COMMUNITY HEALTH OFFICER

Training Manual

(FACILITATOR’S GUIDE)

Volume 2

MINISTRY OF HEALTH/GHANA HEALTH SERVICE NATIONAL HEALTH LEARNING MATERIALS CENTRE
Acknowledgements

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Agyeman Badu Akosa  Former DG - GHS
Elias K. Sory  DG - GHS
Ken Sagoe  HRDD - GHS
Said Al-Hussein  HFDD - GHS
Kobina Bainsom  CHPS - TA
Barbara Jones  CHPS - TA
Irene B. Bangpourri  CHPS - TA
Caronline Tetteh  CHPS - TA
Isabella Rockson  CHPS - TA

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Stella Deiwah  DHD-Kwahu North
A. K. Ankuvie  DHD-Kwahu North
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Justice Acheampong  NHLMC-Kumasi
Andrew Adjei Druye  NHLMC-Kumasi
Samuel Kissi Boateng  NHLMC – Kumasi
Mawuli Albert Gadzanaki  NHLMC – Kumasi
Bridget Brenya-Boateng  NHLMC – Kumasi
Frank Ohene Kankam  NHLMC – Kumasi
Vera Gaitu  RHD- Volta Region
Ellen Sarpong-Akorsah  RHD-Volta Region
Comfort Agbadja  RHD-Volta Region
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<td>DHD-Sefwi Wiawso</td>
</tr>
<tr>
<td>Emmanuel Edum-Kankam</td>
<td>RHTS, Kintampo</td>
</tr>
<tr>
<td>Elizabeth Corney</td>
<td>DHD-Bia District</td>
</tr>
<tr>
<td>Beatrice Kunfah</td>
<td>DHD-Jirapa Lambusie District</td>
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<td>Phoebe Bala</td>
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<td>Charlotte Eninful</td>
<td>CHNTS Winneba</td>
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<td>Patricia Antwi</td>
<td>DHD-Gomoa</td>
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<td>Yaw Brobbey Mpiani</td>
<td>GHS, HQ, Accra</td>
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The levels of health care provision are clearly defined and articulated in the Ghana Health Service and Teaching Hospitals Act, 1996 (Act 525). It is a fact that if the health sector is to contribute to the achievement of the Millennium Development Goals in Ghana, then there is the need for a paradigm shift in health services provision from over concentration on curative and institutional care to a more community-based level or close-to-client health services delivery with household and community involvement.

The Community-based Health Planning and Services (CHPS) initiative is one of the new paradigm shifts which have been adopted to re-orient and relocate health services from clinical to community levels, which is contributing to the realization of the goals of primary health care.

From the initial trials in Nkwanta and Juaboso Bia district, the CHPS initiative has now become a national policy in health care delivery. All districts are in the process of implementing the scheme and the training of personnel needed is on going. The effectiveness of the training of these personnel for CHPS depends on the availability of appropriate materials. It is for this reason that this training manual has been developed to guide and support CHO training.

The manual consists of fourteen modules which have been organized into three volumes. The manual which has been tried and tested over a period of five years will continue to be useful in the training of the personnel needed for CHPS. Over the period, the manual has been reviewed and current issues such as the Millennium Development Goals, poverty reduction, mental health and regenerative health and nutrition have been integrated.

It is my hope that this manual will guide health service providers in improving and expanding CHPS implementation.

Dr. Elias Sory
Director General, Ghana Health Service
May, 2008
Preface

The Community-based Health Planning and Services (CHPS) is the Government of Ghana’s strategy to bring quality health care to the door step of the people. The government recognizes that the main producers of health are individuals and households. By involving individuals and households in planning and delivering health care CHPS aims to establish sustainable systems for improving the community’s health. Community Health Officers serve as the link between the sub-district and the community, working through health extension workers and community volunteers.

Since CHPS became a national policy the regions and districts have developed various training programmes and trained Community Health Nurses as CHOs; however, these training programmes have not been structured as a coherent national training programme on CHPS. Thus, there is the need to develop a structured training programme for improving the quality of health services delivered in CHPS zones.

The training package comprises the CHO Manual (Facilitators’ Guide) and the CHO Workbook. The facilitators guide are to be used by facilitators and CHO workbook are for CHO. However, the two documents are complementary to each other. The development of the CHO manual (Facilitator’s Guide) and CHO Workbook has been informed by the job description of the CHO as well as changes in health policies both globally and nationally.

There are two objectives for writing the CHO training manual and workbook. First, it is a standard in-service training manual that health managers, CHO Supervisors and training facilitators can use to orient newly qualified community health nurses as well as train existing CHOs to improve service delivery in CHPS. Second, the documents should serve as a resource for use by CHOs to improve the management of CHPS zones and improve the quality of services delivered.

The CHO Manual (Facilitator’s Guide) is in three volumes which cover the CHO’s work, including delivering reproductive and child health services, curative care, health promotion and prevention, and health care management. Volume one discusses the CHO’s work in the community, including home visiting, behaviour change communication, and managing CHO activities. Volume two covers maternal and child health care, including family planning, antenatal care, safe emergency delivery, postnatal care and HIV/AIDS. Improving immunization, promoting good nutrition, disease control and management of common ailments and emergencies are important in reducing under-five and maternal mortality; therefore, these subjects have been covered in Volume three.

Each module has module objectives and content. The content section is sub-divided into units, and each unit relates to the one of the objectives of the module. Each unit in the module starts with a Terminal Performance Objectives (TPO) followed by the topics.
How to use the Facilitator’s Guide and Workbook

Facilitator’s Guide

The Facilitators’ Guide contains details of the suggested approaches and activities to enable you to facilitate each unit within the module. References have been provided, but as a facilitator, you are encouraged to consult other reference materials.

Advance Preparation

You need to prepare ahead for facilitating each unit. Some of the preparations require gathering various materials, preparing copies of case studies for distribution, session notes and other materials that may be needed. You may also need to contact chiefs and opinion leaders of the various sites that you intend to use as field visits sites. It is further advised that facilitators should meet to discuss the mode of training and related issues before training starts.

Facilitator-Participants’ Interaction

As a facilitator, you are encouraged to use interactive approach to enable your trainees achieve proficiency in applying the requisite skills. You also need to be as innovative as possible to enable the trainee CHO to achieve the specified TPO. Even though facilitation approaches have been suggested, you may use other approaches as you deem fit. Lectures and other less participatory approaches should be kept to a minimum. You should aim to involve the trainees as much as possible in the process of skills transfer and acquisition.

Periodic refresher training on specific modules using on-the job training (OJT) approaches must be organized for the CHO.

Field Visits

The training is to enable CHO’s to attain proficiencies in the various skills needed for their practice. Therefore you should devote more time in the field to enable them have real hands-on experience. Make arrangement for transport where necessary.

Training Needs Assessment

This should be conducted ahead of each training. Sample case studies have been prepared for distribution to potential trainees before they arrive at the training site. Encourage trainees to respond to all the questions and also to complete the CHO Workbook before every session. The information gathered from the use of the case studies, the CHO Workbooks, and the pre-test
scores will enable you tailor the training programme to enable maximum benefit to be obtained by the CHOs.

**CHO Workbook**

The CHO Workbook contains the content organized as units as well as the activities, including case studies, role plays, and discussion points. The CHO Workbook is similar to the Facilitators’ Guide. However, the answers to the various questions and case studies have been deleted from the Workbook. This will enable the CHO learn the contents of the module on his/her own using the notes included as reference material. It will also enable the CHO use it to take notes during training.

**Advance Preparation for CHO Trainees**

Each trainee should receive the CHO Workbook at the beginning of the in-service training. Trainees should be encouraged to read through the Workbook, reference notes and complete all the assignments listed. The facilitator should also give the trainees a number of case studies to study and provide answers. Encourage trainees to consult the reference listed in the module as well as any other reference materials that may be available to you. The case studies are meant to assess trainees’ knowledge of some procedures that they need to perform when they are in the field. A pre-test should be conducted at the start of the training to complete the assessment of trainees’ training needs.

**Participation in Training Sessions**

During the training, facilitators should interact closely with the trainees to maximize the acquisition of knowledge, appropriate attitudes and skills.

**Supervisory Visits and Support**

Regular supportive supervision is encouraged after the training programme. You should receive supervisory visits from your supervisor(s) to help you consolidate the skills you have acquired from the training and improve your performance as CHO. Your supervision may organize On-the Job Training (OJT) for you during these supervisory visits. These OJTs will be based on your needs as identified by yourself and your supervisor. It is therefore important to keep records of your experiences in the field and the cases that you encounter. This will enable you and your supervisor plan the OJTs effectively.
## Abbreviations

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<tr>
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<th>Description</th>
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<tbody>
<tr>
<td>ANC</td>
<td>Ante natal care</td>
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<tr>
<td>APGAR</td>
<td>Appearance, pulse, grimace, activity, respiration -</td>
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<tr>
<td>APH</td>
<td>Ante-partum haemorrahage</td>
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<td>ART</td>
<td>Anti-retroviral therapy</td>
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<td>AVSC</td>
<td>Association of Voluntary Surgical Contraception</td>
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<tr>
<td>BCC</td>
<td>Behaviour change communication</td>
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<tr>
<td>BCG</td>
<td>Bacille Calmette-Guerin vaccine</td>
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<tr>
<td>BF</td>
<td>Blood film</td>
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<td>BNI</td>
<td>Basic needs income</td>
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<td>BP</td>
<td>Blood pressure</td>
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<td>BTL</td>
<td>Bilateral tubal ligation</td>
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<tr>
<td>CBA</td>
<td>Community-based agent</td>
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<tr>
<td>CBD</td>
<td>Community-based distribution</td>
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<tr>
<td>C-COPE</td>
<td>Client-oriented provider efficient service</td>
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<tr>
<td>CD</td>
<td>Communicable disease</td>
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<tr>
<td>CD1 or C.D.1</td>
<td>Communicable disease form 1</td>
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<td>CDS</td>
<td>Community decision system</td>
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<tr>
<td>CHC</td>
<td>Community Health Compound</td>
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<td>CHO</td>
<td>Community Health Officer</td>
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<td>CHPS</td>
<td>Community-based Health Planning and Services</td>
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<td>CHV</td>
<td>Community health volunteer</td>
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<tr>
<td>CHW</td>
<td>Community health worker</td>
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<tr>
<td>COC</td>
<td>Combined oral contraceptive</td>
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<td>CPI</td>
<td>Client provider interaction</td>
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<td>CSM</td>
<td>Cerebro-spinal meningitis</td>
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<td>CWC</td>
<td>Child welfare clinic</td>
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<tr>
<td>DDHS</td>
<td>District Director of Health Service</td>
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<td>DHD</td>
<td>District Health Directorate</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>DHMT</td>
<td>District Health Management Team</td>
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<td>DMPA/NET-EN</td>
<td>Depot Medroxy Progrestone Acetate</td>
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<tr>
<td>DOT</td>
<td>Directly observed treatment</td>
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<tr>
<td>DPT/Hib/Hep</td>
<td>Diphtheria/Pertussis/Tetanus/Haemophilus</td>
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<td>GHS</td>
<td>Ghana Health Service</td>
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<td>HRDD</td>
<td>Human Resource Development Division</td>
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<td>IDSR</td>
<td>Integrated disease surveillance and response</td>
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<tr>
<td>IEC or IE&amp;C</td>
<td>Information, education and communication</td>
</tr>
<tr>
<td>IMCI</td>
<td>Integrated management of childhood illnesses</td>
</tr>
<tr>
<td>IP</td>
<td>Infection prevention</td>
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<tr>
<td>IPC</td>
<td>Inter personal communication</td>
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<td>ITN</td>
<td>Insecticide-treated net</td>
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<tr>
<td>IUD</td>
<td>Intra uterine device</td>
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<tr>
<td>IV</td>
<td>Intravenous</td>
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<td>LBW</td>
<td>Low birth weight</td>
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<tr>
<td>LCD</td>
<td>Liquid crystallized display</td>
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<td>MAP</td>
<td>Men as partners</td>
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<td>MIS</td>
<td>Management information systems</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MTCT</td>
<td>Mother-to-child- transmission</td>
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<td>NGO</td>
<td>Non-governmental organisation</td>
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<tr>
<td>NHLMC</td>
<td>National Health Learning Materials Centre</td>
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<tr>
<td>NHRC</td>
<td>Navrongo Health Research Centre</td>
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<td>OHP</td>
<td>Overhead projector</td>
</tr>
<tr>
<td>OJT</td>
<td>On-the-job training</td>
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<tr>
<td>OPV</td>
<td>Oral poliovirus vaccine</td>
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<tr>
<td>ORS</td>
<td>Oral rehydration salt</td>
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<tr>
<td>PAS</td>
<td>Public address system</td>
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<tr>
<td>PID</td>
<td>Pelvic inflammatory disease</td>
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<tr>
<td>PLWHA</td>
<td>People living with HIV and AIDS</td>
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<tr>
<td>Abbreviation</td>
<td>Description</td>
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<td>---------------</td>
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<tr>
<td>PNC</td>
<td>Post natal care</td>
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<tr>
<td>RCH</td>
<td>Reproductive and child health</td>
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<tr>
<td>RHMT</td>
<td>Regional Health Management Team</td>
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<tr>
<td>RPR</td>
<td>Rapid Plasma Reagin Test</td>
</tr>
<tr>
<td>RTI</td>
<td>Respiratory tract infection</td>
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<tr>
<td>SCHN</td>
<td>Senior Community Health Nurse</td>
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<td>SDHT</td>
<td>Sub- District Health Team</td>
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<tr>
<td>SHEP</td>
<td>School health education programme</td>
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<td>SHI</td>
<td>School health inspection</td>
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<tr>
<td>STD</td>
<td>Sexually transmitted disease</td>
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<tr>
<td>STG</td>
<td>Standard treatment guidelines</td>
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<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
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<tr>
<td>TBA</td>
<td>Traditional birth attendant</td>
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<tr>
<td>TPO</td>
<td>Terminal performance objectives</td>
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<td>TT</td>
<td>Tetanus toxoid</td>
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<td>VCT</td>
<td>Voluntary counselling and testing</td>
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<tr>
<td>VDRL</td>
<td>Venereal Disease Reference Laboratory</td>
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<td>VHC</td>
<td>Village health committee</td>
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<tr>
<td>VVM</td>
<td>Vaccine vial monitor</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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<td>WIFA</td>
<td>Women in fertile age</td>
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The Community-Based Health Planning and Services (CHPS) Concept

Health Situation Post-independence

Bringing basic health care services to all Ghanaians has been the major objective of the Government of Ghana. Since independence, the Government of Ghana has worked on improving health care services by building large hospitals in cities and big towns and health centres in smaller towns and villages. While the hospitals satisfied the needs of the urban populations, many people in rural communities did not have access to even basic health services, because they lived far away from health facilities. Thus, a vast majority of the rural population was left without any health services. As a result, children died from preventable diseases such as malaria, diarrhoea, measles, acute respiratory tract infection and cholera. Pregnant women also died from complications because the danger signs were not recognized early enough, services were unavailable or there was lack of transport, bad roads, or other difficulties.

To improve access to health service, the Government introduced the outreach services. Selected communities became outreach posts. Staff from the health centres travelled there on regularly scheduled days to provide health care. The staff always returned to the health facility until the next scheduled date. However, the outreach points did not improve access significantly. Why? Only those rural people who could go to the outreach point got access to health services.

Origin of CHPS

The government decided to do something about the situation. The Ministry of Health asked community members how they wanted health services to be delivered to them. The people said they wanted health services delivered at their doorstep and that they wanted to be involved in the process. Therefore, the Ministry chose Navrongo in the Kassena-Nankana district of the Upper East region to test the various ways in which health services can be delivered close to the people. The pilot project was the Community-based Health and Family Planning Project.

The Upper East region was the poorest region in Ghana. The Ministry therefore chose the Upper East region because if the strategy worked among poor communities, it was likely to succeed in other parts of the country that were relatively better off. The Ministry provided a nurse who lived among the people and attended to their health needs. The people also committed themselves to support the programme by providing accommodation for the nurse. They also agreed to select health volunteers to work with the nurse in addition to forming health committees to oversee the community health care delivery system and supervise the volunteers.

It is important to note that community members played a vital role in the Navrongo research. In spite of that, some questions remained at the back of the minds of both the health workers...
and community members. The Navrongo Health Research Centre was tasked to test the various options and assess their effect on the health of the people. Five years later, all the questions were answered. The people reported that the community health nurses and the community volunteers were working together very well. The results of this experiment were obvious to the community. Fewer and fewer of their children were dying because a lot of them received life-saving care at the right time. More and more pregnant women survived during child birth because trained health personnel were available to assist them have a safe delivery. Women said they had access to family planning counselling and services which were now close to them.

From Research to Policy

The Ministry of Health and the Ghana Health Service were happy with these results. Results of the project were replicated as Community-based Health Planning and Services (CHPS) initiatives in Nkwanta, Birim North and Abura-Asebu-Kwamankese districts. These districts also found that the strategy was very effective in meeting the basic health needs of the people. Thus the Ministry’s thinking that if the strategy worked in Navrongo it could work in other parts of the country came true.

Based on these results, in 2000, the Ministry of Health introduced the CHPS initiative as a national strategy for increasing access to primary health care services in underserved locations. The overall goal of CHPS is to improve the health status of people living in Ghana, by facilitating actions and empowerment at household and community levels. CHPS aims to provide health services to the large number of people who live in disadvantaged communities including those that are remote or poor. It is based on a strategy that has been tested by community members and found to be effective and different from the traditional way of delivering health services. The traditional way of providing health services is for people to visit the hospital or any health facility when they are sick. The emphasis was on treatment or curative care. In CHPS, the slogan is: “prevention is better than cure”.

All districts in Ghana are now implementing CHPS. Under CHPS, health services are community-based. This means a trained health worker goes to live in the community and involves the community members in planning and delivery of health services.

Key Elements of CHPS

- The Community (as Social Capital)
- Households and individuals (as Target)
- Planning with community members as prime beneficiary of health services (community participation)
- Service delivery with their involvement (client-focused, need based services)
CHPS in Organisational structure

The Ghana Health Service organisational structure has a national headquarters that provides programmatic direction and support to the regions. The regions provide technical support to and coordinate the work of the districts, which in turn support the sub-district. CHPS zones are part of the sub-district system.
CHPS Implementation Process

A key component of CHPS is a community-based service delivery that focuses on improved partnership with households, community leaders and social groups – addressing the demand side of service provision and recognising the fact that households are the primary producers of health. A CHO engages each Community within the zone (catchment area) in micro planning of health activities, sometimes termed “community decision making systems.” The CHPS organizational change process relies upon community resources for construction, labour, service delivery, and programme oversight including monitoring and evaluation. As such, it is a national mobilization of grass-root action and leadership in health service delivery.

Based on these CHPS activity sequence, six general implementation activities that change primary health care services from a sub-district clinic based operation to a comprehensive community-based programme are achieved. Each of the specific elements is referred to as a “CHPS milestone”:

1. **Planning**: “CHPS zones,” are geographical areas where services are to be delivered, are mapped district-wide, dialogue with communities about their health needs is held, and a situation analysis of the existing health services within a district is conducted.

2. **Community Entry**: Activities with chiefs and leaders residing within a CHPS zone are conducted in order to introduce and gain acceptance for the process, a durbar to introduce CHPS to the entire community is held, and a Community Health Committee, responsible for community-level and volunteer components of the CHPS process, is selected and trained.

3. **Community Health Compound (CHC)**: This is the site where the CHO will live and provide services. This phase includes securing funds for building or renovating a structure to serve as the CHC, selecting a site for the CHC that is acceptable and easily accessible to the entire community, and mobilizing communal labour for CHC construction.

4. **Community Health Officer (CHO)**: This is the title given to a certified community health nurse who has received additional training in order to provide the full complement of CHPS services. This phase includes the training and deployment of the nurse to the CHPS zone and holding a durbar to introduce the CHO to the CHPS zone residents.

5. **Essential Equipment**: In this phase, equipment essential for conducting CHPS services is procured. This includes a motorbike for CHO community and home visitation and purchasing bicycles for health volunteers as well as essential service delivery equipment such as weighing scales, BP apparatus, thermometer.

6. **Volunteers**: These are community residents who will aid the CHO by conducting health promotion activities and providing basic services. This phase consists of selecting and training the community health volunteers, convening a durbar to introduce them, holding
training for the Community Health Committee to oversee the work of volunteers and the procurement and distribution of their supplies, and training the CHO on how to work with health committees and volunteers. The training sessions for each group of worker usually combine all the components described above.

Completion of these six CHPS milestones heralds in a functional CHPS, ready to provide comprehensive primary health care services with strong health system strengthening at the community level.

Roles of CHO in the CHPS Zone

1. Planning health services and programmes with community members
2. Implementing health programmes with community participation
3. Supervising community level health workers, including health care assistants, TBAs, volunteers, and health committee members
4. Preparing and submitting monthly CHPS activity reports to sub-district

Icons

The following icons have been included in the CHO Training Manual to highlight main headings in the book. These also add some aesthetic value to the manual. Below are the icons and how they have been used in the manual.

Case study icon

Facilitator/Participants’ Interaction

It is our expectation that you find this manual very useful.
Module 1

Family Planning
Purpose and Organisation

A community that is sensitised on family planning make better informed decisions and choices that lead to improvement in their reproductive health. The Community Health Officer is expected to provide family planning information to community members. So she needs special skills to counsel and trace clients.

This module has four units that cover the core skills you will need in providing information and counselling services to the community members, especially to family planning clients in your community.

Objectives

Review these objectives now and all subsequent unit objectives as you begin each unit by:
1. Reading each objective yourself
2. Having a participant read the objectives aloud to the group

After studying this module the CHO will be able to:

1. Counsel new clients for family planning
2. Provide specific family planning methods
3. Conduct follow-up visits for discontinuing users of FP methods
4. Conduct defaulter tracing
5. Integrate other Reproductive Health (RH) services (e.g. breast examination, youth friendly services, male involvement, referral of clients with RH problems)

Content

Unit 1: Counselling New Clients for Family Planning (FP)

Unit 2: Provide Chosen Methods of Family Planning

Unit 3: Conduct Follow up Visits for Continuing Users of Family Planning Methods

Unit 4: Trace Family Planning Clients Lost to Follow up or Discontinuing Users
Expected Outcome

Knowledge
- The CHO will acquire knowledge on family planning and contraceptives
- Acquire knowledge on counselling techniques

Attitudes
The CHO will be able to exhibit the following attitudes:
- Tactfulness
- Tolerance
- Confidence
- Trustworthiness
- Sensitivity to socio-cultural issues
- Understanding
- Respectfulness

Skills
The CHO will acquire the following skills after going through the module:
- Communication and interpersonal relations
- Decision making
- Counselling
- Listening
- Technical
- Teaching
- Recording and reporting
Table 1.1: Materials Needed

<table>
<thead>
<tr>
<th>Samples</th>
<th>CHO Materials</th>
<th>Facilitator Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Contraceptives</td>
<td>• Stationery - paper - pencils - pens</td>
<td>• Overhead projector (where available)</td>
</tr>
<tr>
<td>• Client’s card</td>
<td>• Performance guide for family planning counselling</td>
<td>• Transparencies</td>
</tr>
<tr>
<td>• Record cards</td>
<td>• Performance guide on injectables</td>
<td>• Felt pens/markers</td>
</tr>
<tr>
<td>• Referral forms</td>
<td></td>
<td>• Flip-chart paper</td>
</tr>
<tr>
<td>• Leaflets on all</td>
<td></td>
<td>• Role play props: table, 3 chairs, pen, card, client’s records</td>
</tr>
<tr>
<td>contraceptives</td>
<td></td>
<td>• Case studies or referral activity</td>
</tr>
</tbody>
</table>

Teaching Methods

- Use learner-centered methods in this module
- Introduce new materials through a guided discussion
- Start each unit with a guided discussion

Help participants apply their knowledge in “real life” situations. In addition field practice is highly recommended.

Getting Started

1. Do a warm-up exercise
2. Review any topics from previous sessions that are relevant to this module
3. At the beginning of each module, review the purpose, contents and objectives
4. At the beginning of each unit, review the topic outline to enable participants understand how the module is organised

Facilitator-Participants Interaction

Depending on the manner in which you choose to facilitate the class, ask relevant questions on each of the questions in the Workbook. It is ideal to have participants attempt all the questions in their Workbook before the session.

Call on participants to read their answers

- Ask one person to volunteer to read first
- After he/she reads the answer, comment positively on it
Let another person read his/her answer
After he/she reads the answer, comment positively on it
Compare and contrast what both have written or ask others if they see similarities or differences

Group Activities
- Role plays, case studies, group discussions
- Give each participant a copy of the material to read or instructions on where the material is found in the Workbook
- Divide the participants into small groups. Tell each group to discuss the questions on the case study and provide answers to the questions that follow

During the presentations
- Ask if others have any additions
- Ask if others have any suggestions
- Comment on what they did well
- Offer suggestions for improvement
- Ask for lessons learnt
Unit 1

Counselling Individual Clients and Couples (New Clients) for Family Planning

Terminal Performance Objectives

After studying this unit, the CHO will be able to:

- Use effective communication and feedback skills to assist clients and couples to make decisions about their reproductive health needs
- Use counselling skills to assist individual clients and their partners to identify and discuss sexuality issues and how they relate to FP, STI and HIV/AIDS prevention and other reproductive health behaviours and decision-making
- Apply principles of good counselling
- Apply active listening skills
- Refer clients for FP methods

Rationale

Explain why these objectives are important to CHOs:

- When providers apply principles of good counselling, they are able to help clients make and carry out their own choices about reproductive health and family planning
- Application of active listening skills by providers will let clients feel valued by providers and satisfied with services
- Counselling clients for informed choices will make them use methods better
- Knowing referral sites and services available will help with effective referral and reduce client’s waiting time

Topic Outline

1. Interpersonal Communication Skill
2. Factors that Enhance Positive CHO and Client Relationships in FP and RH Services
3. Definition of Informed Choice
4. Counselling for Informed Choice
5. Referral System

Advance Preparation

1. Distribute CHO workbook to participants a day before the session to read
2. Ask participants to write the answers to the questions in their Workbooks
Topic Outline 1: **Interpersonal Communication Skills**

**Facilitator-Participants Interaction**
Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

1. List any three verbal communication skills you will use to encourage a client to speak freely when discussing FP or RH issues.
   a. Using open-ended and probing questions
   b. Listening actively or allowing client to finish speaking
   c. Encouraging and praising clients
   d. Reflecting and focusing on the discussion according to the client’s concerns
   e. Repeating and using paraphrasing
   f. Responding to client’s non-verbal communication
   g. Summarising and ensuring a common understanding of discussion

Topic Outline 2: **Factors that Enhance Positive CHO and Client Relationships in FP and RH Services**

**Facilitator-Participants Interaction**
Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

1. List factors that will enhance a positive relationship between the CHO and her clients.
   a. Establishing and maintaining privacy and confidentiality of client’s personal and medical history
   b. Helping client feel at ease and respected
   c. Using effective interpersonal communication skills that will allow free flow of information
d. Respecting cultural, religious and other personal beliefs, practices and socio-economic status.

e. Respecting clients’ rights

f. Assuring that clients receive the services and supplies they need at each visit

g. Giving old clients or the community an opportunity to share their opinions about FP/RH service and acting on the feedback.

2. What is feedback and why is feedback important in maintaining positive interpersonal relationships?

a. Feedback is a way of letting a client know what you the CHO have observed, heard and understood

b. Feedback helps the CHO to find out if the client understands important information and instructions regarding a FP method, or other RH decisions and relevant behaviours to be followed

c. Feedback can help build positive interpersonal relationships between the CHO and her clients or community members.

Activity 1: **Group work on Listening to a Partner**

Explain to participants that they are going to do an exercise to enable them to listen to a partner.

**Discussion**

1. Ask each to pair with the person next to him/her. One partner will be the speaker and the other the listener

2. The speaker will speak for two minutes about how to counsel a particular client or about any other interesting issue

3. The listener is allowed to show non-verbal interest but is not allowed to speak

4. Switch roles and repeat the exercise

5. Ask participants to answer the questions below. List responses on flip chart and discuss

6. Summarise and emphasise the importance of active listening in counselling

**Questions**

1. How did you feel to talk without interruption?

2. Describe how you felt not being allowed to speak.
3. When you were the speaker, did you feel you were understood? If so, how was that feeling conveyed to you? If not, how was the feeling conveyed to you?

Activity 2: **Case Study on Client-Provider Interaction**

*Application of communication skills, clients’ rights and listening skills*

1. Let each participant read the case study in his or her Workbook as you read aloud
2. Ask them to answer the question that follows
3. Call on volunteers to read out their answers. Discuss and summarise, stressing the importance of the skills

**Background**

You are on home visiting and realised that Madam Akos, a 32 year old was giving birth to her 5th born assisted by the TBA. Meanwhile the first four children were still small and she had never practised family planning. Judging from her situation, as a CHO, you introduced her and the husband to family planning. The husband initially did not want to hear the word “Family planning” but through much effort he finally agreed. So you booked them for the services on your next visit.

**Questions and Answers**

1. What communication skills will you apply?
   - Giving and receiving feedback, paraphrasing, questioning and summarising
2. What listening skills will you display in respect to client’s rights when husband prevents her from using contraceptive devices?
   a. Verbal skills: use of encouraging words, e.g. OK, go on, I’m listening. Consider client’s rights
   b. Non-verbal skills: nodding head, leaning forward, maintaining eye contact, etc.

   Guide the participants to discuss the following questions in groups and tell them to write their responses on flip chart for plenary discussion.

**Discussion**

1. What client’s rights should you consider during counselling? Every family planning client has the right to:
   a. Dignity: to be treated with courtesy, consideration and attentiveness
   b. Information: to learn about the benefits and availability of FP
   c. Safety: to be able to receive and practise effective FP
   d. Choice: to decide freely whether to practise FP and which method to use
Counselling Individual Clients and Couples (New Clients) for Family Planning

2. Define the phrase “counselling a client”

Counselling means assisting a client to explore an issue, request for a specific FP method or a problem in the context of the individual client’s life, in order for the client to voluntarily make her/his decision.

3. How does a “client counselling session” differ from “client education session”?

Counselling focuses on helping clients or couples make choices in their lives; education focuses on the transfer of information to individuals, couples or groups.

Topic Outline 3: **Definition of Informed Choice**

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

Questions and Answers

1. What does “informed choice” mean to you?

   “Informed Choice” means a person makes a decision based on accurate and useful information

2. Describe ways in which a CHO must discuss sexuality issues with her clients. A CHO must:

   a. Learn to use the vocabulary used by the particular age group of her client.

   b. Be prepared to provide accurate information objectively and comfortably refer to a more experienced colleague

   c. Observe and respond to questions or concerns the client presents from non-verbal cues (e.g. frowning, looking ashamed or alarmed)
d. Use counselling skills to help client explore the issues and make a plan to communicate with partner or develop alternative strategies for self-protection.

e. Be ready to make more time than usual with client, understanding that the time invested may mean greater client satisfaction and continuation of method (i.e. FP and protection against STI and HIV)

Topic Outline 4: COUNSELLING FOR INFORMED CHOICE

Facilitator-Participants Interaction

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

Questions and Answers

1. List some interrelated human sexuality issues relevant to good-quality FP counselling or RH service delivery.
   a. Woman’s lack of bargaining power with her partner regarding:
      i. when to have sex
      ii. the number of children to have
      iii. the decision to initiate and continue FP practice
      iv. treatment for a partner with or exposed to STIs or HIV/AIDS
      v. insisting on sexual monogamy with husband or partner
   b. Need for RH education for adolescents
   c. Sensitivity about female in relation to female circumcision
   d. Fear of discussion of sexual coercion, incest or rape
   e. Lack of cultural acceptance of women who initiate discussions pertaining to sexuality and FP issues
   f. Sexuality issues relevant to choice of FP method (e.g. Can condom become a part of role play and thus acceptable to partner; will heavy bleeding interrupt sexual relations?)

2. Describe the counselling process that counsellors are to follow during counselling. Refer to the reference material for the steps and summarise the discussion. (Note: the steps are to be covered in details in Unit 2).
a. Let participants read the background information for the demonstration as you read aloud

b. Ask for a volunteer to play the client while you play the counsellor. Demonstrate each of the counselling steps

c. Ask participants to observe how you carry out the counselling steps. Lead a group discussion and summarise

Activity 3: **Case Study on Initial FP Counselling**

**Background**

On your home visiting as a CHO you met Madam Adjoa who is 26 years old. During your interaction with her, she told you about a friend who is using the oral pills and so she also wanted to use it.

**Question and Answers**

What are the steps you will use in counselling Madam Adjoa?

- **G** – Greet clients in an open, respectful manner to create rapport
- **A** – Ask clients about themselves
- **T** – Tell clients about choices
- **H** – Help client make informed choices
- **E** – Explain fully how to use the method chosen
- **R** – Return visit should be planned

**OR**
- **R** – Rapport building
- **E** – Exploration
- **D** – Decision making
- **I** – Implementation of decision

Activity 4: **Case Study on Family Planning Counselling**

**Background**

Ms. Adzo who is 18 years old, calls at your compound after having unprotected sexual intercourse with her boyfriend. Tearfully she tells you how afraid she is of becoming pregnant. During the interaction with her, she informs you a friend said there is a pill that she can take to prevent this from happening. She asks if you could help her. You explain that there is what is
called Emergency Contraceptive which can be taken within 72 hours after unprotected sexual intercourse and may help to prevent pregnancy.

Questions and Answers

1. What are the main points that should be in Ms. Adzo’s sexual health history?
   a. Number of hours since unprotected intercourse

2. What are the common side effects and the advise you would give concerning the Emergency Contraceptive pills you have provided?
   a. Nausea
   b. Vomiting

3. What health education message would you give to Ms. Adzo?
   a. The need for STI protection
   b. The need for short-term (after Emergency Contraceptive Pill) and long-term contraceptives
   c. Warning signs of pregnancy, or instructions to return to you or clinic if no menstruation within one (1) month

Activity 5: **Group Work on Eligibility Criteria**

1. Ask participants to read the questions on eligibility criteria as you read aloud
2. For each question, ask volunteers to read out their answers
3. Discuss and summarise before moving on to the next question
4. Refer to eligibility criteria in the Workbook

From Question 1-3, tick the appropriate answers

1. Mrs. Enoba has not had her menstrual period since she delivered 8 weeks ago. She is breastfeeding exclusively. Which of these contraceptives is not appropriate for her?
   a. LAM
   b. Progestin-only pills
   c. Progestin-only injectable
   d. COC

2. Mrs. Thommy was treated for abnormal vaginal discharge a month ago and also at one other time during the last six months. Which of these contraceptives is not appropriate?
   a. Combined oral contraceptives
   b. Progestin-only pills
   c. Progestin-only injectable
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d. Tubal ligation

3. Mrs. Dicks has sickle cell anaemia, which contraceptives are appropriate?
   a. Progestin-only pills
   b. Progestin-only injectable
   c. Female condom
   d. Oral Contraceptive

Close topic: Summarise main ideas and link to next topic

Topic Outline 5: **Referral Systems**

Facilitator-Participants Interaction

Introduce topic using question and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

**Referring Clients**

Explain the steps in referring clients:

- Hand out sample referral forms
- Demonstrate how to fill out the form, using a flip chart or transparency
- Provide a case study and ask participants to fill out the referral form
- Walk round to assist if necessary
- Summarise

Close topic: Summarise main ideas and link to next topic
Unit 2

Providing Family Planning Services

Terminal Performance Objectives

After studying this unit the CHO will be able to:

- Explain the benefits of FP to individuals and couples
- Counsel clients to enable them make informed choices of FP methods
- Use the GATHER, CPI, REDI related steps to provide chosen FP method
- Correctly prescribe and dispense selected FP devices following appropriate procedures
- Instruct clients on the use of the selected FP method and further discuss the method’s most common side effects
- Conduct routine follow-up for FP clients in a way that enhances continuing satisfaction and acceptance
- Help clients manage common side effects of contraceptive methods
- Apply principles of good counselling to assist individual clients and couples in making reproductive health decisions according to their age or life – stage needs, health risk factors, special life – circumstances and preferences
- Refer clients for FP methods and FP/RH services that are not provided by the CHO

Rationale

Mention why these objectives are important to CHOs. Using the GATHER, CPI, REDI related counselling steps during counselling sessions will:

- Help both the client and the provider to learn
- Allow clients to weigh choices, make decisions and carry them out
- Help to meet special needs of the client

Topic Outline

1. Greet clients
2. Ask the clients about themselves
3. Tell clients about FP choices
4. Help clients make an informed choice
5. Explain fully how to use the chosen method
6. Return for follow-up or refer

Advance Preparation

- Distribute CHO Workbook to participants a day before the session to read
- Ask participants to write the answers to the questions in their Workbooks

Activity 6: **Group Activity on Demonstrating the GATHER Steps**

Use the following questions to cover the different GATHER Steps

1. For each step, ask two volunteers to read out their answers. Discuss with the whole group the correct answers and summarise. (Refer to reference materials in Workbook)
2. Ask volunteers to demonstrate the steps. Comment positively
3. Ask others to repeat the demonstration. Comment and summarise the steps

**What does the acronym GATHER mean to you?**

- **G** – Greet clients in an open and respectful manner to create rapport
- **A** – Ask clients about themselves
- **T** – Tell clients about FP methods
- **H** – Help clients make an informed choice
- **E** – Explain fully how to use the chosen method
- **R** – Return visits should be planned
Topic Outline 1: **Greet Clients**

**Facilitator-Participants Interaction**
Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

**Question and Answers**

**G** – How do you greet clients to establish rapport?

- Pay full attention
- Talk in a private place
- Assure the client of confidentiality
- Find out how you can help and explain what you can do

Topic Outline 2: **Ask Clients about Themselves**

**Facilitator-Participants Interaction**
Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

**Question and answers**

**A** – In asking clients about themselves, what are the things to consider?

- Help clients talk about their FP and RH experiences, their intentions, concerns, wishes, and current health and family life
- Ask if the client has a particular method in mind
- Pay full attention to what clients express with their words and their gestures and expressions
- Put yourself in the client’s place
- Express your understanding
- Find out the client’s knowledge, needs and concerns so that you can respond helpfully
Facilitator-Participants Interaction

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

Questions and Answers

T – What do you tell clients about their choices?

1. Tell clients about:
   a. Basic reproductive anatomy using visual aids
   b. FP methods depending on needs and RH choices using samples and other visual aids.
   c. Risk of infertility from Sexually Transmitted Infections (STI) and Pelvic Inflammatory Disease (PID), and their prevention (emphasise these for adolescents).
   d. Available methods, where they can be obtained and cost.
   e. Ask if the client has a particular method in mind
   f. Pay full attention to what clients express with their words and their gestures and expressions
   g. Put yourself in the client’s place
   h. Express your understanding
   i. Find out the client’s knowledge, needs and concerns so that you can respond helpfully

2. What should clients know about the chosen family planning method?
   a. What FP is (types)
   b. How it works (let client handle contraceptive)
   c. Whether it gives protection against STI/HIV
   d. Its effectiveness
   e. Characteristics (advantages and disadvantages)
   f. Eligibility of use (who can use/who cannot use)
   g. Possible side effects
h. Reasons for unscheduled visits
i. Emergency contraceptive
j. Clarify rumours and misconceptions, if any
k. Tell her about possible waiting time

**Topic Outline 4: Help Clients Make an Informed Choice**

**Facilitator/Participant Interaction**

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

**Questions and Answers**

**H** – How do you help clients to make an informed choice?

1a. Help the client think about what course of action best suits his or her situation and plans
b. Encourage the client to express opinions and ask questions
c. Respond fully and openly

2. What information about the client can assist you in helping her assess her choice of method(s)?
   a. Client’s plans and family situations
   b. Client’s reproductive goals
   c. Client’s ability to follow method instructions
d. Client’s partner’s cooperation
e. Client’s frequency of sexual intercourse
f. Client’s number of sexual partners
g. Client’s STI risk

3. Stress client’s STI risk
   a. Partnership status (singles, married/living with a regular partner/having sex with men, women, or both)
   b. New or more than one sexual partner in the last three months
c. Partner has other/multiple sex partners

d. History of HIV drug use

e. History of being sexually abused or coerced; currently or in the past

f. History of STI or PID, or previous syndromic treatment for STI

g. Partner with symptoms of an STI

h. Current symptoms or signs which may indicate an STI

i. Unanswered questions

j. Method suitability or unsuitability

k. Final and informed decision- Ask what client has decided to do or use

l. Ensure that the client has made informed decision by asking her to recap the characteristics of the method chosen

m. Consider medical eligibility criteria for the family planning method or methods that interest the client. Also, ask if the client’s sex partner will support client’s decisions. If possible, discuss choices with both partners. In the end, make sure that the client had made a clear decision. The provider can ask, “What have you decided to do? or What method have you decided to use?”

