensus among SAs and programme managers for the recommended changes. The findings from the different field reviews were then discussed by an international expert panel in a meeting at WHO Headquarters in Geneva. Maternal and newborn health specialists were asked to review the Handbook and provide their comments which were also reviewed in the above-mentioned meeting. The expert group provided guidance as to revisions and amendments to be made. Finally, the MNH Counselling Handbook was edited for comprehension, technical accuracy, grammar and punctuation.

### 2.3 Content

The MNH Counselling Handbook is divided into three main sections. Part 1 is an introduction which describes the aims and objectives and the general layout of the Handbook. Part 2 describes the counselling process and outlines the six key steps to effective counselling. It explores the counselling context and factors that influence this context including the socio-economic, gender, and cultural environment. A series of guiding principles is introduced and specific counselling skills are outlined. Part 3 focuses on different maternal and newborn health topics which are outlined in Box 2 on the next page.

The MNH Counselling Handbook contains specific aims and objectives for each session, clearly outlining the skills that will be developed and corresponding learning outcomes. Practical activities have been designed to encourage reflection, provoke discussions, build skills and ensure the local relevance of information. The information generated through these activities may prove valuable for SAs during their counselling sessions. For example, one activity asks the participants to identify local beliefs and practices related to pregnancy and childbirth, and then categorize these practices into helpful, harmless, or harmful to the woman and her newborn. This list can guide future discussions with women and their families. Another activity aims to improve the physical counselling environment and asks the SAs to examine their health facilities from a woman's perspective and make concrete changes to improve the overall atmosphere. There is a review at the end of each session to ensure the SAs have understood the key points before they progress to subsequent sessions.

#### Box 2 MNH Counselling Handbook's Topics

<i>Box 2</i>	<i>MNH Counselling Handbook's Topics</i>
Session 6	General care in the home during pregnancy
Session 7	Birth and emergency planning
Session 8	Danger signs in pregnancy
Session 9	Post-abortion care
Session 10	Support during labour
Session 11	Postnatal care of the mother and newborn
Session 12	Family planning counselling
Session 13	Breastfeeding
Session 14	Women with HIV/AIDS
Session 15	Death and bereavement
Session 16	Women and violence
Session 17	Linking with the community

Figure 1 illustrates the core counselling concepts outlined in the MNH Counselling Handbook. At the beginning of each topic session, the image is repeated, with the relevant counselling skills/concepts highlighted specifically for each particular session. These are not mutually exclusive and an SA can work through the topics systematically or simply choose topics or counselling skills that she/he needs to strengthen. The Handbook is designed to build on the SAs' existing knowledge and strengthen their counselling skills.

**Figure 1 Schematic Overview of the Counselling Process**



## 2.4 Key Principles

The MNH Counselling Handbook promotes a participatory, interactive approach and focuses on counselling methods that accentuate dual communication, interaction and dialogue. Counselling principles including self reflection, empathy and respect, and shared problem-solving are emphasized. The value of forming an alliance with the pregnant woman and her family (or the community at large) is discussed and ways of facilitating a two-way discussion through open questioning and active listening are explored. The MNH Counselling Handbook addresses the importance of:

- the woman making health decisions in partnership with the SA
- the woman's wishes and choices being respected
- the SA helping to find solutions and generate alternatives to suit the woman's needs
- the SA respecting the woman, ensuring confidentiality, and demonstrating a non-judgemental attitude.

## 2.5 Intended Users

The MNH Counselling Handbook is primarily designed for use by Skilled Attendants<sup>2</sup>. A universal definition of a “skilled” attendant is difficult to operationalize, as levels of education and competency/skills vary from country to country. During the field reviews, it was discovered that the educational status of SAs varied from practitioners with Master’s Degrees, to those with primary levels of education assisting in births following a six-month training course. While it is recognized that most countries are working towards the definition stated below, the MNH Counselling Handbook has been designed using simple language, and aims to cover a broad audience, even those with lower levels of education. The successful use of the MNH Counselling Handbook will obviously depend on the overall literacy and educational levels of the SAs, and their current standards of practice.

The definition stated below has been used for the purpose of the MNH Counselling Handbook and adaptation guide:

*The term **skilled attendant** is defined as “an accredited health professional - such as a midwife, doctor or nurse - who has been educated and trained to proficiency in the skills necessary to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborn.” (WHO et al, 2004)*

If a different definition of SA is used by certain countries, or the MNH Counselling Handbook is to be used in SA pre-service training, or for a different type of health worker, adaptation issues will vary accordingly. Where this was the case in the field reviews, some programmes suggested using a facilitated approach with role-plays and taped versions of the MNH Counselling Handbook as a way to ensure that those health workers with lower reading levels could fully understand its contents.

## 3. Adaptation Process

The next session suggests a methodology for the adaptation process. The framework has been drawn from a variety of WHO adaptation guides (WHO, 2007; WHO, 2005; Church K, 2006), data from field reviews, and comments from the WHO expert panel.

### 3.1 Assessing the Need to Adapt

The MNH Counselling Handbook has been designed as a generic document. The decision on whether to adapt the Handbook and the degree of adaptation required will be dependent on each country’s needs and circumstances. The purpose of this document is to provide a suggested framework for programme managers to analyse the MNH Counselling Handbook, helping them to change the global document into a locally acceptable, culturally sensitive version to suit their country context. The team is encouraged to consider national norms, modifications to the PCPNC, language and dialect issues, and local terms related to maternal and newborn care.

---

<sup>2</sup> The MNH Counselling Handbook may be used in pre-service or in-service training.

The generic MNH Counselling Handbook is available on-line and for a free download access on [http://www.who.int/making\\_pregnancy\\_safer/publications/en/](http://www.who.int/making_pregnancy_safer/publications/en/). For a hard copy or a CD of the MNH Counselling Handbook write to:

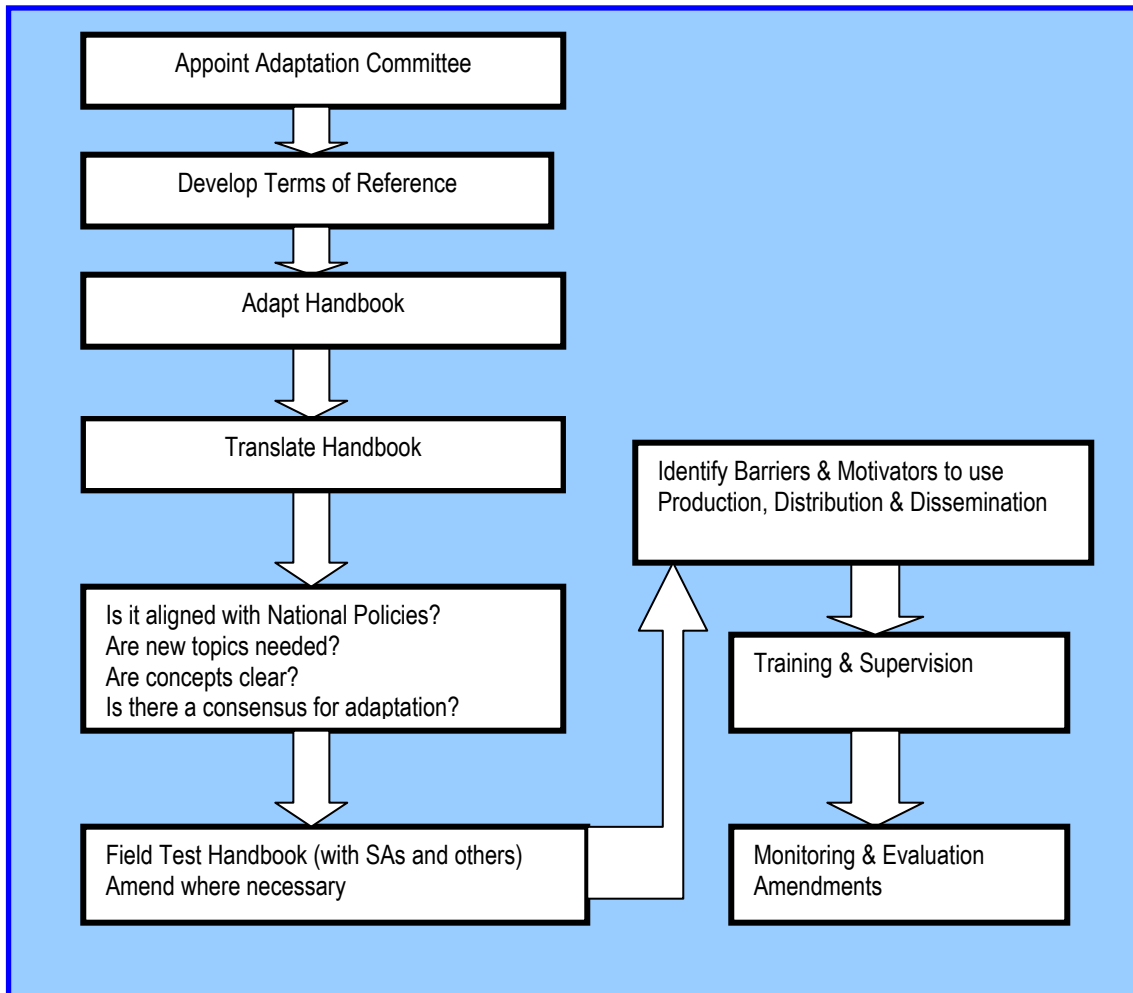
The Department of Making Pregnancy Safer (MPS)  
World Health Organization (WHO)  
20 Avenue Appia  
1211 Geneva 27  
SWITZERLAND  
Tel: +41 22 791 3371  
Fax: +41 22 791 4171  
Email: [MPSinfo@who.int](mailto:MPSinfo@who.int)

The software used is ADOBE InDesign CS 2 and CS 3. The original document has been printed in colour but we have also included a black and white version on the CD to facilitate photo copying and use in workshops, etc.

### 3.2 Process of Adaptation

Figure 2 outlines a flow diagram with a suggested process to facilitate the adaptation of the MNH Counselling Handbook. Each entry is explained below in more detail.

Figure 2 Flow Diagram: Suggested Adaptation Process



#### 3.2.1 *Appoint an Adaptation Committee*

It is important to identify a group of key stakeholders and appoint a committee or an adaptation taskforce. If a committee has already been formed to adapt the PCPNC, a small subgroup from this committee could be appointed to ensure that the changes to the PCPNC are taken into account when reviewing the MNH Counselling Handbook. If a committee does not exist, a variety of members could be invited to join the committee, including representatives from the Ministry of Health, non-governmental organizations, professional associations (including different cadres of nurses, midwives, doctors and obstetricians), health managers of private and government institutions, district health officers, other key ministries, and departments (e.g. social work, counselling, community services, media, communication, health education etc.), local opinion leaders, women's groups, religious groups and youth groups. The size of the adaptation committee will depend on each country's needs, but experience has shown that large groups for these tasks are often less functional. You may wish to include a larger group to review and provide comments

but designate a smaller adaptation committee charged with making final decisions; you may wish to organize a number of different working/sub-groups that can provide technical input. For example, one sub-group could provide technical input if a new maternal health or newborn health session needs to be developed, or they could ensure that the MNH Counselling Handbook is aligned with national policies. Another sub-group may be responsible for the production and dissemination of the MNH Counselling Handbook, and the third sub-group could organize training, supervision and evaluation strategies.

### *3.2.2 Develop the Terms of Reference*

Once an adaptation committee and/or technical sub-groups have been appointed, a working brief or terms of reference for the group could be developed. This will determine how the group will function. Issues to consider include the appointment of a chair, someone to take minutes, and perhaps a principle coordinator who could review the document in detail before the larger group meets. Goals, specific objectives and a timeline should be drawn up, and activities outlined.

