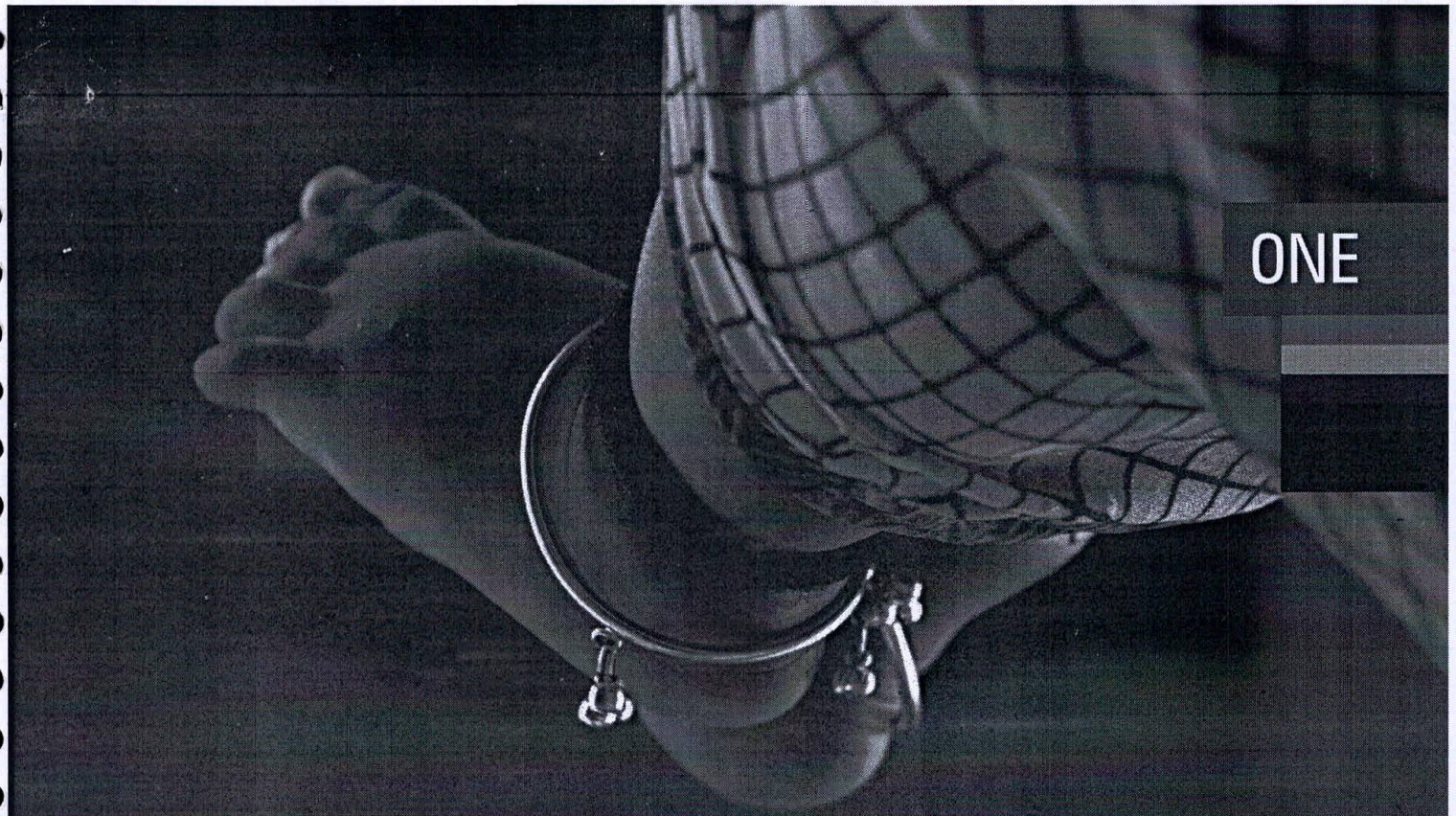

ONE

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Community Level Interventions For Improving Maternal, Neonatal And Child Health: A Training Tool Kit

DESIGN, PLANNING AND IMPLEMENTATION OF THE SUKSHEMA PROJECT

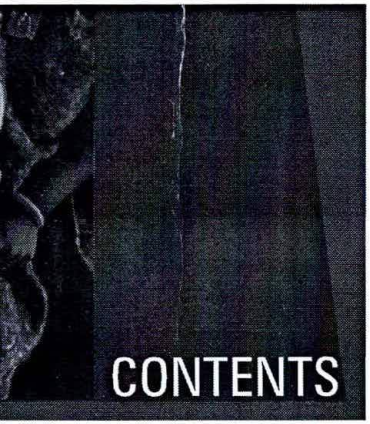
1

Community Level Interventions For Improving Maternal, Neonatal And Child Health: A Training Tool Kit

DESIGN, PLANNING AND IMPLEMENTATION OF THE SUKSHEMA PROJECT

ಸುಕ್ಷೇಮ
sukshema
Improved Maternal, Newborn & Child Health

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन



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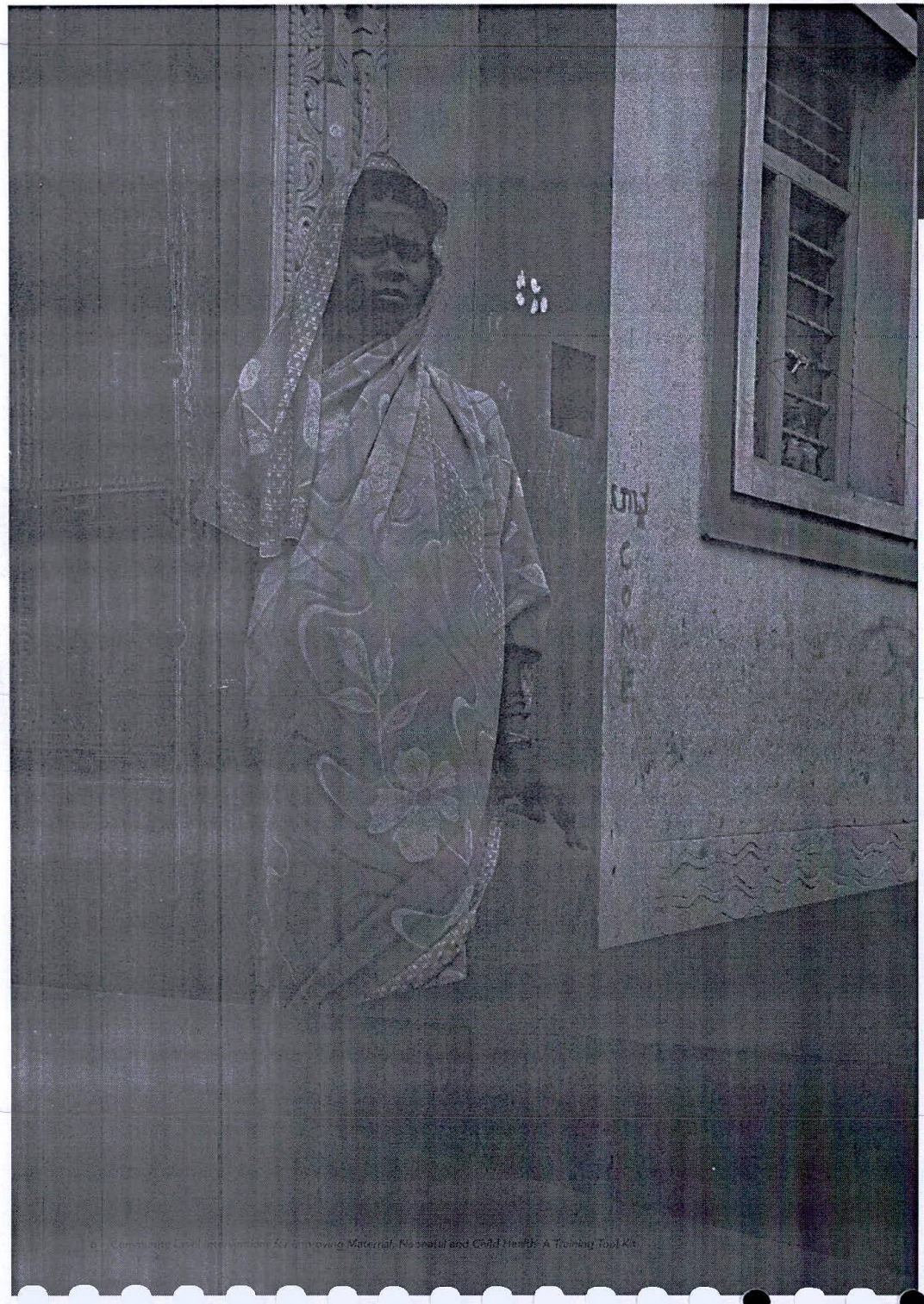