**Topic Outline 5: Explain fully how to use the chosen Methods**

**Facilitator-Participants Interaction**

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations etc.

**Questions and Answers**

1. **E** – What do you explain to clients in the E step of “GATHER”?  
   a. Explain how family planning supplies are to be used after a client has chosen a method
   b. Give him or her supplies, if appropriate

2. Explain the following to clients:
   a. When and where to get supplies/services
b. Possible waiting time for specific procedures, e.g. mini laparotomy

c. Consent form where required: Bilateral Tubal Ligation (BTL) and Vasectomy

d. Client’s instructions: make sure he/she understands them (let client repeat and fill in, if necessary)

e. Return to fertility

f. Unscheduled visits

g. Scheduled visits

h. If chosen Family planning method is not available, direct client where to obtain it.
i. To decrease STI risk, advise on the need to always use condom for safer sex

j. The need for screening and treatment of client and all partners whenever STI is suspected

Topic Outline 6: Return for Follow-Up or Refer

Facilitator-Participants Interaction

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations etc.

Questions and Answers

1. **R** – What do you do during the return visits?

   a. Discuss and agree when the client should return for follow-up or more supplies

   b. Encourage client to come to you at anytime and for any reason

   c. Complete client cards and records as appropriate

2. During the return visit, do you treat continuing clients differently from new clients? Give reasons for your answer.

   a. Continuing clients are just as important as new clients

   b. When counselling continuing clients, focus on talking with clients about their experience and needs

   c. Counselling continuing clients can be flexible and should be changed to meet the client’s needs
3. What should you as a CHO do when you visit a family planning client for follow-up?
   a. Ask if client is still using method (after the usual greetings and other formalities)
   b. Enquire if he/she is satisfied with family planning method or other reproductive health services
   c. For satisfied clients:
      i. verify if method is being used correctly
      ii. remind client of reasons for scheduled visits
      iii. give supplies, if necessary - encourage client to ask questions
      iv. Fill in or correct wrong information
      v. plan for return or unscheduled visits
      vi. encourage him/her to motivate others
   d. For unsatisfied clients:
      i. enquire about any problems and side effects
      ii. reassure client as appropriate - manage side effects and refer
      iii. ask about any other questions
      iv. help client to change method or refer to other RH service if necessary
      v. provide condoms if the client is using dual method
      vi. reinforce information about emergency contraception
      vii. plan for the next visit
      viii. thank client
      ix. say good-bye

Tick the correct answer(s)

4. Under which of the following situations would informed choice counselling regarding alternative FP methods be urgently needed?
   a. When a continuing client has used a particular method for one year
   b. For a para 0, gravida 0 and a new bride who requests an IUD and whose husband is a truck driver
c. When a fully breast feeding mother with lactational amenorrhea and a baby aged one month comes to the under-five children’s clinic
d. When helping new clients to choose FP methods
e. For a para 5, gravida 10 client who is using combined oral pills
f. For a para 1, gravida 4 client in the antenatal clinic
g. For a para 6, gravida 6 client using the Depo Provera injections

Activity 7: **Group Work**

To help participants with the steps, teach this song to the tune of “I need thee every hour”

**SONG**

Greet clients that you go to see  
Ask clients about themselves  
Assess their knowledge and all about themselves  
Tell clients about the methods  
Help clients to choose a method  
Explain how to use the method  
Return for follow-up

Activity 8: **Role play to enable CHO utilise GATHER in Family planning Counselling**

1. Refer to the case study on Madam Adjoa in Unit 1. Re-read the story with participants
2. Ask for volunteers to play the characters and assign roles (CHO, Madam Adjoa)
3. Ask the other participants to observe and take notes on the use of the GATHER steps
4. After the role play, ask the “actors” how they felt. Then ask them to assess themselves; comment positively
5. Ask observers to share their notes, based on the questions that follow (found in the CHO Workbook)
6. Discuss responses and summarise

**Questions**

1. How did the CHO introduce these clients to family planning?
Activity 9: **Case study on providing family planning methods**

**Background**

After having counselled sister Mansah who visited you earlier on she decided on taking the injectable (Depo-provera). Using the information from the “performance guide on clinical skills for clients choosing injectable” you are to ask sister Mansah for some information, explaining to her the importance of her giving you accurate information.

**Note:** This exercise may be used as a case study and/or a role play. It appears in the CHO Workbook as a case study with participants answering how they would approach the situation. In either case, refer participants to the performance guide on counselling and choosing injectable.

**Questions and Answers**

1. What specific steps in counselling will you apply? Ask client about her reproductive goals:
   a. How many more children she/he wants
   b. If she/he is interested in spacing her pregnancies or preventing them completely
   c. How many years does she/he want between pregnancies
   d. Take a productive and basic medical history of the client:
      i. age
      ii. number of pregnancies
      iii. number of births - number of living children, their ages and sex
      iv. any family planning methods they may have used in the past, for how long, why method was stopped, any problems with the method

2. What process of history-taking will you apply? The questions include:
   a. Are you breastfeeding a baby less than 6 weeks old?
   b. Do you have problems with your heart or blood vessels? Have you ever had such problems? If so, what problems?
   c. Do you have or have you ever had breast cancer?
d. Do you have severe cirrhosis of the liver, a liver infection or tumour? (Are her eyes or skin unusually yellow?)

e. Are you pregnant?

f. Do you have vaginal bleeding that is unusual for you?

g. Review the findings of the history so as to establish whether only injectable is suitable for the client

h. Share the findings with the client

i. Tell the client about injectables e.g. DMPA, NET-EN:
   i. effectiveness
   ii. how the injectable prevents pregnancy
   iii. advantages and disadvantages

3. What education will you give to the client? Clients selecting injectable shall get instructs on the following:

   a. When to use a back-up method
   b. Expected change in menstrual bleeding pattern
   c. Common problems she may experience and what to do if she experiences them
   d. How to prevent and protect herself against RTIs/STIs/HBV/HIV/AIDS
   e. Use of dual method
   f. The possible symptoms of serious problems that require immediate medical attention
   g. Reasons for return to the provider
   h. When to use Emergency Contraception (EC)
   i. Emphasise that the client may discontinue the method anytime she wants to and for any reason
   j. Explain the schedule of injections -every 2 months (NET-EN) or 3 months (DMPA)
   k. Reassess woman’s knowledge about the major side effects (amenorrhoea and irregular menstrual periods)
   l. Describe how the injection will be given and what to expect in terms of side effects and reaffirm if the woman would like to receive the injection
   m. Allow the client to repeat the instructions to be sure she understands
4. What safety measures must you take when giving the injection?
   a. Sterile techniques must be used: carefully wash hands, wear gloves, clean the injection site with an alcohol swab, and use sterile syringe and needles (2 or 5ml) sterile syringe
   b. Check name, dose and expiry date on the injectable (Depo Provera) ampoule or vial
   c. Shake the vial well, wipe top of vial and stopper with disinfectant, and fill syringe with full dose
   d. Insert sterile needle deep into the upper arm (deltoid muscle) or into the buttock (gluteal muscle, upper outer portion). Inject the full contents of the syringe
   e. Do not massage the injection site. Tell client not to massage or rub the site
   
   Explain that this could cause DP to be absorbed too fast. Place the syringe and needle in a puncture resistant or proof container after use. Ensure that the client has understood the information discussed
   h. Encourage the client to ask questions, respond in simple language and accurately
   i. Allow her to repeat what she has learnt about the use of the injectable
   j. Commend and add omitted information

5. How will you book an appointment for a follow up visit?
   a. Discuss return visits and follow-up with client
   b. Encourage client to return at any time she has a question or a problem

6. Describe how you will close the session
   a. Allow the client time for questions
   b. Respond factually and add omitted information
   c. Provide the maximum number of condoms according to client needs and stock available
   d. Provide spermicides in addition to condoms if the client desires extra protection
   e. Provide information about Emergency Contraception and if possible, provide Emergency Contraceptive pills
   f. Give a return date at 12 weeks after the current visit
   g. Inform the client that the routine visit will be every 12 weeks
h. A client should also return if she feels she needs protection from RTI/STI/ HIV/AIDS and is not currently using the dual method
i. Plan a return visit in time to give her next injection
j. Record the supply issued in the client’s “appointment” card and in the Daily Activity Register
k. If her partner is not with her during this visit, encourage her to have him present at the next visit
l. Bid her farewell

Facilitator-Participants Interaction

1. In table 1.2 below, match the statements found in column A with the appropriate FP method found in column B.

Table 1.2: Appropriate Family Planning Methods

<table>
<thead>
<tr>
<th>Column A</th>
<th>Column B</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The penis is erect just before intercourse and immediately after ejaculation.</td>
<td>Diaphragm</td>
</tr>
<tr>
<td>2. One of the factors that make a man have sexual desires is the production of testosterone mainly by the testes.</td>
<td>Foaming tablets</td>
</tr>
<tr>
<td>3. One main factor necessary for a woman to become pregnant is ovulation. Some FP methods prevent ovulation.</td>
<td>Tubal Ligation</td>
</tr>
<tr>
<td>4. The axis of the vaginal canal and the uterine cavity are at the right angle.</td>
<td>Withdrawal</td>
</tr>
<tr>
<td>5. The direction of the vaginal when a client is lying down is downwards and backwards. When standing, it is upwards and backwards towards the sacrum.</td>
<td>IUD</td>
</tr>
<tr>
<td>6. Menstruation occurs mainly due to the withdrawal of oestrogen and progesterone from the blood stream in the woman who still has her uterus.</td>
<td>Condoms</td>
</tr>
<tr>
<td>7. The Cowper’s gland secrets seminal fluid during sexual excitement.</td>
<td>Vasectomy</td>
</tr>
<tr>
<td>8. Ovulation occurs 12 to 16 days before menstruation</td>
<td>Hormonal FP methods</td>
</tr>
</tbody>
</table>

2. Outline some of the health benefits of family planning for mothers, children and families.
Providing Family Planning Services

a. Reduced incidence of poor maternal health related to pregnancy, delivery and post-partum

b. Mother has adequate time for breastfeeding and subsequent gradual weaning of each child

c. There is reduced incidence of low birth weight or stillborn babies

d. Reduced incidence of protein calorie malnutrition

e. Mother and child have more time to interact resulting in a greater likelihood of having a well-adjusted child

f. Children born to mothers under 18 years of age are unlikely to survive and enjoy good health

g. Mothers under 18 years old are often not prepared emotionally, economically or socially to provide the required childcare

h. Family planning advances individual, couple or community development e.g. promoting adequate education and improves access to schools, health facilities and medicines, income generation or employment opportunities

Activity 10: Case Study

Mrs. Turkson is on her second pack of Lo-Feminal (a COC brand). She is complaining of spotting and feeling nauseated on and off. History taking and physical examination detect no abnormalities.

Questions and Answers

1. What advice will you give her? Check the correct response(s)

   a. Reassure her and advise her to continue Lo-Feminal because spotting and nausea may occur during the first few months of starting any new oral contraceptive

b. Reassure her and advise her to take two pills a day for the next two days

c. Schedule a return visit for her when she has completed the third pack. Encourage her to return to the clinic if she has more concerns about nausea or spotting

2. What changes in hormones occur in the bloodstream when menstruation occurs?

   Hormone levels drop

3. How does your response to the question above (question 2) apply to the use of combined oral contraceptives (COCs)?
Menstruation occurs after completion of the pills that contain hormones

4. Why do some women who breastfeed and have lactational amenorrhea during the post-partum period sometimes become pregnant “without knowing” they are fertile again?

   The woman became pregnant during her first post-partum ovulation, which occurred two weeks before the first menses would have been noted.

In each of the items below indicate why each of the listed FP method(s) is suitable for the woman.

1. Mrs. Teteley has not had her period since delivery eight weeks ago. She is breast feeding exclusively

   a. Lactational Amenorrhea Method
   b. Progestin-only methods
   c. Depo Provera
   d. IUD

2. Mrs. Laadi was treated for abnormal vaginal discharge one month ago and also at one other time during the last six months

   a. Combined estrogen-progestin methods
   b. Depo Provera
   c. Progestin-only methods

3. Mrs. Karikari has one child. She had a miscarriage two weeks ago and her husband wants her to be pregnant but she wants to wait

   a. Combined estrogen-progestin methods
   b. Depo Provera
   c. Progestin-only methods
   d. Combined injectable contraceptives

4. Mrs. Darko has Sickle Cell Anaemia

   a. Progestin-only methods
   b. Depo Provera

5. Madam Sraha has a history of frequent, severe headaches. She is unwilling to ask her husband to wear condoms (for fear he will accuse her of infidelity)

   a. IUD
b. Progestin-only methods

6. Miss Fafali is a sexually-active 16-year-old who wants to begin FP. However, she has never been pregnant
   a. Combined estrogen-progestin methods
   b. Depo Provera
   c. Combined injectable contraceptive

7. Maame Mansa is a 40-year-old mother of five and wants to start FP
   a. Depo Provera
   b. IUD

8. Daavi Abla’s husband strongly disapproves of family planning. She bled heavily with her last delivery 9 months ago and has heavy periods
   a. Depo Provera
   b. Combined injectable contraceptives

2. Describe the steps to be followed when referring a client
   a. Follow the referral system
   b. Explain reason for referral
   c. Give direction to referral point and when to go
   d. Fill referral form
   e. Give a backup method if a client wants protection and method is not available
   f. Accompany if necessary
   g. Return visit should be planned

3. What are the reasons to refer a client?
   a. Clients who need methods that are beyond what the CHO can provide e.g. IUD, BTL, Vasectomy
   b. Clients wanting to remove IUD or Norplant
   c. Clients with problems, side effects of methods that the CHO cannot manage

**Close topic:** Summarise main ideas and link to next topic
Unit 3

Conducting Follow-up Visits for Continuing Clients

Terminal Performance Objectives

After studying this unit, the CHO will be able to:

- Follow up clients according to the National Reproductive Health Service protocols and complete client’s cards as appropriate.

Rationale

Mention why these objectives are important to CHOs:

- Find reasons why clients do not keep appointments
- Identify clients who are having problems and help manage the problems
- Make clients feel satisfied and wanted
- Keeping proper records will help the CHO plan, monitor and evaluate her activities

Topic Outline:

1. Establish Rapport
2. Conduct Interview
3. Supply the method
4. Manage or refer
5. Conduct next follow up visit
Topic Outline 1: Establish Rapport

Facilitator-Participants Interaction

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

How do you establish rapport?

- Greet clients in an open, respectful manner to create rapport
- Pay full attention
- Talk in a private place
- Assure the client of confidentiality
- Find out how you can help, and explain what you can do

Activity 11: Group Work

Instructions:

Divide participants into 3 groups. Each group should select a leader and a reporter. Using their Workbooks as a reference, ask each group to discuss the questions and write down their answers.

Discussion

Assign each group a topic to present:

G1: Establish rapport and conduct interview
G2: Supply the method
G3: Manage or refer and conduct next follow up

Give time for group work. Walk round and assist if necessary. Re-assemble the big group, ask G1 to present their answer and ask other groups to contribute if they have other ideas. Comment positively, discuss and summarize.

Questions and Answers

1. What family planning methods are available?
   a. Male and female condoms
   b. Oral contraceptives and injectables
Module 1 Family Planning

c. Intrauterine devices
d. Sterilization
e. Natural methods

2. What are the steps for using condoms?

Male condom

1. Check manufacture or expiration date on package
2. **Hint:** Make sure condoms have been stored properly and obtained from a good source
3. Remove condom from package. **Hint:** Do not use teeth, long nails or a sharp object to open condom package
4. Unroll condom slightly to make sure it unrolls properly
5. Place condom on the tip of the erect penis
6. Unroll condom down penis. **Hint:** If condom is initially placed on the penis backward and it doesn’t unroll, do not turn it around, throw it away and start with a new one
7. Squeeze air out of tip of condom
8. Smooth out air bubbles
9. With condom on, insert penis for intercourse
10. After ejaculation, hold on to condom at base of penis while withdrawing penis
11. Withdraw while still erect
12. Remove condom from penis
13. Tie condom to prevent spills or leaks
14. Dispose of the condom

Female condom

1. Check manufacture or expiration date on package. **Hint:** Make sure condoms are stored properly and obtained from a good source
   - Rub the outside of the package to spread the lubrication evenly
2. Remove condom from package. **Hint:** Do not use teeth, long nails or a sharp object to open condom package
3. Squeeze the ring on the closed end with your thumb and middle finger
4. Spread the outer and inner lips (labia) with the other hand
5. Insert the squeezed inner ring into the vagina
6. Using your index finger, push the inner ring as far up into the vagina as it will go. Hint: make sure the condom is inserted straight, not twisted
7. Leave the outside ring to rest against the outer lips of the vagina
8. Guide the penis to enter the vagina in the condom. Hint: If the penis starts to enter the vagina underneath the sheath, STOP having intercourse and start again with a new condom
9. After ejaculation, hold on to the outer ring and twist to keep the semen inside
10. Gently pull out the condom
11. Tie condom to prevent spill or leaks
12. Dispose of the condom safely

Repeat process for G2 and G3

**Topic Outline 2: Conduct Interview**

**Facilitator-Participants Interaction**

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

**Question and Answers**

1. What are the steps in conducting an interview?
   a. Ask how you may be of help
   b. Exhibit qualities of a good counsellor or (apply effective listening skills)
   c. Verify if current method is being used correctly and whether client is satisfied
   d. Reassure client
   e. Help to solve any problems

**Close topic:** Summarise main ideas and link to next topic
Topic Outline 3: Supply the Method

Facilitator-Participants Interaction

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

Question and Answers

1. What do you do if you are re-supplying a method?
   a. Re-supply if client does not have any problem
   b. If client is ineligible, help client to make an informed choice of a new method
   c. If change in method desired, help client to make an informed choice of a new method
   d. If client wants to stop, discuss reproductive needs with client
   e. Thank client
   f. Motivate client

1. If the man is not circumcised, pull the foreskin back. Squeeze the tip of the condom and put it on the end of the hard penis.

2. Keep squeezing the tip while unrolling the condom, until it covers all the penis. The loose part on the end will hold the man’s sperm. If you do not leave space for the sperm when it comes out, the condom is more likely to break.

3. Take off the condom. Do not let sperm spill or leak

4. Tie the condom shut and dispose by burning or burying it away from children and animals
Figure 2: How to use a female condom

1. Hold one packet reality lubricant
   a. Rub the outside of the pouch together to be sure the lubrication is evenly spread inside the pouch from the bottom
   b. To add more lubricant, simply give one quick squeeze of extra lubricant. Try different amounts to see what’s best for you and your partner. Try starting with two drugs

2. Find a comfortable position
   a. Try standing with one foot up on a chair or sit with one foot up on chair, or sit with knees apart, or squat
   b. Be sure the inner ring is at the bottom, close-end of the pouch
   c. If you wish, add a drop of extra lubricant to the closed-end outside tip of the pouch or to the outside ring for extra comfort before you insert reality

3. Hold the pouch with the open end hanging down.
   a. While holding the outside of the pouch, squeeze the inner thumb and middle finger
   b. Place your index finger between the thumb and middle finger and keep squeezing the inner ring
   c. Insert the squeezed condom as shown below. Take your time. If the condom is slippery to insert, let it go and start over

4. Now push the inner ring and the rest of pouch all the way up into the vagina with your index finger, check to be sure the inner ring is up just above the pubic bone by curving your index finger when it is a couple of inches inside the vagina.
   Take your time and push condom up to where you can feel the bone. Make sure the condom is inserted straight (not twisted) into the vagina. Movement side to side of the outer ring is normal
5 It is also important that the outside ring lies against outer lips as shown above.

During Intercourse
you may notice that the condom moves around during sex.

1. Movement side-to-side of the outer ring is normal

2. Sometimes female condom may slip up and down in the vagina, “riding” on the penis. If you notice Reality is slipping, add lubricant to the penis or inside the pouch.

3. But, if you begin to feel the outer ring being pushed into the vagina, STOP. See Figure 5 (b). If the penis starts to enter underneath or beside the sheath, STOP. See 5 (c) take out condom. Put in a new condom, and add extra lubricant to the opening of the pouch or on the penis. Make sure the outside part lies over the lip area.

6 After intercourse take out condom, squeeze and twist the outer ring to keep the sperm inside the pouch. Pull out gently. Throw away in a trash can. Do not flush (Figure b.). Do not reuse. Use a new condom every time you have sex.
Male Sterilization

Female Sterilization

Pills

Figure 3: Female Contraceptive

Close topic: Summarise main ideas and link to next topic
Topic Outline 4: **Manage or Refer**

**Facilitator-Participants Interaction**

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

**Question and Answers**

1. In managing or referring, what do you have to consider?
   a. Manage side effects or other problems according to the FP method
   b. Refer if problem is beyond your expertise

**Close topic:** Summarise main ideas and link to next topic

Topic Outline 5: **Conduct Next Follow up**

**Facilitator-Participants Interaction**

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

How do you conduct the next follow-up visit?

a. Plan next return visit
b. Encourage client to return before planned date should there be a problem
c. Thank client and say good-bye
d. See client off (if possible)

Activity 12: **Case Study on Conducting Follow-up Visits**

Charity is 32 years old. She has three children aged 12, 10 and 4 and she lives with her husband in Katima community. Her husband works in the mines in the south of the country and only returns home when he has annual leave or whenever there is a social function (e.g. birth, funeral). Charity has been using an IUD for some time. During your periodic home visiting, she says that she would want to change her method because she has heard that sometimes the IUD can go missing in the body. What would you do as the CHO of Katima community?
Questions and Answers

1. Using the performance guide for counselling what are the positive aspects of interaction you would show?
   a. Find out from Charity what she knows about the IUD, her concerns and fears. Dispel rumours, allay fears and reassure her. Use flipchart and visual aid to explain where the IUD is inserted
   b. Let Charity express her understanding during the interaction
   c. Give positive feedback, using both verbal and non-verbal communication and observation skills

2. What will be the role of Charity’s husband in this decision-making process?
   a. CHO can counsel both Charity and her husband together
   b. Her husband can support by explaining and reassuring Charity about what the CHO said

Close topic: Summarise main ideas and link to next topic
Unit 4

Tracing Family Planning Clients Lost to Follow-up

Terminal Performance Objectives

After studying this unit, the CHO will be able to:

• Compile a list of family planning clients lost to follow-up and clients who have discontinued use of a method
• Prepare a schedule of visits to follow up defaulting clients.
• Carry out the follow-up of clients lost to follow-up according to schedule
• Keep records

Rationale

Explain why these objectives are important to CHOs:

• Compiling the list of clients lost to follow-up/discontinuing clients will help the provider to identify the number of clients who have completed their schedules in the community
• Preparing the schedule to follow will help make the provider’s work easier

Topic Outline

1. Preparing for Tracing Clients Lost to Follow-up
2. Following up Clients Lost to Follow-up
3. Develop Skills to Increase Continuation Rate
4. Record Keeping
Topic Outline 1: Preparing for Tracing Clients Lost to Follow-Up

Facilitator-Participants Interaction
Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

Questions and Answers
1. What is the definition of “client lost to follow-up”/discontinuing client?
   a. A client is lost to follow-up or discontinuing client may be defined as one who has failed to keep an appointment for review or to obtain additional supplies and commodities

2. How do you prepare for tracing clients lost to follow-up?
   a. Information needed to prepare itinerary. Compile names and addresses of defaulters from your register
   b. Plan for them, where, who, i.e. decide on the day and time to go and visit them
   c. Materials needed e.g. visiting notebook, FP devices, BP apparatus

Close topic: Summarise main ideas and link to next topic

Topic Outline 2: Following up Clients Lost to Follow-Up

Facilitator-Participants Interaction
Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

Questions and Answers
1. How do you carry out the follow-up of client according to schedule?
   a. Ask simple questions
   b. Listen attentively to clients
c. Manage side effects and problems of FP methods, e.g. misconceptions and help clients make an informed choice about resuming use of method, changing the method, or not using a method

2. What are the benefits of following up defaulting Clients?
   a. Find out reasons why clients are not keeping appointments and address them.
   b. Make clients feel satisfied and wanted
   c. Keeping proper records will help the CHO plan, monitor and evaluate her activities

Close topic: Summarise main ideas and link to next topic

Topic Outline 3: **Develop Skills to Increase Continuation Rate**

Facilitator-Participants Interaction

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

Question and Answers

1. What skills are needed to increase continuation rate?
   a. Involving men in FP issues
   b. Regular follow-up visits
   c. Education to dispel misconceptions
   d. Durbars to discuss concerns openly

Close topic: Summarise main ideas and link to next topic

Topic Outline 4: **Record Keeping**

Facilitator-Participants Interaction

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.
Questions and Answers

1. Show samples of record cards and discuss.
   a. What types of records should be kept?
   b. Why is it important to keep these records?

2. Tracing Clients lost to Follow-up
   a. Divide the participants into small groups and have groups select a leader and a reporter
   b. Have participants in each group read and discuss the case and record their findings. Walk round and help, if necessary
   c. Reassemble the large group. Ask reporters to present, adding on to answers that have been given before
   d. Discuss and summarize
   e. Review the session objectives

3. What are the reasons why the clients do not complete their schedule?
   There are various reasons why clients may fail to complete their schedule e.g. attitude of CHO, rumours about methods, lack of money, shortage of contraceptives and no time on the client’s part

4. What should Agnes do to ensure that all the women who have not completed their routine review do so and continue to honour their sessions?
   a. Have enough contraceptives
   b. Change attitude towards clients
   c. Address misconceptions and rumours about methods
   d. Contraceptives should be affordable
   e. Change time to suit clients

**Close topic**: Summarise main ideas and link to next topic
Checklist 1.1: Performance Guide for Family Planning Skills in the CHPS Zone for CHO

Instructions:

Rate the performance of each task/activity observed using the following rating scale.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Task/Activity omitted</td>
</tr>
<tr>
<td>1</td>
<td>Task/Activity incorrectly performed</td>
</tr>
<tr>
<td>2</td>
<td>Task/Activity correctly performed (Hesitated)</td>
</tr>
<tr>
<td>3</td>
<td>Task/Activity correctly done and with confidence</td>
</tr>
<tr>
<td>N/A</td>
<td>Task/Activity not required in this observation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Task/Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Counselling Skills</strong></td>
</tr>
<tr>
<td>Initial Group Counselling</td>
</tr>
<tr>
<td>1. Greets clients responsibly, makes them comfortable</td>
</tr>
</tbody>
</table>
| Offers seats
| Provides privacy where necessary
| Assures clients of confidentiality                                           |
| 2. Introduces self to the clients                                           |
| 3. Tells the clients about the family planning methods available and how they work, using the necessary visual aids:
| Shows contraceptive samples
| Uses the family planning chart
| Demonstrates with anatomical models if necessary
| Shows posters/drawings                                                      |
| 4. Tells clients the advantages and disadvantages of the available methods   |
| 5. Asks which methods interest the clients                                   |
| 6. Determines what the clients already know about these methods              |
| 7. Corrects any misinformation that the clients may have, appropriately      |
| 8. Answers any questions the clients may have                                |
Checklist 1.2: Performance Guide for Family Planning

Instructions:

Rate the performance of each task/activity observed using the following rating scale.

<table>
<thead>
<tr>
<th>Task/Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Greets client respectfully and with kindness; makes them comfortable</td>
</tr>
<tr>
<td>2.</td>
<td>Introduces self to client/couple</td>
</tr>
<tr>
<td></td>
<td>Offers client/couple seat (s)</td>
</tr>
<tr>
<td></td>
<td>Provides privacy where necessary</td>
</tr>
<tr>
<td></td>
<td>Assures client(s) of confidentiality</td>
</tr>
<tr>
<td>3.</td>
<td>Asks the client which methods interest him/her and what he/she already knows about the methods</td>
</tr>
<tr>
<td>4.</td>
<td>Corrects any misconceptions that the client has, appropriately</td>
</tr>
<tr>
<td>5.</td>
<td>Gives client more information about the methods</td>
</tr>
<tr>
<td>6.</td>
<td>Asks about the client’s reproductive goals</td>
</tr>
<tr>
<td>7.</td>
<td>Takes a reproductive and basic medical history of the client</td>
</tr>
<tr>
<td>8.</td>
<td>Assists clients to make a preliminary choice of an appropriate method based on his/her reproductive goals and history</td>
</tr>
<tr>
<td>9.</td>
<td>Conducts any additional evaluation or client assessment that is necessary for the preliminary method chosen; determines the client assessment that is necessary for the preliminary methods chosen; refers the client for this evaluation if unable to do it himself/herself</td>
</tr>
<tr>
<td>10.</td>
<td>Helps the clients choose a different method if the preliminary choice is found to be unsuitable after additional evaluation</td>
</tr>
<tr>
<td>Task/Activity</td>
<td>Rating</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>11. Provides the methods of choice, if available, or refers the client</td>
<td></td>
</tr>
<tr>
<td>to the nearest facility where it is available</td>
<td></td>
</tr>
<tr>
<td>12. Gives the client instructions on:</td>
<td></td>
</tr>
<tr>
<td>a) How to use the method</td>
<td></td>
</tr>
<tr>
<td>b) Its side effects and their management</td>
<td></td>
</tr>
<tr>
<td>c) Possible problems or complications that mean the client</td>
<td></td>
</tr>
<tr>
<td>must return to the facility promptly</td>
<td></td>
</tr>
<tr>
<td>d) Any other relevant information</td>
<td></td>
</tr>
<tr>
<td>13. Allows the client to repeat the instructions to be sure that he/she</td>
<td></td>
</tr>
<tr>
<td>understands</td>
<td></td>
</tr>
<tr>
<td>14. Discusses return visits and follows up with the client:</td>
<td></td>
</tr>
<tr>
<td>15. Encourages the client to return at any time he/she has a question or</td>
<td></td>
</tr>
<tr>
<td>problem</td>
<td></td>
</tr>
<tr>
<td>16. Says good-bye to the client/couple politely and invites the client/couple</td>
<td></td>
</tr>
<tr>
<td>to come again</td>
<td></td>
</tr>
</tbody>
</table>
Checklist 1.3: Performance Guide for Family Planning Counselling Follow-up

Instructions:
Rate the performance of each task/activity observed using the following rating scale.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Task/Activity omitted</td>
</tr>
<tr>
<td>1</td>
<td>Task/Activity incorrectly performed</td>
</tr>
<tr>
<td>2</td>
<td>Task/Activity correctly performed (Hesitated)</td>
</tr>
<tr>
<td>3</td>
<td>Task/Activity correctly done and with confidence</td>
</tr>
<tr>
<td>N/A</td>
<td>Task/Activity not required in this observation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow-up Counselling</td>
<td></td>
</tr>
<tr>
<td>1. Greets the client respectfully and with kindness; makes him/her comfortable:</td>
<td></td>
</tr>
<tr>
<td>a) Offers seat</td>
<td></td>
</tr>
<tr>
<td>b) Provides privacy where necessary</td>
<td></td>
</tr>
<tr>
<td>c) Assures client of confidentiality</td>
<td></td>
</tr>
<tr>
<td>2. Introduces self to the client</td>
<td></td>
</tr>
<tr>
<td>3. Explores changes in the client’s current health status or lifestyle that may mean he/she needs a different method or may not need a method at all</td>
<td></td>
</tr>
<tr>
<td>4. Finds out if the client is satisfied with the method and is still using it</td>
<td></td>
</tr>
<tr>
<td>5. Explores how the client is using the method to be sure that he/she is using it correctly; if appropriate, have the client repeat the instructions</td>
<td></td>
</tr>
<tr>
<td>6. Asks the client about any problems he/she may be having with the method</td>
<td></td>
</tr>
<tr>
<td>7. Reassures the client about any minor side effects he/she may have and treats them if appropriate</td>
<td></td>
</tr>
<tr>
<td>8. Checks for medical complications and refers the client for medical evaluation, if necessary</td>
<td></td>
</tr>
</tbody>
</table>
## Checklist 1.4: Performance Guide for Physical Examinations Skills

**Instructions:**
Rate the performance of each task/activity observed using the following rating scale.

- **0** - Task/Activity omitted
- **1** - Task/Activity incorrectly performed
- **2** - Task/Activity correctly performed (Hesitated)
- **3** - Task/Activity correctly done and with confidence
- **N/A** - Task/Activity not required in this observation

### Follow-up Counselling

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Asks for questions from the client and answers them appropriately</td>
<td></td>
</tr>
<tr>
<td>10. Provides supplies if necessary</td>
<td></td>
</tr>
<tr>
<td>11. Makes arrangement for a return appointments by the client, if necessary</td>
<td></td>
</tr>
<tr>
<td>12. Says good-bye to the client and invites him/her to return to the clinic, when necessary</td>
<td></td>
</tr>
</tbody>
</table>

### Preparing for Examination of Clients

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepares for examination of client</td>
<td></td>
</tr>
<tr>
<td>a) Room/screen</td>
<td></td>
</tr>
<tr>
<td>b) Adequate light</td>
<td></td>
</tr>
<tr>
<td>c) Chairs</td>
<td></td>
</tr>
<tr>
<td>d) Table</td>
<td></td>
</tr>
<tr>
<td>e) Weighing scale</td>
<td></td>
</tr>
<tr>
<td>f) Examination couch</td>
<td></td>
</tr>
<tr>
<td>g) Client’s files and cards</td>
<td></td>
</tr>
<tr>
<td>h) Daily activity book</td>
<td></td>
</tr>
<tr>
<td>i) Linen</td>
<td></td>
</tr>
<tr>
<td>Ensures privacy</td>
<td></td>
</tr>
</tbody>
</table>

---

50
### Task/Activity Rating

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Communicates with the client throughout the procedure</td>
<td>0 1 2 3 N/A</td>
</tr>
</tbody>
</table>

### General Examination

1. Ensures that the client is comfortable

2. Takes:
   - a) BP
   - b) Weight

3. Prepares the client for the examination:
   - a) Explains the procedure to the client
   - b) Asks the client to empty her bladder
   - c) Positions client on the couch

4. Washes hands with soap and running water before the examination. Dries hands with clean, dry towel before examination.

5. Checks the head:
   - a) Hair for:
     - Cleanliness
     - Head lice
     - Scalp ringworm, dandruff
     - Alopecia
   - b) Eyes for:
     - Pallor
     - Jaundice
     - Infection
   - c) Ears for:
     - Discharge
   - d) Nose for:
     - Nasal polyps/growths
     - Discharges
   - e) Mouth for:
     - Oral hygiene
     - Lips – Inflammation
     - Tongue – for paleness, thrush, hairy leukoplakia
     - Gums for bleeding, inflammation
     - Throat for enlarged, inflamed tonsils
<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>f) Face for:</td>
<td></td>
</tr>
<tr>
<td>- Hair/beard</td>
<td></td>
</tr>
<tr>
<td>- Rash</td>
<td></td>
</tr>
<tr>
<td>- Acne</td>
<td></td>
</tr>
<tr>
<td>6. Checks neck for:</td>
<td></td>
</tr>
<tr>
<td>- Enlarged lymph nodes</td>
<td></td>
</tr>
<tr>
<td>- Enlarged thyroid gland</td>
<td></td>
</tr>
<tr>
<td>- Engorged neck veins</td>
<td></td>
</tr>
<tr>
<td>7. Checks hands for:</td>
<td></td>
</tr>
<tr>
<td>a) Hygiene</td>
<td></td>
</tr>
<tr>
<td>b) Spooning of fingernails</td>
<td></td>
</tr>
<tr>
<td>c) Discolouration of fingernails</td>
<td></td>
</tr>
<tr>
<td>d) Symmetry</td>
<td></td>
</tr>
</tbody>
</table>

**Breast Examination**

1. Inspects the breast while at the same time teaching the client self-breast examination. Inspects the breast while the client is sitting with her arms at her side and with arms raised over her head: Examine for:
   a) Symmetry
   b) Any abnormal colour
   c) Dimpling
   d) Nipple inversion, discharge
   e) Cracks, ulcers
   f) Abnormal size/shapes
   g) Enlarged and tender nodes in clavicular region

2. Palpates breast while the client is the supine/back position (stretch arm over head on side being examined) and examine for:
   a) Masses
   b) Lumps
   c) Tenderness
   d) Abnormal discharges

3. Palpates the axillae for:
   a) Tenderness of lymph nodes
   b) Enlargement of lymph nodes

4. Gives the client feedback on the findings of the examination
<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abdominal Examination</strong></td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>1. Inspects abdomen for:</td>
<td></td>
</tr>
<tr>
<td>a) Symmetry</td>
<td></td>
</tr>
<tr>
<td>b) Scars</td>
<td></td>
</tr>
<tr>
<td>c) Rashes</td>
<td></td>
</tr>
<tr>
<td>d) Any other abnormalities</td>
<td></td>
</tr>
<tr>
<td>2. Performs light palpation</td>
<td></td>
</tr>
<tr>
<td>3. Asks the client if she feels pain anywhere in the abdomen</td>
<td></td>
</tr>
<tr>
<td>4. Performs deep palpation for:</td>
<td></td>
</tr>
<tr>
<td>Masses</td>
<td></td>
</tr>
<tr>
<td>Tenderness</td>
<td></td>
</tr>
<tr>
<td>Examination of lower limbs</td>
<td></td>
</tr>
<tr>
<td>1. Check leg for:</td>
<td></td>
</tr>
<tr>
<td>a) Symmetry</td>
<td></td>
</tr>
<tr>
<td>b) Oedema</td>
<td></td>
</tr>
<tr>
<td>c) Varicose veins</td>
<td></td>
</tr>
<tr>
<td>d) Tenderness of calf muscles by feeling temperature with the back of the palm</td>
<td></td>
</tr>
<tr>
<td><strong>Post Examination</strong></td>
<td></td>
</tr>
<tr>
<td>1. Gives client feedback on findings of general examination</td>
<td></td>
</tr>
<tr>
<td>2. Prepares client for next part of examination (if required)</td>
<td></td>
</tr>
<tr>
<td>3. Records the findings into the client's file/card and register</td>
<td></td>
</tr>
</tbody>
</table>
Checklist 1.5: Performance Guide for Counselling Clients Choosing Oral Contraceptives

Instructions:
Rate the performance of each task/activity observed using the following rating scale.