### *3.2.3 Review the MNH Counselling Handbook<sup>3</sup>*

Before reviewing the MNH Counselling Handbook, it is essential to agree upon the intended users. As previously mentioned, a clear definition of the SAs' literacy levels, educational background and skills level should be established. This will affect a number of factors as you go through the MNH Counselling Handbook. For example:

- Are there any concepts that are either too difficult or self-evident for the intended group of users?
- Even in English speaking countries, there may be language issues. In a non-English speaking country, at what moment in the process does the MNH Counselling Handbook need to be translated and in how many languages or dialects, depending on the context? In any language consider if the language is clear for the SAs? Are national/local terms for MNH used and appropriate?
- Are the images acceptable? Do they accurately portray the reality?
- Are the technical aspects appropriate to the SAs' skill level?
- Does the MNH Counselling Handbook adhere to national policies, guidelines and protocols?
- Do other MNH counselling guides exist? If so, is there new information in this MNH Counselling Handbook relevant to your setting? If other counselling guides exist, it would be beneficial to review them and decide which one best addresses the SAs' MNH needs or if different content from the different guides need to be pulled together.

---

<sup>3</sup> Note - We have placed "Translation" after "Adaptation" in the flow diagram above. However, translation may need to occur prior to review by the Adaptation committee. See section 4. below

You may wish to determine who would be best suited to review the different sessions of the MNH Counselling Handbook and could consider dividing sessions up to ensure the individuals with the most expertise review their areas of speciality. Examples of speciality topics include family planning (FP) counselling, post-abortion care, breastfeeding, violence against women, and HIV/AIDS.

It is also important to ensure your country's relevant existing Reproductive Health (RH) and MNH manuals, policies and guidelines are readily accessible for reference. A copy of the WHO PCPNC would be helpful.

### *3.2.4 Adaptation*

Once the MNH Counselling Handbook has been reviewed by the committee and/or working sub-groups, a decision will be made on whether it needs to be adapted, and if so, which priority areas require attention. The following list of questions could be considered to guide you as you adapt the document:

- What changes need to be made to ensure that the MNH Counselling Handbook adheres to national policies, guidelines and protocols? Or what national policies, guidelines and protocols need to be reviewed based on evidence from the PCPNC?
- Are there any RH or MNH issues that need to be addressed? For example, highly prevalent issues, like malaria or female genital mutilation, that have not been addressed in the generic MNH Counselling Handbook.
- Are there any issues that are not relevant to your country or programme context that you wish to remove?
- Are there any legal issues that need to be addressed that are not currently considered?
- Are there any human, sexual and reproductive rights issues that have not been adequately addressed?
- Is the technical information relevant to your specific health care setting?
- Are there any specific cultural beliefs or traditions which need to be addressed?
- Are the changes you plan to make based on sound evidence?
- Is the language clear and easy to understand?
- Do the illustrations adequately portray the key messages? Are there enough images? Too many images? Do they reflect the customs and culture?

These issues will be discussed in more detail under section 5 of this guide.

### *3.2.5 Align with National Policies*

Each country will have its own maternal and newborn health policies, procedures, protocols and standards. It is important that the information contained in the MNH Counselling Handbook is consistent with these policies. However, if there is a disparity, the adaptation committee should consider if the national policy has been based on the latest body of evidence. When reviewing the MNH Counselling Handbook, pay special attention to the topic sessions, screening them for policies that are not familiar or endorsed in your environment. You may wish to appoint a maternal and newborn health expert from the working sub-group to concentrate on this task. Further specific details of areas of potential discrepancy will be discussed in section 5.7.

## 4. Translation

Most countries will need to translate the MNH Counselling Handbook into their language. In countries where different dialects are spoken, it may need to be translated into several languages. This is a very important part of the adaptation process and can prove quite difficult. The WHO field reviews in Sudan and Indonesia exposed fairly substantial problems related to translation issues. For example, the divergent educational background of the SAs meant that while certain higher educated SAs (obstetricians, physicians, and registered nurses, to name a few) fully understood the English version, for less well educated, rural SAs, many terms were found to be confusing and misunderstood. It is important to give enough time, thought, and resources to this vital task. WHO recommends translations be done by bilingual experienced MNH experts, preferably with sound local knowledge. A few tips are listed in Box 3 to help produce a high-quality translation.

### Box 3 Translation Tips

- It is important to keep the essence /integrity of the MNH Counselling Handbook.
- Use exact words rather than summaries or interpretations.
- Keep it simple and clear.
- Do not omit ideas and concepts because they are hard to translate.
- Translate ideas even if they seem culturally unfamiliar.
- Develop a glossary of key medical and counselling terms that is consistent so that words or phrases can be repeated throughout the MNH Counselling Handbook to help the SAs reinforce ideas.
- “*Back translation*” may be required. This was found to be an important part of the translation process in the field reviews. In other words, once the document is translated into a second language, ask a third bilingual party (not the translator) to re-translate the document into English, and then compare it with the original English version. It would be helpful to provide the glossary of key medical/counselling terms to ensure internal consistency.

## 5. Suggested Adaptations

### 5.1 Links with PCPNC

The technical information in the MNH Counselling Handbook has been principally drawn from the PCPNC. It is likely much of this information has already been approved and/or adapted with the introduction of the PCPNC into your country programmes. Table 1 summarizes areas of the PCPNC that correlate with the adaptation guide and the MNH Counselling Handbook.

**Table 1 PCPNC Links to Adaptation Guide & MNH Counselling Handbook**

<b>Content</b>	<b>PCPNC Section</b>	<b>Adaptation Guide Page nos.</b>	<b>MNH Counselling Handbook Sessions</b>
Managing pregnant adolescents <ul style="list-style-type: none"> <li>Helping adolescents consider options</li> </ul>	H3	Pages 23	Session 2
Emotional support for women with special needs	H2	Page 23	Session 2
Supporting women living with violence	H4	Page 18	Session 16
Community links & co-ordination with health care providers/TBAs	I12		Session 17
HIV/AIDS key information <ul style="list-style-type: none"> <li>VCT care</li> </ul>	G2 G3	Page 21	Session 14
MTCT <ul style="list-style-type: none"> <li>Counselling on feeding choices</li> <li>Replacement feeding</li> </ul>	G6 G7 G8	Page 20	Sessions 13 & 14
Newborn care	J10		Session 11
Breastfeeding <ul style="list-style-type: none"> <li>Assessing breastfeeding</li> <li>Counselling re breastfeeding</li> <li>Alternative feeding methods</li> <li>Information/counselling sheets</li> </ul>	K J4 K2 K5 M7	Page 20	Session 13
General care during pregnancy	M2	Page 19	Session 6
Preparing Birth and Emergency plans	M3	Page 19	Session 7
Care for mother after birth	M4		Session 11
Care for mother post abortion <ul style="list-style-type: none"> <li>Advice and counsel/self-care&amp; support</li> <li>Family planning</li> </ul>	M5 B21 B21	Page 18  Page 20	Session 9  Session 12
Care for baby post birth	M6		Session 11
Preventive measures/additional treatment <ul style="list-style-type: none"> <li>Iron and folic acid</li> <li>Malaria prevention</li> </ul>	F F3 F4	Page 19  Pages 23	Session 6
Antenatal care <ul style="list-style-type: none"> <li>Assessment</li> <li>Signs and symptoms</li> <li>Developing birth &amp; emergency plans</li> <li>Advice on danger signs</li> <li>Family planning</li> </ul>	C C2-C6 C7-11 C14-C15 C15 C16	Page 19  Page 19	Session 8  Session 8 Session 12
Childbirth: labour, delivery & postpartum care <ul style="list-style-type: none"> <li>Supportive care in labour</li> <li>Birth companion</li> <li>Problems immediately postpartum</li> <li>Home delivery</li> </ul>	D D6-7 D7 D22-D25	Page 14 Page 14	Session 10 & 11  Session 11
Postpartum care	E		Session 11 & 13

Content	PCPNC Section	Adaptation Guide Page nos.	MNH Counselling Handbook Sessions
Clean home delivery <ul style="list-style-type: none"> <li>Home delivery by skilled attendant</li> </ul>	M8-M9 D29		
Emergency treatments for the woman <ul style="list-style-type: none"> <li>Bleeding</li> <li>Pre-eclampsia/Eclampsia</li> <li>Infection</li> <li>Malaria</li> <li>Urgent referrals</li> </ul>	B B10-12 B13-14 B15 B16 B17	Pages 23	Session 8

## 5.2 Considerations for Adaptation

Table 2 below summarizes considerations for adaptation and provides issues for the adaptation committee to focus on. This is by no means an exclusive list, and the taskforce may come up with additional issues to consider. Annex 4 provides recommendations from the field reviews in Indonesia, the Philippines and Sudan. Note when making modifications, it is important to maintain the internal consistency of the MNH Counselling Handbook, so if the team makes changes in one session, for example in family planning methods or breastfeeding techniques, related points may be discussed in different sessions, and they should also be adapted accordingly.

The main objective of the adaptation process is to ensure that the MNH Counselling Handbook is relevant, applicable and understandable to SAs or the intended users, and reflects the national policies, culture and maternal and newborn health context.

**Table 2 Summary Table: Considerations for Adaptation**

Issue	Considerations
<b>Cultural Considerations</b>	Are cultural issues addressed sensitively & appropriately?
<b>Illustrations</b>	Are images appropriate? Clear?
<b>Local Terminology &amp; Concepts</b>	Are concepts understandable? Words familiar?
<b>Legal, Human &amp; Reproductive Rights</b>	Are there legal issues that clash with current policy? Are there reproductive rights issues not addressed? Are there elements which can help you advocate for improved women's rights?
<b>Consistency with National Protocols</b>	Are all procedures in line with national policy?
<b>Priority MNH issues not addressed</b> <ul style="list-style-type: none"> <li>Female Genital Mutilation</li> <li>Obstetric Fistulae</li> <li>Malaria</li> </ul>	Have all prevalent MNH issues been covered? Are issues that are not relevant included? (For example, malaria in non-malaria areas?)

### 5.3 Cultural Considerations

In many societies cultural beliefs and practices play an important role in pregnancy, childbirth and the post natal period and therefore need to be carefully considered throughout the MNH Counselling Handbook. This section covers some cultural issues that arose from the field reviews, but there may be additional issues relevant to your own countries' belief systems that the adaptation committee identifies or discovers as they conduct initial reviews.

As it stands, the MNH Counselling Handbook provides ways to help SAs explore local customs and cultures in order to assist them to communicate effectively and provide quality care to women, families and communities. She/he can support those beliefs and practices that are helpful or neutral, such as exclusive breastfeeding and burial of the placenta respectively, and deter those deemed harmful, through a series of activities and interactive discussions with the broader community. In this way, local customs are respected *except* where the practice causes harm. One example of a harmful practice is the custom whereby male partners are encouraged to engage in sexual relations outside the marriage or primary relationship, placing the pregnant woman at risk of sexually transmitted infections. Other examples of harmful practices include placing cow dung on the baby's umbilical cord which can cause infections and neonatal tetanus, giving the newborn other fluids (like honey) instead of exclusive breast milk, and rituals which delay accessing emergency care when danger signs are noted. In these cases the SAs could have a dialogue with the community and key decision-makers or a discussion could be held with the working group to address harmful practices, guided by a trained facilitator, in order to reach an agreement on how best to address the local custom, while ensuring that women or babies are not placed at risk.

Another issue for the team to consider is the use of the word "partner" throughout the MNH Counselling Handbook, rather than "husband". (This word was chosen in order to take into account couples in union or single pregnant women). Some countries in the field reviews preferred to use "husband" and if this is the case, this would need to be adjusted throughout.

