

MATERNITY CARE WITH RESPECT
RESPECTFUL MATERNITY CARE

**Educational workshops for cultivating effective
communication skills
among perinatal healthcare professionals:**



**Role-playing exercises for practical skills development, with a focus on Shared
Decision-Making and structured Peer Feedback.**

#WordsMatter #BirthsMatter

#EmpoweredWords #EmpoweredBirths

#RespectfulMaterinityCare #RespectfulBirths



**Με τη συγχρηματοδότηση
της Ευρωπαϊκής Ένωσης**

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Foreword

Effective communication is a fundamental measure of the quality of care provided to pregnant women and new mothers. It plays a crucial role in building trust between perinatal health professionals and the women they care for, in ensuring a positive experience and satisfaction for pregnant women and new mothers, and ultimately, in improving outcomes for the woman and child, and their family.

While communication is an integral part of clinical practice and something that all healthcare providers do on a daily basis in all settings, there is always room for improvement. Effective communication encompasses not only the accuracy, completeness, and clarity of the information itself, but also, if not even more importantly, the understanding of the pregnant or new mother's thoughts, ideas, concerns, and expectations (often referred to by the acronym ICE – Ideas-Concerns-Expectations), always with respect and empathy. This enhances the experience of women and their families and is a prerequisite for providing quality, safe, and person-centered care.

A key aspect of effective communication in maternity care is **the collaborative, shared decision-making** between healthcare professionals and those receiving care (Shared Decision-Making). According to the National Institute for Health and Care Excellence (NICE) 1, shared decision-making is a collaborative process in which healthcare professionals and those receiving care, work together to make informed decisions about care, balancing clinical expertise with the preferences and values of individuals. The "three-talk model of shared decision-making" - which describes the structural components of the process - refers to three "key" stages that do not always develop sequentially, but are all necessary:

- The need for the healthcare professional to recognize that various decisions are personal decisions for which there are usually alternative options, and that the preferences and concerns of the pregnant or new mother are important and must be taken into account, with the strong assurance that any decision will be made jointly.

- **TEAM TALK:** *supporting consultation and a relationship of trust.*

- The healthcare professional's obligation to provide accurate, comprehensive, and balanced information, clearly outlining the advantages and disadvantages of each option, always without a judgmental attitude towards expressed preferences or a one-sided presentation of the options. This can sometimes unintentionally include either romanticizing certain options, failing to mention alternatives, or even using, however unconsciously, "intimidating" language about the risks

involved in the pregnant woman's expressed preference, especially when it may not align with medical recommendations and guidelines.

- **OPTION TALK:** *recognizing alternative options and providing information about those options.*

Highlighting empathy and a genuine effort from healthcare professionals to understand the pregnant woman's thoughts, concerns, preferences, and expectations, while making an effort to incorporate these thoughts into the decision-making process in a way that aligns as closely as possible with the choices that the pregnant or new mother considers correct and appropriate for herself, without pressure, provided that time allows, and with clear directions for more information and support.

– **DECISION TALK:** *highlighting and incorporating preferences.*

Effectively achieving this goal requires specialized communication skills that go beyond the usual exchange of information. It requires an active effort to engage, support, and empower pregnant women in making informed choices about taking care of themselves and their babies.

Effective communication is not a matter of personality or preference – it is a professional responsibility, a measure of quality, and it is a fundamental right. Therefore, let's not forget that...

Every decision requires BRAINS

... and the best choices are always those served on ICE!

The acronym BRAIN - BRAIN

The acronym BRAIN (Benefits, Risks, Alternatives, Intuition, Now/Nothing) succinctly, but very effectively, describes the essential elements for decision-making.

It is used internationally in various versions in national languages and was created to remind both healthcare professionals and those receiving care of the importance of balanced information when making any decision, even recognizing that not making a decision when it is not needed (perhaps a hasty one) or not accepting a proposed intervention or treatment, is one of the options.

In Greek, the RESPECT team translated the acronym BRAIN into the corresponding term “ΜΥΑΛΟ”!

B	<i>Benefits</i>
R	<i>Risks</i>
A	<i>Alternatives</i>
I	<i>Intuition</i>
N	<i>Nothing</i>

Purpose

The aim of the RESPECT workshops is to enhance the clinical communication skills of perinatal health professionals (midwives, obstetricians, obstetricians- gynecologists and others) with emphasis on Shared Decision **Making**, to effectively support pregnant women and new mothers in making informed decisions about alternative options care that meet their preferences and expectations.

Specific objectives:

- **Communication skills:** Recognize the core principles, stages, and techniques of Shared Decision-Making within the context of counseling that ensures women—the recipients of maternity care services—are aware of and understand the advantages, disadvantages, and potential outcomes and consequences of various care and treatment options.
- **Practical training:** Enhance communication skills, focusing on the elements that comprise the collaborative process of Shared Decision-Making, through role-playing in specially designed realistic simulation scenarios with trained 'actors.'
- **Professional development:** Become familiar with the process of peer-to-peer feedback/feedforward in a safe and respectful environment and with the use of structured observation tools:
 - for evaluating/self-evaluating communication skills in general (Calgary-Cambridge Guide per scenario), and
 - of the components of Participatory Decision Making in particular (Option5 observation tool)
- **Reflection:** Cultivate a shared understanding of the importance of good communication and collaboration in supporting women, and promote reflection for self-improvement within the framework of effectively undertaking and expanding the educational role of midwives.

The educational program was designed within the framework of Work Package 4 (WP4) of the broader RESPECT project for Respectful Maternity Care, entitled "Toward a Culture of Respectful Maternity Care (RMC): Enhancing Shared Decision Making and Informed Choice in Cyprus and Croatia."

Method of Implementation

The educational program offers some flexibility in terms of implementation. For example, during the RESPECT project, it was offered three times, either as a standalone workshop or as part of educational meetings organized by other entities. Each implementation also had a different duration (2-hour, 3-hour, or 6-hour), although the basic structure of the educational workshop remained the same, both in terms of content and educational materials, and especially in terms of the sequence of educational activities. The sequence of educational activities is considered important to support the pedagogical method.

The core of the training is practical practice through role-playing, which is accompanied by structured peer feedback, under the coordination of the trainers.

Audience Size

In general, this type of training is best suited for small audiences (e.g., 10-12 people) so that the practical exercise of the scenarios can be done in parallel groups (e.g., 5-6 people), ensuring that all participants have a role and active involvement.

In addition to the coordinator, the trainers, and the 'actors,' the roles for the trainees are as follows:

- One healthcare professional voluntarily takes on the role to "play" the scenario as it is stated in the instructions given and any additional material the scenario requires. For example, this may be:
 - An Information Leaflet that he/she has available to use during the session with the pregnant woman as he/she sees fit (as in the case of the elective cesarean section scenario).
 - Detailed information on the content of the scenario that may cover medical recommendations and any other information deemed necessary to know about the topic under discussion (as in the case of the induction of labour in prolonged pregnancy scenario). This serves the purpose.
- The rest observe the interaction with the 'actor' trained in the scenario and take notes on the structured feedback form provided for each scenario. The form is structured into sections based on the Calgary-Cambridge model. With the aim of involving all those present in the discussion, each person or group of people is assigned to take notes on a specific aspect of communication

(e.g., information gathering or providing, either in terms of content or techniques, etc.). Of course, this can be modified accordingly if it is decided that it is preferable to focus on a specific aspect only, especially in applications with a shorter duration, where time does not allow the discussion to cover all aspects. For example, the trainees could be asked to focus only on one aspect and not comment on the others, e.g., only the effort made by the healthcare professional to elicit the thoughts, concerns, and expectations of the pregnant/new mother in order to effectively integrate them into either the information gathering or providing.

In larger audiences, and depending on the available time, resources, and the ability to conduct parallel groups for practical exercises, the program can be adapted accordingly. For example, if time does not allow, the repetitive practical exercise can be removed. Or, if there is no availability of parallel rooms, then a practical exercise of only one scenario can be done, depending on the goals set each time, before the plenary session. For peer feedback, the trainees can be grouped into teams to discuss a specific aspect of communication that will be assigned to them and summarize their observations through a team representative.

Adaptation:

Depending on the circumstances, as described above, the educational activities can be adapted to the needs and conditions. This is determined both in terms of basic elements, such as the total number of participants, their professional status, the nature of the event, and the total available time, as well as practical issues, such as the venue and the ability to conduct parallel groups for the practical exercise of the scenarios.

However, the basic structure of the educational workshop can remain the same, to the greatest extent possible, both in terms of content and educational material and in terms of the sequence of educational activities in order to support the pedagogical method, with the necessary adjustments mainly concerning

- (a) the duration of each educational unit, always giving greater weight to practical application and reducing, if and where necessary, the duration of the theoretical part (seminars), and
- (b) the way the practical application of the scenarios is implemented through role-playing and whether this is done in smaller parallel groups with the same scenario or different scenarios, or whether this is done before the plenary session of the conference attendees.

Although the ideal implementation of the educational program, to maximize the benefit, would require all participants to have the opportunity to apply one of the scenarios themselves, in order to receive peer feedback, this is not realistic for large audiences, and even for smaller audiences, it requires time availability.

Therefore, the implementation of the scenario can be done by a volunteer from the trainees in the role of the Healthcare Professional in front of the team of colleague-observers, whether this concerns small parallel groups, where there is the possibility and availability of rooms, or in front of the plenary session of the trainees, where in both cases, however, specific individual tasks can be assigned.

Specifically, the observers of the Healthcare Professional (volunteer) – Pregnant/New Mother ('actor') session can be expected to give feedback on specific aspects of the interaction in each simulated scenario based on the structure proposed by the Calgary-Cambridge communication model on which the Feedback Guide is also based. For example, a group of people may focus on elements of the session that concern only Information Gathering Techniques, another group should focus and comment on elements that concern Information Provision Techniques, a third group of people on elements that concern the content (either of the gathering or the provision of information), etc.

This would aim to achieve the maximum active participation of all those present and is achieved to varying degrees depending on the size of the audience and the availability of parallel rooms to separate the audience into smaller groups. In cases of large audiences, and for ease of use, tasks can be assigned according to the arrangement of the seats (e.g., first two rows, next two rows), while in applications with smaller audiences and the possibility of separating the audience into smaller parallel groups, this allows the assignment of feedback tasks on individual aspects of communication per 2 people or even individually (for groups of 10 people). In the feedback that concerns aspects of the verbal and non-verbal behavior of the Healthcare Professional for structure development, relationship building, and highlighting empathy, it is considered preferable for everyone to participate.

Applications of the Training within the RESPECT Project

Specifically, during the RESPECT project, the educational workshop was offered in the following ways, each time with the necessary modifications:

- Educational workshop integrated in the work of the Midwifery Session of the 31th Pancyprian of Nursing and Midwifery Conference, "Nurses and Midwives: Our Future"
 - Organizer: Pancyprian Association of Nurses and Midwives
 - Date: Friday, 6/12/2024, 11.30-13.
 - Duration: 2 hours, without a break
 - Venue: Hotel Hilton , Nicosia, Nicosia

- *Training venues: lecture hall*
- *Scenario: Planned elective cesarean section (before a plenary session)*
- *Participants: Midwives, Nurses, Health Visitors*

● Educational workshop integrated into a 2-day breastfeeding workshop for health professionals

- *Organizer: National Breastfeeding Committee of Cyprus, Ministry of*
- *Date: Wednesday, 11/12/2024, 09.00-12.*
- *Duration: 3 hours, with half an hour break*
- *Venue: Shacolas Educational Center for Clinical Medicine, Medical School, University of Cyprus*
- *Training facilities: lecture hall and three smaller rooms for parallel groups*
- *Scenario: Challenges with breastfeeding in the early days (in parallel groups)*
- *Participants: Community Midwives, Health Visitors*

● Educational workshop (in-hospital/in-service training) in collaboration with the Gynecological-Obstetrical Clinic, Arch. Makarios III Hospital, and the Trainee Education Sector, Ministry of Health

- *Organizer: Nursing Department, School of Health Sciences, and Training Sector, Arch. Makarios III Hospital*
- *Date: Friday, 14/02/2025, 08.00-13.30*
- *Duration: 5 hours, with half an hour break*
- *Venue: Shacolas Educational Center for Clinical Medicine, Medical School, University of Cyprus*
- *Training areas: Lecture hall and three smaller rooms for parallel groups*
- *Scenarios: Planned elective caesarean section and Induction of labour in prolonged pregnancy (in parallel groups) and Challenges with breastfeeding in the first days (repetitive application before plenary session)*
- *Participants: Midwives, Gynecology-Obstetrics Trainees*

Educational Workshop Outline

As an example, the outline of the educational workshop with a 6-7 hour duration is given below, showing the proposed sequence and duration of each educational activity.

Indicative Workshop Program for 6-7 hours duration		
15-30	Registration - Welcome - Getting to know each other - Workshop programme (<i>Annex A</i>) - List of presentations (<i>Annex B</i>)	Moderator
Educational Activity A (1 hour)		
15	Setting Objectives Linking Effective Communication to the Standards Quality for Respectful Maternity Care - RMC	Seminar presentations by a trainer (<i>Annex I - Presentation</i>) Slides
15'	Basic Principles	
15'	Communication skills: Model and Guide	
15-30'	Discussion	Participants
Educational Activity B (1 hour)		
45'	Recognition of good communication practices - Video of role-playing in a scenario breastfeeding support in the context of the Baby Buddy Communicator project (Erasmus+). <i>Available from the research team under licence</i> - Video Y2Mate.is - Unicef UK Baby Friendly Initiative Communication in pregnancy (7'30' - 11'25"). <i>Available at the link below: https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/antenatal-care-resources/communication-in-pregnancy-video/</i>	- Taped sessions: ✓ Baby Buddy Communicator: E. Lazarou (Midwife) & A. Anatolitou (Mother) ✓ Unicef UK - Discussion
15'	Presentation of scenarios & definition of groups and roles	Group coordinators
Educational Activity C (1 hour)		
30'	Practical application in parallel groups: Role-playing with 'simulated actors' Scenarios: <i>Optional planned caesarean section</i> <i>Prolongation of pregnancy-Recommendations for inducing</i> Training material for each scenario (<i>Annexes C & D for each of the two scenarios</i>) <i>Instructions to Professional</i> <i>Supplementary material/ Educational leaflet</i> <i>Instructions to simulated 'actor' (not given)</i>	- Role-playing: ✓ Volunteer trainees ✓ 'Actors' ✓ Colleagues in the role of observers ✓ Trainers in the role of facilitators - Material to study

	• <i>Feedback guide</i> (given to observers) • <i>Session objectives</i> (given at the end after the discussion)	
30'	Discussion of scenario implementation: structured feedback/feedforward • using the structured self-assessment/assessment guide Calgary-Cambridgeper scenario, and • on the basis of the model ALOBA to identify & define objectives	• An/Adaptation in the following order: ✓ trainee, ✓ actor, ✓ Colleagues, ✓ trainers
15-30'	Break	

Educational Activity D (1 and a half hour)		
15-30'	Feedback from parallel groups proposed management scenario by ChatGPT (<i>Annex E</i>)	- Group coordinators - Material to study
15'	Participatory Decision Making: - Participatory Decision Making Making model three-stage Shared Decision (<i>Annex I - Presentation</i>) Slides - OPTION5 Guide (<i>Annex F</i>)	- Seminar presentation - Material to study
30'	<u>Practical application of role-playing in front of a plenary:</u> Repetitive practice with emphasis on the stages of Participatory Decision Making <u>Script:</u> <i>Breastfeeding management in the first few days: Challenges and dilemmas for supplementation</i> Comprehensive training package for the new scenario (<i>Annex G</i>)	- Role-playing: ✓ Volunteer trainee ✓ 'Actress' - Material to study
30'	Discussion of the script and highlighting exemplary effort - using guide observation - proposed scenario management by	- Participants - Moderato - Material to study
Educational Activity E (1 hour)		
15'	Reflective process (<i>Annex I - Indicative presentation</i>) Slides	Seminar presentation
15'	Self-Assessment: research findings Baby Buddy Communicator HP Communications Skills Scale tool (<i>Annex H</i>)	- Seminar presentation - Material to study
30'	Structured participatory mapping exercise Recognition of challenges in assuming an educational role (<i>Annex I - Indicative presentation slides</i>)	- Participants - Moderato - Material to study
15'	Closure: Workshop evaluation (<i>Annexes I</i>)	Participants



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Simulated 'actors' for role-playing in scripts	• Aphrodite Anatolitou, Volunteer, Birth ○ Script: <i>Challenges to Breastfeeding in the Early Days</i> • Marianna Moore, Volunteer, Birth ○ Script: <i>Scheduled elective Caesarean</i> ○ Script: <i>Challenges to Breastfeeding in the Early Days</i> • Paraskevi Kini, Research Associate RESPECT ○ Script: <i>Induced labour in prolonged pregnancy</i> ○ Script: <i>Challenges to Breastfeeding in the Early Days</i> • Maria Stavrou, Volunteer - Board Member, Birth ○ Script: <i>Scheduled elective Caesarean</i> • Margarita Kapsou, Project Manager RESPECT - CEO Birth Forward ○ Scenarios: <i>all, in a reserve role</i> • Ioli Orphanidi Eteocleous, Volunteer, Birth Forward ○ Scenarios: <i>all, in a reserve role</i>
Project partners	 Cyprus University of Technology  birth forward  RODA® 2021 GODINA RODE  Università di Genova  ΟΣΑΚ ΟΡΓΑΝΙΣΜΟΣ ΑΓΩΓΗΣ ΚΥΡΩΣΕΩΣ  MEDITERRAN INSTITUTE GENDER STU
Funding	Co-funded by the European Union through the <i>Citizens, Equality, Rights & Values</i> programme Citizens, Equality, Rights & Values

Pedagogical approach

The pedagogical approach of the educational workshops is aligned with the principles of adult education and is based on the following principles:

- **Situational-, problem-based learning:** where learning is based on specific situations and scenarios, and the trainees must put their existing knowledge and skills into practice and manage the various alternative turns that the scenario may take during role-playing, based on previous instructions given to the trained 'actors' to react according to the reaction of the trainees, thus promoting critical thinking and the ability to apply good communication practices, rapid adaptation, and adaptability to situations.
- **Inverted learning:** where trainees first proceed to practical application of the scenarios before presenting new learning material or only to a minimal extent (e.g., in this case, reminder of basic principles and communication techniques through watching recorded sessions), thus bringing to the surface current practices and highlighting the different "starting point" of each individual. By making existing knowledge and usual practices visibly apparent both to themselves and to the observers, who are given a role to provide peer feedback/feedforward, the trainees are in a better position to reflect, identify deviations from the desired, and explore, under the guidance of the trainers, the issues under discussion and the related concepts both with tangible examples and in greater depth.
- **experiential learning**, i.e., learning through practical application in role-playing in specific selected scenarios but also through repetition in scenarios with other requirements, supporting the ability to transfer the basic principles and adapt communication techniques to different situations.
- **interdisciplinary dimension**, i.e., bridging communication skills with the application of evidence-based clinical practice, since beyond the skills of effective communication, each scenario sets specific requirements as to the content when providing information both as to the correctness of the information based on international recommendations and as to the transmission of information in a balanced way.

Selected scenarios

The selected scenarios are realistic and have been specifically designed to reflect the Cypriot reality both in terms of the roles, structures, and peculiarities of the health system and in terms of the issues they address, as they relate to priority areas. The first three scenarios developed for the implementation of the communication workshops within the framework of the RESPECT project concern the following.

- **elective planned caesarean** section (based on the scenario, pregnant at 36th week of gestation),
- **induction of labour in prolonged pregnancy** (based on the scenario pregnant at 40+6 weeks gestation)
- **challenges in breastfeeding in the first few days** (based on the scenario, mother with older child, 5 days postpartum)

With the exception of the scenario for the induction of labor in prolonged pregnancy, for which it is not known how often healthcare professionals in Cyprus face this situation, mainly due to established clinical practices, the other two scenarios concern "frequently recurring" situations within the Cypriot reality with specific clinical communication requirements.

Characteristically, Cyprus has one of the highest cesarean section rates in Europe, and a common explanation for this phenomenon put forward by the clinical community is that a large percentage of these are due to the pregnant woman's own choice, although this cannot be confirmed by statistics, mainly due to gaps and deficiencies in the way data is recorded.

Also, both the data recorded by the Monitoring Unit of the Ministry of Health and related research findings (e.g., the BrEaST start in Life study) show that exclusive breastfeeding rates in Cyprus are and remain among the lowest in Europe, even in the first 48 hours, and many new mothers discontinue breastfeeding (exclusive or mixed) prematurely.

Finally, in the absence of national guidelines and related protocols, the management of prolonged pregnancy differs significantly between maternity clinics, even between gynecologists-obstetricians. Although there is no good statistical data to have a clear picture, in general it seems that prolonged pregnancy is not a practice that is widely supported. Unfortunately, the data of the Perinatal Health Report maintained and published by the Health Monitoring Unit of the Ministry of Health is not as detailed as it should and could be. For example, in the case of gestational age at delivery, usually only the percentage of deliveries after the 37th week of gestation is presented, as a single percentage, which does not allow us to have data on the distribution of deliveries in terms of the exact gestational age, let alone to have a picture regarding prolonged pregnancy. At the same time, perinatal health reports do not include any reference to induction of labor. In fact, there is generally a significant delay in the publication of any data, resulting in a lack of recent data.

It is also mentioned that two additional scenarios have been developed which were not implemented in the first phase in the context of practical training and concern:

- the management of the discussion around the **birth plan** (since it seems that while it is a clear wish of pregnant women that offers tremendous opportunities for discussion with healthcare

professionals, it is not a practice that is supported to the extent that it should be and would require the effective undertaking of the educational role by healthcare professionals).

- the discussion between a pregnant woman and the midwife about the concern for the performance of an (unnecessary) **episiotomy**, since it has come to her attention that it is a practice that seems to be used as a routine in Cyprus, contrary to the recommendations (again, the available data from the Perinatal Health Reports do not easily allow conclusions on this issue, since the most recent data published are very old and relate to 2017-2018, and which show that the percentage of episiotomies was very high at 70%. Subsequent reports do not even include a reference to episiotomies).

In general, it is recommended to select scenarios that reflect the priorities and peculiarities of the health system and services where the training will be implemented, while they should realistically reflect socio-cultural perceptions about the issues they address. For this reason, it is important that the development and shaping of the scenarios is done using a participatory approach in order to convey through them the perspective of both the healthcare professionals themselves on the possible reactions of the person in the role of the healthcare professional, and the women themselves (pregnant/new mothers) so that they stem from lived experiences and reflect common practices, attitudes, behaviors and/or perceptions (correct or incorrect) about the issues under discussion.

How to select scenarios

Beyond the fact that the scenarios must reflect the socio-cultural reality and, ideally, concern "frequently recurring" situations, an important parameter that must also be taken into account is the degree of "difficulty."

During the development of these scenarios, multiple parameters that affect the complexity of the scenario itself were taken into account, through the Shared Decision-Making (SDM) approach, leading to variations in the degree of difficulty of the scenario and, therefore, to variations in the expected communication skills required.