<table>
<thead>
<tr>
<th>0</th>
<th>Task/Activity omitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Task/Activity incorrectly performed</td>
</tr>
<tr>
<td>2</td>
<td>Task/Activity correctly performed (Hesitated)</td>
</tr>
<tr>
<td>3</td>
<td>Task/Activity correctly done and with confidence</td>
</tr>
<tr>
<td>N/A</td>
<td>Task/Activity not required in this observation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Greets client/couple respectfully and with kindness; makes them comfortable</td>
<td></td>
</tr>
<tr>
<td>2. Introduces self to the client/couple</td>
<td></td>
</tr>
<tr>
<td>3. Asks about the client’s reproductive goals:</td>
<td></td>
</tr>
<tr>
<td>4. Takes a reproductive and basic medical history of the client:</td>
<td></td>
</tr>
<tr>
<td>(a) Age</td>
<td></td>
</tr>
<tr>
<td>(b) Number of pregnancies</td>
<td></td>
</tr>
<tr>
<td>(c) Number of births</td>
<td></td>
</tr>
<tr>
<td>(d) Number of living children, their ages and sex</td>
<td></td>
</tr>
<tr>
<td>(e) Any family planning methods they may have been used in the past and for how long. Why stopped the method?</td>
<td></td>
</tr>
<tr>
<td>(f) Family planning methods currently being used</td>
<td></td>
</tr>
<tr>
<td>(g) Any conditions that may be precaution for oral contraceptives</td>
<td></td>
</tr>
<tr>
<td>(h) Knows or suspects pregnancy</td>
<td></td>
</tr>
<tr>
<td>(i) Undiagnosed vaginal bleeding</td>
<td></td>
</tr>
<tr>
<td>(j) If she is breastfeeding</td>
<td></td>
</tr>
<tr>
<td>(k) Taking rifampicin for TB or medications for seizure disorders, heavy smoker (if over 35 years)</td>
<td></td>
</tr>
<tr>
<td>(l) Jaundice known or suspected</td>
<td></td>
</tr>
<tr>
<td>(m) High blood pressure (160/100 mm Hg or more) (if over 35 years and a heavy smoker)</td>
<td></td>
</tr>
<tr>
<td>5. Asks the client what she already knows about pills, appropriately corrects any misinformation that the client has.</td>
<td></td>
</tr>
<tr>
<td>Task/Activity</td>
<td>Rating</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>6. Tells the clients about pills:</td>
<td></td>
</tr>
<tr>
<td>a) Effectiveness</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>b) How the pill prevents pregnancy</td>
<td></td>
</tr>
<tr>
<td>c) How the pill is used</td>
<td></td>
</tr>
<tr>
<td>d) Advantages and disadvantages</td>
<td></td>
</tr>
<tr>
<td>e) Side effects and warning signs</td>
<td></td>
</tr>
<tr>
<td>7. Emphasizes that the client may discontinue the method anytime she wants to</td>
<td></td>
</tr>
<tr>
<td>and for any reason</td>
<td></td>
</tr>
<tr>
<td>8. Provides 3 packets of oral contraceptives to the client</td>
<td></td>
</tr>
<tr>
<td>Gives the client instruction on how to use the pill:</td>
<td></td>
</tr>
<tr>
<td>a) When to start using the pill</td>
<td></td>
</tr>
<tr>
<td>b) How to use the pill correctly</td>
<td></td>
</tr>
<tr>
<td>c) What to do for missed pills</td>
<td></td>
</tr>
<tr>
<td>9. Allows the client to repeat the instructions to be sure she understands</td>
<td></td>
</tr>
<tr>
<td>10. Asks the client if she has any questions or concerns</td>
<td></td>
</tr>
<tr>
<td>11. Discusses return visits and follow-up with the client</td>
<td></td>
</tr>
<tr>
<td>12. Encourages client to return at any time she has a question or a problem</td>
<td></td>
</tr>
<tr>
<td>13. Says goodbye to the client politely and invites her to come again</td>
<td></td>
</tr>
<tr>
<td>for follow-up and re-supply</td>
<td></td>
</tr>
</tbody>
</table>
Checklist 1.6: Performance Guide for Counselling Clients Choosing Spermicides

Instructions:
Rate the performance of each task/activity observed using the following rating scale.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Task/Activity omitted</td>
</tr>
<tr>
<td>1</td>
<td>Task/Activity incorrectly performed</td>
</tr>
<tr>
<td>2</td>
<td>Task/Activity correctly performed (Hesitated)</td>
</tr>
<tr>
<td>3</td>
<td>Task/Activity correctly done and with confidence</td>
</tr>
<tr>
<td>N/A</td>
<td>Task/Activity not required in this observation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Task/Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Greets client respectfully and with kindness; makes client comfortable</td>
</tr>
<tr>
<td>a) Offers seat</td>
</tr>
<tr>
<td>b) Provides privacy where necessary</td>
</tr>
<tr>
<td>c) Assures client of confidentiality</td>
</tr>
<tr>
<td>2. Introduces self to client</td>
</tr>
<tr>
<td>3. Establishes purpose of visit</td>
</tr>
<tr>
<td>4. Asks client about her reproductive goals</td>
</tr>
<tr>
<td>5. Takes reproductive and basic medical history</td>
</tr>
<tr>
<td>a) Age</td>
</tr>
<tr>
<td>b) Parity</td>
</tr>
<tr>
<td>c) Number of living children, ages and gender</td>
</tr>
<tr>
<td>d) Any family planning method(s) used in the past</td>
</tr>
<tr>
<td>e) If yes, for how long</td>
</tr>
<tr>
<td>f) Any method(s) discontinued</td>
</tr>
<tr>
<td>g) What family planning method she is currently using</td>
</tr>
<tr>
<td>h) Any previous use of spermicide</td>
</tr>
<tr>
<td>6. Asks client what he/she knows about spermicide</td>
</tr>
<tr>
<td>7. Tells clients about the spermicide</td>
</tr>
<tr>
<td>8. Provides method to the client</td>
</tr>
<tr>
<td>9. Instructs client how to use the method (spermicide)</td>
</tr>
<tr>
<td>Task/Activity</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>10. Asks client to repeat instructions</td>
</tr>
<tr>
<td>11. Asks client if she has any question</td>
</tr>
<tr>
<td>12. Answers any question</td>
</tr>
<tr>
<td>13. Encourages client to return to clinic anytime she wants to</td>
</tr>
<tr>
<td>14. Says goodbye to the client</td>
</tr>
</tbody>
</table>

**Follow-up counselling**

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Greets the client in a friendly manner</td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>2. Finds out how client is using spermicide</td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>3. Asks client if she has any complains</td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>4. Asks client if she is satisfied with the method</td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>5. Counsels for alternative method if client is not satisfied</td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>6. Reminds client to return to the clinic when more spermicide is needed</td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>7. Says goodbye to client</td>
<td>0 1 2 3 N/A</td>
</tr>
</tbody>
</table>
Checklist 1.7: Performance Guide for Counselling Clients Choosing Lactation Amenorrhoea (LAM)

Instructions:

Rate the performance of each task/activity observed using the following rating scale.

- 0 - Task/Activity omitted
- 1 - Task/Activity incorrectly performed
- 2 - Task/Activity correctly performed (Hesitated)
- 3 - Task/Activity correctly done and with confidence
- N/A - Task/Activity not required in this observation

<table>
<thead>
<tr>
<th>Tasks/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td>1. Greets client/couple respectfully and with kindness; makes them comfortable</td>
<td></td>
</tr>
<tr>
<td>Offers seat</td>
<td>Provides privacy</td>
</tr>
<tr>
<td>2. Introduces self to the client</td>
<td></td>
</tr>
<tr>
<td>3. Asks about client’s reproductive goals:</td>
<td></td>
</tr>
<tr>
<td>a) How many more children she wants</td>
<td></td>
</tr>
<tr>
<td>b) If she is interested in spacing her pregnancies or prevent them completely</td>
<td></td>
</tr>
<tr>
<td>c) How many years does she want between pregnancies</td>
<td></td>
</tr>
<tr>
<td>4. Takes a reproductive and basic medical history of the client</td>
<td></td>
</tr>
<tr>
<td>a) Age</td>
<td>b) Number of pregnancies</td>
</tr>
<tr>
<td>Tasks/Activity</td>
<td>Rating</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>5. Asks client what she already knows about LAM; appropriately corrects any misinformation that the client has</td>
<td></td>
</tr>
</tbody>
</table>
| 6. Gives a brief information about:                                                                                           
| a) Effectiveness  
| b) How LAM prevents pregnancy  
| c) Advantages  
| d) Disadvantages  
| e) When to return to clinic for contraception                                                                                           |        |
| 7. Emphasizes that the client may begin another contraceptive method anytime she wants to and for any reason                                                                                        |        |
| 8. Gives the client instructions on the 3 conditions necessary for LAM to be effective in preventing pregnancy                                                                                  |        |
| 9. Allows the client to repeat the instructions to be sure she understands                                                                                                                                     |        |
| 10. Asks the client if she has any questions or concerns                                                                           |        |
| 11. Discusses return visits and follow-up with the client and provides a back-up method such as condoms to the client in order that she can begin using it immediately when any of the above conditions occurs |        |
| 12. Encourages the client to return at any time she has a question or a problem                                                      |        |
| 13. Politely says good-bye to the client and invites her to come again                                                               |        |
Checklist 1.8: Performance Guide for Counselling Clients Choosing the Natural Family Planning (NFP) Method

Instructions:

Rate the performance of each task/activity observed using the following rating scale.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Task/Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Task/Activity omitted</td>
</tr>
<tr>
<td>1</td>
<td>Task/Activity incorrectly performed</td>
</tr>
<tr>
<td>2</td>
<td>Task/Activity correctly performed (Hesitated)</td>
</tr>
<tr>
<td>3</td>
<td>Task/Activity correctly done and with confidence</td>
</tr>
<tr>
<td>N/A</td>
<td>Task/Activity not required in this observation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Greets client/couple respectfully and with kindness; makes them comfortable</td>
<td>0</td>
</tr>
<tr>
<td>a) Offers seat</td>
<td>1</td>
</tr>
<tr>
<td>b) Provides privacy</td>
<td>2</td>
</tr>
<tr>
<td>c) Assures client of confidentiality</td>
<td>3</td>
</tr>
<tr>
<td>2. Introduces self to the client</td>
<td>N/A</td>
</tr>
<tr>
<td>3. Asks about client’s reproductive goals</td>
<td>N/A</td>
</tr>
<tr>
<td>4. Asks the couple what they know about Natural Family Planning</td>
<td>N/A</td>
</tr>
<tr>
<td>5. Tells the couple about Natural Family Planning</td>
<td>N/A</td>
</tr>
<tr>
<td>6. Tells clients about each type of NFP</td>
<td>N/A</td>
</tr>
<tr>
<td>7. Gives client detailed instruction on selected method:</td>
<td>N/A</td>
</tr>
<tr>
<td>a) How to identify ‘fertile’ days</td>
<td>N/A</td>
</tr>
<tr>
<td>b) What symptoms and signs to observe and how to interpret them</td>
<td>N/A</td>
</tr>
<tr>
<td>c) How to chart appropriate findings (e.g. temperature chart)</td>
<td>N/A</td>
</tr>
<tr>
<td>8. Allows the client to repeat the instructions to be sure they understand</td>
<td>N/A</td>
</tr>
<tr>
<td>9. Asks client if she or her partner has questions or concerns</td>
<td>N/A</td>
</tr>
<tr>
<td>10. Discusses return visit and follow up with client</td>
<td>N/A</td>
</tr>
<tr>
<td>11. Encourages clients to return at anytime they have a question or problem</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### Checklist 1.9 Performance Guide for STIs Counselling

**Instructions:**

Rate the performance of each task/activity observed using the following rating scale.

- **0** - Task/Activity omitted
- **1** - Task/Activity incorrectly performed
- **2** - Task/Activity correctly performed (Hesitated)
- **3** - Task/Activity correctly done and with confidence
- **N/A** - Task/Activity not required in this observation

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preparation for counselling:</strong></td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>1. Ensures room is well-lit and ventilated</td>
<td></td>
</tr>
<tr>
<td>2. Ensures availability of chairs and tables</td>
<td></td>
</tr>
<tr>
<td>3. Assembles teaching aids (posters, diaphragms, pamphlets, etc)</td>
<td></td>
</tr>
<tr>
<td>4. Ensures availability of writing materials (client file, daily activity register, follow-up cards, etc)</td>
<td></td>
</tr>
<tr>
<td>5. Greets client/couple respectfully and with kindness; makes client comfortable</td>
<td></td>
</tr>
<tr>
<td>a) Offers seat</td>
<td></td>
</tr>
<tr>
<td>b) Provides privacy where necessary</td>
<td></td>
</tr>
<tr>
<td>c) Assures clients of confidentiality</td>
<td></td>
</tr>
<tr>
<td>6. Introduces self</td>
<td></td>
</tr>
<tr>
<td>7. Reassures the client that the information in the counselling session is confidential</td>
<td></td>
</tr>
<tr>
<td>8. Listens to the client actively; give client complete attention</td>
<td></td>
</tr>
<tr>
<td>9. Uses body language to show interest in and concern for the client</td>
<td></td>
</tr>
<tr>
<td>Task/Activity</td>
<td>Rating</td>
</tr>
<tr>
<td>---------------</td>
<td>--------</td>
</tr>
<tr>
<td>0 1 2 3 N/A</td>
<td></td>
</tr>
</tbody>
</table>

| 10. | Asks questions appropriately |
| 11. | Asks questions that elicit more than ‘yes’ or ‘no’ answers |
| 12. | Encourages the client to ask questions |
| 13. | Uses language that the client can understand |
| 14. | Explains information in different ways to be sure the client understands |
| 15. | Uses visual aids such as posters, flip chart, drawings and anatomic models |
| 16. | Asks the client to repeat what he/she has understood as a way to be sure that he/she has the correct information |

Checklist 1.10: Performance Guide for Post Abortion Family Planning Counselling

Instructions:
Rate the performance of each task/activity observed using the following rating scale.

0 - Task/Activity omitted
1 - Task/Activity incorrectly performed
2 - Task/Activity correctly performed (Hesitated)
3 - Task/Activity correctly done and with confidence
N/A - Task/Activity not required in this observation

<table>
<thead>
<tr>
<th>Tasks/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 N/A</td>
<td></td>
</tr>
</tbody>
</table>

| 1. | Greets client/couple respectfully and with kindness; makes client comfortable  
Offers seat  
Provides privacy where necessary  
Assures client of confidentiality |
<p>| 2. | Assesses whether counselling is appropriate at this time (if not, arrange for her to be counselled at another time) |
| 3. | Assures necessary privacy |</p>
<table>
<thead>
<tr>
<th>Tasks/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Obtains biographic information (name, address, etc)</td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>5. Asks if she was using contraception before she became pregnant. If she was, find out if she:</td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>a) Used the method correctly</td>
<td></td>
</tr>
<tr>
<td>b) Discontinued use</td>
<td></td>
</tr>
<tr>
<td>c) Had any trouble using the method</td>
<td></td>
</tr>
<tr>
<td>d) Has any concerns about the method</td>
<td></td>
</tr>
<tr>
<td>6. Provides general information about family planning</td>
<td></td>
</tr>
<tr>
<td>7. Explores any attitudes or religious belief that either favours or rules out one or more methods</td>
<td></td>
</tr>
<tr>
<td>8. Gives the woman information about the contraceptive choices available and the risks and benefits for each:</td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>a) Shows where and how each is used</td>
<td></td>
</tr>
<tr>
<td>b) Explains how it works and its effectiveness</td>
<td></td>
</tr>
<tr>
<td>c) Explains possible side effects and other health problems</td>
<td></td>
</tr>
<tr>
<td>d) Explains benign nature of the common side effects</td>
<td></td>
</tr>
<tr>
<td>9. Discusses client’s needs, concerns and fear in a thorough and sympathetic manner</td>
<td></td>
</tr>
<tr>
<td>10. Helps client begin to choose an appropriate method</td>
<td></td>
</tr>
<tr>
<td>11. Screens client carefully to make sure there is no medical condition that would be a problem (completes Client Screening Checking)</td>
<td></td>
</tr>
<tr>
<td>12. Explains potential side effects and make sure that each is fully understood</td>
<td></td>
</tr>
<tr>
<td>13. Performs further evaluation (physical examination), if indicated (non medical counselors must refer client for further evaluation)</td>
<td></td>
</tr>
<tr>
<td>14. Discusses what to do if the client experiences any side effects or problems</td>
<td></td>
</tr>
<tr>
<td>15. Provides follow-up visit instructions</td>
<td></td>
</tr>
<tr>
<td>16. Assures client she can return to the same clinic at any time to receive advice, medical attention</td>
<td></td>
</tr>
<tr>
<td>17. Asks the client to repeat instructions</td>
<td></td>
</tr>
<tr>
<td>18. Answers client’s questions</td>
<td></td>
</tr>
</tbody>
</table>
Checklist 1.11: Performance Guide for Counselling the Infertile Couple

Instructions:
Rate the performance of each task/activity observed using the following rating scale.

- 0 - Task/Activity omitted
- 1 - Task/Activity incorrectly performed
- 2 - Task/Activity correctly performed (Hesitated)
- 3 - Task/Activity correctly done and with confidence
- N/A - Task/Activity not required in this observation

<table>
<thead>
<tr>
<th>Tasks/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Greets client/couple respectfully and with kindness; makes client comfortable</td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>a) Offers seat</td>
<td></td>
</tr>
<tr>
<td>b) Provides privacy where necessary</td>
<td></td>
</tr>
<tr>
<td>c) Assures client of confidentiality</td>
<td></td>
</tr>
<tr>
<td>2. Introduces self to clients</td>
<td></td>
</tr>
<tr>
<td>3. Asks for reason for the visits</td>
<td></td>
</tr>
<tr>
<td>4. Obtains reproductive and basic medical history of both partners</td>
<td></td>
</tr>
<tr>
<td>a) Age</td>
<td></td>
</tr>
<tr>
<td>b) Menstrual history (LMP), cycle, dysmenorrhoea</td>
<td></td>
</tr>
<tr>
<td>c) Parity, number of living children, if any</td>
<td></td>
</tr>
<tr>
<td>d) History of STDs/HIV/AIDS</td>
<td></td>
</tr>
<tr>
<td>e) Past medical and surgical history</td>
<td></td>
</tr>
<tr>
<td>f) Family and social history</td>
<td></td>
</tr>
<tr>
<td>g) History of present complaints</td>
<td></td>
</tr>
<tr>
<td>h) Sexual history</td>
<td></td>
</tr>
<tr>
<td>i) Drug history</td>
<td></td>
</tr>
<tr>
<td>5. Explains procedure of infertility consultation</td>
<td></td>
</tr>
<tr>
<td>6. Finds out what the couple know about physiology of menstruation and reproduction and corrects any wrong information</td>
<td></td>
</tr>
<tr>
<td>7. Asks them about the factors which can influence infertility</td>
<td></td>
</tr>
</tbody>
</table>
**Tracing Family Planning Clients Lost to Follow-up**

<table>
<thead>
<tr>
<th>Tasks/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Explains the nature of infertility test:</td>
<td></td>
</tr>
<tr>
<td>a) Sperm analysis</td>
<td></td>
</tr>
<tr>
<td>b) Test of ovulation</td>
<td></td>
</tr>
<tr>
<td>c) Test of tubal patency</td>
<td></td>
</tr>
<tr>
<td>d) Any other relevant tests</td>
<td></td>
</tr>
<tr>
<td>9. Refers clients to appropriate facility or service centre</td>
<td></td>
</tr>
</tbody>
</table>

**Checklist 1.12: Performance Guide for Processing of Instruments and Items Used**

**Instructions:**

Rate the performance of each task/activity observed using the following rating scale.

- **0**  - Task/Activity omitted
- **1**  - Task/Activity incorrectly performed
- **2**  - Task/Activity correctly performed (Hesitated)
- **3**  - Task/Activity correctly done and with confidence
- **N/A** - Task/Activity not required in this observation

<table>
<thead>
<tr>
<th>Tasks/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Decontamination</strong></td>
<td></td>
</tr>
<tr>
<td>1. Leaves on surgical gloves after procedure or puts on utility gloves</td>
<td></td>
</tr>
<tr>
<td>2. Places all instruments in 0.5% chlorine solution for 10 minutes immediately after completing the procedure</td>
<td></td>
</tr>
<tr>
<td>3. Disposes of waste materials in leak-proof container or plastic bag</td>
<td></td>
</tr>
<tr>
<td>4. Decontaminates examination table or other surfaces contaminated during the procedure</td>
<td></td>
</tr>
<tr>
<td>5. Removes instruments from chlorine solution after 10 minutes and places them in water</td>
<td></td>
</tr>
<tr>
<td>6. Cleans instruments immediately (Refer section on cleaning) or continues to soak in water until cleaning can be done</td>
<td></td>
</tr>
<tr>
<td>Tasks/Activity</td>
<td>Rating</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>7. Immerse both gloved hands in 0.5% chlorine solution, before removing surgical and examination gloves. Removes gloves by turning inside out</td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>8. If disposing of gloves, place in leak-proof container or plastic bag. Use utility gloves to clean instruments</td>
<td>0 1 2 3 N/A</td>
</tr>
</tbody>
</table>

**Cleaning Instruments**

<table>
<thead>
<tr>
<th>Tasks/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Places instruments in a basin with clean water</td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>2. Completely disassembles instruments and opens jaws of joint instruments</td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>3. Washes all instruments surfaces with a brush or cloth until visibly clean (holds instruments under water while cleaning) using non-abrasive detergent</td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>4. Cleans serrated edges (e.g. jaws of forceps) of instruments using small brush</td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>6. Rinses all surfaces thoroughly with clean water until no soap or detergent remains</td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>7. Towel dries instruments or allows them to air dry</td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>8. Removes utility gloves and allows them to air dry, after cleaning all items</td>
<td>0 1 2 3 N/A</td>
</tr>
</tbody>
</table>

**High-level disinfection**

**Boiling**

<table>
<thead>
<tr>
<th>Tasks/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Submerges completely cleaned instruments and other items in water</td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>2. Places lid on boiling pot and brings water to a gentle, rolling boil</td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>3. Starts timing when rolling boil begins</td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>4. Keeps at rolling boil for 20 minutes</td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>5. Removes items with high level disinfected forceps/pickup</td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>6. Places in covered, dry high-level disinfected container and air dry</td>
<td>0 1 2 3 N/A</td>
</tr>
</tbody>
</table>

**Steaming**
<table>
<thead>
<tr>
<th>Tasks/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>1. Places cleaned instruments, gloves or other items into steamer pan</td>
<td></td>
</tr>
<tr>
<td>2. Stacks steamer pans on top of pan containing water for boiling</td>
<td></td>
</tr>
<tr>
<td>3. Covers top steamer pan with a lid</td>
<td></td>
</tr>
<tr>
<td>4. Brings water to a rolling boil and waits for steam to escape from between the top and pan and lid</td>
<td></td>
</tr>
<tr>
<td>5. Starts timing and steam for 20 minutes</td>
<td></td>
</tr>
<tr>
<td>6. Removes steamer pans from heat. Gently shakes excess water from items and places on an extra empty bottom pan</td>
<td></td>
</tr>
<tr>
<td>7. Allows to air dry and cool. (Items can then be stored in the covered steamer pans)</td>
<td></td>
</tr>
<tr>
<td>8. Removes items with high-level disinfected forceps/pickups)</td>
<td></td>
</tr>
</tbody>
</table>

**Chemical**

<table>
<thead>
<tr>
<th>Tasks/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>1. Prepares fresh solution of chemical sterilant or checks to be sure solution is not out of date</td>
<td></td>
</tr>
<tr>
<td>2. Submerges clean, dried items in appropriate high-level disinfectants</td>
<td></td>
</tr>
<tr>
<td>3. Covers container and soaks for 20 minutes</td>
<td></td>
</tr>
<tr>
<td>4. Removes items from chemical solution using high-level disinfected gloves or high level disinfected forceps/pickups</td>
<td></td>
</tr>
<tr>
<td>5. Rinses items thoroughly with boiled water to remove all traces of chemical disinfectant</td>
<td></td>
</tr>
<tr>
<td>6. Places instrument in high level disinfected container and air dries</td>
<td></td>
</tr>
<tr>
<td>7. Stores in HLD container</td>
<td></td>
</tr>
</tbody>
</table>
Reasons for Counselling

- Good counselling helps clients make and carry out their own choices about reproductive health and family planning
- Makes clients satisfied
- Helps clients use methods longer and successfully

What is needed for counselling? For new clients who are choosing a new method there are six principles in the counselling process. These will be described separately but during counselling you will need to combine them.

Six (6) Principles of Counselling

i. Treat each client well
   - Be polite and show respect to every client, and create a feeling of trust
   - Show to the client you can speak openly, even about sensitive matters
   - Speak openly and answer questions tactfully
   - Assure the client of confidentiality

ii. Interact with the client
   - Listen, learn, and respond to the client
   - Treat each client as an individual
   - Have empathy
   - Encourage clients to ask questions

iii. Tailor information to the client
   - By listening to the client, you will learn what information each client needs.
• The stage of a person’s life will suggest what information may be most important, e.g. a young, newly married woman may want to know more about temporary methods for birth spacing. An older woman may want to know more about female sterilization. A young, unmarried man or woman may need to know more about STI prevention.
• Give information accurately in a language that the client understands
• Help client understand how information applies to his/her personal situation and daily life.
• Personalizing the information will bridge the gap between your knowledge and the client’s understanding.
• Tailoring information to the client will not waste the client’s time.

iv. Avoid too much information
• Client will need information to make informed choices
• No client can use all information about every family planning method.
• When you give too much information it makes it hard for clients to remember the important ones. This is called “Information Overload”
• When you spend all the time giving information, little time is left for discussion of the client’s questions, concerns and opinions

v. Provide the method that the client wants
• You will help clients make their own informed choices and the provider should respect those choices, even if a client decides against using family planning or puts off a decision
• Most new clients already have a method in mind and good counselling about method choice starts with that method
• In the course of counselling, check whether the client understands the method including advantages and disadvantages and how it is used
• Correct any misconceptions gently
• Help the client think about other similar methods and compare them
• This will help you make sure that the client is making an informed choice
• If there is no medical reason against client’s choice, provide the method the client wants
• When you provide the method the clients want, they will use them longer and more effectively
vi. Help the client understand and remember

- Show sample of family planning methods to clients and encourage them to handle and show them how they are used
- Show and explain flip charts, posters, simple pamphlets or printed pages with pictures to clients
- Check from time to time to see whether clients understand
- Give the clients printed materials. These remind them of what to do and also what should be shared with other clients.
- Counselling should be tailored to each client. At the same time, most counselling about method choice covers 6 topics
- Information on these topics should also reach clients in many other ways - for example, on radio and television, in posters and pamphlets, and in community meetings
- When clients have accurate information even before they see a provider, the provider’s work is easier, and the client can make better decisions
- The information from different sources should be consistent

Effectiveness

- How well a method prevents pregnancy depends more on the user for some methods than for others
- Pregnancy rate for methods as commonly used, will tell your clients what to expect and their own experience may be better or worse
- Pregnancy rates for methods used consistently and correctly give an idea of the best possible effectiveness
- Help clients consider whether and how they can use a specific method consistently and correctly
- For some clients, effectiveness is the most important reason for choosing a method. Others have other reasons for their choices

Advantages and Disadvantages

- Clients need to understand both advantages and disadvantages of a method to enable them decide
• It is important to remember that disadvantages for some people are advantages for others. For example, some women prefer injections whilst others want to avoid injections.

Side Effects and Complications
• If methods have side effects, tell clients about them before they choose and start a method.
• Clients who learn about side effects ahead of time tend to be more satisfied with their methods and use them longer.
• Tell clients which side effects may be bothersome but are not signs of danger or symptoms of a serious condition.
• Tell clients what signs and symptoms should prompt them to see you.
• Let clients understand the difference between minor side effects and complications.

How to Use the Method
• It is important to let clients have clear and practical instructions.
• Instruction you give should cover what clients can do if they make a mistake with the method (such as forgetting to take a pill) and also what clients and providers can do if problems come up (such as bothersome side effects).
• Give clients special help on matters like remembering to take a pill each day or discussing condoms with a sex partner.

Sexually Transmitted Infections (STIs)
• Some STIs, including HIV/AIDS, are spreading in communities.
• Help clients understand and measure their risk of getting STIs by being sensitive.
• Show clients how to use condoms correctly if they are at risks of STIs even if they are using another method.
• Explain the ABCs of STI prevention:
  a. abstinence
  b. being mutually faithful
  c. correct and consistent use of condoms
When to Return

- There are many good reasons why you need to return to the client or why they need to return to the clinic
- Some methods need return visits for more supplies
- Tell client when you will return for more supplies
- Tell clients about methods you did not provide and that they are free to visit the clinic whenever necessary
- Provide information and advice on these methods whenever necessary

Informed Choice

What does informed choice mean?

**Definition:** “Informed choice,” means a person makes a thought out decision based on accurate, useful information.

Informed

This is when clients have the clear, accurate, and specific information that they need to make their own reproductive choices including a choice among FP methods.

- Explain each method as needed without information overload to help each client use the method effectively and safely
- Clients understand their own needs because they have thought about their own situations. Through person-to-person discussions and counselling and through community meetings you can help clients match family planning methods with their needs

Choice

Choice means that clients have a range of family planning methods to choose from. Good quality family planning services offer different methods to suit people’s different needs - not just 1 or 2 methods. If you cannot provide a method or service, refer clients somewhere else for that method.

- Clients make their own decisions. Help clients think through their decisions, but do not pressurize clients to make a certain choice or to use a certain method
Clients’ Rights

What are the rights of clients?

a. It is important to place the clients at ease and gain their confidence and trust

b. Receive them in a warm and respectful manner

c. Communicate with them in a language and vocabulary that they understand and accept

d. If possible and practicable, counsel both the client and the partner

e. Family Planning/other Reproductive Health care counselling is a very important and delicate task because intimate and personal issues are discussed. You should therefore bear in mind the client’s rights

These can be remembered with the acronym “DISCCACCOP”

RIGHTS OF THE CLIENT

Every family planning client has the right to “DISCCACCOP”

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Dignity</td>
<td>To be treated with courtesy, consideration for age, sex, creed, colour, marital and financial financial</td>
</tr>
<tr>
<td>2</td>
<td>Information</td>
<td>To learn about the benefits and availability</td>
</tr>
<tr>
<td>3</td>
<td>Safety</td>
<td>To be able to receive and practise effective family planning</td>
</tr>
<tr>
<td>4</td>
<td>Choice</td>
<td>To decide freely whether to practise family Planning and which method to use.</td>
</tr>
<tr>
<td>5</td>
<td>Confidentiality</td>
<td>To be assured that any personal information will remain confidential</td>
</tr>
<tr>
<td>6</td>
<td>Access</td>
<td>To obtain services regardless of sex, creed, colour, marital and financial status or location</td>
</tr>
<tr>
<td>7</td>
<td>Comfort</td>
<td>To feel comfortable when receiving services</td>
</tr>
<tr>
<td>8</td>
<td>Continuity</td>
<td>To receive contraceptive service</td>
</tr>
<tr>
<td>9</td>
<td>Opinion</td>
<td>To express views on the service offered</td>
</tr>
<tr>
<td>10</td>
<td>Privacy</td>
<td>To have private environment during counselling or services</td>
</tr>
<tr>
<td>Method</td>
<td>Eligibility</td>
<td>Non-eligibility</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Condom</strong></td>
<td>• All men</td>
<td>• Persons with definite allergy to latex products</td>
</tr>
<tr>
<td></td>
<td>• All women</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Individuals &amp; couples needing a backup method</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Persons at risk of RTI including STI/HIV/AIDS</td>
<td></td>
</tr>
<tr>
<td><strong>Diaphragm/ Cervical Cap</strong></td>
<td>• All women</td>
<td>• Abnormal anatomy of the vagina that interferes with satisfactory fit</td>
</tr>
<tr>
<td></td>
<td>• Women who need intermittent contraception</td>
<td>• Persons definitely allergic to latex products</td>
</tr>
<tr>
<td></td>
<td>• Women who need a backup method</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Abnormal anatomy of the vagina that interferes with satisfactory fit</td>
<td>• Immediate post-partum and post abortion</td>
</tr>
<tr>
<td></td>
<td>• Persons definitely allergic to latex products</td>
<td></td>
</tr>
<tr>
<td><strong>Spermicides</strong></td>
<td>• All women</td>
<td>• Definite allergy to active ingredients</td>
</tr>
<tr>
<td></td>
<td>• Women who need intermittent contraception</td>
<td></td>
</tr>
<tr>
<td><strong>Natural Family Planning Methods</strong></td>
<td>• All individuals and couples</td>
<td>• Women with irregular menses</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Individuals with uncooperative partners</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Immediate post-partum and abortion period</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Women with amenorrhea</td>
</tr>
<tr>
<td><strong>Injectable (Progesterone only)</strong></td>
<td>• All women including lactating women</td>
<td>• Pregnancy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Unexplained vaginal bleeding</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Current Trophoblastic tumour</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Current breast cancer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Jaundice (active liver disease or liver tumours)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Current history of stroke or ischaemic heart disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Angina pectoris, myocardial infarction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• BP over 180/100 mm Hg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Retinopathy/nephropathy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Neuropathy due to diabetes or hypertension</td>
</tr>
<tr>
<td>Method</td>
<td>Eligibility</td>
<td>Non-eligibility</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Absolute</td>
<td>Relative</td>
</tr>
<tr>
<td>Implants</td>
<td>• All women including lactating women</td>
<td>• Clients on liver enzyme inducing drugs: rifampicin, griseofulvin, phenytoin, barbiturates</td>
</tr>
<tr>
<td></td>
<td>• Pregnancy</td>
<td>• Current history of ischaemic heart disease or stroke</td>
</tr>
<tr>
<td></td>
<td>• Unexplained vaginal bleeding</td>
<td>• Jaundice (active liver disease) or liver tumours</td>
</tr>
<tr>
<td></td>
<td>• Current Trophoblastic tumour</td>
<td></td>
</tr>
<tr>
<td>Tubal ligation</td>
<td>• Women who do not wish to have any more children</td>
<td>Heart disease, hypertension, vascular disease</td>
</tr>
<tr>
<td></td>
<td>• Pregnancy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Reproductive tract</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Infection</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Anaesthesia risks</td>
<td></td>
</tr>
<tr>
<td>Vasectomy</td>
<td>• Men who do not wish to have any more children</td>
<td>Obesity</td>
</tr>
<tr>
<td></td>
<td>• Recent or current reproductive tract infection</td>
<td>Anaemia</td>
</tr>
<tr>
<td>Combined Oral Contraceptives (COC, pill)</td>
<td>• Women who do not wish to have any more children for some period</td>
<td>Breastfeeding mothers 6 weeks to 6 months</td>
</tr>
<tr>
<td></td>
<td>• Pregnancy</td>
<td>History of hypertension</td>
</tr>
<tr>
<td></td>
<td>• Breastfeeding less than 6 weeks post partum</td>
<td>Moderate-severe hypertension</td>
</tr>
<tr>
<td></td>
<td>• Heavy smokers over age 35yrs (more than 20 sticks/day)</td>
<td>Unexplained vaginal bleeding</td>
</tr>
<tr>
<td></td>
<td>• Stroke, heart disease</td>
<td>Sickle Cell Disease</td>
</tr>
<tr>
<td></td>
<td>• Thrombo-embolic disorders</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Recurrent severe headaches with focal neurological symptoms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Breast cancer</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Active liver disease or liver tumour</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Vascular disease due to hypertension and diabetes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• BP more or equal to 160/100mm HG</td>
<td></td>
</tr>
<tr>
<td>Method</td>
<td>Eligibility</td>
<td>Non-eligibility</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Progesterone</td>
<td>• All women including lactating mothers</td>
<td>• Pregnancy</td>
</tr>
<tr>
<td>Only Pill (POP, mini pill)</td>
<td></td>
<td>• Current trophoblastic tumour</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pregnancy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Current trophoblastic tumour</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Clients on liver enzyme inducing drugs: rifampicin, griseofulvin, phenytoin, barbiturates</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Jaundice (active liver disease) or liver tumours</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Breast cancer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Unexplained vaginal bleeding</td>
</tr>
<tr>
<td>Lactational</td>
<td>• Women breast feeding exclusively day and night and not less than 6 times a day</td>
<td>• After 6 months post-partum</td>
</tr>
<tr>
<td>Amenorrhoea Method (LAM)</td>
<td></td>
<td>• Resumption of menstruation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interactive Device</td>
<td>• Women</td>
<td>• Pregnancy</td>
</tr>
<tr>
<td>(copper T)</td>
<td></td>
<td>• Unexplained vaginal bleeding (before evaluation)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Cancer of the reproductive tract</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Current reproductive tract infections</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Allergy to copper</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The table above shows the eligibility criteria for the use of different family planning methods. Relative non-eligibility implies that the method can be used where the risks of pregnancy outweigh the disadvantages of using the method. In this context, ‘women’ refers to females of reproductive age.
Table 1.4: Referral Form for Community level Provider

Referral Form

Part 1

Name of Patient: ........................................................................................................
Age: ............................................................... Sex: ..............................................
Condition Referred/History: ....................................................................................
Address: ..................................................................................................................
Facility Referred from: ............................................................................................
Facility Referred to: .................................................................................................
Date of Referral: .....................................................................................................
Name and Title of Referring Officer: ........................................................................

Signature: .................................................

Table 1.5: Feedback Form

Feedback to CHO

Part 2

Name of Institution Receiving Patient/Client: ............................................................
Date Received: ........................................................................................................
Condition of Patient/Client on Reporting: ..............................................................
...............................................................................................................................
Findings: ................................................................................................................
Action(s) taken: .....................................................................................................
Recommendation(s) for Follow-up: .........................................................................
...............................................................................................................................
...............................................................................................................................

Name &Title ........................................ Signature
Procedure for Referrals

When referring a client, the CHO should follow the following steps:

1. Referral Reason

The CHO should inform the client about the reason for the referral, impressing on the client why it is important that she or he goes to see a doctor or nurse.

2. Back-up Method

If the client is a family planning client, she or he should be given a backup family planning method, either condoms or foaming tablets, with instructions for use.

3. Referral Form

The CHO should complete the referral form and give a copy to the client to take to the nurse or doctor. The referral form will introduce the client and will explain the reason for the referral.

4. Directions

Carefully explain to the client how to find the health facility and when she or he should go there. If possible, tell the client what to expect when she or he arrives there.

5. Follow-up

The CHO should ask the client to return to see her after visiting the health facility to inform the CHO about what happened. If the client does not return to see the CHO after one week, the CHO should visit the client at home. During the visit, the CHO can find out if the client visited the nurse or doctor and what transpired during the visit. If the client has not visited a nurse or doctor, the CHO should evaluate whether the referral is still necessary. If so, the CHO should encourage the client to go for the referral visit.

6. Accompany

Sometimes clients are afraid to visit the health facility. In these cases, the CHO can help by accompanying the client to see the nurse or doctor.
Table 1.6: Follow-up Visits for Family Planning

<table>
<thead>
<tr>
<th>Method</th>
<th>Starters</th>
<th>Continuing users</th>
<th>Follow-Up date</th>
<th>Quantity supplied/dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral pill</td>
<td>One month</td>
<td>Three months</td>
<td>One month</td>
<td>Three months supply of pill</td>
</tr>
<tr>
<td>Depo Provera</td>
<td>One month</td>
<td>Three months</td>
<td>One month</td>
<td>1ml</td>
</tr>
</tbody>
</table>

Six (6) Steps in Counselling New Clients

- Deciding on a method and using it depends on a step by step process
- The process includes learning, weighing choices, making decisions, and carrying them out
- Counselling new clients about family planning is a process which consists of six steps
- These steps can be remembered with the word GATHER
- To do good counselling you need to be flexible and make changes to meet the special needs of the client and situation
- Not every new client needs all the 6 steps
- Some clients need more attention to one step than another

The GATHER Steps

G - Greet clients in an open, respectful manner to create rapport
A - Ask clients about themselves
T - Tell clients about FP methods, basic reproductive anatomy, sexually transmitted diseases and their prevention
H - Help clients make an informed choice
E - Explain fully how to use the chosen method
R - Return visits should be planned

Remember the song (tune: “I need thee every hour”)

Greet clients that you go to see
Ask clients about themselves
Assess their knowledge and all about themselves
Tell clients about the methods
Help clients to choose a method
Explain how to use method
Return for follow up

In choosing a family planning method, the following must be considered:

- What it is and types
- How it works (let client handle contraceptive)
- Protection against STI/HIV
- Effectiveness
- Characteristics (advantages and disadvantages)
- Eligibility of use (who can use/who cannot use)
- Possible side effects
- Reasons for unscheduled visits
- Emergency contraceptive
- Clarify rumours and misconceptions, if any
- Waiting time of clients

Counselling continuing clients

Continuing clients are just as important as new clients.

When counselling continuing clients, focus on talking with clients about their experience and needs. Counselling continuing clients can be flexible and should be changed to meet the client’s needs.

Return for follow-up

Ask if client is still using method. Enquire if he/she is satisfied with family planning method or other reproductive health services.

For satisfied clients:

a. Verify if method is being used correctly
b. Remind client of reasons for unscheduled visits
c. Give supplies, if necessary  
d. Encourage client to ask questions  
e. Clarify misconceptions  
f. Plan for return or unscheduled visits  
g. Encourage him/her to motivate others

For unsatisfied clients:  
a. Enquire about any problems and side effects  
b. Reassure client, as appropriate  
c. Manage side effects and refer, if appropriate  
d. Ask about any other questions  
e. Help client choose/change method or refer to other reproductive health service if necessary  
f. Provide condoms if the client is using dual method  
g. Reinforce information about emergency contraception  
h. Plan for the next visit  
i. Thank client  
j. Say good-bye  
Complete client cards/records as appropriate.

Unit 3 and 4  

A client lost to “follow-up”/discontinuing client may be defined as one who has failed to keep an appointment for review or to obtain additional supplies/ commodities. Normally, FP clients are required to return to the service provider to obtain additional FP commodities and to discuss any problems. In this case the CHO is required to follow up the clients in their homes. These visits are scheduled at regular intervals based on the method being used by the client and the client’s medical and social history. Occasionally, some clients do not return for such follow up visits or they are not at home when visited. Their reasons may vary. It is important that such clients be traced to determine what the reasons are for failing to keep the appointment.

Tracing Clients Lost to Follow-up  

**Identification of clients lost to follow up:** Reviewing your family planning client register periodically and frequently will help you to determine those lost to follow up.
Reasons for lost to Follow-up

**Defaulting:** The client may have moved, or forgotten about the appointment, be ill or sometimes may have discontinued the use of the method. There could be other reasons as well.