#### 5.3.1 Counselling Skills (Session 3)

Different cultures have different ways of communicating effectively. For example, it may be appropriate in one country to maintain eye contact, smile and nod to show that you are empathetic and actively listening; however this behaviour may be inappropriate in another culture. Page 37 contains a list of active listening behaviours. The team can review this list, and ensure culturally appropriate actions are included.

#### 5.3.2 Factors influencing the Counselling Session (Session 4)

This session was the focus of considerable discussion during the field reviews. The concept of gender, which was initially not well understood, has been addressed in the generic version of the MNH Counselling Handbook. The boxes on pages 54 and 55 can be adapted to suit the local context and the national maternal mortality ratio could be included. Are there examples of gender roles in your community that you could also incorporate? The team may wish to examine gender inequalities relevant to their national context. National statistics could reveal important discrepancies: including the gender gap in education levels between men and women, differences between male and female infant mortality rates, the number of female versus male-headed households, who acts as the major decision-maker in the household, and the status of women in society.

Self-reflection as an activity was another concept that many SAs during the field reviews found hard to understand. When field testing the MNH Counselling Handbook in your country, this is an area that might be worth better explaining.

Counselling on issues of sexuality (page 61 and addressed in other parts of the Handbook as well) and the section that explores perceptions about women's bodies (page 56) are both areas that may need to be reviewed. The field reviews have shown this to be a challenging area and one in which local adaptation is particularly important. Counselling around this area will be guided by local custom, religion and practices (including sexual practices) and this will ensure that the counselling is acceptable to the community. This could mean that some of the suggestions on counselling around sexual issues that are included in the generic MNH Counselling Handbook may not be considered acceptable to the community, in which case alternatives can be suggested by the group. Certain cultures may not be used to openly addressing sexuality, and may be reluctant to include these topics in the newly adapted MNH Counselling Handbook; however they are fundamental issues and as such may need to be discussed by the adaptation team before they decide how to manage them.

It will also be beneficial to include local terms and phrases for sexual issues which are commonly used and acceptable to the community. To gain information about local sexual practices the working group may decide to divide into male and female discussion groups.

Results from the field tests in Sudan and Indonesia indicate that some SAs did not wish to include the sentences that discuss FP methods for unmarried women or adolescents. Teenage pregnancies contribute to maternal mortality and morbidity and it is therefore not recommended to delete these sentences, but this remains an important issue for the adaptation team to resolve. There is the scope in this session to add more information about religious beliefs and perspectives as per local belief systems.

### *5.3.3 Support during Labour (Session 10)*

Some countries do not allow the presence of a companion of the woman's choice during labour and childbirth (also referred to as companions in childbirth or social support during labour and childbirth). This may be due to a variety of reasons (cultural beliefs, policy barriers, providers' attitudes, or limited space in birthing rooms, for example). Research shows that a woman with support during labour – a birth companion of her choice rather than a staff member – has a shorter labour, is more likely to have a spontaneous vaginal delivery, is less likely to need analgesia, is less likely to need medical intervention, and is less likely to be dissatisfied with her birth experience (Hodnett et al, 2003). Social support during childbirth is likely to lead to SAs paying more attention to the labouring woman's wishes, and to more information being provided about the labouring process (PANOS, 2001). There may be an opportunity to advocate for birth companions if it is currently not the common practice. Advocacy for a supportive policy environment to encourage birth companions during labour is necessary. This involves not only improving SAs' skills and knowledge levels, but also ensuring space in the birthing rooms, increasing the involvement of men, or other family or community members during childbirth, birth and emergency planning, with the selection of a clearly defined companion prior to labour. Another important policy implication involves improving the collaboration with other care providers, including Traditional Birth Attendants (TBAs) (WHO, 2003).

#### 5.3.4 *Death and Bereavement (Session15)*

This session was very well received by all SAs in the field reviews, as the information was new to them and relevant to their practice. Some felt there should be more information on religion and there is the scope in the adaptation process to incorporate different religious perspectives. The list of practical tasks to perform when someone dies (page 192) can be reconsidered and specific rituals significant to local culture could be added. This session focuses on burial only, but in countries where cremation is the norm, practical advice and information can be added relating specifically to cremation (page 192).

#### **5.4 Illustrations**

The MNH Counselling Handbook's illustrations were intended to reflect different country contexts and include a cross-section of nationalities and cultures. A selection of different scenarios is presented in both rural and urban settings. The team may wish to add more illustrations. Feedback from the field reviews indicated that the concepts conveyed by the images were understood by most of the participants. Nevertheless, each programme should carefully review and field test the images to ensure their comprehensibility, acceptance by intended users, and applicability to their local context. In general, background scenes can be changed to more realistically illustrate the settings where the MNH Counselling Handbook will be used.

Several images contain signs written in English to help convey key concepts. If the MNH Counselling Handbook is maintained in English, the words in the signs should be studied and adapted if necessary to make sure they are locally understood. If it is translated, the signs should also be translated. Listed below are the images with English signs:

- Session 2, page 25: translate text bubble
- Session 5, page 66: translate sign
- Session 14, Cover: field test image and ensure availability of Voluntary Testing and Counselling services
- Session 15, Cover: translate writing on tombstone
- Session 17, page 223: translate sign

Certain images in particular are noted below as they may require specific modifications to reflect the national or local context. For example:

- Session 3, page 37: is eye contact appropriate in your country?
- Session 6, page 79, Cover: may wish to adapt food to those available locally.
- Session 7, page 95: if the national programme has a birthing card, it could be inserted here.
- Session 12, page 147: should reflect all FP methods available in the country.
- Session 15, Cover: may want to ensure an appropriate burial (or cremation) as per country's religious beliefs and practices.

If a new section has been developed, innovative images can be inserted to break up the text and help the reader understand key messages. A local artist or graphic designer may be hired to develop the illustrations, which should then be field tested.

During the field reviews, many of the participants expressed an interest in having coloured illustrations, and a glossy, waterproof cover. This will be much more expensive to produce and will

depend on the allocated budget for this project. The generic MNH Counselling Handbook was produced using four colours however a black and white version is available on the CD to facilitate photocopying.

### 5.5 Local Terminology and Concepts

The MNH Counselling Handbook, designed to use simple and clear language, has been developed with input from primary stakeholders in the field. Texts were further simplified after the field review process as many participants found the sentences were too long and some of the words and concepts new and confusing. Many concepts have now been explained in more detail, and a glossary of key terms has been added as an Annex. The adaptation team may wish to further simplify the vocabulary and medical terms, depending on the educational level of those health workers intending to use it in the country. The translation of medical and counselling terms can also prove problematic. As previously discussed, it is important to develop a glossary of approved (and field-tested) translations to use consistently throughout the MNH Counselling Handbook. Table 3 on the next page lists some of the terminology and concepts that proved to be difficult to understand, and may need to be adapted and/or translated with caution.

**Table 3** *Potential Language Barriers*

Medical terms	Key concepts	Other words
Morbidity	Gender	Socio-economic
Mortality	Empowerment	Objectives
Discordant	Self-reflection	Context
Miscarriage	Interaction	Confidentiality
Prevalence	Alliance	Facilitation
Epidemic	Empathy	Implications
Postnatal blues	Disclosure	Motivators
Convulsions	Self-esteem	Deceased
Blurred vision	Violation	Taboos
Oedema		
Vaginal discharge		
Mother-to-Child Transmission		
Lochia		
Episiotomy		

### 5.6 Legal, Human and Reproductive Rights

What are the policy and legal issues relevant to maternal and newborn health in your country? This is particularly pertinent to the sessions discussing domestic violence, family planning and abortion. It is important to advocate for change to advance the rights of women even if such policies are not yet in place. WHO has developed a Health and Human Rights Assessment Framework and a tool *Using Human Rights to advance Sexual Reproductive Health; strengthening laws, regulations and policies* to help countries analyse the policy environment from a maternal and newborn health perspective and this may be a valuable means of assessing women's and newborns' health rights in your region (WHO, forthcoming).

### *5.6.1 Post-Abortion Care (Session 9)*

19 million unsafe abortions occur globally with approximately 68 000 women dying as a result (UNDP et al, 2000). The adaptation committee should consider the following when reviewing: Is abortion legal in the country? What kind of abortion and post-abortion services are provided? Do women have access to emergency contraception? These issues may be sensitive in some countries. Session 9 on Post-Abortion care is designed for both miscarriages and elective abortion/termination. You may wish to adapt this section to suit your local context. It is an important advocacy point as abortion rates were found to be no lower (overall) in regions where abortion is illegal than where it is legal (Sedgh S et al., 2007). Abortion and the consequences of unsafe abortion contribute to maternal mortality and should be addressed in the future as an important strategy to safeguard women's reproductive rights, reduce maternal deaths and improve women's health.

### *5.6.2 Women and Violence (Session 16)*

Domestic violence, the most common type of gender-based violence, affects many women worldwide. In countries where dependable large-scale studies were performed, 10% to 50% of women surveyed reported physical abuse by a partner in their lifetime (WHO, 2000). In some cultures domestic violence may increase during pregnancy. Yet, it is often a difficult and sensitive topic for health workers to approach and many SAs may feel they do not have the confidence, skills or training to tackle this delicate issue. There may therefore be a need to provide a training course for SAs in specific counselling on violence, if this is a prevalent problem in your area.

This session on women and violence includes an activity (Table on page 197 that explores myths surrounding domestic violence. There is an opportunity for the team to add in any local beliefs relevant to their country's setting to contextualize this activity and make it more relevant to the national population. Laws and policies designed to protect the fundamental human and reproductive rights of women may not yet be in place. After analysing session 16, are there any ways you can advocate to improve women's human and reproductive rights? This session (as with the HIV/AIDS session) is meant to be an introduction to familiarize SAs with the problem and provide some basic counselling principles. However this session does not intend to be exhaustive and provide all the necessary skills. It is important that if violence is prevalent in your area, the programme makes contact with other organizations specializing in violence against women, who can provide further support to the women in need.

## **5.7 Consistency with National Protocols and Guidelines**

Are there any important policies or protocols that have been omitted from the MNH Counselling Handbook? Are there national RH or MNH policies that are not consistent with the MNH Counselling Handbook? If so, are they based on the latest research and sound evidence? For technical issues the team can refer to their national guidelines and policies, and in their absence refer to WHO guidelines as outlined in the PCPNC.

### *5.7.1 Counselling Paradigms (Sessions 2-5)*

Sessions 2 through 5 outline the key counselling principles the SA will learn as he/she works through the MNH Counselling Handbook. It is important that the concepts are well understood. As the adaptation team reviews the counselling paradigms, they can consider how the proposed concepts differ from what is currently in use. Are there any additional counselling concepts the team would like to add into sessions 2 and 3?

The counselling context schematic diagram (page 5 in this document and Session 2 in the MNH Counselling Handbook) is introduced in session 2, and then reappears at the beginning of each session thereafter, highlighting different principles and skills for each session. It is fundamental to the MNH Counselling Handbook, and therefore essential that it is understood and accurately adapted if needed. The diagram could be reviewed by experts on the adaptation team and then included during the field testing with different groups of SAs.

Session 3) contains a diagram that demonstrates how each guiding principle feeds into the different counselling skills. During field reviews, some SAs in rural areas found the arrows confusing as they were not used to this type of drawing. Conversely, the more educated SAs from urban areas were able to understand the diagram and found it very helpful. This image may need to be reviewed and also carefully field tested.