ACRONYMS

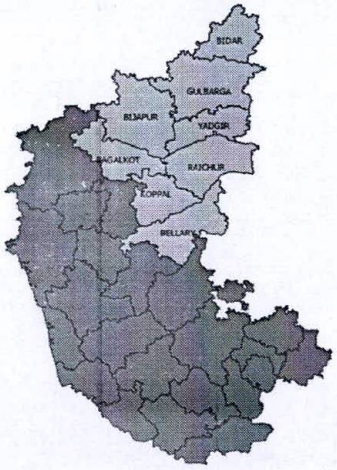
ANC	Ante Natal Care
ARI	Acute Respiratory Infection
ARS	Arogya Raksha Samitis
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BCC	Behaviour Change Communication
BPL	Below Poverty Line
CBO	Community Based Organization
CDL	Community Demand List (CDL1) Tool
DOH	Department of Health
EDD	Expected Date of Delivery
FLW	Frontline Health Worker
FP	Family Planning
FRU	First Referral Unit
GoK	Government of Karnataka
HBMNC	Home Based Maternal Newborn Care
IEC	Information, Education, Communication
IMR	Infant Mortality Rate
IPC	Inter Personal Communication
JHA	Junior Female Health Assistant
JSY	Janani Suraksha Yojana
JHA	Junior Female Health Assistant
KHPT	Karnataka Health Promotion Trust
MDG	UN Millennium Development Goals
MMR	Maternal Mortality Rate
MNCH	Maternal, Newborn and Child Health
NGO	Non-Government Organization
NRHM	National Rural Health Mission
PHC	Primary Health Centre
PNC	Post-natal Care
PRI	Panchayat Raj Institution
RP	Resource Person
SBA	Skilled Birth Attendant
SC	Sub Centre
SC/ ST	Scheduled Caste/ Scheduled Tribe
SCM	Supportive Community Monitoring
SHRC	State Health Resource Centre
SHS	State Health Society
SRS	Sample Registration System
TBA	Trained / Traditional Birth Attendant
TT	Tetanus Toxoid
VHW	Village Health Worker
VHSNC	Village Health and Sanitation Nutrition Committee

1. INTRODUCTION

1.1 BACKGROUND OF THE SUKSHEMA PROJECT

India launched its National Rural Health Mission (NRHM) in April 2005 to tackle the high burden of maternal, neonatal and child morbidity and mortality in India's rural populations. Key aspects of the NRHM are its enormous scale, its focus on extending services to the rural poor, and its inherent flexibility for introducing innovative approaches for improving health system responses to improve maternal, newborn and child health (MNCH) outcomes.

Congruent with the NRHM's objectives and approaches, the Bill & Melinda Gates Foundation's (the Foundation's) Maternal and Neonatal Health (MNH) Strategy seeks to improve MNCH outcomes in the world's poorest regions by catalysing health system responses to ensure that critical, proven interventions during pregnancy and in the neonatal period reach underserved populations. While the NRHM provides a broad canvas with processes and funding mechanisms to achieve health goals, the Foundation's strategy focuses on a critical technical intervention package to enhance the performance of health systems. The Foundation has awarded funds to the University of Manitoba and the Karnataka Health Promotion Trust (KHPT) to support the Government of Karnataka (GoK) to develop and implement strategies to improve MNCH in alignment with the NRHM's objectives and approaches.



Sukshema project districts

The Sukshema project was designed and planned to focus on improving the availability, accessibility, quality, utilization and coverage of critical MNCH interventions among the rural poor in eight priority districts in northern Karnataka: Bagalkot, Bellary, Bidar, Bijapur, Gulbarga, Koppal, Raichur and Yadgir.

The goal of the Sukshema project is to support the GoK to improve MNCH outcomes in rural populations through the development and adoption of effective operational and health system approaches within the NRHM. To achieve this goal, the project is designed to integrate and align key aspects of the Foundation's MNH strategy with the NRHM's health system infrastructure and mechanisms in the eight project districts, with the following four key objectives:

1. Enable expanded availability and accessibility of critical MNCH interventions for rural populations.
2. Enable improvement in the quality of MNCH services for rural populations.
3. Enable expanded utilization and population coverage of critical MNCH services for rural populations.
4. Facilitate identification and consistent adoption of best practices and innovations arising from the project at the state and national levels.

The project had two phases: planning and implementation. The 12 month planning phase was intended to: 1) carry out various assessments related to project objectives; 2) design implementation models for improving availability, quality and coverage of the interventions; and 3) develop health system responses necessary to implement the models. The 48 month implementation phase focuses on supporting the NRHM to implement and assess strategies for delivering the intervention package, and translating knowledge developed through the project for wider dissemination, as well as advocacy and adoption of key elements by the NRHM at state and national levels.

2. GAPS IN MNCH SERVICES

The assessments carried out under the project have indicated that critical gaps in the availability, accessibility, quality, utilization and coverage of MNCH services exist at three levels: health system, facility and community. level. The latest available data on maternal mortality rate (MMR) is for the period 2010-12. During this period, the MMR of India was 178 per 100,000 live births. The latest infant mortality rate (IMR) for the country as per the Sample Registration System (SRS) 2012 was 42 per 1000 live births, which had decreased from 47 in 2o10 and from 50 in 2009. The Maternal Mortality Estimation Inter-Agency Group - WHO,UNICEF,UNFPA, World Bank report titled "Trends in Maternal Mortality: 1990 to 2010" ranked India 126 out of 180 countries in ascending order of MMR. As per the report published by UNICEF in 2012 titled "Committing to Child Survival; A Promise Renewed" India ranked 45 out of 195 countries in the world in descending order of IMR. Although much effort has gone into health system strengthening, such as enhancing the functional abilities of staff nurses, providing job aids and checklists to simplify their work, improving the drug supply and strengthening referrals, there are a number of gaps that still exist.

2.1 GAPS IN AWARENESS AND GENDER

Currently, there is a lack of awareness in the community on healthy practices and available services for the mothers and newborns through the MNCH continuum of care. Often existing cultural practices and beliefs, and insufficiently informed decisions, become barriers to access of MNCH services. The findings from Sukshema's assessment of community facilitators and barriers for utilization of MNCH services have re-confirmed that the practices related to pregnancy, delivery, and post-natal care, as well as the decisions to seek care, are institutionalized within the family. The elders in the family, particularly the mothers-in-law and the mothers, as well as the husband, play an important role in decisions on seeking care, as well as in perpetuating unhealthy practices. Therefore, the Sukshema project plans to focus not only on the pregnant woman or new mother, but to also target family members and the wider community. Otherwise, its MNCH activities would only be partially successful.

The status of women in Indian society must also be taken into account when looking at the situation of maternal and child health. Before pinning all the blame on poor awareness levels among women, it is important to look at other factors that either directly or indirectly affect a woman's health during the MNCH continuum of care stages. In rural India the family members have a bearing on all aspects of an individual's life. Members of the family, especially the male and the elderly, generally make decisions for the rest of the family. These decisions are usually based on "family values" and what is considered socially "appropriate", rather than based on individual needs and facts.

For example, several cultural and traditional beliefs that exist in rural and even some pockets of urban India drive women and families to make decisions that are more often detrimental to the health of the women and the child. There are prevalent myths and misconceptions about pregnancy, delivery, new mothers and child care. The preference for sons leads to repeated abortions and poor birth spacing. The belief that hard work during pregnancy will help prevent caesarean deliveries. The belief that more blood loss after child birth means more body impurities are expunged, thus keeping the body slim after delivery. The belief that the first breast milk (actually very rich in colostrum), is impure because of its yellow colour, so the newborn should not be fed with it. All of these misconceptions have been culturally intertwined within families and are repeatedly reiterated by the elders in the family.

Studies have shown that the father, mother, husband, in-laws, grandfather and grandmother, living together in an extended family situation, exert a tremendous influence on the pregnant woman, leaving her with little option but to succumb to the pressure and submit to their decisions.

Addressing awareness about the larger gender realities is essential to build a holistic perspective of MNCH. Thus, the Sukshema project plans to offer an intensive training that brings front line health workers (FLWs) together and leads them through a process of critical thinking, reflection and evaluation of issues around MNCH and gender-social perspectives.

2.2 GAPS IN COVERAGE AND OUTREACH

In the MNCH continuum of care, existing data indicates that the coverage of target populations is poor and inequitable. More than half of all maternal and newborn deaths occur during childbirth and the first few days of a baby's life; this is also the period when health coverage is lowest. An effective MNCH continuum of care focuses on two dimensions in its provision:

- Time; recognizing the need to ensure essential services for mothers and children during pregnancy, childbirth, the postpartum period, infancy and early childhood.
- Place; or linking the delivery of essential services in a primary health care system that integrates home, community, outreach and facility based care. The impetus for this focus is the recognition that gaps in care are often most prevalent at the locations – the households and community – where care is most required.