Preparing for Tracing Clients Lost to Follow-up

- Information needed to prepare itinerary - compile names and addresses of defaulters from your register
- Plan for them: where and who
- Decide on the day and time to go and visit them
- Materials needed e.g. Visiting notebook, FP devices

Carry out the Follow-up of Client according to Schedule

- Ask simple questions
- Listen attentively to clients
- Manage side effects and problems of Family Planning methods e.g. misconceptions, and help clients make an informed choice about resuming use of method, changing the method, or not using a method

Record Keeping

- Types of records kept
- Use of record /information
- Information on client, e.g. particulars and method
- Outcome of tracing i.e. what informed choice client made after the tracing visit

Develop Skills to Increase Continuation Rate

- Involving men in FP issues
- Regular follow-up visits
- Education to dispel misconceptions
- Durbars to discuss concerns openly
Purpose and Organisation

A CHO is expected to educate community members especially pregnant women on available Antenatal services. On some occasions, her role will include screening and providing care to pregnant women and also making appropriate decisions concerning women at risk. In addition, she may be called upon to identify common pregnancy-related conditions and follow relevant procedures for management of such conditions.

The facilitation approaches focus on discussing a CHO’s experiences through the use of case studies, demonstrations, coaching and role-plays.

Objectives

Review these objectives now and all subsequent unit objectives as you begin each unit by:
• Reading each objective yourself or
• Having a participant read the objectives aloud to the group

After completing this module, the CHO will be able to:

1. Educate and counsel pregnant women and their families to participate in ANC service.
2. Monitor pregnant women to ensure the promotion of health and survival of the mother and foetus.
3. Recognize deviation from the normal and provide care as required of a CHO, using the national standard.

Contents

Unit 1: Promoting the Health of Pregnant Women and their Families during Antenatal period
Unit 2: Providing Care to Pregnant Women including Adolescents
Unit 3: Managing Pregnancy-related Conditions in the Community

Expected Outcome

Knowledge

The CHO should acquire knowledge in ANC to include
• Registration
- History taking
- Routine laboratory investigations to be carried out
- Routine examinations, to include
  - Physical
  - Obstetric
  - Vulval
- Drug supplementation
- Immunization
- Health education
- Pregnancy-related conditions and management
- Referrals
- Socio-cultural practices
- Birth preparedness
- Complication plan
- Recording, report writing, analysis and submission
- Problem solving

Attitudes
The CHO is expected to have gained the following attitudes
- Confidentiality
- Tact
- Socio-cultural sensitivity
- Understanding
- Self appraisal
- Tolerance
- Hardworking and perseverance
- Initiative and drive
• Courtesy, kindness
• Self discipline
• Trustworthy
• Empathetic

Skills
The CHO is expected to have received the following skills:

• Communication skills:
  ▶ Counselling
  ▶ Listening
  ▶ Questioning
  ▶ Feedback
  ▶ Writing

• Technical/Examination skills:
  ▶ Examination.
  ▶ Palpation
  ▶ Auscultation
  ▶ Physical examination (head to toe)
  ▶ Monitoring skills

• Decision making
• Recording and reporting
Table 2.1: **Materials Needed**

<table>
<thead>
<tr>
<th>Samples</th>
<th>CHO Materials</th>
<th>Facilitator Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Material Health Record Cards</td>
<td>• Stationery - pencils - pens - writing pad</td>
<td>• Overhead projector (where available)</td>
</tr>
<tr>
<td>• T.T Immunization Cards</td>
<td></td>
<td>• Transparencies</td>
</tr>
<tr>
<td>• Laboratory Request Forms</td>
<td></td>
<td>• Felt pens/markers</td>
</tr>
<tr>
<td>• Referral forms</td>
<td></td>
<td>• Flip chart sheet</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Urine testing strips</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• BP apparatus</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Tape measure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Hb estimation scale (Talquist)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Gloves</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Foetal stethoscope</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Adult weighing scale</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Model of pregnant women</td>
</tr>
</tbody>
</table>

**Teaching Methods**

- Use learner-centered methods in this module
- Introduce new materials through a guided discussion
- Start each unit with a guided discussion

Help participants apply their knowledge in “real life” situations. In addition field practice is highly recommended.

**Getting Started**

1. Do a warm-up exercise
2. Review any topic from previous sessions that are relevant to this module
3. At the beginning of each module, review the purpose, contents and objectives
4. At the beginning of each unit, review the topic outline to enable participants understand how the module is organized

**Facilitator-Participant Interaction**

Depending on the manner in which you choose to facilitate the class, ask relevant questions on each of the questions in the Workbook. It is ideal to have participants attempt all the questions in their Workbook before the session.
Call on participants to read their answers

- Ask one person to volunteer to read first
- After he/she reads the answer, comment positively on it
- Let another person read his/her answer
- Compare and contrast what both have written or ask others if they see similarities or differences

Group Activities

Role plays, case studies and group discussions

- Give each participant a copy of the material to read or instructions as to where the material is found in the Workbook
- Divide the participants into small groups. Tell each group to discuss the questions on the case study and provide answers to the questions that follow

During the presentation

- Ask if others have any additions
- Ask if others have any suggestions
- Comment on what they did well
- Offer suggestions for improvement
- Ask for lessons learnt
Unit 1

Promoting the Health of Pregnant Women and their Families during Antenatal Period

Terminal performance objectives

After studying this unit, you will be able to:

- Conduct individual or group prenatal health education
- Counsel clients and their families to prepare for a birth

Rationale

These objectives are intended to develop the CHO’s ability to:

- Give health education to pregnant women and their families
- Help clients and their families to prepare for birth

Topic Outline

1. Client Education
2. Preparing for a Birth
3. Education for Community Members
Topic Outline 1: **Client Education**

**Facilitator-Participants Interaction**

Introduce topics using questions and answers (Q & A), brainstorming, role plays, case studies, group discussions, demonstrations etc.

1. Divide participants into groups
2. Each group should read and discuss the case study and provide answers to the questions that follow
3. Tell them to write their answers in their CHO Workbooks
4. Allow time for this
5. Walk around to determine when they are through
6. Call on each group to present their answers on flip chart
7. Ask if the other group members have different answers or contribution to make
8. Comment positively on the answers
9. Compare and contrast what both groups have written or ask others if they see similarities or differences
10. Summarise the answers and close the session

**Activity 1: Case study on Antenatal Care**

**Background**

Maame Akosua Mansa is 24 weeks pregnant. You do a follow-up visit. She has no complaints, no danger signs or factors associated with risk. She followed your advice given during an earlier visit and went to see a midwife for antenatal care.

**Questions and Answers**

1. What topics should be covered during the first visit as part of client education?
   
   a. Explain the purpose of ANC: use of ANC records and findings, changes that occur in the pregnant woman’s body, and what to expect during visits
b. Care of the pregnant woman’s health such as her diet and nutrition, rest and sleep and also personal hygiene

c. Danger signs during pregnancy including swelling of feet, hands or face, severe headache or blurred vision, offensive or discoloured discharge from the vagina, fever

d. Education on drugs, their effects and why they are given; abuse of drugs, and alcohol and harmful effects of smoking

e. Effect of exposure to sexually transmitted infections including HIV

f. Socio-cultural practices which are useful and those which are harmful

Topic Outline 2: **Preparing for a Birth**

**Facilitator-Participant Interaction**

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

1. What do you expect the midwife or trained TBA to discuss with Maame Akosua now that she is in her second trimester?
   a. Review what was discussed during the last visit
   b. Give information on what to expect during labour and preparations to make for delivery

2. What key topics will you review with Maame Akosua if you meet her during the third trimester? (over 7 months pregnant)
   a. Where to deliver depends on whether she has any risk factors or complications
   b. How to recognise that true labour has begun, signs of complications during labour
   c. Preparation towards breastfeeding
   d. Family planning-child spacing and methods

Topic Outline 3: **Education for Community Members**

**Facilitator-Participant Interaction**

Introduce topic using questions and answers (Q & A), brainstorming, role plays, case studies, group discussions, demonstration, etc.
1. What should community members or caregivers know about a pregnant woman?
   a. Place of birth i.e. where the delivery will take place
   b. Choice of a skilled attendant (midwife or TBA)
   c. Establish how to contact the skilled attendant or how to get to the place of delivery
   d. Establish who will take care of the family while the woman is absent
   e. Prepare the necessary items for the delivery e.g. sanitary pads, clothes, soap, new blade, gloves, plastic sheet

It is impossible to predict which women will have complications. It is therefore important to work with women to recognize danger signs and to decide what should be done in case of emergency.

2. How can you help pregnant women in your community to prepare themselves for complications?
   a. Assist community members to establish a savings fund which they can fall on in case of emergency
   b. In collaboration with the Sub-district Health Team (SDHT), Village Health Committee and other opinion leaders, arrange a system of transport for pregnant women who need emergency care
   c. Tell pregnant women and their families where to go and what to expect when they get there
   d. Advise pregnant women and their families to arrange to donate blood
   e. Encourage pregnant women and their families to establish who will take charge in making decisions if the primary decision-maker e.g. partner is absent

Activity 2: Case study on Subsequent ANC Visit

Background
During your routine home visit, you meet Alimatu a 19 year old pregnant woman. Her antenatal history reads as follows:

History of this pregnancy:
First ANC visit was six weeks ago, at 16 weeks gestation. Her uterine size was normal for her gestation at that visit. Her Hb was 11gm/dl. At that visit Alimatu was given her first dose of Tetanus toxoid and some other drugs e.g. Sulphadoxine Pyremetamine (SP).

Findings of physical examination during her last visit -
General appearance: normal; palms, gums and conjunctiva appear pink
Temperature – 37.4 degrees celsius
B.P – 100/60 mm/Hg
Pulse – 88 beats per minute
Respiratory rate – 20 breaths per minute
Reflexes – not checked

Urine:
| Protein - | Negative |
| Sugar - | Negative |
| Acetone - | Negative |

Breast - both enlarged, no masses
Abdomen - no scars
Fundal height - 20cm
Foetal heart beats - 136/min
Foetal movement - present
Genitals - clear mucus discharge

Questions and Answers

1. How will you assess Alimatu’s pregnancy based on the findings from the two visits?
   a. Normal pregnancy

2. Does she need laboratory and other specialized tests or procedures?
   a. None needed. Urine protein was checked

3. Does she need consultation with a specialist?
   a. No, she has no signs of complications

4. What health education messages will you give?
   Topics for health education would include:
   a. Prevention of diseases including malaria, tetanus and intestinal parasites. She needs to know why the treatment is important and other ways she can protect herself and her family
   b. Danger signs and appropriate actions to take
   c. Discuss preparations being made towards her delivery and care
d. Nutrition, rest and personal hygiene

5. How will her family members be included in the process of health education?
   a. Involve her family members especially her partner in discussions about her welfare and in preparations towards delivery

6. Does Alimatu need health education or prescription for common complaints or minor disorders? No, because she has no complaints

7. What immunizations and drugs will be given to Alimatu at the second visit as part of her routine ANC?
   a. Second dose of Tetanus toxoid and anti helmintic drugs (a dewormer)
   b. Antihelmintics (deworming drug)
   c. Sulphadoxine pyrimetamine (SP)

Outlined in the table below are some challenges which community members face that prevent them from supporting pregnant women and the health information the CHO can give to enable them support their women.

<table>
<thead>
<tr>
<th>Issues/Problems</th>
<th>Information for the community</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inadequate information on the female and male reproductive systems</td>
<td>• Provide basic information on the parts of the body (female and male anatomy) and on how conception occurs</td>
</tr>
<tr>
<td>• Inadequate understanding of what happens to a woman’s body during pregnancy</td>
<td>• Educate on changes in the female body during pregnancy (changes in the womb, breasts, etc)</td>
</tr>
<tr>
<td>• Poor understanding of the purpose and benefits of ANC</td>
<td></td>
</tr>
<tr>
<td>• Inadequate information on when to start ANC, number of visits and where to receive care</td>
<td>• Educate on the importance of ANC</td>
</tr>
<tr>
<td>• Lack of or inadequate awareness of high-risk groups, and the need for more frequent ANC for women in these groups</td>
<td>• Emphasize the importance of receiving ANC from a trained midwife or trained TBA</td>
</tr>
<tr>
<td></td>
<td>• Provide guidance on when to start ANC and the recommended number of visits</td>
</tr>
</tbody>
</table>
Issues/Problems | Information for the community
---|---
• Inadequate knowledge of danger signs | • Confinement: Advise on how to prepare for baby and delivery (e.g. clothes, napkins) and encourage families to save money to pay for the cost of delivery
• Lack of or inadequate support or assistance from the men folk | • Provide basic information on what happens during labour and delivery and allay any fears associated with these events
• | • Educate on use of safe birth kits (e.g. for TBAs, spiritualists)
• | • Encourage men to support their wives during pregnancy financially and otherwise
• | • Educate men on the importance of ANC for protecting the health of mother and baby

Close topic: Summarise main ideas and link to next topic.

Checklist 2.1: Performance Guide for Individual Health Education during Antenatal Care

Instructions:
Rate the performance of each task/activity observed using the following rating scale.

0 - Task/Activity omitted
1 - Task/Activity incorrectly performed
2 - Task/Activity correctly performed (Hesitated)
3 - Task/Activity correctly performed with confidence
N/A - Task/Activity not required in this observation

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principles of Good Health Education</td>
<td></td>
</tr>
<tr>
<td>1. Educates on personal and environmental hygiene</td>
<td></td>
</tr>
<tr>
<td>2. Educates on exercise, rest and sleep</td>
<td></td>
</tr>
<tr>
<td>3. Educates on sexual activity during pregnancy</td>
<td></td>
</tr>
<tr>
<td>4. Discusses “safer sex” and use of condoms during pregnancy to prevent HIV/AIDS</td>
<td></td>
</tr>
<tr>
<td>Task/Activity</td>
<td>Rating</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>5. Educates on care of breasts and preparation for breastfeeding</td>
<td></td>
</tr>
<tr>
<td>6. Discusses family planning</td>
<td></td>
</tr>
<tr>
<td>7. Discusses care of the mother during post-partum period</td>
<td></td>
</tr>
<tr>
<td>8. Educates on care of the infant</td>
<td></td>
</tr>
<tr>
<td>9. Educates on exclusive breastfeeding</td>
<td></td>
</tr>
<tr>
<td>10. Discusses danger signs which indicate the mother needs to report for immediate examination and treatment:</td>
<td></td>
</tr>
<tr>
<td>a) Rupture of membranes</td>
<td></td>
</tr>
<tr>
<td>b) Vaginal bleeding</td>
<td></td>
</tr>
<tr>
<td>c) Fever</td>
<td></td>
</tr>
<tr>
<td>d) Excessive vomiting</td>
<td></td>
</tr>
<tr>
<td>e) Excessive weight gain</td>
<td></td>
</tr>
<tr>
<td>f) Oedema of face and hands</td>
<td></td>
</tr>
<tr>
<td>g) Headache and blurred vision</td>
<td></td>
</tr>
<tr>
<td>h) Loss of foetal movement</td>
<td></td>
</tr>
<tr>
<td>i) Dizziness, excessive tiredness</td>
<td></td>
</tr>
<tr>
<td>11. Gives opportunity for the group to ask questions and provides answers to questions</td>
<td></td>
</tr>
<tr>
<td>12. Ensures that the group has completely understood the information provided by asking questions and allowing them to provide answers</td>
<td></td>
</tr>
<tr>
<td>13. Reviews most important information</td>
<td></td>
</tr>
<tr>
<td>14. Thanks the group for their attention</td>
<td></td>
</tr>
<tr>
<td>15. Records the date of education and prepares a report of the activity as appropriate</td>
<td></td>
</tr>
</tbody>
</table>
The Antenatal Visit

Table 2.3 outlines the activities performed by a trained attendant at the specified antenatal visits. The physical examination is divided into subheadings: checking for infection and checking for pre-eclampsia so that information is goal-directed. For example, when checking for pre-eclampsia the midwife will group all the findings that go with detection of pre-eclampsia, i.e. BP, protein in the urine and reflexes. This will allow her to make a diagnosis of pre-eclampsia or allow her to rule out pre-eclampsia.

Table 2.3: **Physical Examination Schedules**

<table>
<thead>
<tr>
<th>Parameter Physical examination</th>
<th>First visit (or less than 16 weeks)</th>
<th>20-24 weeks</th>
<th>28-32 weeks</th>
<th>36 weeks+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess general health</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Check for infection</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Check for asymptomatic bacturia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Check for signs of pre-eclampsia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Blood pressure</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>- Proteinuria</td>
<td></td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>- Reflexes (only if elevated BP and proteinuria)</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Check for anaemia</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>- Haemoglobin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Conjunctival and palmar pallor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Pulse</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>- General appearance</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Check breasts</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Check for surgical risk</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Check height</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Check the abdomen for scars and musculature</td>
<td>√</td>
<td></td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>- Check the baby’s presentation and lie</td>
<td>√</td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>- Check engagement of the baby’s head</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>- Check fundal height</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parameter</td>
<td>First visit (or less than 16 weeks)</td>
<td>20-24 weeks</td>
<td>28-32 weeks</td>
<td>36 weeks+</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------------------------------</td>
<td>-------------</td>
<td>-------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Check the well-being of the baby</td>
<td></td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>- Baby's movements</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Baby's heart beat</td>
<td></td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Check genital health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening Procedures</td>
<td></td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Haemoglobin</td>
<td></td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>- Grouping and rhesus factor (if not known)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- VDRL or RPR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- HIV (if indicated)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Sickle cell (if indicated)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- protein</td>
<td></td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>- Sugar</td>
<td></td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>- Pregnancy test (if indicated)</td>
<td></td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stool</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Ova and parasites (if laboratory is available)</td>
<td></td>
<td>√</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Terminal Performance Objectives

After studying the unit, the CHO should be able to:

- Provide routine antenatal care according to national standard
- Identify high risk conditions in pregnant women and adolescents
- Assist women make appropriate decisions about their care

Rationale

Mention why these objectives are important to CHOs:

- Facilitate the screening of pregnant women and early identification of complications
- Enable CHO to assist the SDHT to provide appropriate care to pregnant women

Topic Outline

1. Steps of Antenatal Care
2. Health Education
3. Risk categories/factors associated with complications
4. Referral system
Topic Outline 1: **Steps in Antenatal Care**

**Facilitator-Participants Interaction**

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstration, etc.

1. Divide the participants into groups. Each group should read and discuss the case study and provide answers to the questions that follow. Tell them to write their answers in their CHO workbooks. Allow time for this.

2. Call on each group to present their answers on flipchart

3. Ask if the other group members have different answers or contributions to make

**Activity 3: Case study on Focused Antenatal Care**

**Background**
You visited the home of Maame Akosua Mansah a 22 year-old primipara for a routine home visit. During your interaction with her, she confirms that she is about five months pregnant. However, she has not had any antenatal care.

**Questions and Answers**

1. **What would you do for Maame Akosua Mansah as a CHO?**
   
   Provide some antenatal care service like registration, taking a history, doing a general examination and encouraging her to see the midwife for a thorough examination and care

2. **When will you recommend that the woman begins antenatal care?**
   
   As soon as she thinks she is pregnant

3. **The number of times a client needs to be seen during pregnancy may vary. What is the standard recommended for pregnant women?**

**Table 2.4: Frequency of Antenatal Visits**

<table>
<thead>
<tr>
<th>Gestation</th>
<th>Frequency of visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to the 28th week of pregnancy</td>
<td>Once a month</td>
</tr>
<tr>
<td>From the 28th – 36th week of pregnancy</td>
<td>Once every two weeks</td>
</tr>
<tr>
<td>Gestation</td>
<td>Frequency of visits</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>From the 36th week to</td>
<td></td>
</tr>
<tr>
<td>delivery</td>
<td>Once a week</td>
</tr>
</tbody>
</table>

4. If for any reason the woman is not seen as recommended, then a minimum of four visits should be made. When should these visits be made?
   a. First visit at the 10th week
   b. Second visit at the 20th week
   c. Third visit at the 30th week
   d. Fourth visit at the 36th week

During the first visit, the health worker is expected to take a comprehensive history to assess the health of the pregnant woman and identify any problems which could affect child bearing.

5. What are the key steps of antenatal care during the first visit?
   a. Registration (name, address, age, occupation, etc.)
   b. Comprehensive medical history including past obstetric history
   c. Examinations:
      i. General examination (temperature, pulse, BP, weight, etc)
      ii. Physical examination from head to toe
      iii. Obstetric examination (palpation for foetal maturity, auscultation of foetal heart, etc)

6. What laboratory investigations are carried out during the first visit?
   a. Blood tests - Hb, Sickling, Rhesus factor, VDRL
   b. Urine - protein and bacteria
   c. Stool - for parasites

7. You do a follow-up visit to Maame Akosua Mansah when she is 24 weeks pregnant. She has no complaints, no danger signs or factors associated with risk. What examinations will you recommend that a midwife performs on her today?
   a. Assess her general health, temperature, blood pressure, respirations, pulse and weight.
   b. Check for conjunctival and palmar pallor and jaundice
c. Baby’s movements

d. Fundal height

e. Baby’s heart beat

f. Laboratory investigations (urine, stool, Hb)

g. Routine administration of drugs – oral iron, TT immunization, and malaria prophylaxis

h. Education on topics such as diet and nutrition, rest

i. Manage complications and refer client

8. What relevant investigations should be done during every subsequent visit?

a. Haemoglobin (Hb) levels

b. Urine for sugar, proteins and acetone

c. Weight

d. Blood Pressure

9. State some normal findings you expect to observe during the screening of a pregnant woman such as Maame Akosua.

Table 2.5: Normal Findings for ANC Screening

<table>
<thead>
<tr>
<th>Examination Done</th>
<th>Finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height</td>
<td>1.5m and above</td>
</tr>
<tr>
<td>Blood pressure (BP)</td>
<td>100/80 – 130/80mm Hg</td>
</tr>
<tr>
<td>Hb</td>
<td>10gm or more</td>
</tr>
<tr>
<td>Urine:</td>
<td></td>
</tr>
<tr>
<td>- Protein in urine</td>
<td>Less than 1+</td>
</tr>
<tr>
<td>- Sugar trace</td>
<td>Nil</td>
</tr>
<tr>
<td>- Acetone</td>
<td>Nil</td>
</tr>
<tr>
<td>- Colour</td>
<td>Straw</td>
</tr>
<tr>
<td>- Deposits</td>
<td>Nil</td>
</tr>
<tr>
<td>Foetal Heart</td>
<td>After 20 weeks is 120 – 160 beats per minute</td>
</tr>
<tr>
<td>Blood film for malaria parasites</td>
<td>No parasites</td>
</tr>
</tbody>
</table>
Topic Outline 2: Health Education

Facilitator-Participants Interaction

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

Educate on topics such as:

a. Nutrition - diet, micro nutrient deficiencies e.g. iron, iodine deficiency
b. Care of the body - clothing, rest, sleep and exercise
c. Maintaining a clean environment
d. Prevention of malaria in pregnancy
e. Importance of TT immunisation
f. Prevention of worm infestation
g. Birth preparedness

Topic Outline 3: Risk Categories

Facilitator-Participants Interaction

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

Ideally, all women must receive antenatal care from a trained midwife. If for some reason this is not possible, then women who meet all of the following conditions can be identified as low risk and may be cared for by a trained TBA in the community. The conditions include a pregnant woman who is expecting her second, third or fourth baby; is between 18 and 35 years old; is in good health during her present pregnancy and also had no complications with previous pregnancy and delivery.

Every pregnancy is unique and every pregnancy carries a risk. However, there are some pregnant women who require special attention. They include women:

a. with a first pregnancy who are below 18 years of age
b. who are more than 35 years and pregnant for the first time
c. who have had more than four previous births
d. with short stature (less than 4ft/1.5m)
e. who bleed during pregnancy

Close Topic: Summarise main ideas and link to next topic

Topic Outline 3: Referral

Facilitator-Participants Interaction

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

Question and Answers

1. What are the steps in the referral system?
   a. Explain the situation to the client giving reason(s) for referral
   b. Arrange for transportation
   c. Fill the referral form, ANC register and client card
   d. Refer pregnant woman to the next level
   e. Accompany when necessary
   f. Get feedback on referral

Close Topic: Summarise main ideas and link to next topic
Terminal Performance Objectives

After studying this unit, the CHO will be able to:

- Recognize common conditions in pregnancy
- Provide necessary care and advice in the community
- Refer pregnant women who may be at risk of complications

Rationale

Mention why these objectives are important to CHO:

- Enable the CHO to identify common conditions that affect pregnant women
- Enable the CHO to help pregnant women manage these conditions timely before complications set in
- For prompt referral of pregnant women who may be at risk of complications
- Help clients understand how certain practices impact positively or negatively on pregnancies
- Enable CHO assist clients prepare for birth

Topic Outline

1. Common conditions in pregnancy
2. Major conditions in pregnancy:
   a. Bleeding
   b. Pregnancy-induced hypertension
3. Screening of pregnant women (refer to unit 2)
4. Referral
5. Report writing, analysis and submission
Topic Outline 1: **Common Conditions in Pregnancy**

**Facilitator-Participants Interaction**

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

**Questions and Answers**

1. What are the common minor problems during pregnancy? What will you do for a pregnant woman who has any of these conditions in the community?
   
   a. **Morning sickness:**
      
      This is persistent nausea or vomiting throughout the day. It starts during the second or third month of pregnancy and is usually worse in the morning. Signs and symptoms include weight loss, apathy, dry and cracked lips and dark urine.
      
      Management - Reassure client and advise her to increase fluid intake and eat low-fat meals at short intervals. Refer client to the next level if condition persists.
   
   b. **Heartburns:**
      
      It is a burning sensation at the epigastric region due to regurgitation of gastric juice.
      
      Management:
      
      - Advise clients to eat small amounts of food at a time at short intervals and to sleep with the head and chest lifted up with some pillows.
      
      - Avoid fatty and spicy foods.
   
   c. **Constipation:**
      
      This is due to the high levels of progesterone in the blood that relaxes the muscles or due to pressure of the enlarged uterus.
      
      Management:
      
      - Encourage the client to take fruits, vegetables and drink a lot of fluids.
      
      - She should not take any laxatives or have an enema.
      
      - If the condition does not subside refer to the next level.
d. Varicose Veins:

These are abnormal enlargement of the venous walls during pregnancy due to the relaxing effect of progesterone. These are common in pregnancy due to the weight of the baby pressing on the lower limbs veins.

Management:

- Use elasticated stockings, crepe bandages and avoid prolonged standing.
- Advise the woman to put her feet up often e.g. on a stool when sitting. If the veins get very big or hurt, refer her to the next level.

e. Vaginal discharge:

Refer client to clinic for laboratory investigation to identify causative organism for effective treatment.

Close Topic: Summarise main ideas and link to next topic.

Topic Outline 2: **Major Conditions in Pregnancy**

Facilitator-Participants Interaction

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

Questions and Answers

1. Complications may occur during pregnancy. What are some of the major complications of pregnancy?
   
   a. Vaginal bleeding
   b. Hypertension
   c. Pregnancy-related hypertension
   d. Severe anaemia

2. List some danger signs associated with the complications of pregnancy which you should look out for in the community.

   a. Swelling of face, hands or feet
   b. Severe headache or blurred vision
c. Very pale conjunctiva, tongue, palms or nails
d. Bleeding from the vagina
e. Offensive or discoloured discharge from vagina
f. Severe abdominal pain
g. Persistent vomiting
h. Jaundice
i. Fever
j. Premature rupture of the membranes
k. A pregnant woman with signs of any of these conditions must be referred immediately to the health centre

Activity 4: **Role Play on Minor Problems during Pregnancy**

Depending on the size of the group, either divide participants into groups or do this as one group. Ask participants to read the role play then ask for volunteers to play the role of one of the characters. Make sure there is somebody to play each character. Have the other participants observe and tell them that the whole group will discuss the role play exercise when it is over.

**Background**

A CHO visits Ms. Beatrice Iddrisu, a 19 year-old primipara who attended the last ANC session held at the clinic. During the visit, Beatrice requests to know why she is unable to have free bowel movement since she is used to emptying her bowels at least once daily. The CHO explains by discussing the common ailments in pregnancy and assists Beatrice to identify ways of addressing and relieving any problems she is encountering. She goes further to differentiate between these common conditions and the major conditions that have to be reported to the midwife immediately for management.

**Instructions for the class:**

1. Observe the interaction between the CHO and Beatrice and discuss the interaction at the end of the role play
2. Take note of all the common conditions in pregnancy mentioned and how they are to be treated
3. Also take note of the major conditions in pregnancy mentioned
Lead the discussion of the role play:

1. Was the CHO able to mention all the common conditions in pregnancy?
2. Did the CHO monitor all the major conditions in pregnancy?
3. Was the CHO able to address her client’s concerns?
4. How could the CHO have improved her performance?

Summarize the discussion by reviewing the minor and major conditions in pregnancy. List the summaries on flip chart.

**Close Topic**: Summarise main ideas and link to next topic

**Topic Outline 3: Referral**

**Facilitator-Participants Interaction**

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

**Table 2.6: Referral Form**

**Feedback to CHO**

**Part 2**

Name of Institution Receiving Patient/Client: ..............................................

Date Received: .................................................................

Condition of Patient/Client on Reporting: ..................................................

.................................................................

Findings: ..................................................................................

Action(s) taken: .............................................................................

Recommendation(s) for Follow-up: ......................................................

.................................................................................................

.................................................................

Name & Title ................................................................. Signature
Procedure for Referrals

When referring a client, the CHO should observe the following steps:

1. **Reason for Referral**
   
The CHO should inform the client about the reason for the referral, impressing on the client why it is important to be referred to the next level

2. **Steps in referral:**
   
a. Explain the condition to the client and the need for her to be referred
   
b. Complete referral form, ANC register and client card
   
c. Refer woman to appropriate centre
   
d. Accompany where necessary
   
e. Get feedback from referral centre

**Topic Outline 4: Report Writing, Analysis, and Submission**

**Facilitator-Participants Interaction**

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc

**Questions and Answers**

1. Write a monthly report on antenatal activities e.g. the number of pregnant women registered, attendance, TT given and referrals

2. Compare with previous month’s report and assess if there has been an increase or decrease and comment on findings

3. Solve the problems that you can handle and refer the rest to the appropriate level

4. Submit a copy of the report to the next level

**Close topic:** Summarize main ideas and link to next topic
Checklist 2.2: Performance Guide for General Examination

Instructions:
Rate the performance of each task/activity observed using the following rating scale.

- 0 - Task/Activity omitted
- 1 - Task/Activity incorrectly performed
- 2 - Task/Activity correctly performed (Hesitated)
- 3 - Task/Activity correctly performed with confidence
- N/A - Task/Activity not required in this observation

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Palpation</strong></td>
<td>![Table](data:image/png;base64,iVBORw0KGgoAAAANSUhEUgAAAotAAAA2CAYAAAA4Z7QYAAAAGXRFWHRTb2Z0d2FyZQBBZG9iZSBJbWFnZVJkYWRvb2tvblwiZW50aWZ...</td>
</tr>
<tr>
<td>a) Measure the symphysiofundal pubis</td>
<td>![Cell](data:image/png;base64,iVBORw0KGgoAAAANSUhEUgAAAotAAAA2CAYAAAA4Z7QYAAAAGXRFWHRTb2Z0d2FyZQBBZG9iZSBJbWFnZVJkYWRvb2tvblwiZW50aWZ...</td>
</tr>
<tr>
<td>b) Locates the upper border of the symphysis pubis</td>
<td>![Cell](data:image/png;base64,iVBORw0KGgoAAAANSUhEUgAAAotAAAA2CAYAAAA4Z7QYAAAAGXRFWHRTb2Z0d2FyZQBBZG9iZSBJbWFnZVJkYWRvb2tvblwiZW50aWZ...</td>
</tr>
<tr>
<td>c) Puts the zero mark of the tape measure on the upper border of the fundus</td>
<td>![Cell](data:image/png;base64,iVBORw0KGgoAAAANSUhEUgAAAotAAAA2CAYAAAA4Z7QYAAAAGXRFWHRTb2Z0d2FyZQBBZG9iZSBJbWFnZVJkYWRvb2tvblwiZW50aWZ...</td>
</tr>
<tr>
<td>d) Extends the tape along the contour of the abdomen along the midline to the symphysis pubis.</td>
<td>![Cell](data:image/png;base64,iVBORw0KGgoAAAANSUhEUgAAAotAAAA2CAYAAAA4Z7QYAAAAGXRFWHRTb2Z0d2FyZQBBZG9iZSBJbWFnZVJkYWRvb2tvblwiZW50aWZ...</td>
</tr>
<tr>
<td>e) Notes the measurement in centimeters</td>
<td>![Cell](data:image/png;base64,iVBORw0KGgoAAAANSUhEUgAAAotAAAA2CAYAAAA4Z7QYAAAAGXRFWHRTb2Z0d2FyZQBBZG9iZSBJbWFnZVJkYWRvb2tvblwiZW50aWZ...</td>
</tr>
<tr>
<td>f) Palpates the abdomen, (using palms and pads rather than tips of fingers)</td>
<td>![Cell](data:image/png;base64,iVBORw0KGgoAAAANSUhEUgAAAotAAAA2CAYAAAA4Z7QYAAAAGXRFWHRTb2Z0d2FyZQBBZG9iZSBJbWFnZVJkYWRvb2tvblwiZW50aWZ...</td>
</tr>
</tbody>
</table>

**Fundal**

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Faces client and places palms on either side of the fundus</td>
<td>![Cell](data:image/png;base64,iVBORw0KGgoAAAANSUhEUgAAAotAAAA2CAYAAAA4Z7QYAAAAGXRFWHRTb2Z0d2FyZQBBZG9iZSBJbWFnZVJkYWRvb2tvblwiZW50aWZ...</td>
</tr>
<tr>
<td>b) Curves fingers around top of fundus</td>
<td>![Cell](data:image/png;base64,iVBORw0KGgoAAAANSUhEUgAAAotAAAA2CAYAAAA4Z7QYAAAAGXRFWHRTb2Z0d2FyZQBBZG9iZSBJbWFnZVJkYWRvb2tvblwiZW50aWZ...</td>
</tr>
<tr>
<td>c) Determines what lies in the fundus</td>
<td>![Cell](data:image/png;base64,iVBORw0KGgoAAAANSUhEUgAAAotAAAA2CAYAAAA4Z7QYAAAAGXRFWHRTb2Z0d2FyZQBBZG9iZSBJbWFnZVJkYWRvb2tvblwiZW50aWZ...</td>
</tr>
</tbody>
</table>

**Lateral**

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Places palms of hands on both sides of uterus, midway between symphysis pubis and fundus</td>
<td>![Cell](data:image/png;base64,iVBORw0KGgoAAAANSUhEUgAAAotAAAA2CAYAAAA4Z7QYAAAAGXRFWHRTb2Z0d2FyZQBBZG9iZSBJbWFnZVJkYWRvb2tvblwiZW50aWZ...</td>
</tr>
<tr>
<td>b) Stabilizes uterus with one hand and examines with the other</td>
<td>![Cell](data:image/png;base64,iVBORw0KGgoAAAANSUhEUgAAAotAAAA2CAYAAAA4Z7QYAAAAGXRFWHRTb2Z0d2FyZQBBZG9iZSBJbWFnZVJkYWRvb2tvblwiZW50aWZ...</td>
</tr>
</tbody>
</table>
### Module 2: Antenatal Care

#### Task/Activity Rating

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

**c)** Palpates entire area from abdominal midline to the lateral side and from the symphysis pubis to the fundus in a rotary manner. Locates foetal back (smooth curve indicates back, irregular part indicate limbs)

**d)** Changes hands and repeats palpation for the other half of the abdomen

#### Pelvic

**a)** Turns and faces client’s feet

**b)** Asks client to bend knees slightly. Helps client to relax by guiding her to breathe out slowly.

**c)** Places palms of hands on either side of the uterus, with palms just below level of umbilicus and fingers directed towards symphysis pubis, with thumbs almost meeting. Determine if head is presenting

#### Descent of Head

**a)** Locates the anterior shoulder (anterior shoulder is usually below umbilicus, approximately 2.5cm from linea nigra where the limbs are located).

**b)** Keeps two fingers over the anterior shoulder

**c)** Locates symphysis pubis

**d)** Places fingers below the anterior shoulder and symphysis pubis

**e)** Notes the number of finger breadths that can be accommodated (record in fifths)

#### 2. Auscultation

**a)** Warms foetal stethoscope by rubbing in palm

**b)** Places foetal stethoscope on area where back was located

**c)** Moves stethoscope to another area if necessary

**d)** Compares rate with maternal pulse

**e)** Counts foetal heart for one full minute
### Task/Activity

<table>
<thead>
<tr>
<th>Rating</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>N/A</th>
</tr>
</thead>
</table>

#### 3. After Examination

- a) Communicates findings to woman/support person
- b) Helps her out of couch/bed
- c) Washes hands or applies alcohol hand rub
- d) Records findings

#### 4. Clinical Decision Making

- a) Evaluates findings and makes appropriate decisions. If anaemic and client has symptoms, refer
  - i. there is a history of surgical intervention on the uterus, refer
  - ii. uterine size is smaller or bigger than expected at gestational age refer for further investigations
  - iii. presentation is abnormal, e.g. breach or transverse, refer
- b) Decides with the client the appropriate place for her delivery
- c) Assesses the educational needs of the client and gives health education or counselling
## Checklist 2.3: Performance Guide for Physical Examination of a Pregnant Woman

Instructions:

Rate the performance of each task/activity observed using the following rating scale.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Task/Activity omitted</td>
</tr>
<tr>
<td>1</td>
<td>Task/Activity incorrectly performed</td>
</tr>
<tr>
<td>2</td>
<td>Task/Activity correctly performed (Hesitated)</td>
</tr>
<tr>
<td>3</td>
<td>Task/Activity correctly performed with confidence</td>
</tr>
<tr>
<td>N/A</td>
<td>Task/Activity not required in this observation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Rating 0</th>
<th>Rating 1</th>
<th>Rating 2</th>
<th>Rating 3</th>
<th>Rating N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Explains procedure to the client</td>
<td></td>
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<tr>
<td>2. Asks her to empty the bladder</td>
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<tr>
<td>3. Provides privacy (if support person is present ask the client if she wants this person to stay during the examination)</td>
<td></td>
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<tr>
<td>4. Performs systemic examination:</td>
<td></td>
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<tr>
<td>a) Observes emotional state of the client by watching her facial expression and body language</td>
<td></td>
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<tr>
<td>b) Observes posture</td>
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<tr>
<td>c) Takes and records height, blood pressure, weight</td>
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<tr>
<td>d) Takes and records haemoglobin level with Talquist</td>
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<tr>
<td>e) Tests urine for protein</td>
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<tr>
<td>f) Assists the client to get on the bed or examination couch</td>
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<tr>
<td>g) Washes hand and dries or applies alcohol hand rub</td>
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<tr>
<td>5. Head and Neck:</td>
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<tr>
<td>a) Inspects hair for cleanliness, ringworm and parasites</td>
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<tr>
<td>b) Inspects the face for oedema</td>
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<tr>
<td>6. Inspects eyes for:</td>
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<tr>
<td>a) Pallor of conjunctivae</td>
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<td>b) Puffiness of the eye lids</td>
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<tr>
<td>Task/Activity</td>
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<tr>
<td><strong>Mouth: Inspects</strong></td>
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<tr>
<td>a) Lips for dryness, cracks and inflammation (sign of dehydration)</td>
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<tr>
<td>b) Gums and tongue for pallor, sores and teeth for decay (asks the woman to open mouth or says something to make her laugh)</td>
<td></td>
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<tr>
<td><strong>Inspects and palpates neck for:</strong></td>
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<tr>
<td>Enlarged thyroid gland</td>
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<tr>
<td>Enlarged lymph glands</td>
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<tr>
<td>Distended neck veins</td>
<td></td>
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<tr>
<td><strong>Inspects breasts for:</strong></td>
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<tr>
<td>a) Size</td>
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<tr>
<td>b) Shape</td>
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<tr>
<td>c) Signs of pregnancy (darkness of areola and appearance of secondary areola)</td>
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<tr>
<td>d) Dimpling and retraction of nipples</td>
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<tr>
<td>e) Palpates breasts for lumps; axillary lymph nodes for enlargement</td>
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<tr>
<td>f) Asks about breast feeding history if client is multipara and desires to breast feed</td>
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<tr>
<td>g) Teaches client about breast care and self-examination</td>
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<tr>
<td><strong>Extremities:</strong></td>
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<tr>
<td><strong>Upper:</strong></td>
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</tr>
<tr>
<td>a) Asks the client for tingling and tightness of fingers on clenching of fist</td>
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</tr>
<tr>
<td>b) Inspects the hands and fingers for oedema and palms and nail beds for pallor</td>
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<tr>
<td><strong>Lower: Inspects legs for:</strong></td>
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<td></td>
<td></td>
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<tr>
<td>a) Oedema (Tibia bone)</td>
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</tr>
<tr>
<td>Task/Activity</td>
<td>Rating</td>
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<td>------------------------------------------------------------------------------</td>
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<tr>
<td>b) Tenderness in the calf muscles</td>
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<tr>
<td>c) Varicose veins</td>
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<tr>
<td>d) Abnormal size and inequality</td>
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<tr>
<td><strong>Back:</strong></td>
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<tr>
<td>a) Examines the back for:</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>b) Tenderness of vertebral column</td>
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<tr>
<td>c) Spine deformity</td>
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<td></td>
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<tr>
<td>d) Oedema of sacral region</td>
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<tr>
<td>e) Tenderness at sides of the vertebra (in the region of the kidney)</td>
<td></td>
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</tr>
<tr>
<td>f) Asks the client for permission to examine her genital area. If she agrees</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>g) Examines the vulva for oedema and varicose veins, sores, warts</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>h) Inspects vaginal introitus for discharge (colour and odour of discharge), warts if present, when it started (If the client does not want you to inspect the vulva, ask questions about the above. Never force a client to undergo any examination for which she has refused but rather, document it for future reference.)</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>i) Washes and dries hands and communicates findings to client.</td>
<td></td>
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<tr>
<td>j) Records findings</td>
<td></td>
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</tr>
</tbody>
</table>

11. **Decision making:**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Documents and discusses any abnormality detected with client</td>
<td></td>
</tr>
<tr>
<td>b) Manages and or refers client</td>
<td></td>
</tr>
<tr>
<td>c) Gives routine drugs and tells client the date of her next visit and when she would have to take SP and TT</td>
<td></td>
</tr>
</tbody>
</table>
Checklist 2.4: Performance Guide for Group Health Education during Antenatal Care

Instructions:
Rate the performance of each task/activity observed using the following rating scale.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Task/Activity omitted</td>
</tr>
<tr>
<td>1</td>
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</tr>
<tr>
<td>2</td>
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<tr>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Principles of Good Health Education</strong></td>
<td></td>
</tr>
<tr>
<td>1. Raises voice so that all can hear</td>
<td></td>
</tr>
<tr>
<td>2. Shows enthusiasm about the topics</td>
<td></td>
</tr>
<tr>
<td>3. Maintains eye contact with the listeners</td>
<td></td>
</tr>
<tr>
<td>4. Uses audio-visuals effectively</td>
<td></td>
</tr>
<tr>
<td><strong>Introduction</strong></td>
<td></td>
</tr>
<tr>
<td>5. Greets listeners and introduces herself/himself</td>
<td></td>
</tr>
<tr>
<td>6. Creates a comfortable atmosphere</td>
<td></td>
</tr>
<tr>
<td>7. Explains the purpose of health education during pregnancy</td>
<td></td>
</tr>
<tr>
<td><strong>Health Education</strong></td>
<td></td>
</tr>
<tr>
<td>8. Asks general questions about the group’s knowledge about pregnancy and antenatal care</td>
<td></td>
</tr>
<tr>
<td>9. Discusses the various aspects of antenatal care and the complications which may occur. Chooses one topic per session. Provides information on:</td>
<td></td>
</tr>
<tr>
<td>a) Preparation for birth (birth preparedness)</td>
<td></td>
</tr>
<tr>
<td>b) Preparation in case of complications (complication readiness)</td>
<td></td>
</tr>
<tr>
<td>c) Process of pregnancy and labour</td>
<td></td>
</tr>
<tr>
<td>d) Routine examination during pregnancy</td>
<td></td>
</tr>
<tr>
<td>Task/Activity</td>
<td>Rating</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>e) Helpful traditional practices that should be encouraged</td>
<td></td>
</tr>
<tr>
<td>f) Danger of self-medication in pregnancy</td>
<td></td>
</tr>
<tr>
<td>g) Nutrition</td>
<td></td>
</tr>
<tr>
<td>h) Taking iron tablets</td>
<td></td>
</tr>
<tr>
<td>i) Prophylaxis for malaria</td>
<td></td>
</tr>
<tr>
<td>j) Tetanus vaccination</td>
<td></td>
</tr>
</tbody>
</table>
Unit 1

Prenatal Health Education

Health education is an essential part of antenatal care. Through education, women learn what they can do to protect their health during pregnancy, why medical care is important and what danger signs to watch out for.

