

PRACTICAL GUIDE: PREPARING FOR BIRTH AND PARENTING

COMBINED EXPERIENCE
FROM THE SANSAS (SENEGAL)
AND SHAPE (SIERRA LEONE) PROJECTS

SANSAS
Sunu wergu yaram, sunu yite

SHAPE
SEXUAL AND REPRODUCTIVE HEALTH ACCESS AND PROMOTION OF EMPOWERMENT

Solthis
Committed expertise in health

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1. The watercolour images are based on photographs taken by the author or contributors on the ground, or on detailed descriptions of work on the ground.

INTRODUCTION

This document was produced as part of projects to improve access to sexual and reproductive health and rights led by Solthis and its partners: phase 1 of the SANSAS project (2021-2026) in Senegal and the SHAPE project (2024-2028) in Sierra Leone, with financial support from the French Development Agency (AFD). The aim of this document is to share the experience and key learnings on Preparing for Childbirth and Parenthood (PCP) approaches implemented in these two projects in West Africa.

What is Preparing for Childbirth and Parenthood (PCP)?

Preparing for Childbirth and Parenthood (PCP) is a health education approach aimed at supporting women and their loved ones throughout pregnancy, birth and postpartum. It focuses on improving their knowledge, autonomy and ability to actively participate in decisions about their health and that of their child. The approach aligns with World Health Organization (WHO) recommendations on positive pregnancy and childbirth experience (WHO, 2016, 2017), as well as recommendations relating to sexual and reproductive health self-care interventions, particularly in terms of preparation for birth, psychoeducation, relaxation, psychosocial support, involvement of birthing partners and empowering women and their families (WHO, 2019) [2].

The PCP sessions presented in this document are facilitated by midwives and organized in small groups of pregnant women — and young women who have given birth — and their birthing partners. Sessions take place from the second trimester of pregnancy until the postpartum period and combine three inter-connected areas:

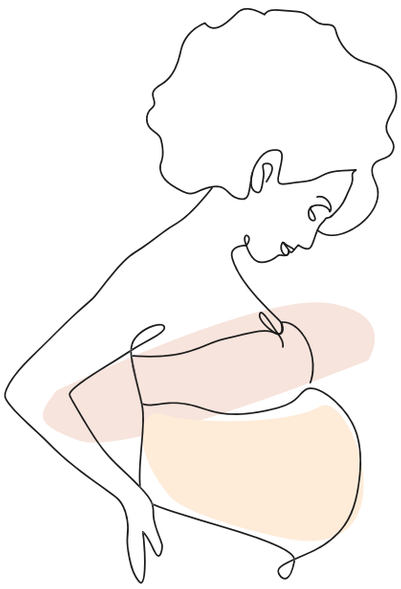
- **Mind and body -** breathing, movement, positions, relaxation, massage, touch, vocalisation, dance and exercises to promote self-awareness.
- **Education and reflection** - needs, concerns and realities experienced by participants (around pregnancy, birth, postpartum, parental care, how the baby adapts life outside the womb and sexual and reproductive health), that allow them to share and take ownership of knowledge that is useful for both their health and their baby's.
- **Interpersonal and social** - promoting experience-sharing, involving birth partners, making the most of resources within the family and at community level, and peer support between participants.

2. 2. WHO (2019) Consolidated Guidelines on Self-Care Interventions for Health: Sexual and Reproductive Health and Rights. Executive Summary.

WHO (2017). WHO recommendations: intrapartum care for a positive childbirth experience.

WHO (2016) recommendations on antenatal care for a positive pregnancy experience

Topics covered:



➔ **Topic 1.** Pregnancy, mind and body changes and emotional wellbeing

➔ **Topic 2.** Body, movement and comfort during pregnancy

➔ **Topic 3.** Preparing for birth: physiology, movement during labour and birthing positions, pain management, role of birthing partners, birthing experience

➔ **Topic 4.** Maternal health, seeking care and symptoms you need to get help for

➔ **Topic 5**. Newborns, parenting, breastfeeding and dietary diversification, first aid, carrying babies and baby massage

➔ **Topic 6**. Taking care of yourself in the postpartum period: support from those around you, nutrition, rest, perineal health, massage and pelvic tightening, sexuality and contraception

Why use this approach?

This approach is aligned with international and national recommendations promoting respectful care, positive birth experience and increased participation of women and their loved ones in decisions about their health during pregnancy, childbirth and postpartum[3]. It complements antenatal consultations, community talks and other common health education activities.

3. WHO (2019). Consolidated Guideline on Self-Care Interventions for Health: Sexual and Reproductive Health and Rights. Executive Summary.

WHO (2017). WHO recommendations: intrapartum care for a positive childbirth experience.

WHO (2016) recommendations on antenatal care for a positive pregnancy experience.

Ministry of Health and Public Hygiene. Republic of Senegal. *Management of pregnancy, childbirth, the postpartum period, and post-abortion care*. Dakar. p. 92.

Ministry of Health and Social Action of Senegal (2016). *Maternal, Perinatal, and Neonatal Health Policies, Standards, and Protocols*. Dakar.

Sierra Leone Ministry of Health and Sanitation (2017). *Sierra Leone National reproductive, maternal, newborn, child and adolescent health strategy 2017–2021*. Freetown: Ministry of Health and Sanitation.Pp.37-38

The PCP approach aims to:

► **Enhance empowerment of women and their loved ones**, by supporting bodily autonomy and involvement in decision-making.

►**Strengthen knowledge, skills and resources that can be used during the perinatal period**, to improve the birth and parenting experience.

► **Making the most of family, social and community-level resources around birth**, promoting dialogue on biomedical knowledge, women's lived experience knowledge and community knowledge.

► **Strengthen linkages between women, communities and health facilities** to promote care that is more adapted to the local context, and fosters more trusting relationships with health care teams and better use of care services.

How has the PCP approach been adapted to the contexts in Senegal and Sierra Leone?

In both countries, developing the PCP approach was a gradual process involving co-creation, experimentation and continuous adjustments. The table below shows key steps in the approach and results achieved at each stage of implementation.



Training of midwives on PCP, SANSAS Project, Senegal

Stage	Aim	Key activities	Results
Exploratory phase	Understand each context and co-create the approach with local stakeholders	› Document review › Visits to health facilities › Interviews with decision-makers, midwives and communities › Identifying pilot sites	Identification of needs, constraints, resources and opportunities for implementing PCP
Implementation and local adaptation	Developing an approach adapted to the real-life context for facilities and communities	› Socio-anthropological survey in Casamance on protective community practices in perinatal health › Targeting midwives at pilot sites and co-facilitated by two clinician-trainer midwives (one national, one international)[1]: participatory group sessions including training on PCP, how to structure PCP in health facilities, identifying your target groups, adapting the content and method of delivering PCP workshops to the socio-cultural context.	At this point (June 2026), the SANSAS project in Senegal has trained 48 midwives on PCP[2], has started up PCP workshops for pregnant women and their birthing partners in 3 pilot sites (health centres in Goudomp, Bambaly and Sédhiou) and plans to roll out PCP in four new sites in 2027. In Sierra Leone, the SHAPE project has implemented approximately the same level of activities and started up PCP workshops in pilot sites at the start of 2026. The two projects prioritised targeting pregnant adolescent girls and young women and their birthing partners.
Ongoing experimentation and adjustments	Progressively improve the approach based on feedback from the field	› Collecting feedback from participants, midwives, Solthis teams and decision-makers › Adapting the facilitation content, structure and methods	Gradual development of the approach based on needs observed
Learning	Draw learning from early implementation experiences	› Participative observation in participatory group sessions for midwives and PCP workshops led by midwives for pregnant adolescents and young women and their birthing partners › Self-assessment surveys and satisfaction questionnaires following participatory group sessions for midwives › Interviews held with Solthis team members, decision-makers, midwives who took part in participatory group sessions, midwives who facilitated PCP workshops, and pregnant adolescents and women who participated in at least two PCP workshops.	Beneficial impact of training midwives in PCP on daily professional practice, good social and institutional acceptability of PCP approaches, significant potential to strengthen linkages between women, families, communities and health facilities[3]. Lessons learned from implementation andmonitoring were also highlighted. The results are mentioned later in this document.

1. This co-facilitation approach supported expertise from the local context, clinical and educational experience, and also fostered the identification of peer participants and taking ownership of the proposed approaches.