The following aspects were incorporated into the methodological approach of selecting the scenarios. A table was developed where various important aspects were integrated (as shown below), in order to facilitate the final selection, taking into account the relative expected degree of difficulty of each scenario. Therefore, when considering the various suggestions in the context of the selection of the scenarios, the various possible scenarios were first categorized according to their characteristics, taking into account simultaneously all these important parameters, as shown in the table below:

		Equivalent options (equivalent)		Non-equivalent complications (non-equivalent)	
		Neutral attitude	Expressed preference	Neutral Stop	Expressed preference
Prenatal I	Time pressure				Challenge to prolong pregnancy
	No time pressure				Elective planned caesarean section
Prenatal	Time pressure				
	No time pressure				
Prenatal	Time pressure				
	No time pressure			Challenges in breastfeeding in the first few days	

- Equivalence of available options: A fundamental aspect of SDM is whether the options presented to the recipient of care (pregnant/new mother) have comparable risks and benefits. In some scenarios, the options may be relatively equivalent, while in others they are not, with some of the possible options not comparing favorably to another in terms of disadvantages, the consequences of the choice on the birth experience, and/or the risks to the mother and/or the newborn.
- Expressed preference of the woman: The possible scenarios may differ in whether the expressed preference of the woman is relatively neutral and open to all available (equivalent) options or not fully aligned with the expected recommendations of healthcare professionals based on clinical guidelines, in which case, if the expressed preference concerns a non-equivalent option, this increases the degree of difficulty of the scenario and the challenges regarding communication. Specifically:
 - Neutral stance - no clear or clearly expressed preference: The healthcare professional facilitates the informed choice more easily since there are no predetermined expectations or expressed preferences.
 - Misalignment of expressed preference with recommended care: The healthcare professional is expected to manage the discussion by providing balanced information, recognizing the woman's autonomy, and at the same time expressing clear direction and guidance based on the recommendations.
- Timing of the decision (prenatal, perinatal or postnatal): The training emphasized prenatal and postnatal decisions, as perinatal scenarios often involve increased urgency, which makes them less suitable for structured role-playing exercises.
- Time pressure: In combination with the above, scenarios where there is greater time pressure for decision-making, significantly increase the degree of difficulty. The urgency of the decision, especially perinatally, significantly affects the complexity of the scenario:
 - When there is no time pressure: healthcare professionals are given the opportunity to encourage discussion and further exploration of the options, since perhaps the appropriate management of such a scenario is the non-(hasty) decision-making.
 - Some time pressure: Healthcare professionals are expected to balance the urgency of decision-making while ensuring that the woman actively participates in the process and that her autonomy is ensured during decision-making.
 - High time pressure: These scenarios were avoided (for example, situations that require quick decisions e.g., management of complications during childbirth, or an emergency cesarean section) due to the advanced SDM skills required (significantly increasing the degree of difficulty), as well as for practical reasons (as mentioned above) due to the

challenges they pose for representing such situations in a simulation environment in the context of a short educational program.

Selection Criteria for the Specific Application of the Educational Program

Based on the methodological approach described above, the following choices were made in the context of shaping the educational scenarios:

- Exclusion of perinatal scenarios: Given the complexity associated with real-time decision-making during childbirth, perinatal situations were not included, in order to maintain the feasibility of representation in the context of role-playing, but also to emphasize scenarios where healthcare professionals could fully develop the SDM process.
- Inclusion of scenarios where the expressed preferences of the women 'actors' did not align with the recommendations: In order to provide a realistic educational experience, scenarios were designed where the expressed preference of the woman did not fully align, at least based on the initial positioning, with clinical guidelines. Two basic examples:
 - Preference for elective cesarean section: The healthcare professional is expected, in a non-judgmental way, to recommend delaying the decision, explaining that cesarean section should be avoided when there are no medical indications, listing some of the risks compared to normal delivery, and encouraging the woman to explore more information.
 - Preference to avoid induction of labor in prolonged pregnancy: The healthcare professional is expected to present information on prolonged pregnancy and the recommendations for induction, explaining when it may be preferable, taking into account any time pressure that may exist, but at the same time recognizing the woman's concerns and expectations of some time constraints.
- Moderate complexity: While cases of high urgency were avoided, some scenarios included a degree of time sensitivity to better reflect the real context of decision-making in maternity care.

Recommendations for future iterations

In future applications of the training programme, the following recommendations can enhance its effectiveness:

- Evaluation and improvement of the complexity of the scenarios: The evaluation of the degree of difficulty of the scenarios and the substantive feedback from the trainees themselves can guide the further improvement of the educational material, the even more targeted shaping of the existing scenarios, ensuring both the relevance to the real needs and the effectiveness of the training.

- Formulating additional scenarios, taking into account a wider range of both clinical situations and socio-cultural contexts, ensuring the possibility of application in diverse maternity care settings.
- Incorporating perinatal scenarios with a higher degree of communication difficulty to address SDM skills in high time pressure environments.
- Introducing elements of observation in real-world settings of a healthcare professional-pregnant woman interaction so that the training actively promotes (not only indirectly through reflection and self-assessment) reflection on the application of SDM skills in the context of daily clinical practice.

Structure and Description of the Educational Program

The RESPECT project's communication skills enhancement educational program is aimed at prenatal healthcare professionals and primarily uses experiential learning through role-playing and active involvement of participants (trainees) in the learning process through structured peer feedback, as this is also the main learning goal of the training.

The educational activities of the program are developed in six successive units, including the evaluation of the workshop and feedback from the trainees for improvement suggestions.

These are described in the following units.

Beginning:

Welcome - Day's Program

Introduction to trainers and among trainees - Icebreaker

Duration: 15-30 minutes, depending on the total duration.

Required material:

- *Day's Program (Annex A - indicative example from RESPECT training)*
- *Attendance Sheet (Annex B - indicative example from RESPECT training)*

Purpose

Welcome - Introduction - Icebreaker

Description - Implementation Instructions

- Arrange the room in the best way for the needs of the training and care for the comfort of those present. In advance, arrange for coffee and snacks for the break depending on the total duration of the training.
- Welcome from the coordinator of the training and the trainers and instructions-explanations for the planning that has been done, giving in printed form the program for the day that has been prepared for this purpose.
- "Icebreaker":
 - If there is no time pressure, a good suggestion is the "1 minute" game where each person present must introduce themselves to the person sitting next to them, where they must talk to him/her about themselves for 1 whole minute, without interrupting him/her. The aim of this game is to highlight how much we can say about ourselves and learn about another person in just 1 minute (open question).
 - If there is time pressure, then people can simply introduce themselves to the group, saying their name and the first word that comes to their mind, or successively the first word they thought of after the word that was mentioned by someone previously, or, if there is a little more time, the group can play the game with the "broken telephone". The aim of this game is to highlight how important it is to really listen and repeat correctly what the other person told us (active listening - repetition for confirmation).
- Ask the trainees to sign the attendance sheet, making special reference to the consent to take photographic material and to arrangements in case someone does not want to be photographed.



- Creating a generally friendly and supportive atmosphere and providing assurances that the workshop has purely educational purposes in a safe environment, with confidentiality and respect for colleagues.

Educational Activity A:

Introduction to the Principles of Effective Communication and Peer Feedback as a Criterion for the Quality of Care Provided.

Duration: 1 hour

Required material:

- seminar presentations-slides on the topics under development (*indicative example from training RESPECT - Annex I - Indicative Slides for Seminar Presentations*)

General purpose

To cultivate a common understanding of the basic principles of effective communication in clinical practice, to connect its necessity both as a professional obligation and as a quality indicator, and to introduce the principles of peer feedback.

Specific objectives

- Definition of effective communication as a critical component of Healthcare Quality, based on the WHO Quality Standard
- Usefulness of a structured approach to communication based on the Calgary-Cambridge model of clinical communication.
- Familiarization with the principles of structured peer feedback and its importance as a means of personal self-improvement and setting personal goals at the individual level, and at the same time a prerequisite at the organizational level, when this is done in the context of a collective and organized effort to improve the quality of care provided.

Description - Implementation Instructions

Effective communication skills are essential for Perinatal Health Professionals and are an element of the quality of maternity care provided. This unit includes 3 short 15-minute seminar presentations by one or more trainers (Annex I – Indicative slides of seminar presentations) on the following topics:

- communication as a quality indicator of the care provided,
- the importance and basic principles of peer feedback/feedforward as a method of self-improvement and collective improvement of the quality of maternity care provided, and

- a brief introduction or reminder to the Calgary-Cambridge clinical communication model, on which the feedback guides for the role-playing scenarios that will be used later in the context of the experiential workshops are based.

Educational Activity B:

Recognizing Good Communication Practices: We all have our strengths and there is always room for self-improvement.

Duration: 1 hour

Required material:

- Recorded session (video) of either a "model" session to highlight exemplary communication skills
- and/or example of role-playing from previous training sessions

General purpose

To remind the basic principles and techniques of communication and to activate the existing knowledge and the different "starting point" for each individual. At the same time, the aim of this activity, through highlighting good practices as well as "missed opportunities," is to enhance the trainees' awareness of existing communication practices, challenges, and areas that need improvement.

Specific objectives

- Identify and determine effective and ineffective communication techniques and strategies in videotaped consultations.
- Activate existing knowledge about communication techniques and enhance interest in the educational program.
- Indirectly recognize the personal "starting point" through the process of comparing their own self-image with colleagues in the videotaped sessions.
- Familiarize with the concept of peer feedback, cultivating acceptance through practical tangible examples of the correct way to provide it to colleagues.

Description - Implementation Instructions

In this unit, participants have the opportunity to watch videotaped sessions with the aim of recognizing good communication practices, and at the same time recognizing aspects that, in their judgment, need improvement. This mainly serves as a reminder of the basic principles and techniques of communication and the activation of existing knowledge, since the program is aimed at health professionals for whom communication is something with which they engage on a daily

basis in the context of their clinical practice, without necessarily meaning that they have attended a structured communication skills program in the past. Therefore, it also serves to recognize the different "starting point" from which each one begins.

Specifically, in the context of the RESPECT program, one or both of the following videos were used, if time allows, depending on the needs (model session versus session videotaped for educational purposes) and the total duration of the workshop:

- The first, on breastfeeding counseling in the context of a prenatal visit, was created by UNICEF UK as part of the Baby Friendly Hospital program. It is freely accessible on the internet. From this video, which is lengthy and includes references to the principles and skills of effective communication, only a short excerpt is used, which presents a "model" session highlighting a range of good practices, which participants are expected to recognize and name.
- The other video comes from the communication skills training program of the Nursing Department of the Cyprus University of Technology (TEPAK), which was designed and implemented in the context of the co-funded Baby Buddy Communicator program (Erasmus+)3. It was specifically aimed at the mentors of the Department's postgraduate Midwifery program in order to cultivate educational skills in communication issues, so that they can function from the role of trainer to Midwifery students in an academic and clinical environment.

In this specific program, the pedagogical method of "social video" was used as a learning tool. The aim was to recognize the importance and value of self-assessment, as well as the direct familiarization of trainees with the process of providing and accepting structured peer feedback. The use of audiovisual material from this program, which is done through securing permission from the people appearing in the video (both the healthcare professional who is "evaluated" and the 'actor' who plays the role of the scenario), serves two purposes:

(a) offers an example of providing and accepting peer feedback, and in fact from a culturally familiar environment since they come from Cyprus - the fact that in these videos appear people (other colleagues) who are known and recognizable for many who will attend the RESPECT educational workshops brings a clear added advantage, and

(b) serves to highlight the usefulness, but also the correct way of providing peer feedback which must be done in a safe environment, with respect for the individual with the aim of individual and team self-improvement.

Educational Activity C:

Practical practice of communication skills through role-playing

Duration: 1 hour

Material:

- Scenario instructions for Health Professional

Given to the volunteer-HP who will take on the scenario to study it before the start of role-playing, as well as to the rest of the group.

- Supplementary material for the scenario

Given to the volunteer-HP who will take on the scenario to use it as he/she sees fit during role-playing, as well as to the rest of the group.

- Instructions to simulated 'actor'

Not given - it only concerns the 'actor' of the scenario.

- Feedback guide based on the Calgary-Cambridge model

Given to the rest of the trainees who, as observers of the session, are asked to take notes and give feedback.

- Session objectives and desired scenario outcome

Given to everyone at the end after the group discussion of the scenarios.

The package with the material for each of the two scenarios is included in Annex C (elective planned cesarean section) and Annex D (induction of labor in prolonged pregnancy).

General purpose

To provide practical practice in communication skills through simulated scenarios with trained actors, self-assessment, and structured feedback from colleague-trainees.

Specific objectives

- Practical application of communication techniques in simulated midwifery care scenarios through role-playing.
- Self-assessment and group discussion with mutual feedback through structured sheets based on the Calgary-Cambridge model.

- Recognition of good practices as well as critical points in the interaction, where alternative approaches from the healthcare professional could be potentially more effective and could improve the outcome.

Description - Implementation Instructions

This unit is the core of the educational program and includes interactive practical practice of communication skills in realistic clinical scenarios with simulated 'actors' who have been trained in the specific scenarios. The purpose is mutual feedback and group discussion based on a structured approach since each scenario is accompanied by a structured Feedback Guide based on the Calgary-Cambridge model, which was mentioned in a previous unit. The remaining trainees also have the opportunity to use the Guide (one for each scenario) to provide feedback to a colleague who takes on the role required by the scenario. The scenarios have been carefully selected to reflect frequently recurring situations in the context of the Cypriot reality and health system, ensuring relevance to daily practice.

In each role-play, a trainee voluntarily takes on the role of the healthcare professional, as described in the scenario, receiving a brief briefing on the "situation" and what is expected. The instructions are brief, providing only a rough direction (e.g., providing information, understanding the pregnant woman's concerns, etc.), and not the expected goals and the desired outcome of the scenario. This is only given at the end to the entire group as material for study. The remaining trainees act as observers, with instructions to take notes on the structured evaluation sheet, which is given, so that they are able to give feedback on specific elements and points of the interaction they have observed (such as information gathering, information provision, the techniques used, or the content of the information itself, where needed, both in terms of correctness and in terms of clarity and balanced presentation of the data, and/or the available options and/or the consequences and risks, depending on the scenario).

The role of the pregnant/new mother, the recipient of health care, is played by a suitably trained actor, who, based on written instructions she has received and studied, is expected to react according to the approach and behavior of the healthcare professional, both in relation to the content of the discussion, i.e., the way the healthcare professional collects or provides information, and in relation to the general attitude and behavior.

At the end of the role-playing process, the trainers coordinate the discussion that develops, always first giving the opportunity to the person who played the role in the scenario to proceed to a first self-assessment (i.e., what does the person think went well, what could they have done differently),

followed by feedback from the "actor" (e.g., how she felt herself, what else she would have liked, what was not asked), then proceeding to a structured group discussion aimed at constructive feedback from the colleagues who watched the interaction, based on their notes. Towards the end of the discussion, and after everyone has had the opportunity to contribute to the discussion, the coordinators summarize, with references to at least the following - how the healthcare professional understood the needs of the scenario, what goals they had set - could have set to manage the situation, what things they should perhaps know about the thoughts, concerns and expectations of the "pregnant woman" / "new mother" to be able to better target the discussion and counseling.

Preparation (before the workshop)

- Scenarios that reflect frequently recurring are selected situations in the context-environment in which the training is implemented and that are aligned with the health system, roles and services provided.
- The 'actors' are trained in the corresponding scenarios, ensuring that they know the scenario well and the different reactions (attitude and behavior) they are expected to have in response to the approach of the healthcare professional (content, behavior). These are described in the Guide to Actors and the 'actors' are expected to have studied them in advance, as well as to have some trial applications with the trainers in order to resolve questions and discuss with the trainers the possible turns that the scenario may take.
- For each scenario, a structured evaluation sheet is formed with clear criteria for the communication elements that the observers will evaluate based on the Calgary-Cambridge model.

Separation of groups & assignment of roles

- On the day of the training, the participants are divided into small groups, ideally 5-6 trainees per group. Alternatively, for larger audiences, the appropriate adjustments are made, as described above.
- Two coordinators per group are appointed to coordinate the process and the discussion, providing above all a safe environment, so that the discussion is productive and the feedback is given with respect. One trainer acts as the coordinator of the discussion while the second keeps notes on the Guide to facilitate the discussion on specific points.
- One of the participants takes on the role of the healthcare professional (midwife, specialist or trainee gynecologist), while the remaining participants are observers, to whom specific

instructions are given for structured note-taking, so that they are able to contribute to the discussion and give their feedback to the colleague.

Execution of the role-play

- After studying the instructions that were given, and any supplementary material, the healthcare professional - volunteer who will develop the scenario starts the session with the 'actor', who has received relevant training to react naturally according to the approach of the healthcare professional and the direction the scenario takes.
- Observers watch carefully, using the feedback sheet to evaluate specific aspects of the interaction.

Report & feedback

- The coordinator of the group first invites the healthcare professional who played the scenario to reflect on the session, identifying what he/she believes went well and what he/she could have done better, what points were difficult and why, and generally to develop his/her thoughts.
- Then, feedback is given by the 'actor' from the perspective of the recipient of care, who shares with the group her experience of the interaction, and focuses on how she felt, how she felt, whether she wanted to hear or learn something more, what the healthcare professional did not ask that she considered important, etc.
- Then, the remaining trainees who watched the interaction as observers contribute in turn to the discussion, and based on the instructions given to them, pointing out the main points from their notes, ensuring that the feedback is structured and constructive.
- An effort is made to involve everyone in the discussion, to identify points of agreement or disagreement. Depending on the initial instructions, the discussion either focuses on the aspect of communication that was decided or an effort is made, time permitting, to cover more or all aspects.
- The coordinator, with the help of the colleague who keeps notes, selects the most important points they deem should be brought to the attention of the group, and if they are not mentioned spontaneously by any of the participants, then relevant questions are asked. In general, the coordinators guide the discussion, suggesting alternative approaches and strategies that could have led to a more effective interaction, and invite the group to think about what "key" points in the discussion they identify that the treatment of the healthcare professional could have led the scenario in another direction, either better or worse, in their judgment. For example, references or non-verbal reactions from the 'actor', missed opportunities, things that were not asked while they were important, etc.

Conclusion

- The coordinator summarizes the main conclusions, reinforcing good practices and identifying areas for improvement
- If time permits [in longer training], the process can be repeated with a different scenario, alternating roles, so as to give another person the opportunity to play a role as well as to allow the others to practice peer feedback more, focusing on different aspects this time.

Educational activity D:

Repetitive practice with emphasis on the stages of Participatory Decision Making

Duration: 1 and a half hour

Material:

- Proposed management of the scenarios applied by the groups and desired outcome as proposed by ChatGPT (Annex E - Proposed scenario management by ChatGPT)
- Seminar presentation on the stages of Shared Decision-Making based on the “three-talk model” (Annex I - Indicative presentation slides)
- OPTION5 observation tool (<http://www.optioninstrument.org>) with a table of examples of exemplary effort (after securing permission from the manufacturers for translation and adaptation to Greek). (Annex F - OPTION5 Observer observation tool – Greek translation)
- Complete package for a new scenario, which includes: Instructions to HP, Scenario Objectives, Instructions to 'actor', Proposed scenario management by ChatGPT (Annex Z - Challenges with breastfeeding in the first days).

General purpose

To enhance the consolidation of learning through discussion of the main points of the role-playing scenarios previously applied in groups, with examples of "exemplary effort" based on the OPTION5 tool and the model of Shared Decision-Making (SDM), thus introducing "new" knowledge, which is put directly into practice by repeating the practical exercise in a new role-playing scenario before the plenary session.

Specific objectives

- Brief presentation of the conclusions from the practical exercise of the scenarios by the group facilitators and highlighting of the main points for discussion where alternative approaches could improve the outcome.
- Recognition of the common elements regarding the principles and communication skills in a structured approach as proposed regardless of the scenario based on the "proposal" of artificial intelligence (AI) for the management of specific scenarios and at the same time highlighting the specificities of each scenario depending on the requirements, objectives and desired outcome (e.g. decision making or non-decision making, equivalent or non-alternative options, whether or

not the expressed preference of the pregnant woman is in alignment with medical recommendations, etc.)

- Introduction to the three-talk model Participatory Decision Making and review of the scenarios through examples of "exemplary effort" communication based on the OPTION5 tool.
- Consolidation through repetition of practical exercise and peer-to-peer feedforward in a new scenario (challenges in breastfeeding) both based on the principles and communication techniques already discussed and through Shared Decision-Making.

Description - Implementation Instructions

An important element of education is repetition and consolidation of learning through an inverted learning process. The trainees first proceed to practical application of the scenarios, before presenting new learning material or only to a minimal extent, thus bringing to the surface current practices and highlighting the different "starting point" of each individual. Making existing knowledge and usual practices visibly apparent.

After the role-playing workshops in the parallel groups are completed, the group coordinators summarize the observations recorded by each group in its own scenario before the plenary session and provide the participants with clarity on the key aspects of the scenario. The discussion focuses on the main points they want to bring to the attention of the others who applied a different scenario. The coordinators choose which points to focus on due to the time constraints, but participants are given material for further study.

This includes:

- both a description of the objectives of each scenario with reference to the main components and a suggestion of the proposed management approach, as well as
- the proposed management of the scenario based on the suggestion of **ChatGPT** giving the relevant scenario as a prompt and the instruction to draw up a complete management plan with emphasis on the principles of shared decision-making and a related guide for the stages with which the healthcare professional could develop the discussion.

At this stage, the concept of Shared Decision-Making (SDM) and the "three-talk" model is introduced for the first time in the session. The participants review the proposed management of the scenario by ChatGPT (which was prompted to structure the management suggestion both in the basic principles and communication skills and at the same time to make visible in the process the principles and stages of the SDM process). The aim is for the trainees to appreciate the diversity of

different approaches to cultivating and enhancing communication skills, while recognizing the value of structured methodologies.

This is followed by a seminar presentation that analyzes SDM in greater depth, along with the OPTION5 observation tool, highlighting what an exemplary SDM effort would entail for the specific scenarios that were previously applied in the parallel groups during role-playing.

With this theoretical basis, the participants proceed to a second round of practical exercise, applying the structured SDM approach to a new scenario. Observers undertake to use the OPTION5 tool to take notes and provide feedback to the colleague who will play the role.

The session concludes with a discussion about the new scenario, with references both to the basic principles and communication skills that were discussed before, but this time with an emphasis on SDM, enhancing the integration of SDM principles into the practice of communication.

The OPTION5 tool is a tool for evaluating through observation the constituent elements of SDM 4. It assesses the degree of effort made by the Healthcare Provider to comprehensively support the Shared Decision-Making process. It is an observation tool of the interaction between Provider-Beneficiary of Healthcare in clinical environments and can be used in the context of live or videotaped sessions, or even with transcribed texts of sessions.

It assesses five key areas based on the three-talk model of SDM, which are summarized in the following, while at the same time accompanied by tangible examples in the continuum of no, minimal, moderate, skillful and exemplary effort:

- recognition of the importance of the decision and availability of alternatives (OPTION talk),
- description of options and assurance of support (TEAM talk),
- discussion of the advantages and disadvantages of the options (OPTION talk),
- exploration of preferences through understanding the ideas/thoughts, concerns and expectations (ICE) of the individual (DECISION talk), and
- active efforts to incorporate these preferences into decision making (DECISION talk).

Empirical observations from the implementation of training

Context A: Integration of Artificial Intelligence in education

It is worth noting that this point requires subtle handling, since the reference to the "communication skills" of Artificial Intelligence (AI), and the possible comparison that may be made by the trainees, can also have negative consequences if it is taken as an exhortation for the "superiority" of AI. The purpose is not this, but to bring to the attention of the trainees that communication is governed by some basic principles, skills and techniques, presenting an "idealized" but clearly tangible example of standardization of the structured approach and the common characteristics, which can be adapted according to the scenario and the specific circumstances. It is important, in this presentation, to make clear reference to the challenges that the healthcare professional has to face in "real" time and in "real" conditions, which clearly do not easily allow the degree of "standardization" proposed by AI. However, it is a good means to highlight that effective communication is a skill that is cultivated and that the effort to adopt some basic "structure" and maintain the basic constituent elements in all interactions facilitates the process, as this becomes a habit.