Available data indicates that the coverage of target populations for MNCH services is poor and inequitable: there are unreached populations for many services, and those who are reached do not receive a complete package of services through the MNCH continuum of care from antenatal to child care. For instance, as per the DLHS (District Level Household Survey) for northern Karnataka, while 74% of pregnant women received tetanus toxoid (TT) injections, fewer than 27% received the full set of ANC visits. Similarly, only 52% of recently delivered women received a postnatal care visit within 48 hours of delivery. A large proportion of certain populations, particularly migrants, and those belonging to scheduled castes and tribes, seem to be left out of the registers maintained at the Sub Centres (SCs). While the proportion of institutional deliveries has risen in recent years, only a small proportion of mothers stay for 48 hours after delivery in facilities. As per the state Health Management Information Systems (HMIS), only 38% of women delivering in institutions during August 2010 -July 2011 stayed for at least 48 hours after delivery.

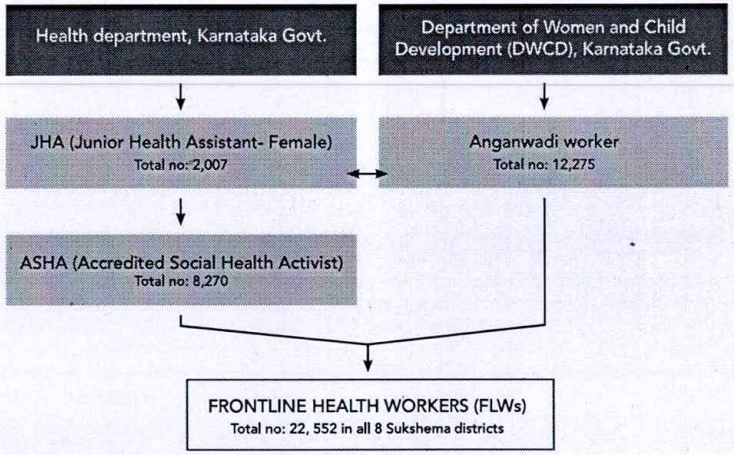
In order to ensure that services are rendered at the right time and place, there needs to be a plan to maintain and track the beneficiaries of maternal and new born services. Currently there is no standard format for planning services. A critical gap in outreach includes unreached target populations such as migrants, poor families, those belonging to the Scheduled Caste/ Scheduled Tribe (SC/ ST) community. Very often these marginalised groups are left out due to social and cultural factors along with the practical difficulties in reaching these groups. Even if they are targeted, not all services reach them due to lack of individual-centred assessments and lack of focus on prioritizing hard-to-reach populations. This renders the MNCH programme inequitable.

Another gap is those who are reached receive incomplete package of services that puts mothers and infants at risk of morbidity and mortality, increasing their vulnerability. This is because poor planning and monitoring, especially at the individual level, affects outreach for service delivery. Gaps caused by lack of tools and job aids for planning effective outreach, poor communication skills and absence of clear concise key messages affect the health seeking behaviour among the target populations, resulting in poor access of all services across the MNCH continuum of care. All of these challenges point to the need for building capacity to provide services.

Another important factor is the underlying role of the larger community to be aware of the issues and barriers to maternal and child health at the village level and exercise responsibility and accountability to reduce maternal and infant deaths. The process of ensuring increased coverage should provide ample space for the community to participate and develop ownership. Effective outreach therefore is a result of skilled and well trained FLWs equipped with the needed tools and job aids, and an aware community that supports and owns this effort.

2.3 GAPS IN ROLES AND RESPONSIBILITIES

Community outreach activities in providing MNCH care services is of utmost importance. Strong outreach means increased coverage for services and improvement in the demand and the accessibility of MNCH services. At the community level the FLWS, including the Junior Female Health Assistant (JHA), the Accredited Social Health Activist (ASHA), and the Anganwadi Worker (AWW) all play a vital role in providing the health services related to pregnant women, nursing mothers and newborns.



In Karnataka State, the term Junior Female Health Assistant (JHA) has now replaced the role of the Auxiliary Nurse Midwife (ANM). The JHA plays a multitude of roles including:

- Informing women about the side effects of immunisation, importance of breast feeding, maternal and new born care at home, permanent and temporary family planning options
- Enrolling pregnant women and filling in "Thayi" card during the registration
- Explaining immunisation process to new mothers and giving TT injections
- Measuring the blood pressure of pregnant woman, checking the weight of the child after delivery and giving iron tablets 5 months after delivery
- Educating about nutritious food, hygiene and institutional delivery to the woman
- Providing Information to the pregnant woman about the benefits of scanning
- Providing information about the government schemes available to 1st and 2nd delivery mothers
- Referring pregnant women with complications to higher care centres
- Conduct deliveries in case of emergencies in the sub centres
- Conducting home visits
- Educating the family about home based care needed for the new born baby, especially with low birth weight
- Providing information to nursing mothers about precautions to be taken to avoid infection
- Collecting blood samples if the pregnant woman or the nursing mother has a fever

The Accredited Social Health Activist (ASHAs), being members from the neighbourhood, are the community resources to facilitate a positive change in awareness and practices around maternal and child health through the continuum of care. They have been described as activists in the community who will create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services. Their tasks include outreach activities such as motivating women to give birth in hospitals, linking them to MNCH services provided by the government, mobilizing children to attend immunization clinics, encouraging family planning (e.g. surgical sterilization), treating basic illness and injuries with first aid, keeping demographic records and participating in activities to improve village sanitation. ASHAs also serve as an important communication channel between the healthcare system and rural communities.

Although the ASHAs undergo a fairly comprehensive initial training about their functions, in practice, their focus has been on referrals, or bringing people to services – particularly for institutional delivery. There has been very little emphasis and expectation from them as a change agent – in influencing awareness and practices related to critical MNCH services. There are no easy-to-use interpersonal communication materials and job-aids to facilitate ASHAs in performing the role of a change agent. There also is a need for focus on the critical MNCH issues around which the ASHAs need to work with the families to improve their awareness and practices.

The Anganwadi Worker (AWW), delivering services through the Department of Women and Child Development, focus on health education promotion highlighting nutrition. They are tasked with:

- Mobilizing pregnant women for immunisation camps
- Encouraging and motivate people to seek institutional delivery and adopt family planning methods
- Registering newborns
- Conducting home visit to give nutritional advice to pregnant and nursing mothers of children 6 months to 3 years old
- Conducting mother's meeting and nutrition camps to provide health education and distribute nutritious food for pregnant women , nursing mothers and children 6 months to 3 years old
- Keeping track of the children's weight and refer malnutrition cases to higher care centres
- Enrolling malnourished children in the Bhagyalakshmi scheme (only for the BPL card holders)
- Identifying sick children and refer them to higher care center for treatment under the "Bala Sanjeevini" program
- Conducting Balavikasa Samithi meetings
- Identifying healthy children and showcasing them in baby shows

2.4 GAPS IN COORDINATION

Although all three FLW groups were supposed to be working towards the same goal - improving MNCH - one of the key gaps that was noted in the field was the lack of coordination between them. This gap affected their relationship with each other as well as that with the community. In the field these three groups had created barriers between themselves, making sure they did not mix either personally or through their work. Rather than having the community needs drive them, it was their own department guidelines and personal differences that guided them. For example, age difference, varying work experiences, caste differences and being employed by different Government Departments kept these workers from being united on the ground for a common cause.

Although each group does have designated roles, focusing on collaborating and coordinating their roles would allow them to get more satisfaction out of their work. If they worked together they could channel their energy and efforts towards finding effective strategies to challenges and sharing burdens. For any program to be successful it is crucial that the stakeholders involved are sensitive to and supportive of each other. Therefore, while each group of FLWs has to take care of their own responsibilities, they also need to understand the responsibilities of other groups and to build effective coordination on the ground. This could create an enabling work environment for all FLWs. Working together in a coordinated manner can also help them take a united stand when faced with hurdles like non-supportive community members and families.

2.5 GAPS IN COMMUNITY SUPPORT AND ENGAGEMENT

Engaging the community in planning and monitoring health service delivery is central to enhancing the availability, accessibility, quality and use of the public health system. The NRHM has positioned community ownership as central to its strategy, primarily through the Village Health, Sanitation and Nutrition Committee (VHSNC). The VHSNCs are village-level bodies comprised of key stakeholders who serve as a forum for village planning and monitoring. VHSNCs were formed to ensure that no section of the village community is excluded from services; to prepare a village health plan to suit local realities and necessities; to provide monitoring and oversight to all village health activities; and to ensure that untied funds are appropriately used for improving maternal and neonatal health in the village. Facilitative monitoring and support to FLWs through VHSNCs to better MNCH outcomes is a feature of strengthening community accountability. As well as the VHSNCs, in Karnataka, Arogya Raksha Samitis (ARS) have been established as sub-committees of the Public Health Planning and Monitoring Committees to provide community oversight at the facility level.