2. The total of 48 midwives was composed of 8 midwives trained during a session held in Goudomp in May 2025, 15 midwives trained at a regional workshop in February 2026, 25 midwives trained during a national workshop with the National Association of State Midwives of Senegal (ANSFES) in February 2026.

3. As participants were only recently involved in PCP trainings and workshops, it is too early to be able to document the potential impact on care uptake practices, birth experience or health outcomes.

Results

The survey conducted for learning purposes highlighted three inter-connected areas:

- the impact of midwife PCP training on day-to-day care practice;
- the socio-cultural acceptability of the PCP approach among decision-makers, women and communities;
- lessons learned from implementing PCP group sessions.

Impact of midwife PCP training on day-to-day care practice

PCP training for midwives (organised as participatory group sessions) aimed to strengthen the skills needed to facilitate group PCP sessions, but also to foster greater coherence between messages shared during PCP sessions and practices actually put in place in health facilities.

Training took place over three days and the content focused primarily on:

- **clinical and mind-body skills,** including obstetric biomechanics, movement during labour, birthing positions, and non-drug approaches to pain management;
- **interpersonal skills,** focusing on respectful care provision, empathetic communication and dialogue balancing biomedical knowledge, women's lived experience and community knowledge;
- **facilitation skills** to prepare teams to lead groups, support discussions and be able to practically organise future PCP sessions.

Bodily wellness experiences and role plays as a pathway to adherence to the PCP approach

Several participants described the importance of feeling they were a catalyst to adherence to mind-body PCP approaches.

> *Each session was followed by practicals or exercises that the trainer had us do. Even if you are not pregnant, you feel an extraordinary sense of wellbeing, an extraordinary relief.*
> Badiénou gokh[4] (Senegal)

> *During the training and exercises, I felt comfortable, I felt good, and I thought to myself that it must be good for pregnant women.*
> Sage-femme (Senegal)

4. Badiénou Gokh is a Wolof expression literally meaning "neighbourhood godmother". In Senegal, Badiénou Gokh are often community outreach workers and are women recognised for their social leadership and ability to support other women and families on health, education and social protection issues, particularly around maternal, newborn and reproductive health.





Training of midwives in PCP: SANSAS (Senegal) and SHAPE (Sierra Leone) projects

Some midwives stated that this approach and the role plays have led them to reflect deeply on their own experience of giving birth and the way they support women. A Senegalese midwife shared that following her first day of training a thought came to her during the night: *" Last night, I was thinking about my first birth. I was very young and didn't know anything. My mother had only said to me: "You take a handful of sand in your hand, and when it becomes water, you are going to give birth." Last night I said to myself: no, women should be giving birth any more without explanations. They need to understand what's going on in their bodies."*

Role plays supporting empathy and transforming professional practice

These midwife quotes also show the impact of role plays on their professional practice, as they have to embody being a midwife, a birthing partner and a female patient.

In another exercise, a participant playing the role of a woman in labour received a back massage from a colleague. Afterwards she shared how she felt:

"When she massaged me I was blessing her in my head because it felt so good. I told myself that massaging a woman at work is really a gift that we can give them. Women who receive this will also bless midwives", (Senegal midwife).

> ***The training allowed me to put myself in the patient's shoes and this feeling pushed me to take care of her more. I have more compassion for the patient***
> Midwife (Senegal)




PCP training for midwives, SANSAS Project, Senegal)

Participants describe that the experience they gained from trainings improved their professional approach: *" What struck me during this training was care for the woman. There is humanism in the way we take care of women, we are attending to their needs. Putting this focus on the patient herself has had an impact on me. Previously, when a patient came for a consultation, I wouldn't open the door for her. Following the training, I get up to open the door for her and welcome her with a smile",* (Senegal midwife).

"The training made me less judgemental and more empathetic towards women", (Senegal midwife).

Midwives explain that they have gone from giving women orders and telling them what not to do to now taking the time to explain and negotiate, and seek buy-in and collaboration.

> ***There has been a change since the training. When we are working we communicate more with women. We ask them for their opinion, what they need: something to drink or eat, if a birthing partner will be present.... We teach them different types of massages to provide some relief. Before we did the training, we would forbid women from consuming liquid to stop them taking traditional decoctions because they caused complications. Since the training, we are more flexible, we communicate with them rather than forbid things, but we are still firm. When we explain, patients themselves assess the risks and it makes our work easier.***
>
> Midwife (Senegal)

An emerging fruitful dialogue that combines biomedical knowledge and community knowledge

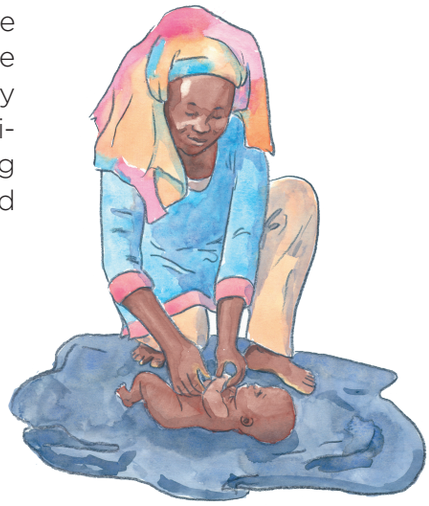
The role plays used during the training ask participants to explore the interactions between biomedical knowledge, lived experience knowledge and community knowledge around supporting pregnancy, birth and postpartum. The exercises created a space where midwives, who are often also holders of community knowledge, were able to share their own experience and practices within their families. During these participatory group sessions, the discussions between midwives, as well as with health workers, a Badiénou gokh, or a pregnant woman invited to the training, promoted taking back ownership of local cultural resources and combining it with biomedical knowledge.

In Sierra Leone, a traditional welcome song in Krio was spontaneously transformed into a welcome song for pregnant adolescents arriving at a PCP session. In Senegal, during a role play, a midwife sang a Wolof lullaby and invited participants playing the role of pregnant women to rock the babies in their bellies by dancing. Other Senegalese participants demonstrated traditional massages for newborns and women who have just given birth. Participants in both Senegal and Sierra Leone talked about traditional birthing positions. This led to a reflection on how to promote protective community health knowledge and practices through PCP.

> ***I thought back last night to what we saw here... And what I would like to say is: hats off to our mothers. They knew. Crouching childbirth, massages for babies and mothers... They already had these practices. Now it's up to us to show that these practices are scientifically legitimate.***
>
> Midwife (Senegal)



Participants stressed that during their initial training they were told to be wary of traditional health practices and weren't able to explore the fact that community practices that can be highly protective. The new experience provided by this ongoing training has opened up reflections about identifying and promoting community practices for maternal and newborn health that could potentially provide protection.



> ***By talking to each other during the training, we understood that traditional massage after giving birth and massage during labour are things that can be done. Before the training, patients were forbidden from doing these things.***
>
> Midwife (Senegal)

These reflections echoes an issue that has been identified in the field of global health. Despite a wealth of literature on harmful practices and social norms detrimental to maternal and reproductive health, knowledge remains more limited in terms of protective practices, supportive norms and community mechanisms for resilience[4]. This is why during the

4 Mwakawanga DL, Mwilike B, Kaneko M, Shimpuku Y.(2022) Local knowledge and derived practices of safety during pregnancy, childbirth and postpartum: a qualitative study among nurse-midwives in urban eastern Tanzania. BMJ Open. 2022 Dec 15;12(12):e068216. doi: 10.1136/bmjopen-2022-068216. PMID: 36521900; PMCID: PMC9756159.

International Confederation of Midwives. (2021). Position statement: Partnership between indigenous and non-indigenous midwives. https://www.internationalmidwives.org/assets/files/statement-files/2021/09/ps2021_es_indigenous-and-non-indigenous-midwives.pdf

Deneffe Dobrzynski, M.-L. (2025). Emotions de rébellion et résistances à bas bruit chez les sages-femmes et les femmes-patientes. Enquête internationale au cœur de la fabrique d'une maïeutique émancipatrice. Doctoral thesis in Education and Training Sciences, University Paris 8.https://cnrs.hal.science/tel-05401459v1

implementation and local adaptation phase of the PCP approach by the SANSAS project, a socio-anthropological survey was conducted in Casamance on postpartum community practices. The results of this survey led to inviting Badiénou gokh to the training to perform traditional massage for newborns and women who have just given birth. It also led to inviting the interviewer who conducted the community-based interviews on community practices. In this way, by participating in role plays where they assumed the role of grandmother or mother-in-law, they themselves demonstrated these practices to the group of midwives being trained in Casamance.