For the education to be effective, the CHO must follow these principles:

- Courtesy and kindness – Clients should be treated with respect and where they appear unsure of themselves or frightened, they must be treated with empathy and sympathy
- Listen and ask – Many women already know a great deal about pregnancy and child bearing. Before telling them what they should do, ask questions to find out what they know and what they want to learn
- Answer questions – In addition to providing basic information, be sure to respond to any other concerns the woman may have
- Give personal attention – Give every woman information and counselling as an individual because every woman is different, has unique problems and needs both in terms of her medical care and the information she requires.

Helping community women to help themselves

- Share your knowledge. Many problems can be prevented if people have adequate knowledge. But remember that you do not have all the answers. It is alright to admit when you do not know something and to refer or ask for help
- Treat women with respect. Never blame a woman for her problem or for past decisions she has made
- Health problems should not be discussed when others can hear. Never tell anyone about someone’s problem unless the person with the problem gives approval
- Remember that listening is more important than giving advice. As the woman talks, she may find that she has some of the answers to her problem
- Solve problems with others, not for them. As a health worker, you can help her realize she has choices, and help her find the information she needs to make her own decisions
- Learning how others solve their own problems can help you to help others better and sometimes yourself
- Respect your community’s traditions and ideas. Use what is good in both traditional and modern methods
- Find out what people want to learn about. If you find out exactly what people want to know, then you can give knowledge that is useful to them
- Develop an awareness of what gender roles are, and how they are passed on by parents, community traditions and the media
- Examine different gender roles to see which are harmful and need to be changed. Work with community and other social groups for change

Unit 2

Antenatal Care -The Steps

Antenatal care is any care given to the pregnant woman at any time during her pregnancy. Antenatal care must be organised to:

- Include detection of early signs of disease or complications which may affect the health and survival of the woman or foetus
- Provide timely intervention to manage the identified disease or complications
- Provide four antenatal visits which are of high quality for women not experiencing any complications

Apart from routine visits, the client should report to the clinic anytime she feels unwell or has any complications. Every pregnancy is special and every pregnancy is potentially at risk. Many complications cannot be predicted. The CHO must therefore ensure that she, together with the SDHT:

- Educate all pregnant women and their families about the possibility of complications and about actions they can take if and when a problem arises
- Support the community leaders to create a functioning system of communication and transportation between the pregnant women in the communities and the nearest health facility
• Provide adequate care as close as possible to where women live e.g. by training TBAs to deliver women in a clean environment (infection prevention techniques)
• Improve women’s overall well-being and reproductive health through prevention, screening and treatment of existing problems that contribute to poor reproductive health

Registration

Essential information for registration of clients including the name, age, address, parity and next of kin should be entered into the antenatal register.

History Taking

This is to assess the pregnant woman’s previous experience with pregnancy, her present state of health, any family medical history that may hamper smooth labour and delivery. This includes:

• Taking history of both past and present medical and surgical conditions including known allergies to medication
• Family medical history - whether there is any disease that can be transmitted from generation to generation e.g. asthma, hypertension, diabetes mellitus
• The obstetric history - if the client has had any problems related to previous pregnancies, labour and delivery
• Social history e.g. occupation, alcohol consumption, cigarette smoking
• Women with history of an operative delivery, stillbirth, neonatal death, or low birth-weight baby may be at risk of a recurrence of the problem in subsequent deliveries. She should be managed by a trained midwife since she is at risk of complications during labour or delivery

The risk factors include:

• Primipara or young age; less than 15 years old
• A woman whose last baby was stillborn or died a neonate
• Woman who has had post-partum haemorrhage or birth with heavy bleeding
• Woman who suffered from eclampsia or had convulsions in her previous pregnancy
• Woman whose last birth was preterm
• Woman who has undergone a caesarean or had forceps or vacuum delivery
• Woman who is undergoing treatment for some chronic illness e.g. TB
• Routine Investigations
Table 2.7: **Investigations during ANC Visits**

<table>
<thead>
<tr>
<th>First Visit</th>
<th>Subsequent Visit (every visit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urine for proteins, sugar</td>
<td>Haemoglobin</td>
</tr>
<tr>
<td>Stool for worms</td>
<td>Urine</td>
</tr>
<tr>
<td>Blood for:</td>
<td>Weight</td>
</tr>
<tr>
<td>Haemoglobin</td>
<td>Blood pressure</td>
</tr>
<tr>
<td>Sickling</td>
<td>FH</td>
</tr>
<tr>
<td>Blood group/Rhesus factor</td>
<td>Blood film for malaria parasites</td>
</tr>
<tr>
<td>VDRL</td>
<td></td>
</tr>
<tr>
<td>HIV (on request)</td>
<td></td>
</tr>
<tr>
<td>Blood film for malaria parasites</td>
<td></td>
</tr>
</tbody>
</table>

**Examination of pregnant women**

1. **Physical examination** – Conduct examination from head to toe. Emphasis is laid on the conjunctiva and nail beds for pallor (anaemia); the breast for lumps or inverted nipples; vital signs; gait or deformity, weight, height, and extremities for oedema.

   Observe:
   - Emotional state of woman
   - Hair, eyes, gums, teeth
   - Breasts
   - Legs, etc.

2. **Obstetric examination** - Inspect abdomen for scars, palpate to determine maturity, presentation and lie and auscultate for foetal heart beat

3. **Vulval examination** - Inspect for oedema, warts, scars, sores, discharges, varicosity

**Drug Supplementation for a Pregnant Woman**

The following drugs are given to women during pregnancy: iron, folic acid, multivitamin, calcium and Intermitten Preventive Treatment (IPT) of Malaria using Sulphadoxine Pyrimethamine (SP). Women with pica (abnormal cravings) should be treated for iron deficiency anaemia i.e. 1 tablet of iron-folate and multivitamin twice daily. They should also be dewormed with Mebendazole.

Reasons for drug supplementation - iron reduces the risk of anaemia and, calcium helps the formation of bones in the foetus. In areas of deficiency consider giving vitamin A and iodine. Malaria prophylaxis helps prevent malaria.
Tetanol Immunization in Pregnancy

- Inspect Immunization card to see which doses have already been received
- Give immunization e.g. two doses of tetanol (from 20 weeks with second dose four weeks later)
- Record findings or care given on ANC register, client card and tally sheets
- Inform woman about number of doses required to be taken and when the next dose is due

Client Education

This is an essential part of antenatal care. Through education, women learn what they can do to protect their health during pregnancy, why medical care is important and what danger signs to watch out for. Promote the use of insecticide treated nets. Please refer to Unit 1 for more information.

Pregnant women who need special care

Every pregnancy carries a risk. There are some pregnant women who for one reason or the other will require special attention. These include:

- First pregnancy
- Pregnancy after age 35
- More than four previous births
- Short stature
- Bleeding in pregnancy
- Bad obstetric history e.g. previous caesarian section

Table 2.8: Assessment of Pregnancy

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Normal Findings</th>
</tr>
</thead>
</table>
| General appearance      | • A normal, healthy and well nourished pregnant woman is happy, has enough energy to do her chores, feels good, looks good, and does not have skin diseases, abscesses or sores  
• The absence of physical handicaps also improves the outcome of pregnancies |
| Symptoms of infection   | • No signs and symptoms of infection                                          |
## Assessment: Normal Pregnancy

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Normal Findings</th>
</tr>
</thead>
</table>
| Blood pressure    | • Systolic BP between 90 – 140mg/Hg  
                        • Diastolic BP between 60 – 90mg/Hg                                                                                                       |
| Reflexes          | • The lower leg will move a little as soon as you tap the tendon                                                                               |
| Signs of anaemia  | • In a healthy woman, the conjunctiva, nail beds, gums and palms will be pink  
                        • Respiratory rate is 16-24 breaths/minute  
                        • Woman tolerates exercise and works without being short of breath  
                        • Normal haemoglobin levels for a pregnant woman are: 10-12gm/dl                                                                 |
| Breasts           | • Bilateral increase in size often accompanied with tingling, tenseness and tenderness. Occurs in the first trimester  
                        • Increased generalized course, nodular and lobular feel of the breast as a result of hypertrophy of the mammary alveoli Occurs in the first trimester  
                        • Escape of colostrum as nipple discharge May appear as early as the sixth week of gestation as a clear viscous fluid; may become yellow and less viscous later in the pregnancy  
                        • Enlargement and increased erectility of the nipples. Occurs in the first trimester  
                        • Broadening and increased pigmentation of the areola. Starts in the first trimester  
                        • Dilated subcutaneous veins usually seen beneath the skin as bluish veins. Occurs in the first trimester  
                        • Vascular spiders on the upper chest (also upper arms, neck, and face). Occurs in the second trimester  
                        • Striae of the breasts. May occur with excessive increase in the size of breasts                                                                 |
| Abdomen           | • Unscarred abdomen  
                        • Linea nigra and striae gravidarum may or may not be present but are both normal, and hormonally induced  
                        • Mild diastasis recti is normal                                                                                                              |
| Foetal position   | • 7th month (28 weeks) – foetal parts can be identified  
                        • 8th month (32 weeks) – foetal parts easily outlined  
                        • 9th month (36 weeks) – foetus in position; ratio of amniotic fluid to foetus decreases so changes in foetal position are not as frequent  
                        • 10th month (40 weeks) – infant in position for birth                                                                                       |
| Foetal movements  | • 4th month (16 weeks) – may feel quickening  
                        • 5th month (20 weeks) – quickening should have occurred  
                        • Baby should move at least 10 times in 12 hours  
                        • Babies have periods of sleep and rest, and his/her movements will be decreased at the time                                                                 |
Assessment: Normal Pregnancy

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Normal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitivity</td>
<td>• Sensitivity to foetal movement varies from woman to woman – some women are not always aware of foetal movement, especially of short duration; other women may interpret foetal hiccups or Braxton Hick’s Contractions as foetal movement</td>
</tr>
<tr>
<td></td>
<td>• Many non-threatening factors may affect foetal movement e.g. sound, nutritional intake, touch, external stimulation</td>
</tr>
<tr>
<td>Fundal height</td>
<td>• From 20 weeks on, the number of centimetres measured should be approximately equal to the weeks of gestation (2cm)</td>
</tr>
<tr>
<td>Foetal heart</td>
<td>• Normal range is 120 – 160 beats/minute</td>
</tr>
<tr>
<td></td>
<td>• 3rd month (12 weeks) – foetal heart is usually audible using ultrasonic Doppler</td>
</tr>
<tr>
<td></td>
<td>• 4th month (16 weeks) – uterine soufflé heard</td>
</tr>
<tr>
<td></td>
<td>• 5th month (20 weeks) foetal heart is audible with foetal stethoscope</td>
</tr>
<tr>
<td>Genital health</td>
<td>• Normally the skin in this area is smooth and no sores or lymph nodes can be felt</td>
</tr>
<tr>
<td></td>
<td>• Normally there is no itching, swelling, sores or bleeding</td>
</tr>
<tr>
<td></td>
<td>• Increased oestrogen during pregnancy causes hyperplasia of the vaginal mucosa and increased production of mucus by the cervical glands. This means that most pregnant women will have normal leucorrhoea, but normal vaginal discharge will be clear or white, odourless and not itchy</td>
</tr>
</tbody>
</table>

Unit 3

History taking and investigation help detect pregnant women who need special care

Table 2.9: **ANC Examinations and Interpretations**

<table>
<thead>
<tr>
<th>Examination</th>
<th>Normal</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height</td>
<td>1.5m and above</td>
<td>Less than 1.5m</td>
</tr>
<tr>
<td>Protein in Urine</td>
<td>Less than 1+</td>
<td>Protein 1+ or more</td>
</tr>
<tr>
<td>Sugar</td>
<td>Trace</td>
<td>Acetone present, Sugar 1+ or more</td>
</tr>
<tr>
<td>Colour</td>
<td>Straw</td>
<td>Smoky</td>
</tr>
<tr>
<td>Deposits</td>
<td>Nil</td>
<td>Some deposits</td>
</tr>
<tr>
<td>BP</td>
<td>100/70 – 130/80 mmHg</td>
<td>140/90 mmHg or more</td>
</tr>
<tr>
<td>Examination</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td>------------------</td>
<td>----------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Hb</td>
<td>10 gm/dl or more</td>
<td>Less than 10gm/dl</td>
</tr>
<tr>
<td>Foetal Heart</td>
<td>After 20 weeks is between 120 – 160 beats per minute</td>
<td>More than 160 or less than 120 beats/minute or even absent</td>
</tr>
<tr>
<td>Size for date</td>
<td>Size = date</td>
<td>Size is more or less than 2cm for date</td>
</tr>
</tbody>
</table>

### Major Conditions in Pregnancy

Some women experience the following problems:

- **Bleeding:** Vaginal bleeding any time during pregnancy should be referred and every woman should be instructed to report to the midwife. It could be due to trauma, cervical incompetence or infection.

- **Pregnancy-induced hypertension/eclampsia:** It is a pregnancy-related hypertension, which is common in primigravida and manifests around 30 weeks of pregnancy. The cardinal sign is a raised blood pressure of 140/90 mmHg or higher and proteinurea which may be mild or marked. In mild cases the pregnant woman is advised to rest and take low carbohydrate and high protein diet. A sedative may be prescribed.

- **Pregnancy related hypertension/eclampsia:** This occurs when the diastolic is 90-110mm/Hg 4hrs apart; after 20 weeks there may be proteinurea ++, oedema or excessive weight gain.

- **Anaemia:** This occurs when Hb is less than 10mg/dl

In all these cases, refer client if you are not a trained midwife

### Referral System

**Steps in referral:**

a. Explain condition to client and the need for the client to be referred  
b. Complete referral form, ANC register and client card  
c. Refer client to appropriate level  
d. Accompany where necessary  
e. Get feedback from referral centre
Report writing, Analysis and Submission

- Write a monthly report on antenatal activities e.g. the number of pregnant women registered, TT given and referrals
- Compare with previous month’s report to see if there has been an increase or decrease and comment on findings
- Solve the problems that are within your means and refer the rest to the appropriate level
- Submit a copy of the report to the next level.
Module 3

Safe Emergency Delivery
Purpose and Organisation

As the health care provider in the community, the CHO should have the knowledge and skills to conduct safe delivery, aiming to prevent complications to the mother or baby. This module has two units which assist the CHO to assess the stages of labour, monitor labour and conduct delivery.

Objectives

Review these objectives now and all subsequent unit objectives as you begin each unit by:
• Reading each objective yourself
• Having participant read the objectives aloud to the group

After studying this module, the CHO will be able to:

1. Assess the Stages of Labour
2. Manage Delivery

Contents

Unit 1: Assessing the Stages of Labour
Unit 2: Managing Delivery

Expected Outcome

Knowledge
• Stages of labour
• Monitoring of labour
• Examination
• Infection prevention
• Differentiate between false and true labour
• Manage labour
• Delivery
Attitude
- Be friendly
- Confident
- Trustworthy
- Have initiative
- Empathetic

Skill
- Delivery
- Examination (abdominal, vaginal)
- Communication skills (counselling, listening)
- Recording and reporting
- Monitoring infection prevention skills

Table 3.1: Materials Needed

<table>
<thead>
<tr>
<th>Samples</th>
<th>CHO Materials</th>
<th>Facilitator Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical chart</td>
<td>Stationery:</td>
<td>Overhead projector (where available)</td>
</tr>
<tr>
<td>Dilatation chart</td>
<td>- pencils</td>
<td>Transparencies</td>
</tr>
<tr>
<td>Stages of labour chart</td>
<td>- pens</td>
<td>Felt pens/markers</td>
</tr>
<tr>
<td>Different positions chart</td>
<td>- note pads</td>
<td>Flip chart stand and sheets</td>
</tr>
<tr>
<td>Processes of delivery chart</td>
<td></td>
<td>Model of vulva &amp; vagina</td>
</tr>
</tbody>
</table>

Teaching Methods
- Use learner-centered methods in this module
- Introduce new materials through a guided discussion
- Start each unit with a guided discussion

Help participants apply their knowledge in “real life” situations. In addition, field practice is highly recommended.

Getting Started
1. Do a warm-up exercise
2. Review any topics from previous sessions that are relevant to this module
3. At the beginning of each module, review the purpose, contents and objectives
4. At the beginning of each unit, review the topic outline to enable participants understand how the module is organized

Facilitator-Participants Interaction

Depending on the manner in which you choose to facilitate the class, ask relevant questions on each of the questions in the Workbook. It is ideal to have participants attempt all the questions in their Workbook before the session.

Call on participants to read their answers

- Ask one person to volunteer to read first
- After he/she reads the answer, comment positively on it
- Let another person read his/her answer
- After he/she reads the answer, comment positively on it
- Compare and contrast what both have written or ask others if they see similarities or differences

Group Activities

Role plays, case studies, group discussions

- Give each participant a copy of the material to read or instructions on where the material is found in the Workbook
- Divide the participants into small groups. Tell each group to discuss the questions on the case study and provide answers to the questions that follow

During the presentations

- Ask if others have any additions
- Ask if others have any suggestions
- Comment on what they did well
- Offer suggestions for improvement
- Ask for lessons learnt
Assessing the Stages of Labour

Terminal Performance Objectives

After studying this unit, the CHO will be able to:

- Perform physical examination during labour
- Identify normal labour
- Monitor the different stages of labour using the partograph
- Practise effective infection prevention measures

Rationale

Mention why these objectives are important to CHOs:

- Examine a pregnant woman and assess the stages of labour
- Identify normal labour
- Monitor labour progression
- Practise effective infection prevention measures

Topic Outline

1. Physical Examination
2. Normal Labour
3. Monitoring Labour
4. Infection Prevention
Topic Outline 1: **Physical Examination**

**Facilitator-Participants Interaction**

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

1. What four (4) basic physical examinations should be conducted on a woman in labour?
   a. General
   b. Abdominal
   c. Vulval
   d. Vaginal

2. What are the major signs to look out for during each examination?
   a. General
      – appearance
      – build
      – stature
      – signs of anaemia, oedema and infection
   b. Abdominal
      – presenting part
      – descent
      – contractions
      – foetal heart beat
   c. Vulval
      – discharge
      – lesions
      – varicosities
      – warts
      – scars
Assessing the Stages of Labour

female genital cutting scars
d. Vaginal
   - vaginal wall temperature
   - moisture
   - cervical dilatation
   - state of bag of waters
   - amniotic fluid - colour and odour

Topic Outline 2: Normal Labour

Facilitator-Participants Interaction

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations etc.

1. What is normal labour?
   It is a process whereby the foetus, placenta & membrane are expelled through the birth canal, foetus is born at term, presents by the vertex, and is delivered spontaneously. Duration is not more than 18 hours.

2. What are the 3 positive signs of labour?
   a. Painful rhythmic uterine contractions
   b. Dilation of the cervical os
   c. Show

3. When do the following stages of labour begin and end?
   a. 1st stage:
      - from the onset of labour (dilation – 1cm) to full dilation of the cervical os (10cm)
   b. 2nd stage:
      - complete cervical dilation to expulsion of the foetus
   c. 3rd stage:
      - Separation and expulsion of the placenta and membranes till bleeding is controlled
d. 4th stage:
   - observation of baby and mother for 6 hours after delivery

**Activity 1: Group Activity on Labour and Delivery**

Divide the participants into small groups. Working in their groups, participants are to answer the questions below and present their work during the plenary:

1. Differentiate between true and false labour
2. How would you monitor the 1st, 2nd and 3rd stages of labour
3. List the infection prevention measures you will observe during vaginal examination
4. List the minimum logistics you will need for safe delivery

Make sure they are able to differentiate between true and false labour, monitor the stages of labour using the major observational signs shown.

<table>
<thead>
<tr>
<th>Observational Sign</th>
<th>True labour</th>
<th>False Labour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pains</td>
<td>Regular intervals</td>
<td>Irregular</td>
</tr>
<tr>
<td>Intervals</td>
<td>Shortens gradually</td>
<td>No change</td>
</tr>
<tr>
<td>Contractions</td>
<td>Duration &amp; severity</td>
<td>No change</td>
</tr>
<tr>
<td>Show</td>
<td>Increase</td>
<td>Absent</td>
</tr>
<tr>
<td>Cervical os</td>
<td>Dilatation</td>
<td>No dilatation</td>
</tr>
</tbody>
</table>

**Close Topic:** Summarise main ideas and link to the next topic

**Topic Outline 3: Monitoring Labour**

**Facilitator-Participant Interaction**

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc
Question and Answers

How often would you monitor during labour? These are listed in table 3.3 below.

Table 3.3: Monitoring of Labour

<table>
<thead>
<tr>
<th>Observation</th>
<th>1st Stage</th>
<th>2nd Stage</th>
<th>3rd Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP</td>
<td>4 hourly between contractions</td>
<td>15 minutes</td>
<td>Immediately after delivery of baby</td>
</tr>
<tr>
<td>Pulse</td>
<td>15 minutes between contractions</td>
<td>15 minutes</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Temperature</td>
<td>4 hourly between contractions</td>
<td>Hourly</td>
<td>Hourly</td>
</tr>
<tr>
<td>Respiration</td>
<td>4 hourly between contractions</td>
<td>30 minutes</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Foetal heart</td>
<td>Latent phase-hourly</td>
<td>In between contractions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Active phase – 30 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraction</td>
<td>Hourly</td>
<td>Every 30 minutes</td>
<td></td>
</tr>
</tbody>
</table>

Summarise main ideas and link to the next topic

Topic Outline 4: Infection Prevention Measures

Facilitator-Participant Interaction

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

1. What infection prevention measures should be observed during the following procedures?
   a. Vaginal examination
      - Washing of hands and drying them
      - Wearing of sterile gloves
   b. Swabbing of vulva
   c. Disposal of used items
   d. Processing of used items
2. Delivery
   a. Maintaining a clean environment
   b. Washing of hands and drying them
   c. Wearing of sterile gloves
   d. Disposal of used items
   e. Processing of used items

Close topic: Summarise main ideas and link to next topic
Unit 2
Managing Delivery

Terminal Performance Objectives

After studying this unit, the CHO will be able to:

- Conduct delivery according to the national protocol
- Manage 3rd stage of labour
- Manage and refer most common problems associated with labour and delivery

Rationale

Mention why these objectives are important to the CHOs:

- Conduct delivery
- Manage the 3rd stage of labour
- Identify, manage and refer problems and complications associated with labour and delivery

Topic Outline

1. Logistics Needed
2. Signs of 2nd Stage of Labour
3. Delivery Procedure
4. 3rd Stage of Delivery
5. Common Problems and Complications
6. Referral
Module 3 Safe Emergency Delivery

**Topic Outline 1: Logistics Needed**

**Facilitator-Participant Interaction**

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

List the minimum logistics the CHO will need to conduct the delivery

- a. Clothing for mother and child
- b. Protective clothing for the CHO (e.g. gloves, rubber apron)
- c. New blade and ligature
- d. Oxytocin
- e. Water and Bleach (0.5%)
- f. Resuscitation material e.g. Suction tube/SKAMGOA
- g. Dressings

**Activity 1: Group Work on 2nd stage Labour**

Divide participants into groups and ask each group to:

1. Identify signs of the 2nd stage of labour
2. List the steps they will follow to deliver the foetus
3. Indicate the infection prevention measures they will observe

After the activity:

4. Call on the groups to present
5. Guide discussions on each group’s presentation
6. Summarise and close the topic
Topic Outline 2: **Signs of Second Stage**

**Facilitator-Participant Interaction**

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

**Question and Answers**

1. What are the signs of the 2nd stage of labour?
   a. Expulsive uterine contractions
   b. Trickling of blood
   c. Vulva gaping
   d. Presenting part appearing
   e. Bulging of perineum

Topic Outline 3: **Delivery Procedure**

**Facilitator-Participant Interaction**

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstration, etc.

**Question and Answers**

1. What are the various positions used for delivery?
   a. Dorsal lithotomy
   b. Side lying – left lateral
   c. Squatting
   d. Hands and knees
   e. Semi sitting
<p>| | |</p>
<table>
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<td>(a)</td>
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<td>(b)</td>
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<td>(c)</td>
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<td>(d)</td>
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<td>(e)</td>
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</tbody>
</table>
2. Which one should the CHO adopt?
   The woman’s choice

3. Which infection prevention measures should the CHO adopt?
   a. Maintain clean environment
   b. Wash hands and dry them
   c. Maintain asepsis throughout delivery

Instructions:
Divide participants into groups. Ask them to choose someone to read the following case study out aloud

1. Ask each group to write the Infection Prevention (IP) measures and the delivery process on a flip chart for presentation and discussion

2. Compare the IP measures and the delivery process written by each group. Discuss any differences in the points presented

3. Write these on a flip chart for all to see

4. Write/compare these with answers in their Workbook and make the necessary correction for completeness

Activity 2: **Case Study on Conducting Delivery**

**Background**
Akosua Yaago is rushed to the community health compound at 6.00 pm in 2nd stage of labour with the baby’s head in the vagina. The CHO quickly puts her delivery kit on the table and gets ready to deliver Yaago.

What steps will she follow (in conformity with the national protocol) to deliver Yaago?

a. Encourage woman to push only when she has the urge to do so
b. Assist the woman with controlled pushing especially with the delivery of the head
c. Ask the woman not to push after delivery of the head
d. Gently wipe the baby’s face - eyes, nose and mouth
e. Feel for cord around neck
f. Allow restitution to take place
g. Deliver the anterior shoulder
h. Deliver the posterior shoulder
i. Deliver the rest of the body. Note time
j. If baby is normal (breathing), put baby on mother’s abdomen, (skin-to-skin) for her to hold, tie and cut the cord
k. Immediately assess if baby needs resuscitation (APGAR Score).
l. Dry baby with a clean cloth and wrap with a warm dry cloth
m. Cover mother and baby with another clean cloth
n. Put baby to breast as soon as he/she is born

Summary of steps in delivering a foetus

a. Deliver head by controlling the crowned head
b. Feel for cord around the neck
c. Deliver the anterior shoulder
d. Deliver the posterior shoulder
e. Deliver rest of the body
f. Tie and cut cord

Topic Outline 4: Third Stage of Labour

Facilitator-Participant Interaction

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

Questions and Answers

1. Ask participants to list the signs of placental separation.
   a. Uterus feels harder and round
   b. Lengthening of the cord
   c. Small gush of blood from the vagina
   d. Placenta in the vagina
2. How will you deliver the placenta?
   a. Put baby to breast as soon as he/she is born
   b. Use controlled cord traction to deliver the placenta
   c. Examine the placenta-lobe and membranes for completeness
3. How will you control bleeding during the 3rd stage?
   a. Massage the uterus after delivery of the placenta
   b. Verify if there is no undiagnosed twin before giving Oxytocin injection, make sure the bladder is kept empty
4. What is the commonest drug you can use to ensure firm contraction of the uterus?
   Oxytocin injection
5. Within the first hour after delivering the placenta, how often will you check the following vital signs?
   a. BP Every 15 minutes for 1 hour
   b. Pulse Every 15 minutes for 1 hour
   c. Temperature Hourly
   d. Respiration 15 minutes
   e. Fundus 15 minutes
   f. Bleeding Continuously

**Topic Outline 5: Common Problems and Complications**

**Facilitator-Participant Interaction**
Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

**Question and Answers**
1. List the common problems and complications you are likely to face during:
   a. Labour: Foetal/maternal distress, APH
   b. Delivery: Cord prolapse/malpresentation
   c. 3rd stage: Delay in the delivery of the placenta and bleeding
Topic Outline 6: **Referral**

**Facilitator-Participants Interaction**
Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

**Question and Answers**

1. Explain the steps you will take in referring women with common problems and complications in the 1st, 2nd and 3rd stages of labour
   a. Work with community to establish emergency transport system and emergency funds for obstetric emergencies
   b. Recognize problems and complications at an early stage
   c. Explain the need for referral to family members
   d. Perform obstetric first aid including stabilization
   e. Complete referral form
   f. Accompany client when necessary
   g. Get feedback

**Activity 3: Case Study on Referral for Delivery**

1. Break participants into small groups.
2. Have participants in each group read and discuss the following case study.
3. Ask each group the questions that follow.

**Background**

Madam Abiba, a primipara and 36 weeks pregnant is brought to the community health compound by her mother and husband. Abiba complains of severe lower abdominal pain which has been on and off for the past 24 hours. On examination, the CHO observes that Madam Abiba is healthy, the contractions are irregular and weak with no descent of the presenting part and the cervix is 1cm dilated.

The CHO explains her findings to the mother and the husband. She goes on further to explain to them on the need for referral to the next level for delivery.
Questions and Answers

1. In what phase of labour is Madam Abiba?
   a. Latent phase

2. Why is the CHO referring Madam Abiba to the next level.
   a. Abiba is a primipara
   b. In the latent phase - dilatation is 1cm
   c. Contraction irregular and weak

3. What preparations should the CHO make for the referral of Madam Abiba?
   A. Explain the need for referral to her mother and husband
   b. Ensure birth preparedness
   c. Arrange for transport
   d. Give first aid and stabilisation
   e. Complete referral note
   f. Accompany client where necessary
   g. Get feedback

4. How does the CHO get the feedback from the referral centre?
   a. Request for feedback on the referral note
   b. Request husband to give feedback
   c. Follow up to Madam Abiba’s home

Activity 4: Case Study on Emergency Delivery

Instructions:
Break participants into small groups. Have participants in each group read and discuss the following case study.

Background
A CHO returned from an outreach session to meet Madam Foriwaa who is a multipara of 2, with her children all alive and her husband at her compound. Foriwaa complains of severe lower abdominal pains and losing liquor. On examination, she is found to be in labour with 8cm dilatation. What will you do as a CHO to ensure safe delivery of mother and baby?
Questions and Answers

1. In what phase is Madam Foriwaa?
   
   Active phase

2. What shows she is in the active phase?
   
   a. Severe lower abdominal pain
   b. Losing liquor
   c. Dilatation of 8cm

3. How would you prepare to deliver Foriwaa?
   
   a. Set delivery kit on a table
   b. Prepare basic resuscitation materials e.g. suction tube
   c. Ask her to empty her bladder
   d. Assist her into position of her choice
   e. Put on protective clothing
   f. Wash hands with soap and water and dry them
   g. Wear sterile gloves
   h. Swab vulva and confirm dilatation

4. How often would you monitor Foriwaa?
   
   a. Vital signs – every 15 minutes
   b. Foetal heart – after each contraction
   c. Observe for descent of presenting part after each contraction
   d. Urge to push with each contraction

5. What position would you adopt to deliver her?
   
   Position of her choice e.g. dorsal lithotomy, side lying, left lateral, squatting, hands and knees

Close topic: Summarise main ideas and link to next topic
Checklist 3.1: Performance Guide for Emergency Delivery

Instructions:
Rate the performance of each task/activity observed using the following rating scale.

0  -  Task/Activity omitted
1  -  Task/Activity incorrectly performed
2  -  Task/Activity correctly performed (Hesitated)
3  -  Task/Activity correctly done and with confidence
N/A -  Task/Activity not required in this observation

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<thead>
<tr>
<th>Task/Activity</th>
<th>Rating</th>
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<tbody>
<tr>
<td>Delivery of Baby</td>
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<tr>
<td>1. Sets delivery trolley/pre-packet kit</td>
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<tr>
<td>2. Explains procedure to client</td>
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<tr>
<td>3. Asks client to adopt position of her choice</td>
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<td>4. Puts on protective clothing</td>
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<td>5. Washes and dries hands</td>
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<td>6. Draws 10 units of oxytocin in syringe</td>
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<td>7. Wears sterile gloves</td>
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<td>8. Puts clean cloth under the client</td>
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<td>9. Swabs vulva</td>
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<td>10. Confirms signs of 2nd stage of labour</td>
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<td>11. Applies pad or small clean cloth to anus</td>
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<td>12. Encourages client to bear down with contractions</td>
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<td>13. Places fingers on the head when fixed at the vulva</td>
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<td>14. Maintains flexion of the head</td>
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<td>15. Delivers head by extension when crowning takes place</td>
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<td>16. Cleans eyes, face and mouth</td>
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<td>17. Feels for cord around the neck</td>
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<td>18. Waits for restitution of head</td>
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<td>N/A</td>
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<tr>
<td>19. Delivers anterior shoulder</td>
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<tr>
<td>20. Guides the baby and delivers the posterior shoulder and the rest of the baby</td>
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<tr>
<td>21. Asks mother to hold the baby, dries baby and sucks mouth if necessary</td>
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<td>22. Checks Apgar score at 1st minute.</td>
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<td>23. Clamps and cuts cord and rinses hands</td>
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<tr>
<td>24. Palpates abdomen for presence of another foetus</td>
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**Active Management of 3rd Stage of Labour (AMTSL)**

1. Gives 10 units of oxytocin.
2. Removes placenta by Controlled Cord Traction (CCT).
3. Examines placenta and membranes
4. Massages uterus and expels clots
5. Examines genital tract
6. Congratulates mother
7. Observes infection prevention practices
8. Records findings

**Immediate Care of Mother and Baby**

1. Mother
2. Makes mother comfortable
3. Assesses and records blood loss
4. Checks pulse and blood pressure
5. Gives a drink to mother

**Baby**

1. Changes baby’s wet cloth and keeps it warm with mother
2. Assesses Apgar score at 5 minutes
3. Initiates breast feeding if possible

**4th Stage of Labour**
### Task/Activity Rating

<table>
<thead>
<tr>
<th>Task/Activity</th>
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<tbody>
<tr>
<td>1. Keeps mother comfortable in bed</td>
<td>0</td>
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<tr>
<td>2. Feels for uterine contraction</td>
<td>1</td>
</tr>
<tr>
<td>3. Inspects pad or vulval cloth</td>
<td>2</td>
</tr>
<tr>
<td>4. Monitors mother’s temperature, pulse and blood pressure</td>
<td>3</td>
</tr>
<tr>
<td>5. Observes baby and puts baby to breast if not already done</td>
<td>N/A</td>
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<tr>
<td>6. Records all findings and gives mother feedback</td>
<td>0</td>
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<td>7. Takes decision where necessary</td>
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</table>

### Subsequent Care

<table>
<thead>
<tr>
<th>Task/Activity</th>
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<tbody>
<tr>
<td>1. Carries out examination of the newborn from head to toe</td>
<td>0</td>
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<tr>
<td>2. Continues monitoring the established respiration by keeping the airway clear</td>
<td>1</td>
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<tr>
<td>3. Maintains warmth by keeping the baby covered in warm, clean clothes and keep the baby with his/her mother</td>
<td>2</td>
</tr>
<tr>
<td>4. Continues to observe and facilitate breastfeeding on demand</td>
<td>3</td>
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<tr>
<td>5. Observes the colour, respirations, heart beat, cry, umbilical cord, bowel action, sleep and urinary output</td>
<td>N/A</td>
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<tr>
<td>6. Maintains proper hygiene and warmth by bathing the baby no sooner than six (6) hours after birth and with warm water</td>
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<tr>
<td>7. Dresses cord</td>
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<tr>
<td>8. Ensures rooming in/bedding in</td>
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<tr>
<td>9. Continues exclusive breastfeeding on demand</td>
<td>3</td>
</tr>
<tr>
<td>10. Weighs baby, immunizes baby (BCG, Polio 0)</td>
<td>N/A</td>
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<tr>
<td>11. Records immunization and weight on health card</td>
<td>0</td>
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</tbody>
</table>
Checklist 3.2: Performance Guide for Emergency Normal Delivery

Instructions:
Rate the performance of each task/activity observed using the following rating scale.