### *5.7.2 General Care (Session 6)*

The WHO recommendations on care for the woman in the home during pregnancy could be adapted to suit the national context. Are there any specific Antenatal care protocols in your country that have not been included here? The adaptation team could consider brainstorming with community groups (in Activity 1) to ensure all important aspects of general care for the pregnant woman and her family are met. One way to customize this section is to develop a list of locally available and affordable foods that meet the nutritional requirements of pregnant women.

This section does not include any malarial prophylaxis. You could consider adding local recommendations if you live in an endemic malarial zone, for example a sentence on the importance of taking malaria prophylaxis during pregnancy as per local/national guidelines, or the benefits (to the woman and her baby) of sleeping under an impregnated bednet. (For more details, refer to the malaria section in this document, 5.8.3).

### *5.7.3 Birth and Emergency Planning (Session 7)*

Are birth and emergency cards already established in the country? The team may wish to check the sample card in the session to ensure all relevant local information is included and make amendments as necessary. The questions for birth and emergency planning on, or the sample card, can be replaced with a scanned copy of the national birth and emergency planning card.

Community transport plans can play an important role in improving women's access to skilled care during pregnancy and birth, and for the mother and baby in the postnatal period. Transport plans are briefly discussed but you may have successful examples from your country or other countries in your region that the adaptation team could consider introducing here.

#### 5.7.4 Family Planning Counselling (Session 12)

Some family planning (FP) methods mentioned in the text or the table may not be available in your country, others may be about to be introduced, or some methods phased out, depending on availability, and national or local protocols. The team should check to make sure the methods mentioned are available nationally, and at the first level of care.

This session is not designed to provide all the FP information but highlights the basic and essential information for counselling women and their partners. For additional detailed FP information, refer to the WHO's "*Evidence-based guidance: Decision-making tool for family planning clients and providers*" on the following link:

[http://www.who.int/reproductive-health/family\\_planning/counselling.htm](http://www.who.int/reproductive-health/family_planning/counselling.htm)

For both FP or for counselling a woman following an abortion, the MNH Counselling Handbook talks about providing emergency contraception to women to prevent future unwanted pregnancies. Is this available in your country? If not, consider advocating for it as an important strategy for reducing maternal morbidity and mortality related to unwanted pregnancies and abortions.

Providing adolescents with FP is often a topic of debate and discussion. It is an important concern however, as teenage pregnancies are common, largely preventable, and contribute to maternal morbidity and mortality. For additional information on the specific skills required to counsel adolescents, refer to section 5.8.4 below..

#### 5.7.5 Breastfeeding (Session 13)

Breastfeeding materials may be available and you may wish to engage some national breastfeeding groups to support the review of this session and ensure its link with existing materials, trainings and support. This section is intended to provide basic information as SAs should refer to those more trained if available. The following link [http://www.who.int/child\\_adolescent\\_health/documents/who\\_cdr\\_93\\_3/en/index.html](http://www.who.int/child_adolescent_health/documents/who_cdr_93_3/en/index.html) will provide additional information and tools available on breastfeeding.

Prevention of Mother-to-child Transmission (PMTCT) of HIV/AIDS is also addressed in this session and is an important public health concern in many developing countries. Each country will have its own PMTCT strategies in place which can be drawn upon and included in this section. The Handbook covers basic information And health workers are encouraged to seek additional training if in their area more experienced counsellors are not available or if HIV is prevalent. The following link <http://www.who.int/hiv/pub/vct/tc/en/index.html> can also direct you to additional tools and training available from WHO.

### 5.7.6 Women with HIV/AIDS (Session 14)

Although the guidance in the PCPNC assumes a high HIV/AIDS prevalence area, the information provided in this session of the MNH Counselling Handbook is designed merely as an introduction. This section is intended to provide basic information as SAs should refer to those more trained if available. Additional information and tools available are provided in the following link [http://www.who.int/child\\_adolescent\\_health/documents/9241592494/en/index.html](http://www.who.int/child_adolescent_health/documents/9241592494/en/index.html). The team should determine whether the high prevalence rates apply to their context, and if so, links can be made with other support services available in the region, such as testing and counselling services, or People Living Positively with AIDS (PLPWA) groups. There are references to Antiretroviral (ARVs) medications and testing in this session of the MNH Counselling Handbook, and the team should ensure that these services are available and accessible, or adapt the text accordingly. Counselling and the topic information surrounding these issues may need to be adapted with assistance from local HIV/AIDS experts in the country, and additional training for counselling women with HIV/AIDS may need to be provided.

If a low HIV/AIDS prevalence exists, more emphasis could be placed on prevention and the text adapted according to local policies for low transmission areas, with the help of local RH/HIV/AIDS experts.

## 5.8 Priority Maternal and Newborn Health issues not addressed

Does the MNH Counselling Handbook currently cover the main maternal and newborn health issues related to maternal and newborn care that are prevalent in the country? Each country will be aware of their key maternal and newborn health problems, through a detailed RH situation analysis and data from health surveys. Existing qualitative and quantitative studies may also provide information concerning care in the home, care-seeking behaviour, and the community's perception of the quality of the MNH services. This information can also help reveal counselling and communication gaps. These issues can be compiled and then compared with the topics covered in the MNH Counselling Handbook. Does the Handbook adequately cover the main maternal/newborn and counselling issues relevant to your country? The following text provides a few examples of additional priority problems, prevalent in a number of countries, which, if applicable, could be considered for inclusion.

### 5.8.1 Female Genital Mutilation (FGM)

Approximately 130 million women and girls have been mutilated, with 2 million females undergoing FGM worldwide annually (WHO, 2001). A WHO prospective study on FGM conducted in six African countries shows that women with FGM are much more likely to experience negative outcomes including: increased C-section rates, episiotomies, postpartum haemorrhage, urinary tract infections, and infants who require resuscitation. The study findings show women with FGM are more likely to require longer hospital stays and that the obstetric risk increases with the magnitude of FGM (WHO, 2006). This has important implications for the adaptation teams in terms of planning for antenatal care, birth and emergency preparedness, and immediate post-operative care for the mother and newborn.

Field reviews of the Handbook in some countries exposed FGM as a priority RH issue, and the participants in Sudan expressed strong interest in adding a special session devoted to this practice as there are many unique physical and psychological issues to consider. It was felt that the session should include a definition of FGM (outlining the different types), and the main disadvantages that

occur such as infection, bleeding, obstetric fistulae (OF) (see section 5.8.2), and disease transmission. Important counselling issues were discussed including the problems surrounding SAs conducting a physical examination and catheterising women who have undergone FGM, the difficulties pregnant women experience with first intercourse and labour, and their violation of human and reproductive rights. Pregnancy may also be a good time to talk to women and their families about FGM and sensitize them to consider the harms to the girl-child. In addition to a separate session on FGM, it is a theme that may need to be added to Session 17 for discussion with the broader community.

Culturally sensitive activities in the FGM session could be designed to allow discussion on how to replace harmful practices with less harmful or neutral ones. For example, a “*coming of age*” ceremony could still take place but beads could be given instead of the customary cutting ceremony or if certain songs are meaningful, the tunes could be maintained while the words could be changed. Gatekeepers here play a vital role, especially the grandmothers, elderly women, and husbands, so it would be advisable to include other individuals in the counselling sessions to ensure the harmful behaviour is modified. (See Annex 4 for details of FGM sources and issues.)

The following WHO links provide additional information on FGM:

<http://www.who.int/reproductive-health/fgm/index.html>

<http://www.who.int/reproductive-health/publications/articles/lancetfgm.pdf>

#### 5.8.2 Obstetric Fistulae

Obstetric Fistula (OF) is a common, yet often neglected, obstetric complication in countries with a high prevalence of obstructed labour (and FGM), and contributes to maternal morbidity. It is estimated that obstructed labour occurs in approximately 4.6% of live births causing more than 40,000 deaths, with an additional 73,000 women suffering serious health disabilities including OF (AbouZahr, 2003). Roughly 2 million women globally live with untreated OF (UNFPA & FIGO, 2002 as cited in WHO, 2006). This RH problem is not often discussed or counselled, yet may cause considerable fear in women and their SAs, who may not know how to deal with it. The team may consider adding a session on fistulae if relevant, as it does have specific counselling implications in terms of physical factors (obstetric care and complications), and emotional or social factors (relationship difficulties, stigma and self-esteem).

For more information on obstetric fistulae go to the WHO web site link:

[http://www.who.int/reproductive-health/docs/obstetric\\_fistula/index.html](http://www.who.int/reproductive-health/docs/obstetric_fistula/index.html)

[http://www.who.int/making\\_pregnancy\\_safer/publications/obstetric\\_fistula.pdf](http://www.who.int/making_pregnancy_safer/publications/obstetric_fistula.pdf)

### 5.8.3 Malaria

Annually, approximately 25 million women in Africa become pregnant and are at risk of developing *Plasmodium falciparum* malaria (WHO, 2004). In areas of unstable malaria transmission, these women have no immunity and pregnancy increases their likelihood of developing severe disease by two to three times (WHO, 2004). If the country is in an endemic malarial zone, the team could consider adding a special session to address this priority public health concern as pregnant women constitute such a high risk group. Collaboration with national malarial experts is advisable. The signs and symptoms of malaria, and how it impacts on the pregnant woman (febrile illness, anaemia, cerebral malaria, hypoglycaemia, spontaneous abortion, puerperal sepsis and haemorrhage), her unborn fetus (stillbirth, prematurity), or her newborn baby (low birth weight, malaria illness and neonatal death) (WHO, 2004), could be discussed. Prevention strategies including the need for malaria chemoprophylaxis, and iron supplements, and the protection provided by impregnated bednets, could be emphasized. Biting patterns of the mosquito could also be included to help local communities address prevention issues and minimize their exposure at prime biting times. The fact that malaria is often more dangerous for primigravidae (WHO, 2004; Macgregor, 1984) could be highlighted. In a population where HIV/AIDS is prevalent, HIV-positive multigravidae are equally as vulnerable to severe disease as non-HIV-infected primagravidae (WHO, 2004). Issues around what to do if a pregnant woman develops a fever, treatment of malaria during pregnancy, and strategies to protect the newborn could also be included. Images may be added showing pregnant women sleeping under impregnated bednets or other locally acceptable malaria reduction strategies could be illustrated.

For more information on malaria in pregnancy and a WHO strategic framework for treatment and control please refer to:

[http://www.who.int/malaria/rbm/Attachment/20041004/malaria\\_pregnancy\\_str\\_framework.pdf](http://www.who.int/malaria/rbm/Attachment/20041004/malaria_pregnancy_str_framework.pdf)

### 5.8.4 Adolescents and Women with Special Needs

Adolescence constitutes a special time in life which can present both prospects and risks for this susceptible population. The “*World Health Report 2005 – Make every mother and child count*” identifies a need to target adolescents to prevent unwanted pregnancies (WHO, 2005) <http://www.who.int/whr/2005/en/>.

The MNH Counselling Handbook does not address in detail adolescents as a distinct group, as most of the clinical care is the same, however ensuring access to care for pregnant adolescent girls and the way they are counselled need special attention. The approach a health worker or SA adopts to communicate with or counsel a pregnant adolescent girl will differ from the way he/she counsels an adult woman. It is important to understand the specific characteristics of adolescents, in order to provide them with age-appropriate, effective and sensitive care and counselling. Page 26 briefly addresses the counselling needs of pregnant adolescents.