Several Solthis project members expressed interest in expanding investigations into protective community health practices in the next phase of the SANSAS and SHAPE projects. This would involve both exploring other themes in maternal and newborn health (pregnancy, childbirth, etc.) and trying them out in the different intervention areas.

> ***I think there is a need to further document protective community practices through desk research and qualitative studies. In Senegal in at least the two SANSAS 2 intervention areas (Thiès and Sédhiou).***
> Doctor (Senegal)

Spontaneous experimentation, sharing with peers and rapid ownership of suggested approaches

In Casamance, a midwife was on night shift between the second and third day of training. She returned the morning of the third day with a video she had taken at her health post the previous night. She explained that she had wanted to immediately try out some of the approaches discussed during the first two days of training.



Video screenshots: woman giving birth and her partner in the delivery room in Casamance, SANSAS project, Senegal

The video shows a woman pregnant with her first child. Her waters have broken and her cervix is five centimetres dilated. The midwife supports her using different approaches she has learned in the training: crouching position holding on to her spouse using a wrapper to promote foetal engagement, moving the pelvis to music and lumbar massages carried out by the spouse during contractions. She enthusiastically described how these practices helped with obstetric work and helped with movement for the woman and strengthened involvement of the spouse, who took turns with the patient's mother to give massages and physical support.

Her experience, which she shared spontaneously with the group, prompted various discussions around the potential to adapt practices in maternity wards. With agreement from the couple and the midwife, the video was then used as a teaching aid in subsequent trainings.

In the days following the training, other videos and feedback on similar experiences were shared by midwives from other facilities: *" After the training, I tried things straight away. We did exercises, walks, back massages. I called the birthing partner if she wanted me to",* (Senegal midwife).

The fact that these videos were shared between peers — whether it took place during training or afterwards in health facilities — suggests not only rapid ownership of the proposed approaches, but also the emergence of local dynamics of collective learning, professional curiosity and informal dissemination of practices within midwifery networks.

Positive experimentation in labour and delivery rooms demonstrate lasting learning

Interviews conducted separately to the training show that positive experimentation in labour and delivery rooms are an indication that the approach is being taken on board.

A midwife described how patients adhering to the approaches they been taught had made her overcome her apprehension about whether women would find them acceptable: *"We were apprehensive and we thought to ourselves: will a woman in severe pain listen to us? Will a woman in pain do the exercises? We were pleasantly surprised because patients have complied despite the pain. We try to support them, we talk to them, we approach them, we give them water to drink. If we do a few massages it creates a trusting atmosphere. As soon as you gain her trust, she lets her guard down. She is no longer afraid"*, (Senegal midwife).

There has also been positive experiences after the first few birthing partners were allowed in labour or delivery rooms. Birthing partners are being seen as both emotional support for the woman and a resource for the health provision team.

> ***When we involve the birthing partner, they are proud and very happy. They feel useful. It's like we're responding to their expectations. Through the training I have learned that patients needs the birthing partner and they have their own role to play.***
> Midwife (Senegal)

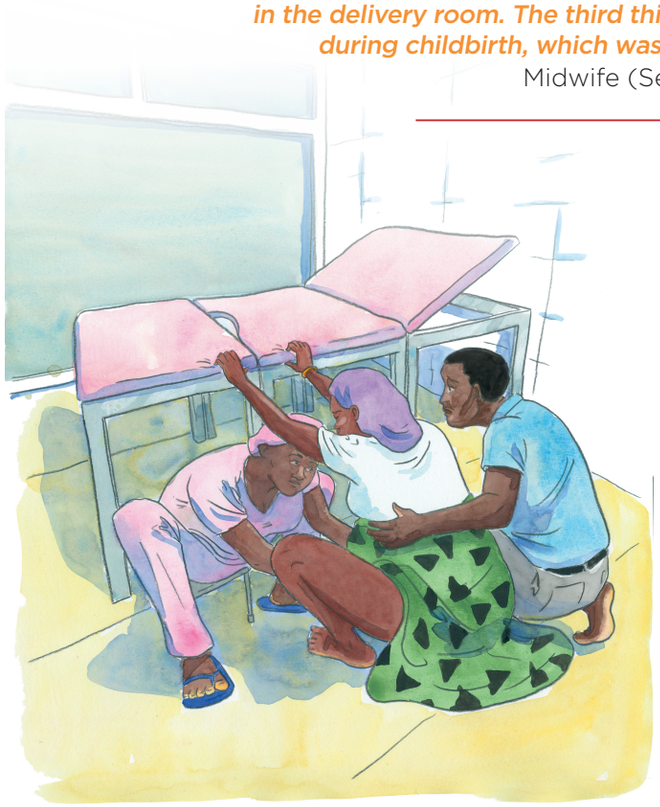


Woman giving birth and her birthing partner in the delivery room in Casamance, SANSAS project, Senegal

> ***You understand that when birthing partners are involved, they are very happy and feel useful. It's when you ignore them that they get frustrated. If they are sidelined, they don't know what's going on inside. If they are right next to the patient and they are involved, they are satisfied. It reassures them.***
> Midwife (Senegal)

It has also changed perceptions around the role of partners in labour and delivery rooms. Midwives have reported that although birthing partners are generally mothers, grandmothers, sisters or aunts, they are gradually seeing male partners being present in delivery rooms.

> ***One thing that is new since the training is that there is more flexibility and understanding between health care staff and patients. The second thing is that more birthing partners are present and involved in the delivery room. The third thing is husbands being present during childbirth, which was unthinkable before. (...)***
> Midwife (Senegal)





Teaching about the body as a catalyst for adherence to international recommendations on freedom to choose birthing positions.

Many midwives describe having also transformed their practice during childbirth itself, such as questioning the conventional birthing position during the pushing phase.

> ***Before, we only focused on women giving birth lying on their back. Now we know that we must give them the opportunity to choose the position they prefer.***
> Midwife (Sierra Leone)

Midwives have testified that the practical learning about obstetric biomechanics convinced them to give women the freedom to choose their position during labour and childbirth: *"When I felt my ischia close in the lithotomy position that women are put in, I understood that the position I was taught in school is a problem (...). When the baby is coming out, patients*

automatically closes their legs and since the initial training we had at school we have been asking them to open them. However, closing their legs is the right reflex as it allows the pelvis to open when pushing", (Senegal midwife).



Midwife training on PCP, SANSAS Projects – Senegal

> ***It had an effect on me feeling in my body how to engage quickly and how to quickly push the baby out. Learning all these modules on the positions makes it possible to support childbirth in good conditions.***
> Midwife (Senegal)

> ***When you do it in practice, you give more thought to how to implement it.***
> Midwife (Senegal)



Some midwives describe having agreed to more requests from women wanting to use alternative positions: *"Just after the training, a patient came to give birth. I put her on the table but she had problems pushing and said she wanted to give birth on the floor. I used the mat and helped her until the baby was born. I was in a squatting position to make sure I could take hold of the newborn and provide immediate care"*, (midwife, Senegal).

Testimonies suggest a shift towards support that is more focused on patient preferences: *"Women give birth in a relaxed way in the position they want - squatting, sitting or lying on their side. (...) Since the PCP training, we know that it can support women and it has helped a lot. We had a lot of cases"*, (midwife, Senegal).



> ***Women can express their wishes to give birth using their community practices. In instance like this, we let them get into the position they want.***
> Midwife (Senegal)

Barriers encountered and ways of overcoming them

Despite a high level of motivation from midwives to change their practices following the training, they are faced with realities on the ground: heavy workload, lack of space, insufficient available equipment and organisational constraints sometimes limit the proposed approaches being implemented in full.

> ***You want to do it but you are restricted.***
> Midwife (Senegal)

A heavy workload appears to be one of the main obstacles to implementing mind-body and interpersonal approaches, particularly in facilities with a large number of patients.

> ***When I don't have many patients, I do the movements with them, I make them dance, I do massages too. That is possible with two or three patients. It's not possible when I am overloaded and overwhelmed, which often happens.***
> Midwife (Senegal)

The lack of space, the way maternity wards are structured and the lack of certain equipment also appear to be common barriers to implementing the approaches.