A review of the existing community based bodies, their current functions, and the existing gaps and challenges suggest poor knowledge about health systems and procedures among the members, poor understanding of their role in the community, especially with regard to MNCH, and an absence of tools to help VHSNC members to systematically support the monitoring processes. Additionally, there was a felt need to change the perception of monitoring among the VHSNC members of being authoritative, probing and supervisory, to being supportive, participatory and facilitating.

Under Sukshema, as part of the community interventions, the Supportive Community Monitoring (SCM) intervention was designed, piloted and implemented in order to address the above gaps. This intervention helps sensitize and strengthen the existing community structures as envisaged by NRHM, which would in strengthens community monitoring at the village levels. The SCM intervention contributes to this process by assisting the VHSNCs to systematically and periodically assess and reflect on the key MNCH and health related indicators and processes around service delivery in their areas. This in turn contributes to their planning and ownership of the health system delivery processes on the ground.

Another key expected outcome form this process is to bridge the widening gaps between the community structures and the health service delivery mechanisms at the village level. The Sukshema project believes that improved supportive community monitoring could lead to building mutual trust between the FLWs and the community representatives, and encourage them to take joint responsibility of improving MNCH outcomes. Every village has VHSNCs in place as per the mandate of the NRHM. To form an SCM a six-member group should be selected and approved that includes the VHSNC president, representatives of FLWs, representatives from women's and youth groups, and people from the SC/ST community. In Karnataka, the NRHM has also engaged non-government organisations (NGOs) in building the capacities of these community structures. KHPT is one of these NGOs, working in Bagalkot and Koppal to build VHSNC capacity through the Samartha project.

3. INTERVENTION THEORY AND APPROACH

In line with the Foundation's MNH strategy, the Sukshema project has prioritized technical interventions and solution levers. Through piloting and field testing of innovations and adaptations, and scale up at all levels, the Sukshema project aims to improve MNCH outcomes in northern Karnataka. The broad intervention approaches and strategies are represented in Figure 1.

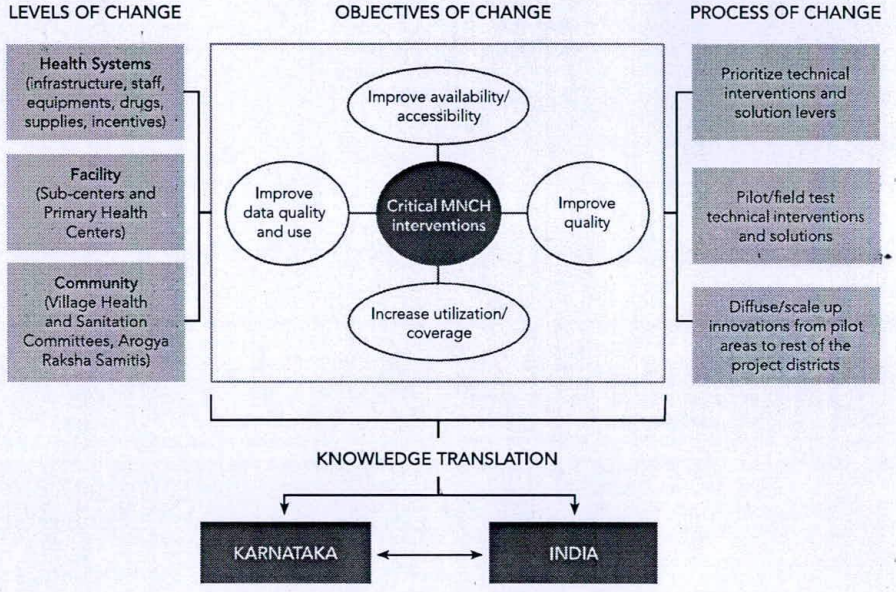


Figure 1: Sukshema intervention approach and strategy

4. SUKSHEMA'S FOCUS ON A MNCH CONTINUUM OF CARE

MNCH represents one of the greatest areas of global inequities in health, with disparities both across and within regions. Each year far too many women and infants die from causes that are both preventable and easily treatable. Yet effective interventions exist that can be delivered through well-functioning health systems, along the MNCH continuum of care. These interventions can significantly reduce maternal and neonatal morbidity and mortality.

These interventions can be broadly grouped into the following main categories: comprehensive family planning; skilled health care for women and newborns (antenatal care, quality delivery care with a skilled birth attendant, emergency obstetrics and neonatal care, postnatal care and essential newborn care); safe abortion services (where abortion is legal); and improved childhood nutrition. Sukshema's interventions and the location of the intervention (facility, community or both), are indicated in Figure 2.

The MNCH continuum of care extends from pre-pregnancy to the postnatal period and up to 12 months of age for the infant and up to 5 years for a child. However, extra focus has been given to interventions at the time of delivery and the period from 48 hours to 1 week after birth. This period represents a critical time where more than half of maternal and neonatal deaths occur. Additionally, the success of the Janani Suraksha Yojana (JSY) scheme in northern Karnataka has led to an increase in facility-based deliveries predominantly at primary health centres (PHCs), which has overburdened facilities and compromised quality of delivery and neonatal care. With over 80% of pregnant women now delivering in facilities, the project has also prioritized interventions that specifically target improved MNCH care at the facility level. The need to strengthen existing critical skilled birth and postnatal care services at PHC level is essential and very timely given the local context and shift towards facility based delivery; failure to do so will result in a critical lost opportunity to improve MNCH.

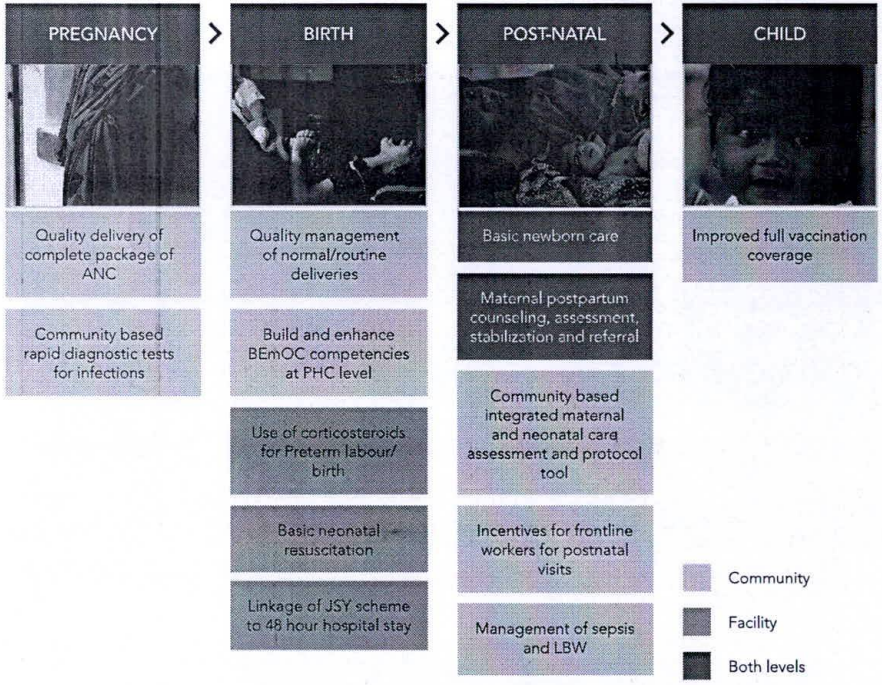


Figure 2: Interventions across continuum of care

5. SUKSHEMA'S TECHNICAL INTERVENTION PACKAGE

A key to the Sukshema project is the selection of a critical technical intervention package that is relevant to the local context and is based on strong evidence. This technical intervention package forms the basis for the improvements in MNCH that the project wishes to attain, and represents the "what" of the project. It consists of two types of interventions:

1. Primary – interventions that have been prioritized to be included in the Sukshema project due to: (a) strong evidence; (b) need for the intervention in project districts driven by current levels of utilization and coverage; and (c) fit with the Foundation's priorities; and
2. Innovations – interventions that are either new to Karnataka or need to be adapted to the local context.