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<tr>
<th>Rating</th>
<th>Description</th>
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<tbody>
<tr>
<td>0</td>
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</tr>
<tr>
<td>1</td>
<td>Task/Activity incorrectly performed</td>
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<tr>
<td>2</td>
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<tr>
<td>3</td>
<td>Task/Activity correctly done and with confidence</td>
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<tr>
<td>N/A</td>
<td>Task/Activity not required in this observation</td>
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<th>Task/Activity</th>
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<tbody>
<tr>
<td>1. <strong>Delivery of Baby</strong></td>
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<tr>
<td><strong>Preparation:</strong></td>
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<tr>
<td>a) Prepares the necessary equipment</td>
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<td>b) Allows woman to push spontaneously</td>
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<td>c) Allows woman to adopt the position of her choice</td>
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<td>d) Explains procedure to her and listen to her questions</td>
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<tr>
<td>e) Puts on protective material</td>
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<tr>
<td><strong>Delivery of the Head:</strong></td>
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<tr>
<td>a) Washes hands and puts on gloves</td>
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<tr>
<td>b) Swabs vulva and perineum</td>
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<td>c) Puts fingers on head and applies a gentle downward pressure to maintain flexion</td>
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<tr>
<td>d) Delivers head by extension when crowning takes place</td>
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<tr>
<td>e) Feels for cord around neck</td>
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<td>f) Allows restitution and external rotation of head and internal rotation of shoulders</td>
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<td>g) Wipes baby’s face with clean gauze</td>
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<tr>
<td><strong>Delivery of shoulders:</strong></td>
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<tr>
<td>a) Makes sure shoulders are in anterior-posterior diameter of outlet</td>
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<td>Task/Activity</td>
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<tr>
<td>b) Applies gentle downward traction on the head using both hands</td>
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<td>c) Allows anterior shoulders to escape under the symphysis pubis</td>
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<tr>
<td>d) Guides head in an upward curve to deliver the posterior shoulders from the perineum</td>
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<tr>
<td>e) Delivers the rest of the body by lateral flexion unto mother’s abdomen (skin to skin). Note the time</td>
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<td>f) Assesses the condition of the baby by Apgar score in the 1st minute</td>
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<td>g) Wipes the baby’s body to prevent hypothermia and asks mother to hold him/her</td>
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<td>h) Clamps and cuts the cord</td>
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<tr>
<td>i) Palpates the abdomen to exclude another foetus.</td>
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<tr>
<td>j) Puts baby to breast if practicable and asks her to keep close eye on baby’s colour</td>
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<td>k) Gives 10 units of oxytocin</td>
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**3rd Stage:**

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<tr>
<th>Task/Activity</th>
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<tbody>
<tr>
<td>a) Rinses hands in 0.5% chlorine solution</td>
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<tr>
<td>b) Feels for uterine contractions. If present, position hand at the symphysis pubis and pushes uterus gently upwards</td>
<td>0</td>
</tr>
<tr>
<td>c) Winds cord around forceps and finger; applies gentle downward traction to deliver the placenta. (Controlled Cord Traction-CCT). Note the time</td>
<td>0</td>
</tr>
<tr>
<td>d) Teases the membranes out gently using both hands if placenta is seen</td>
<td>0</td>
</tr>
<tr>
<td>e) Examines the placenta and membranes for completeness</td>
<td>0</td>
</tr>
<tr>
<td>f) Massages the uterus to maintain contraction and to expel clots</td>
<td>0</td>
</tr>
<tr>
<td>g) Rinses hands again, swabs vulva and examines the genital tract for tears</td>
<td>0</td>
</tr>
<tr>
<td>h) Teaches mother how to massage the uterus</td>
<td>0</td>
</tr>
<tr>
<td>Task/Activity</td>
<td>Rating</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>i) Keeps mother clean and comfortable and congratulates her</td>
<td></td>
</tr>
<tr>
<td>2. <strong>Immediate Care of Mother and Baby After Delivery to 4th Stage (1st six hours after delivery)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Baby:</strong></td>
<td></td>
</tr>
<tr>
<td>a) Keeps baby warm and dry by changing the wet cloths</td>
<td></td>
</tr>
<tr>
<td>b) Assesses Apgar score at 5 minutes</td>
<td></td>
</tr>
<tr>
<td>c) Observes cord for bleeding</td>
<td></td>
</tr>
<tr>
<td>d) Observes baby’s excretion (meconium and urine)</td>
<td></td>
</tr>
<tr>
<td>e) Keeps baby with mother and initiates breast feeding if not done already</td>
<td></td>
</tr>
<tr>
<td><strong>Mother:</strong></td>
<td></td>
</tr>
<tr>
<td>a) Continues to massage uterus and expels clots at every 15 minutes for one hour</td>
<td></td>
</tr>
<tr>
<td>b) Listens to mother’s complaints and addresses them</td>
<td></td>
</tr>
<tr>
<td>c) Gives mother something to drink</td>
<td></td>
</tr>
<tr>
<td>d) Teaches mother or support person how to massage the uterus</td>
<td></td>
</tr>
<tr>
<td>e) Teaches mother and support person the danger signs of baby and mother:- bleeding from cord or vagina, breathing difficulty in baby, blue lips and hands of baby</td>
<td></td>
</tr>
<tr>
<td>f) Records temperature, pulse, blood pressure, lochia and urinary output over the next six hours</td>
<td></td>
</tr>
<tr>
<td>3. <strong>Apply infection prevention procedure:</strong></td>
<td></td>
</tr>
<tr>
<td>a) Decontaminates used items</td>
<td></td>
</tr>
<tr>
<td>b) Processes used instruments/items</td>
<td></td>
</tr>
<tr>
<td>c) Disposes of placenta and used dressings and gloves</td>
<td></td>
</tr>
<tr>
<td>d) Cleans the bed and floor using chlorine solution 0.5%</td>
<td></td>
</tr>
<tr>
<td>4. <strong>Decision making:</strong></td>
<td></td>
</tr>
<tr>
<td>Refers immediately if any of the following occurs:</td>
<td></td>
</tr>
<tr>
<td>Task/Activity</td>
<td>Rating</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>a) Prolonged 2nd stage of labour of more than 1 hour</td>
<td></td>
</tr>
<tr>
<td>b) Retained placenta with bleeding or no bleeding</td>
<td></td>
</tr>
<tr>
<td>5. <strong>Bleeding with placenta out</strong></td>
<td></td>
</tr>
<tr>
<td>a) Massages uterus</td>
<td></td>
</tr>
<tr>
<td>b) Repeats oxytocin</td>
<td></td>
</tr>
<tr>
<td>c) Asks relatives to arrange for transportation</td>
<td></td>
</tr>
<tr>
<td>d) Applies external bimanual compression of the uterus and refer</td>
<td></td>
</tr>
<tr>
<td>6. <strong>Asphyxiated baby:</strong></td>
<td></td>
</tr>
<tr>
<td>a) Resuscitates baby with Ambu bag or SKAMGOA.</td>
<td></td>
</tr>
<tr>
<td>b) Keeps baby warm and dry</td>
<td></td>
</tr>
<tr>
<td>c) Refers if condition does not improve. Otherwise continues to monitor condition and encourages breast feeding.</td>
<td></td>
</tr>
</tbody>
</table>

**Checklist 3.3: Performance Guide for External Bi-Manual Compression of the Uterus**

**Instructions:**

Rate the performance of each task/activity observed using the following rating scale.

- 0 - Task/Activity omitted
- 1 - Task/Activity incorrectly performed
- 2 - Task/Activity correctly performed (Hesitated)
- 3 - Task/Activity correctly done and with confidence
- N/A - Task/Activity not required in this observation

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Before Procedure:</strong></td>
<td></td>
</tr>
<tr>
<td>a) Explains procedure to woman and support person</td>
<td></td>
</tr>
<tr>
<td>b) Rubs uterus to make it contract</td>
<td></td>
</tr>
</tbody>
</table>
### Task/Activity

<table>
<thead>
<tr>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Task/Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>c) Gives oxytocin</td>
</tr>
<tr>
<td>d) Expels clots from the uterus and vagina</td>
</tr>
<tr>
<td>e) Ensures that the bladder is empty</td>
</tr>
<tr>
<td>2. <strong>During Procedure:</strong></td>
</tr>
<tr>
<td>a) Talks to the woman continuously to keep her awake.</td>
</tr>
<tr>
<td>b) Places hand on the lower abdomen and gently presses the uterus upwards to push lower uterine segment up</td>
</tr>
<tr>
<td>c) Places one hand flat on the abdomen and the other hand flat behind uterus</td>
</tr>
<tr>
<td>d) Presses uterus with both hands for about 20 minutes</td>
</tr>
<tr>
<td>e) Asks a family member to put the baby to the breast if practicable</td>
</tr>
<tr>
<td>f) Inspects vulva to see if bleeding has stopped</td>
</tr>
<tr>
<td>3. <strong>After Procedure:</strong></td>
</tr>
<tr>
<td>a) Estimates blood loss. (Refers woman if heavy)</td>
</tr>
<tr>
<td>b) Gives plenty of fluids orally, if client is not referred</td>
</tr>
<tr>
<td>c) Continues to observe the vulva for bleeding and the uterus for contractions</td>
</tr>
<tr>
<td>d) Monitors pulse and blood pressure</td>
</tr>
</tbody>
</table>
Checklist 3.4: Performance Guide for Infant Resuscitation using SKAMGOA

Instructions:

Rate the performance of each task/activity observed using the following rating scale.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Task/Activity omitted</td>
</tr>
<tr>
<td>1</td>
<td>Task/Activity incorrectly performed</td>
</tr>
<tr>
<td>2</td>
<td>Task/Activity correctly performed (Hesitated)</td>
</tr>
<tr>
<td>3</td>
<td>Task/Activity correctly done and with confidence</td>
</tr>
<tr>
<td>N/A</td>
<td>Task/Activity not required in this observation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 N/A</td>
<td></td>
</tr>
<tr>
<td>1. Clears air passage, mouth first and where necessary, nostrils</td>
<td></td>
</tr>
<tr>
<td>2. a) Uses a sucker (electric or manual pump) or catheter</td>
<td></td>
</tr>
<tr>
<td>b) Wraps a little gauze around the small finger and clears mucus from the mouth</td>
<td></td>
</tr>
<tr>
<td>c) Sucks mucus from the mouth with a bulb syringe</td>
<td></td>
</tr>
<tr>
<td>3. Keeps baby dry and warm</td>
<td></td>
</tr>
<tr>
<td>a) Wipes baby's body gently and quickly with the cloth used to receive him</td>
<td></td>
</tr>
<tr>
<td>b) Covers him with a new dry cloth</td>
<td></td>
</tr>
<tr>
<td>4. Positions the baby's head in a slightly extended position with baby on his back so as to open the air passage</td>
<td></td>
</tr>
<tr>
<td>5. Places folded cloth or a towel under the shoulders to maintain the slightly extended position of the head</td>
<td></td>
</tr>
<tr>
<td>6. Positions the SKAMGOA on baby's face so that the nose and mouth are seen through it</td>
<td></td>
</tr>
<tr>
<td>6. Forms a seal by placing the finger and thumb of one hand around the SKAMGOA and maintains it in position with little pressure.</td>
<td></td>
</tr>
<tr>
<td>8. Checks the seal by ventilating twice (give two breaths) and observes the rise and fall of the chest.</td>
<td></td>
</tr>
</tbody>
</table>
9. Ventilates by giving 30 breaths per minute. After each cycle, i.e. 30 breaths, observes if the chest is rising and falling easily.

10. Repeats the cycle until the baby breaths normally.

11. Repeats suction of the mouth after each cycle if there is a need.

12. Observes the baby’s skin for a pink colouration and regular respiration and if satisfied, stops the procedure.

13. Washes and dries hands.

14. Educates mother or her relatives to observe the baby to see if its chest is rising and falling regularly and its entire body pink in colour, and to report to the provider if any change is observed.

---

Checklist 3.5: Performance Guide for Infant Resuscitation using Face Mask or Ambu-Bag

Instructions:

Rate the performance of each task/activity observed using the following rating scale.

0 - Task/Activity omitted
1 - Task/Activity incorrectly performed
2 - Task/Activity correctly performed (Hesitated)
3 - Task/Activity correctly done and with confidence
N/A - Task/Activity not required in this observation

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Clear airway, mouth first and nose if necessary</td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>2. Keeps baby dry and warm</td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>3. Selects an appropriate mask size (1 for normal baby and 0 for small baby)</td>
<td>0 1 2 3 N/A</td>
</tr>
<tr>
<td>Task/Activity</td>
<td>Rating</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>4. Positions the baby with neck slightly extended, by placing a folded piece of cloth under the shoulders</td>
<td></td>
</tr>
<tr>
<td>5. Forms a seal between the mask and baby’s face</td>
<td></td>
</tr>
<tr>
<td>a) Places mask on baby’s face to cover chin, mouth and nose</td>
<td></td>
</tr>
<tr>
<td>b) Places your thumb and index fingers on the mask and applies gentle pressure</td>
<td></td>
</tr>
<tr>
<td>c) Supports the chin with remaining 3 fingers; places the heel of his/her hand on the forehead to maintain position of the neck</td>
<td></td>
</tr>
<tr>
<td>6. Checks seal</td>
<td></td>
</tr>
<tr>
<td>a) Pumps/squeezes bag 2 to 3 times with fingers only or whole hand depending on size of the bag</td>
<td></td>
</tr>
<tr>
<td>b) Observes for the rise of the chest</td>
<td></td>
</tr>
<tr>
<td>7. Checks for probable cause and takes corrective action if the chest is not rising</td>
<td></td>
</tr>
<tr>
<td>8. Ventilates the newborn with 30 – 60 breaths per minute if seal is formed (First ventilation requires higher inflation pressure than later ventilation)</td>
<td></td>
</tr>
<tr>
<td>9. Stops after every minute and look for spontaneous breathing</td>
<td></td>
</tr>
<tr>
<td>10.继续 until spontaneous cry/breathing begins (Stop breathing for baby when it starts to cry)</td>
<td></td>
</tr>
<tr>
<td>11. Observes the chest for an easy rise and fall (breathing) when baby stops crying</td>
<td></td>
</tr>
<tr>
<td>12. Continues breathing for baby if baby’s breathing is slow (less than 30 breaths per minute) and seeks medical aid</td>
<td></td>
</tr>
<tr>
<td>13. Stops the procedure if its breathing is 30 – 60 breaths per minute</td>
<td></td>
</tr>
<tr>
<td>14. Ties cord and keeps baby dry and warm and continues to observe baby while attending to the mother</td>
<td></td>
</tr>
<tr>
<td>15. Stops procedure if baby does not respond after 20 minutes</td>
<td></td>
</tr>
<tr>
<td>16. Applies infection prevention procedure following use of Ambu bag</td>
<td></td>
</tr>
</tbody>
</table>
Unit 1

The CHO has only had some basic training in obstetrics and thus is limited in the management of obstetric conditions. Nevertheless, he or she may be faced with an emergency normal delivery where a woman comes to a CHPS compound in the second stage of labour or for that same reason, he or she may be called to a client’s home. In such a situation, it is important for him or her to follow some laid down procedures in order to save a mother and her baby.

He or she should have a clear understanding of and should be able to define emergency normal delivery. Emergency normal delivery is a delivery by a health care provider when a woman is in an advanced stage of labour or the woman is ready to deliver, i.e. she is in the second stage of labour.

Stages of Labour:

It is important for the CHO to know and understand the stages of labour in order to recognize where he/she fits with regards to the management of labour in the community.

- **First Stage**: It starts from the onset of true labour, i.e. the presence of bloody mucoid discharge from the vagina (show), regular uterine contractions and dilatation of the cervical os from 1cm and ends with full dilatation (10cm). It should not last for more than 8 hours. A woman who reports to the CHO at this stage of labour must be referred to the next health facility for monitoring by a midwife.

- **Second Stage**: It starts from full dilatation of the cervical os to complete birth of the baby. It should not last for more than one hour. The duration may be considerably less in women with good expulsive uterine contractions.

**How is the second stage recognized?** Look for the signs of the second stage of labour which are:

- vulva gapes
- perineum bulges
- anus gapes
- head is seen with uterine contractions
- the woman pushes (expulsive contractions)
- membrane may rupture (colour of liquor is normally clear and not offensive)
• **Third stage**: It starts from the birth of the baby to the complete expulsion of the placenta and membranes and the control of bleeding. It should not last for more than 30 minutes. The use of the active management of the third stage of labour (AMTSL) shortens the third stage and controls bleeding. It provides a very effective way of controlling bleeding and must be encouraged.

**The steps in AMSTL are:**

- giving of oxytocin
- removal of the placenta by controlled cord traction (CCT),
- uterine massage

• **Fourth Stage**: This corresponds to the first six hours after delivery during which the woman and the baby are critically observed. *(See learning guide on emergency normal delivery)*

**Perform Physical Examination**

The following steps should be used in examining a woman in labour

- General examination
- Abdominal examination
- Vulval examination
- Vaginal examination

The following information will be required to identify any deviations from the normal.

- Definition of labour
- Normal labour
- Stages
- True and false labour
- Monitoring
  - vital signs
  - descent of presenting part
  - cervical dilatation
  - amniotic fluid
Infection prevention measures during:
- Vaginal examination
- Delivery
- Also in all other procedures

Unit 2

Logistics needed
- Clothing for mother & child
- Blade & ligature
- Protective clothing
- Water/bleach
- Drug e.g. Oxytocin injection
- Resuscitation materials
- Dressing

Signs of 2nd Stage
- Full cervical dilatation
- Presenting part in vagina

Delivery procedure
- Positioning
- Infection prevention
- Delivery

Signs of placental separation
- Lengthening of cord
- Gush of blood
- Placenta in vagina
Delivery of placenta
- Controlled cord traction

Controlling bleeding
- Expel clot
- Massage uterus
- Give Oxytocin injection

Placenta Examination
- Lobes
- Membranes

Drug Administration
- Oxytocin injection

Monitoring
- Vital signs every 15 minutes for the first one hour after delivery
- Uterine contraction
- Bleeding

Common Problems
- Maternal/foetal distress
- Cord prolapse/presentation
- Retained placenta
- Bleeding

Referral
- Complete referral note
- Transport to next level
Feedback on referral

Assessment of the baby’s condition at birth:

This is done using the Apgar score rating which is accepted in all health facilities. It will help the provider to identify babies who have to be breathed for.

How to conduct Apgar score on a baby:

Table 3.4: Conducting Apgar Score

<table>
<thead>
<tr>
<th>Signs</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>A - Appearance (Colour)</td>
<td>Blue or pale body and face</td>
<td>Pink body, blue or pale arms and face</td>
<td>Completely pink body and face</td>
</tr>
<tr>
<td>P – Pulse or heart beat</td>
<td>No heart beat</td>
<td>Heart beat or pulse less than 100 bpm</td>
<td>Heart beat or pulse more than 100 bpm</td>
</tr>
<tr>
<td>G – Grimace or response reflex action</td>
<td>No response</td>
<td>Puckering on squeezing face</td>
<td>Crying coughing or sneezing</td>
</tr>
<tr>
<td>A – Activity</td>
<td>No movement in Limps and arms in response to stimulation</td>
<td>Some movement to stimulation</td>
<td>Active movement waving arms and legs</td>
</tr>
<tr>
<td>R – Respiratory</td>
<td>No breathing</td>
<td>Slow irregular breathing (Gasping respiration)</td>
<td>Strong cry</td>
</tr>
<tr>
<td></td>
<td>No crying</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Most babies need only cleaning of face and mouth but a baby with an Apgar score of 6 and below needs to be resuscitated.

Common Problems in Labour and Delivery:

- **Maternal distress**: The mother looks exhausted and anxious, has a raised pulse, temperature, blood pressure and lips and mouth dry and yet refuses fluid intake. Encourage oral intake of fluids. Ask support person to assist in this.

- **Foetal distress**: Foetal heart rate swings or may be more than 160 or below 120 bpm. There is meconium stained liquor if membranes have ruptured and excessive foetal movements seen by the health provider or felt by the mother.
In both cases of maternal and foetal distress, the woman has to be referred.

- **Cord prolapse/presentation:**
  - Put cord back into the vagina and apply a pad firmly
  - Let the woman lie on her left side with a pillow under her buttocks (This will prevent pressure of the presenting part of the baby on the cord)
  - Refer

- **Retained placenta:**
  - Give fluids orally and refer

- **Bleeding:**
  - Perform external bimanual compression of the uterus
    - *(See learning guide on external bimanual compression)*
    - Give fluids orally and refer if bleeding does not stop

- **Asphyxiated baby:**
  - Resuscitate baby using ambu bag or SKAMGOA

**Referral**

Referral is part of management of abnormal conditions that may occur in obstetrics. The health provider must be conversant with the danger signs of pregnancy, labour, post-partum (mother and baby) so as to take quick and appropriate actions. Use the GHS referral forms.

**Points to note on referral:**

- Explain the procedure to the woman and her relatives and make sure the referral form has been completely filled with particular attention given to the time, date, the reason for the referral and the treatment/drugs that have been given
- If a drug has been given, note the name of the drug, dosage, time given and the route of administration
- Since the need for referral is possible in obstetric practice, intensify education on birth preparedness and complications response during the antenatal period. Educate community members to assist with transportation and money as well as the danger signs in pregnancy, labour and post-partum period. This would enable them to refer mother or baby early if they need assistance.
- The health provider should be conversant with the referral health facility which has the necessary logistics and personnel to manage obstetric complications.

- Always ask for feedback on the referral

**Note:**
Accurate record keeping is a great asset to obstetric management.
Purpose and Organisation

The Community Health Officer needs special skills to provide quality care to postnatal clients and the newborn during the immediate and late postnatal period at home and in the community.

This module has four units that cover the essential issues and procedures needed to develop skills in assisting postnatal clients and their families to improve their health.

Objectives

Review these objectives now and all subsequent unit objectives as you begin each unit by:
- Reading each objective yourself or
- Having a participant read the objectives aloud to the group

After studying this module, the CHO will be able to:

1. Assess postnatal clients (mothers and babies)
2. Provide quality care to a client in the immediate postnatal period at home and in the community
3. Provide health education on postnatal care to clients and their families
4. Identify complications and problems of postnatal period, give immediate care and refer where necessary

Contents

Unit 1: Care of Clients Immediate Post-partum (0-7 Days) at Home and in the Community
Unit 2: Care of Clients during Late Postnatal Period (8-40 Days)
Unit 3: Care of Newborns at Home (Different From Delivery Section)
Unit 4: Health Education for Postnatal Clients

Expected Outcome

Knowledge:
- Examination of postnatal mother and baby
- Problems of immediate post-partum care
• Client assessment and classification of problems/complications
• Referral and follow-up

Attitudes:
• Confidentiality
• Kindness
• Initiative and drive
• Tact and socio-cultural sensitivity
• Respect
• Self discipline
• Understanding
• Tolerance

Skills:
• Examination of postnatal mother and baby
• Decision-making
• Investigation
• Communication and interpersonal relationship
• Immunisation
• Recording and reporting
• Monitoring

Table 4.1: Materials Needed

<table>
<thead>
<tr>
<th>Samples</th>
<th>CHO Materials</th>
<th>Facilitator Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Child Health</td>
<td>• Stationery</td>
<td>• Overhead projector (where available)</td>
</tr>
<tr>
<td>• Record Book or Child Welfare Card</td>
<td>- pencils</td>
<td>• Transparencies</td>
</tr>
<tr>
<td></td>
<td>- pens</td>
<td>• Felt pens/Markers</td>
</tr>
<tr>
<td></td>
<td>- note pad</td>
<td>• Flip chart stand and sheet</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Baby doll</td>
</tr>
</tbody>
</table>
Teaching Methods

- Use learner-centered methods in this module
- Introduce new materials through a guided discussion.
- Start each unit with a guided discussion.

Help participants apply their knowledge in “real life” situations. In addition field practice is highly recommended.

Getting Started

1. Do a warm-up exercise
2. Review any topics from previous sessions that are relevant to this module
3. At the beginning of each module, review the purpose, contents and objectives
4. At the beginning of each unit, review the topic outline to enable participants understand how the module is organised

Facilitator-Participant Interaction

Depending on the manner in which you choose to facilitate the class, ask relevant questions on each of the questions in the Workbook. It is ideal to have participants attempt all the questions in their Workbook before the session

Call on participants to read their answers

- Ask one person to volunteer to read first
- After he/she reads the answer, comment positively on it
- Let another person read his/her answer
- After he/she reads the answer, comment positively on it
- Compare and contrast what both have written or ask others if they see similarities or differences.
Group Activities

Role plays, case studies, group discussions

• Give each participant a copy of the material to read or instructions as to where the material is found in the Workbook

• Divide the participants into small groups. Tell each group to discuss the questions on the case study and provide answers to the questions that follow

During the presentations

• Ask if others have any additions

• Ask if others have any suggestions

• Comment on what they did well

• Offer suggestions for improvement

• Ask for lessons learnt
Unit 1

Care of Post-partum Clients (0-7 days) at Home and in the Community

Terminal Performance Objectives

After studying this unit, the CHO will be able to:

- Provide health education to postnatal mothers, their families and the community
- Counsel and assist mothers to provide care to their babies

Rationale

Mention why these objectives are important to the CHOs:

- Enable CHOs to provide health education
- Enable CHOs to counsel and assist mothers to provide care to their babies

Topic Outline

1. Purpose of immediate postnatal care (PNC)
2. Immediate PNC
3. Health problem during immediate postnatal period
4. Dealing with harmful traditional practices
Topic Outline 1: **Purpose of Postnatal Care**

**Facilitator-Participant Interaction**

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

Ask participants to mention reasons for postnatal care

- Immediate postnatal period is the period from delivery up to 7 days
- Because of the delivery, the woman’s body is going through several changes, and she needs to adjust to these changes
- The postnatal woman therefore needs care to help her maintain her health and prevent diseases
- The purposes of postnatal care are:
  - Maintain health
  - Help the body cope with changes following pregnancy and delivery
  - Help the woman care for her body appropriately
  - Prevent diseases and other health problems
  - Promote family support and integration

Topic Outline 2: **Care Given During Postnatal Period**

**Facilitator-Participants Interaction**

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

What care does the postnatal woman require?

a. **Nutrition:**
   - Adequate nutrition is required to meet her own body requirement and meet the needs of her body by producing adequate milk
   - There should be adequate intake of water and other fluids
   - Diet should be balanced
b. Personal Hygiene: This includes:
   ▶ Regular daily baths
   ▶ Regular care of the genital areas
   ▶ Washing the breasts and keeping them dry
   ▶ Care of clothing and hair

c. Adequate Exercises and Rest

d. Emotional Support

There should be care from the husband, family members and close associates.
It helps the woman to cope with the stresses of delivery and caring for the baby

Activity 1: Case Study on Postnatal Care

Background

You visited Madam Adizah in her home. During your interaction with her, Madam Adizah informs you that she delivered two days ago with the assistance of the TBA.

Questions and Answers

1. What topics should be covered during the first review visit by the CHO?
   a. Education should be given on the various foods rich in protein, calcium and vitamins. Information should also be given on the dangers associated with the abuse of drugs, alcohol intake and harmful traditional practices concerning food consumption
   b. Mother is educated on personal hygiene, use of sanitary pads, care of breasts and nipples
   c. Mother is educated on the danger signs of the postnatal period (fever, lower abdominal pain, offensive vaginal discharge, excessive bleeding) and know that she should go to the health facility immediately if any of these problems develop
   d. Mother should be encouraged to breastfeed exclusively for six months and taught how to deal with problems that may arise, such as sore nipples and difficulties with suckling
   e. Education is also given on the care of the baby, especially if infant develops fever, diarrhoea, difficulty in breathing or refuses to feed
f. Other information given will deal with immunisation schedule for the baby, post-partum exercises and birth spacing. The baby’s first immunisation (BCG and Polio 0) is given at birth.

g. Discussions on family planning which started during the antenatal period is continued. Information is given on the choice of available contraceptive methods and how to get services and supplies.

h. Postnatal exercises

i. Educate on the use of Insecticide Treated Net (ITN)

j. Growth monitoring

k. Educate mother to visit postnatal clinic for assessment

2. What role can the CHO play in ensuring that the information given is adhered to by the post-partum woman?

   a. The CHO can reinforce the message given. The CHO can also support the woman to identify hindrances or factors which prevent her from utilising the information. He/she can identify ways of involving her family members, especially her partner in discussions about the welfare of baby and mother.

   b. Ask her to demonstrate how to position and attach the baby to the breast

   c. Examine the baby

   d. Examine mother - especially fundal height and lochia

The whole community needs education on some issues to ensure that post-partum women and their babies are supported to have good health.

1. What issues or problems can the CHO discuss with community members?

Table 4.2: Issues/Problems in Relation to Postnatal Care and Responses

<table>
<thead>
<tr>
<th>ISSUES/PROBLEMS</th>
<th>INFORMATION FOR THE COMMUNITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Inadequate attendance at postnatal clinic, lack of understanding of purpose of PNC</td>
<td>• Encourage women to make their first visit within the first 7 - 10 days after delivery and the second visit during the sixth week. Women should also report any time there is a problem.</td>
</tr>
<tr>
<td></td>
<td>• Explain the benefits of PNC for both mother and baby (detection and treatment of complications, counselling and education, etc.)</td>
</tr>
<tr>
<td>ISSUE/PROBLEM</td>
<td>INFORMATION FOR THE COMMUNITY</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>2. Lack of awareness of danger signs/risk factors and lack of understanding of what action is necessary</td>
<td>• Explain that a woman with any of the danger signs need to go to the nearest facility as soon as possible</td>
</tr>
<tr>
<td>3. Lack of knowledge about what happens in the woman’s body during the postnatal period</td>
<td>• Provide information on what happens to the woman’s body during the post-partum period. Reassure if any discomfort is experienced</td>
</tr>
<tr>
<td>4. Confusion about when to resume sexual relations</td>
<td>• Explain that sexual relations can be resumed whenever the woman/couple feels comfortable doing so and the risk of infection is gone e.g. six weeks after delivery • Promote use of family planning before sexual relations are resumed, especially if the woman is not breastfeeding exclusively</td>
</tr>
<tr>
<td>5. Misuse of drugs</td>
<td>• Advise against self-medication, encourage women to consult trained health personnel before taking drugs</td>
</tr>
<tr>
<td>6. Lack of compliance with prescribed Drugs</td>
<td>• Encourage women to take iron/folic acid tablets during postnatal period</td>
</tr>
<tr>
<td>7. Inadequate personal hygiene</td>
<td>• Encourage women to bath and change sanitary pads regularly and to wash hands with soap before and after changing pads</td>
</tr>
<tr>
<td>8. Poor diet/nutrition</td>
<td>• Encourage women to eat nutritious diet, locally available healthy foods and explain that nursing mothers should drink plenty of fluids</td>
</tr>
<tr>
<td>9. Use of harmful traditional practices - dressing of cords with herbs - moulding of the scalp with hot water - douching babies with hot water</td>
<td>• Identify traditional practices during the postnatal period, encourage those that are positive, such as giving the new mother nutritious diet, and discourage those that are harmful in a culturally appropriate and acceptable manner</td>
</tr>
<tr>
<td>10. Lack of information on exercise, rest, sleep and resumption of normal activities</td>
<td>• Inform women that post-partum exercises help strengthen the abdominal muscles and help the woman regain her figure • Explain that lack of sleep can cause exhaustion, reduce milk flow, slow recovery from pregnancy and make the psychological adjustment harder</td>
</tr>
</tbody>
</table>
11. Inadequate understanding of the benefits of breastfeeding

<table>
<thead>
<tr>
<th>ISSUES/PROBLEMS</th>
<th>INFORMATION FOR THE COMMUNITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.</td>
<td>• Provide information on the advantages of breastfeeding</td>
</tr>
<tr>
<td></td>
<td>• Inform woman about the need to wash hands with soap before breastfeeding</td>
</tr>
</tbody>
</table>

**Topic Outline 3: Health Problems during Postnatal Period**

**Facilitator-Participants Interaction**

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

**Questions and Answers**

1. Main health problems during the immediate postnatal period:
   a. Fever
   b. Lower abdominal pains
   c. Bleeding
   d. Offensive vaginal discharge
   e. Engorgement of breast

   These are managed symptomatically. If the symptoms persist refer the woman to the next level.

   Continue to support the family and provide health education according to the woman’s and family’s needs.

2. What are the danger signs to look for during the immediate postnatal period?
   a. Excessive bleeding
   b. High fever
   c. Excessive offensive vaginal discharge
   d. Refusing to eat
Whenever the CHO observes any of these danger signs, she must refer the woman promptly to the next level for treatment.

**Topic Outline 4: Dealing with Harmful Traditional Practice**

**Facilitator-Participants Interaction**

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

**Questions and Answers**

1. What are some of the harmful traditional practices that may affect the health of the postnatal woman?

   a. Use of herbal preparation
   
   b. Using drugs on baby’s cord
   
   c. Mothers advised to take alcohol to reduce size of abdomen

2. How do CHO’s deal with these traditional practices in their communities?

   a. Identify the specific practices and their rationale
   
   b. Explain to community opinion leaders how these practices affect the woman’s health and that of the community
   
   c. Provide education to postnatal women, support groups and the community
Unit 2

Care for Clients during Late Post-partum Period

Terminal Performance Objectives

After studying this unit, the CHO will be able to:

- Register and take history of clients during postnatal period
- Conduct systematic physical examination of client in postnatal period
- Provide appropriate advice and follow up clients
- Refer health problems during the postnatal period to the appropriate facility

Rationale

Mention why these objectives are important to the CHOs:

1. Register and take history of client
2. Conduct systematic physical examination on postnatal clients
3. Provide appropriate advice

Topic Outline

1. Assessment of the Post-partum Woman
2. Care during the Postnatal Period
3. Minor Problems of the Postnatal Period
4. Problems and Complications during the Postnatal Period
Topic Outline 1: **Assessment of the Post-partum Woman**

**Facilitator-Participants Interaction**

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

- Divide the class into smaller groups
- Have the participants in each group read the case study. Continue the discussion by asking each group the questions that follow one at a time
- Ask volunteers in each group to demonstrate history-taking and physical examination to their colleagues

**Activity 2: Case Study on Assessing a Post-partum Woman**

**Background**

Eight days after delivery, the CHO visited Madam Adizah at home. After taking her history, the CHO conducted a general and physical examination. During the procedure, she checked Adizah’s vital signs and examined her from head to toe for any abnormalities. She also asked her whether there was any abnormal bleeding from the vagina and examined the perineum as well.

**Questions and Answers**

1. What assessment is done on the post-partum woman in the community during the first review visit?
   
   a. History taking: identify health problems such as infection, hypertensive complications, excessive bleeding and other dangers
   
   b. General examination: these include vital signs, weight, examination of conjunctiva, personal hygiene and lower extremities for oedema, varicosities and tenderness in the calves
   
   c. Examination of specific areas:
      
      - breast for warmth, cracked or sore nipples, and engorgement
      - abdominal inspection for involution of uterus and tenderness
Care for Clients during Late Post-partum Period

1. Care for Clients during Late Post-partum Period

   - perineum for swellings, tears, lochia (colour and odour)
   d. Examination of infant

2. What is the minimum number of review visits to be made by a post-partum mother and what are the recommended times for these visits?

   a. There should be two review visits
   b. The first visit should be within 7 - 10 days after delivery in a clinic if possible, or through a home visit by a CHO or midwife. Give vitamin A to the mother
   c. The second visit is made six weeks after delivery. The post-partum woman should be seen by a trained midwife at the CHC or during outreach service

3. List the danger signs and symptoms which you as a CHO will look out for during a visit to Madam Adizah in the postnatal period i.e. first six weeks after delivery.

   a. Offensive (foul-smelling) vaginal discharge, with or without fever (may be a sign of genital tract infection)
   b. Fever (may be a sign of infection)
   c. Abnormal behaviour (as in puerperal psychosis)
   d. Dizziness or fits (may be a sign of eclampsia or high blood pressure)
   e. Bleeding that continues for more than one week after delivery (a sign of infection or retained products)
   f. Severe lower abdominal pain and feeling of tenderness (sign of infection, retained products)
   g. Urgent need to urinate, frequency or burning sensation during urination (sign of urinary tract infection)
   h. Breast engorgement (breast tenderness or redness which could be the result of a clogged milk duct, cracked or sore nipples)
   i. Infected episiotomy wound, tears or abscesses

4. Outline the steps in referral and follow up of postnatal mothers

   a. Assess client’s condition and give first aid if required
   b. Advise client and family on the need for referral
   c. Get family to arrange for transport and for a blood donor if necessary
   d. Write referral note. Accompany client if necessary
e. Refer client for prompt treatment

f. Arrange home visits to the postnatal mother when she returns home

g. Get feedback from referral centre

Topic Outline 2: **Care during the Postnatal Period**

Facilitator-Participants Interaction

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

Questions and Answers

1. What type of care is given to the new mother and her infant during the immediate postnatal period, i.e. within the first seven days?
   a. Personal hygiene and perineal care
   b. Exclusive breastfeeding for infant
   c. Eating balanced diet with lots of fluid intake
   d. Exercises to strengthen muscles are encouraged
   e. Family planning services are provided
   f. Education on how to care for herself and the infant to promote health is given to the mother, her partner and family
   g. Together with the woman’s partner and family, plans are made to take care of any emergency that may arise (complication and decision-making plans established)
   h. Correction of misconceptions

Activity 3: **Group Work on Care of the Neonate**

Discussion

1. Refer participants to the table that follows
2. Divide them into smaller groups
3. Ask them to attempt the exercise and write their responses on a flip chart
4. Presentation should be done by one group
5. Allow the other participants to contribute to answers and discuss the presentation
6. Summarise and conclude
7. Compare these with the answers in the table to ensure completeness

Complete the following table to show how information can be gathered in a goal-directed way during physical examination of a post-partum woman.

Table 4.3: Physical Examination during Post-partum Period

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Complication</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Skin, general appearance, night blindness, goitre</td>
<td>Malnutrition (nutritional state)</td>
</tr>
<tr>
<td>2. Temperature, rapid pulse, lochia/discharge: odour, colour, quantity</td>
<td>Infection</td>
</tr>
<tr>
<td>3. Blood pressure, proteinuria, reflexes</td>
<td>Pregnancy-related hypertension</td>
</tr>
<tr>
<td>4. Haemoglobin, conjunctiva/palms/tongue</td>
<td>Anaemia</td>
</tr>
<tr>
<td>5. Baby’s weight, breasts, Breastfeeding</td>
<td>Breastfeeding problems</td>
</tr>
<tr>
<td></td>
<td>Breast infection</td>
</tr>
<tr>
<td>6. Fundal height, abdominal musculature, vaginal bleeding</td>
<td>Uterine sub-involution</td>
</tr>
<tr>
<td>7. Bowel and bladder function</td>
<td>Perineal complications from labour and birth</td>
</tr>
<tr>
<td>8. Calf muscles</td>
<td>Thrombophlebitis</td>
</tr>
<tr>
<td>9. Examination of external genitalia speculum examination (at six weeks)</td>
<td>Sexually transmitted infections or infection from laceration or episiotomy (genital health)</td>
</tr>
<tr>
<td>10. Unexplainable bruises, scratches, contusions, abrasions, swellings, fractures, cuts</td>
<td>Domestic violence</td>
</tr>
<tr>
<td>11. Abdominal examination</td>
<td>Uterine sub-involution</td>
</tr>
<tr>
<td>12. Lower extremities - for oedema, varicose veins</td>
<td>Pregnancy-related hypertension</td>
</tr>
<tr>
<td>13. Perineum and vagina - any tears, discharges, colour and scent of lochia</td>
<td>Puerperal sepsis, infection</td>
</tr>
</tbody>
</table>
Questions and Answers

1. Why is physical examination conducted in a postnatal mother although she was examined during the antenatal period?
   
a. Changes have occurred in the mother so she must be assisted to care for herself to enable her revert to her usual self as quickly as possible

b. It is necessary to continue observing the postnatal mother to ensure complications can be eliminated

c. A comparison of the information collected during the antenatal period with that of the postnatal period enables the CHO to make decisions that will lead to improved health

Topic Outline 3: **Minor Problems of the Postnatal Period**

Facilitator-Participants Interaction

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

Instructions:

Divide the class into smaller groups. Have the participants in each group read the case study.

Continue the discussion by asking each group the questions that follow, one at a time

**Activity 4: Case Study on Managing Post-partum Problem**

**Background**

Akosua Mansa delivered her third baby about two weeks ago. Her mother and other siblings were busy working on the farm and, therefore, were unable to assist her in her daily household chores as well as the care of the baby. When the CHO visited at 3 o’clock in the afternoon, Mansa was crying and had not eaten since morning. She also complained of insufficient breast milk.