If the adaptation team wishes to elaborate on this session, there are a number of valuable resources which may be helpful. WHO's Department of Child and Adolescent Health works in the area of sexual and reproductive health as well as nutrition, development, adolescent-friendly health services, and prevention/care of illness. Their web site contains a broad-range of studies and resources on adolescents located on: <http://www.who.int/child-adolescent-health/asrh.htm>. WHO addresses issues related to adolescent HIV/AIDS, specifically why adolescents are affected by the disease, what can be done, and includes activities and strategies. The documents are divided into four groups: advocacy papers, technical reports, research and evidence-based studies, and specific tools and guidelines. One tool the adaptation committee (and policy makers) may find particularly useful is the counselling guide entitled: "Orientation programme on adolescent health for health care providers" which aims to strengthen health worker's understanding of the specific health care needs of adolescents and help them to learn how to treat this vulnerable group with more compassion and empathy ([http://www.who.int/child\\_adolescent\\_health/documents/9241591269/en/index.html](http://www.who.int/child_adolescent_health/documents/9241591269/en/index.html)) also available in electronic form on the Email: [cah@who.int](mailto:cah@who.int)). There are modules on unsafe abortion, STIs, HIV/AIDS, nutrition and care of the adolescent during pregnancy and childbirth. There is a valuable discussion paper on adolescent pregnancy ([http://www.who.int/child\\_adolescent\\_health/documents/9241593784/en/index.html](http://www.who.int/child_adolescent_health/documents/9241593784/en/index.html))

If the adolescent pregnancy rates are very high in your region, the adaptation team could also consider liaising with youth groups to customize this section.

For a summary of WHO's latest publications and direct links to their internet locations go to USAID's Interagency Youth Working Group web site on: <http://www.infoforhealth.org/youthwg/pubs/who.shtml>

The WHO publications listed above (<http://www.who.int/child-adolescent-health/asrh.htm>) should provide the adaptation team with extensive guidelines for the development of adolescent-friendly health care services with a specific focus on maternal and newborn health.

The MNH Counselling Handbook briefly covers women with disabilities and special populations. Each country will have vulnerable groups of women with distinctive needs. Session 2 deals with the special needs of some groups of pregnant women. There is an opportunity for the team to develop this section, adding their country's most prevalent disabilities and counselling priorities.

## **6. Building Consensus for Adaptation**

Once all the adaptations have been made, try to build consensus among the working groups, task force and other important stakeholders approving the changes before finalizing the document. A presentation outlining the principal changes could be given to interested parties.

## **7. Field Testing**

Once the entire MNH Handbook has been reviewed, translated, and adapted, field testing should be conducted. This is an important part of the adaptation process in order to highlight any areas that have not been properly understood by the SAs, and issues that may not be culturally relevant to your context. If new sessions have been developed, the field testing provides an opportunity for the SAs to review this material for the first time, to ensure that they fully understand the new

content. When field testing, it is important to include *all* cadres of SAs or you may find that much of the core content is only understood by a small minority of the workforce, and not at health centre level- depending on the intended users. Remember to choose SAs with a mix of educational levels and backgrounds and in different health settings (rural, peri-rural and urban) so that you obtain an accurate picture of how well the newly adapted MNH Counselling Handbook is received and understood. Different regions or zones in the country may have certain needs, and the design of the field testing process will need to take this into account.

The field testing should be a participatory consultative process, allowing SAs an opportunity to comment on different aspects of the MNH Counselling Handbook. A description of the methodology and a selection of the qualitative tools used in the original field reviews (and amended for this process) is included in Annex 3. For example, a good way to ensure a session is understood may be to use the observation guide coupled with group discussions. By observing a group of SAs working through the sessions you will notice any concepts they find confusing, or areas that are misunderstood. These issues can then be highlighted in a topic guide, with open-ended questions developed for use during a group discussion. The information can be compiled, analysed and used to further refine the session.

## 8. Implementation

Implementation issues will vary by country and will be dependent on the availability of local human, logistics and financial resources. The following section briefly discusses issues the adaptation team may like to consider when implementing the MNH Counselling Handbook and scaling it up.

### 8.1 Production, Distribution and Dissemination

Once the adaptation committee has agreed on the final version of the counselling MNH Counselling Handbook, it can be produced and distributed to interested organizations. Harmonization with the different existing programmes is a good way to ensure a better integration within primary health care settings and structures. Hopefully many of this group will have participated in the adaptation or field testing process.

A budget and estimation of the time line can be drawn up. Consider human, financial and logistical resources.

### 8.2 Introducing the MNH Counselling Handbook

Opportunities for introducing the manual can be discussed by the adaptation committee. One way to ensure the uptake and sustainability of the MNH Counselling Handbook is to introduce it into nurses', midwives' and physicians' pre-service and in-service training curricula/programmes or refresher courses. It is a good idea to get different levels of the Ministry of Health (MOH) and donor commitment to the MNH Counselling Handbook by involving interested parties in key decisions early on in the adaptation process. It is also important to consider the different levels of health care in your setting. How the MNH Counselling Handbook is used by SAs in a demanding, large, comprehensive emergency obstetric care (CEOC) setting may differ from its use in a more remote, rural, basic emergency obstetric care (BEOC) facility or by a midwife who works in the community.

There are a number of other practical strategies that can be employed when introducing the MNH Counselling Handbook. If a self-directed learning approach is used, an initial meeting can be held to present the Handbook to the SAs, where copies can be distributed and sessions assigned for the SAs to work through. A second meeting can then be scheduled to discuss any problems the SAs may have encountered while working through it. Field reviews from Sudan and Indonesia revealed that the majority of SAs would prefer some guidance when first introduced to the MNH Counselling Handbook. In this case, different sessions could be reviewed by small groups of SAs and they could then meet up to discuss their progress in a larger group setting, facilitated by a trained counsellor (or someone familiar with the MNH Counselling Handbook). Each group could conduct brief presentations highlighting the key issues from each different session/topic to familiarize all SAs with the content of the MNH Counselling Handbook.

The content of the MNH Counselling Handbook could be used to strengthen other existing programmes including counselling and MNH programmes, and also to reinforce MNH topics from the PCPNC.

### **8.3 Ensuring MNH Counselling Handbook's Use**

There may be a number of barriers to the introduction or sustained use of the MNH Counselling Handbook. Try to think of all the potential factors in your country that could prevent it from being used effectively. This issue was addressed in the field reviews. The SAs were asked to identify motivational factors which would encourage their use of the MNH Counselling Handbook, and also whether they preferred to use it in groups, with a facilitator or as a self-learning guide. The response varied by country and by group, but generally the SAs expressed an interest in having a brief orientation to the MNH Counselling Handbook at its launch, followed by specific facilitated sessions periodically to ensure they had a comprehensive understanding of the core counselling concepts and activities.

By brainstorming a list of obstacles, you may be able to come up with a strategy that is more likely to succeed. Motivational factors for busy SAs who feel they do not have adequate time to use the MNH Counselling Handbook are important. These factors can be identified by the adaptation committee and the SAs prior to its introduction. Important motivational factors, including the new knowledge and skills (both related to counselling practices and new information regarding MNH) each SA could gain, could be presented at the onset of the training to ensure positive uptake of the MNH Counselling Handbook. In Sudan, for example, many Sudanese SAs suggested they would like to receive a counselling certificate, a prize, or new uniforms once they completed the MNH Counselling Handbook, and this would motivate them to use it consistently with pregnant women, new mothers, and their families. Indonesian respondents felt the new counselling knowledge would be an incentive to use the MNH Counselling Handbook, but thought enhanced career prospects, or some kind of accreditation system would also be a good motivator.

Many countries have Health Education, Information, Education and Communication (IEC) or Health Promotion departments within their ministries (either in the ministry of health, or the ministry of information). These departments can play an important role in developing the MNH Counselling Handbook, and in devising ways to launch or disseminate its contents. They can also play a role in developing further support and educational materials for the MNH health programmes and for the SA to use in communication and counselling sessions.

## 8.4 Training and Supervision

As indicated, the field reviews indicated many SAs would like an initial orientation and brief training session for facilitators. It may be possible to combine this with an existing meeting of SAs to cut costs. The training element will largely depend on how and where the MNH Counselling Handbook is introduced, and whether a self-directed learning, facilitated approach or a combination of the two is pursued. As discussed in section 8.3, the adaptation committee may decide to introduce the MNH Counselling Handbook into their SAs' pre-service training courses, which would provide a valuable background in counselling and communication concepts early on in the careers of the SAs, and help to improve the overall quality of care they are able to provide to women and their newborn.

Supportive supervision was highlighted as crucial by most countries in the field reviews. For SAs working alone in rural health settings, supervisory visits could clarify any confusing issues and help motivate them to use the MNH Counselling Handbook.

## 9. Monitoring and Evaluation

Before introducing the MNH Counselling Handbook, it is recommended that you conduct a baseline survey, and then after it has been used for a pre-determined length of time (one year, for example), an evaluation can be conducted to examine whether it has been used consistently by the SAs, and whether it has improved their counselling and communication skills. The adaptation committee or sub-groups can consider how they want to evaluate the MNH Counselling Handbook. A baseline survey of the current knowledge levels and counselling practices of SAs would be a good starting point, and useful for the purpose of comparison. Table 4 provides some suggestions on evaluation strategies. It is not only important to measure the use of the MNH Counselling Handbook by the SAs, but also its effectiveness in terms of improving the SAs' counselling skills and practices, women's use of services, and women's and community's knowledge of some of the key information, as well as their overall satisfaction with the care they receive. Feedback can be used to make further adaptations to the MNH Counselling Handbook, or to the implementation strategies as required. If any problems are revealed, the adaptation committee may want to consider making further changes before re-distribution of the MNH Counselling Handbook.

**Table 4 Evaluating the MNH Counselling Handbook**

Use	Effectiveness
Observe SAs in health facilities using a structured checklist to see whether they are using principles of counselling and referring to Handbook.	Measure satisfaction levels of women post counselling session through exit interviews (pre and post Handbook introduction). <ul style="list-style-type: none"> <li>• Were they able to ask questions?</li> <li>• Were they part of the conversation?</li> <li>• Did they make their own decisions/ plans?</li> <li>• Could they follow-through on these decisions/plans?</li> <li>• Were there any improvements noted after the introduction of the Handbook?</li> </ul>
Conduct exit interviews with women post ANC, after birth or postpartum visits to determine whether there was two-way or one-way communication.	Hold discussions with SAs to explore their perceptions of whether their counselling skills have improved. Hold discussions with women and families to explore their perceptions of whether the SAs' counselling skills have improved.
Hold discussions with SAs to explore Handbook's uptake and any barriers to uptake.	Conduct pre and post tests or observe SAs using a structured checklist- containing key counselling skills- to measure any changes in skill levels.
	Are Birth and Emergency preparedness cards now used? I.e. If you have a baseline of use, then you can determine whether there has been an increase in use. <ul style="list-style-type: none"> <li>• Is there an increase in knowledge in the population regarding danger signs?</li> <li>• Is there an increase in the number of community transport plans?</li> <li>• Is there an increase in births assisted by a SA?</li> <li>• Has there been a decrease in the length of time it takes a woman in labour to reach hospital?</li> </ul> There are many questions that can be added to other studies to determine whether knowledge or certain behaviours have changed.

## 10. Adaptation Bibliography

This adaptation guide was based on the following sources:

Churck K. Decision-making tool for family planning clients and providers: technical adaptation guide, Geneva, World Health Organization, 2006.

World Health Organization. Introducing WHO's reproductive health guidelines and tools into national programmes: principles and process of adaptation and implementation. Geneva, World Health Organization, 2007.

World Health Organization. Draft adaptation guide prepared by the Making Pregnancy Safer Department for the PCPNC, 2004 (unpublished draft).

World Health Organization. Draft human rights tool prepared by the Reproductive and Health Research: Using Human Rights to advance Sexual Reproductive Health; strengthening laws, regulations and policies (unpublished draft).

## 11. Other References

Abou Zahr C. Global burden of maternal death and disability. *British Medical Bulletin*, 2003, Vol 67.