> ***The delivery room is narrow to accommodate several patients and their birthing partners. There is also a privacy issue because there are not enough screens.***
> Midwife (Senegal)

> ***There is a space problem. We do not have enough rooms to accommodate the number of patients we receive per day.***
> Midwife (Senegal)

Some participants also highlighted limitations due to available equipment: *"The fact that we don't have a ball limits our exercises. I put into practice what I have learned with the resources I have available",* (midwife, Senegal).

Despite experiencing obstacles, midwives have described many different ways they have adapted. Midwives have also described more creative use of available spaces to promote movement and birthing partners being present: *"When a patient is in labour we use the hallway, which is wider, and we get the birthing partner involved. They can walk around and do positions together",* (midwife, Senegal).

> ***If necessary, I use screens so each patient can stay with their birthing partner and to respect their privacy. Some use the ball, others walk with their patients, and others do relaxation sessions. The main thing is to be well organised.***
> Midwife (Senegal)

This new role for birthing partners also appears to be an organisational resource in high workload contexts: *"This training is useful because it allows you to rely on the birthing partners when you have several patients to manage ",* (Midwife, Senegal).

Some midwives also highlight that supporting women into the various positions can be physically demanding for the midwives themselves. Many describe lower back pain when they have to adapt their own posture to the woman's, especially when the delivery isn't on the birthing table.



Midwives being trained on PCP training and trying out tools to support their own health as care providers. SANSAS Project, Senegal

These findings led training providers to also focus on the physical wellbeing of midwives themselves. Participants were asked to experiment with different ways of getting comfortable during birth using alternative positions (e.g. in a semi-squatting position on a small stool or step usually used by women to climb onto the delivery table) and also to think about ways of preventing musculoskeletal disorders during their work. Discussions focused in particular on the benefits of taking time to recover, giving each other massages, and, where possible, using a birthing ball to self-massage against the wall.

In this sense, adapted approaches relate not only to women and their partners, but also to conditions that help midwives to sustainably protect their own health while developing their practice.

Increased confidence in respectful and physiological childbirth recommendations and in the ability to lead PCP sessions

When viewed together, these outcomes suggest that training provides a catalyst for transforming routine care practices: it changes professional interventions, care provision relationships, the role women and their loved ones play, and the way professionals view providing support during childbirth. It raises awareness of the complementarity of the PCP approach and respectful care provision recommendations.

> ***This training has brought me closer to the patients. You are close to the patients all the time, communicating, reassuring them, soothing them, stroking them, giving instructions. It feels more humanised. You are giving the pregnant woman her rightful place. She deserves more consideration and understanding about the pain she is in. The presence of the midwife and birthing partner supporting her makes her feel reassured. PCP complements humanised childbirth and respectful care provision.***
>
> Midwife (Senegal)

This approach also seems to make people more confident to pass on the skills they have learned to women and to communities: *"The practical sessions where we tried out PCP allowed everyone to practice and learn how to communicate with the community"* (midwife, Senegal).

Midwives who delivered PCP sessions with adolescent girls said after the training: *"The project also teaches us how to provide care to pregnant adolescents. We shouldn't judge them. We need to have empathy for them",* (Sierra Leone).

> ***The practical exercises gave us the confidence to facilitate groups. It wasn't just theory; we practised with each other before trying it out with pregnant women.***
>
> Midwife (Sierra Leone)

Several participants also described feeling more able to lead PCP sessions: *"Now we can explain things better to women. Before, we mainly just gave talks. Now, we get women involved; we get them moving, breathing, trying things out"* (midwife, Sierra Leone).





PCP workshops with pregnant adolescents and their birthing partners, SHAPE project, Sierra Leone, SANSAS project Senegal

Finally, several participants emphasised that taking ownership of this approach requires maintaining regular practice: *"We need to practice to get competent so as trainers we have to continue practising these techniques to get enough knowledge before passing them on to others",* (midwife, Senegal).

Socio-cultural acceptability of group PCP sessions

In Senegal, regular group sessions for pregnant women started being rolled out in early June 2026 at the pilot sites identified at the start of the project. In Sierra Leone, the first cohorts of pregnant adolescents began PCP sessions supervised by Solthis in early 2026. Several lessons learned are already emerging around acceptability and ownership of these approaches.





PCP workshops with adolescents and young pregnant women and their birthing partners, Casamance, SANSAS project, Senegal

Rapid buy-in from decision-makers and institutional leaders

In both countries, early involvement of institutional stakeholders, senior management of organisations and partners appears to have fostered a positive response to the approach. Discussions held during exploratory phases, field visits and participatory workshops made it possible to gradually build a shared understanding of the intended objectives.

Several decision-makers and senior management from organisations saw PCP as an opportunity to simultaneously enhance quality of care, the patient experience and the reputation of health facilities. The approach is deemed to be consistent with national priorities around respectful care provision, reducing maternal and neonatal mortality, and strengthening community participation.

Encouraging initial feedback from pregnant women and adolescent girls

Initial feedback from participants in Sierra Leone suggests that the proposed group-based, mind-body and participatory interventions are highly acceptable. Adolescent girls feel that spaces are more welcoming, less stigmatising and more focused on their needs.

> ***We no longer feel ashamed going to antenatal consultations like we did before attending the sessions.***
> Adolescent girl (Sierra Leone)

Several participants also said that discussions with care providers have improved, they feel more listened to and have a closer relationship with them: *"Now, we trust the health-care system to take care of us. Now they listen to us and we talk together"* (adolescent girl, Sierra Leone).

> ***We have a strong relationship now. When we come for our consultations, we dance and play. They know us by our names.***
> Adolescent girl (Sierra Leone)

Some adolescent girls also describe feeling a renewed sense of hope and a change in the way they experience pregnancy: *"As a pregnant adolescent, you sometimes think that all is lost. But now I know that all is not lost. I still have hope "*, (adolescent girl, Sierra Leone).

The fact that the sessions are interactive and take a mind-body approach, appears to be particularly appreciated: *"Everyone takes part",* (adolescent girl, Sierra Leone).

> ***The space is calm, we dance and we move our bodies.***
> Adolescent girl (Sierra Leone)

This initial feedback suggests that the sessions are seen not only as a space to access information, but also a place of trust, engagement, support and relationship building with professionals.

Interviews with Senegalese women who took part in PCP sessions led by a midwife also highlight the perceived benefits in terms of wellbeing during pregnancy, marital relationships and newborn care.

In relation to mind-body exercises and relaxation during pregnancy: *"The exercises, movements and relaxation helped me a lot during pregnancy. When I had back pain or I was stressed, I would do certain exercises at home, and it would help me feel better",* (woman after giving birth to her first child, Senegal).

In relation to involving husbands: *"Before, my husband just watched. The sessions taught him how to give massages. It has brought us closer together because he was more involved in the pregnancy and he understood better what I was going through",* (woman after giving birth to her third child, Senegal).

In relation to post-natal baby massage: *"We continued with baby massages after the birth. We could see that he was calmer afterwards, and he slept better",* (woman after giving birth to her second child, Senegal).

Rapid community ownership of proposed interventions

In Senegal, a trained midwife and doctor presented the approach to female community leaders. The mind-body exercises, singing, massage, movements and participatory discussions generated a great deal of enthusiasm. The approach resonated with existing community practices, meaning they were more accepted. The mind-body, musical and interpersonal approaches appeared to enhance ownership.

Workshop with female community leaders in Casamance, SANSAS project, Senegal







Female leaders running a community awareness session on PCP workshops and the option of using different birthing positions in health centres in Goudomp, Sédhiou and Bambaly. Casamance. SANSAS Project, Senegal.

Then during a community discussion, an imam and a father publicly welcomed introducing music and dance into healthcare facilities, saying they could help to make maternity units more welcoming for women and their families.

In Sierra Leone, ownership also seems to extend well beyond the sessions themselves. Several participants describe actively sharing content via social networks and WhatsApp groups, where the exercises, positions and messages from the sessions are still being discussed, commented on and shared among participants.

Some adolescent girls also said they had spontaneously shared the birthing positions they had learned with other women: *"In the past, in our parents' time, they gave birth lying on their backs. Now we've learned different positions – on the side, crouching... I even sent it to our WhatsApp group so that others could see it",* (adolescent girl, Sierra Leone).

We saw a similar dynamic after the midwives' training courses, where videos, photos and feedback were being quickly shared among professionals. Initial implementation of these sessions therefore appears to expand horizontal knowledge sharing, between midwives and between pregnant women, creating learning and ownership loops that go far beyond the formal training or care provision spaces.