After examination and discussion of the evidence from baseline surveys and secondary data, a list of possible technical interventions was prepared. The technical interventions were prioritized for inclusion if they met all of the following criteria:

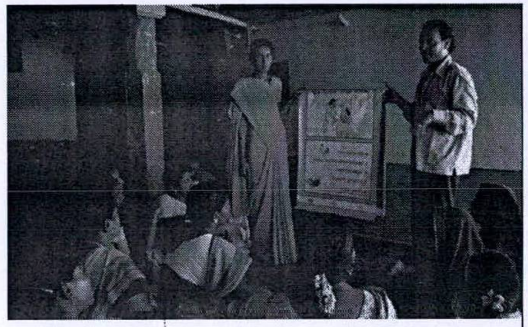
- Strong evidence of effectiveness in improving MNCH outcomes (morbidity and mortality);
- Need (poor coverage) for the intervention;
- Intervention a priority for NRHM and the GoK;
- Intervention a priority for the Foundation;
- Minimal duplication of the intervention with other programmes; and
- Feasible and scalable implementation in the local context.

The technical interventions that make up the critical package were selected because they represent a group of proven and innovative interventions that collectively address the most pressing gaps in current MNCH services in northern Karnataka. Therefore, these interventions are likely to produce the greatest improvement in MNCH outcomes in the area. Table 2 shows the level of change expected, the objective of the change and the critical gaps that fit within the solution categories.

TABLE 2: CRITICAL GAPS/BARRIERS AND SOLUTION CATEGORIES

Levels of change	Objectives of change	Critical gaps/Barriers	Solution categories
Health systems	Enable expanded availability and accessibility of critical MNCH interventions for rural populations	• Inadequate distribution of facilities and staff across populations and geographies • Inadequate availability of, supplies and equipments • Inadequate access for the rural poor to specialist services for delivery and newborn care	1. Influencing policy and planning 2. Improving capabilities of and tools for health providers 3. Engaging community in planning and monitoring 4. Shaping demand 5. Strengthening data management and use
Facility	Enable improvement in the quality of MNCH services for rural populations	• Weak clinical, managerial, and administrative competencies inhibit the ability to deliver critical health interventions and services	
Community	Enable expanded utilization and population coverage of critical MNCH services for rural populations	• Limited awareness of available services and incentives for maternal and newborn health • Cultural practices and beliefs that determine health seeking behaviour • Poor community engagement in exercising rights to quality services • Poor coverage of target populations for MNCH services– unreached target populations and reached by incomplete package of services	
Cross-cutting	Improve data quality and use	• Poor data quality and analytical skills weaken programme management delivery and improvement	

6. SOLUTION CATEGORIES AND LEVERS



6.1 PRIMARY AND INNOVATIONS SOLUTIONS

The solution levers represent the "how" of the package, i.e. these are the activities that need to be undertaken for effective implementation of the technical package. These solution levers address critical gaps and have impacts across several project objectives and technical foci. Two types of solution levers are envisaged:

1. Primary – solution levers that have been shown effective in India or elsewhere, that can be readily integrated into existing platforms and taken to scale quickly.
2. Innovations – solution levers that have less evidence to support their effectiveness, and that would need to be applied in a significantly novel way, or that involve a fundamentally different operating model. These solution levers would need targeted creation of infrastructure or new capabilities and would need to be pilot tested for feasibility of implementation and/or effectiveness.

Within each solution category, specific solution levers have been identified as key. The coloured areas in Table 3 represent community interventions, many of which are innovations.

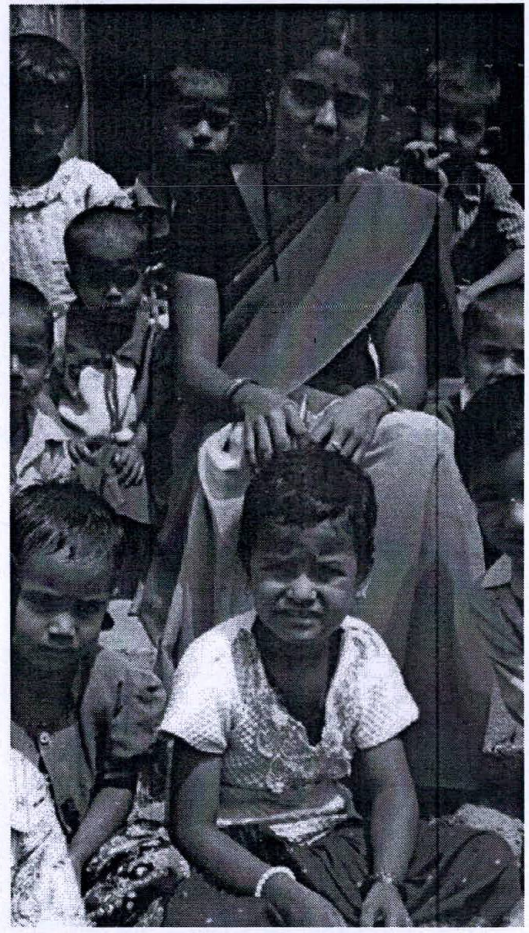
TABLE 3: SPECIFIC SOLUTION LEVERS

1. Influencing policy and planning	2. Improving quality of care at birth and immediate postpartum care at facilities	3. Improving management and delivery of outreach services and shaping demand	4. Strengthening accountability	5. Strengthening data management and use
(1) Facilitation of policy changes that respond to critical issues related to infrastructure, staff, supplies and financial incentives (2) Improvement of public-private partnerships	(3) On-site mentoring for improved clinical care and service delivery	(4) Micro-planning tools and methods to ASHAs and ANMs to improve coverage (5) Integrated maternal and newborn management tools to improve identification and actions for postnatal danger signs (6) Family focussed communication tools and materials to use with families to influence awareness and practices	(7) Community monitoring tools for VHSCs	(8) Development and implementation of data quality controls and audits (9) Development and implementation of protocols for data analysis and use for programme review, planning and problem solving

6.2 SUKSHEMA'S COMMUNITY INTERVENTION OBJECTIVES

Sukshema community interventions are designed and implemented with the following objectives:

1. To increase ***the frequency and quality of interactions*** between beneficiaries and FLWs.
2. To ensure that <u>all</u> pregnant and postpartum women, newborns and infants ***enter*** into the MNCH care continuum.
3. To ensure that <u>all</u> pregnant and postpartum women, newborns and infants ***continue*** in the MNCH care continuum.
4. Enhance participation of community-level structures in ***supporting and monitoring*** the utilization and coverage of MNCH services.



7. SUKSHEMA'S TOOLS TO IMPROVE MNCH SERVICES

A critical gap in monitoring and planning coverage for services through the MNCH continuum of care was that there were no tools and aids available for FLWs to map and track pregnant women and children. The existing tools available did not provide an integrated approach to the health of the mother and the baby and there was no focus on the FLWs to be change agents to encourage improved MNCH practices in the community. There were also no tools that could aid FLWs to screen for danger signs among mothers and newborns and to quickly link them to skilled care when needed.

To improve the coverage for routine maternal and newborn services, particularly for the SC/ST and poor families, the Sukshema project designed interventions and developed tools and aids in consultation with the FLWs to help make these interventions successful.

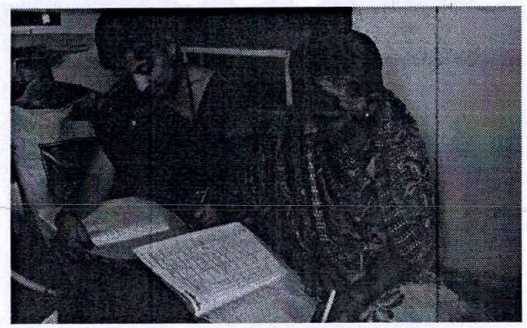
First of all, family-focused communication (FFC) is an intervention to improve the engagement and communication with community members, be it pregnant women, families or children. It aims to build rapport and trust so that the knowledge shared by the FLWs can be translated into positive behaviour change among the community members. For this to happen, every FLW needs to be trained on personality development and communication skills including convincing, persuading and positive authority over her target audience to build enabling environments. FFC Tools and behaviour change communication (BCC) materials include a diary, calendar with story-line messages on birth planning and emergency preparedness, and reminder cards – a set of cards with key messages used during home visits. Module 4 gives more details about the FFC Tools.

Secondly, an intervention designed to improve the enumeration and tracking of pregnant women was developed to improve planning for outreach services and coverage. The Community Demand List (CDL) Tool is a visual aid that replaces multiple registers, reduces manual entry of columns and is easy to carry. Using this tool, the ASHA will be able to list all the target population (pregnant women, recently delivered women and the newborns) in her allotted geographic area in a particular month, and track the same during pregnancy, delivery, 42 days post-delivery and nine months of immunization of the newborn. It will identify gaps in reaching target populations to help her plan activities accordingly, while being able to prioritise services due to selected risk and vulnerability factors such as age, caste, poverty level, migration, gravida, complications in previous pregnancies, and previous place of delivery. Module 5 gives more details about the CDL Tool.