Ashwood-Smith H et al. High risk or Low risk: Do pregnant women care? (2000) Poster presentation at XVI FIGO Congress of Gynaecology and Obstetrics, September 3-8, 2000, Washington D.C., USA.

Brown L et al.. *Improving patient-provider communication: implications*. Bethesda, MD: University Research Corporation, 1995.

Sedgh S et al. Induced abortion: estimated rates and trends worldwide. *Lancet*, 2007; 370:1338-45.

Hodnett ED, Gates S, Hofmeyr G J, and Sakala C. Continuous support for women during childbirth (Cochrane Review). *The Cochrane Database of Systematic Reviews*, 2003, Issue 3. Art.

Hulton LA, Matthews Z, and Stones R. *A framework for the evaluation of quality of care in maternity services*. Southhampton, University of Southhampton, 2000.

Jacobson JL. *Women's reproductive health: The silent emergency*. Worldwatch paper 102. Washington D.C., TheWorldwatch Institute, 1991.

MacGregor I. Epidemiology, malaria and pregnancy. *Am. J. Trop. Med. Hyg*, 1984. 33: 517-525.

Nicholas DD, Heiby JR, Hatzell TA. The Quality Assurance Project: introducing quality improvement to primary healthcare in less developed countries. *Quality Assurance in Health Care*, 1991, 3(3):147-165.

Panos Institute. *Birth rights: new approaches to safe motherhood*. London, Panos Institute, 2001.

Portela, A and Santarelli C. Empowerment of women, men, families and communities: true partners for improving maternal and newborn health *Br Med Bull*, 2003, 67: 59-72.  
<http://bmb.oupjournals.org/cgi/content/abstract/67/1/59?etoc>

Roter D and Hall J. *Doctors talking with patients, patients talking with doctors: improving communication in medical visits*. Westport, CT, AuburnHouse, 1992.

United Nations Development Programme, United Nations Population Fund, World Health Organization and World Bank: *Unsafe abortion - Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2000 - 4th ed*. Geneva, World Health Organization, 2004. [http://www.who.int/reproductive-health/publications/unsafe\\_abortion\\_estimates\\_04/index.html](http://www.who.int/reproductive-health/publications/unsafe_abortion_estimates_04/index.html)

World Health Organization. A strategic framework for malaria prevention and control during pregnancy in the African Region. Brazzaville: WHO Regional office for Africa, 2004 AFR/MAL/04/01.

World Health Organization: Violence against Women Fact sheet # 239. Available at [www.who.int/mediacentre/factsheets/fs239/en/index.html](http://www.who.int/mediacentre/factsheets/fs239/en/index.html), revised June 2000.

World Health Organization.. *Working with individuals, families and communities to improve maternal and newborn health*. WHO, Geneva, 2003. WHO/FCH/RHR03-11.

World Health Organization: *World Health Report 2005-Make every mother and child count*. WHO, Geneva, 2005.

World Health Organization.. *Female Genital Information: Information Pack*.

World Health Organization. *Female Genital Mutilation and obstetric outcome: WHO collaborative prospective study in six African countries*. *The Lancet* 2006; 367:1835-1841.

World Health Organization: *Obstetric fistula: guiding principles for clinical management and programme development*. WHO, Geneva, 2006

World Health Organization, International Confederation of Midwives and FIGO. *Making pregnancy safer: the critical role of skilled attendants*. A joint statement by WHO, ICM, FIGO, 2004

World Health Organization, Department of Reproductive Health and Research, and the INFO Project at the Johns Hopkins Bloomberg School of Public Health / Center for Communication

Programmes *.Evidence-based guidance: Decision-making tool for family planning clients and providers*. 1st ed., 2005.

Young Mi Kim et al., "Operations Research: 'Smart Patient' coaching in Indonesia as a strategy to improve client and provider communication" (paper delivered at the annual meeting of the American Public Health Association [APHA], Atlanta, Oct. 21-25, 2001).

## **Annex 1**

# **Bibliography**

1. National Collaborating Centre for Women's and Children's Health. Antenatal care: Routine care for the healthy pregnant woman: Clinical guideline. London: RCOG Press, 2003.
2. National Collaborating Centre for Women's and Children's Health. Caesarean Section: Clinical guideline. London: RCOG Press, 2004.
3. Smith, J. R. and Low-Beer, N. M. Management of HIV in pregnancy: Guideline In Preparation. 2004. Guidelines and Audit Committee of the Royal College of Obstetricians and Gynaecologists. 21-1-2004.
4. Brocklehurst, P. Interventions aimed at decreasing the risk of mother to child transmission of HIV infection. The Cochrane Library (2). 2001. Oxford, Update Software.
5. Lyall EG, Blott M, de Ruiter A, Hawkins D, Mercy D, Mitchla Z *et al.* Guidelines for the management of HIV infection in pregnant women and the prevention of mother-to-child transmission. *HIV Medicine* 2001; 2:314-34.
6. Hodnett, E. D. Caregiver support for women during childbirth. The Cochrane Library (3), 1-9. 2001. Oxford, Update Software.
7. Momoh C, Ladhani S, Lochrie DP, Rymer J. Female genital mutilation: Analysis of the first twelve months of a southeast London specialist clinic. *British Journal of Obstetrics and Gynaecology* 2001;108:186-91.
8. World Health Organization. A systematic review of the health complications of female genital mutilation including sequelae in childbirth. 1-180. 2000. Geneva, World Health Organization (WHO).
9. McCaffrey M, Jankowska A, Gordon H. Management of female genital mutilation: The Northwick Park Hospital experience. *British Journal of Obstetrics and Gynaecology* 1995;102:787-90.
10. Larsen U, Okonofua FE. Female circumcision and obstetric complications. *International Journal of Gynaecology and Obstetrics* 2002; 77:255-65.
11. David K James, Philip J Steer, Carl P Weiner and Bernard Gonik, High Risk Pregnancy - Management Options (3rd edition); Saunders, 2004.
12. S Bewley, J Friend and G Mezey. Violence Against Women, Saunders, 1997
13. Luesley D, Baker P. Obstetrics and Gynaecology - an evidence-based text for MRCOG. Arnold, 2004.

## Annex 2

### **MNH Counselling Handbook References by subject**

### **Abortion**

EngenderHealth *Counselling the Post abortion Client: A training curriculum*. New York: EngenderHealth 2003.

World Health Organization *Complications of abortion: technical and managerial guidelines for prevention and treatment*. Geneva: WHO 1995

### **Adherence**

Mann CN. *Improving adherence behaviour with treatment regimens*. Geneva: WHO 1993.

World Health Organization. *Adherence to long-term therapies. Evidence for Action*. Geneva: WHO, 2003

### **Adolescents**

Brown A D, Jejeebhoy SJ, Shah I, Yount KM. Sexual relations among young people in developing countries: evidence from WHO case studies. Dept of Reproductive Health and Research. Geneva: WHO, 2001

World Health Organization, Adolescent Health Programme. *Counselling skills training in adolescent sexuality and reproductive health: a facilitator's guide*. Geneva: WHO 1993.

### **Client-Provider Interaction**

Burnard P and Hulett I. *Nurses counselling: the view from the practitioners*. Butterworth-Heinemann 1996.

Murphy E. *Best practices in Client-Provider interactions in Reproductive Health Services: A review of the literature*. USAID, Maximising Access and Quality.

Rollnick S, Miller WR. What is Motivational Interviewing? *Behavioural and Cognitive Psychotherapy*, 23: 325-334. 1995.

Young Mi, K. Haki Yako: *A client provider information, education and communication project in Kenya*. Report from Center for Communications Programs, Johns Hopkins School of Public Health. 1996

### **Community as partners**

Anderson, ET and McFarlane J. *Community as partner: theory and practice in nursing*. Philadelphia: Lippincott. 1996.

Kureshy, N. *Mothercare's community assessments: understanding family and community behaviours and practices*. Mothercare Matters 8:3-4 John Snow, Inc. Arlington VA 2000

Santarelli C. *Working with individuals, families and communities to improve maternal and newborn health*. Geneva: WHO 2003.

### **Couple Counselling**

Becker S. Couples and reproductive health: A review of couple studies. *Family Planning* 27 (6): 291-306. 1996

DeRose, L need to include all authors here Does Discussion of Family Planning Improve Knowledge of Partner's Attitudes Toward Contraceptives? *International Family Planning Perspectives* 30 (2): 87-93. 2004.

EngenderHealth . *Counselling and Communicating with Men*. New York: EngenderHealth 2003.

Varkey LC need to include all authors here. *Involving men in Maternity Care in India*. Unpublished Report funded by USAID, Population Council, New Delhi India April 2004.

### **Counselling for Maternal and Newborn Health**

Gender and Health Research Group *Towards the healthy women counselling guide*. UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases. 1997.

Steele C. Counselling: An evolving process. *International family Planning Perspectives* 19 (2) :67-71. 1993.

WHO. Health Workers Manual on Counselling for Maternal and Child Health, Second Edition. *Western Pacific Education in Action Series No 9*. Manila: WHO 1998.

### **Counselling Tools and Aids**

Action Research and Training for Health Picture stories aid women who cannot read. *Safe Motherhood Newsletter* (28):12, 2000.

Bosompra, K. Dissemination of health information among rural dwellers in Africa: a Ghanaian experience. *Social Science and Medicine* 29(9):1133-1140, 1989.

Centre for health and population research. Picture cards explain pregnancy complications. *Safe Motherhood Newsletter* (23):3, 1997.

Coeytaux, F.M., Kilani, T., and McEvoY, M. The role of information, education, and communication in family planning service delivery in Tunisia. *Studies in Family Planning*, 1987, Vol.18, No.4, pp.229-234, 2001.

Goodwell, V. Posters as a health education medium in a rural setting [letter]. *National Medical Journal of India*. 8(3):145,147, 1995.

Piotrow, P.T., Rimon, J.G., Winnard, K., Kincaid, D.L., Huntington, D., and Convisser, J. Mass media family planning promotion in three Nigerian cities. *Studies in family planning*, Sep-Oct 1990, Vol.21, No.5, pp.265-274, 1990.

Rogers, E.M., Vaughan, P.W., Swalehe, R.M., Rao, N., Svenkerud, P., and Sood, S. Effects of an entertainment-education radio soap opera on family planning behavior in Tanzania. *Studies in Family Planning*. 30(3):193-211, 1999.

Safe Motherhood Newsletter (1995) Getting the message across: communicating safe motherhood. *Safe Motherhood*. 1995; vol 3 no 19; 4-8, 2001.

Gender and Health Research Group. *Mucoore (trusted friend), let's share with others! Developing radio and illustration materials for the Healthy Women Counselling Guide*. UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases 1997.

### **Decision-making and client involvement**

Fingers W. A client perspective helps improve services. *Network*, Family Health International 1998 19 (1).

Kettenun T, Poskiparta M, Liimatainene L. Empowering Counselling – a case study: nurse-patient encounter in a hospital. *Health Education research*, 2001, 16:227-238.

Kettunen T, Poskiparta M, Karhila P. Speech practices that facilitate patient participation in health counselling – A way to empowerment? *Health Education Journal* 62 (4): 326-340. 2003.

Kettunen T, Poskiparta M, Gerlander M. Nurse-patient power relationship: preliminary evidence of patients' power messages. *Patient Education and Counselling* 47: 101-113. 2002.

Population Council (2005) A client-centered approach to reproductive health. A trainer's manual. Pg 85.

### **Family Planning Counselling**

Cotton N Need to include all authors here. Early Discontinuation of Contraceptive use in the Niger and the Gambia. *International Family Planning Perspectives*. 18 (4): 145-49. 1992.