For example, a midwife supporting these adolescent girls with PCP stated: *"A midwife who had done PCP training shared the side position in a WhatsApp group for midwives and explained to others how to do it",* (midwife, Sierra Leone).

New emphasis on birthing partner roles

Initial feedback also suggests there has been a positive response to birthing partners being more actively involved. Their involvement seems to be perceived as reassuring for women, empowering for families and helpful for some health care teams.

> ***It's important for someone to come and learn what we're being shown, particularly the person who will be with me during labour. That way it doesn't need to be explained to them during labour.***
> Adolescent girl (Sierra Leone)

Even if they are not physically present at the sessions, some birthing partners appear to be participating indirectly in the learning, particularly through exercises carried out at home or discussions via WhatsApp.

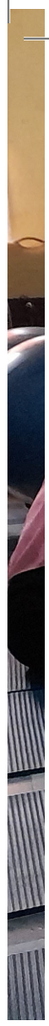
> ***They take part in the discussions we have in the WhatsApp group... even their husbands are in the group and help them do the exercises.***
> Midwife (Sierra Leone)

Involving family members therefore appears to be one of the most visible catalysts for bringing communities and health facilities closer together.

WHAT LESSONS HAVE BEEN LEARNED FROM IMPLEMENTING GROUP PCP SESSIONS?

The results presented above highlight several important factors for implementing PCP. This includes the value of using physical and experiential teaching methods in midwifery training, the importance of prior socio-cultural adaptation, the need to train midwives before starting the sessions, and the role of birthing partners and community resource involvement.

The lessons presented below are based on observations and interviews carried out during the launch of the first PCP cohorts in Sierra Leone, where group sessions began to be rolled out and monitored in several health facilities from the start of 2026. Although they are interim results, they already enable us to identify several operational recommendations around structuring cohorts, engaging pregnant adolescents, involving birth partners, follow-up with participants and the support needs of health care teams.



Adapting the cohort structure to the realities of women

The Sierra Leone experience demonstrates the value of organising groups into relatively homogeneous cohorts based on their phase of pregnancy, to tailor the content, exercises and discussions to the needs of the participants. Groups organised by phase (e.g. 4–5 months, 6–7 months or 16–20 / 24–28 / 32–36 weeks pregnant) appear to have facilitated content relevance and group dynamics.

Things to note:

- prioritise having the same cohort groups from the first antenatal session to the postnatal session;
- adapt the size and number of groups to the capacity of the facility;
- but have a limited number of participants (around 6–12 participants max) to encourage discussion.

Integrate sessions into existing care pathways

Scheduling sessions on the same day as antenatal or postnatal consultations (ANC) appears to reduce dropouts, limits costs and avoids repeated trips.

Good practices identified:

- combining PCP and ANC appointments where possible;
- creating WhatsApp groups, in particular to remind participants of the dates and times of sessions;
- limiting additional travel.



Adapting the approach for pregnant adolescents

Adolescent girls often face more obstacles to cover transport costs due to their high level of vulnerability and economic dependency. They often have low levels of literacy. They generally find out late about their pregnancies and are stigmatised.

Useful adaptations:

- use simple language and practical demonstrations;
- create spaces that are really welcoming, reassuring and non-judgemental;
- place greater emphasis on implementing all the good practices identified here.

Maintaining contact between sessions

Active follow-up seems to play an important role in adolescents continuing to participate.

Approaches used:

- WhatsApp groups;
- phone calls;
- participants reminding each other;
- involvement of community leaders or outreach workers.

Actively engaging birthing partners

Birthing partners attending group sessions does not generally happen spontaneously. Work-related pressures, social norms or practical constraints can limit their participation.

Useful tips:

- explicitly invite birthing partners;
- provide other ways for them to be involved if they are absent (e.g. sharing educational videos of mind-body exercises in the WhatsApp group so that they can try the exercises at home with the pregnant woman);
- use adapted methods if partners are absent so pregnant woman can still do all the exercises during the session (e.g. attaching a piece of fabric to a window for certain exercises that normally require a partner).

Using simple easily adopted approaches

It is often easiest for people to do exercises that require fewer resources (pieces of fabric, mats, chairs, etc.) and are easy to replicate at home.

Exercises frequently used in group sessions:

- movement and mobility;
- massage;
- breathing and relaxation;
- singing and dancing.

Regular refresher training and supervision for midwives

Providing a single one-off training session in PCP does not appear to be sufficient to sustainably support changes in practices in health centres, particularly in contexts with high turnover of healthcare staff.

Needs identified:

- supervision for facilities starting up PCP (including support to structure new activity and observing initial sessions): by a midwife PCP trainer or by a midwife who has already set up PCP workshops in a neighbouring facility;
- refresher training (6–12 months);
- peer mentoring;
- support for new recruits.

Expanding training beyond just midwives to promote changes in practice

The experience in both countries shows that implementing PCP approaches does not rely solely on midwives. The way care is structured, how birthing partners are treated, mobility of women, availability of spaces and the continuity of messaging often rely on other stakeholders involved in the care pathway.

Stakeholders to be included where possible:

- nurses and nursing assistants or senior midwives;
- doctors and maternity ward managers;
- community health workers;
- female and male community leaders;
- staff involved in welcoming and directing patients;
- supervisors and institution managers.

Planning and adapting PCP to structural constraints

Experience has shown that there are certain structural constraints that can limit implementation of PCP approaches: lack of space, shared rooms, limited equipment or limited team capacity. However, there are various approaches that can support implementation despite these constraints.

Recommended actions:

- use alternative spaces if rooms in the health care facility are too small (lobby, outdoor areas, community rooms, etc.);
- ensure the group size is compatible with the capacity of the facility;
- schedule sessions at times when more space is available and take into account weather conditions (e.g. avoid the hottest part of the day);
- adapt the session structure to the available human resource;
- use simple, inexpensive equipment that can be easily replaced locally;
- gradually plan the layout of labour and delivery rooms to promote movement, privacy and birthing partners being present;
- provide a visual tour of the labour and delivery rooms for pregnant women and their partners when the rooms have people in them: film or photograph the rooms and equipment available. When rooms are available plan an in-person visit.

  This experience has shown that changing practices involves not just skills developed by staff, but also the ability of facilities to gradually create environments that are conducive to these approaches.



EQUIPMENT & LAYOUT

To make these workshops run as smoothly as possible, we recommended the following equipment.

- ☐ Rug or mats
- ☐ Birthing balls (if available)
- ☐ Wrapper or large pieces of hard-wearing fabric
- ☐ Cushions
- ☐ Demonstration baby and pelvis or anatomical model (if available)
- ☐ Vegetable oil suitable for massage
- ☐ Flipchart, sheets and markers (optional)
- ☐ Illustrated materials (if available)
- ☐ Portable speaker or phone to play music
- ☐ Drinking water and cups
- ☐ Arrange participants in a circle

FACTSHEET 1

LEADING AN ANTENATAL PCP SESSION ON: SIGNS YOU SHOULD SEEK HELP FROM A HEALTH CARE FACILITY; LABOUR POSITIONS

Duration 1.5 hour

OBJECTIVES

➜ Recognising signs that labour has begun and warning signs that require immediate health care attention

➜ Building the confidence of women and their birthing partners during labour and childbirth

➜ Trying out non-pharmacological pain relief techniques

➜ Learning about different positions that help during labour and childbirth

➜ Encouraging birthing partners to be involved

Target group: Pregnant women (ideally in third trimester of pregnancy) and their birthing partners

Group size: maximum 12 to 15 people (e.g.: 6–8 pregnant women + birthing partners)

Facilitation: 1 to 2 facilitators (ideally midwives)

INTRODUCTION

The facilitator reminds participants that the session aim is to help women and their families have a better understanding of what happens during labour, to try out different mind-body techniques and to prepare for the baby's arrival together.