The third intervention and tool was designed to improve comprehensive home based care through identification of complications and knowledge about suitable remedial measures. The Home Based Maternal and Newborn Care (HBMNC) Tool can improve the quality of interactions between the ASHA and the pregnant/recently delivered woman and the newborn during the antenatal and postnatal periods. It helps ASHAs remember to seek certain information from the mother about herself or the newborn. The HBMNC Tool captures the health status of the pregnant/nursing mother in the same format as the health centre, which helps the ASHA to track important care services. Module 6 gives more details about the HBMNC Tool.

Lastly, the supportive community monitoring (SCM) intervention and tool addresses the following gaps: lack of community platforms for planning and monitoring village health programs; the negative perception that monitoring is authoritative, probing and directive; the lack of ownership and accountability of the village health programs in general and MNCH issues in particular; and the widening gap between needy communities and the health service system. The Supportive Community Monitoring (SCM) Tool focuses on the VHSNC members and encourages discussion with ASHAs, AWWs, and community representatives. It also highlights the need for VHSNC members to reflect on the gaps in support they provide to FLWs focused on MNCH, availability of health staff, sub-populations that need support, and community practices and beliefs. Module 7 gives more details about the SCM Tool.

8. IMPLEMENTATION ACTIVITIES



8.1 IMPLEMENTATION STRATEGY

The Sukshema project's community intervention implementation strategy included field testing of the tools and methods in two of the projects districts, including Bagalkot and Koppal, and then scaling-up to the remaining six districts of Bellary, Bidar, Bijapur, Gulbarga, Raichur and Yadgir, based on the learning. This also included leveraging support from the GoK departments for rolling out these tools and methods.

The recruitment and training of Resource Persons (RPs) to support the FLWs was also piloted in Bagalkot and Koppal, before being rolled out throughout the Sukshema project area. The RPs included the technical leads and managers at the central office, district program specialists, and district monitoring and evaluation (M & E) specialists.

The three-day induction training covered the following topics: introduction to Sukshema's goals, objectives, technical interventions and solution levers; services to be provided throughout the MNCH continuum of care; service delivery mechanisms; and proposed interventions at the community level for the FLWs and community structures. The training method included lectures, group work and role plays.

There was a second 3-day training that took place during June 2012 for FLWs on all the components of FCC. The topics covered included: perspectives on community outreach; improving basic communication skills among FLWs; achieving coordination among all the FLWs at the village level; and skills to facilitate SC level meetings and coordination among functionaries.

8.2 DEVELOPMENT OF MATERIALS

The Sukshema project organized field testing of the developed tools and processes that would empower the FLWS to strengthen the MNCH activities in the target district. A three day tool development consultation workshop was organized that included a selected group of FLWs, ASHA mentors, VHSNC/Panchayat members, RPs, sub-district coordinators, district coordinators, the project technical leads and managers, district program specialists and district M&E specialists. The workshop participants reviewed the tools and then drafted the guidelines for use of these tools.

Selected members of FLWs were trained on how to use the tools and the initial reaction was encouraging. For example, after using the tools in the field for a few days, the ASHAs reported that the ETT tool was beginning to bring positive results with improved planning and outreach. One ASHA in Bagalkot reported that, "This is the simplest tool that we have ever used and it has drastically simplified our recording process and the burden of referring to innumerable registers has been reduced". Another ASHA from Koppal stated, *"One single woman can be tracked throughout her service cycle using this single tool. It helps us to plan our monthly home visits and also track migrant women, which had been a big challenge."*

After piloting the HBMNC Tool and the SCM Tool, the following voices reflected their usefulness. Another ASHA from Koppal said, "This training helped me to gain more clarity on the importance of prioritizing messages when we do home visits. Earlier, during each of my visits, I found myself giving the woman the same messages. This training has helped me to use it as a checklist to see if the right messages are reaching the women for the particular stage they are in." A VHSNC member from Bagalkot noted that, "Before the training we all had heard about monitoring, but we had no idea about what exactly we had to monitor to improve on MNCH in our village. The training gave us clarity on how and what to monitor."

8.3 DEVELOPING THE TOOL KIT

The aim of the Tool Kit was to develop a participatory resource that would increase the availability, accessibility, quality, utilization and coverage of critical MNCH continuum of care interventions focused on rural poor

pregnant women and their family members to improve services. Existing MNCH materials, developed through GoK programs and other development initiatives across the country, were critically reviewed by MNCH experts, KHPT staff and FLWS in the target communities. The materials adapted for inclusion in the modules of the Sukshema project's Tool Kit were then critically evaluated for relevance, applicability and usefulness to ensure that the information would be extremely relevant in the field. Then these materials were piloted.

8.4 TRAINING OF TRAINERS (TOT)

Qualified individuals who could act as Trainer of Trainers (ToTs) were identified. This group of facilitators was a mix of mid-level and senior staff who had a good understanding of the context of the field and the issues faced by FLWs. They also had experience in sharing information and transferring skills. They were trained on all six modules using the same participatory methods that they would then pass on to the FLW facilitators. FLWs who had good communication skills, a deep understanding of the context in the field, adequate knowledge of MNCH issues, and high confidence levels were chose to be facilitators.

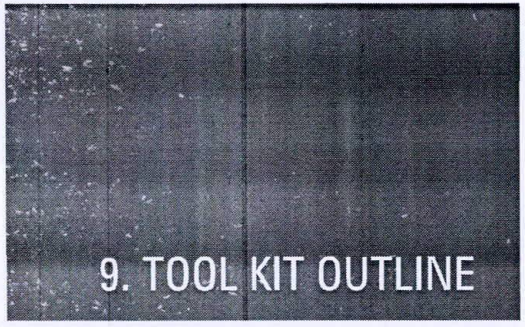
8.5 ROLL OUT AND REACTION TO THE TRAINING

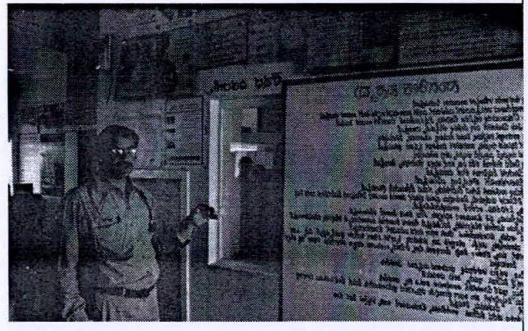
A plan to rollout the Sukshema project's Tool Kit was implemented and the results were equally as positive as with the individual tools. The FLWs were appreciative of the training opportunity, which brought all the FLWs together under one roof for the first time. The training served as an opportunity for them to understand each other's roles and challenges and encouraged mutual support for their work and their personal challenges. The training also dealt with socio-cultural issues around MNCH that helped build perspectives of the team. The following quotations highlight the positive reactions:

"In my 30 years of experience I have not attended a training of this kind. This is the first time that all three FLWs: ASHAs, JHAs and AWWs, were brought under the same roof for training. It was an excellent thing to do. We always worked in isolation and we carried our department wise differences into our work. This training helped us break that unhealthy practice" – **JHA, Bagalkot.**

"Previously, when I did home visits, my concentration was only on pregnant women and nursing mothers. At the end of this training I understood that family members also should be counselled closely as they have a great influence on women and their decisions during pregnancy and delivery" – **ASHA, Bagalkot.**

"We had very poor perception concerning MNCH issues. The training helped us see that we are working for women and not for any particular government department. We are now able to identify with the issues and struggles of women and give them support and advice" – **AWW, Koppal.**





9.1 PLANNING FOR THE TRAINING

The Tool Kit was specifically developed to strengthen the capacity of the FLWs in the eight priority districts of the Sukshema project in northern Karnataka. The project has envisaged a new workforce of local level workers designated as Resource Persons (RPs). The RPs are trained on all modules in the Tool Kit and function as ToTs for the FLWs.

The RPs not only train, but support and mentor the FLWs. It is expected that the newly trained and motivated FLWs will in turn build the capacities of the ASHAs working under different PHCs to help them improve the quality of their performance in providing MNCH continuum of care services to pregnant women, their families, and their community.

The Tool Kit should be used after recruiting the RPs. Each RP is in charge of one PHC which comprises of about 16-20 villages. The training will be conducted at the PHC or the SC level with approximately 20 to 30 participants in each training session. Local training venues for both residential and non-residential trainings should be identified to ensure easy travel and provide a comfortable stay for the participants to maximize their utilization of time. Travel Allowance (TA)/ Daily Allowance (DA) for the participating FLWs can be mutually agreed upon after discussion with the concerned GoK departments.

All the modules have been field tested with a variety of participants with varying literacy levels. The ToTs have ensured that the facilitators know how to present the information in each session so that all participants can absorb it verbally, or through the use of participatory facilitation methods. The role of the facilitator will be to determine what level the participants are at, and what information, and in which form, to deliver in the training. It is envisaged that medical staff, for example Medical Officers, either in the project staff or within the GoK's health department, could be leveraged as resource people for technical sessions.