DeRose, L need to include all authors here Does Discussion of Family Planning Improve Knowledge of Partner's Attitudes Toward Contraceptives? *International Family Planning Perspectives* 30 (2): 87-93. 2004.

Simmons GB. *Techniques for improving client relations in family planning programs*. Washington: World Bank. 1992.

### **HIV/ AIDS**

Cooper PJ, Landman M, Tomlinson M, Molteno C, Swartz L, Murray L. Impact of a mother—infant intervention in an indigent peri-urban South African context. Br J Psychiatry. 2002 Jan;180:76-81.

Oberzaucher, N. *HIV voluntary counselling and testing: a gateway to prevention and care: 5 case studies related to prevention of mother-to-child transmission of HIV, tuberculosis, young people and reaching general population groups*. UNAIDS 2002.

The Cochrane Library. *Condom effectiveness in reducing heterosexual HIV transmission*. Cochrane Library 4, 2004.

World Health Organization, Dept of HIV/AIDS. *Nutrition counselling, care and support for HIV-infected women: guidelines on HIV-related care, treatment and support for HIV-infected women and their children in resource-limited settings*. Geneva: WHO 2004.

World Health Organization, Dept of HIV/AIDS. *Prevention of mother-to-child transmission of HIV generic training package*. Geneva: WHO 2004.

WHO/UNAIDS/UNFPA Position Statement on condoms and HIV Prevention.  
[http://www.who.int/hiv/pub/prev\\_care/en/Condom\\_statement.pdf](http://www.who.int/hiv/pub/prev_care/en/Condom_statement.pdf)

UNAIDS *HIV/AIDS care, support and counselling*. UNAIDS 2000.

### **Infant Feeding Practices**

Brown K, Dewey K, Allen L. *Complementary Feeding of Young Children in Developing Countries: A Review of Current Scientific Knowledge*. Geneva: WHO, 1998.

Kramer MS and Kakuma R. *The Optimal Duration of Exclusive Breastfeeding. A systematic review*. Geneva: WHO, 2002.

WHO / Unicef *Breastfeeding Counselling: A Training Course*. Geneva, WHO 1993.

WHO *Breastfeeding and replacement feeding practices in the context of mother-to-child transmission of HIV. An assessment tool for research*. Dept of Reproductive Health and Research. Geneva: WHO, 2001.

WHO *HIV and Infant feeding. Framework for priority action*. Geneva: WHO 2003.

WHO *HIV transmission through breastfeeding. A review of available evidence*. Geneva WHO 2004

WHO *HIV and Infant Feeding Counselling Cards. A guide for health-care managers and supervisors*. Geneva: WHO 2003.

WHO *HIV and infant feeding: Guidelines for decision-makers*. Geneva: WHO 2003.

### **Maternal and Newborn Health – General**

Bulatoa, R.A and Ross, J.A. Which health services reduce maternal mortality? Evidence from ratings of maternal health services. *Tropical Medicine and International Health* Vol. 8 Issue 8, August 2003

Jafarey, SN and Korejo R. Social and cultural factors leading to mothers being brought dead to hospital. *International Journal of Gynaecology and Obstetrics*, 50(2): 597-9,1995.

Jowett, M. Safe motherhood interventions in low-income countries: an economic justification and evidence of cost effectiveness. *Health Policy* 53:201-228, 2000.

Lovich R et al *Where women have no Doctor: A health guide for women*. Hesperian Foundation; 1997.

Moore KM. *Safer motherhood, safer womanhood: review of literature and lessons learned*. WHO, 2002. (unpublished document).

Moore KM et al. *Assessing the “caring” behaviours of skilled maternity care providers during labour and delivery: experience from Kenya and Bangladesh*. Washington DC, CHANGE project, Manoff Group. 2002.

Rooney, C. Antenatal care and maternal health: How effective is it? A review of the evidence” WHO/MSM/92.4 Geneva, World Health Organisation, 1992

Starrs, Ann. *The Safe Motherhood Action Agenda: Priorities for the Next Decade*, report on the Safe Motherhood Technical Consultation (New York: Family Care International, 1998):37.

WHO Maternal and Newborn Health / Safe Motherhood Unit. *Care of mother and baby at the health centre: a practical guide*. Geneva: WHO, 1994.

WHO Maternal and Newborn Health / Safe Motherhood Unit. *Postpartum Care of the mother and newborn: a practical guide*. Geneva: WHO, 1998

### **Sexual Health**

Smith E.J. Training Providers to talk about sex. *Network FHI* Vol 21: (4): 7 2002.

Smith EJ. Discussing Sexuality Fosters Sexual Health. *FHI* Vol 21 (4): 5-8 2002.

Shears KH Gender Stereotypes Compromise Sexual Health *FHI* Vol 21 (4) : 12-18. 2002.

### **Reproductive Health - general**

Campbell O, Cleland J, Collumbien M, and Southwick K. *Social science methods for research on reproductive health*. Geneva: WHO, 1999.

EngenderHealth *COPE for Reproductive Health Services: A toolbook to Accompany the COPE Handbook*. New York EngenderHealth 2003.

Laski, L. *Community Participation in designing and monitoring reproductive health programmes*. New York, UNPF 2000 (technical report 36).

### **Transportation and Waiting Homes**

*Safe motherhood, maternity waiting homes: a review of experiences*. Geneva: WHO 1996.

Schmid T et al. Transportation for maternal emergencies in Tanzania: empowering communities through participatory problems solving. *American Journal of Public Health*, 2001 91:1589-1590.

## **Violence against women**

Campbell JC The health consequences of intimate partner violence *The Lancet* 2002; 359 (9314):1331-6.

Garcia-Moreno C Dilemmas and opportunities for an appropriate health-service response to violence against women. *The Lancet* 2002; 359 (9316): 1509-14.

Jewkes R. Intimate partner violence: causation and primary prevention. *The Lancet* 2002; 359:1423-29.

United National Population Fund. (2001) *A practical approach to gender-based violence: a programme guide for health care providers & managers*. UNFPA. New York.

Watts C, Zimmerman C Violence against women: global scope and magnitude. *The Lancet* 2002; 359 (9313): 1232-7.

Christofides N, Muirhead D, Jewkes R, Penn-Kekana L, Conco ND Women's experiences of and preferences for services after rape in South Africa: interview study. *BMJ*, doi:10.1136/bmj.38664.482060.55 (published 5 December 2005)

Jacobs T, Jewkes R, Usdin S. *Vezimfihlo! A training manual for building a health sector response to gender-based violence*. Medical Research Council, Pretoria. 2006.

Naker D, Michau L *Rethinking domestic violence. A training process for community activists*. Raising Voices, Kampala 2004.

Guedes A, Bott S, Cuca Y. Integrating systematic screening for gender-based violence into sexual and reproductive health services: results of a baseline study by the International Planned Parenthood Federation, Western Hemisphere Region. *International Journal of Obstetrics and Gynaecology* 2002; 78 Suppl 1: S57-63.

Bott S, Guedes A, Guezmes A the health service response to sexual coercion/violence: lessons from IPPF/WHR member associations in Latin America. In: Jejeebhoy S *Non-consensual sex amongst adolescents*. Sage Publications, New Delhi (in press)

## **Annex 3**

# **Summary of Methodology for Field Reviews<sup>4</sup> & Tools**

---

<sup>4</sup> For full copies of the field reviews in the Philippines, Sudan, Indonesia and the Global Summary Report, please write to A. Portela of WHO/MPS at [portelaa@who.int](mailto:portelaa@who.int).

## 1.0 Objectives of the Field Reviews

The main objectives of the field reviews in Indonesia and Sudan were:

1. To determine the comprehensibility, usability and acceptability of the Handbook by the Indonesian and Sudanese SAs
2. To identify amendments needed in the Handbook to maximize its function for improved counselling and communication skills by the SAs
3. To explore country processes for future use of the Handbook including introduction, adaptation, and training of SAs to achieve competency in counselling and communicating issues.

## 2.0 Summary of Methods

The methodology and research tools employed were identical in each country. Six methods were combined to ensure a degree of validity to the findings. An additional Focus Group was required in Sudan as the selection criteria of the respondents initially excluded a large proportion of the least qualified (but most prevalent) rural SAs who were deemed the most likely target group to use and benefit from the Handbook.

1. Summary of data synthesized from 30 comment sheets (15 per country) filled out prior to the consultant's arrival
2. Four Key Informant Interviews:
  - a. *Indonesia*: Dr. Laura Guarenti (WHO MCH Medical Officer), and Ms. Anne Hyre (Senior Midwifery Advisor, MNH, responsible for maternal health communication manual)
  - b. *Sudan*: Dr. Firdous (Head of Reproductive Health Unit in the MOH), and Dr. Ragia and Dr. Hassan (Senior UNFPA Managers).
3. Ten In-Depth Interviews (five per country) with SAs
4. Three Group Discussions: One in Indonesia and two in Sudan to compensate for the initial sampling limitations
5. Two Observation techniques (one per country) involving a total of eight respondents
6. Two final consensus-building summary Workshops (one per country) with all 30 respondents

## 3.0 Process

Detailed comment sheets were handed out to all 30 SAs two weeks before the start of the consultancy. These were completed in English by the Sudanese respondents, and translated into *Bahasa* for the Indonesian respondents. The comment sheets were then gathered at the start of the consultancy, analysed and recorded. Problem areas, interesting comments or sections that were misunderstood were reviewed with the SAs prior to the Workshop.

Key Informant Interviews were held with stakeholders possessing pertinent knowledge related to counselling skills and existing national counselling and/or communication resources or training programmes for SAs. These were conducted in English using an amended version of the Interview topic guides and lasted one to two hours each.

In-Depth Interviews were conducted using translated topic guides for the Indonesian SAs and English guides for the Sudanese SAs.

The comment sheets for each SA were reviewed at this time and any clarifications were made. These interviews lasted two hours each and the transcriptions attempted to use verbatim quotations. The Country Link in Indonesia conducted these interviews along with the WHO Link person who then translated each Interview for the consultant.

The three Group Discussions were conducted using topic guides with homogenous groups of SAs and provoked lively debate. These lasted between one and a half to two hours each. These were transcribed immediately and the data analysed each evening. One Group Discussion per country was conducted in English but the supplemental group added in Sudan with six lower level Village Midwives was conducted in Arabic using an abbreviated version of the topic guide. This group, due to the time constraint and lack of initial inclusion in the study, had reviewed only one session (8- on danger signs, which was translated into Arabic by the Country Link Person at the start of the consultancy).

Four respondents per country were also observed working through one session of the Handbook they had not previously reviewed. In Indonesia they reviewed Session 8 (*Danger Signs*) and in Sudan they reviewed Session 10 (*Support during Labour*). These sessions were observed by three members of the review team in each country who took notes during the process then held a discussion at the end of each Observation. It took each group about one hour to work through their designated session.

The final method employed in this review culminated in a consensus building summary Workshop with all 15 respondents per country. Data from the five above methods was analysed carefully and themes were presented to the Workshop sub-groups for them to reach an agreement on issues related to the Handbook (including use, language, content, length etc.). The Workshop took six hours in Indonesia and five hours in Sudan. Respondents had been given exercises to complete in their groups several days before the Workshop (titles, images, problem areas) to facilitate the process on the day of the Workshop and ensure more critical input.

#### **4.0 Tools used in Field Reviews**

The following tools were used with groups of SAs in Sudan and Indonesia (and were amended from the feedback following field reviews in Malawi and the Philippines).

##### **4.1 Observation Tool**

*Observation of a group of SAs working through one Handbook session*

Welcome the group and start with a presentation of yourselves (the observers), the participants, and an explanation of the review process as part of the process of the adaptation of the handbook, present the next steps for the development, and then present the objectives of this observation session.