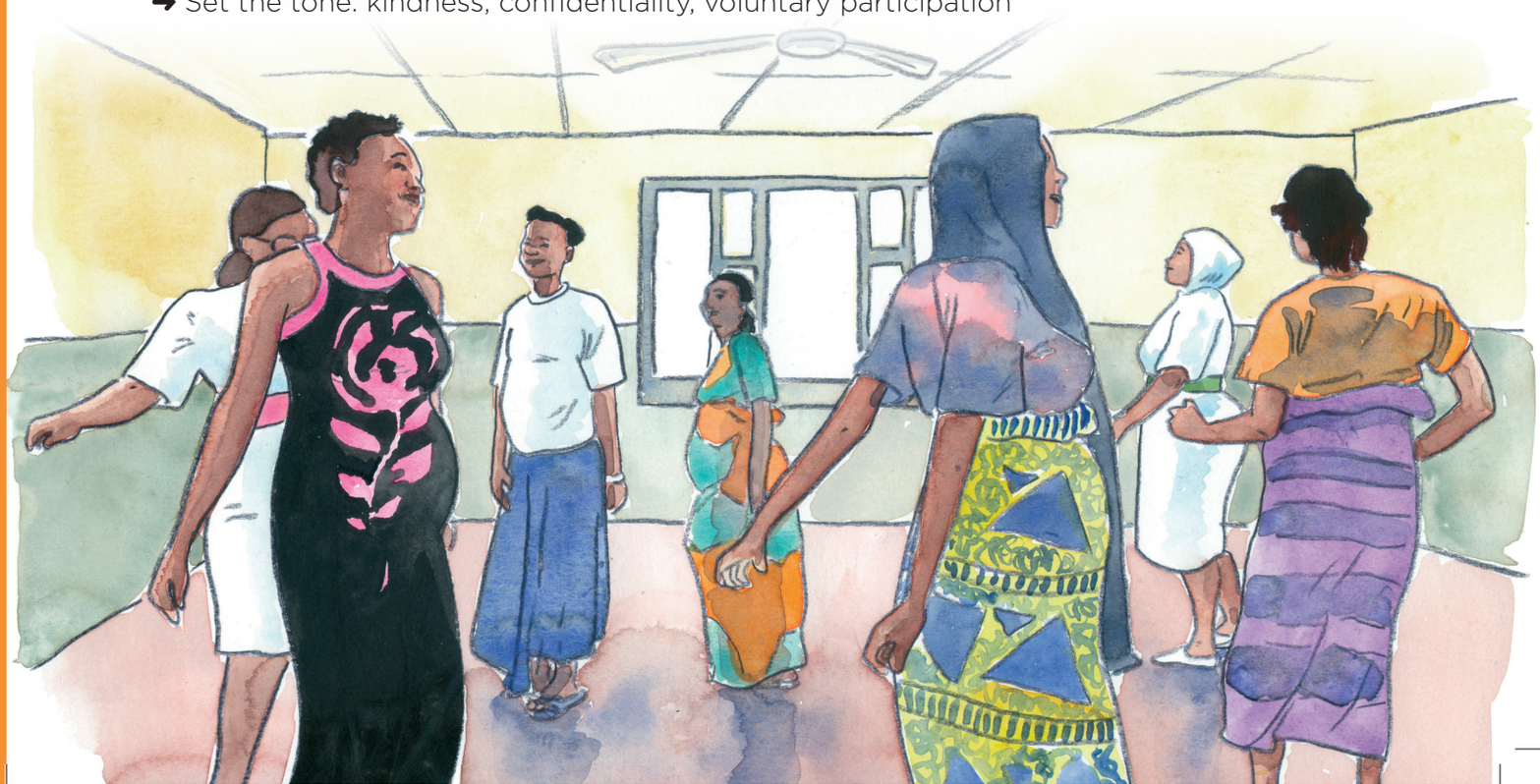
1. WELCOME AND WARM-UP (10–15 min)

➜ Welcome people with music

➜ Gentle group dance with pelvic movements

➜ Introduction circle: first name ***+ how am I feeling today?***

➜ Set the tone: kindness, confidentiality, voluntary participation



2. DISCUSSION: HOW DO YOU KNOW WHEN LABOUR IS STARTING? WHEN SHOULD YOU CONSULT A HEALTH-CARE PROFESSIONAL, EVEN IF LABOUR HAS NOT STARTED? (20 min)

Ask the group:

"How do you know that labour has started?"

Listen and, if necessary, write down the answers, then fill in the gaps or correct:

Signs labour has begun:

➜ regular contractions;

➜ with or without your waters.

Ask the group:

"What are the reasons you should go quickly to the healthcare facility for a consultation?"

Listen and, if necessary, write down the answers, then fill in the gaps or correct them:

Signs that you should immediately go to a healthcare facility whether or not it is time to give birth:

➜ start of labour;

➜ bleeding;

➜ waters break;

➜ decreased movement of baby;

➜ severe headaches;

➜ swelling of the limbs or face;

➜ seeing spots;

➜ difficulty breathing;

➜ fever;

➜ loss of consciousness or seizures.

(Illustrated flipcharts can be used to summarise this activity and visually reinforce the key messages.)

3. TRYING OUT LABOUR POSITIONS (40 min)

Bring the positions to life by involving the birthing partner:

➜ standing and rhythmically swaying your hips to music;

➜ sitting on a birthing ball, making rhythmic pelvic movements to music (if a ball is available);

➜ squatting holding on to the birthing partner using a piece of cloth (alternating between squatting on tiptoe and squatting with the soles of the feet flat on the ground);

➜ on all fours (alternating between the "cow" pose, with the back arched and head raised, and the "cat" pose, with the back rounded and the chin against the chest);

➜ standing up leaning forward, supported by the birthing partner, a wall or a piece of furniture;

➜ lunging, leaning on outstretched arms or with arms crossed and resting on the seat of a chair.

After each position, ask:

"How did you feel?"

"When might this position be useful?"

Repeat each exercise several times.
At the end of the exercises, say:

- moving helps with labour;
- your body knows the positions that will help your baby to be born;
- you and your birthing partner are a team.





CLOSING: QUALITY TIME WITH MY BABY (10–15 MINS)

Play some soft music in the background and invite participants to take a moment to connect with their unborn babies. You can read this text in a calm and slow voice, or simply use it as inspiration:

"Pregnant women and their birthing partners should get into a comfortable position, sitting or lying down side by side, in contact with each other if they wish.

Close your eyes. Gradually relax each part of your body. Relax your shoulders, and relax your arms and hands. Relax your stomach and let it expand freely with each inhale.





Imagine a wave of wellbeing rising and falling rhythm of your breathing. Stay in this relaxed state for a few minutes while listening to the music.

(Wait a few minutes)

Now, pregnant mums, place your hands on your bump and make slow, enveloping movements with the palms of your hands over the entire surface of your bump. With your palms, try occasionally applying gentle pressure, then go back to circular strokes, following the curve of your bump. Be aware of your baby under your hands, and imagine them reacting to you stroking them. Feel the baby's movements, respond to them with your hands, and let this moment last as long as necessary.

Meanwhile, birthing partners can hum a lullaby for the mother and baby."

Idea for a Wolof lullaby to sing: Kuy Laal Mademba by Fatou Kassé
https://www.youtube.com/watch?v=Rdc_57XVZHs

English translation of the lyrics of the lullaby in Wolof:

Who's giving Mademba a cuddle? Ndayane's tom-tom drum... Who's giving him a cuddle? Ndaat say!!

Who's cuddling my baby? Ayo beeyo beyo!!

My child, my friend

Long life to you, that's my prayer, my wish

When you grow up,

I know I won't be lacking anything Who is giving my baby a cuddle

Ayo beeyoo beeyoo!!

A child must respect their parents; a respectful child will be rewarded by Rabbi (Allah) in this world and in the Hereafter.

Oh God, let my child grow up to be like his father...
This is my prayer, my wish

Who is giving my baby a cuddle? Ayo beyo beyo!!

Don't be condescending towards them. Never betray them.

This harms the disrespectful child. Never do that, Mademba, if you want to grow old

Don't cry, my baby. Ayo beeyoo beeyoo!

Don't cry, my baby. Ayo beeyo beeyoo!

FACTSHEET 2

LEADING AN ANTENATAL PCP SESSION ON: THE ROLE OF BIRTHING PARTNERS; NON-PHARMACOLOGICAL PAIN MANAGEMENT

OBJECTIVES

➜ Understanding that labour pain can be managed in different ways

➜ Trying out non-pharmacological methods that can be used during labour and childbirth

➜ Strengthening women's confidence in the resources they have in their minds and bodies

➜ Actively involving birthing partners to provide support during labour

➜ Enabling participants to identify approaches that suit them best

Duration
1.5 hour

Target group: Pregnant women (ideally in their third trimester of pregnancy) and their birthing partners

Group size: maximum 12 to 15 people (e.g.: 6–8 pregnant women + birthing partners)

Facilitation: 1 to 2 facilitators (ideally midwives)







INTRODUCTION

The facilitator reminds the group that each woman experiences pain differently and that there is no one right way to give birth. This session aims to try out different things can that can support with the sensation of labour, reduce fear and build confidence.