It is also important to mention that, although each scenario has different requirements as to the method of management and the "desired" outcome, often the points for discussion are common regardless of the scenario since specific aspects of communication are highlighted as more "problematic", which however are necessary regardless of the content of the discussion. For example, in the scenario of the elective cesarean section, the emphasis is expected to be on the collection of information on the reasons that lead the couple to this preference, while in the scenario of the induction in prolonged pregnancy, the emphasis is expected to be on the provision of information and explanation of the medical recommendations, without a critical attitude towards the woman. In both scenarios, of course, it is expected that the healthcare professional should make a substantial effort to understand both (a) the "starting point" of the pregnant woman (i.e., what she knows, what she does not know, and what she wants to learn) regarding the issues that concern her and (b) her own thoughts, ideas, concerns, preferences and expectations, so that the information she gives is both targeted in terms of content and aligned with the real concerns of the woman.

Some elements are basic components of effective communication in all cases and situations, such as the use of "open questions" to first identify the problem and the various issues that concern the pregnant woman and the highlighting of empathy for her concerns, without a critical attitude, which however often, and for many different reasons, may be overlooked or not fully implemented,

resulting in "information" being given based on the healthcare professional's perception and understanding of the problem, which is not always aligned with the woman's thoughts. For example, in the scenario of the elective cesarean section, it would not be surprising for the healthcare professional to begin to list the benefits of natural childbirth unilaterally, in a way that feeds the reluctance of the woman of that particular scenario to listen and participate in the discussion, since inadvertently he/she reinforces her basic concern, which in that particular scenario, concerns the intense emotional charge that she has at that moment from comments she has read in some mom-group that those who give birth by cesarean section "are not the same mothers." While, through a balanced listing, comparatively, of the available options, with the advantages and disadvantages, without a critical attitude is more likely to lead to the desired result, which in that particular scenario would be the non-decision-making before seeking more information, which the healthcare professional is expected to support her to obtain, especially since, in that particular scenario as written, the pregnant woman does not know much about cesarean section, and as much as she expresses her preference for C/S, the 'actor' of the scenario is open to listen, depending on the reaction of the Healthcare Professional.

Context B: Parallel use of two structured feedback approaches

During the discussion and the final summary of the session, the coordinators should emphasize that the Calgary-Cambridge Model and the SDM Model are not mutually exclusive but rather complementary. For example, it can be mentioned that the Calgary-Cambridge Model provides an overall structure for the session-consultation, emphasizing, among other things, that information gathering is critical before providing any information. It also offers guidance on the basic principles and communication skills that are necessary. On the other hand, the structured SDM approach introduces a perspective based primarily on values, in particular the right to full information regarding the available options and ensuring the right of autonomy of the pregnant/new mother.

This requires substantial support for her active participation in the decision-making process for herself and her baby. This is achieved only with the necessary support from healthcare professionals to highlight the woman's thoughts, concerns, preferences, and expectations and integrate them into the process. While ensuring that decision-making is based on complete and balanced information (provision of information), it is aligned with the values, preferences, and circumstances of the individual, something that healthcare professionals are called to explore thoroughly with empathy (information gathering).

By integrating these two approaches, the training emphasizes both the techniques of structured communication and the approach of shared decision-making, ensuring that healthcare professionals are able to effectively guide pregnant/new mothers through complex choices with clarity, empathy, and respect.

Educational activity E:

Analysis of Challenges in Communication through Reflection

Duration: 1 hour

Material:

- Seminar presentation on Reflection and the Reflective process (Annex I – Indicative presentation slides)
- Seminar presentation of key results from relevant research studies on communication (skills and challenges) with a sample of perinatal health professionals (midwives) from Cyprus
- Health Professionals' Communications Skills Scale - CSS-HP®¹ after obtaining permission to translate and use (**Annex H**)
- [if there is time] structured exercise mapping challenges in daily clinical practice based on the COM-B behavior model (Annex I – Indicative presentation slides).

General purpose

To encourage participants to reflect on their own "starting point," the scope for self-improvement, and at the same time to reflect on the personal and collective challenges in communication in daily clinical practice and the effective undertaking of their educational role.

Specific objectives

- Presentation of the concept and importance of reflection in professional practice and urging participants to identify and address their own communication difficulties (e.g., think of a case from the clinical setting that comes to mind and relates to communication, to reflect on what you would do differently next time?)
- Indirectly guiding participants to reflect on their own strengths and points for improvement through reference to research findings on the evaluation of the communication skills of midwives in Cyprus
- Cultivating a common understanding of the challenges related to communication in daily clinical practice through a structured mapping exercise to give impetus to individuals to develop strategies for self-improvement and addressing these challenges.

¹ Leal-Costa, C., Tirado, S., RodríguezMarín, J., y van-der Hofstadt, C.J. Psychometric properties of the Health Professionals Communication Skills Scale (HP-CSS). *Clinical International Journal of and Health Psychology* 2016;. 1: 76-86.

Description - Implementation Instructions

In the last unit, participants explore the importance of reflection in improving communication through a seminar on the process of reflection. The goal is to encourage them to adopt reflective habits in their daily practice, starting with keeping a reflective diary on the challenges in communication.

This is followed by a seminar presentation of the main results from relevant research studies on communication among perinatal health professionals from Cyprus.

Specifically, the following are used:

- Selected findings from the Baby Buddy Communicator educational program (co-funded by the Erasmus+ program) regarding the self-assessment and peer assessment of the communication skills of midwives 6 , and
- Selected findings from the Baby Buddy research program (co-funded by the Erasmus+ program) regarding the challenges in effectively undertaking the educational role 7

This is followed by an open discussion with the participants about their own experiences regarding challenges in communication, as well as the impact they believe the various challenges mentioned have on professional development and the continuous improvement of the quality of respectful maternity care provided. In context A, a brief description of some key points for discussion follows.

The importance of changing "mindset" towards continuous professional development and self-improvement is underlined, while recognizing that the challenges are multiple and, often, beyond the sphere of influence of the individuals themselves. Participants are invited, reflecting on the conditions in the existing work and the wider socio-cultural environment, to identify the obstacles and the factors that facilitate effective communication. The aim is to enhance the importance of reflection and the cultivation of a common understanding of the challenges in the context of continuous improvement.

Participants are encouraged, leaving the workshop, to start a reflection diary, if they do not already do so. If there is time, we proceed to a structured participatory mapping exercise based on the COM-B model for the obstacles and factors that influence and determine the ability of healthcare professionals to effectively develop their educational role and to integrate SDM as a habit in daily practice. Following, in context B, a brief description of this activity is provided.

Context C: Key messages (take-home messages)

Some of the key points that are emphasized during the presentation, based on the research data, are the following:

- Midwives in Cyprus tend to evaluate their own communication skills more positively than they evaluate their colleagues, in all dimensions of communication, highlighting the importance of self-awareness but also the challenge in the context of professional development. It is important to emphasize that we all have a different starting point, and only through personal self-assessment, recognition of our strengths and weaknesses, can we improve. Effective communication is not a matter of personality, but requires learning, willingness to improve, and goal setting.
- The continuous improvement of communication skills is necessary and achievable through continuous professional development for which ongoing education, practical practice, peer-to-peer feedforward, reflection, and the setting of personal goals are required, giving the example of the complete Baby Buddy Communicator educational program, which is based on the same structural elements as this workshop, but is developed over a period of 5 weeks with a total duration of 30 hours and a combination of face-to-face meetings and practical role-playing workshops as well as self-directed learning. Conveying the experience of the participants in that educational program, it is important to mention the importance of incorporating education in communication skills, but also more generally, into the clinical environment as an institutionalized process (in-hospital training) and the adoption of an effective and productive system of supervision and mentoring, which encourages self-assessment and self-improvement and peer feedback.
- Of course, continuing education and professional development is only one aspect of the issue, because the obstacles to effective communication are not exclusively individual, and do not only concern skills. The ability to adopt good, structured, and systematic communication practices in daily clinical practice and support respect for the right to active participation of pregnant/new mothers are influenced by multiple and interrelated socio-cultural and organizational factors, which are beyond the immediate sphere of influence of individuals.

Box D: Structured participatory mapping exercise

*"**Shared decision-making** based on the shared-decision making model (NICE) is a demanding and dynamic process. Do healthcare professionals in Mother-Newborn Care in Cyprus adequately develop their educational role? Do they promote and support the active participation of women in the decision-making process?*

- ☐ *Based on your experiences, what are the obstacles and challenges (real and/or projected as such) to effectively undertaking the educational role/supporting shared decision-making?*
- ☐ *What do you think might promote/facilitate/support the implementation of this clinical practice model?"*

Participants are given the above description and are invited to note on post-it notes their thoughts which they share with the group, successively giving everyone the opportunity to contribute to the discussion.

The coordinators roughly classify them based on the dimensions of the COM-B model, depending on whether the perceived obstacles or facilitating factors fall into Capabilities, Opportunities, or Motivation.

At the end of the process, the coordinators provide a summary, while explaining the dimensions of the model and that the conscious support of Shared Decision-Making through effective communication with women and their families is not only a skill, but it is behavior, and the determinants of the adoption or modification of any behavior concern three interrelated dimensions:

- We need to **"be able to do it"** (i.e. develop effective communication with women and their families), to know the way and the process (Capability). This is the dimension that includes, but is not limited to, knowledge skills, communication techniques, etc. Participants can be assisted with the questions below:
 - Is it a matter of knowledge, skills, and abilities? Is training needed?
 - Possibility of controlling behavior & decisions? Role adequacy?
- But at the same time we must **"be given the opportunities,"** e.g., to allow the conditions, the framework, and the specific circumstances (Opportunity) - whether this concerns the structurally defined framework, the availability of resources, or concerns the wider socio-cultural framework and the organizational culture of the organization.
 - Is it a matter of resources, equipment, framework, and/or working conditions? Does it concern norms?

- Would it be easier if some elements and characteristics and/or peculiarities of the general socio-cultural framework were different?
 - Does it depend on perceptions, expectations, and/or behaviors of third parties (who?)
- And finally, we must also "**want to do it**". This dimension concerns Motivation - whether this is the result of automatic processes or is the result of a reflective process. It may include perceptions of the benefits, consequences, and overall value of this behavior, to us or to others, the perception of our own role, and beliefs about our own abilities. It may also include the presence of incentives (e.g., appreciation, recognition, reward) or and requirements (e.g., application of protocols, part of the evaluation, accountability, quality assurance requirements, etc.)
 - Is it worth the effort (perceived benefit/risks)? Is it a matter of attitudes and beliefs?
 - Is it a matter of perception of the professional role? Doesn't the routine allow it?
 - Are there incentives/ disincentives? Requirements of professional bodies, legislation, citizens, others?

Closing

Evaluation and Completion of the program

Duration: 15' minutes

Material:

- Educational workshop evaluation questionnaire (Annex I).

General purpose

To evaluate the effectiveness of the workshop and provide feedback from participants for continuous improvement of the education.

Specific objectives

- Collect comments on the participants' experience of the workshop and suggestions for future applications of the training
- Evaluate the impact of the training on the skills and confidence of the participants.

Description - Implementation Instructions

The questionnaire, which is anonymous, is given to the participants through which they have the opportunity to give feedback to the training team regarding their impressions, impact and effectiveness of the training, as well as to record suggestions for improvement in future applications.

ANNEX A: Daily programme (*indicative example*)

MATERNITY CARE WITH RESPECT

RESPECTFUL MATERNITY CARE



**A training workshop to cultivate skills effective communication for
perinatal health professionals:**

**practical training in Participatory Decision Making
and structured Syn Adaptive Feedback**

Friday, 14/02/2025, 08.00-13.30

in cooperation with

Gynecology and Obstetrics Clinic, Arch. Makarios III

Residency Training Division, Ministry of Health

Workshop Program

08:00-08.15	Setting Workshop Objectives : Link Quality for Respectful Maternity Care Standards - RMC	N. Middleton
08.15-08.30	Basic Principles of Peer Feedback	O. Kolokotronis
08.30-08.45	Communication skills: Calgary-Cambridge Guide	
08.45-09.15	Recognition of good communication practices video of role-playing in scenario a breastfeeding support in the framework of the Baby Buddy Communicator project (Erasmus+)	Role-playing - video: E. Lazarou (Midwife) A. Anatolitou (Mother)
09.15-09.30	Presentation of scenarios - defining groups and roles	Role-playing & peer feedback -: - Volunteer trainees 'Actors': A. Anatolitou, M. Moore, P. Kinni, M. Kapsou (Birth Forward)
09.30-10.00	<u>Practical application in groups:</u> Role-playing with 'simulated actors' - Scenarios: <i>Optional planned caesarean section</i> <i>Prolongation of pregnancy-Recommendations for inducing labour</i>	
10.30-11.00	Scenario Application Discussion: Structured Peer Feedforward - Using a structured self/assessment guide, Calgary-Cambridge model per scenario, and - Based on the ALOBA model for recognizing and setting goals (trainee, actor, colleague, other observers, trainers)	Team coordinators: O. Kolokotronis E. Hadjigeorgiou X. Nikolaou - M. P. Zissimou E. Manolis
11.00-11.30	Coffee break	
11.30-11.45	Feedback from teams	Group coordinators
11.45-12.00	Participatory Decision Making: OPTION5 Guide	P. Zissimou
12.00-12.30	Practical application: Role-playing - iterative practice with emphasis on the stages of Participatory Decision Making <i>Breastfeeding management in the first few days: Challenges and dilemmas for supplementation</i>	- Volunteer trainee 'Actor': (Birth Forward)
12.30-12.45	Script discussion using guideOPTION5 observation	P. Zissimou
12.45-13.00	Reflective process	E. Hadjigeorgiou
13.00-13.15	Self-assessment & identification of challenges in assuming an educational role HP Communications Skills Scale tool	N. Middleton
13.15-13.30	Laboratory evaluation	Participants

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[Project: 101096681 - RESPECT - CERV-2022-DAPHNE]



Purpose	Strengthening the clinical communication skills of midwives with an emphasis on shared decision making to support women in making informed decisions about alternative options care that meet their <u>expectations.preferences and?</u>
Objectives	• Communication skills: Recognizing the basic principles, stages, and techniques of Shared Decision-Making within the context of counseling that ensures women—recipients of maternity care services—know and understand the advantages, disadvantages, and potential outcomes and consequences of various care and treatment options. • Practical training: Enhancing communication skills, focusing on the elements that make up the collaborative process of Shared Decision-Making, through role-playing in specially designed realistic simulation scenarios with trained 'actors'. • Professional development: Becoming familiar with the process of peer-to-peer feedback/feedforward through structured observation tools for evaluating/self-evaluating communication skills in general (Calgary-Cambridge Guide) and the constituent elements of Shared Decision-Making in particular (Option5). • Reflection: Cultivating a shared understanding of the importance of good communication and collaboration to support women and promoting reflection for self-improvement within the framework of effectively undertaking and expanding the educational role of midwives.
Scientific Body of the Project	 Τεχνολογικό Πανεπιστήμιο Κύπρου  Τμήμα Νοσηλευτικής
Educators-Project Team Scientific	Dr. Nikos Middleton, Associate Professor - Project Coordinator Dr. Ourania Kolokotroni, Assistant Professor, TEPAK Dr. Eleni Hadjigeorgiou, Assistant Professor, CUT Dr. Christiana Nikolaou, Assistant Professor, CUT, CUT Dr. Maria Karanikola, Associate Professor, TEPAK Mrs. Prodromoula Zissimou, Research Associate/ PhD Candidate Ms. Emmanouela Manoli, Special Education Staff/PhD Candidate
Part of a wider project	It is part of WP4 of the wider RESPECT project on Respectful Maternity Care, entitled " <i>Toward a culture of Respectful Maternity Care (RMC): Enhancing Shared Decision Making and Informed Choice in Cyprus and Croatia</i> ". [project: 101096681 - RESPECT - CERV-2022-DAPHNE]
Project partners	 Cyprus University of Technology  birth forward  RODA 2020 GODINA RODE  Università di Genova  OZAK  MEDITERRANEAN INSTITUTE OF GENDER STUDIES
Funding	Co-funded by the E.E. through <i>Citizens, Equality, Rights & Values</i>



ANNEX B: Presentation (*indicative example*)

**Training workshop on skills effective communication
perinatal health professionals: practical training
in Participatory Decision Making and Structured Conjoint Feedback**

**Gynaecology and Obstetrics Clinic, Arch. Makarios III
Friday, 14/02/2025, 08.00-13.30**



Με τη συγχρηματοδότηση
της Ευρωπαϊκής Ένωσης

**The list of participants is required based on the provisions of the programme. In addition, during the meeting, it is foreseen to take photographic material for the purpose of preparing relevant reports to the donors as evidence of the implementation of the planned activities of the programme. Some of the photographs may be shared in a relevant press release to the media or to the MDBs. If you do not wish to be included in the photographic material to be made public, you may indicate this above. No minutes will be taken at the meeting - the only written material to emerge from the meeting will be an evaluation of the workshop with a structured questionnaire to participants for the purpose of recording their views and contributions.*

Full name	Title Agency/Organisation	Contact details (tel. email)	Consent to take photographs (YES/NO)	Signature

**The list of participants is required based on the provisions of the programme. In addition, during the meeting, it is foreseen to take photographic material for the purpose of preparing relevant reports to the donors as evidence of the implementation of the planned activities of the programme. Some of the photographs may be shared in a relevant press release to the media or to the MDBs. If you do not wish to be included in the photographic material to be made public, you may indicate this above. No minutes will be taken at the meeting - the only written material to emerge from the meeting will be an evaluation of the workshop with a structured questionnaire to participants for the purpose of recording their views and contributions.*

ANNEX C: Training material for the scenario "*elective planned caesarean section*"

ANNEX C1: Scenario Instructions for Health Professionals

Scenario: "Elective Planned C-Section" - Instructions for Healthcare Professional

You are a perinatal healthcare professional (midwife or obstetrician-gynecologist) and at the parenting preparation class you have just completed, Andria Philippou, who has just attended the lecture, approaches you with her partner.

You know from the prenatal appointments that Andria is a first-time mother, 36 weeks pregnant, low-risk pregnancy, and fetal development is within normal limits. She has no medical history and takes no medication other than vitamin D due to deficiency.

They mention that in discussions with their friends about the births of their acquaintances, bad experiences were mentioned and they express their uncertainty about the mode of delivery they will follow. They are even thinking that perhaps it would be easier to follow a planned (elective) Cesarean Section, thus avoiding the hassle with the pain and hours of waiting for Natural Birth.

You tell them to move away, since not all the women have left the room, so that you can discuss comfortably in order to:

- (a) assess the reasons that lead them to this thought, as well as
- (b) provide information about the physiology of childbirth and about C-section.

Note - you have a leaflet that the clinic has created with a comparative presentation of cesarean section and natural childbirth, which you can give them to study at home.



ANNEX C2: Supplementary material for the scenario

Comparative table	C/T	F/T
Recovery	It usually takes longer, maybe even weeks	Faster
Stay in the maternity hospital	Average 4 days	Average 2,5 days
Perineal/abdominal pain during childbirth and 3 days after (scale 1 - no pain to 10 - most intense pain)	Postoperative Mono - needs painkillers (average 4,5)	During childbirth (median = 7.3) And 3 days later (median= 5,2)
Bay Injury	Not expected	Approximately 560 out of 100 000 (1 in 179) women are expected to have some degree of rupture but the chances are reduced with antenatal preparation and reduced interventions
Breastfeeding	Reduced chances of success	Smooth and immediate start of breastfeeding, increased chances of success
Perinatal hysterectomy	200 women per 100 (2 in 1000)	100 women per 100 000 (1 in 1000)
Retrograde Placenta in a future pregnancy *Risk is higher after multiple CT and emergency CT than after planned CT	100 per 100 000 pregnancies (1 in 1000)	40 per 100 000 pregnancies (1 in 2500)
Uterine rupture in a future pregnancy (NICE, including planned & emergency)	About 200 out of 100 000 (1 in 500)	About 7 out of 100 000 (1 in 14000)
Maternal Death	24 women per 100 000 (1 in 4200)	4 women per 100 000 (1 in 25 000)
Urinary incontinence for more than a year (RCOG)	Approximately 27 520 per 100 000 women (about 1 in 4)	Approximately 48 700 per 100 000 women (about 1 in 2)
Fecal incontinence up to one year	Approximately 7 800	The same for unassisted vaginal



after childbirth (RCOG)	per 100 000 women (about 1 in 13)	delivery. About 15 100 per 100 000 women in assisted vaginal delivery (about 1 in 7)
Other Perinatal Complications	Organ injury, thrombosis, secondary infertility, placental complications in future pregnancies, increased blood loss - need for transfusion, incision infection	Postnatal bleeding
Care of the newborn	Difficult in the first few days, especially on the day of the C/T	Direct and active
Infant	- Stillbirth - 50 in 100 000 births (1 in 2 000)Respiratory problems (asthma) about 1 809 births in 100 000 - Increased chances of admission to an ICU - Increased chances of morbidity (diabetes, obesity, allergies)	- Stillbirth - 30 newborns in 100 000 births (1 in 3300) - Reduced respiratory morbidity 1 500 out of 100 000 births - More developed immune system (due to the "good microbiome" of the vagina)
Companion	Reduced participation	- More active participation in childbirth support - strengthening the couple's bond - Developing confidence to achieve childbirth and newborn care

Sources:

Caesarean section - NHS (2023). Available at: <https://www.nhs.uk/conditions/caesarean-section/> (Accessed: 8 November 2024).

NICE (2021) *NICE guideline on caesarean birth: Appendix A, NICE guideline*. Available at: <https://www.nice.org.uk/guidance/ng192/resources/appendix-a-benefits-and-risks-of-vaginal-and-caesarean-birth-pdf-9074971693>.

Royal College of Obstetricians and Gynaecologists - Consent Advice No. 14 Planned Caesarean Birth: www.rcog.org.uk/ca14

Republic of Cyprus-Ministry of Health (2023) *Normal delivery and reduction of prematurity*. Edited by Republic of Cyprus Printing Office. Press and Information Office.



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ANNEX C3: Instructions for simulated 'actor'

Scenario: "Elective Planned C-Section"

Instructions for Simulated Pregnant Woman (actress)

You are Andria Philippou, 30 years old, first-time mother at 34 weeks of pregnancy, and you have just attended childbirth classes with your partner. After the midwife finishes, you approach her and mention that in discussions with your friends about the births of their acquaintances, they mentioned that they had bad experiences. **You express your uncertainty about the mode of delivery you will choose.**

Opening Statement:

"Thank you very much for the information - it was useful. The truth is that we are thinking that maybe we will proceed with a C-section to avoid the hassle and hours of labor. What do you think?"

It is expected that the HP will show interest in the issue that concerns you, starting with open-ended questions to understand where your thoughts come from and to understand your concerns.

You share the following freely with the midwife provided that

- asks open-ended questions, and
- shows a genuine interest in the issue that concerns you

You can mention that:

- A friend of yours recently, after her "water broke", had pain for 2 days and ended up with a cesarean section because it was not progressing.
- Another friend of yours chose a planned C/S because she was afraid that VBAC would cause problems with sexual intercourse. Your husband, hearing this, was worried that it would affect the relationship between you. However, he told you to do what you want.