9.2 REGISTRATION PROCESS

Before the training starts for any of the seven modules, ensure that every participant registers himself or herself. Each participant must enter their name, designation, place of work, contact number and signature in a register provided at the entrance to the training hall. Once the participant finishes entering these details, the facilitator or an assistant will distribute the training kit with a note pad, pen, and handouts of the reading material to the participants and guide them inside the hall. The facilitators need to ensure that all the participants complete the registration process.

9.3 THE SEVEN MODULES

The Community Level Interventions for Improving Maternal, Neonatal and Child Health Tool Kit is a series of seven modules:

Module 1: Design, Planning and Implementation of the Sukshema Project
Module 2: Core Concepts of Maternal, Neonatal and Child Health
Module 3: Sukshema's Community Level Interventions
Module 4: Communication and Collaborative Skills for Front Line Health Workers
Module 5: Improving the Enumeration and Tracking Process
Module 6: Home Based Maternal and Newborn Care
Module 7: Supportive Community Monitoring

Module 1: Design, Planning and Implementation of the Sukshema Project
is aimed at Resource Persons (RPs) and other developmental professionals working in the area of Maternal Neonatal and Child Health (MNCH). It gives the background of the Sukshema project and its intervention theory and approach to MNCH in reducing the infant mortality rate (IMR) and the maternal mortality rate (MMR) in eight northern districts of Karnataka. It highlights the main strategies in the project aimed at enhancing the community's engagement in improving outreach, increasing demand for MNCH services and building accountability and transparency in the service delivery systems in the field. The module explains the participatory development of tools, approaches, and training of trainers (ToTs) processes. For facilitators it gives an overview of sessions included in the seven modules of the Tool Kit, including a suggested time frame. It also sets the stage for training with guidance on facilitation, including preparation, process management, resource management, and human relations. The section 'Getting Started: Doorway to Successful Training' should always be used to start a training workshop: initially if covering all modules at one time, or as a refresher if modules are scheduled over a period of time. It contains a set plan of sessions that set the stage for the workshop activities and logistics, covering welcome, introductions, objectives, hopes and fears, and ground rules.

Module 2: Core Concepts of Maternal Neonatal and Child Health
trains the resource persons (RPs) employed by the Sukshema project on technical information on the maternal neonatal and child health (MNCH) continuum of care. This continuum includes four stages: Antenatal care – care during pregnancy; Intra-natal care – care during the delivery and first two hours after the delivery; Post-natal care (mother and newborn) – care during the first 42 days; and Child care – care of the child up to year 5. The training sessions details critical issues in the MNCH continuum of care's four stages and lays the foundation and understanding of related concepts and medical

terminologies among the front line health workers (FLWs), including the Junior Female Health Assistant (JHA), the Accredited Social Health Activist (ASHA), and the Anganwadi Worker (AWW).

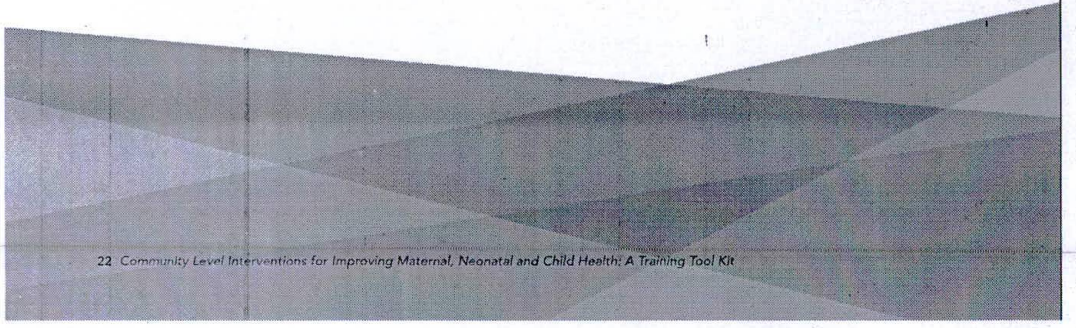
Module 3: Sukshema's Community Level Interventions
is aimed at Resource Persons (RPs) to provide an overview of the community level interventions planned under the Sukshema project. Enhancing communication is highlighted in the family focused communication intervention and the enumeration and tracking intervention seeks to bridge the gaps that occur in the Maternal Neonatal and Child Health (MNCH) continuum of care. Two other tools are introduced: one to improve the quality of interaction during home based care, the Home Based Maternal Newborn Care (HBMNC) Tool; and the other to enhance planning, accountability and monitoring of health service delivery through the Supportive Community Monitoring (SCM) Tool. This module also gives participants the opportunity to clarity roles and responsibilities of a number of field level workers in the Sukshema project and in the Government of Karnataka (GoK) health service.

Module 4: Communication and Collaborative Skills for Front Line Health Workers
focuses on the Junior Female Health Assistant (JHA), the Accredited Social Health Activist (ASHA), and the Anganwadi Worker (AWW), the three groups that are key front line health workers (FLWs) in the Sukshema's project. The module will lead them through sessions that will enhance their understanding about: gender and social issues related to the acceptability and access to Maternal Neonatal and Child Health (MNCH) continuum of care services; the importance of focussing on the family as a unit for bringing about desired changes related to MNCH practices; and addressing the gaps in coordination among FLWs in the field. Overall the module aims to improve communication skills during outreach and interactions with the pregnant woman, her family and the community through Family Focused Communication (FFC) Tools, which can help FLWs value themselves and their work, both when working independently or in a group.

Module 5: Improving the Enumeration and Tracking Process
enhances the capacities of the Accredited Social Health Activist (ASHA) and the Junior Female Health Assistant (JHA) to identify, register and track all pregnant women in her area across the Maternal Neonatal and Child Health (MNCH) continuum of care. One of the key challenges identified in the field was the absence of effective enumeration and tracking tools. This led to gaps in the number of pregnant women accessing the full extent of services throughout the MNCH continuum of care service. The Community Demand List (CDL) Tool was developed specifically to identify which women in a specific area should be given what services and when the next service is due. The practical hands-on introduction to this tool should improve utilization of all MNCH services by all pregnant or recently delivered women and their newborns.

Module 6: Home Based Maternal and Newborn Care
is a training module for Accredited Social Health Activists (ASHAs) developed to enhance their communication skills and quality of homes visits. Once the ASHAs complete the enumeration and tracking of their area, they have the responsibility to ensure that all services reach the beneficiaries. It is the ASHAs' prerogative to reach out to the mother and child through home visits to deliver information, create awareness, identify symptoms of risk early and make timely referrals. In this context the quality of home visits conducted by the ASHAs need to result in bridging the information gap to a greater extent and bring about the expected results mentioned above. This module aims to specifically improve the capacities and the skills of the ASHA to conduct effective home visits by using the Home Based Maternal Newborn Care (HBMNC) Tool.

Module 7: Supportive Community Monitoring (SCM)
aims to develop the capacity of the members of the Village Health and Sanitation Nutrition Committee (VHSNC). These members are tasked with providing support to the front line health workers (FLWs) in their village, monitor service access and delivery, as well as participate and share responsibility to improve the Maternal Neonatal and Child Health (MNCH) outcomes and general health status of their village. The module is intended to help the VHSNC members understand the concept of supportive community monitoring as opposed to authoritative supervision. It aims to help VHSNC representatives engage the community in planning and monitoring health service delivery to enhance the availability, accessibility, quality and use of the public health system. Through the formation of a smaller group of active Supportive Community Monitoring (SCM) members who are trained to carry out specific roles and responsibilities, this can be achieved. These SCM members will be trained to use a SCM Tool that allows them to conduct a regular joint reflection process, leading to community monitoring and evaluation of health delivery systems on the ground.



9.4 TOOL KIT TRAINING SCHEDULE

The Tool Kit modules have been envisaged, designed, piloted and piloted in the filed as an interrelated package of information. For effective results it is recommended that each module is presented as part of the entire Took Kit, and not in isolation. However, although a detailed outline of the Modules and the Sessions is presented below, there is scope for facilitators to adapt this training depending on the profile, background, literacy level of the participants and overall context of the training environment.