1. WELCOME AND WARM-UP (10–15 min)

➜ Welcome people with music

➜ Gentle group dance with pelvic movements

➜ Introduction circle: ***"When you think of the pain of childbirth, what words come to mind?"***

➜ Set the tone: kindness, confidentiality, voluntary participation

2. DISCUSSION: HOW DOES THE BODY RESPOND TO PAIN? (20 min)

Ask the group:

"What helps when you're in pain?"

"What often increases the pain?"

Answer the question together:

Pain can be affected by:

- ➜ fear
- ➜ loneliness
- ➜ fatigue
- ➜ stress
- ➜ not being able to move
- ➜ and also by breathing, support, movement and relaxation.

Conclusion:

- ➜ pain does not mean failure;
- ➜ moving around can help;
- ➜ breathing can help;
- ➜ having support can help.

3. TRYING OUT NON-PHARMACOLOGICAL TECHNIQUES FOR MANAGING LABOUR (40 MIN)

BREATHE, RELEASE, VOCALISE

Support pregnant women and their birthing partners to try out:

► Breathing:

- ➜ breathe in deeply, then breathe out slowly;
- ➜ take long breaths;
- ➜ blow as if you are blowing out a candle;
- ➜ place your hands on your stomach and feel it rise as you breathe in and fall as you breathe out.

Afterwards ask:

"How did you feel? How can deep breathing from the diaphragm help you and your baby during labour?"

► Vocalising:

Everyone standing up in a circle:

➜ spread your feet hip-width apart;

➜ unlock your knees (bend them slightly);

➜ breathe in deeply, expanding your stomach;

➜ breathe out very slowly, making a loud, low-pitched sound (a low "om" sound);

➜ keep the sound going until you have finished exhaling (make it last as long as possible, forcing yourself to keep it going without taking another breath);

➜ repeat 10 times, in time with your breathing.

Afterwards ask:

"How did you feel? How could this sound help during labour?"

Suggest that pregnant women and their birthing partners do this exercise in pairs:

➜ the birthing partner asks permission to place their hands on the pregnant woman's stomach;

➜ they ask her if she agrees to place her hands on their stomach;

➜ without speaking, the birthing partner starts to do deep, full breathing from the diaphragm;

➜ in time with their own breathing, they lighten their hands on the pregnant woman's stomach as they inhale to encourage her to expand her stomach by inhaling at the same time as them;

➜ they make their hands heavier as they breathe out, to encourage the pregnant woman to deflate her stomach and breathe out at the same time as them.

(Repeat 10 times, synchronising breaths with the pregnant woman).

Afterwards ask:

"How did you feel? How can your birthing partner help you to be able to manage pain better during labour?"

MASSAGES

Encourage the birthing partners to participate.

Try out:

➜ lower back massages;

➜ pelvic pressure;

➜ shoulder/arm massage;

➜ supporting the sacrum with your hands;

➜ circular movements on the back.

Ask the group:

"What provides the most relief?"

Say:

➜ there is no need to massage vigorously;

➜ always ask what feels best;

➜ the birthing partner can be a resource.

MOVEMENT, RHYTHM AND EMBRACING TOUCH

Put on some gentle, rhythmic music, and ask the pregnant women and their birthing partners to move around the room to the rhythm of the music. Then ask them to dance in pairs. Finally, ask them to sit face to face, swaying to the same rhythm and hugging each other.

Say: ***"Find a movement that both of your bodies like."***

Ask the group:

"How did you feel when you moved to the rhythm?" When you were dancing alone? And when you were dancing together? When you were in each other's arms? How might this help during labor?"

LOSING: GUIDED RELAXATION, MY WAVE OF CALM (10–15 MIN)

Calm music

Ask people to:

➜ sit comfortably or lie on your side;

➜ close your eyes;

➜ relax your shoulders, face and stomach;

➜ imagine each contraction as a wave that rises and then falls;

➜ visualise a calming place.

End by saying:

"Your body already knows a lot."

FACTSHEET 3

LEADING AN ANTENATAL PCP SESSION ON: TAKING CARE OF YOURSELF AND YOUR BABY AFTER CHILDBIRTH

Duration
1.5 hour

OBJECTIVES

➜ Supporting physical and emotional recovery after birth

➜ Building confidence in baby care

➜ Trying out simple mind-body practices for the postpartum period

➜ Promoting a parent-baby bond

➜ Valuing family and community support

Target group: Women in their first month following childbirth and their birthing partners

Group size: maximum 12 to 15 people (e.g.: 6–8 mothers + birthing partners)

Facilitation: 1 to 2 facilitators (ideally midwives)

INTRODUCTION

The facilitator reminds the group that, after the birth, the mother needs care as well as the baby. This session aims to nurture the body, emotions and the bond with the baby.

1. WELCOME AND WARM-UP (10–15 MIN)

➜ Welcome people with soft music

➜ Participants get comfortable with their babies

➜ Gentle small body movements with the baby in their arms or in a carrier

➜ Go round the circle and ask: ***"What has been good for you since the birth?", "What has been most difficult for you?"***

➜ Set the tone: kindness, confidentiality, voluntary participation

2. DISCUSSION: TAKING CARE OF YOURSELF AND KNOWING WHEN TO ASK FOR HELP (20 MIN)

Ask the group:

"What helps a woman recover after giving birth?"

"Who takes care of you?"

"When should you seek help?"

Listen and then go through the answers together:

<u>Things requiring immediate medical attention:</u>

➜ severe bleeding;

➜ severe pain;

➜ fever;

➜ difficulty breathing;

➜ severe headaches;

➜ persistent sadness or loss of motivation;

➜ significant difficulty breastfeeding or feeding the baby;

➜ paby who doesn't feed, sleeps excessively or seems unwell.

(Potential to use illustrated flipcharts to visually reinforce messages.)

Conclude by saying:

➜ mothers also need care;

➜ asking for help is normal;

➜ taking care of yourself also helps you to take care of your baby.

3. TRYING OUT MIND AND BODY WELL-BEING PRACTICES FOR MOTHER AND BABY (40 MIN)

POSTNATAL PELVIC TIGHTENING

Pelvic tightening is a traditional practice found in many cultures after childbirth. It is designed with the mother's comfort in mind and provides a feeling of support and wellbeing. Scientific data on pelvic support techniques suggest they may be beneficial to reduce pain and improve comfort for some postpartum women[5]. This can be carried out after childbirth and done regularly during the postpartum period. It can be done several times a day. Women who have just given birth can choose to wear a wrapper to support her pelvis when she moves or exerts herself. For women who have given birth by caesarean section, it is advisable to wait until the wound has healed completely before trying the technique described below. For vaginal births, this tightening technique can be done immediately after delivery or at any other time postpartum.

How to do it:

➜ The woman lies on her back in a comfortable position (with a cushion under her head and knees), with her newborn safely held against her.

➜ A wrapper is slipped under her hips and then crossed over her.

➜ The midwife and the birthing partner gently and gradually pull on each end of the wrapper.

➜ As they pull on the fabric, they regularly check with the woman if the pressure being applied is comfortable and pleasant for her: at which point they stop pulling and maintain the pressure. The new mother should feel good and should not experience pain or difficulty breathing. She should feel comfortably supported but not constricted. If she shows signs of discomfort, loosen the wrapper until you find the correct level of pressure for her.

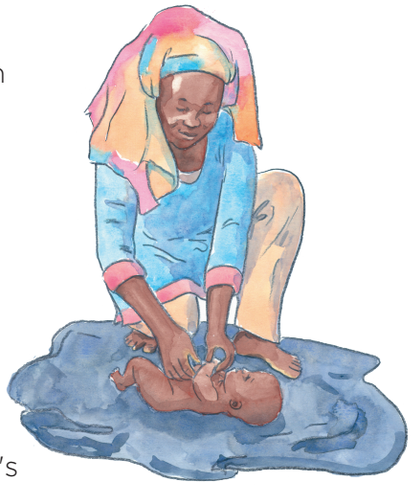
[5].Jafarian, F.S., Jafari-Harandi, M., Yeowell, G. et al. Comparative efficacy of lumbar and pelvic support on pain, disability, and motor control in women with postpartum pelvic girdle pain: a three-armed randomised controlled trial. BMC Musculoskelet Disord 26, 100 (2025). https://doi.org/10.1186/s12891-025-08350-3



➜ To maintain the level of pressure the woman is happy with: twist the wrapper and then slide the ends under the wrapper, which is already tightened around the woman's hips.