Use the following headings to guide comments on your observations:

### 1. Timing of Session

- Start time:
- Finish time:
- Time session took to complete:
- Estimated time taken on each activity (specify for each):

### 2. Background information about the skilled attendants:

- Age:
- Sex:
- Qualifications:
- Average number of monthly deliveries:
- Setting of health centre- Rural or Urban:
- Length of time working as a skilled attendant:
- Length of time at this health facility/current position:
- Previous training on counselling and communication skills:

### 3. Comprehension

- Understanding of content
- Understanding of instructions for activities
- Difficulties encountered and how / (if) resolved:

### 4. Process

- How was the session approached – individually or as a group?
- Was a leader elected?
- Did they read through whole session before going back activities or did they work through section by section?
- Please describe any areas of consensus and disagreement and the process used to resolve.
- Observers' opinion of comfort with self-learning approach vs. a facilitator?

### 5. Activities

- Were the activities completed?
- Problems with activities (what and why)
- Observers' opinion – How well does the commentary match with how the activity was carried out by the group? Does the commentary reinforce what they did?

### 6. Learning and Self-reflection

- Did the group members share ideas or previous experiences? Examples:
- Did the group members refer information in the handbook back to their own practice? Examples

## 7. Closure

- Ask participants their opinion about the session
- Were the objectives of the session met? Why or why not?
- What do they think about the self- learning approach?
- Did they find the activities useful?
- Do they have any suggestions to improve the session?

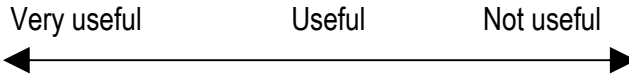
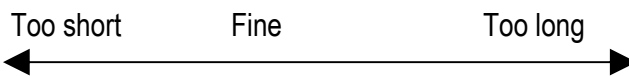
**THANK THE PARTICIPANTS FOR THEIR COOPERATION**

## 4.2 Topic Guide for the In-depth Interviews

Welcome the participant, introduce yourself and explain the objectives of the review process for the adaptation of the Handbook, and the main objectives of the in-depth interview. Assure him/her that his/her feedback and time is greatly appreciated. We encourage him/her to be as honest as possible as this information will be of great use to us.

1. Timing of Interview
  - Start time:
  - Finish time:
2. Background information about the skilled attendant:
  - Age:
  - Sex:
  - Qualifications:
  - Average number of monthly deliveries:
  - Setting of health centre- Rural or Urban:
  - Length of time working as a skilled attendant:
  - Length of time at this health facility/current position:
  - Previous training on counselling and communication skills:
3. Ask the SA to review one session (or the newly written session) before the interview. They can write comments and observations for you to go through together in a discussion format.
  - Pre-select one session reviewed by the SA, one that has comments and observations, and review this in-depth with her/him trying to get a feel for the extent of the comments, i.e. are they isolated, is it something that repeats through the various sessions.
  - Ask questions as you go through the pages, such as her/his view about the commentary in relation to the activity in this session, any words which you think he/she may not be familiar, etc.
  - Review the images of this selected session.
  - Ask the SA whether he/she thinks the session's aims and objectives were met.
4. General impression of the handbook

Go through each of the bullets below and rank them according to the scale provided. Ask him/her to provide an explanation of each response.

- Usefulness of handbook 
- Length of handbook 

- Language
 

Too Easy                      Fine                      Too Difficult
  
- Presentation/Format/layout
 

Very Clear                      Clear                      Confusing
  
- Images
 

Excellent                      Fine                      Bad

#### 5. Counselling for Decision-Making

- Could you explain in your own words what this means?
- What is the difference between Counselling for Decision-Making and Providing Information?
- How could your interactions with women contribute to their empowerment?
- Does the book help you to develop the skills to do this? If so, why? If not, what should we change?
- After having gone through the handbook, what do you think you will do differently in your work with women, their partners and their families?

#### 6. Knowledge and Skills

- Was the information contained in handbook new to you? Please specify.
- Which of these skills did you already have before using the handbook?
  - questioning skills
  - communication skills
  - listening skills
  - others (explain)
- Do you feel you developed new skills in any of these areas after using the handbook? (Do not repeat if mentioned above.)
  - questioning skills,
  - communication skills
  - listening skills
  - others (explain)
- Any skills, information or content missing in the handbook which should be added?
- Any skills, information or content in the handbook which should be removed? Why?

#### 7. Use of Handbook

- In general, did you find the handbook useful? Why?
- What is the likelihood of the other SAs completing activities when not part of a review—i.e., in everyday practice?

- What would encourage or motivate other SAs to work through the handbook?
- Anything else you wish to add?

**THANK THE SKILLED ATTENDANT FOR HIS/HER COOPERATION**

### 4.3 Topic Guide for Group Discussion

The group discussion begins the process of consensus building. The group discussion will revisit many of the areas already examined through the interviews, observations but the discussion should highlight areas of conflict and consensus to take forward to the adaptation taskforce for consideration.

#### Introduction

Welcome the group. Start with a presentation of the facilitator and observer, the participants, an explanation of the review process as part of the process of the adaptation of the handbook, present the next steps for the development, and then present the objectives of this group discussion.

Encourage their participation and ask them to be as open as possible as their suggestions will be very useful to us in adapting the handbook to suit the local country context.

NOTE: As the facilitator you should try to reach some consensus on the points rather than just individual responses. Also remember, you are not conducting an interview but are trying to facilitate an active discussion among the participants.

1. Background information about the skilled attendants:
  - Age:
  - Sex:
  - Qualifications:
  - Average number of monthly deliveries:
  - Setting of health centre-Rural or Urban:
  - Length of time working as a skilled attendant:
  - Length of time at this health facility/current position:
  - Previous training on counselling and communication skills:
2. Knowledge and Skills of SAs in Counselling and communication
  - Describe the SAs in your district (i.e., doctors, midwives, and nurses).
  - What kind of training do they receive in counselling and/or in communication?
  - In your opinion, is this an important area of the work of a SA?
  - What is your opinion about the skills of SAs in their district in this area?
  - What are some common weaknesses?
3. General impression of the handbook
  - What is your general opinion of the handbook?
  - What did you like most about the handbook? (As a group, come up with three points)
  - What did you like least about the handbook? (As a group, come up with three points)
4. Self-Directed Learning Approach
  - What is your opinion about the self-directed learning approach used in the handbook?
  - How comfortable were you with a self-directed learning approach?
  - Is this a useful way for other SAs in your district to learn these skills?

- Do you think SAs in your district would prefer a more formal training session?

#### 5. Use of the Handbook

- For those who know the PCPNC, is this handbook useful as companion guide? Why?
- Is the content applicable to everyday work/practice? Why?
- What is the likelihood of the other SAs completing activities when not part of a review– i.e., in everyday practice?
- What would encourage or motivate other SAs to work through the handbook?

#### 6. Language

- Any terms in particular which you did not understand?
- Any terms in particular that you think other SAs will not understand?

#### Closing

**THANK THE PARTICIPANTS FOR THEIR COOPERATION**

## **Annex 4**

### **Summary of Recommendations from Field Reviews**

## Recommendations from the Field Review in Khartoum, Sudan

- Translate the Handbook into Simple Arabic. Field-test the translation and conduct a back-translation into English for quality assurance purposes
- Conduct a small Pilot study with rural Village Midwives to ensure concepts are well understood
- Consider adapting the Handbook into radio cassettes for the illiterate rural midwives
- Add a section on Female Genital Mutilation as FGM is prevalent in 90% of women in Sudan (CBS 2001), and all respondents unanimously agreed on the importance of adding information devoted to this harmful practice which requires special technical and counselling expertise. One discussion in the workshop considered whether FGM sections could simply be added into each existing session. However, only two respondents (out of 15) were in favour of this. There is an Information, Education, and Communication (IEC) FGM Working group in Sudan and two local FGM guidelines<sup>5</sup> that could be important sources of information if a new session is endorsed by the taskforce.
- Consider the possibility of ... a Sudanese FGM group using existing guidelines with below suggestions from one SA taken from an in-depth interview in an urban setting in Sudan:

*“As the topic is new to me I really don’t know but I do think an entire session on Female Genital Mutilation is critical. It is a very big problem in our country and holds with it many difficulties in reproductive health such as first intercourse, and labour-even just physical examinations and catheterisations. Although men are slowly changing their ideas about it, the grandmothers still insist on this. We need to include a definition, the types of FGM, and mainly about the disadvantages (infection, bleeding, and disease transmission). The handbook should discuss the problems with counselling and examining these circumcised women. It can also refer to the guidelines developed.”*
- Ensure more detailed explanations of key concepts of gender and empowerment
- Amend the images to effectively reflect the Sudanese cultural context
- Ensure less selection bias with the intended users for the next stage of the review
- Introduce the ECPG manual into Sudan or, if this is not a feasible option, consider adding more technical information to this Counselling Handbook

---

<sup>5</sup> Two Sudanese Guidelines available on FGM are: “FGM in the Sudan: A Community-Based Study” by the Sudan Fertility Care Association (UNFPA & FPIA), March 2001; and “Strategy and Action Plan: To Abolish FGM in Sudan” MOH, November 2002.

### Recommendations from the Field Review in Serang District, Banten Province, Indonesia

- Re-translate the Handbook into simpler *Bahasa* Indonesian. Field-test the translation and conduct a back-translation into English for quality assurance purposes. Ensure the translation of the more complex terms outlined above is re-translated and extensively field tested to ensure better understanding.
- Simplify the compound sentences
- Clarify concepts of “gender” and “empowerment” and include more detailed explanations and practical examples
- Amend the images to effectively reflect the Indonesian cultural context
- Consider the use of certain sessions (AIDS and Bereavement) to add into existing manuals if the MOH does not yet want to invest in another communications manual.
- Consider a comparison study of all available/existing communications manuals with the Handbook to test effectiveness and use among SAs in Indonesia.

### Recommendations from Field Review : Manila, The Philippines

All the participants recommended the adoption the Handbook if their programme was interested in improving the skills of SAs in counselling and communication.

In order to ensure that the Handbook is more applicable and responsive to local needs and context, they suggested the following (besides all changes suggested in the previous discussions):

- Provide an orientation to the health workers before they start using the Handbook
- Organize prerequisite training e.g. BF, FP, PCPNC
- Define target groups
- Add counselling for specific target groups and special needs for instance teenage pregnancy, adolescents
- Adjust the Handbook to ‘Sentrong Sigla’ quality standards (standards adopted by Metro Manila Health Department)
- PCPNC is endorsed by the country
- Introduce the counselling Handbook and provide an orientation on its use during the PCPNC training

The participants thought that the Handbook contributes to improving maternal and newborn health because of the following:

- Clients are empowered
- The emphasis is put upon the importance of working with support group especially in preparing birth plans
- Handbook serves as a guide in providing quality health services
- It helps women and families to gain additional knowledge and to be more ‘compliant’.

In conclusion, in addition to the recommendations from the Philippines team, the following suggestions are put forth for consideration:

- Reinforce the skills development part of the Handbook by strengthening the activities so that they lead in a practical way to developing the skills for counselling. For instance, some activities could

be designed as group exercises among the SAs where they could support each other in developing these skills through observation and feedback, role-play.

- The key concepts of the Handbook need to be defined and reinforced throughout the Handbook. Additional exercises may need to be designed to help the SAs to understand and internalise some of the concepts presented at the beginning of the Handbook. This would avoid misinterpretations and allow self-reflection on a sound basis.

When introducing the Handbook, programmes have to plan a strategy where the SAs have the opportunity to spend time working through the Handbook. This may entail a briefing by the supervisors, a different organization of duties and possibly arranging group sessions and exercises.