Your mother gave birth to all 3 of her children by C/S, because the first was breech and the subsequent ones because VBAC was not supported. She told you that she struggled with the recovery, but if you want to proceed in this way, she will help you with whatever you need.

Partner

Your partner does not participate in the discussion, while carefully observing what the HP says. He seems worried but does not express an opinion. Besides, you yourself do not give him the opportunity to participate in the discussion since you believe that the decision is yours and does not concern him. Inwardly, through non-verbal communication, he gives the impression that he may even "doubt" what the HP says. If the HP tries to include him in the discussion, he will show with his attitude that he believes that it is your decision and he is ready to support you whatever you choose, as much as he himself is not sure about everything he hears, but he has not researched it at all.

ONLY if asked specifically do you share the following:

- There has never been a problem in your pregnancy. You have done all the prenatal tests and ultrasound checks and the results were normal.
- After discussions with the people around you, you searched a little on the internet for the C/S and realized that it is now a very common procedure, especially in our country. Although you realized that it has its complications as an intervention, which however you do not know in detail, you have not researched it particularly (starting point; e.g., question from HP: "What do you know about the C/S"?).
- Although your own mother gave birth by C/S, as much as it was not her choice (but due to medical indications) and while she told you about her experience and the difficulty in recovery, you consider that VBAC is a painful and unnecessary process.
- You have a little myopia, for which you wear glasses on the computer and when you read, and from what you read in a group on the internet, vision is affected by VBAC and myopia increases.
- Your obstetrician-gynecologist has stated that if this is your wish then you can schedule a C/S, but you have not discussed the issue in detail, she has not provided you with any comparative data nor has she referred you to any reliable source for more information.

- Also, she has not informed you that the GHS covers up to 6 visits to a midwife. If the midwife mentions it in the discussion, you will seem surprised since you did not know it, but you will express doubts about its usefulness (so that your gynecologist does not suggest it).

Medical History

You have no pathological medical history, apart from vit D deficiency

Medication

You do not take medication other than pregnancy multivitamins and additional vitamin D, due to deficiency.

Family Medical History

Mother 55 years old - healthy

Father 56 years old - healthy

You have two brothers - 35 and 25 years old - healthy males (born with C/S)

Social History

You are a teacher and you love children and your profession very much. You really like to exercise. Your partner is a trainer and owner of a gym in Tseri. You are not yet married. You are expecting your first child, 34/40, which has been cephalic since 26 weeks. In recent days you have felt a few tugs low down, which after a Cardiotocography check, they told you are normal "mock contractions", Braxton Hicks.

Your mother spoke to you about her childbirth experiences because you asked her, but she supports you in whatever decision you make for your own childbirth. Through discussions with your friends you created the impression that VBAC is very difficult. Most of your friends and acquaintances also gave birth by CS and you do not personally know a woman who gave birth naturally.

Although you are not active on social media, you have recently read in a mom-group, "an online squabble", about the issue of C/S, and specifically that you are not the same mother, since you do not give birth to your child yourself, and you have been affected.

Information you would like to receive:

1. You would like to know the midwife's opinion about childbirth and whether she, through her experience, considers vaginal birth to be a long and unnecessary "hassle".
2. How long does the C/S take and how is it done?
3. By when do you have to make a final decision to inform the obstetrician-gynecologist and schedule the C/S?
4. How will you be after C/S? How long will recovery from C/S take?

Issues that you were NOT aware of *(and are surprised if the EY mentions them):*

1. That C/S also has complications and that unexpected things can happen
2. That beyond the increased risk for some conditions and the different experience of childbirth, C/S can also affect the health of the baby.
3. That the GHS provides the possibility of visits to a midwife both prenatally and postnatally

Ideas/Concerns/Expectations

- You have no fear of VBAC, but you consider that it may be unnecessary hassle. You consider the C/S solution to be "simpler", without "bothering" either you or your baby
- You wonder if there must be some reason why C/S is so common in our country and inwardly you think that if so many women no longer "succeed" in giving birth naturally, maybe you will not succeed either
- You realize that you may have a few weeks to think about it and decide because if you go planned you must inform your obstetrician who told you that he will follow what you want, without explaining the options you have, nor the pros and cons of the C/S procedure
- You want to discuss the issue because you have never heard anyone talk to you about VBAC and the positives, nor the risks that C/S has

- You do not want the relationship with your partner to be affected after childbirth because he himself expressed his concern with what he has heard even if you consider that the decision is yours.

Expected reaction and behaviour of the midwife and approach method

The scenario has elements of information gathering ("what are the reasons behind the thought of choosing C/T") but mainly information provision ("how does C/T compare to F/T"). The emphasis should be on the skills of the HP to include to some extent elements from all the steps/stages of shared decision-making (three-talk model of shared decision-making).

Specifically, it is expected:

- To make clear reference that it concerns a personal decision, but for which there are alternative options, and that her preferences and concerns are important and must be taken into account (OPTION TALK: recognition of alternative options)
- To explain that it is more important to have complete and valid information and that you do not need to rush to decide and to make clear reference that you are available to discuss with her (TEAM TALK: supporting consultation/building relationship)
- To mention that any decision should be made jointly with the obstetrician/HP, urging you to discuss with him/her the risks, disadvantages and advantages of each option (OPTION TALK: providing information on alternative options)
- To present some comparative data in a clear, simple and understandable way (OPTION TALK: providing information on alternative options), explaining, however, that due to the little time available, she urges the pregnant woman to arrange an appointment with a midwife through the GHS to receive more information and support both for this decision and in general in preparing for childbirth
- To show real interest in the issue that concerns you, with empathy and without a critical attitude, and to make a substantial effort to understand your thoughts, concerns, preferences and expectations and effort to confirm and integrate these preferences to make a decision that you consider correct and appropriate for you (DECISION TALK: highlighting and incorporating preferences)

In detail,

Initially, the HP is expected to ask for information about your pregnancy, about your medical and obstetric history, to ask you about the well-being of your baby (if you feel it move, and how often), how you and your partner are feeling about the pregnancy and the upcoming childbirth, and to focus on how she can help you.

You will answer for the history and the rest that she asks you, and you will focus on the fact that

- you have not heard about VBAC, but only about C/S, and these from the experiences of friends and your mother.
- very little, from your own search on the internet, without any guidance since you did not discuss the issue with the gynecologist-obstetrician.
- You will show worried and confused, looking for information in the beginning ONLY about the C/S.

The HP is expected to perceive your concern and reassure you, showing interest and empathy, without a critical attitude for any opinion or thought of yours. You expect her to analyze your options, the positives and negatives of these options, and at the same time try to elicit your concerns and expectations. But, only if asked, you will share your thoughts and concerns, including that the "online squabble" in the mom-group about the issue of C/S has affected you.

First, the HP should try to understand the reason(s) for your expressed preference to give birth by C/S, but at the same time, she should try to understand how informed this thought of yours is (starting point) as well as whether it represents your true desire.

You expect her to provide you with all the information you are looking for and to resolve questions, regarding the C/S (advantages/disadvantages, possible risks and complications) compared to the VBAC, as well as ways you can manage the pain in the VBAC. You expect that she will leave open the possibility of a next meeting to discuss this further if you wish.

Depending on the response from the HP, your reaction will be, that is,

- if she provides information on C/S versus VBAC in a comparative way, then you will begin to show more interest in both modes of delivery.

- if, however, she presents the information unilaterally (e.g., either beautifies the VBAC or overemphasizes the risks of C/S, vaguely without listing specific and clear data on the frequency of risks/complications), then you will simply listen to what she has to say, and will only ask clarifying questions to what she mentions.
- if she simply promotes VBAC and tells you that "you should not be afraid" (which, moreover, is not your main concern) and that "it is better for you and for the baby" (without, however, presenting any data), then you should show annoyed and say that "you have almost decided that you will proceed with C/S" and "just for that 10% you will talk to your gynecologist".

It is also expected, after you discuss the options, to explain to you that it is important to discuss with your partner what you ultimately want, based on the information you received, your concerns and expectations and to record any questions you have for a possible next meeting with her or with the obstetrician.

Also, she should emphasize the importance of supporting your informed choice by the obstetrician, based on your history and your knowledge, taking with him/her the final decision.

You expect her to reassure you and tell you to take your time, since it does not need to be a hasty decision, but a conscious choice, knowing all the possibilities on the basis of valid and complete information.

Other reactions

- Understanding: In case what she says and explains is not understandable, you will interrupt asking for clarifications. If she uses difficult words and terms, and/or the discussion does not follow a clear structure and/or does not answer your questions clearly or rambles in the answers, then you will bring her back, insisting on your thoughts.
- Interest: If at any stage she shows that she is not interested and simply wants to tell you what she wants, or even if she shows great zeal to provide information without, however, giving you the opportunity to ask what you want or/and to make sure that you understood the information she gives you then you will say that "you did not understand exactly", "if she can repeat" or even "to question the correctness" of what she said.
- Empathy/ Empowerment: If at any stage she shows that she is not interested in mentioning your concerns or does not show empathy and creates guilt for the choice of C/S, then become more anxious, mention that "okay, after all, you have decided 90% that you will proceed with CS" and "just for that 10% you will talk to your gynecologist".

Summary

In general, the response of the HP should respond to your thoughts and questions, show interest in the issue and in you personally, without a critical attitude or one-sided presentation of the data (e.g., to present only the possible complications or disadvantages of the CS without making a comparative reference to the VBAC, or to beautify the VBAC and make you feel "guilty" if you finally choose the CS.

Also, he/she should make a substantial effort to clearly provide the data, comparing the CS and the VBAC, to confirm that you have understood the information, to give you the opportunity for additional questions and questions and to urge you to seek further information and support.

ANNEX C4: Feedback guide based on the model Calgary-Cambridge

A Guide to Synadhelpic Feedback Communication and Participatory Decision Making Skills

(based on the communication skills guide CALGARY - CAMBRIDGE and the observation tool OPTION5 for participatory decision making)

Script: Optional/ Planned Caesarean

OPENING OF THE CONFERENCE	0	1	2	3	4
1. Greet your wife and partner and learn their names (1). Actively try to include the partner (1)					
2. Presentation of yourself (1) and your role/ capacity (1)					
3. Showing respect and interest in the issue of their concern (2)					
4. Privacy (1) and physical comfort (e.g. suggest sitting down). Sit opposite at the right distance/appropriate position (1)					
5. Problem identification : although the problem is mentioned, clarify the reason (1) with an open-ended question.(1)					
6. Negotiating an agenda - explain what you would like to discuss (1) taking into account his/her needs (1)					
COLLECTION OF INFORMATION - Content	0	1	2	3	4
7. Validate feelings (1) and confirm the information you know (firstborn, gestational weeks, etc.) (1)					
8. Brief investigation of the Surgical (1) , Pathological (1) , (1) , Prenatal History (1)					
9. " Starting point ": exploration of prior knowledge of birth physiology (1), C/T (1) and maternal-neonatal outcomes (1)					
10. In relation to the expressed preference for caesarean section, explore without judgment (2), the:					
- woman's (2) thoughts and concerns					
- women's (2) expectations and desires					
INFORMATION Gathering - Communication Techniques	0	1	2	3	4
10. Encourage her to tell the story of the thought/decision from when it started to the present day in her own words (2)					
11. Use of open and closed type question , starting with open (1) and moving to closed (1)					
12. Clarity of questions: short/ specific (1) and clear questions (1)					
13. Active listening , allowing the woman to finish without interruption, leaving time for thinking, etc. (2)					
14. Facilitate responses verbal and non-verbal e.g. by encouragement, examples, silence, repetition, paraphrasing (2)					
15. Effective management pause , repeating and continuing questions (2)					
16. Summarize at times to confirm what is said, encouraging to correct or provide further information (2)					
PROVISION OF INFORMATION - Communication techniques	0	1	2	3	4
17. Provide information in small sections (1) and slowly (1)					
18. Use simple and understandable language (1) and explain terms, statistics , etc. in an understandable way (1)					
19. Periodic summary (1) and confirmation of understanding - teach-back (1)					
20. Providing opportunities for the woman to contribute to the discussion with questions and/or to express questions/doubts (2)					

21. Encourage the woman to share thoughts/ideas, think about her choices, express her preferences (2)					
22. Provide suggestions (e.g. additional information) (1) & options for action (e.g. postponement of decision, discussion with EY, birth plan) (1)					
23. Negotiating a mutually acceptable management plan with the woman (2)					
PROVISION OF INFORMATION - Content	0	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
24. Provide information on the physiology of childbirth (1), on C/T (1) and on maternal/neonatal (1) risks/complications					
25. Comparison of PT/CT in terms of: complications (1), recovery (1), other effects mother, newborn/partner (1)					
26. Information that it is not necessary to take a decision (1) and that he/she has the right to decide after being fully informed (1)					
27. Informed that it is useful to discuss the issue with the obstetrician (1) and establish a relationship of trust (1)					
PARTICIPATORY DECISION-MAKING - Skills	0	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
28. Identification of alternatives (1), need to make a decision (1), on the basis of information (1), taking into account preferences (1)					
29. Intention to support (1), empathetic (1), respect for the right to information, non-judgmental attitude (1)					
30. Quoting information (1), comparing alternatives (1), checking understanding (1), providing clarification (1)					
31. Feedback on comparing options (1), including not making a decision (1), exploring preferences (1), understanding concerns (1)					
32. Summary (1) and consideration of preferences (1), incorporation in decision making (1) taking into account suggestions (1)					
STRUCTURE DEVELOPMENT	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
33. Linking explanations: use of linking explanations or keywords mentioned in previous answers (2)					
34. Logical sequence of development of topics in the discussion (2)					
RELATIONSHIP BUILDING	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
35. Non-verbal behaviour					
- eye contact, facial expression (1)					
- posture, position and movement (1)					
- vocal cues e.g. rhythm, volume, tone (1)					
36. Empathy: showing understanding and genuine concern (1) for feelings (1) and the importance of the decision (1)					
Grade by Simulated Actress - The Health Professional	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
• He made me feel that there was genuine interest (1), acceptance without judgment (1), and he understood the problem (1)					
• Provided clear information (1), assisting in comparing options (1), taking into account my preferences (1)					
Other Comments/ Remarks:					

ANNEX C5: *Session objectives* and desired scenario capture

Scenario: "Elective Planned C-Section" - Instructions for HP**Session objectives:**

The HP (midwife or obstetrician-gynecologist) is expected, without a critical attitude towards the expressed preferences of the woman/couple, to mention that without medical indications it is better to avoid C-section, as well as to present data on how a planned elective C-section compares to VBAC, so that the decision that the pregnant woman will take is well informed and meets her own preferences and expectations.

While the HP (midwife or obstetrician-gynecologist) must present some initial data, she is expected to actively urge the pregnant woman not to make any final decision before discussing the issue thoroughly with the gynecologist-obstetrician, explaining to him/her her thoughts, concerns and concerns and asking him/her to discuss the options on the basis of comparative data.

- *Indicatively, an information leaflet could be given (which the midwife has available during the session) and/or a reference could be made to a reliable online source, so that the pregnant woman is informed in a documented and complete way about the indications for CS, the risks it has, but also the consequences on the experience of childbirth, compared to the VBAC.*
- *Also, it would be an omission not to ask the pregnant woman if she has visited a midwife through the GHS and not to mention that there is a possibility of creating a birth plan that meets her own expectations - something that in this particular scenario is considered important precisely because the 'actor' had been instructed to state that she did not know about this possibility provided through GHS.*

The scenario gathers elements of both information gathering ("what are the reasons behind the pregnant woman's thought to choose the C/S") and mainly information provision ("how does the C/S compare to the VBAC"). The emphasis should be on the skills of the HP to include elements to some extent from all the steps/stages of shared decision-making (three-talk model of shared decision-making).

Specifically, the HP (midwife) is expected to:

- Recognize, without a critical attitude, that the mode of delivery concerns a personal decision, for which there are alternative options, and that the preferences and concerns of the pregnant woman are important and must be taken into account (OPTION TALK: recognition of alternative options)
- Explain that it is more important to have complete and valid information and that there is no need to rush to decide and to make clear reference that he/she is available to discuss with her (TEAM TALK: supporting consultation and building a relationship)
- Mention that any decision should be made jointly with the obstetrician/HP, knowing the risks, disadvantages and advantages of each option, some of which are expected to be listed in a simple and understandable way by the HP during the current session (OPTION TALK: providing information on alternative options), explaining, however, that due to the little time available, she urges the pregnant woman to arrange an appointment with a midwife through the GHS to receive more information and support both for this decision and in general in preparing for childbirth
- Show empathy and make a substantial effort to understand the pregnant woman's thoughts, concerns, preferences, and expectations, while at the same time trying to incorporate these thoughts into the process of making a decision that the pregnant woman considers correct and appropriate for herself (DECISION TALK: highlighting and incorporating preferences)

ANNEX D: Educational material for scenario "*induction of labour in prolonged pregnancy*"

ANNEX D1: Scenario Instructions for Health Professionals

Scenario "Prolonged Pregnancy and Induction of Labor" - Instructions for HP

Chrysilia Georgakopoulou is a first-time mother, pregnancy 40+6/40. She has just finished the appointment with her gynecologist-obstetrician and was given a deadline until the next day to decide about **induction of labor due to prolonged pregnancy**. She is not sure what to do and is very worried.

Before leaving the clinic/hospital, she comes to you (midwife or gynecology-obstetrics trainee) to complete some information in her file that the clinic needs (and to take the consent form).

At some point she says to you "I have to think about it until tomorrow, but I'm not sure I want to proceed with induction. I think I prefer to wait for the process to evolve on its own - what do you think?".

You want to:

- (a) assess what she knows about induction, as well as
- (b) provide information on the estimated risks and consequences of each option (induction and spontaneous onset of labor in prolonged pregnancy).

Note - you have an information leaflet that the clinic has created with basic information on prolonged pregnancy and the recommendations for induction, which you can refer to. Also, you can refer her to reliable sources of information.



Scenario "Prolonged Pregnancy and Induction of Labour" - Preparation Stage

Data on gestational Age, Prolonged Pregnancy And Induction of Labor

Introduction

Pregnancy lasts approximately 280 calendar days (40 weeks), while if this period elapses up to 14 days (2 weeks), then it is referred to as prolonged pregnancy (Gülmezoglu et al., 2012). In the literature, the percentage of pregnancies that go into prolonged pregnancy varies depending on the characteristics of the population, as well as the practices applied in each country (Galal et al., 2012). For example, in America, data for 2023 state that the percentage of prolonged births was 4.82%.

Based on the data provided by NICE, 17.2% of pregnancies enter prolonged pregnancy, with 16.2% of these having spontaneous onset of labor between 41+0 and 41+6, while approximately 1% enter the 42nd week without spontaneous onset. In the UK, 1 in 3 women are induced for various reasons, one of which is prolonged pregnancy (National Institute for Health and Care Excellence, 2021).

Recommendations for Induction in Prolonged Pregnancy

Based on NICE guidelines (2021) it is recommended:

- **induction of labor at 41+0 weeks of gestation and before the 42nd week.**

This was deemed necessary since, although the data regarding the outcomes in prolonged pregnancy beyond the 42nd week are incomplete and/or not of good quality to allow safe conclusions, there are indications that the chances of adverse outcomes for the newborn (e.g., admission to NICU, stillbirth) and complications for the pregnant woman during childbirth (e.g., emergency cesarean section) are reduced.

When the pregnancy completes 40 weeks, a detailed discussion takes place between the obstetrician/midwife and the pregnant woman and her partner about the available options, assessing the desires, the benefits, and the perinatal risks (for the woman and for the fetus-newborn).

If the pregnant woman chooses not to proceed with induction and prolong the pregnancy, either C-section or increased monitoring of the fetus is recommended, but this does not guarantee the avoidance of complications and adverse outcomes.

Revised Guidelines NICE 2021

It is noted, however, that unlike the previous guidelines of 2008 (which were limited to the recommendation for induction), the revised guidelines of 2021 clearly recognize that every opportunity should first be given for spontaneous onset of labor. Specifically, here's the quote from the revised Guidelines below:

- 1.2.1 Give women with uncomplicated pregnancies every opportunity for spontaneous labour. [2008]
- 1.2.2 Explain to women that labour usually starts normally before 42+0 weeks, based on gestational age estimated by ultrasound (see Table 1). [2008, amendment 2021]
- 1.2.3 Using the information in ANNEX A, explain to women that some risks associated with continuing pregnancy beyond 41+0 weeks may increase over time and these include
- increased likelihood of a caesarean section
 - increased likelihood of the baby needing admission to a neonatal intensive care unit
 - increased likelihood of stillbirth and neonatal death. [2021]
- 1.2.4 Discuss with women that inducing labour from 41+0 weeks can reduce these risks, but that they should also consider the impact of induction on their birth experience (see recommendations on information and decision making) when making their decision. [2021]

As for the rationale, the Committee states the following: "The main aim of induction is to lead to the safe delivery of the baby and therefore the committee considered it important to discuss the risks of a prolonged pregnancy with the woman, so that women can decide whether to have induction or whether to wait until spontaneous onset of labour. [...]"

- The comparison of induction at 39 weeks versus 40 to 42 weeks, as well as at 42 weeks versus 43 weeks, showed that it was the induction that takes place earlier reduces the risk of caesarean delivery.
- The data also showed that, when comparing induction at 41 weeks with delaying induction to 42 weeks, the likelihood of perinatal mortality and admission to the ICU was reduced.

The committee discussed that it was very difficult, based on the evidence, to recommend an absolute gestational age at which the risk suddenly increases, since the data show that there is an increased risk from the 41st week and that this increase in risk is continuous, with the risks increasing as the prolongation of pregnancy increases.

Possible causes for prolonged pregnancy

The reasons that lead to a pregnancy over 40 weeks are not known.

The most commonly accepted etiological factor is:

- miscalculation of gestational age.

Assessment of Gestational Age

The assessment of gestational age must be confirmed to avoid unnecessary interventions, because the entire pregnancy monitoring is based on this. The probable date of delivery (EDD) is a guide point for calculating gestational age, as well as the stages of fetal development.

1. In the case of a pregnant woman with a fixed 28-day period cycle, an easy way is based on the last period (TEP): add 7 days, subtract 3 months and add one year (*Naegele's rule*).
2. Determination of gestational age by ultrasound in the first half of pregnancy (*which is considered safer than LMP*).

Other factors

Other factors that have been associated with prolonged pregnancy are:

- First pregnancy,
- History of prolonged pregnancy in a previous pregnancy.
- BMI >35,
- Low socio-economic background
- Genetic abnormalities, e.g. anencephaly due to the fact that the embryonic pituitary-adrenal axis is affected.
- Rare deficiency of maternal enzymes (placental sulfatase).

Recommendations for Management of Prolonged Pregnancy

In low-risk pregnancies, prolongation of pregnancy is allowed provided that certain conditions apply (see table below), always after informing the pregnant woman about all possible complications that may arise.