The CHO examined Akosua Mansa and found everything to be normal.
Questions and Answers

1. What do you think is Mansa’s problem?
   a. Post-partum blues (emotional disturbances) most probably as a result of lack of support
   b. The breasts may be drying up because the baby is not suckling as much as he should

2. What are some immediate postnatal period problems a woman may experience?
   a. After birth pain
   b. Abdominal discomfort
   c. Restricted movement as a result of pelvic bones returning to normal or due to vaginal tear
   d. Bleeding
   e. Hyperpyrexia
   f. Postnatal blues
   g. Backache due to retroverted uterus
   h. Cramps (due to loss of salt in excessive sweating)

3. If you were the CHO, what would you have done? How can Akosua Mansa’s problem(s) be reduced?
   a. Mansa will be reassured that many women experience post-partum blues, and that these will disappear. She should be counselled to know about the impact of her worries on herself and the baby. Explain that this condition happens to many women
   b. Explain Mansa’s condition to the mother and the other siblings. A family member could stay with Mansa to assist her with the household chores. This will allow Mansa to have more time to herself, have enough rest, sleep and feed the baby
   c. CHO should encourage Mansa’s partner and other family members to support her
Topic Outline 4: **Problems and Complications During the Postnatal Period**

**Facilitator-Participants Interaction**

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

**Questions and Answers**

1. What are some of the problems and complications that can occur during the late postnatal period?
   - a. Urinary tract infection
   - b. Fatigue
   - c. Depression
   - d. Psychosis
   - e. Post-partum blues (emotional disturbances)
   - f. Breastfeeding difficulties or breast complications
   - g. Sub-involution of the uterus
   - h. Genital infection, bleeding or discharge
   - i. Anaemia: pallor (tongue, conjunctiva, palms)

2. What advice will you give to a mother whose baby dies during the postnatal period?
   - a. Advise her family to give her extra care and support; give her companionship, care and food
   - b. The woman’s breasts will probably be engorged, especially around the third day after the death. Cloths soaked in cool, clean water (cold compress) may reduce the soreness. She should not squeeze out any milk from the breast
   - c. The woman should be encouraged to wait for at least three months before trying to get pregnant again. This will allow her body time to heal
   - d. The CHO or TBA must look for signs of breast infection and treat or refer if necessary
e. The CHO or TBA must support the woman to start using a family planning method. This is to prevent the woman from getting pregnant immediately

**Close topic:** Summarise main ideas and link to next topic
Unit 3

Care of Newborns at Home

Terminal Performance Objectives

After studying this unit, the CHO will be able to:

- Screen for possible problems of the newborn
- Provide appropriate care, advice and refer as appropriate
- Educate on exclusive breastfeeding

Rationale

Mention why these objectives are important to the CHOs:

- Assess problems of the newborn
- Provide appropriate care to newborns
- Make appropriate referrals

Topic Outline

1. Teaching and Counselling Mother and Family about Care of the Baby
2. Problems and Abnormalities in the Newborn
Topic Outline 1: Teaching and Counselling Mother and Family about Care of the Baby

Facilitator-Participants Interaction

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

Questions and Answers

1. What is involved in the care of a baby at home?
   a. Exclusive breastfeeding by the mother
   b. Keeping baby warm, allowing baby to sleep most of the time between feeds, and ensuring baby feels comfortable and secure
   c. Protection from infection, bathing and cord stump care (keeping cord area dry and clean) by the mother and family
   d. Ensuring that baby is given his immunizations e.g. BCG, oral polio in a timely manner and growth monitored by CHO and supported by SDHT
   e. Circumcision (in male babies) and care of wound by “wanzam”, family or CHO
   f. CHO makes planned follow-up visits to the home to check on the health of the baby on the first, third and seventh day after delivery and also within the fifth and sixth week

2. An important part of the care a CHO can give to the baby, mother and family is teaching and counselling on baby care. What will you say to them when teaching or counselling them?
   a. The newborn’s body is small and not able to maintain heat properly. Therefore, the baby needs to be dressed or covered with one or two more layers of clothing than an adult. However, tight clothing and coverings that do not allow the baby to move must be avoided
   b. Healthy babies wake up every 2 - 4 hours to feed. Newborns do not distinguish day from night. They wake for night feeds. Because of this a mother needs to rest or sleep during the day when the baby sleeps. However, a baby that cannot be easily awakened or who sleeps too much may be sick
   c. The immune system (system to fight infections) is not mature in a newborn. The mother and family will need to take great care to protect the baby from infection
d. Babies do not need a full bath every day. Give a sponge bath or full bath every 2 – 3 days. This would allow the cord to stay dry and fall off quickly. The baby’s buttocks can be washed each time the diaper or cloth is soiled.

e. Cord stump and umbilicus care is an important way to prevent a baby from developing tetanus and septicaemia (infection of the blood).

f. Vaccinations are given for illnesses that cause serious disability and even death.

g. Babies need vitamin A and other nutrients to grow and develop well. Vitamin A also helps the baby to resist infections and fight infection when they get one. Breast milk, including colostrums, is rich in nutrients. Exclusive breastfeeding supplies the baby with essential nutrients at minimum cost.

h. Babies cannot tell what they feel or need. Therefore, caregivers must know how to recognize signs of illness or danger, and what to do to protect the baby. Never leave a baby alone on a bed. Do not throw baby into the air and then catch the baby or hold a baby by its feet with the head down.

3. What advice will you give to a mother and family on the care of the cord stump 1. after delivery and 2. when the umbilicus stump falls off?

   a. Do not put anything on the cord stump.

   b. Keep the cord stump exposed above and outside the diaper under clean clothing.

   c. If the cord becomes soiled from the diaper, wash your hands before washing the cord with clean water and soap. Dry the cord stump with a clean cloth and place it carefully outside the diaper to avoid further contact with stool and urine.

   d. The cord normally falls off around five to seven days after birth. This leaves the umbilicus to heal.

   e. Keep the umbilicus clean. Do not put anything on it.

   f. Give baby a sponge bath until cord stump and umbilicus are healed.

   g. Look at the cord stump and umbilicus for signs of infection every day until it is dry and healed. Signs of infection are:

      - Redness of the skin around the umbilicus

      - Purulent discharge from the umbilicus

      - Delay in separation and offensive smell

   h. Get help from a trained health worker if you see any signs of infection.
Topic Outline 2: Problems and Abnormalities in the Newborn

Facilitator-Participants Interaction

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc

Question and Answers

1. List some danger signs in the newborn that have to be reported to a trained health worker.
   These include:
   a. Baby not sucking or having feeding difficulties
   b. Baby with breathing problems
   c. Baby with convulsions or fits
   d. Baby is warm to touch (fever)
   e. Baby is cold to touch
   f. Bleeding from the cord or rectum
   g. Severe jaundice: yellow skin which begins before day 2 or lasts more than 10 days
   h. Diarrhoea and or continuous vomiting
   i. Severe infections of the umbilicus, eyes or skin

The CHO is expected to explain these signs to the mother, family and community.

Close topic: Summarise main ideas and link to next topic
Terminal Performance Objectives

After studying this unit the CHO will be able to:

- Identify areas that need health education
- Give health education on postnatal care to mothers, families and communities

Rationale

Mention why these objectives are important to the CHOs:

- Identify techniques for health education
- Give health talks to postnatal mothers and their families

Topic Outline

1. Individual and Group Needs for Health Education on Postnatal Care
2. Topics for Health Education during the Postnatal Period
3. Giving the Health Education Talk and Evaluation
Topic Outline 1: Individual and Group Needs for Health Education on Postnatal Care

Facilitator-Participants Interaction

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc

Health Education is teaching individuals, families and communities to be healthy and avoid illnesses. Prioritise health education needs - depending on the occurrence of common preventable conditions e.g. incidence of high rate of anaemia among pregnant women

Baby Care: 6 Hours - 6 Weeks

History-taking:

1. Has the mother seen anything in the baby that worries her?
2. Is the baby suckling well?
3. How often does the baby feed during the day and night? (Normal is 12 times in 24 hours)
4. Does the baby wake up to breastfeed at least every 2 - 3 hours, or does the mother need to wake the baby up?
5. How many times does the baby urinate in one day? (should be at least 6 times in 24 hours)
6. Does the baby seem very sleepy? Is the baby hard to wake up?
7. How does the baby’s stool look and how often does the baby move his/her bowels?
   What is the consistency of the stool? (stool should be soft, yellow and “seedy”; it should not be watery)
8. How many meals does the mother eat a day? What quantity and type of food constitute each meal?
9. How much fluid does the mother drink in a day?
10. Has she taken her Vitamin A capsule? (where this is available)
12. Is she getting enough rest?
Examination of baby

Days 1 – 4: May lose up to 10% of birth weight
Days 7 – 10: Back to birth weight
Up to 4 months: Gains about a kilogramme per month
6 months: Doubles birth weight
1 year: Birth weight triples

1. Skin - colour and any rashes
2. Breathing - should be regular and rate is 30 - 60 breaths per minute
3. Eyes - look for discharge
4. Mouth - look at the mucus membrane for possible signs of thrush and congenital malformations
5. Umbilicus - for redness or pus around umbilicus
6. Temperature - normal temperature under the arm is 36.5 - 37.5 degrees celsius
   With an infection, the temperature can be higher or lower
7. Decide if the baby has any problems. Educate or refer as appropriate

Topic Outline 2: Issues for Health Education during the Postnatal Period

Facilitator-Participants Interaction

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

Questions and Answers

1. What issues will be the focus of health education during the postnatal period?
   a. Personal and environmental hygiene
   b. Nutrition of both mother and baby
   c. Rest and sleep
d. Family planning  
e. Danger signs/signals  
f. Exclusive breastfeeding of baby for 6 months  
g. Physiologic/pathologic jaundice  
h. Importance of having postnatal examination to ensure the health of baby and mother  
i. Immunisation and side-effects of vaccines  
j. Management of side-effects of vaccines  
k. Promote use of insecticide-treated nets (ITNs)  
l. Importance of HIV testing and mother-to-child transmission (MTCT)

**Topic Outline 3: Giving the Health Talk and Evaluating the Talk**

**Facilitator-Participants Interaction**

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc

**Questions and Answers**

1. How would you plan to give and evaluate a health talk to postnatal mothers?

   In planning to give health education talks, the following should be considered to enhance the effectiveness of the talk:

   a. The audience - whether group or individual, literate or illiterate  
   b. Topics or issues for the education or pressing health problems  
   c. Venue and time should be accessible and convenient for the clients  
   d. Prepare contents for the talk based on current information on the topic  
   e. Assemble audio-visual, where applicable  
   f. Do the presentation i.e. deliver the message  
   g. Get feedback from audience and discuss issues at length
h. Summarize and thank audience
i. Record activities and observations
j. Review feedback from clients to assess whether there has been any change in their health status e.g. reduction in the rate of anaemia in pregnant women
k. Self assessment strategies: To evaluate the effectiveness of strategies used to effect change

Checklist 4.1: Performance Guide for Late Postnatal Care

Instructions:
Rate the performance of each task/activity observed using the following rating scale.

0 - Task/Activity omitted
1 - Task/Activity incorrectly performed
2 - Task/Activity correctly performed (Hesitated)
3 - Task/Activity correctly performed with confidence
N/A - Task/Activity not required in this observation

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Rating</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery Procedure</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1. Conducts physical examination and looks out for signs of</td>
<td></td>
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</tr>
<tr>
<td>a) Anaemia i.e. Hb level, pallor (tongue, conjunctivae, palms)</td>
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<tr>
<td>b) Jaundice i.e. yellowish discoloration of skin and mucous</td>
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<tr>
<td>c) Oedema i.e. swelling of hands, feet, face</td>
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<td></td>
</tr>
<tr>
<td>d) Breast problems i.e. engorgement, cracked or sore nipples</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2. Notes conditions requiring additional care or referral (e.g. fever, abnormal bleeding, abdominal pain and offensive vaginal discharge) If the woman needs to be referred explain why she is being referred.</td>
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<tr>
<td>3. Counsels the woman about the following subjects:</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>a) Rest and sleep: Talks with mother about the importance of resting as much as possible</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task/Activity</td>
<td>Rating</td>
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<td>------------------------------------------------------------------------------</td>
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<td></td>
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</tr>
<tr>
<td><strong>b)</strong> Nutrition: Talks with mother about types of food available to her that are rich in protein and iron and the importance of eating these varieties of food regularly and drinking plenty of fluids</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>c)</strong> Hygiene: Talks with mother about the importance of washing hands and perineum after passing urine and stool, and changing her pad or cloth.</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td><strong>d)</strong> Malaria: Talks about early recognition of signs and symptoms and treatment. Encourages the woman to sleep under ITN with the newborn baby</td>
<td></td>
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</tbody>
</table>

**Delivery Procedure**

<table>
<thead>
<tr>
<th>Delivery Procedure</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a)</strong> Danger signals: Talks with mother about</td>
<td></td>
</tr>
<tr>
<td>1.  early recognition and prompt action for abnormal bleeding</td>
<td></td>
</tr>
<tr>
<td>2.  foul smelling discharge, fever, abdominal pain</td>
<td></td>
</tr>
<tr>
<td>3.  breast pain and tenderness</td>
<td></td>
</tr>
<tr>
<td>4.  mother feeling sad or unable to care for herself or the baby and</td>
<td></td>
</tr>
<tr>
<td>5.  night blindness</td>
<td></td>
</tr>
<tr>
<td><strong>b)</strong> Breastfeeding: Explains the benefits of breastfeeding and how to practise exclusive breastfeeding</td>
<td></td>
</tr>
<tr>
<td><strong>c)</strong> Family Planning: Discusses methods and need for family planning and talks with mother about resumption of sexual activity, child spacing and available and suitable contraceptive methods</td>
<td></td>
</tr>
<tr>
<td><strong>d)</strong> STI, HIV/AIDS prevention: Explains that condoms should be used for protection against STIs, including HIV/AIDS. Explains that abstinence and a long term mutually faithful relationship are the safest approaches to avoiding STI and HIV/AIDS (transmitted by sexual intercourse)</td>
<td></td>
</tr>
</tbody>
</table>

4. Writes and explains any prescriptions. For example, Iron, Folic Acid, Mebendazole or Albendazole (if dose is due), Vitamin A 200,000 IU by mouth in line with national protocol |

5. Provides TT if dose is due, otherwise remind the woman when her next dose is due |

6. Provides contraception as indicated or provides condoms for safer sex as needed
<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Records all information obtained as appropriate. At the end of the visit,</td>
<td></td>
</tr>
<tr>
<td>look at all the information you have gathered and interpret what you have</td>
<td></td>
</tr>
<tr>
<td>found. Interpretation includes:</td>
<td></td>
</tr>
<tr>
<td>a) Deciding if the post-partum period is evolving normally.</td>
<td></td>
</tr>
<tr>
<td>b) Differentiating between common complaints and a possible complication</td>
<td></td>
</tr>
<tr>
<td>c) Identifying any problems and deciding how best to manage them</td>
<td></td>
</tr>
<tr>
<td>d) Deciding if the woman needs specialised care</td>
<td></td>
</tr>
<tr>
<td>e) Identifying areas of possible educational needs</td>
<td></td>
</tr>
<tr>
<td>8. Attends to the baby. This may include:</td>
<td></td>
</tr>
<tr>
<td>a) Weighing the baby and plotting the weight on the Road-to-Health card</td>
<td></td>
</tr>
<tr>
<td>b) Immunising the baby (give BCG if not already given, give first doses of</td>
<td></td>
</tr>
<tr>
<td>Oral Polio and DPT) and recording immunisations given</td>
<td></td>
</tr>
<tr>
<td>9. Schedules a follow-up visit</td>
<td></td>
</tr>
</tbody>
</table>
Unit 1

The postnatal period is the period from the end of delivery to six weeks after delivery.

The purpose of postnatal care is to maintain the physical and psychological well-being of the mother and child. Postnatal care includes education of the mother on the care of her baby, and detection, treatment or referral of any abnormalities for further management.

 Mothers should be informed about the following issues during postnatal care:

- Nutritional requirements for mother’s health and breastfeeding
- Personal hygiene
- Signs of complications
- Infant feeding
- Care of the baby
- Immunisation schedule for the baby
- Post-partum exercises and early ambulation
- Birth spacing
- Postnatal care services

Unit 2

Caring for a New Mother

Mothers need care after birth just as the baby does. People often pay so much attention to the baby and may neglect the mother’s needs. To prevent infection, the mother should not have sex or put anything in her vagina until her bleeding stops. She should try to stay clean by bathing at least twice a day and keep her genitals very clean.

She should get a lot of rest for at least six weeks. A new mother needs to eat more food than usual. She can eat any kind of food: fish, meat, beans, grains, vegetables and fruits. These will help her to recover from the delivery and be healthy. She should drink plenty of fluids.

She should start a family planning method as soon as possible, especially if she is not feeding her
baby exclusively on breastmilk. For good health, she should start using a family planning method before she has sex again otherwise she could become pregnant very soon.

Mothers who are alone, very young, mentally slow, very poor or who already have poorly nourished or sick children may have a harder time caring for themselves and their babies. The CHO must take special interest in these mothers and help them get the care, food and companionship they need.

Most women have healthy pregnancies and give birth to healthy babies. But sometimes, no matter what anyone does, the baby dies. This is always a hard time for a mother.

She feels great sadness and loss. At the same time, she has been through pregnancy and delivery and she needs to rest and get her strength back, just like a mother with a new baby.

The whole family, especially the father of the baby must be encouraged to show his partner that he cares for her by helping with the house chores or getting someone else to help her. Holding and caring for the baby so that the mother has a chance to sleep is necessary, so the partner should not force to have sex with mother when she is not ready or bleeding. This helps to prevent an infection. The partner must also share the responsibility for using a family planning method.

Unit 3

Baby Care: Six hours to six weeks

The first week and month of the newborn’s life is still a time of risk. Over half of newborn deaths happen in the first seven days. Although the risk of death decreases as time passes, careful attention is still needed during the first month of life.

When the baby has recovered from birth and is warm and breathing normally the mother and family can start to take over the baby’s care. The TBA/CHO will make sure the mother is able to care for and feed the baby.

The CHO will save lives and improve the health of babies by teaching and counselling mothers and families on how to care for their babies. During teaching and counselling, explain what to do (good practices in baby care) and why it is done. Even if a woman has had a baby before, there may be new information that can help her. Include other family members like a grandmother, mother-in-law, aunt, sister and husband to give them all a chance to hear the same things as the mother. This gives the mother and family an opportunity to ask questions and clarify information they may have that is incorrect.

1. What can the CHO do to support the mother and family?

   Counsel the mother and family on the following topics:
• Keeping the baby warm and comfortable (maintenance of body temperature)
• Ensuring mother has adequate rest when baby sleeps especially during the day
• Handling the baby with love by ensuring that baby feels comfortable and secure
• Protecting the baby from infection
• Bathing the baby, caring of cord stump
• Ensuring baby is immunised and on time
• Breastfeeding baby exclusively for six months and continuing to breastfeed for two years

2. How do you recognise danger signs of the newborn?

• Do follow-up assessment and care of the baby at 12 to 24 hours, three days, seven days and 5-6 weeks after birth (and more often if needed)

Each time you see a baby during follow-up visit, use the following information to help you identify and solve the baby’s problems

As you start the history:

− use good communication skills; show respect to the mother and family
− explain to the mother and family what you are going to do
− ask the mother what she has observed about the baby
− if the mother or family are worried about anything, listen to their concerns
− because breastfeeding is so important to the health of a baby, include questions for the mother about her meals, how much fluid she is drinking and if she is getting enough rest

• Before you begin the physical examination:

− wash your hands thoroughly with soap and water. Dry with a clean dry cloth or air-dry if cloth is not clean. You may put on gloves if available
− review in your mind the parts of the physical examination. If you did a complete examination during your first visit, then this examination will be brief. Focus on the needs of a normal newborn and find any common problems

• As you start the physical examination, ask the mother to uncover the baby:

− look carefully at the baby before you touch him/her. You will see if the baby is normal
− breathing before he/she starts crying. You will also be able to see how the mother is
interacting with her baby

− handle the baby gently during the examination
− follow the steps in the chart below
− examine the baby for any abnormalities and treat or refer as appropriate

• During the physical examination:
  − explain what you are doing and answer any questions the mother and family may have.
  − show the mother and family how to look at the baby’s breathing and cord, and feel the baby for warmth
  − ask the mother to do this and to tell you what she sees and feels
  − give her feedback and praise her for learning to do this
  − compliment the baby as you do the examination. A mother wants to be proud of her baby; this make her feel good

Physical examination of the baby:

1. APGAR score after birth
2. Weigh baby
3. Examine baby from head to toe:
   ▷ skin - colour, septic spot
   ▷ head/neck - head size, fontanelle, sutures, deformities and shape
   ▷ eyes - conjuctiva, discharge, cataract, squint and other abnormality
   ▷ extremities - deformities (e.g. extra digits, clubbing, webbed fingers or toes)
   ▷ chest - breathing, retraction of chest, abnormal pulsation and abnormalities of the breast
   ▷ abdomen - distention, cord stump, tenderness
   ▷ external genitalia - deformities, undescended testis, labia adhesion, sex
   ▷ anus - abnormalities (e.g. imperforate anus), meconium passed
   ▷ any functional abnormality or deformity should be referred e.g. difficulty in
   ▷ breathing, talipes, tongue tie, cleft lip, excessive vomiting and skin colour changes
Unit 4

Table 4.4: Physical Examination of the Baby

<table>
<thead>
<tr>
<th>Risk condition</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asphyxia</td>
<td>• If infant has trouble breathing (irregular or slow breaths or grunting)</td>
</tr>
<tr>
<td></td>
<td>• Clear airways</td>
</tr>
<tr>
<td></td>
<td>• Refer</td>
</tr>
<tr>
<td>Ophthalmia neonatorum</td>
<td>• Wipe eye discharge with clean damp cloth or cotton wool, from inside to out</td>
</tr>
<tr>
<td></td>
<td>• Refer</td>
</tr>
<tr>
<td>Septic skin spots</td>
<td>• Assess size of lesion</td>
</tr>
<tr>
<td></td>
<td>• Apply gentian violet</td>
</tr>
<tr>
<td></td>
<td>• Advise on hand washing before handling baby and use of antiseptics (e.g. Dettol) in bathing water</td>
</tr>
<tr>
<td></td>
<td>• Refer if lesion is extensive, if there is fever or if no improvement after 72 hours of treatment</td>
</tr>
<tr>
<td>Twitching and convulsions</td>
<td>• Clear airway if necessary</td>
</tr>
<tr>
<td></td>
<td>• Keep warm (do not sponge down and do not give paracetamol)</td>
</tr>
<tr>
<td></td>
<td>• Refer to hospital immediately</td>
</tr>
<tr>
<td>Cord infection</td>
<td>• Clean cord with spirit and leave dry</td>
</tr>
<tr>
<td></td>
<td>• Examine cord and surrounding area - if there is odour and pus from a wet cord or fever and redness of skin around the cord, refer</td>
</tr>
<tr>
<td>Jaundice</td>
<td>• Refer any yellowish discolouration of eyes</td>
</tr>
<tr>
<td>Engorged breast</td>
<td>• Avoid undue manipulation of the engorged breast</td>
</tr>
<tr>
<td></td>
<td>• Assess breast. Refer if warm and red</td>
</tr>
</tbody>
</table>

Health Education is teaching individuals, families and communities to keep healthy and avoid illness.

1. Individual’s and group’s needs for health education on postnatal care:
   Prioritise health education needs - depending on the occurrence of common preventable conditions e.g. incidence of high rate of anaemia among pregnant women

2. Topics for health education during the postnatal period:
   a. Personal/environmental hygiene
   b. Nutrition of both mother and baby
c. Rest and sleep  
d. Family planning  
e. Danger signs/signals  
f. Exclusive breastfeeding of baby for 6 months  
g. Physiologic/pathologic jaundice  
h. Importance of having postnatal examination to ensure the health and safety of mother and baby  
   • Well-baby check-ups  
   • Immunisation and side-effects of vaccines  
   • Management of side-effects of vaccines  
   • Promote insecticide treated nets (ITNs)  
   • Importance of HIV testing and mother-to-child transmission (MTCT)  

3. Giving the health talk

In planning to give health education talks, the following should be considered to enhance the effectiveness of the talk:

▷ the audience - whether group or individual, literate/illiterate  
▷ topics/issues for the education  
▷ venue and time should be accessible and convenient for the clients  
▷ prepare contents for the talk - based on current information on topic  
▷ assemble audio-visual aids  
▷ do the presentation i.e. deliver the message  
▷ get feedback from audience and discuss issue at length  
▷ summarise and thank audience  
▷ record activities and observations

4. Evaluating Health Education

a. Review feedback from clients - to see whether there has been any change in their health status e.g. reduction in the rate of anaemia in pregnant women  
b. Self assessment strategies - to evaluate the effectiveness of strategies used to effect change
Module 5

HIV/AIDS
Module 5 HIV/AIDS

Purpose and Organisation

The Human Immuno-Deficiency virus (HIV) and its accompanying disease syndrome referred to as Acquired Immune Deficiency Syndrome (AIDS) have become a worldwide health problem. The Community Health Officer needs adequate knowledge and skills to motivate community members to adopt appropriate behaviour to reduce the spread of the infection.

This module has three (3) units, which cover the core issues that help the CHO understand the HIV/AIDS phenomenon, to enable him/her educate and help the community overcome the spread of the infection.

Objectives

Review these objectives and all subsequent unit objectives as you begin each unit by:
• Reading each objective yourself or
• Having a participant read the objectives aloud to the group

After studying this module, the CHO will be able to:

1. Give basic explanation to the phenomenon of HIV/AIDS
2. Provide information to families on prevention of mother to child transmission (MTCT) of HIV/AIDS
3. Refer individuals for HIV/AIDS counselling and testing
4. Give supportive care to PLWHA and their families

Contents

Unit 1: Informing Individuals and Communities on HIV/AIDS

Unit 2: Referring Individuals and Families for HIV/AIDS Counselling and Testing

Unit 3: Giving Supportive Care to Persons Living with HIV/AIDS (PLWHA) and their Families

Expected Outcome

Knowledge:
• HIV/AIDS
• Mother-to-child transmission
• Referring cases
• Preventive strategies
• Voluntary counselling and testing
• Family planning
• Infection prevention

Attitude:
• Empathetic
• Confident
• Trustworthy
• Initiative
• Friendly

Skills:
• Counselling (pre- and post-test)
• Communication (listening, reassuring, asking questions)
• Monitoring
• Communicating with families of PLWHA

Table 5.1: Materials Needed

<table>
<thead>
<tr>
<th>Samples</th>
<th>CHO Materials</th>
<th>Facilitator Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female condom</td>
<td>Stationery  - pencils  - pen  - note pads</td>
<td>Overhead projector(where available)</td>
</tr>
<tr>
<td>Male condom</td>
<td></td>
<td>Transparencies</td>
</tr>
<tr>
<td>Journey of hope kit</td>
<td></td>
<td>Felt pens/markers</td>
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<tr>
<td></td>
<td></td>
<td>Flip chart stand and sheet</td>
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<tr>
<td></td>
<td></td>
<td>Penis model</td>
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<tr>
<td></td>
<td></td>
<td>Pelvic model or female mannequin</td>
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<tr>
<td></td>
<td></td>
<td>TV</td>
</tr>
<tr>
<td></td>
<td></td>
<td>VCR, DVD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Video clips</td>
</tr>
</tbody>
</table>
Teaching Methods

- Use learner-centered methods in this module
- Introduce new materials through a guided discussion.
- Start each unit with a guided discussion.

Help participants apply their knowledge in “real life” situations. In addition, field practice is highly recommended.

Getting Started

1. Do a warm-up exercise
2. Review any topics from previous sessions that are relevant to this module
3. At the beginning of each module, review the purpose, contents and objectives
4. At the beginning of each unit, review the topic outline to enable participants understand how the module is organised

Facilitator-Participants Interaction

Depending on the manner in which you choose to facilitate the class, ask relevant questions on each of the questions in the Workbook.

It is ideal to have participants attempt all the questions in their Workbook before the session.

**Call on participants to read their answers**

- Ask one person to volunteer to read first
- After he/she reads the answer, comment positively on it
- Let another person read his/her answer
- After he/she reads the answer, comment positively on it
- Compare and contrast what both people have written or ask others if they see similarities or differences.
Group Activities

Role plays, case studies, group discussions

- Give each participant a copy of the material to read or instructions as to where the material is found in the Workbook
- Divide the participants into small groups. Tell each group to discuss the questions on the case study and provide answers to the questions that follow

During the presentations

- Ask if others have any additions
- Ask if others have any suggestions
- Comment on what they did well
- Offer suggestions for improvement
- Ask for lessons learned
Informing Individuals and Communities on HIV/AIDS

Terminal Performance Objectives

After studying this unit, the CHO will be able to:

- Describe HIV/AIDS, how it is spread and preventive measures to be taken
- Describe how cultural influences and beliefs affect the development of HIV/AIDS
- Explain how developmental and gender issues relate to HIV/AIDS

Rationale

Mention why this objectives is important to the CHOs:

Have knowledge and skills to address the issues of HIV/AIDS in the community

Topic Outline

1. HIV/AIDS
2. Spread of HIV/AIDS
3. Strategies for Preventing HIV/AIDS Infection
Topic Outline 1: **HIV/AIDS**

### Facilitator-Participants Interaction

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

### Questions and Answers

1. **Awareness creation and behaviour change are the major weapons against HIV infection.**
   What will be your goal when giving information on HIV/AIDS to your community members?

   The main aim of giving information is to correct misinformation and reinforce good behaviours. The CHO should make sure that community members understand the following:

   a. What AIDS is
   b. What HIV is
   c. Mode of HIV transmission
   d. Behaviours that put a person at risk of getting infected
   e. What the HIV antibody test is. (It is not an AIDS test, this is important - repeat and reinforce constantly)
   f. What the HIV test can tell you and what it cannot tell you
   g. The possibility of discrimination and other negative consequences of a positive HIV test result
   h. How to use condoms
   i. Use of sterile instruments for shaving, circumcision, etc

2. **What is AIDS?**

   AIDS stands for Acquired Immune Deficiency Syndrome. It is caused by a virus.

3. **What is the difference between HIV infection and AIDS?**

   In HIV infection, the virus lives in the body and can be passed to other people.

   The infected person may not have any outward signs or symptoms and may not even know he/she is infected. When the signs and symptoms appear, the disease is called AIDS.
Topic Outline 2: **Spread of HIV/AIDS**

**Facilitator-Participants Interaction**

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

**Questions and Answers**

1. **How is the HIV virus spread?** It is spread through:
   a. Vaginal intercourse with an infected individual
   b. Anal intercourse with an infected person
   c. Other activities that allow semen, vaginal fluid, or blood to enter the mouth, anus, vagina or an open cut or sore
   d. Sharing intravenous hypodermic needles and other sharp objects like razor blades, unsterilised knives for circumcision with an infected person
   e. Transfusion of infected blood
   f. A pregnant woman with HIV is able to pass HIV to her foetus during late pregnancy or childbirth
   g. A breastfeeding woman with HIV can pass the virus to her baby through her breast milk

2. **What factors contribute to the spread of HIV/AIDS?**

   A CHO must identify practices and beliefs that could contribute to HIV/AIDS infection and discourage such behaviours. List four practices that can contribute to the spread of HIV/AIDS
   a. Multiple sexual partners
   b. Practices such as making tribal marks (scarification)
   c. Female genital mutilation or performing male circumcision using unsterilised instruments
   d. Marrying the partner of a relation when the person dies (widow inheritance)

3. **List ways by which HIV/AIDS is not spread**
Community members need to know they will not be infected with the virus if they have any of these casual contacts with persons living with HIV/AIDS:

a. Shake hands
b. Pay a visit
c. Talk
d. Kiss on the cheek
e. Share the same office
f. Sleep together without having sex
g. Eat from one plate
h. Use a common toilet (latrine) seat
i. Use a common bathroom
j. Feed PLWHA
k. Bath PLWHA
l. A bite from a mosquito does not transmit HIV

4. State the major signs and symptoms of AIDS
   a. Diarrhoea for one month or more
   b. Persistent fever more than one month
   c. Weight loss in which more than 10% of body weight is lost or stunted growth in children

5. List the minor signs and symptoms of AIDS
   a. Night sweat
   b. Generalised lymph gland enlargement
   c. Persistent cough
d. Persistent weakness
e. Attacks of shingles (“Ananse”)
   f. Thrush in the mouth and throat
g. Herpes simplex infection
   h. Repeated common infections or generalised skin disease in children
6. When can you say that someone has AIDS?

For Adults:

a. Two major signs plus 1 minor sign plus a confirmed HIV antibody test
b. Three major signs plus a confirmed HIV antibody test

For Children:

a. The infant or child should show at least 2 major and 2 minor signs
b. The diagnosis is confirmed if one of the parents (or both) is also ill with the condition

7. What care can a CHO give to the PLWHA and his family in the community?

a. There is no cure for AIDS. However, the client should be treated for any opportunistic conditions presented. Some of these conditions are: diarrhoea, fever, skin diseases, acute respiratory infection, tuberculosis and depression
b. As a CHO you can prove very supportive to the PLWHA by being non-judgmental in dealing with them. Relations and co-workers should also be counselled to give similar support
c. The family also needs support, as the idea of having a close relation with AIDS can be traumatic. The CHO can educate the family on how the virus is spread, how it is not spread, what they can do to avoid contracting the disease and most importantly, the need to provide total support. They must be told that studies have shown that PLHWA do better when caring family members give them full support.

8. List some issues that are of concern to PLWHA

a. Discrimination and being stigmatised by those who know of their HIV status
b. Fear of losing job and loss of income
c. Fear of separation from partner leading to an unstable family relationship
d. Inability to have sex as a result of fear

9. State the different ways by which individuals may have sexual intercourse

a. Peno-vaginal intercourse or sex (heterosexual) i.e. where the penis is inserted into the vagina
b. Anal intercourse or sex i.e. where the penis is inserted into the anus
c. Oral (mouth) intercourse i.e. where the penis is inserted into the mouth or the vagina is licked
10. Give reasons why even though HIV/AIDS affects both sexes, it appears to have greater impact on females
   
   a. Women are more vulnerable to the infection because of their biological makeup, as well as socio-cultural and economic inequalities

   b. Women suffer greater physical and psychological trauma when they or any member of the family is infected because they are the care takers and at the same time depend on their husbands

   c. Girls are more likely to drop out of school when someone in their family is sick, or may work to support the family financially

   d. Women cannot negotiate for safer sex due to their lower social status in the society and the way in which they are socialized

11. How can HIV/AIDS affect the development of your community?

   a. AIDS has no cure and it is deadly. The productive age groups, that is the young people between 15 - 49 years, are the most affected

   b. An AIDS patient’s death results in the loss of labour and/or income. Hence, the Children (especially girls) affected may have to leave school and work to compensate for losses and to pay for their school fees. Orphans often lose the necessary financial, material and emotional support that they need for successful schooling

   c. Psychosocially, AIDS can have a very serious impact on the lives of women when it affects a family member. In many cases, women do not have a secure occupation. Therefore, if the husband dies, the surviving wife and children may be exploited or may resort to commercial sex

   d. A woman may have reduced ability to be a bread winner, as she needs to spend a lot of time caring for family members who are infected with AIDS
Facilitator-Participants Interaction

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

Question and Answers

1. What are the strategies for preventing HIV/AIDS infection?
   a. Abstinence
   b. Be faithful to your partner
   c. Condom use
   d. Voluntary counselling and testing
   e. Prevention of mother-to-child transmission
   f. Avoid unsafe blood transfusion

Activity 1: Group work on prevention of HIV/AIDS

Lead participants to work on the following points:
1. List the various preventive measures that a CHO can adopt to control the spread of HIV in the CHPS zone
2. Demonstrate how to wear and dispose of the male and female condom
3. Guide participants to do return demonstrations on wearing and disposing of male and female condoms

Refer to instructions on how to wear male condom at the end of the last reference section

Close topic: Summarise main ideas and link to next topic
Unit 2

Referring Individuals and Families for HIV/AIDS

Terminal Performance Objectives

After studying this unit, the CHO will be able to:

• Apply the GATHER and REDI principles of counselling individuals and refer them
• Refer individuals for HIV/AIDS counselling
• Educate individuals and families on benefits of counselling and testing

Rationale

Mention why these objectives are important to the CHOs:

• Improve knowledge and skills of emerging disease conditions that affect the health of a community
• Provide appropriate assistance to control the spread of infection and alleviate pain

Topic Outline

1. GATHER and REDI Steps/Principles of Counselling
2. HIV Testing
Topic Outline 1: **GATHER and REDI Steps/Principles of Counselling**

**Facilitator-Participants Interaction**

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

**Questions and Answers**

1. What does GATHER stand for? It stands for:
   - G - Greet
   - A - Ask
   - T - Tell
   - H - Help
   - E - Explain
   - R - Return visit

   (Refer to Module 1 on Family Planning)

2. What does REDI stand for?
   - It stands for:
     - R - Rapport building
     - E - Exploration
     - D – Decision-making
     - I - Implementation of decision(s)

3. What are the ways by which the CHO can help clients assess their risks of having HIV/AIDS?
   - a. Through education: awareness creation at meetings, durbars, on radio, etc
   - b. Through group and individual counselling
   - c. Through the use of games e.g. the Journey of Hope, drama, storytelling
4. List the three (3) stages in HIV/AIDS counselling
   a. Beginning - exploration stage when CHO learns more about her client
   b. Middle - understanding the client
   c. End - where appropriate action is taken

5. Why is there a need for a client to have pre-test counselling?
   a. To allay the fears of the client
   b. To prepare client for behaviour change
   c. To prepare client for the outcome of the test
   d. To inform clients that there is a need for a second test if the result turns out to be negative

6. What does the counsellor do during the HIV pre-test counselling?
   a. Helps the client to understand what the test is
   b. Lets the client know what is involved in the test
   c. Gets client to understand the implications of the test result

7. What are the opportunities that the CHO may use to introduce HIV pre-test counselling and CT?
   a. When a client:
      i. Reports with an STI
      ii. Indicates having more than one sexual partner or the partner has other sexual partner(s)
      iii. Indicates that he/she has been having unprotected sex
      iv. Expresses fear of being HIV positive
   b. When the CHO:
      i. Gives a talk on reproductive health especially on STI/HIV/AIDS
      ii. Renders reproductive health services e.g. ANC, PNC, FP
      iii. Suspects a client of having HIV/AIDS
Topic Outline 2: **HIV Testing**

**Facilitator-Participants Interaction**

Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

**Question and Answers**

1. **What is the HIV antibody test?**
   
   A blood test used to determine whether a person was infected with the HIV virus. The test detects the HIV antibodies, which people produce in response to HIV infection. It does not detect the virus itself.

2. **Describe some limitations of the HIV antibody test**
   
   a. The antibodies may not be detected till about six months after infection
   
   b. It does not tell when the person is infected
   
   c. A negative test result does not necessarily mean that the person is not infected with HIV

3. **What are the benefits of counselling and testing?**
   
   a. Women/couples in their reproductive age could take a decision on giving birth if HIV positive
   
   b. HIV positive pregnant women can decide whether to breastfeed their babies or not
   
   c. Where there is anti-retroviral therapy, the client should take advantage of it
   
   d. Knowing and maintaining your status

4. **Outline the challenges for accepting to do counselling and testing to the client**
   
   a. Coping with the idea that one might develop AIDS and die
   
   b. Coping with the concern of having transmitted the virus to someone
   
   c. Depression
   
   d. Desire to revenge and other unhelpful desires or behaviour
   
   e. Discrimination and stigmatisation from people who know the client’s status
   
   f. Inability to have sex as a result of fear
5. Why is counselling and testing necessary?
   a. You cannot tell by looking at someone whether he/she has HIV. The only way is to take the test
   b. For the one who is sero-negative, he/she will be counselled to remain negative by keeping to behaviours that will not expose him to the virus
   c. For the one who is sero-positive, he/she will be counselled on how not to transmit the virus to others

6. What does the counsellor do during the post-test counselling session?
   a. Helps client(s) focus on what is said either before and/or after receiving the test result. They might be distracted by anticipating result and then overwhelmed by relief or shock after receiving results
   b. Counsellor provides intensive risk-reduction counselling for clients who are negative as well as to those who are positive

7. What are the critical issues the counsellor must ensure before the post-test session ends?
   The counsellor should ensure that the client:
   a. Is not exhibiting suicidal tendencies
   b. Has some kind of personal support system in place. You can at times organize this at your CHPS compound
   c. Has all the necessary referrals, plus whatever he/she needs to have access to the referrals
   d. Understands the potential for discrimination and what to do to prevent it
   e. Understands the difference between HIV infection and AIDS
   f. Understands how to avoid passing the virus to others
   g. Discusses telling sexual partner(s)
   h. Reflects on informing health care providers
   i. Is given a date for follow-up counselling
Unit 3

Giving Supportive Care to Persons Living with HIV/AIDS (PLWHA) and their Families

Terminal Performance Objectives

After studying this unit, the CHO will be able to:

- Provide health education to PLWHA and families on how to improve their health
- Provide support to PLWHA and their family

Rationale

Mention why this objective is important to the CHOs:

Provide health education and support to PLWHA and their families

Topic Outline

Supportive Care to PLWHA and the Family
Topic Outline 1: **Supportive Care to PLWHA and the Families**

**Facilitator-Participants Interaction**
Introduce topic using questions and answers (Q&A), brainstorming, role plays, case studies, group discussions, demonstrations, etc.