➜ Allow the woman to enjoy this feeling of wellbeing, lying quietly for at least 30 minutes.

MASSAGE FOR NEWBORNS



Massage for newborns and women who have just given birth are practices found in many cultures. The socio-anthropological study carried out by the SANSAS project on community postpartum practices found that massage for newborns and women who have recently given birth are widely practised in Senegal to support mother and child health. Newborn massage in Senegal (dàmp) has also been described in social science as a practice that contributes to the social and cultural construction of the child's body, to their integration into their group of belonging, and to their process of socialisation[6]. Scientific data also suggests that baby massage can foster the parent-child bond, contribute to the infant's wellbeing and psychomotor development, and to reducing crying and improving sleep[7].

During the PCP session:

Before starting with the massage, make sure the newborn is in good general health and that there are no medical concerns, in particular any suspected fractures (e.g. of the clavicle or a limb) or any other complications requiring medical attention.

[6]. Ndiaye, L. (2018). Corps du nouveau-né et techniques corporelles chez les Wolof du Sénégal – le massage (damp) Corps, 16(1), 267–274. https://doi.org/10.3917/corp1.016.0267.

[7]. Chen S.C., Lin S.L., Wang M., Cheung D.S., Liang J.G., Cheng Z.Y., Yuen C.S., Yeung W.F. Paediatric massage therapy in infants and children under 5 years: An umbrella review of systematic reviews. Heliyon. 2024 Aug 8;10(16):e35993. doi: 10.1016/j.heliyon.2024.e35993. PMID: 39211929; PMCID: PMC11357743.

Rakhmawati W, Mediani HS, Dhamayanti M, Maryati I, Setiawan AS, Hendrawati S, Maryam NNA, Hasanah A, Mulyana AM, Mariani D, Rochimat I. Potential of Massage Therapy for Improved Growth and Development Among Infants Under 9 Months: A Systematic Scoping Review of Intervention Type, Technique, and Outcome. J Multidiscip Healthc. 2024 Aug 13;17:3931-3943. doi: 10.2147/JMDH.S475731. PMID: 39155976; PMCID: PMC11330255.

Use a clean, non-irritating vegetable oil suitable for infants[8].Mothers can be asked in advance to bring the massage oil they usually use for their baby, so that it can be discussed as a group and preference should be given to oils that babies already tolerate well.

Suggest that birthing partners or new mothers carry out traditional baby massage. If they are not used to doing it, ask an experienced woman from the group can lead the massage.

Ask the group:

"How does your baby react during the massage?" And after massage?"

"In your families, do women also get massages after giving birth?", Who usually does them? What effect do these massages have?"

CLOSING: BUTTERFLY PERINEUM RELAXATION (10–15 MIN)

Breathing exercises combined with pelvic floor awareness promote muscle relaxation, body awareness and comfort in postpartum women. Secondly, pelvic floor muscle rehabilitation or strengthening, when recommended, helps to prevent or reduce urinary incontinence and certain pelvic floor dysfunctions after childbirth[9]. This visualisation encourages women to become aware of the natural movement of their perineum in time with their breathing, without trying to control or force it.

Guiding the relaxation time and promoting awareness of the perineum:

"Lie down comfortably.

Place one hand on your stomach and the other hand lower down, between your legs.

Breathe in gently...

Breathe out slowly...

Now imagine that inside your body, between your hips, there is a butterfly. A calm butterfly, resting there, safe

When you breathe in,

The butterfly slowly opens its wings...

They gently part, as if to take a breath of fresh air.

When you exhale,

The butterfly quietly closes its wings...

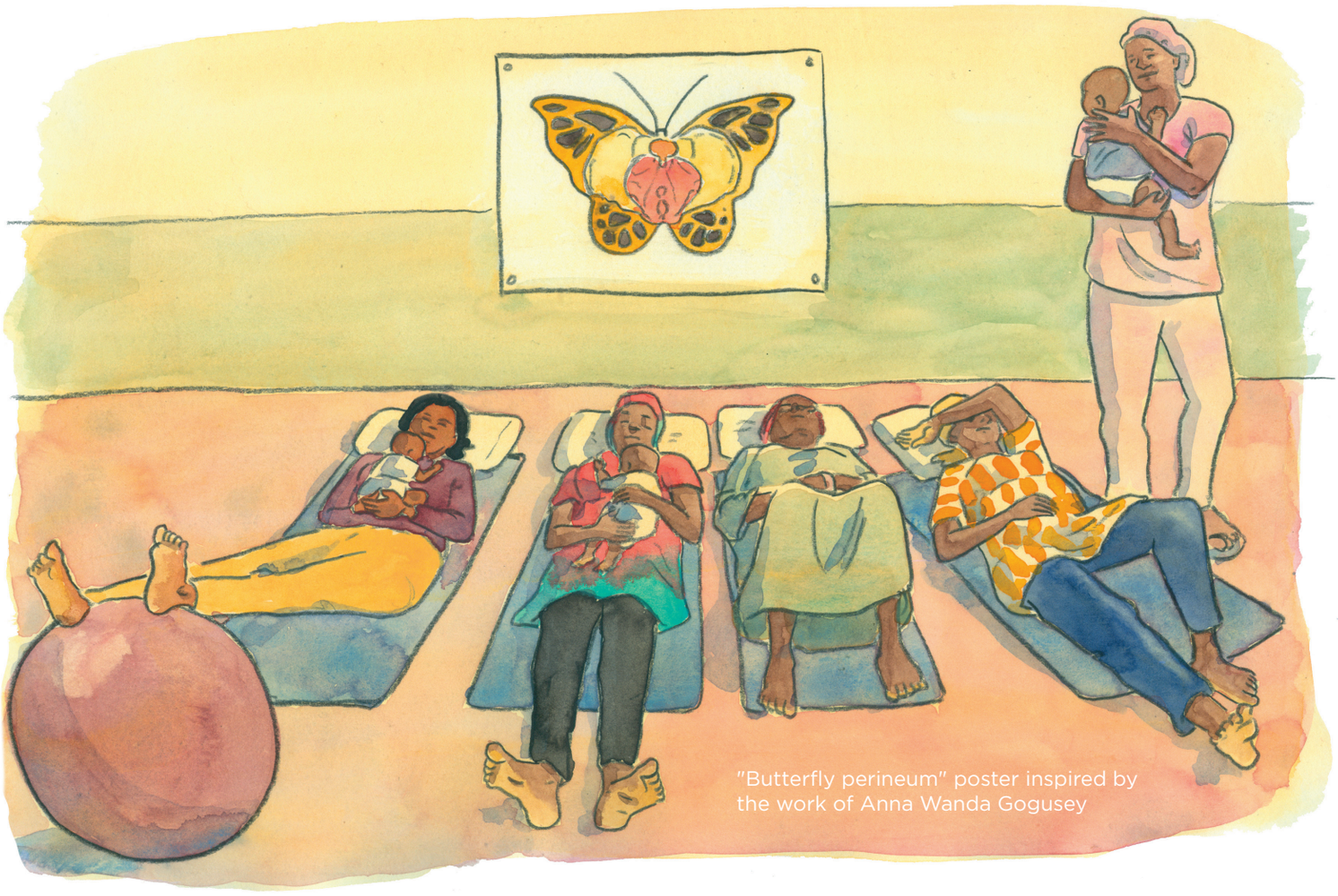
it rests, it gathers itself.

It doesn't try to force anything.

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"Butterfly perineum" poster inspired by the work of Anna Wanda Gogusey

It opens its wings... then closes them...

to the rhythm of your breathing.

Your body knows how to do it.

Simply observe the butterfly's movement.

Let it guide you.

Before standing up, take a moment to breathe: visualise your pelvic floor stretching as you inhale (as you draw air into your lungs) and contracting as you exhale (as you breathe the air out of your body).

You're going to get up as you breathe out (when your pelvic floor tightens):

- *Turn onto your side;*
- *Get in the all-fours position;*
- *Push up on your hands to get down on your knees;*
- *Put one foot on the floor (lunge position);*
- *Push through your foot to come to a standing position."*



Download our practical guides and posters to empower women, support maternal mobility and promote freedom of choice of positions during labour and childbirth.

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