Conditions/ Situation in which Prolongation of Pregnancy is not allowed

• Gestational hypertension and eclampsia	• incompatibility
• Previous 2 C/T	• Unstable position
• IUGR	• PROM mature (prerupture of the follicle)
• Previous Intrauterine Death Background	• Incomplete gynecological-obstetric history
• History of bleeding/small detachment	

Estimated Risks for the mother

Childbirth after 42nd weeks of gestation is associated with an increased likelihood of the following:

• Postpartum hemorrhage • Increased probability of perineal rupture of the 3rd and 4th degree • Dystocia • Prolonged labor due to macrosomia of the fetus over 4kg • Maternal infection (chorioamnionitis and endometritis)	• C/T : from 40 weeks to 41+6 weeks, the probability increases from 20% to 34%, (Weiss <i>et al.</i>, 2014) 1,860 per 10,000 at 39 weeks vs 2,220 per 10,000 at 40-42 weeks (NICE, 2021) • Assisted vaginal delivery: from 40 weeks to 41+6 weeks, the probability increases from 8.5% to 15.5%. (Weiss <i>et al.</i>, 2014)
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Estimated Risks to the Fetus

The most serious risk is the possibility of fetal death or death in the first week as the gestational age increases, perhaps due to uteroplacental insufficiency.. Although a rare outcome, the risk appears to increase up to 2 times from 41st to the 42nd week of pregnancy - specifically:

- 1.04-1.27 per 1,000 41-week pregnant women
- 1.55-3.1 per 1,000 pregnant women 42 weeks and over (Galal *et al.* , 2012)

Based on the data provided by NICE (2021):

- 4 per 10,000 pregnant women when induction is performed during the 41st week to 35 per 10,000 when induction is performed during the 42nd week.

Other **outcomes and complications** include:

- Fetal macrosomia associated with fractures and fetal injuries, peripheral nerve injury due to shoulder dystocia
- Umbilical cord entanglements
- Fetal Hypoxia and reduced amniotic fluid (oligohydramnios) which are associated with the presence of meconium in the amniotic fluid and abnormal fetal heart rates during labor
- Meconium aspiration, increasing the perinatal risk of pneumonia, pneumothorax, low Apgar Scores (<7 even at the 5th minute) and possible admission to the Neonatal Intensive Care Unit
- Intracranial Hemorrhage due to increased probabilities of interventional delivery
- Neonatal Seizures and the need for anticonvulsant administration
- Neurodevelopmental disorders in neonatal and childhood

(Galal *et al.*, 2012; Wang and Fontaine, 2014; Weiss *et al.*, 2014)

Options and Recommendations

1. Induction of Labor

- According to the recommendations of the World Health Organization (WHO, 2010) as well as the revised recommendations of NICE (2021), induction of labor is recommended from the 41+0 weeks of gestation, and before the 42nd week in uncomplicated pregnancies.

2. Intensive Monitoring until spontaneous onset of labor

- If it is decided to wait until the spontaneous onset of labor then intensive monitoring is followed with the measurement of fetal movements by the pregnant woman, Non Stress Test-NST (cardiotocographic monitoring at rest) every 2 days, biophysical profile with U/S to monitor amniotic fluid, movements and fetal heart beats. In case of fetal risk or oligohydramnios, induction of labor is recommended (Wang and Fontaine, 2014).

3. Directly scheduled C/S

- The probability of emergency C/S increases after the 41st week.

Informing the pregnant woman

The recommendations also require informing the pregnant woman

- on the estimated risks associated with prolongation beyond the 41st week,
- and at the same time explaining the process of induction
- and how it may affect the experience childbirth

The Healthcare Professional is expected to refer the pregnant woman to reliable sources of information on the topic. Related information is also available on the educational webapp platform Baby Buddy Cyprus (www.babybuddy.com.cy), which was created by TEPAK and the NGO Birth Forward in collaboration with the Pancyprrian Gynecological and Obstetrical Society of Cyprus and all other relevant scientific societies - *for example*:

- *Prolongation: when and how long can we wait*

<https://www.youtube.com/watch?v=IZtcWjPD87c>

- *Extension: start of labour:* <https://www.youtube.com/watch?v=FTPeNl5Gi0M>

Induction of Labor: Management and Steps for Correct Induction

Induction is performed after assessing cervical maturity (based on the Bishop score), because if the cervix is immature, the chances of failure increase and the labor may lead to a Cesarean section.

As a first choice, prostaglandins are administered intravaginally to induce contractions, in both nulliparous (first-time mothers) and multiparous women. The cervical ripening process can take up to 2 days, and then oxytocin (intravenously) or misoprostol (orally) may be administered to induce contractions.

Misoprostol is not recommended for women with a previous uterine incision, as it increases the chances of uterine rupture. Also, misoprostol may cause a decrease in fetal heart rate and lead to intrauterine death.

Therefore, vaginal examinations and close cardiotocographic monitoring during induction of labor are essential, due to the risk of hyperstimulation and the presence of fetal distress (Gülmezoglu et al., 2012; Wang and Fontaine, 2014; NICE guideline, 2021).

Hyperstimulation is a result of induction of labor. It is defined as uterine tachysystole (more than 5 contractions in a period of 10 minutes, for at least 20 minutes) or hypertonus (i.e., the contraction lasts longer than 2 minutes). This condition may or may not be related to changes in fetal function on the cardiotocogram (prolonged decelerations, tachycardia, or increased/decreased variability (NICE guideline, 2021).

Pain relief

Before a woman undergoes induction of labor, she should be informed that it may be a more painful process compared to spontaneous labor. Available pain relief options should be described to women in different situations. During the induction, women are provided with pain relief methods suitable for them. This may include simple analgesia, water birth, and epidural anesthesia. More methods are described in detail in the NICE guidelines for perinatal care (2023).

Ways to Start Labor

There is some evidence that walking for 30 minutes, three times a week, may help start labor. Many other "practical tips" for starting labor (e.g., sexual intercourse, dates, raspberry leaf tea, etc.) are not accompanied by sufficient or strong scientific evidence. In fact, some suggested ways to start labor may not be safe for all women, so they should be avoided unless discussed with a healthcare professional, who should only guide the pregnant woman to reliable sources of information (as mentioned in the NICE recommendations), such as: <https://www.nhs.uk/start-for-life/pregnancy/preparing-for-labour-and-birth/overdue-have-you-gone-past-your-due-date/>

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ANNEX D3: Instructions for Simulated 'Actress'

Scenario: "Prolonged Pregnancy - Induction of Labor"**Instructions for Simulated Pregnant Woman (actress)**

You are Chrysilia Georgakopoulou, 35 years old, and you are expecting your first baby. Gestation is 40+6/40 weeks. You just finished your appointment with your gynecologist-obstetrician and were given until tomorrow to decide about **induction of labor due to prolonged pregnancy**. You are unsure what to do and are very worried. Before leaving the clinic/hospital, you were asked to see the midwife/obstetrician or the gynecology-obstetrics resident to complete some information in your file that the clinic needs (and to get the consent form, as you were told).

Opening Statement:

"My doctor said I need to think about it until tomorrow, but I'm not sure I want to proceed with induction. I think I'd rather wait for the process to unfold on its own - what do you think?"

The midwife/obstetrician already knows some things about your medical history from before and has your file in front of them.

- There was no problem with your pregnancy.
- You have no contraindications for prolonged pregnancy (after all, you are already 40+6/40).
- You're not taking any medication.
- You have no previous gynecological surgery.
- You have no allergies.

Ideal Scenario Development

It is expected that the midwife/obstetrician will proceed with an open discussion with you:

- (a) First, to show genuine interest and recognize the importance of the decision you have to make, validate your feelings, and
- (b) To inform you about the available options (1. Induction, 2. Waiting for spontaneous labor but with intensive monitoring, 3. Planned C-section).

They should present comparative data, in an objective and balanced way, regarding the estimated risks of each option so that you can decide which is the appropriate option for you. Their manner or words should not reveal a critical attitude or pressure ("you are wrong") and certainly not intimidation (e.g., "your baby is in danger").

Although, given the time pressure and the non-equivalence of the available options, it is expected

- To recommend induction, in accordance with the guidelines, but clearly explaining the reasons why the recommendations suggest that induction should be done at 41+0 and before the 42nd week.
- To draw attention to the need to choose immediately between the available options, while assuring you of the support of the obstetric team regardless of your final choice.
- To explain that in that case, **intensive monitoring** of the fetus will be required, which, however, does not guarantee the avoidance of complications and adverse outcomes.
- To analyze the steps of correct induction of labor (e.g., application of the Bishop Score), assuring that in case you choose induction, you will be informed at every step, and where your own wishes are applicable to the procedure, they will be followed.

Social History:

You are married to Andreas, and this is your first baby. Everything has gone very well with the pregnancy. You and Andreas enjoy walking and have done so together almost every night since the beginning of the pregnancy until now.

From what you've read online and heard from friends, induced labor is a much more painful process compared to the pains you feel when labor starts spontaneously. Also, the chances of ending up in a Cesarean section increase significantly, especially in first-time mothers like yourself. However, you are unaware that waiting for spontaneous labor to begin also has a chance of ending in an emergency Cesarean, and the chances are comparatively higher.

In various forums you've searched, expectant mothers strongly discourage proceeding with induction, viewing it as something terrible and frightening. This is negatively affecting you. Beyond that, you haven't sought any other information about induction from a reliable source.

You've attended some childbirth preparation classes with Andreas, which mainly focused on breathing techniques. You were unaware of the community midwifery service provided through the GHS (General Healthcare System) and haven't visited a midwife.

The following is freely shared with HP provided that

- asks open-ended questions (what worries you; what do you know about prolongation of pregnancy; what do you know about induction?), and
- shows a genuine interest in the issue that concerns you

You can report that:

- Your doctor suggested the induction without explaining the reasons and the possible risks for you and the baby to wait for labour to start
- As long as your pregnancy is normal, without complications, you don't understand why you need to induce labour
- Did you know that sometimes pregnancy can go beyond 40 weeks by 2 weeks?
- A friend of yours gave birth naturally by spontaneous delivery at 41+4 days.

ONLY if asked specifically do you share the following:

- You don't know much about the challenge process. You've heard from acquaintances that they went scheduled and started a "drip" that causes labor pains, and others that they went overnight for "gels" - but you don't know the difference.
- You are concerned that with the challenge you will have to be immobilized and that is something that scares you.
- You are also scared of the possibility that the induction process may not go smoothly and you may end up having a caesarean section.
- You would like your partner to be with you throughout the birth.
- You walk with Andrew every night and you've heard that this can help.

Ideas/ Concerns/ Expectations

- You really want to do what's best for you and your baby
- You read on a website that the baby will be born whenever it wants.
- You are worried that if you choose induction, you won't be able to do it and will end up having a C-section
- You are worried that the fetus will be stressed if you choose to induce labor
- However, you are anxious that if you choose not to have an induction, you will blame yourself if something bad happens.
- You definitely want to avoid a C-section. However, if labor does not start spontaneously before the 42nd week, you recognize the increased likelihood of ending up with a C-section. You believe that your baby will be more mature, so you would accept it after all possibilities of spontaneous labor have been exhausted.

Information you would like to receive from your midwife/gynecologist:

- What are the options for delivery methods that I have, and when is induction recommended? What is medically indicated - what do the recommendations say?
- How exactly is labor induction performed, and what is recommended for me if I choose it?
- You want to know what to expect and how this will affect the labor experience.
- What are the risks for the mother and fetus with induction?
- What happens if I choose not to have my labor induced?
- Do I have to sign a consent form if I don't proceed with induction?
- You have also read about various other ways to start labor, but you don't know if they are actually true and you don't really believe them.

Since the healthcare provider (HP) doesn't do it spontaneously, you persistently ask about the above until you get the answers you want, appearing worried.

- "I didn't quite understand... What exactly does the induction involve? How dangerous is it for me?"
- "Is it really safe? If something goes wrong, what will be the consequences for me and my baby?"

In the event that you are given/asked to sign a consent form (either for induction or for intensive monitoring "at your own risk"), you remain silent for a while and think. Then, you appear hesitant, expressing your doubts and distress.

Issues that you were NOT aware of (and are surprised if the EY mentions them):

- Inducing labor, especially when the procedure does not progress as desired (e.g. weak contractions, abnormal cardiotocography, poor fetal position), increases the chances of a C-section.
- As the expected delivery date passes, placental function decreases, which can affect oxygen supply to the fetus. This may cause fetal hypoxia, leading to complications during natural childbirth or the need for an emergency C-section..
- When reduced fetal movement is observed, with or without a decrease in amniotic fluid, by the pregnant woman or the obstetrician during the ultrasound, induction of labor is recommended to minimize risks (infections, fetal stillbirth, etc.).
- Although rare, there is a risk of stillbirth because after 42 weeks, placental maturation can reduce the transfer of nutrients and oxygen to the fetus.
- Prolonged pregnancy can lead to macrosomia in the fetus. This can lead to difficulty in childbirth, increasing the likelihood of injuries such as neurological damage to the newborn, fractures, significant vaginal trauma in the mother, etc.
- As the pregnancy is prolonged, monitoring needs to be closer to ensure the well-being of the fetus. More frequent ultrasound and cardiotocography checks are performed, where the condition of the fetus and the need for immediate induction of labor are assessed.

Expected Reaction and Behavior of the HP and Approach

The scenario includes elements of providing information ("how does induction compare to spontaneous onset of labor at this stage of prolonged pregnancy"), but equally important are the elements of collecting information ("what are Chrysilia's thoughts, concerns, and expectations, what are the reasons for her expressed preference, what worries her most, are there any outcomes that worry her more, how much do you know about the extension and what do you know about the induction process").

The HP is not expected to only provide information, but to actively involve you in the discussion, ask questions, present your thoughts, concerns, and worries, and generally support you in making a decision..

The desired outcome is to feel that you have confidence in the medical team and that, regardless of your final decision, you will receive continuous care and support. You should feel empowered, both in terms of the information you need and psychologically, without feeling "pressured" to choose induction.

In general, they should listen to you and support you, provided they have given you all the information you seek in order to make a decision with complete and objective information, mentioning all the possible options you have and the likely impact this has on the outcome of labour, without a critical attitude or exaggeration that causes intimidation.

The emphasis should be on the HP's skills in including elements, to some extent, from all the steps/stages of participatory decision-making (three-talk model of shared decision-making).

Specifically, the HP (midwife-obstetrician) is expected to:

- Recognize that the experience of childbirth concerns a personal decision, for which there are alternative options, and that the pregnant woman's preferences and concerns must be taken into account (*OPTION TALK: recognition of alternative options*).
- Explain that comprehensive and valid information is needed to make a decision, although in this case there is time pressure, and make it clear that he/she is available to discuss and help her process the options (*TEAM TALK: supporting consultation and relationship building*).

- Mention that any decision must be made knowing the estimated risks of each option, and present comparative data in an objective, balanced, simple, and understandable way (**OPTION TALK: providing information on alternative options**).
- Show empathy and make a real effort to understand the pregnant woman's thoughts, concerns, and expectations, while making an effort to incorporate these thoughts into the decision-making process (**DECISION TALK: highlighting and incorporating preferences**).
- Recommend the medically indicated recommendation given the time pressure, while assuring her of the support of the midwifery team regardless of her choice (**DECISION TALK: decision making and informed consent**).

Response

Depending on the response from the HP, so will your reaction, i.e.,

Initially, the HP is expected to ask you for information about your pregnancy, your medical and obstetric history, ask you about the well-being of your baby (if you feel it moving, and how often), how the pregnancy and the upcoming birth make you and your partner feel, and focus on deciding to proceed with labor induction, as it is the best option before the 42nd week.

You will answer about your history and the other things you are asked, and you will focus on:

- not knowing about the induction process (e.g. chances of success, methods of induction)
- to better understand the consequences and potential complications, for you and the fetus, from prolonging the pregnancy or inducing labor.

At the same time, an effort should be made to understand how informed the thinking is around the decision to wait for spontaneous onset of labor ("starting point").

- If they proceed from the beginning, without doing any of the above, and repeat the recommendation (e.g. that induction is the only option), without exploring what you know and what you would like to know in order to make a decision, then you will ask even more questions about things you want to know, and/or you will question what they are telling you.

The HP is expected to understand your concern and reassure you, showing interest and empathy, without a critical attitude about any of your views or thoughts.

- But if their attitude causes feelings of guilt, then you will repeat that *"what you are telling me is frightening"* and *"what do you think? That I don't want to make sure that the decision I make is the most appropriate and safest for the baby"*, as you do not want to be led to a decision through intimidation and emotional blackmail.

You expect them to analyze your options in a balanced, structured, and comparative way, and to present the positives and negatives of these options, while at the same time trying to elicit your concerns and expectations.

- But, only if asked, you will share your thoughts and concerns, including that what you read in various mom groups about the pain and the "given" ending of induction in cesarean has greatly affected you.
- That *"you definitely want to avoid a C-section"* - this is your main concern, and
- *"you want your partner to be with you throughout labor"*

The HP should try both to inform and to encourage (due to lack of time) you to seek comprehensive and valid information about the extension of pregnancy. Ideally, they should refer you to a valid website or other source.

- If they don't, and simply continue to give information, without pauses, without trying to confirm understanding, without giving you the opportunity to ask questions, you will listen carefully, but looking troubled, and at some point you can say *"what you are telling me, can I read it somewhere? Is there an information leaflet you can give me?"*)

You expect them to provide you with all the information you are looking for and to resolve questions, regarding induction of labor (potential risks to the mother and fetus, complications) compared to prolonged pregnancy beyond 42 weeks, as well as to mention (a) the correct procedure of induction, in an understandable way, and (b) indicative ways you can manage pain in induction.

- If they don't, you can ask e.g. *"how exactly is induction done?"* or *"anyway, I heard that with induction, the pains are worse"*.

In general, depending on the whole approach of the HP, your response will also depend, i.e.,

- if they provide information about induction of labor versus waiting for spontaneous onset of labor in a comparative way, then you will start to show more interest in both options, and you will not rule out induction.
- but if they present the information unilaterally (e.g. insist and intimidate or overemphasize the risks of prolonged pregnancy, vaguely without presenting specific and clear data as to the frequency of risks/complications), then you will simply listen to what they have to say, and only ask clarifying questions about what they mention.
- if they insist on inducing labor and tell you that "you have to trust us" and "you don't have to be afraid of the pains, everything will be fine" (which is not your main concern anyway - your main concern is to end up in a cesarean) and that "it's better for you and the baby" (without however presenting any data), then you should show annoyed and say that "you want to wait for your baby to decide when to be born and you just wanted to know why most girls do induction".

It is also expected, after you discuss the options, to explain to you that it is important to discuss with your partner and make a decision immediately that ensures the well-being of you and your fetus, according to the information you have received and read.

Also, they should emphasize the importance of supporting your informed choice by the obstetrician, based on your history and knowledge, making the final decision together.

Other reactions

- **Understanding:** If what they say and explain is not understandable, you will interrupt asking for clarifications ("I didn't understand", "can you repeat that", "what exactly does that mean"). If they use difficult words and terms, and/or the discussion does not follow a clear structure, and/or they do not answer your questions clearly, or are verbose in their answers, then you will bring them back, insisting on your thoughts.
- **Interest:** If they simply want to tell you what they want, or even if they show great zeal in providing information without giving you the opportunity to ask what you want and/or to make sure you understand the information they give you, then say "but I told you I prefer to wait" or even "question the correctness" of what they told you.
- **Empathy/ Guilt:** If at any stage they show that they are not interested in you mentioning your concerns or do not show empathy and create guilty feelings about your choice, then become more anxious, mention that "well, anyway you have decided 90% that you will not proceed with the induction" and "I will think about it and see"

Summary

In general, the HP's response should correspond to your thoughts and questions, show interest in the issue and in you personally, without a critical attitude or a one-sided presentation of the data. They are expected to present comparative data, in an objective and balanced way, as to the estimated risks of each option (induction or spontaneous onset of labor).

Of course, given the pressure of time and the non-equivalence of the available options, it is expected, without a critical attitude or pressure, that a recommendation for induction will be made, since comparatively the estimated risks for the mother and baby increase as the pregnancy is prolonged, the HP must encourage the pregnant woman to think about her options and make a decision soon.

The HP is not expected to only provide information, but to encourage "Chrysilia" to actively participate in the discussion, to ask questions, to present her thoughts, concerns, and worries, and to support her in making a decision. They should make a real effort to provide the data clearly, to confirm that you have understood the information, to give the opportunity for additional questions and queries.

The desired outcome is for Chrysilia to feel that she has confidence in the medical team and that, regardless of her final decision, she will receive continuous care and support. She should feel empowered, both in terms of the information she needs and psychologically, without feeling "pressured" to choose induction. So that, when she is asked to give consent for induction, this is conscious (*not just acquiescence*).

ANNEX D4: Feedback Guide Based on the Calgary-Cambridge Model

A Guide to Synadhelpic Feedback Communication and Participatory Decision Making Skills

(based on the communication skills guide CALGARY - CAMBRIDGE and the observation tool OPTION5 for participatory decision making)

Script: Prolongation of Pregnancy and Induction of Labor

OPENING OF THE CONFERENCE	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
1. Greet wife and partner (if present) and learn their names (1). Attempt to include partner (1)					
2. Presentation of yourself (1) and your role/ capacity (1)					
3. Showing respect and interest in the issue of their concern (2)					
4. Privacy and physical comfort (e.g. suggesting that they sit down). Sit opposite at the right distance/appropriate position (1)					
5. Problem identification : although the problem is mentioned, clarify the reason (1) with an open-ended question.(1)					
6. Negotiating an agenda - explain what you would like to discuss (1) taking into account his/her needs (1)					
COLLECTION OF INFORMATION - Content	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
7. Validation of feelings (1) and confirmation of information you know (firstborn, weeks of gestation, etc.) (1)					
8. Brief investigation of the Surgical (1) , Pathological (1) , (1) , Prenatal History (1)					
9. " Starting point ": exploring knowledge about (a) prolongation of pregnancy (1), (b) induction of labour (1) and (c) possible outcomes (1)					
10. In relation to the expressed preference for not inducing labour, explore without judgment (2), the:					
- woman's 2)thoughts and concerns (					
- women's (2)expectations and desires					
INFORMATION Gathering - Communication Techniques	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
10. Encourage her to narrate her expectations/desires for childbirth in her own words (2)					
11. Use of open and closed type questions , starting with open (1) and moving to closed (1)					
12. Clarity of questions: short/specific questions (1) with clear wording (1)					
13. Active listening , allowing the woman to finish without interrupting, leaving time for thinking, etc. (2)					
14. Facilitate responses verbal and non-verbal e.g. by encouragement, examples, silence, repetition, paraphrasing (2)					
15. Effective management pause , repeating and continuing questions (2)					
16. Summarize at times to confirm what is said, encouraging to correct or provide further information (2)					
PROVISION OF INFORMATION - Communication techniques	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
17. Provide information in small sections (1) and slowly (1)					
18. Use simple and understandable language (1) and explain terms, statistics , etc. in an understandable way (1)					
19. Periodic summary (1) and confirmation of understanding - teach-back (1)					
20. Providing opportunities for the woman to contribute to the discussion with questions and/or to express questions/doubts (2)					

21. Encourage the woman to share thoughts/ideas, think about her choices, express her preferences (2)					
22. Provide suggestions (e.g. additional information) and options for action (e.g. pain relief) (1)					
23. Negotiating a mutually acceptable management plan with the woman (2)					
PROVISION OF INFORMATION - Content	0	1	2	3	4
24. Provide information on (a) extension (1), (b) available options (1) and (c) recommendations regarding extension/challenge (1)					
25. Comparative presentation of (a) risks/complications of prolongation for mother-neonate (1), (b) benefits (1) and (c) impact of challenge (1)					
26. Explanation of (a) process induction (e.g. pharmaceutical/non-pharmaceutical) (1), (b) impact on birth experience (1), options management (1)					
27. Confirmation of (a) her own consent (1), (b) encouragement to challenge and (c) what to expect she doesn't (1)					
28. Encourage (a) discussion with doctor, (b) referral to information sources (1), (c) reassurance of support for options (1)					
PARTICIPATORY DECISION-MAKING - Skills	0	1	2	3	4
29. Identification of alternatives (1), need to make a decision (1), on the basis of information (1), taking into account preferences (1)					
30. Intention to support (1), empathetic (1), respect for the right to information, non-judgmental attitude (1)					
31. Provide information (1), explain options (1), check for understanding (1), provide clarification (1)					
32. Feedback on options (1), incl. automatic induction of labour (1), exploration of preferences (1), understanding of concerns (1)					
33. Summary (1) and consideration of preferences (1), incorporation in decision making (1) taking into account suggestions (1)					
STRUCTURE DEVELOPMENT	0	1	2	3	4
34. Linking explanations: use of linking explanations or keywords mentioned in previous answers (2)					
35. Logical sequence of development of topics in the discussion (2)					
RELATIONSHIP BUILDING	0	1	2	3	4
36. Non-verbal behaviour					
- eye contact, facial expression (1)					
- posture, position and movement (1)					
- vocal cues e.g. rhythm, volume, tone (1)					
37. Empathy: showing understanding and genuine concern (1) for feelings (1) and the importance of the decision (1)					
Grade by Simulated Actress - The Health Professional	0	1	2	3	4
● He made me feel that there was genuine interest (1), acceptance without judgment (1), and he understood the problem (1)					
● Provided clear information (1), assisting in comparing options (1), taking into account my preferences (1)					
Other Comments/ Remarks:					

ANNEX D5: Session Objectives and Desired Scenario Outcome

Scenario: "Prolonged Pregnancy and Induction of Labor" - Instructions for HP (Healthcare Professional/Examiner)**Session objectives:**

The HP is expected to present comparative data, in an objective and balanced manner, regarding the estimated risks of each option (*induction or spontaneous onset of labor*), ensuring that Chrysilia understands the data so that the decision she makes is well informed. It is also expected to analyze the steps of the correct induction of labor (e.g., application of the Bishop Score), assuring her that she will be informed at each step, and that wherever her own wishes are applicable in the process, they will be followed.