**Questions and Answers**

1. Outline some of the things that PLWHA need to know for positive living.
   a. That their HIV status is confidential
   b. Factual information about his/her condition
   c. Mode of spread of HIV/AIDS
   d. Information on how to reduce risk of re-infection and of infecting others
   e. Correction of myths
   f. Information on good nutrition or diet
   g. Stress and how it can be managed or minimized
   h. Follow-up care

2. How can you help a client who has tested positive to take actions to prevent spreading the infection to others?
   a. A client who tests positive to the HIV test must be counselled to change from behaviours that could lead him/her to spread the virus to others
   b. He/she must be encouraged to practise safer sex and abstain from donating blood and sharing sharp instruments with others
   c. A lactating mother must be told of the possibility of transmitting the virus to the baby and needs to take a decision as to whether to breastfeed the baby or feed with formula. Tell the pregnant mother that there are drugs that can reduce the risk of transmitting the virus to her baby and support her to get access to the medicines
Activity 2: **Case Study on Supporting PLWHA**

1. Divide the participants into groups. Each group should read and discuss the following case studies and provide answers to the questions that follow.
2. Call on each group to present their answers on flipchart.
3. During the plenary session, ask if the other group members have different answers or contributions to make.
4. Comment positively on the answers.
5. Compare/contrast what both groups have written or ask others if they see similarities or differences.
6. Summarise the answers and close the session.

**Background**

On your visit to Baba Moro Atinga’s compound, you found that his 30-year old daughter, Tene, was brought from her marital home sick. She complained of headaches, persistent weight loss, and persistent cough. She and her family believed that the husband’s first wife was bewitching her.

You referred her to the Health Centre where after several investigations, it was revealed that she was HIV positive. Nevertheless, Tene and her family still believed her rival was behind it all. As such, Tene and the family, including the husband are not taking preventive measures to control the spread of the infection.

**Questions and Answers**

1. **What will you do to get Tene and the family to accept the cause of the infection?**
   
   Continue counselling them until they modify their behaviour. They can continue to hold on to their beliefs of the causes of Tene’s disease but since she is having physical manifestations, they will be encouraged to adopt preventive measures to control the spread of the infection. If this fails, they should be referred to a senior counsellor in the district.

2. **How will you get the husband and his sexual partners to do the HIV test?**
   
   Counsel the husband to undergo the HIV test. If he agrees and the test is positive, counsel him on the need to get the other wives tested. However, if he has a negative test result, then educate him on preventive measures. Counsel the other wives on preventive measures to take without exposing the positive status of Tene.

3. **What preventive measures should Tene take to prevent further spread of the infection to:**
The husband:

a. She should use condoms during sexual intercourse
b. She must not share sharp instruments such as blade, needles

Other family members:

a. She should have her own toothbrush, which she must use alone
b. She must not share sharp instruments such as blades, needles

4. How will the husband protect himself from infection or re-infection?
   a. He should use condoms during sexual intercourse
   b. He should have his own toothbrush, which he must use alone (he must not share with the wives or anybody else)
   c. He must not share sharp instruments such as blades, needles

5. How will the husband protect the other wives or partners from infection?
   a. He should use condoms for all types of sexual intercourse
   b. He and the wives may have non-penetrative sexual practices such as hugging, kissing, and rubbing
   c. He should have his own toothbrush, which he must use alone (he must not share with the wives or anybody else)
   d. He must not share sharp instruments such as blades, needles, etc

6. What effect is the discovery of HIV infection likely to have on Tene’s marital relationship?
   a. A discovery of infection with HIV or a diagnosis of AIDS can create severe marital stress
   b. It can result in suspicion that a spouse has been unfaithful and has also put the other spouses at risk of acquiring HIV infection. This could result in anger that could lead to immediate separation and future divorce

7. Some spouses may want to stay in the marriage to take care of the children and even the spouse.
   Does this mean any emotional distress has been resolved?
   a. No. Unresolved anger may lead to outbursts of rage against the infected spouse or such outbursts may be misplaced on children and/or other family members
   b. The fear of being infected exists so is the fear that one of them will die soon
8. What are some of the issues that spouses who agree to stay together need to deal with?
   a. Spouses who agree to stay together need to decide whether sexual relations will continue, agree on practising safer sex and whether to trust each other again
   b. A counsellor can be very helpful in working with spouses to deal with their feelings and the practical details of their lives together

9. Outline some basic facts you will remind the family about during visits.
   a. AIDS is not spread through social contact
   b. AIDS is not spread by skin contact
   c. PLWHA need nutritious food that provides energy, protein and vitamins
   d. PLWHA need to be touched and caressed
   e. Sexual intercourse with a PLWHA may lead to transmission of HIV infection
   f. Blood, vaginal secretion and semen of a PLWHA are contagious
   g. Clothes and utensils that have been in contact with body fluids of the patient should be boiled and/or soaked in a disinfectant

10. How can relatives of a PLWHA care for him/her?
    a. Relatives of PLWHA need to remember that they need physical and psychological closeness, and support just as anyone else and even more
    b. Their skin or breathing does not transmit the infection. A PLWHA may know that he/she has a deadly disease once a diagnosis is made. This can cause fear, anxiety and anger. Relatives should be prepared for this
    c. The PLWHA needs time and help to deal with these feelings. He/she needs somebody who is prepared to listen and support him/her. He needs to be encouraged to continue to live and take part in daily activities as much as he can
    d. Perhaps, he/she may want to talk to a pastor or counsellor or someone else, who can give him/her spiritual and emotional reassurance. As a CHO you should encourage this and help arrange it
    e. AIDS patients who suffer badly from fever, diarrhoea and pain may need to be cared for in a medical institution for a period of time
    f. Persons who can be cared for at home, however, are likely to be sent home because families can better respond to the social and psychological needs of their sick member
g. Most times, family members can give better care. At home, the patient is in familiar social surroundings where he is likely to feel more secure (that is if he is accepted by the family)

11. What rights do persons living with HIV/AIDS have?
   a. PLWHA have rights just as any person
   b. They have the right to health care, privacy, confidentiality, information, security, etc
   c. They also have a responsibility to their neighbours by behaving in ways that will not transmit the virus to others. For example, using condoms during sexual intercourse and not sharing instruments that have come in contact with their body fluids with others

12. Why are people with AIDS or HIV infection discriminated against or stigmatised in our communities?
   a. This is mainly due to community attitudes on sexuality. Since HIV is mainly sexually transmitted and those with multiple sexual partners are at a higher risk, anybody who becomes infected is seen as immoral and promiscuous. This leads to negative attitudes
   b. The misconception that one can become infected through casual contact with a PLWHA can result in the community rejecting and isolating the sick person
   c. Many households in Ghana are communal, and share bathrooms, kitchen and compounds. The fear of contamination can, therefore, lead to the PLWHA being ejected from a house. Counselling of individual households and general education in the community will help in changing such negative attitudes that result mainly from ignorance

**Close topic**: Summarise main ideas and link to topic
Checklist 5.1: Performance Guide for HIV/AIDS

Instructions:
Rate the performance of each task/activity observed using the following rating scale.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Task/Activity omitted</td>
</tr>
<tr>
<td>1</td>
<td>Task/Activity in correctly performed</td>
</tr>
<tr>
<td>2</td>
<td>Task/Activity correctly performed (Hesitated)</td>
</tr>
<tr>
<td>3</td>
<td>Task/Activity correctly performed with confidence</td>
</tr>
<tr>
<td>N/A</td>
<td>Task/Activity not required in this observation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Task/activity</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Greets client(s)/couple respectfully and makes them comfortable</td>
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</tr>
<tr>
<td>2. Offers seat</td>
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</tr>
<tr>
<td>3. Provides privacy</td>
<td></td>
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<tr>
<td>4. Assures client(s) of confidentiality</td>
<td></td>
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<tr>
<td>5. Introduces self to clients(s)</td>
<td></td>
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<tr>
<td>6. Asks about reproductive goals</td>
<td></td>
</tr>
<tr>
<td>7. Uses GATHER or REDI steps to assess client(s)</td>
<td></td>
</tr>
<tr>
<td>8. Introduces HIV/AIDS topic to clients</td>
<td></td>
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<tr>
<td>9. Allows client(s) to ask questions</td>
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<tr>
<td>10. Talks to client(s) about pre-test counselling</td>
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<tr>
<td>11. Informs client(s) there is the need for a second test if result turns out to be negative</td>
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<tr>
<td>12. Helps client(s) to understand what the test is and what it involves</td>
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<tr>
<td>13. Counsels client about post-test implications</td>
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<tr>
<td>14. Talks to clients about how to reduce re-infection</td>
<td></td>
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<tr>
<td>15. Corrects misconceptions and myths</td>
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<tr>
<td>16. Talks to client(s) about signs and symptoms of the disease</td>
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<tr>
<td>17. Demonstrates how to wear a condom</td>
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</tbody>
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Unit 1

What is AIDS?

AIDS: stands for Acquired Immune Deficiency Syndrome

- **Acquired** means got from; the individual is not born with it i.e. the disease is not genetic
- **Immune** refers to the body’s natural ability to resist infection
- **Deficiency** refers to the situation where the body’s natural ability to resist infection is reduced and therefore cannot fight germs that attack it effectively
- **Syndrome** refers to a set of signs and symptoms, which occur together and may indicate a particular disease

How does HIV affect the body’s defence (immune) system?

The HIV virus attacks the white cells in the blood. When these cells enter the body they multiply and release many identical viruses into the blood stream. These new ones also enter more white cells and produce many viruses, which also enter more white cells. The process continues until at a stage most of the white cells have become diseased and therefore cannot function effectively to fight diseases and protect the body. At this stage the individual develops the disease known as AIDS. The person’s body is not able to fight most infections and therefore becomes ill very often and finally dies.

What is the difference between HIV and AIDS?

When a person becomes infected with the HIV germ, the body produces antibodies against the infection. The antibodies can be identified in a blood sample. If it is detected in a person’s blood the individual is said to have HIV infection. He or she may probably show no signs or symptoms of the disease.

The virus lives in the body and can be passed to other people, even though the infected person has no outward signs or symptoms and may not know he or she is infected. It is not yet clear how long a person can remain a symptom-less carrier. It is estimated to be between 2 to 10 years or even longer. There is no way to eliminate the HIV virus from the body.

Eventually the virus damages the immune system’s ability to repair it, and the person develops signs and symptoms of illness. When certain signs and symptoms appear, especially if supported
by laboratory evidence of severely reduced immunity, the person is said to have AIDS. The signs and symptoms of AIDS have been divided into two main categories: major and minor. Although progress is being made in treatment approaches, there is no known cure for AIDS.

How is HIV transmitted?

HIV is carried in body fluids, and the most important fluids for transmission are semen, vaginal fluids, breast milk and the blood. All forms of penetrative sex, including oral sex, can transmit HIV infection, though anal sex carries the highest risk of transmission of the disease. HIV is transmitted through blood transfusion and intravenous drug use, though the risk of acquiring the infection from needle stick injury is low. HIV may also be transmitted to the foetus during pregnancy and labour and to the newborn during breastfeeding.

What is Mother-to-child transmission?

Mother-to-child transmission is the passage of the HIV virus from the mother to her baby during pregnancy, labour or breastfeeding. Transmission during pregnancy usually occurs in the later stages.

MTCT is by far the largest source of HIV infection in children below the age of 15 years. In countries where blood products are regularly screened and sterile syringes and needles are widely available, it is virtually the only source of the infection in young children.

Referring HIV/AIDS cases

You will make referrals according to the National Reproductive Health Service protocols. You may refer a client known or suspected to be HIV positive or with AIDS for a test or treatment of complications. Such a client should be treated with the same level of respect as if she or he had come to you for counselling about their reproductive health or a family planning method. You will need to focus on providing clear, basic, and accurate information about the condition. Provide privacy for your clients (both young and old) as you provide HIV services and keep your knowledge of their condition confidential.

Make sure that a client who needs to be referred understands what she or he is to do and where to go after leaving you. Be sure the client understands the need to protect others from acquiring the infection. Discuss with clients the need for their partners to be counselled for HIV testing if you are referring the client for a test. Be sure to keep yourself informed about the resources in your community so you can make appropriate referrals.
Management of HIV/AIDS

a) Medicines and herbal preparations

So far there is no cure for AIDS, neither has a vaccine been developed for protecting the body against the infection and the disease. Nevertheless, anti-retroviral drugs are effective in controlling the infection, reducing sickness episodes and prolonging life. Although some herbalists claim to have herbal cures for HIV/AIDS, none of these claims have been proven scientifically.

PLWHA are just like any other person suffering from a terminal disease. Like other sick persons, they need psychological, social and physical support. In reality this may be difficult for some families as AIDS is generally perceived as a disease of shame and affected persons are often socially stigmatized. If this happens to be the attitude of the family members towards the PLWHA, he/she could face some kind of rejection. An attitude like this could hasten the disease process and death, and therefore this should not be allowed.

In some families, the family members may not know or refuse to accept the diagnosis. They may even attribute the disease to witchcraft. This is an equally dangerous stance, because such families are unlikely to take the necessary precautions to avoid contracting the disease.

b) Support and Education

Support in times of calamity has been shown to be very helpful to victims. This is true for PLWHA who live with the perpetual fear that sooner than later they will die. They need among other things physical, emotional and social support. As a CHO you can be very supportive to these clients by being non-judgemental in dealing with them. These clients are already blaming themselves in one way or the other for contracting the infection. A reprimand from you will be too much for them to bear. You therefore need to show empathy and let the clients know that you care for them.

As a CHO, you are ideally suited to help the family to understand the whole disease process. Show them your unflinching support and let them know that you are there for them when they need you. You should liaise with the Department of Social Welfare and other related support groups including religious groups and NGOs in your community.

Preventive Strategies for HIV/AIDS

Your clients need to know about STIs and HIV and how they can protect themselves.

What they need most from you is your help in making appropriate choices. They (including women and adolescents) need encouragement and strategies to negotiate condom use with
their partners. Your good counselling practices and your knowledge of the perception of your community members on sexual issues are your best tools. Your willingness to discuss issues of sexuality frankly with all clients will help them overcome the embarrassment that can interfere with accurate information they need to receive.

As a CHO, you will need to be skillful in demonstrating the techniques of how to put on a condom. This is because the condom is the most effective method for sexually active persons to protect themselves from HIV/AIDS and STIs. Using the penis or a female model, follow the steps in the performance guide for correctly putting on and removing a male and a female condom.

Remember to educate your clients to use non-expired condoms. Be sure to discuss with them the proper methods for disposing of a used condom. Clients will need help in making choices and developing skills for negotiating condom use.

Everyone can avoid HIV/AIDS by modifying their behaviour especially sexual behaviour.

- Abstinence - Some people choose to abstain from sex. This is the safest way of avoiding contracting the disease through the sexual routes
- Having safer sex - Safer sex is any sexual practice that reduces the risk of passing sexually transmitted infections (STIs), including HIV from one person to another.

The safer sex practices are:

- mutually faithful relationship between two uninfected partners
- using condoms for all types of sexual intercourse, i.e. vaginal, anal and oral
- non-penetrative sexual practices such as hugging, kissing, and rubbing.

There are other measures that decrease the risk but are not in the category of “safer sex”. Some of these measures are:

- Reducing the number of sexual partners
- Avoiding sex when there is an open sore on the genitals
- Avoiding sexual intercourse when suffering from any STIs
- Avoiding having sex with partners who have STIs or open sores on their genitals
- Prompt treatment of STIs. This helps a lot in the prevention of HIV infection

Alcohol and drugs impair one’s judgment. You must therefore educate and encourage men, women and adolescents to stay away from alcohol and drugs to avoid taking such risks as having unprotected sex, while under the influence of such drugs.
Prevention of Mother-To-Child Transmission (PMTCT)

Various approaches can be used to reduce the number of children who are infected though you may not be in a position to implement all of them. Therefore, you need to find out the nearest institutions, which offer such services for easy referral.

Primary Prevention of MTCT

What you can do here is to educate people including adolescents on taking preventive measures to protect themselves from contracting HIV through abstinence, safer sex, avoidance of the use of unsterile hypodermic syringes and needles and other sharp instruments.

Encourage women and adolescents to know their HIV status through voluntary counselling and testing. If they are HIV-positive, they may wish to use family planning (FP) methods to avoid pregnancies. Note that irrespective of the choice of method, the client must use condoms to prevent re-infecting himself/herself and infecting others (even if the partner is already HIV-positive).

Anti-Retroviral Therapy (ART)

During late pregnancy and labour, the HIV positive mother and the child could be put on Anti-Retroviral Therapy (ART) where available.

Reducing Transmission during Labour

Observe strict infection prevention measures when conducting delivery by using sterile or high-level disinfected instruments.

Reducing Transmission during Breastfeeding

This means giving the baby replacement feeds. Minimising breastfeeding could reduce transmission of HIV but will also eliminate the significant health benefits that children get from breastfeeding. Furthermore, because of poverty most mothers are not able to afford replacement feeding. This could be worse for an adolescent mother who is a dependant herself. You may need to educate the expectant mother before and after delivery on the probability of transmitting the virus through the breast milk to the baby to ensure that she can make an informed choice on feeding the baby. You can, with her permission, locate a source for donations in kind or cash from individuals and/or charitable organisations for her. In communities where many babies still die from infectious diseases, however, women with HIV should breastfeed their babies especially when no acceptable alternative is available.
Concerns of PLWHA

PLWHA are generally stigmatised. They are seen as accursed people paying for their sin because HIV/AIDS is seen as disease of the promiscuous and unfaithful sexual partner. This is rather unfortunate because this kind of perception discourages PLWHA from informing people including their sexual partners of their HIV status. Consequently, they continue with behaviours that could lead to further spread of the infection.

Concerning employment, PLWHA are more likely to lose their jobs or not get employed if their status is known. This is due to the general stigma suffered by PLWHA. Further, employers generally hesitate to employ someone whose life span they are aware is short, as it were. For similar reasons employers would not like to spend resources to build capacity of PLWHA who are already in employment. Additionally, PLWHA are more likely to be absent from work due to ill-health, which will negatively affect their productivity. Even for those who are self-employed, they may lose a significant number of their clients. For example, a hairdresser who is known to be HIV positive is likely to lose clients because of the misconception that she can transmit the infection to her clients during the course of her services.

Cultural Influences and Beliefs

Culture, which is a way of life, affects every aspect of our lives including the meaning we give to health and disease. In almost all communities in Ghana, disease is seen as a cause of physical and/or spiritual factors. For example, a known commercial sex worker who contracts the infection may attribute it to the HIV virus or to the fact that a spell has been cast on her for having sex with someone’s husband. The causative factor assigned to the infection determines to a large extent the kind of treatment that the patient will seek.

Two other major cultural practices that influence the spread of HIV/AIDS are polygamy and extramarital affairs of men and women. Society has grown to accept polygamy and extramarital affairs of men without questioning. These practices enhance the spread of the AIDS virus as the more sexual partners that one has the more likely it is that one will contract the disease. If the man who practises polygamy and indulges in extramarital affairs does not use condom properly and consistently he is likely to contract the disease and pass it on to his partners.

Other cultural practices such as the use of communal enema kit and any traditional treatment that includes skin piercing or cutting (e.g. circumcision, tribal marks, tattooing) can be a source of infection in a community.

As a CHO find out what prevails in your community that can be a source of infection and discourage such practices. This must be done by educating the community on the fact that whether the infection is perceived as contracted physically or spiritually, the condition manifests itself physically, therefore physical measures must be taken to control its progress within the person’s body and prevent its spread to other people.
Developmental and Gender Issues Related to HIV/AIDS

HIV/AIDS epidemic affects all sectors of development including health, education, labour, economy, transport and agriculture. In some eastern African countries, it has been reported that there are some schools where there are no teachers because all of them were incapacitated or died of AIDS. This puts a lot of burden on an already fragile national economy, as more teachers have to be trained.

Granted that education is the bedrock of development, one can easily see the implications of what infection with HIV can do to the economy by attacking the human resource.

The loss of people in the most productive years of their lives will certainly affect the overall economic output. Some sectors, particularly those that require trained and skilled workers will be the most affected. The productivity of an enterprise will be affected even before an employee dies, due to lost workdays as a result of absenteeism.

The number of workdays lost to illness for a person with HIV/AIDS can range from 30 to 240 days in a year. Even healthy workers may need more time to attend to funerals of relatives and co-workers. AIDS can also have a significant impact on health care cost even for firms that provide health care for employees.

Finding out that one has tested HIV antibody positive or has AIDS can be a very difficult experience. There are some factors that make it even more challenging for women. Traditionally, women are the caregivers of children, partners, other family members and friends. Therefore, even a woman without HIV infection can face problems and stresses.

Although HIV/AIDS affects both sexes, it seems to have a greater impact on women, because of the physical and the psychosocial make up of women. Physically, research suggests that women are two to four times more at risk to HIV infection than men during unprotected sexual intercourse because of the larger surface area exposed to contact. Similarly, women are more vulnerable to other sexually transmitted infections, which facilitate the transmission of HIV infection. STIs that bring on recognisable symptoms in men are often asymptomatic in women and, therefore, remain untreated. Women are also especially prone to AIDS because they may have limited ability to protect themselves from HIV infection. A woman may be at risk of getting HIV even though she is faithful to her husband, because her husband has extra-marital affairs. She may have little or no control over her husband’s actions and no ability to protect herself by asking her husband to use condoms.

Women experience HIV infection differently from men. Here are some of the differences that are reported:

- Vaginal yeast infections become persistent and difficult to treat. Recent studies have suggested that a key health strategy for HIV positive women should be to focus on the
control of Candida (a type of yeast infection) to prevent it from becoming chronic and systemic

- HIV positive women experience changes in menstrual cycles and vaginal discharge
- HIV positive women can experience hormonal changes, for instance, hot flushes
- The incidence of pelvic inflammatory disease (PID) increases in HIV positive women

Information on the effects of HIV and AIDS infection on reproductive health is not fully known. Previously, pregnancy was thought to increase the risk of accelerating the course of AIDS. At the moment, this does not appear to be true in a healthy woman. While some health providers caution against pregnancy others advocate delaying it. In fact, delaying pregnancy reduces the woman’s ability to carry a baby to term as HIV infection progresses into AIDS. In either case, the need to make this decision may create a profound sense of grief or loss.

Many women are economically dependent on their partners and fear the consequences of challenging the status quo in their relationships. Even when provided with information, many women do not have the power to implement changes in their partner’s behaviour or even in their own. They can hardly negotiate for condom use even if they know their husbands have other sexual partners.

Unit 2

Counselling on HIV/AIDS

Apply the GATHER & REDI Steps

The process in providing HIV/AIDS counselling can be conceptualised as follows:

1. Beginning Stage - Organising oneself, prior preparation and reception of client
   - Establishing Rapport
     - Greet
     - Welcome
     - Use body language to express warmth and acceptance
     - Introduce yourself
     - Find out what client’s expectations are - reasons for coming
     - Assure confidentiality
2. Middle Stage - Learning More

- Use open-ended questions and listening skills to learn more about your client especially in specific areas. For example, about personal, family, marital and sexual history, support system available to him/her, adjustment, coping skills.

- Use crisis counselling, information-giving and problem-solving skills to help clients adjust to their HIV status and/or stop risky behaviours. During this stage a combination of skills will be used e.g. empty chair, role reversal.

3. End Stage - Action Plans

- Help client decide what he is going to do
- Help generate alternative action plans
- Help assess consequences of plans and decide on best alternative
- Help client implement plan
- Support and encourage client to maintain behaviour changes. Counsellor should gradually wean client from relationship because client can now function adequately and is capable of coping. Assure client of willingness to help when needed.

These counselling stages are to help provide a working model for counsellors.

However, counsellors should be flexible. Clients come with different needs e.g. a client can enter the counselling relationship already in crisis because his HIV status has been revealed. What counsellors need to do is to ascertain what help clients need most at the time, what their greatest concerns are and counsel to meet these needs.

HIV Pre-Test Counselling

Anyone thinking of having an HIV antibody test should be counselled before having the test. After deciding to have the test, some clients may not appreciate the relevance of such counselling or they may delay testing. Counselling is one means of helping individuals look at the wider and deeper implications of having the test and making informed decisions. This may involve working with partners or families and supporting clients in whatever decisions they make.

It is important for you to determine early whether the client has come voluntarily for counselling or has been pressured into coming. The client must desire to have the test. The client who wants to have the test is more likely to accept the outcome and take information given during the counselling sessions more seriously. You should explain the aims of the pre-test counselling and then ask clients to decide whether they want to continue or not.
In sum, the HIV pre-test counselling helps a client to understand what HIV/AIDS is, what the test involves and gets him to appreciate the implications of the test results.

Need for pre-test counselling

Most people like to be prepared for the unknown. The scary nature of being HIV positive and the consequences demand that all clients, especially adolescents, be helped through counselling to get prepared for any outcome. The adolescent who tests negative also needs to know that being negative at the first test does not mean there is no infection. There is the need for a second test six (6) months after the first test within which time he/she is not exposed to the virus in any way. Even when the results turn out to be negative, the client or adolescent still needs counselling to remain negative. Counselling, therefore, becomes an important strategy in the prevention and control of the disease and in the provision of psychosocial support to those already infected.

As a CHO, you see your clients for various reasons. Use any of these opportunities to introduce HIV.

Pre-test counselling goals

**During a pre-test counselling session, the Counsellor should:**

- Affirm that the testing decision is truly the client’s choice and must constantly be on guard against exerting any influence on the client to make a decision
- Ensure that the client gets important information, including risk-reduction counselling, because the client may not be able to grasp any new information immediately after receiving test results
- Provide an opportunity for the client to ask questions and discuss fears

You can ask the following:

- Why do you want to take the test at this time in your life?
- What do you expect the test to tell you?
- Are you at risk of HIV infection? Through what specific behaviour? How can you reduce these risks?
- What kinds of support do you need to change these risky behaviours?
- How will you react if your test result is positive? If it is negative?
- Who will you tell about your antibody status? How? Why?
- How will you protect yourself from discrimination if your result is positive?
• What kinds of support will you need? Where and from whom will you get this support? When counselling, know that you do not have all the answers. Refer when necessary.

The HIV Test

The HIV antibody test is a blood test used to determine whether a person is HIV infected. The test detects the HIV antibodies, which people produce in response to HIV infection. It does not detect the virus itself. Antibodies will take a few weeks to be produced in sufficient numbers to be detected by the test. The length of time for the antibodies varies from person to person.

What is the Limitation of HIV Antibody Test?

Because of the time lag for the development of antibodies, a person who has been infected recently will not have built up antibodies, and the HIV antibody test will not detect the infection. It can take as long as six months for one to develop the antibodies to the HIV when infected. Thus, what the test tells us is limited. It tells us that HIV has infected a particular person. It does not tell us when the person was infected; neither does it tell us if the person will go on to develop AIDS.

Most persons infected will develop AIDS, in the absence of treatment, but we do not know when. Nonetheless, it usually develops in a few years. Indeed, many people who are HIV positive will develop AIDS sooner or later. It is important that you are fully aware of these limitations of the test. A negative test result does not necessarily mean that the client is not infected with HIV. A second test must be conducted in six months within which time the client should not have been exposed to the virus in any way.

You and the clients should realise that the HIV antibody test is a specific test and that other blood tests such as those for Hepatitis will not detect HIV antibodies.

Post-Test Counselling

Post-test counselling provides the caring, understanding and warmth that reduce the trauma and rejection of family or society. It also helps clients better understand themselves and the nature of the many problems they will face later. Through post-test counselling, the client can learn how to make realistic decisions and cope with situations. A post-test counselling therefore involves crisis intervention, problem solving and decision-making.

Post-test counselling goals

• Tell the client the results of the test without delay to avoid undue anxiety
• Clearly discuss the meaning and implication of test result
If the client tests negative it means that the client:

- Must eliminate or reduce risky behaviours to stay negative
- Should re-test in six months within which period he/she is not exposed to the virus in anyway

If the client tests positive it means that the client:

- Can infect others
- Does not necessarily have AIDS and could stay healthy for a long period
- Should know about risks for reproduction

If the client tests positive, the CHO should:

- Help client develop a plan for future risk reduction:
  - stress the importance of reducing risky behaviour (you should be as specific as possible, must find out what client’s specific risks are)
  - develop specific, concrete plans for reducing risks, (what specific support or referral does client need to do this?)
- Help client find support:
  - health care (medical, dental, experimental drugs)
  - mental health (support groups, therapists)
  - social services (financial, housing, recreation)
  - legal assistance (wills, child custody, discrimination)
- Help client decide who to tell about antibody status. Those he could tell may include:
  - sexual and drug use partners
  - health care providers including dentists
  - family
  - friends

What more does the sero-positive client need to know?

For clients who are HIV positive but not ill, it should be emphasised that they are not ill and can live a normal satisfying life provided they stop risky behaviours and adopt a healthy lifestyle. You should point out that no one knows when and how one will die. Having HIV puts a person
in the same category as numerous others who have conditions with no known cure, e.g. diabetes, hypertension.

Like them, they can learn to cope positively. It is very important for you to respect confidentiality. You are aware of how fast news travel, especially in small communities. Let the client know that strict confidentiality will be maintained and that no information will be revealed to anyone who is not directly involved in their care without their permission. Counselling will also be available to significant others (relatives) who clients would like to confide in.

How to reduce risk of re-infection and of infecting others

- Counsel HIV positive clients especially adolescents to avoid sex if possible, or to use condoms each time. Condoms should be worn correctly and used only once and disposed of properly (wrapped and burnt later). Condoms are not 100% proof but they do protect if used correctly. An adolescent who is HIV infected may have a partner who is also infected with HIV. He/she may be exposed to re-infection by every act of intercourse and it has been suggested that this may increase the risk of progression of the disease. He/she may also be exposed to other sexually transmitted infections, which can further suppress her immunity and thus increase the progression of AIDS

- Girls who have their menses should burn whatever they use, e.g. toilet rolls, cotton wool, sanitary towels. Those who use rags should soak them in household bleach (chlorine/parazone) before washing them (buy household bleach from recognised shops). Bath floors or baths should be disinfected with household bleach after bathing

- Advise clients to use concentrated household bleach

- Household bleach should be used to disinfect articles soiled with body fluids e.g. blood, vomit, faeces

- Open wounds and cuts should be dressed and covered with plaster

- Toothbrushes, razor blades or anything used for shaving or cutting nails, should not be shared because they can be contaminated with infected blood

- There is no risk of infection from sharing cups, plates and other household items where there is no contact with blood. Toilets and bathrooms can be cleaned with 0.5% parazone if blood or faeces contaminate them. Otherwise, they do not need extra attention. These can be shared. Infected persons can eat together at table with uninfected friends and family members without risk of transmitting the virus to them. However, if this client has other infections such as Tuberculosis (TB), precautions that will be taken for a TB patient should apply

- HIV positive people should not donate blood
Correction of myths

Correct false beliefs about AIDS and remind clients that there are other diseases which have no cure, e.g. hypertension, diabetes, sickle cell disease, and inform clients about how to reduce the risk of future infection.

Diet

As much as possible the client should take nutritious diet and avoid foods that will give diarrhoea. Learn about nutritious food items in your locality and encourage clients to eat them, as they are cheaper than imported ones.

Stress

Clients who are HIV positive should be taught to avoid stress as much as possible. Where stress cannot be totally avoided, the client needs to learn to cope with it. This involves exploring the adolescent client’s own ways of coping and his support systems.

Follow-up

Stress the need for follow-up appointments. Book a convenient time for the client and family for your follow-up visits. During the follow-up visits, discuss any problems that the client brings up; see to his medical needs and reiterate needed information. Encourage him to call on you whenever he is not feeling well or if he has any problems.

What clients need to know to remain uninfected if the result is negative

The antibodies to HIV may not appear till about six months after the infection. It is important that the test be repeated after six months. In the interim, they should be counselled to adhere to the same preventive measures as in the case of those who test positive.

You can help a client with HIV negative test result to remain negative by counselling him to avoid risky behaviour. He/she should avoid having multiple sex partners, remain faithful to a sexual partner, and avoid injections from quack doctors. If client decides to have sex he/she should use condoms or other safer sex practices. You also need to remind the adolescent of the probability that the sexual partner is someone else’s former or current sexual partner. Therefore, it is very important to practise safer sex because the status of his/her partners could be positive.
Techniques Needed for a Counselling Session

How will you practise crisis-counselling skills?

Crisis counselling involves the recognition of the trauma a client is going through and helping him/her to overcome it with minimal physical or emotional injury. Reactions to the trauma of testing HIV positive differ from culture to culture, but no matter the type of response, it is a time of crisis for the person. A client in crisis is likely to feel helpless and despair, with little control over what is happening to him/her. The client may or may not express his feelings. If he does not, it is important to encourage him to express feelings. You should also provide a structure through guided questioning to clarify what the crisis is for the client. When this is clear, you together with the client can start working on how to resolve the crisis. In Ghanaian counselling units, a typical response is that the client becomes very quiet or has a stunned look. They may even cry. Tell the client that it is natural to feel that way when such news is broken. As a CHO, express empathy and your availability to offer support. After the client calms down, encourage him to talk, to express his feelings and to ask questions.

A client may react by attributing the infection to curses and witchcraft. As a counsellor, you have to respect his/her view without condemnation. You could use this as a starting point to educate client on the infection without hurting his/her feelings. For example, tell client or a family member that even if it is spiritual, the HIV infection manifests itself physically and therefore the client has to be prepared to attack it in the physical realm.

How will you carry out problem-solving counselling?

As a client calms down and considers realistically the effect of being HIV positive, he/she needs to be helped to clearly define what problems are likely to occur from being HIV positive or having AIDS. For example, how is he going to cope with fear and anxiety, what medical care would be needed, how can re-infection be avoided? You are to help client think through what can be done to enable him/her regain control over what is happening to him/her. Thus, problem-solving counselling and crisis counselling are intertwined. Through this the client can make decisions about his/her life. For instance, who is the client going to inform, what medical options are available to him/her, how to avoid infecting others and re-infecting himself/herself? The process of making such decisions is termed decision-making counselling and involves helping the client to consider alternative decisions and their consequences. The aim is to arrive at the best decision for the client.

The Grieving Process

Grief is a complex emotional reaction to an anticipated or actual loss of someone or something valuable e.g. loss of a relative, a part of the body, a job, life or ill-health. In the case of PLWHA,
he/she grieves because he is about to lose his/her life as he suffers from a deadly disease which has no cure. Family members grieve because their loved one is about to die.

The grieving person passes through three main stages:

- **Shock and disbelief** - the person refuses the condition, as he/she believes that such a thing cannot happen to him/her. His/her attitude could be that of fear or panic

- **Develops awareness** - the reality of the loss becomes clear and client feels the impact of the situation

This could be characterized by:

- anger in which client blames himself/herself or others for the affliction
- crying

Help the client redirect the anger at the disease so that he can, for example, take positive steps to deal with the disease.

- **Restitution** - client gradually accepts the loss and is able to make the necessary adjustment and live a reasonable life. For PLWHA and those affected by HIV/AIDS, this could be the most appropriate time to rehabilitate them. This could be the time to educate and re-educate them on what to do to stop the spread to others and re-infecting themselves (or getting infected, in case of a relation who is not yet infected) and how to cope with life to the best of their ability.

The process of grieving is influenced by cultural factors and the intensity depends on the significance and extent of the loss to the person. It is generally greater if the loss is through sudden death or if the survivor had been particularly dependent on the deceased. As a CHO playing the role of a counsellor, during this grieving period, you are to provide a safe place for client to go through the crisis, talk about his/her fears and to help him/her gain control over his/her emotions before you part company.

You are to talk less during this period whilst allowing the client to ventilate, focus on the immediate problems and make decisions on what to do about them.

Those affected by HIV/AIDS go through similar grieving processes as those living with it. Traditionally in Ghana, the nuclear and extended families serve as the main support for individuals. If a family member falls sick, the family will delegate someone to help the sick person as well as support any children involved. Currently, however, many families are under stress. Lack of financial resources and diminished cohesiveness in the extended family (often results from urban living) has made it difficult for many families to take care of their sick as they used to. A sick family member is often seen as a burden on the family.

HIV/AIDS carries a social stigma, therefore, when a family learns that a family member has the
virus, it goes through the same stress as the individual does. There is the initial shock of knowing that a family member has an incurable disease and the possibility that the individual’s lifestyle may not have been exemplary. Possible revelations of infidelity, prostitution or a secret sexual affair may produce negative attitudes that can lead to rejection of the person. Some families become divided over the issue with some accepting the family member. This can cause family discord. Counselling family members can help resolve this family discord and anger for the sick member to get some support.

Some families accept and are willing to care for the sick family member. Such families still need counselling and not only education on how to care for the PLWHA. Caring for the sick person can affect family life. Someone may need to leave his job to care for the patient and this can lead to reduced family income and possible resentment towards the sick family member.

The sick person’s psychological turmoil over his/her predicament e.g. anger, bitterness, depression may strain the relationship between him/her and the caretakers. This could change their acceptance to rejection. Counselling can help the family to be aware of the person’s emotional turmoil and its effects. Therefore, they should learn to accept and accommodate the person.

PLWHA suffer many losses e.g. status, economic independence, health, appearance. The family experiences these losses also and therefore have to learn to deal with the impending loss. Apart from this, they have to face the fact that this family member they love is likely to die. Memories and grief about previous losses may be evoked resulting in a climate of depression and mourning that discourages and saddens the sick member. Counselling can help the family work through its anticipatory grief for them to support the HIV positive person more effectively.

Symptomatic Treatment in the Home

- **Diarrhoea**
  It is a common symptom, especially among children. As with other diarrhoeas, it is important to prevent dehydration. Give:
  - salt and sugar solution
  - oral rehydration solution
  - available home fluids, like porridge or soup
• Thrush
  ▶ use gentian violet
  ▶ rinse with mineral water

• Herpes zoster
  ▶ give aspirin or paracetamol to relieve pain
  ▶ do not smear with herbs or other preparations

• Fever
  This is a common symptom in both adults and children. Give
  ▶ fluids
  ▶ tepid sponging or cool rubbing
  ▶ aspirin or paracetamol tablets/syrup

• Cough/pneumonia/otitis
  ▶ a course of antibiotic medications may be necessary

• Itching and pain
  ▶ use of antihistamines and pain relievers may be required

Steps for Wearing a Condom

As a CHO, you will need skills in demonstrating the techniques of putting on a condom. This is because the condom is the most important means for sexually active persons to protect themselves from HIV/AIDS/STIs.

Wash hands before the demonstration. The pack should not be dry or brittle. Using the penis and female pelvis models, follow the steps below for correctly putting on and removing a male and female condom.

How to put on and remove a male condom:

1. Check the expiry date and make sure the pack is not damaged
2. Hold the pack at its edge and open by tearing from a ribbed edged. Do not use sharps or the teeth

3. The condom must be placed on an erect penis

4. Hold the condom so that the rolled rim is facing up

5. Pull the foreskin back if the penis is uncircumcised

6. Squeeze the tip of the condom between the fingers to push the air out

7. Still holding to the tip of the condom, place it on the end of the penis

8. Gently unroll the condom with the other hand all the way to the base of the penis, making certain there is extra space at the tip of the condom

9. Immediately after ejaculation, hold the rim of the condom at the base of the penis so the condom does not slip off. Slowly withdraw the penis from the vagina before the penis becomes soft

10. Remove the condom carefully to avoid spilling the semen

11. Wrap the condom and throw it away in a pit latrine, burn or bury it

12. Use a new condom for each act of sexual intercourse

How to put on and remove a female condom

1. Inspect condom for the expiry date

2. If condom has not expired tear the wrapper along the arrow mark indicated at one of the edges

3. Remove condom from the wrapper

4. Rub condom to spread lubricant. You may need to add more lubricant if you realize that the condom is not well-lubricated

5. Hold the inner ring of condom and squeeze it

6. Insert the condom into the vagina as far as it can go

7. Insert finger into the condom and push it up without twisting it

8. Guide the penis inside the condom during the sexual act

9. When the sexual act is over, squeeze and twist the outer ring of the condom, pull it out, wrap it well in a piece of paper and discard in a waste bin
Hints:

- For extra moisture and comfort use any water or oil-based lubricant
- Add extra lubricant if:
  - outer ring is pushed inside
  - penis sticks during sexual intercourse
  - you hear noise during sexual intercourse

Adapted from the Female Health Company’s instruction on how to use female condom

Note:
Remember to educate your clients to use non-expired condoms. Be sure to discuss with them proper methods for disposing of a used condom. Discuss the importance for both men and women to accept responsibility for their health. Women will need help in making choices and developing skills for negotiating condom use.
References