Of course, given the time pressure and the non-equivalence of the available options, it is expected, without critical attitude or pressure, that a recommendation for induction will be made, since comparatively the estimated risks for the mother and baby increase as the pregnancy is prolonged. The HP must encourage the pregnant woman to consider her options and make a decision soon.

- *Could be given some information leaflet and / or reference to a reliable source (online or otherwise), so that Chrysilia is informed documented and complete about the risks of prolonging pregnancy, compared with the induction, the induction process, and the consequences for the experience of childbirth,*

An important element of the scenario is to make the medically indicated recommendation, but respecting the principle of autonomy and the right of Chrysilia to choose the experience of her birth, to have available all the information she needs to make an informed decision. The HP is not expected to simply provide information, but to encourage Chrysilia to actively participate in the discussion, to ask questions, to present her thoughts, concerns, and worries, and to support her in making a decision.

The desired outcome is for Chrysilia to feel that she has confidence in the medical team and that, regardless of her final decision, she will receive continuous care and support. She should feel empowered, both in terms of the information she needs and psychologically, without feeling "pressured" to choose induction. So that, when called to give consent for induction, it is conscious (*not just acquiescence*).

The scenario includes elements of providing information ("how does induction compare with spontaneous onset of labor at this stage of prolonged pregnancy"), but equally important are the elements of collecting information ("what are Chrysilia's thoughts, concerns, and expectations, what are the reasons for her expressed preference, and what does she know about the induction process"). The emphasis should be on the skills of the HP to include elements, to some extent, from all the steps / stages of the participatory decision making (three-talk model of shared decision-making)..

Specifically, the HP (midwife-obstetrician) is expected to:

- Recognize that the experience of childbirth concerns a personal decision, for which there are alternative options, and that the pregnant woman's preferences and concerns must be taken into account (**OPTION TALK: recognition of alternative options**)
 - Explain that complete and valid information is needed to make a decision, although in this case there is time pressure, and to make clear reference that he / she is available to discuss and help her process the options (**TEAM TALK: support consultation and relationship building**)
 - Mention that any decision must be taken knowing the estimated risks of each option, and to present comparative data with an objective, balanced, simple and understandable way (**OPTION TALK: providing information on alternative options**)
 - Show empathy and make a real effort to understand the thoughts, concerns and expectations of the pregnant woman, while trying to integrate these thoughts into the decision-making process (**DECISION TALK: highlighting and integrating preferences**)
 - Suggest the medically indicated recommendation given the pressure of time, assuring her of the support of the obstetric team regardless of her choice (**DECISION TALK: decision making and informed consent**)
- ANNEX E: Proposed scenario management by ChatGPT**

ANNEX E1: Proposed management of the "elective planned caesarean" scenario by ChatGPT

ChatGPT's suggestion: Role Play Scenario for Shared Decision-Making on Elective Caesarean

Scenario Overview:

In this role-play scenario, the primary objective is to facilitate a respectful and informed conversation that supports Andrea and her partner in making a decision **aligned with their values** and preferences, while ensuring they understand **the risks and benefits** of both elective Cesarean and vaginal birth as they apply to her specific situation.

Objectives of the Scenario

- **Build rapport and trust:**
Establish a non-judgmental, open, and supportive atmosphere.
- **Understand concerns and values:**
Explore their motivations, fears, and expectations regarding an elective caesarean.
- **Provide balanced information:**
Offer evidence-based, comparative risks and benefits of vaginal birth versus elective caesarean.
- **Facilitate shared decision-making:**
Empower Andrea/partner to weigh options and make a choice that aligns with their goals & priorities.

Key Skills to Demonstrate

Active Listening:	• Fully focus on Andrea and her partner's words, tone, and non-verbal cues. Use reflective listening to validate their concerns and ensure understanding. • Example: <i>"I hear that you're concerned about the unpredictability of labor. Can you tell me more about how this impacts your feelings about delivery?"</i>
Building rapport & trust:	• Establish a warm, welcoming, and respectful environment. Show genuine interest in their values, preferences, and concerns. • Example: <i>"This is such an important decision for both of you, and I want to help you feel confident and supported."</i>
Empathy and validation:	• Acknowledge their emotions and perspectives without judgment. • Example: <i>"It's completely normal to feel this way -many parents-to-be share similar concerns."</i>
Clear and empathic explanations:	• Present information using plain language, avoiding medical jargon. Use analogies or visual aids to make information more understandable. • Example: <i>"Recovery after a caesarean can take longer because it's major surgery, like recovering from a deep abdominal incision."</i>
Evidence-based guidance & Balanced information delivery:	• Be well-informed about the latest guidelines, risks, and benefits of both delivery options to provide accurate advice. Provide a neutral presentation of the risks and benefits of both options. • Example: <i>"Both vaginal birth and caesarean have their pros and cons. Let's go through them together so you can make an informed choice."</i>

Non-directive and Non-judgmental	Avoid appearing to favor one option unless medically indicated. Avoid imposing personal opinions or preferences. Present information in a non-directive manner, allowing them to make their own choice.
Elicitation of values and preferences:	- Ask open-ended questions to understand what matters most to Andrea and her partner. - Example: <i>"What's most important to you as you think about your delivery options-safety, recovery, convenience, or something else?"</i>
Personalizing information	- Tailor the discussion to their specific needs, concerns, and priorities. - Example: <i>"Since you're worried about recovery time, let's focus on how each option might affect your ability to return to your routine."</i>
Facilitative open dialogue:	- Actively engage both Andrea and her partner, recognizing the importance of their shared decision. Encourage questions, clarifications, and reflection - Example: <i>"This is a lot of information to take in. What questions do you have?", "How do you both feel about the information so far? Is there anything more I can clarify?"</i>
Avoid Pressure and provide reassurance	- Emphasize that they have time and support to make the right decision for their family. - Example: <i>"You don't need to decide today. We can revisit this conversation after you've had some time to think."</i>

expected results

The expected outcome is **not necessarily a final decision** but rather a progression towards an informed, personalized, and mutually agreed-upon plan. An indicator of success would be an evident sense of shared decision-making, with the couple actively engaged in the discussion and the provider guiding without imposing.

The outcomes should include:

- Informed understanding:** Andrea and her partner should leave the conversation with: clear understanding of the **comparative** risks, benefits, and implications of elective caesarean Vs. vaginal birth and receive **clarification** of any misconceptions or fears they initially expressed.
- Emotional reassurance:** Andrea and her partner should feel heard, respected, and supported in their **concerns and preferences**. They should feel **confident** that the healthcare provider is committed to their well-being and the best outcome for both Andrea and the baby.
- Empowered decision-making:** They should feel equipped and empowered to **weigh** the options based on their priorities and circumstances. If they are ready to make a decision, they can express their preference for a birth plan that aligns with their **needs and values**.
- Agreement on next steps:** If they **need more time to reflect**, they should have a clear understanding of the timeline and process for revisiting the decision. The healthcare provider should outline the next steps, such as **scheduling a follow-up discussion or offering additional resources**. Both parties should agree on a tentative plan while keeping flexibility for changes if needed.
- Strengthening relationship:** Andrea and her partner should feel more connected to the healthcare provider, fostering **trust and collaboration** throughout the rest of the pregnancy and delivery process

The following approach fosters trust and ensures Andrea and her partner feel informed, respected, and supported, **regardless of their final decision** - see *steps of the process and decision aid* in next pages.

Acknowledgment of the use of Artificial Intelligence (AI) tools:

We acknowledge the use of ChatGPT to produce the present document with the intention of presenting to participating midwives how AI would approach the communication skills scenario presented to them.

Prompt used:

(1) Suggest the approach a healthcare provider should take in a role-play scenario for shared decision making on the topic of elective caesarean. The scenario is about a couple, Andrea and her partner, at 36 weeks gestation, expressing a preference towards having an elective caesarean, without any medical indications, mainly concerned about the inconvenience and length of a vaginal birth. Focus on the objectives of such a scenario and how the healthcare providers is expected to handle the situation. Following principles of effective communication, include both information gathering processes to understand the reasons behind this expressed preference as well as information giving to provide comparative risks and benefits of the two options (caesarean versus vaginal birth); (2) what are the key skills the healthcare provider is expected to demonstrate and (3) create a decision aid tool to help the healthcare provider present Andrea and her partner how the two options compare in terms of risks and benefits.

Step 1: Setting the Scene	Greet Andrea and her partner warmly, ensuring both feel included in the conversation. Acknowledge the stage of pregnancy and the significance of this decision.	Clarify the goal of the discussion: "Today, we'll explore your thoughts about an elective caesarean and discuss what might be the best approach for you and your baby"
Step 2: information gathering (Active Listening)	Ask open-ended questions to understand their perspective:	"Can you tell me more about what's leading you to consider an elective caesarean?" "What are your main concerns about a vaginal birth?" "What outcomes are most important to you-for Andrea, the baby, and your family?"
	Explore emotional and practical concerns:	"You mentioned inconvenience and the length of vaginal birth. Could you share more about what makes those challenging for you?" "Are there specific experiences or stories that have shaped your view of childbirth?"
	Clarify their understanding of caesarean and vaginal birth:	"What do you currently know about the risks and benefits of caesarean and vaginal birth?"
Step 3: Acknowledge & Validate	Show empathy and respect for their concerns:	"It's completely normal to want a sense of control and predictability in such an important moment." "Many people have similar thoughts about the length and unpredictability of labor-it's understandable to feel that way."
Step 4: information giving (Evidence-Based and Individualized)	Frame the conversation around their concerns:	"Since convenience and predictability are important to you, let's discuss how caesarean and vaginal births compare in those areas, as well as other factors like recovery and long-term health."
	Discuss benefits & risks of both options: <i>Use visual aids, analogies,</i>	Vaginal birth: Benefits: lower risk of major surgery, shorter recovery time, lower chance of complications in future pregnancies (e.g., placenta previa or uterine rupture). Risks: potential for perineal tearing, unpredictable labor duration, possible need for emergency interventions.

	<i>or clear statistics if helpful.</i>	Elective caesarean: • Benefits: Predictable timing, avoids labor pain. • Risks: Longer recovery, higher likelihood of surgical complications (e.g., infection, blood clots), and increased risks in subsequent pregnancies.
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Step 5: Encourage Questions & Shared Decision-Making	Invite them to ask questions :	"What other information would help you feel more confident about your decision?"
	Summarize key points	"It sounds like predictability and minimizing discomfort are your priorities. How do you feel about what we've discussed so far?"
	Offer support :	"Whatever you decide, we'll support you and ensure the safest possible outcome for you and your baby."
Step 6: Close with Empathy and Next Steps	Summarize the discussion:	"We've covered the pros and cons of both options. You've shared that convenience and recovery are important to you. Based on what we discussed, what are you leaning towards?"
	Provide time for reflection :	"This is a big decision. Take your time, and we can revisit this conversation in a few days if you'd like."
	Assure continued support:	"We're here to guide and support you through this process."

Decision Aid Tool: Comparing Vaginal Birth and Elective Caesarean:

A visual aid helps the healthcare provider present the risks and benefits of vaginal birth and elective caesarean in a structured and easy-to-understand manner. It can be used as a conversation too: (a) present how the options compare, (b) highlighting sections most relevant to Andrea and partner's expressed concerns, (c) encouraging questions for clarification and (d) providing supportive resources, such as pamphlets or videos, if needed.

Factor	vaginal birth	Elective Caesarean
Timing and Predictability	Labor is unpredictable in timing and duration.	Scheduled in advance, providing predictability.
Pain During Delivery	Labor pain but can be managed with options like epidurals.	No labor pain; anesthesia used during surgery.
recovery time	Typically, faster recovery (about 4-6 weeks).	Longer recovery time (about 6-8 weeks), as it is a major surgery.
Physical Risks to Mother	Risk of perineal tearing or need for episiotomy. Rare risks: uterine rupture during future labour (if previously had C/S).	Higher risk of surgical complications: infection, blood clots, wound healing issues. Rare risks: complications with placenta/uterus in future pregnancies
Impact on Baby	Lower risk of breathing issues in full-term babies (labour helps clear fluid from lungs).	Slightly higher risk of transient respiratory issues in newborns.
Future pregnancies	Lower risk of complications in future pregnancies.	Increased risk of placenta previa, accreta, or uterine rupture in future pregnancies.
Convenience	May require flexible scheduling and support	More predictable; allows planning for support and arrangements.

Factor	vaginal birth	Elective Caesarean
Long-Term Health for Mother	Lower risk of adhesions or chronic pain.	Possible long-term: adhesions, chronic pelvic pain, surgical complications.
 Με τη συγχρηματοδότηση της Ευρωπαϊκής Ένωσης	<i>Co-financed by the European Union. The views and opinions expressed are solely those of the authors and do not necessarily represent the views of the European Union or the European Education and Culture Executive Agency (EACEA). The European Union and the EACEA cannot be held responsible for the views expressed.</i>	
	[Project: 101096681 -	RESPECT - CERV-2022-DAPHNE]

ANNEX E2: Proposed management of scenario "induction of labour in prolonged pregnancy" by ChatGPT

ChatGPT's suggestion: Role Play Scenario for Shared Decision-Making on post-term pregnancy

Scenario Overview:

In this role-play scenario, the primary objective is to facilitate a respectful and informed conversation that supports Chrisilia in making a decision soon, by (a) providing information in a way that is clear, accurate, and unbiased, ensuring Chrisilia understands the comparative risks and benefits of induction versus waiting, and (b) encouraging Chrisilia's active participation in the decision, making recommendations while respecting her right to choose.

Objectives of Scenario

- **Understand Chrisilia's Perspective**
Explore her preferences, concerns, and reasoning for wanting to wait for spontaneous labour.
- **Provide Balanced**
Clearly outline the risks and benefits of induction versus waiting, using evidence-based information.
- **Explain the Induction**
Discuss the role of the Bishop score in determining induction methods and likelihood of success
- **Support Autonomy and**
Ensure Chrisilia feels heard, respected, and empowered in making an informed decision.
- **Maintain a Supportive Approach**
Reassure her that, regardless of her decision, she will receive continued care and support

expected results

By integrating **active listening, empathy, clear information-giving, and shared decision-making**, the HCP ensures that Chrisilia is fully informed and supported. This approach fosters **trust, respect, and patient-centered care**, empowering her to make the best decision for herself and her baby. The expected outcome should be that Chrisilia feels respected, informed, and empowered to make the best decision for herself and her baby - see *steps-by-step process and decision aid in next pages*.

Acknowledgment of the use of Artificial Intelligence (AI) tools:

We acknowledge the use of ChatGPT to produce the present document with the intention of presenting to participating midwives how AI would approach the communication skills scenario presented to them.

Prompt used: (1) Suggest the approach a healthcare provider should take in a role-play scenario for shared decision making on the topic of post-term pregnancy (overdue). The scenario is about Chrisilia, at 40+6 weeks gestation, expressing a preference to wait for labour to start spontaneously rather than proceed with an induction, which would be the preferable option in this situation. Focus on the objectives of such a scenario and how the healthcare providers is expected to handle the situation. Following principles of effective communication, include both information gathering processes to understand the reasons behind this expressed preference as well as information giving to provide comparative risks and benefits of the two options (induction versus wait) to support her reach her decision, but it has to be soon. The HCP should explain the induction process based on the Bishop score but also reassure the woman that, even though he recommends an induction, he will support her decision whichever it is, (2) what are the key skills the healthcare provider is expected to demonstrate, with examples, and (3) create a decision aid tool to help the healthcare provider present Chrisilia how the two options compare in terms of risks and benefits.

Key Skills to Demonstrate

Active Listening:	- Understand her concerns before giving information - Asking open-ended questions: <i>"Chrisilia, I understand you prefer to wait for spontaneous labour. Can you tell me more about what's influencing your decision?"</i> - Paraphrasing to confirm understanding: <i>"So, you're hoping to avoid medical interventions unless absolutely necessary. Is that right?"</i> - Using non-verbal communication: nodding, eye contact, open body language
Empathy & Validation:	- Acknowledge her feelings and preferences: <i>"Many women feel the same way about wanting labour to start naturally, and that's completely understandable."</i> - Reassuring her, <i>"I hear that you're concerned about induction. It's okay to feel this way. Let's go through the information together so you can make the best choice for you and your baby."</i>
Information Gathering & Exploration	- Asking about concerns: <i>"What have you heard about induction? Is there anything specific that worries you about the process?"</i> - Exploring beliefs: <i>"What's your understanding of the risks of waiting beyond 41 weeks?"</i>
Balanced, Evidence-Based Information:	- Present risks and benefits of both options, using simple language: <i>"As pregnancy continues beyond 41 weeks, the placenta may not work as well, which can increase the risk of complications for your baby."</i> - Comparing risks and benefits: - Waiting for spontaneous labour: <i>"There is a small but increasing risk of stillbirth, and if labour doesn't start soon, you may need an emergency C/S"</i> - Induction <i>"Inducing now reduces these risks and increases the likelihood of a smooth vaginal delivery."</i>
Clarity & Simplicity:	- Break down complex medical information into simple, understandable steps while ensuring informed consent - Explaining the Bishop score: <i>"To determine the best method for induction, we check the condition of your cervix using the Bishop score. If the score is low, we use medications to soften it before starting contractions."</i> - Describing the induction process clearly, <i>"We might use a prostaglandin gel or a Foley balloon to help prepare the cervix, followed by an oxytocin drip to start contractions."</i>
Shared Decision-Making & Autonomy:	- Make a recommendation but reassure her of support regardless of her choice. - Framing the choice collaboratively: <i>"You have two reasonable options-waiting or induction. My role is to provide you with all the information so you can decide what feels right for you."</i> - Expressing recommendation while respecting her autonomy: <i>"I do recommend induction at this stage, but ultimately, this is your decision, and I will support you whichever way you choose"</i>
Reassurance & Continued Support:	- Offering reassurance, <i>"No matter what you decide, we will continue to monitor you and your baby closely to ensure the best possible outcome."</i> - Encouraging questions: <i>"Would you like some time to think about this? Do you have any questions or concerns I can help with?"</i>

Step 1: Building Rapport and Understanding Chrisilia's	Warm greeting. Open-ended question	"Chrisilia, I understand you are considering waiting for labour to start on its own. Could you share with me what's important to you in this decision?"
	Active listening: Validate feelings:	- Give her time to express concerns and preferences. "I completely understand why you would want to wait for spontaneous labour. Many women hope for that experience."
	Ask about specific concerns:	"Is there anything in particular that makes you hesitant about induction?"
Step 2: Providing Balanced, Evidence-Based Information	Risk of Waiting Beyond 41 Weeks	- Small but increasing risks of stillbirth and complications. Placental function declines over time - potentially leading to reduced oxygen and nutrients for the baby. - Higher chance of needing an emergency C-section if labour doesn't progress well.
	Benefits of Induction at This Stage	- Reduces risk of stillbirth and complications as pregnancy continues. - Induction at this stage is generally more successful than later on. - Reduces the likelihood of requiring a C-section for fetal distress.
Step 3: Explaining the Induction Process Based on the Bishop Score	Assessment of the Cervix	"To decide how to induce labour, we check the Bishop score, which tells us if your cervix is ready." "If the score is low, we use medications or other methods to soften the cervix first. If it's high, we may go straight to breaking the waters or using oxytocin."
	What to Expect with Induction	- Step-by-step explanation of methods, including: - membrane sweep, prostaglandins, Foley balloon, and oxytocin drip. - Reassurance that pain relief options are available.
Step 4: Shared Decision-Making and Reassurance	Summarize her options	"You have two reasonable choices: waiting for labour to start naturally, with some increased risks, or proceeding with induction, which has benefits in preventing complications."
	Express recommendation while respecting her autonomy	"Based on what we've discussed, I do recommend induction, but ultimately, this is your decision, and I will fully support whichever path you choose."
	Offer continued support	"We need to make a decision pretty soon. Would you like some time to think it over or discuss with your partner? We're here to support you in whatever decision you make."

Decision Aid Tool: Comparing Induction vs. Waiting for Spontaneous Labour

Risks-Benefits	Induction of Labour (at 40+6 weeks)	Waiting for Spontaneous Labour
Risks to baby	Reduced risk of stillbirth (small but increasing after 41 weeks)	Increased risk of stillbirth (small but rises beyond 41 weeks)
	Stillbirth Risk per 1,000 Pregnancies: At 40 weeks: ~0.3 per 1,000, At 41 weeks: ~1 per 1,000, At 42 weeks: ~1.8 per 1,000	
	Reduced risk of complications from placenta aging.	Potential complications due to declining placenta function
	Lower risk of emergency C-section for fetal distress.	Higher risk of fetal distress if labour doesn't progress well.
Risks to mother	Possible stronger, more painful contractions from induction.	Slightly higher chance of requiring an emergency C-section.
	Risk of failed induction (if cervix isn't ready).	Higher chance of prolonged pregnancy complications.
	More predictable timing of labour.	Possible sudden onset of labour without preparation.
Benefits to baby	Controlled timing ensures close monitoring during delivery.	Potential benefit of natural labour onset for baby's readiness.
Benefits to mother	Reduced uncertainty and anxiety about waiting.	Chance to avoid medical interventions
	Higher likelihood of a vaginal delivery compared to later induction.	Natural progression of labour may feel more empowering.
What to expect:	Before starting: - Bishop score assessment to evaluate cervical readiness. - If the cervix is unready, methods like prostaglandin gel, Foley balloon, or membrane sweep will be used. Induction process: - Oxytocin drip to stimulate contractions. - Continuous monitoring of you and your baby during labour. Pain management - Epidural or other options available to manage pain	Close monitoring - Regular appointments to check baby's growth and placenta health. What happens if labour doesn't start: - Induction may still be recommended if risks increase significantly. Monitoring for signs of labour - Be alert for decreased baby movement, contractions, or other signs.



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ANNEX F - Observer OPTION5 - Greek translation (after obtaining permission for translation and use from the manufacturers)



Observer OPTION 5 - English translation

Purpose

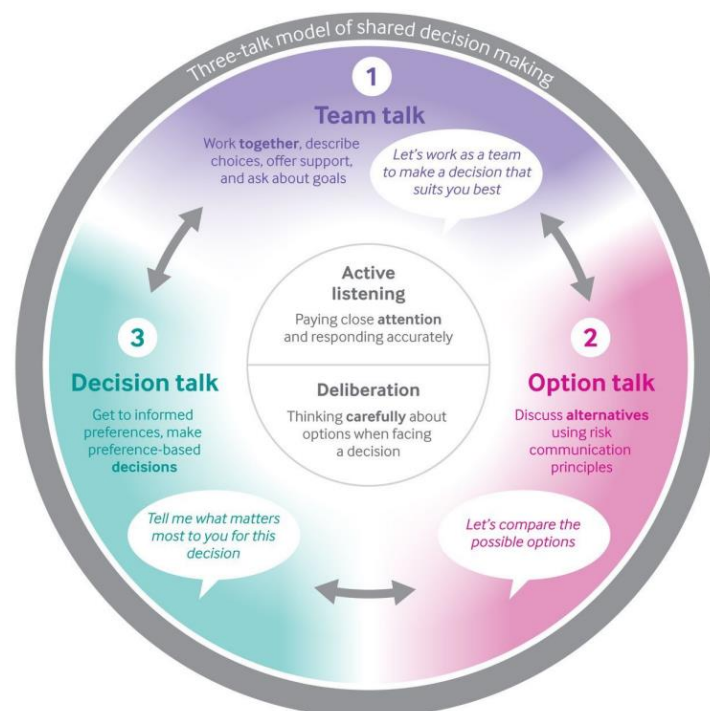
The **tool Observer OPTION5**² assesses the degree of effort a Health Care Provider is making to support the process. Participatory Decision Making It refers to a tool for observing the interaction between Health Care Health Care Provider and Recipient in clinical settings and can be used in the context of face-to-face or audio-visual sessions, or even with transcribed session transcripts.

Introduction

The conceptual origin of the tool is based on the three-stage model of communication between Health Care Health Care Providers and Users, called the three talk model (Elwyn, 2013), as shown in the figure below.

The tool is based on a previous 12-point tool for assessing shared decision making, which is available at the following link: <http://>. The developers identified the need for a shorter version of the tool, which more closely matched the concepts and phases of the process participatory decision-making , and so was developed. this five-point tool

² Elwyn, G., Tsulukidze, M., Edwards, A., Légaré, F., & Newcombe, R. (2013). using a "talk" model of shared decision making to propose an observation-based measure: Observer OPTION (5 Item) .*Patient Educ Couns* , 93 (2), 265-71



The five elements evaluated by the tool OPTION5 are shown in the table below. Each element is evaluated independently of the other.

The total score is obtained by summing up the scores of the points, with a range from 0 to 20. For ease of interpretation, an adjustment is made on a scale of 0 to 100.

As a guide for observer-researchers evaluating the sessions, each item on the scale is accompanied by indicative phrases that successively reflect a greater degree of effort. These are suggestions, not binding guidelines for scoring.

It is recommended that observer-researchers take detailed notes, including specific examples of phrases used, which distinguish between points on the rating scale.

Scoring Guide (See manual for details)

Rating	Description
0 = No attempt	No effort was observed (zero).
1 = Minimum effort	It is only implied or may be interpreted as such
2 = Moderate effort	Key phrases or sentences used
3 = Skilful effort	Noun phrases or sentences used
4 = Exemplary effort	Clear were used and precise methods of communication

Tool Observation Evaluation OPTION 5 - Evaluation Sheet

Name of evaluator:		Date:	
Health Professional Code:		Session number:	
Session topic:		Session duration:	

Item 1: OPTION TALK (identifying the availability of alternative options)

For the health issue being discussed, the health professional (*care provider*) **brings attention to** the the beneficiary **or confirms** that there are alternative options for treatment or management of the issue, and/or that a decision needs to be made. *If the care recipient (patient), rather than the health care professional, mentions the availability of alternatives, the care provider responds by agreeing that the options need to be discussed.*

0= No attempt 1= Minimum effort 2 =Moderate effort 3= Skilful effort 4 = Exemplary effort

Element 2: TEAM TALK (*group discussion: consultation support/relationship building*)

The health professional reassures the beneficiary (patient) or reconfirms that he/she will **support** him/her **to be fully informed and/or discuss** the different options together. *If the beneficiary indicates that he/she has sought or received information prior to the meeting, the health professional encourages and supports the discussion.*

0= No attempt 1= Minimum effort 2 =Moderate effort 3= Skilful effort 4 = Exemplary effort

Element 3: OPTION TALK providing information about alternative options)

The health professional **provides information or checks the understanding** beneficiary's of the alternatives that are considered eligible (which may include no decision/no action) to support in comparing him/her the alternatives. *If the beneficiary requests clarification, the health professional supports the process.*

0= No attempt 1= Minimum effort 2 =Moderate effort 3= Skilful effort 4 = Exemplary effort

Element 4: DECISION TALK

The health professional **shall endeavour to elicit the preferences** beneficiary's regarding the options described. *If the beneficiary indicates his/her preferences, the health professional shall be supportive*

0= No attempt 1= Minimum effort 2 =Moderate effort 3= Skilful effort 4 = Exemplary effort

Element 5: DECISION TALK incorporating preferences)

The health professional **shall endeavour to incorporate the expressed preferences** beneficiary's when a decision is made. *If the beneficiary indicates the best way to incorporate his/her preferences into decisions, the health professional shall make an effort to do so.*

0= No attempt 1= Minimum effort 2 =Moderate effort 3= Skilful effort 4 = Exemplary effort

Total score **0-20**

Update **0-100**

	Typical examples depending on the level of effort (indicative phrases/suggestions)					Exemplary effort requirements
	0 - None	1 - Minimum	2 - Medium	3- Skilful	4 - Exemplary	
Item 1: OPTION TALK (to identify the availability of alternative options)		There are several ways... We have a range of options available to us .. There are different options...	There are alternative options... We can examine which ones are best and choose from a range of options.	These different options are offered because they are alternatives and therefore it makes sense to consider them - each has its own advantages and disadvantages... Different people will react differently to them - so it's important to compare them to help you decide which is suited best to your circumstances.	Now that we have agreed on the problem (issue or diagnosis), let's consider how to proceed with the next steps (management/treatment/further investigation). As in many situations, there are alternative possibilities and options) and each one will be different. Shall I explain these alternatives? My aim is to get information/understand more about these options and then hear from you what matters you most to People have different priorities - that's why I want to understand yours.	An exemplary effort should include checking for understanding (confirming that the beneficiary-patient) understands the issue(s). It also includes sufficient justification for the need to take time to make a decision, especially since people's preferences vary and need to be taken into account in the process.
Item 2: TEAM TALK <i>(group discussion: consultation support / relationship building)</i>		Let's work together to ... I can help you think about [the various options]... My role is to work with you...	This/these [information, options requirements] might be something new for you, so we will try etc.etc..... Looking at various options is not an easy task, so we will do/attempt etc.	I will make sure you receive more information about the options involved, and then we will work together to look at those options. This may sound like a lot of work, but don't worry, I'm here to help you look at these options and choose	I will make sure that you receive more information on the relevant options. Some people (patients) sometimes feel overwhelmed by such information, but I will do my best to make the information clear and easy to understand. I will describe how the available options differ, what benefits rings each , but also what the risks are, and how often this happens.	Scoring at this level requires clinicians to explain to carers/ patients that, working together as a team, including family members where appropriate, will provide support to consider the options for the decision they need to make, ensuring that the person not do feel left to face a difficult decision alone.

				which one might be the best for you.	My job is to make sure that I support you in understanding these options so that we can compare them and find out what is best for you. Do you have any questions?	
Item 3: OPTION TALK providing information about the alternatives)		The following options are available, A and B. Let me describe them for you.	The following options are available, A and B. Let me describe them so that you understand both the benefits of each option and the risks they may have, and how likely they are to happen.	The following options are available, A and B. Let me describe them to you, so that you understand both the benefits of each option and the harms and how likely they are to happen. Do you understand? Do you have any questions? Do you want me to explain something again?	The following options are available, A and B. Let me describe them to you, so that you understand both the benefits of each option and the harms and how likely they are to happen. Do you understand? Do you have any questions? Do you want me to explain something again? In your own words, I would like you to tell me what we have discussed/understood.	It may be necessary to use information material, e.g. leaflets, icons/infographics, to illustrate the different possibilities. The "method teach-back" is an example of an exemplary effort.
Item 4: DECISION TALK highlighting preferences)		What are you thinking? What is your opinion?	Now that I have outlined the options, do you feel that any of them seem to fit your wishes or views ?best	What are your thoughts on the options mentioned? Have you been able to form an opinion about them? Is there an element of the various options that worried you or that you liked/ seemed to prefer? .	Do you have any questions or concerns about the options I've described? Maybe you heard some things you liked or were worried about? That's normal, and my job is to understand your views on the choices. What did you think of the options we described? Were you able to form an opinion about them? Was there any element that you were concerned about or that you liked/ seemed to prefer? Now that you know more about the	

					options we have, I would like to know your feedback to understand your views or priorities.	
Item 5: DECISION TALK integration of preferences)		It seems to me that you are happy with happy option A. Let us proceed with this option.	It seems to me that you are happy with happy option A. Am I right?	So, if I may summarize, you think that both options are appropriate. But you think that option A is better for you because you believe X. Am I understanding this correctly?	So, if I may summarize, you think that both options are appropriate. But you think that option A is better for you because you believe X. Am I understanding this correctly? I want to make sure I understand your preferences or priorities, so please let me know if you want to say anything more about this. My job/ My aim is to make sure that the selection is based on what you think is most important to you and what has the best chance of working in your case.	



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ANNEX G - Educational material for the scenario "*Challenges with breastfeeding in the first days*"

ANNEX G1: Scenario instructions for the Health Professional

Scenario "Breastfeeding management in the first days" - Instructions for EY

You are a midwife and you work in Community Midwifery in Limassol. You provide services through GHS and you also work on a voluntary basis with the Pancyprrian Breastfeeding Association to conduct breastfeeding seminars.

Today, you will visit at home Mrs. Maria Petrou, who gave birth 5 days ago in a private clinic to her second baby, a healthy girl, at 39 weeks, with Apgar Score 9' and 10⁵'. This is the first time you will meet her. Mary was not aware that Community Midwifery services are provided. She found out at the clinic from the midwifery staff who supported her in breastfeeding in the early days, and decided to contact them to make an appointment.

On the phone, Maria told you that she **would like to try to breastfeed exclusively**, although the first days at home were difficult as she has two children to care for. **She has been advised to supplement so that she can have help with the infant and spend more time with her older child.**

She doesn't know what to do and asks for your opinion.



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ANNEX G2: Script instructions to simulated 'actor'

Script: "Breastfeeding management in the early days: Exclusive Breastfeeding and Formula Feeding"**Instructions for simulated new mother (actress)**

You are Maria Petrou, you gave birth 5 days ago in a private clinic to your second baby, a healthy girl, at 39 weeks. Today, the community midwife will visit you at home. It's the first time you'll meet her. You didn't know that community midwifery services are available. You learned about it at the clinic from the midwifery staff, who encouraged you to seek help and you decided to contact them to make an appointment.

On the phone, you mentioned that you breastfed exclusively at the clinic with the help of the midwives and that **you would like to try to continue to breastfeed exclusively**. You have a 16-month-old child whom you have not been able to breastfeed. The first 2 days at home were difficult as you have the care of two children and you would like the advice of the community midwife on how to manage breastfeeding in relation to your other commitments.

Opening statement:

"As I mentioned to you on the phone, I'm kind of confused and don't know what to do. So far I have been exclusively breastfeeding but it is very demanding especially now that I am at home and have both children to look after. At the clinic I was advised to supplement if I am struggling so that my husband and mother-in-law can help with the baby and I can make time for my older son. But with my son I did that and in the end I had no milk to breastfeed him. I don't know what is right and what is wrong.

Medical History

You do not suffer from any illness and have never had to be hospitalized except for the birth of your son.

Medication

Apart from the pregnancy vitamins recommended by your doctor and a Vitamin supplement D due to a deficiency, you are not taking any other medication.

Social Background

You are married to Niko, with whom you run a law firm, which was his father's. You live in Nicosia. You still have a 16-month-old child, a boy whom your mother-in-law looks after during the hours you are away for work. Your husband, an only child, is particularly fond of his mother, who lives very close to your home. Also, she has been a widow since her son was 16 years old. Your parents live in Limassol.

Expected stop IF

It is expected that the EY will show interest in the issue you are concerned about, without a judgmental attitude, starting with open-ended questions to understand your concerns and previous experience with breastfeeding.

The following can be shared freely with the midwife provided that

- asks open-ended questions, and
- shows a genuine interest in the issue that concerns you

You can report that:

- Last time you gave birth by induction. The birth was very long and the baby had to be in the incubator for a few hours. You were told to rest on the first day and when the baby came out of the incubator you were to try to put it on the breast.
- No one explained to you how to pump milk or put the baby to the breast. When you tried after 2 days, the baby had a hard time "catching". At the maternity hospital they continued to give supplementation because we're unable to breastfeed directly from the breast.

- At home you tried to pump and give him milk but the process of pumping was very tiring, you started to give him a supplement because you didn't have enough of your own milk and finally you decided to stop.
- This time, you gave birth naturally and quickly. At the clinic you had the baby with you in the room and you breastfed exclusively with the help of the midwives, although it wasn't easy and you are not confident if you will be able to continue at home, especially because you have the other baby to take care of.
- Before they mentioned it to the Clinic, you didn't know that the Community Midwifery service existed and you thought you had nothing to lose by trying it because you had no guidance last time.

ONLY if asked specifically do you share the following:

- You have not attended a breastfeeding seminar. You have read about the 10 steps to successful breastfeeding and some information about the different breastfeeding positions from the Baby Buddy platform.
- You have a different pediatrician than the one you had for the first baby, for personal reasons. In general, he seems to be a supporter of breastfeeding. He told you that if you supplement sometimes, it doesn't mean you should stop breastfeeding.
- Your husband sees that you are stressed about how to combine breastfeeding with the demands of caring for your other baby and tells you that "*the world is not lost if you don't breastfeed*" and that it is important that everything is fine and that you are not unnecessarily stressed about the whole process.
- You wish you would at least try to at least try to breastfeed exclusively, because a friend of yours who breastfed reported that it was very easy for her and she didn't have the need to sterilize bottles, so she went everywhere without much of anything. You also know it's better for your baby, especially this time of year since it's winter, and you want to protect him/her from infections.
- While you're on maternity leave, you think you'll limp along. Although it won't be easy since now that you're not going to the office you've decided to have the other baby stay at home to give your mother-in-law a break. You're worried that when you get back to the office, things will be much more difficult.

Possible questions that the midwife is expected to ask

- Can you describe your previous experience with breastfeeding (if you tried it)
- How do you feel this time?
- Do you have questions about feeding your newborn? Hours, method, locations, schedule, etc.?
- What are the initial feeding goals for your newborn?
- What are the biggest challenges you are facing right now in relation to breastfeeding?
- How can I best support you with the challenges you are facing now with breastfeeding?
- Do you have help at home with your other child so you can rest and devote yourself to breastfeeding?
- Are you aware of breastfeeding support groups in the community? Would you like me to refer you to one of them?

Information you would like to receive:

5. Would you like to know if the production of milk will be affected and therefore the success of breastfeeding if you supplement in the middle of the day, for example in the morning when breastfeeding is not so easy since you have to take care of the other baby?
6. Wouldn't it be better for your mother-in-law to continue to have the other baby some hours of the day even if you are on maternity leave, at least until the breastfeeding situation is normalized?

Thoughts-Ideas/ Concerns/ Expectations

- You really want to breastfeed, but on the other hand you think it will be difficult with your son claiming you and without help. You've decided to try, but you don't know how you're going to succeed. It's also the afterwards, with going back to work that is stressing you out, but also immediately that the other child might feel neglected.
- You are worried that your husband will not support you, as he is under pressure at work due to your absence and will want his peace and quiet when he returns home. He tells you to do what is easiest for you and your eldest son and "what's the point in stressing" and

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"go ahead and breastfeed now, how will you manage when you have to go back to the office" and "what will happen to the baby if he gets sick once in a while".

- Your mother-in-law says she will support you and help you with the older baby and with the daily cooking. However, since you got home yesterday she has been making comments that the baby *"won't get off your back and maybe she can't get enough"*. She has no breastfeeding experience herself and finds the whole thing strange. But she really wants to help you.
- From what little you have read on the internet, you have realised that breastfeeding is difficult at first and you may encounter various issues, so it would be good to have guidance from a specialist.

Expected reaction and behaviour of the midwife and how to approach her

The script brings together elements of both information gathering (*"what are your concerns, how do you feel about breastfeeding and how do you cope with the challenges of breastfeeding a newborn while caring for another child, what is your daily life like and what support you can get from your family and environment, what are your expectations regarding breastfeeding"*) as well as providing information (*"what are the benefits and challenges of exclusive breastfeeding, what practical management tips you could try, how you can combine exclusive breastfeeding with breastfeeding in the first stage, what are the consequences of mixed breastfeeding if you think it is best suited to your family circumstances and how you can combine breastfeeding with formula feeding gradually"*).

The emphasis should be on the EY's skills to include to some extent elements from all stages of the three-talk model of shared decision-making. In particular, it is expected from the EY (midwife-midwife):

- Acknowledge, without judgment, that feeding the baby is a personal decision for which there are alternatives and solutions, and that your concerns are important and should be taken into account (**OPTION TALK: identifying alternatives**)
- Explain that it is important to have comprehensive information about the options you have and the solutions you can try and that you do not have to rush into deciding to stop breastfeeding, even if you choose to supplement, making it clear that he/she is available

to discuss and think about some solutions (**TEAM TALK:** *support consultation and relationship building*)

- List in a simple and understandable way some practical ways of managing exclusive and mixed breastfeeding, with a clear reference that any decision should be made after comparing the disadvantages and advantages of each option, not so much in terms of the benefits of breastfeeding for you and the baby, but in terms of the extent to which they meet your concerns (**OPTION TALK:** *providing information about the alternatives*)
- Show empathy and make a genuine effort to understand your concerns, preferences and expectations, while making an effort to incorporate these thoughts into the decision making that is appropriate to your situation and that you feel you can adopt, encouraging you to draw up a step-by-step plan together, setting small and achievable goals, which you can review along the way (**DECISION TALK:** *highlighting and incorporating preferences*).

In detail,

- The midwife should take the time to listen to you, without being judgmental and without starting from the beginning to promote the benefits of breastfeeding, in order to first understand your expectations and concerns about the practical issues you are facing.
- After investigating the 'problem', it is expected to provide guidance and advice based on updated evidence-based recommendations for successful breastfeeding, and clarify any misconceptions that may exist.
- She is expected to provide support in a non-judgmental and impartial way (avoiding comments such as "*breastfeeding is the best thing you can do for your child*", or "*don't listen to anyone*" (including her partner) and suggesting practical solutions e.g.e.g. how best to involve the other baby in the breastfeeding process, how to activate your support network, try pumping, if is something you would like to try even if you had a bad experience last time, etc.
- It is expected to help you suggest and/or think together about possible "solutions" that you might try, without mentioning personal opinions and/or personal experiences. The information and advice provided should be tailored to your individual situation, as well as encouraging discussion of your thoughts, concerns, preferences and/or decisions with her support network.

- The decision to breastfeed is yours and is based on what you want and what works best for you. Expect her to suggest that you set small goals (e.g. not thinking about what you will do when you go back to work) and that you work out some kind of gradual plan together for the immediate next period which you may review once you need to, continuing with exclusive breastfeeding, and then if you change your mind and choose mixed feeding you can adjust it, or even stop breastfeeding.
- He is expected to acknowledge the difficulties (and not to sugarcoat things), to stress that your psychology is important, and so is rest, so if you decide to supplement, it is good to do so in accordance with your plan.

Depending on the response from the , your reaction will be the same, i.e,

- If the midwife shows **interest in the issue that is troubling you**, without making critical comments, then you express your concerns openly and honestly, and answer the questions she asks to explore the problem and its background in depth.
- **If it lists all the possible options you have** (exclusive breastfeeding, exclusive breastfeeding with pumping for some hours so that the pumped milk is given by another caregiver, or mixed or formula feeding), and the possible impact each option has on your daily life (e.g. fatigue, time and connection with the infant), without directing you which one to choose, but supporting you to think about and follow the one that best meets you and your expectations, then you are cooperative and actively participate in the discussion, explaining which suggested solutions you think are good and could be tried.
- If the midwife **does not explore interest and depth** the issues that concern you with and/or criticises your own attitude, then you will not be able to share your concerns, you will lose interest in the discussion and will focus on the fact that *"breastfeeding is demanding and you have to supplement, even though you don't want to, since you have to spend time with your son"* (which is your main concern).

Other reactions

- **Understanding:** In case you do not understand what he is saying and explaining, you will interrupt by asking for clarification. If he/she uses obscure words and terms, and/or does not follow a clear structure in the conversation and/or does not answer your questions clearly or is rambling in his/her answers, you will bring him/her back, insisting on your thoughts.

- Interesting: if at any stage he/she shows that he/she just wants to tell you what he/she wants to tell you, or shows great zeal to provide information, but without giving you the opportunity to ask what you want and/or to make sure you understand the information he/she is giving you, then say that "you didn't quite understand", "if he/she can repeat" or even "question the correctness" of what he/she told you.
- Empathy/ Empowerment: If he/she shows that he/she is not interested in you bringing up your concerns and/or does not show empathy and creates guilty feelings, then show concern and aloofness and simply thank them by stating "ok, I don't know, I'll see how it goes then".

Desirable scenario outcome

A flexible breastfeeding plan is set based on the mother's needs and circumstances A follow-up appointment is set at a reasonable time to evaluate the plan and discuss any new questions and challenges that arise. Additional ways and resources for support in the community (e.g. Pancyprrian Breastfeeding Association) are also listed. This ensures ongoing support along the breastfeeding pathway while empowering her to make informed decisions based on experience and changing needs.

ANNEX G3: Feedback guide based on the Calgary-Cambridge model

Guide Communication Skills Convergent Feedback (based on the guide CALGARY - CAMBRIDGE)

Script: Exclusive Breastfeeding and formula feeding in the first days of life

OPENING OF THE MEETING - Communication bases		
1. Recommendations: greet the woman in a cheerful manner and try to include a partner if she is at home	2. Presentation of self, role/role and reason for visit	3. Physical comfort of the woman/baby. Sitting opposite at the right distance/appropriate position
4. Showing genuine interest in the issue and preparation for today's meeting	5. Problem identification and clarification with an open-ended question	6. Negotiating an agenda - what want you to discuss, and whether it meets her needs
COLLECTION OF INFORMATION - Content		
7. Emotion exploration and validation	8. Background investigation and date experience to	9. Inhibiting and confirming effort
10. "Starting point": (a) Past experience	(b) Breastfeeding management	(c) Supporting framework
11. Non-judgmental : (a) exploration Thoughts/ideas	(b) Concerns/worries	(c) Expectations/desires
INFORMATION Gathering - Communication Techniques		
12. Encourage her to share in her own words her concerns and breastfeeding experience so far,	13. Use of open & closed questions, starting with open, then clarifying questions	14. Active listening, without interruptions, allowing time for reflection, questions, etc.
15. Facilitate verbal responses e.g. repetition, examples, paraphrasing & non-verbal	16. Use of pauses, repeating where necessary and continuing the questions	17. Summary at times for confirmation, encouraging clarification or other information
PROVISION OF INFORMATION - Communication techniques		
18. Providing information in small sections & slowly	19. Use of simple and understandable language	20. Summary & confirmation of understanding - teach-back
21. Provide opportunities for the woman to (a) actively participate in the discussion with questions and queries	(b) by encouraging her to share her own thoughts, ideas, and concerns	(c) & encouragement to consider options, express preferences and/or doubts
PROVISION OF INFORMATION - Content		
22. Providing information on (a) benefits of exclusive breastfeeding, identifying difficulties & challenges	(b) advantages/disadvantages of alternatives and consequences of formula administration	(c) ways of maintaining production milk (e.g. pumping, if desired)
23. Providing input (e.g. support from community groups, support from family members)	(b) and for options saction , such as ways to employ an older child	(c) pumping, if this will help to involve family members in care/time with the other baby
24. Encourage discussion with partner & supportive for realistic/applicable environment	25. Recommendation for phased feeding plan & review based on changing needs	26. Negotiation of a mutually acceptable plan management for childcare/continuing breastfeeding
STRUCTURE DEVELOPMENT		
27. Logical sequence of topic development	28. Linking explanations	29. Clarity of questions/information
RELATIONSHIP BUILDING		
30. Non-verbal behaviour: eye contact, facial expression, posture, position and movement, rhythm of speech, volume, tone of voice, vocal cues	31. Empathy: showing genuine interest in emotions, importance of the decision and recognition of challenges	

Evaluation by a Simulated Actress - The Health Professional ...		
Showed sincere interest, acceptance without judgmental attitude, understanding of the problem	Provided clear information and practical advice, helping to compare options	Investigate my preferences and took into account the applicability of the proposed "solutions"

Scenario "Breastfeeding management in the first days"

Session objectives:

The aim is to encourage the mother to describe her concerns so that she can make decisions that meet both her breastfeeding expectations and the demands of her daily life with respect and support in whatever she chooses.

It is expected that any misunderstandings that may exist will be clarified in a well-founded, non-judgmental way and that the issues of concern to the lechois will be explored (*open-type questions and active listening to explore the problem and closed-type questions where necessary*) and that the questions she has will be answered in a targeted way, provided that the "problem" is taken care of first, proposing solutions.

Understanding the woman's expectations of breastfeeding (starting point), the EY is expected to explain that it is not necessary to make an immediate decision (e.g. to stop breastfeeding), encouraging her to continue exclusive breastfeeding, but not simply by listing the benefits of breastfeeding for the baby and herself, but by exploring with her whether she thinks she could adopt some management practices for exclusive breastfeeding.

- Indicatively, practical advice can be given on how best to manage exclusive breastfeeding in the first few days, how to activate the supportive environment, as well as advice on how best to supplement, if this is what the woman eventually chooses.
- Ideally the midwife is expected to explore and evaluate the feasibility of proposed solutions, and together draw up an incremental flexible plan which they can revise as they go along that meets the challenges of everyday life, and
- It would also be good practice to mention additional ways and resources of support in the community.

The scenario brings together elements of information gathering ("what are the woman's concerns, how she feels about breastfeeding and how she copes with the challenges of breastfeeding while caring for another child, what is her daily life like and what support she can get from her family and environment, what are her expectations") as well as information provision (e.g. "what are the benefits and challenges of exclusive breastfeeding, what practical tips for managing the challenges she could try, how she can combine exclusive breastfeeding with caring for the other child, how pumping could involve other people in caregiving, what are the consequences of mixed breastfeeding, and how she could combine breastfeeding with formula feeding gradually").

The emphasis should be on the EY's skills to include to some extent elements from all stages of the three-talk model of shared decision-making. In particular, it is expected from the EY (midwife-midwife)

- Recognize, without judgment, that feeding the baby is a personal decision for which there are alternatives and solutions, and that the woman's concerns are important and should be taken into account (**OPTION TALK: recognizing alternatives**)
- Explain that it is important to have comprehensive information and not to rush into deciding to stop breastfeeding, even if she chooses to pump or even supplement, making it clear that he/she is available to discuss with her (**TEAM TALK: support consultation and relationship building**)
- Provide in a simple and understandable way practical ways of managing exclusive and mixed breastfeeding, with a clear reference that any decision should be made after comparing the disadvantages and advantages of each option, and its applicability to the woman's circumstances (**OPTION TALK : providing information on the alternatives**)
- Show empathy and make a genuine effort to understand the woman's thoughts, concerns and expectations, while making an effort to them incorporate into the decision making process, encouraging her to draw up a together step-by-step plan, setting small and achievable goals, which they can review along the way (**DECISION TALK: highlighting and incorporating preferences**).

ANNEX G5: Proposed management scenario "challenges with breastfeeding in the first days" by ChatGPT

ChatGPT's suggestion: Role Play Scenario for Shared Decision-Making on Breastfeeding

Scenario Overview:

The mother, **Maria**, has recently delivered her third child. She is three days postpartum and is struggling to exclusively breastfeed while managing the demands of her other children. Maria expresses concern that she may not have the time and energy to meet her goal of exclusive breastfeeding and is contemplating mixed feeding as a practical solution. She seeks advice from the midwife.

A midwife's practical advice for Maria, who wants to achieve exclusive breastfeeding but is considering mixed feeding due to the challenges of caring for her toddler, would focus on **personalized, manageable strategies**. The advice would align with current guidelines (e.g., WHO, NHS, or local policies) and aim to balance Maria's well-being with her breastfeeding goals.

Objectives of the Scenario

Enhance Shared Decision-Making (SDM) Skills:

- Facilitate an open and respectful conversation about Maria's preferences, concerns, and goals.
- Provide evidence-based information about breastfeeding and mixed feeding.
- Help Maria weigh the pros and cons of her options to make an informed decision.

Build Empathy and Rapport:

- Ensure the mother feels supported and understood.
- Acknowledge her emotional and physical challenges postpartum.

Provide Practical Advice:

- Suggest strategies to make exclusive breastfeeding more manageable.
- Explore flexible feeding schedules and support systems.

Promote Informed Choice:

- Empower Maria to make a choice that aligns with her values and circumstances, without pressure or judgment.

Key Skills to Demonstrate

Active Listening:	• Reflect Maria's concerns to show understanding: "It sounds like you're feeling torn between wanting to breastfeed exclusively and meeting your toddler's needs."
Empathy and Validation:	• Use affirming statements: "You're doing a wonderful job navigating this busy and challenging time. Let's explore ways to make things easier for you.", "Whatever you decide, you're doing what's best by thinking carefully about your family's needs."
Tailored Guidance/Personalization:	• Adapt advice to Maria's specific situation, such as her support network and available resources: "Who do you have nearby that can lend a hand with your toddler or other household tasks?"
Avoid Pressure	• Reinforce that there's no "one right way" and that her mental health and overall well-being matter just as much.

Encouragement	• Celebrate small wins: "Even a few feeds a day make a difference for your baby. Every bit counts."
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expected outcome

- Maria **feels heard, supported, and empowered** to make a decision about feeding that suits her family's unique circumstances.
- A **flexible feeding plan** is established, with a follow-up appointment scheduled to review progress and address any new concerns.

Healthcare provider's step-by-step approach

Step 1: Build Rapport and Explore Concerns	Opening Statement: "Hi Maria, congratulations on your beautiful baby! I understand this time can feel overwhelming, especially with two more children at home. Let's talk about how I can best support you with feeding your newborn and balancing your other responsibilities."	Key Questions: "What are your goals for feeding your baby?" "What challenges are you currently facing with breastfeeding and caring for your toddler?" "Have you tried any strategies so far, and how have they worked for you?"
Step 2: Provide Information and Validate	Acknowledge Feelings:	"It's completely normal to feel stretched thin right now. You're doing an amazing job, even just by trying to figure out what works best for you and your family."
	Evidence-Based Advice:	- Explain the benefits of exclusive breastfeeding (e.g., immunity, bonding) while acknowledging the practical challenges. - Provide reassurance that partial breastfeeding or mixed feeding can still offer significant benefits if that's the best option.
Step 3: Offer Practical Solutions	Suggestions for Exclusive Breastfeeding:	- Develop a breastfeeding schedule that fits Maria's routine. - Suggest techniques to involve her partner or other family members to care for the toddler or assist with household tasks. - Demonstrate positions or methods that allow her to breastfeed while interacting with her older child.
	Discussing Mixed Feeding:	- Explore mixed feeding as a potential compromise. Explain how to maintain milk supply while supplementing with formula if needed. - Emphasize the importance of tailoring the approach to Maria's comfort and family needs.
Step 4: Engage in Shared Decision-Making	Decision Framework:	"Let's look at the options together. What feels most realistic for you right now? We can adjust the plan over time as things settle." - Use a decision aid if available, highlighting her choices visually.

	Agree on a Plan:	• "Would you like to try this approach for a few days and then revisit how it's working for you?"
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Breastfeeding Decision Aid

Here is a simple **decision aid** tailored to Maria's situation, which can help her visualize her options and the implications of her choice. This format supports shared decision-making in a clear, structured way.

your goals

- Ensure your baby gets the best nutrition.
- Balance the needs of your newborn and toddler.
- Maintain your mental and physical well-being.

your options

Option	Benefits	Challenges	practical solutions	Action Plan Suggestions
Exclusive Breastfeeding	• Maximizes breast milk benefits for immunity and bonding.	• Demands significant time and energy.	• Create a breastfeeding schedule. • Use hands-free nursing positions. • Ask for family support with toddler care & household tasks.	• Use breastfeeding-friendly toddler activities (e.g., reading a story while feeding). • Consider a baby carrier for hands-free feeding while managing household tasks. • Pump milk for a nighttime bottle feed that someone else can handle.
Mixed Feeding (Breast + Formula)	• Reduces breastfeeding pressure. • Keeps some breast milk benefits.	• Risk of reduced milk supply. • May feel like a compromise to goal.	• Use formula for one or two feeds a day. • Prioritize breastfeeding during the times you feel most relaxed or connected, such as mornings or evenings.	• Start with a single formula feed daily while maintaining breastfeeding during times when you're most comfortable or rested. • Ensure proper latch and milk removal during breastfeeding to maintain supply.
Switching to Formula	• Frees up time for toddler care. • May reduce stress and fatigue.	• No breast milk benefits. • May feel like a departure from your goal.	• Gradually transition to formula if needed. • Focus on bonding during other activities like skin-to-skin cuddles.	• If formula becomes necessary, introduce it gradually to ensure your baby adjusts well. • Use the extra time to focus on self-care or bonding with your toddler.

Making a Decision

Key Questions to Reflect On:	follow-up plan
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-
- What matters right now: maintaining exclusive breastfeeding, balancing your time, or reducing stress?
 - What support do you have available to help with feeding and toddler care?
 - How do you feel about using formula as part of your feeding plan?
 - **Review Together:** Set a follow-up appointment in a week to check how the chosen plan is working.
 - **Adapt As Needed:** Reassess if your goals or circumstances change.

Practical Advice for Maria

1. Managing Breastfeeding with a Toddler

Engage the Toddler During Feeding:	● Suggest quiet activities the toddler can do nearby, such as reading, coloring, or puzzles. ● Use breastfeeding time as an opportunity for bonding by telling stories or engaging in play that doesn't require active movement.
Involve the Toddler:	● Frame breastfeeding as a special time for the family. For example, let the toddler "help" by passing a burp cloth or sitting next to Maria.

2. Optimising breastfeeding

Feed on Demand When Possible:	● Encourage frequent feeds to stimulate milk production, particularly in the early days. ● Prioritize nighttime feeds, when the house is quieter, and hormones promoting milk production are highest.
Express Milk for Flexibility:	● Teach Maria how to use a breast pump to express milk. This provides flexibility for someone else to bottle-feed her newborn, allowing her to rest or attend to her toddler.

3. Support for Managing Both Children

Partner or Family Involvement:	● Suggest that Maria ask her partner or family members for help with the toddler's care during breastfeeding sessions.
Create a Routine:	● Recommend establishing a predictable schedule for feeding, napping, and activities to reduce stress and improve time management.

4 Exploring Mixed Feeding as a Backup Option

Maintain Milk Supply:	● If Maria chooses to incorporate mixed feeding, advise her to continue breastfeeding or pumping during peak milk production times (e.g., early morning).
Start Gradually:	● Introduce formula for one feed per day to test how it fits into her routine and adjust as necessary.

5. Self-Care and Mental Health

Rest When Possible:	● Remind Maria that breastfeeding can be physically demanding and emphasize the importance of resting whenever possible.
Avoid Guilt:	● Reassure her that a healthy, happy mother is more important than meeting any specific feeding goal. All her efforts to breastfeed, even partially, are valuable.

Acknowledgment of the use of Artificial Intelligence (AI) tools

We acknowledge the use of ChatGPT to produce the present document with the intention of presenting to participating midwives how AI would approach the communication skills scenario presented to them.

Prompt used: (1) Suggest a role-play scenario for shared decision making on the topic of breastfeeding with a mother of two, five days after the birth of her second child, needing practical advice for achieving exclusive breastfeeding but concerned that the demands of taking care of a toddler might not allow her to achieve that goal and is considering mixed feeding. Focus on the objectives of such a scenario and how the midwife is expected to handle the situation, (2) What practical advice would the midwife give the new mother in this situation, (3) Create a decision aid to help with presenting the options.

Communication skills of Health Professionals:

Self-assessment on the basis of the tool

Health Professionals Communications Skills - CSS-HP©

Dear Colleague,

Effective communication plays an important role in the quality of obstetric care provided. Of course, there are many and varied **barriers and challenges** that do not always allow health professionals to achieve effective communication in the clinical setting. *This is to be expected and completely understandable.*

This is why continuing education and professional development is important in enhancing and developing advanced communication skills. In the context of communication skills training programmes and/or for feedback purposes in the clinical setting, structured observation tools are most commonly used to assess and provide feedback on communication skills. As we did in today's workshop!

At the same time, self-assessment tools for the communication skills of health professionals have been developed in parallel. One of these is the **Health Professionals' Communications Skills Scale (CSS-HP©)**, which has been developed through an integrated methodological process by Leal-Costa et al (2016) from the University of Murcia, Spain.

Leal-Costa, C., Tirado, S., RodríguezMarín, J., y van-der Hofstadt, C.J. (2016). Psychometric properties of the Health Professionals Communication Skills Scale (HP-CSS). *Clinical International Journal of and Health Psychology*, 1, 76-86. <http://dx.doi.org/10.1016/j.ijchp.2015.04.001>.



Image source: educational Baby Buddy Forward webapp platform (copyright)

Instructions for use

The **Health Professionals' Communications Skills Scale (CSS-HP®)** tool consists of 18 statements, which are grouped into 4 dimensions (subscales):

- **Respect:** three items (1, 3, 15) assessing the degree of respect shown by the health professional for the needs, autonomy and rights of the beneficiaries of care
- **Information:** six items (5, 8, 9, 14, 17, 18) and reflects how health professionals collect and provide information.
- **Empathy:** five elements (2, 4, 6, 11, 12) reflecting the ability of health professionals to understand the feelings of the people they care for and to make their empathy evident by demonstrating active listening skills.
- **Social skills:** four items (7, 10, 13, 16) reflecting the ability of health professionals to demonstrate social skills in the clinical relationship they establish with the people they care for, e.g. agenda negotiation.

Section A is about your own self-assessment. It will help you to identify what your strengths are and where there is room for improvement.

In Section B, the questions are repeated with reference to all midwives as a professional group - i.e., how would you rate your colleagues in terms of their efforts to develop effective communication with pregnant women.

- Read each question and think about what is "" true *usually* in your situation.
 - There is no right or wrong answer - only your honest answer!
- The challenges are many and varied. After all, this is why the response scale refers to a frequency from 1 = "*Almost never*" to 6 = "*Almost always*".
 - So that you can think about the '*frequency*' with which you develop and/or are enabled to develop effective communication, as the tool recognizes the difficulties that exist in the context of clinical practice.
- The reference point is answer 4 = "*as a rule*". This represents the case where this statement is generally valid, even though some exceptions to the rule are to be expected.
 - Answers to the right of the point refer to the case where more effort is made to systematize implementation and minimize such exceptions,
 - Answers to the left of the point refer to cases where the application is less systematic.

SECTION A: Self-assessment of Communication Skills

In my communication with women (pregnant women), in daily clinical practice...	A l m o s t n e v e r	R a r e	S o m e t i m e s	A s a r u l e	M o s t o f t h e t i m e	A l m o s t a l w a y s
1. I respect the right of women to express themselves freely .						
2. I explore the feelings of the women I care for						
3. I respect the freedom and autonomy of the women in my care						
4. I show interest when a woman talks to me through non-verbal communication (such as eye contact, voice cues, posture, gestures, smile, etc.)						
5. I provide information and answers to women's concerns (as far as my professional status allows me to do so)						
6. I listen to women without prejudice and regardless of their appearance, temperament or way of expression						
7. I express my opinions and wishes clearly to women						
8. When providing information, I use silence (e.g. frequent pauses) to allow the woman to absorb what I am saying						
9. When providing information to the women I care for, I use understandable terms (e.g. simple language)						
10. When a woman does something that doesn't seem right, I express my or discomfort disagreement						
11. I take time to listen and try to understand women's needs						
12. I try to understand the feelings of the women I care for						
13. In my interaction with women, I express my views clearly and unequivocally						
14. I believe that it is every woman's to receive information about health/care right						
15. I feel that I respect the needs of women						
16. I find it difficult to make demands of the women I care for (e.g. setting the agenda of the conversation, seeking cooperation, etc.)						
17. I make sure that women have understood the information provided						
18. I find it difficult to gather information from the women I care for (e.g. background, thoughts, concerns, expectations)						

SECTION B: Overall assessment of midwifery colleagues

When communicating with women (pregnant women) in daily clinical practice, I believe that <u>perinatal health professionals (colleagues)</u> ...	A l m o s t n e v e r	R a r e	S o m e t i m e s	A s a r u l e	M o s t o f t h e t i m e	A l m o s t a l w a y s
1. Respect the right of women to express themselves freely .						
2. Explore the feelings of women caregivers						
3. Respect the freedom and autonomy of women caregivers						
4. They show interest when a woman talks to them through non-verbal communication (such as eye contact, voice cues, posture, gestures, smiling, etc.)						
5. Provide information and answers to women's concerns (as far as their professional status allows them to do so)						
6. They listen to women without prejudice and regardless of their physical appearance, temperament or way of expression						
7. Express their views and wishes clearly to women						
8. When providing information, use silence (e.g. frequent pauses) to allow the woman to absorb what is being said						
9. When providing information to caregivers, use understandable terms (e.g. simple language)						
10. When a woman does something that doesn't seem right, they express their or discomfort disagreement						
11. They take time to listen and try to understand women's needs						
12. Try to understand the feelings of the women they care for						
13. In their interaction with women, they express their views clearly and unequivocally						
14. They believe that it is every woman's to receive health/care information right						
15. Respect the needs of women						
16. They find it difficult to make demands (e.g. setting the agenda of the discussion, seeking cooperation) of women caregivers						
17. Do women ensure that they have understood the information provided?						
18. They find it difficult to gather information from the women they care for (e.g. background, thoughts, concerns, expectations)						

*Improving communication is **an on-going** process,
which is achieved through continuing professional development.*

Key elements: Self-evaluation, Feedback, Reflection!



Coordinator: Department of Nursing, School of Health Sciences, CUTU



Τεχνολογικό
Πανεπιστήμιο
Κύπρου

Τμήμα
Νοσηλευτικής

The translation, adaptation and evaluation of the Greek version of the questionnaire was carried out in the context of a postgraduate thesis in the MTX programme in Obstetrics of the CUT (Marina Papapetrou), after obtaining the necessary permission from the manufacturers of the tool (Leal-Costa et al) and from the National Bioethics Committee of Cyprus for its use for research-educational purposes (EEBC ΕΠ 2023.01.214).

The adaptation of the questions to refer to the assessment of the communication skills of colleagues (instead of the individual answering it), as it appears in Section B, was initiated by the research team of the Department of Nursing, CERC. It is not included in the original scale, which only refers to the self-assessment of the individual and not of all perinatal health professionals as a professional group.

ANNEX I - Evaluation questionnaire of the training workshop.

EVALUATION OF THE TRAINING WORKSHOP FOR CULTIVATION OF EFFECTIVE COMMUNICATION SKILLS in the context of MATERNITY CARE WITH RESPECT

Please take some time to answer the following questions. Your feedback will make an important contribution to improving our training seminars.

1. Please rate each of the statements below on different aspects of the programme, giving your answer on a scale of 1 to 5, where:

1 = Strongly disagree

5 = agree



The level of difficulty was demanding but at an acceptable level

The training material was useful

The choice of the scenario was appropriate

The role-playing was interesting

The feedback was constructive

2. What do you think are some of the positive aspects of the training programme?



3. Which elements do you think could be improved? Please share your suggestions to improve these elements?

(a) Need improvement



(b) Recommendations for improvement



4. List 3 important take-home messages that you took away from your participation in the workshop:

(1)

.....

(2)

.....

(3)

5. Rate each of the statements below on a scale of 1 to 5, where:

1 = Strongly disagree

5 = agree



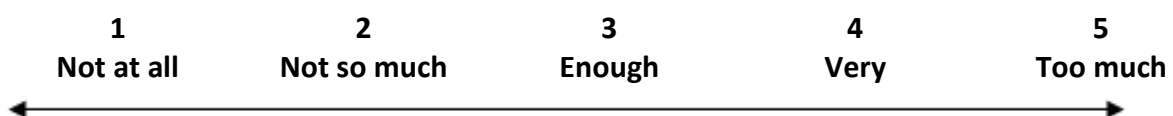
The workshop will help me to reflect to identify elements of my communication skills that need

I will integrate information, knowledge and skills gained from the training into my daily practice

I feel more confident to aim for effective communication with the women I care for

I would recommend the training workshop to colleagues

6. Please mark on the scale below from 1 = Not at all to 5= Very much, how useful you found your participation in the workshop overall:



Thank you very much for your participation!



ANNEX I - Indicative slides of seminar presentations.

Every decision needs a MILL

... and the best choices are always the ones served on ICE!



Με τη συγχρηματοδότηση
της Ευρωπαϊκής Ένωσης

The views and opinions expressed are solely those of the authors and do not necessarily represent the views of the European Union or the European Commission (EU.)The European Union and the European Commission - EU cannot be held responsible for the views expressed.

Project name: Toward a culture of Respectful Maternity Care (RMC): Enhancing Shared Decision Making and Informed Choice in Cyprus and Croatia

Project acronym: RESPECT

Project number: 101096681

Project duration: 1/4/2023-31/3/2025 (24 months)

Call: CERV-2022-DAPHNE