The proposed training schedule is as follows:

Module 1 Design, Planning and Implementation of the Sukshema Project
1. Introduction 1.1 Background of the Sukshema Project
2. Gaps in MNCH services 2.1 Gaps in awareness and gender 2.2 Gaps in coverage and outreach 2.3 Gaps in roles and responsibilities 2.4 Gaps in coordination 2.5 Gaps in community support and engagement
3. Intervention theory and approach
4. Sukshema's focus on a MNCH continuum of care
5. Sukshema's technical intervention package
6. Solution categories and levers 6.1 Primary and innovations solutions 6.2 Sukshema's community intervention objectives
7. Sukshema's Tools to improve MNCH services
8. Implementation activities 8.1 Implementation strategy 8.2 Development of materials 8.3 Development of the Tool Kit 8.4 Training of Trainers (ToT) 8.5 Roll out and reaction to the training
9. Tool Kit Outline 9.1 Planning for the training 9.2 Registration process 9.3 The seven modules 9.4 Took Kit training schedule
10. Facilitation approach and process 10.1 Qualities of a facilitator 10.2 Roles and capacities of a facilitator 10.3 Facilitation skills 10.4 Preparing for the training 10.4.1 Preparation 10.4.2 Process management 10.4.3 Resource management 10.4.4 Human relations management 10.5 Energizers

10.6 Recap sessions and evaluation activities	
11. Getting started 11.1 Doorway to successful training Welcome participants Introductions of participants Objectives of the workshop Hopes and fears Ground rules for the workshop	3 hours

Module 2 Core Concepts of Maternal, Neonatal and Child Health	
Session 1: Understanding MNCH continuum of care	2 hours 30 minutes
Session 2: Antenatal care (ANC)	2 hours 30 minutes
Session 3: Delivery / intra-natal care	3 hours
Session 4: Post-natal care (PNC)	3 hours
Session 5: Child care	3 hours
Session 6: Critical issues in MNCH continuum of care	1 hour
Session 7: Post-test and training evaluation and feedback	30 minutes
Total time for Module 2	**15 hours 30 minutes**

Module 3 Sukshema's Community Level Interventions	
Session 1: Understanding Sukshema's community level interventions	1 hour
Session 2: Enhancing communication and coordination using family focused communication	2 hours
Session 3: The Arogya Mantap - providing space for collaboration and discussion	30 minutes
Session 4: Bridging gaps in MNCH continuum of care through enumeration and tracking	1.5 hours
Session 5: Improving the quality of interaction in providing home based maternal, neonatal and child care	1 hour
Session 6: Enhancing accountability through supportive community monitoring	2 hours
Session 7: Staff structure, roles and responsibilities and drawing-up an action plan	1 hour
Session 8: Training evaluation and feedback	30 minutes
Total time for Module 3	**9 hours 30 minutes**

Module 4 Communication and Collaborative Skills for Front Line Health Workers	
Session 1: Underlying causes of mother and infant mortality	1 hour 30 minutes
Session 2: Understanding family focused communication (FFC)	1 hour 30 minutes
Session 3: Enhancing communication skills: five activities for FLWs	4 hours (for all 5 activities)

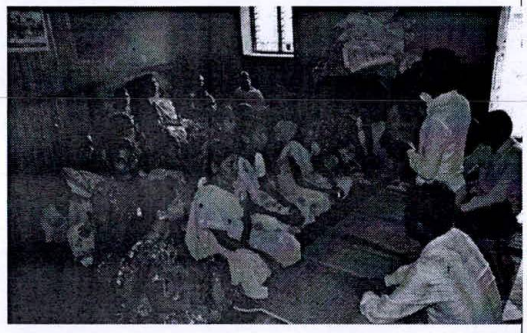
Session 4: Understanding women and their status in the society	1 hour 30 minutes
Session 5: Power walk	1 hour 30 minutes
Session 6: Developing different perspectives	45 minutes
Session 7: Maternal and child care: Then and now	1 hour
Session 8: Coordination and collaboration in the field	4 hours 30 minutes (for all 6 activities)
Session 9: Training evaluation and feedback	30 minutes
Total time for Module 4	**16 hours 45 minutes**

Module 5 Improving the Enumeration and Tracking Process	
Session 1: Community outreach for MNCH continuum of care	1 hour
Session 2: Critical role of job aids and Tools in outreach	1 hour
Session 3: Challenges in outreach	1 hour
Session 4: Introduction & practice of the Community Demand List (CDL1)Tool	2 hours
Session 5: Introduction and use of the Community Demand List (CDL2) Tool	1 hour 30 minutes
Session 6: Vulnerable groups: identification and problem solving	2 hours
Session 7: Training evaluation and feedback	30 minutes
Total time for Module 5	**9 hours**

Module 6 Home Based Maternal and Newborn Care	
Session 1: Maternal, infant and child mortality	30 mins
Session 2: Stages of service delivery	1 hour
Session 3: Front line health workers: providing MNCH continuum of care services	1 hour
Session 4: The HBMNC Tool:providing quality MNCH continuum of care services	1 hour
Session 5: Using the HBMNC Tool – Section 1 Identification	1 hour
Session 6: Providing ANC services	1 hour
Session 7: Using the HBMNC Tool – Section 2 ANC	1 hour
Session 8: Providing Intra-natal (Delivery) care services	1 hour
Session 9: Using the HBMNC Tool – Section 3 Delivery	1 hour
Session 10: Providing PNC services	1 hour
Session 11: Using the HBMNC Tool – Section 4 PNC	1 hour
Session 12: PNC home visits: Health education and counselling	1 hour
Session 13: Introducing IEC materials	30 minutes
Session 14: Practical use of the HBMNC Tool	2 hours
Session 15: Training evaluation and feedback	30 minutes
Total time for Module 6	**14 hours 30 minutes**

Module 7 Supportive Community Monitoring	
Session 1: Sharing knowledge and purpose	30 minutes
Session 2: Critical MNCH issues	1 hour
Session 3: Understanding the importance of the SCMT	1 hour
Session 4: Modalities, role and responsibilities of the SCMT	1 hour
Session 5: Understanding the SCM Tool	2 hours
Session 6: Selection of a SCMT convener	45 minutes
Session 7: Responsibilities of the SCMT members	30 minutes
Session 8: Drawing up a SCMT action plan	1 hour 15 minutes
Session 9: Quiz and training evaluation and feedback	30 minutes
Total time for Module 7	8 hours 30 minutes

10. FACILITATION APPROACH AND PROCESS



10.1 QUALITIES OF A FACILITATOR

Almost anyone can become a facilitator as long as they have the ability to acquire the right attitudes, behaviours, knowledge, and facilitation skills, and be able to apply these confidently in a workshop focused on MNCH.

Ideally, facilitators should:

- Speak the local language of the participants
- Understand the culture of the participants and the social context
- Be willing and interested in learning from the participants
- Have a basic knowledge of MNCH services and activities
- Be committed to improving the MNCH continuum of care services
- Have an open attitude to using participatory training activities/ tools to fully involve and engage participants
- Be able to plan, monitor, and evaluate the training process, or be able to acquire these skills

10.2 ROLES ANDCAPACITIES OF A FACILITATOR

Roles of a facilitator

A facilitator needs to perform several roles effectively and efficiently:

Planner: Need to be familiar with the topic, session plans, materials and training process in advance to ensure that the objective of each training session is achieved.

Advocate for participation: Need to encourage and elicit active participation of all participants to build their capacity in all areas of improving the MNCH continuum of care services

Trust builder: Need to build trust between participants and yourself, as well as between different participants and groups who may have different viewpoints and priorities, such as the FLWs.

Capacities of a facilitator

Knowledge and skills:

- Knowledge of MNCH and basic services. Facilitators should be able to provide basic and accurate information about the current situation for specific populations and how to improve outreach and increase demand for services in the field.
- Knowledge of a range of examples to illustrate the relevant social context and how to build accountability and transparency in the MNCH service delivery systems in the field to create a strengthened environment.

Attitudes and Behaviours:

- Perhaps the most important quality of a facilitator is that they acknowledge the importance and benefit of mobilizing the participants so that they want to develop the knowledge and skills necessary to carry out their job duties.
- A facilitator should also commit themselves to the principles of participation so each of the participants can fully explore their role in providing quality MNCH services.
- Facilitators should model attitudes and behaviours that are empowering rather than disempowering, enabling rather than dominating, participatory rather than excluding, flexible rather than rigid.
- There are many factors that encourage or inhibit a participant from fully taking part in workshop activities, such as language, experience speaking in public, and experience related to the topic.
  - Some FLWs have attended very few training programs. Even if they have attended a workshop/meeting, it probably would have been a traditional situation where there would have been minimum opportunity for participation in the process. The current training program is designed to be participatory in its approach.
  - Power relations related to people's social and economic position in the community can also have an effect and may affect a person's capacity to fully speak up and out during a workshop.
- To correct and balance such situations, a facilitator must create an environment that is conducive to open.discussion, sharing of experiences, and asking and answering personal questions. He or she must create an atmosphere in which everyone feels respected, safe, and encouraged to share their true views, and to listen to, respect and interact with others who might have diverging views.
- To ensure learning:
  - Use the local language as much as possible. Introduce any medical terms in English, but explain them using the local terminologies.
  - Consolidate the learning at the end of each activity, session or day. Encourage participants to describe what happened, how they felt, or reacted to it; how does it relate to their work; and how they may apply it in future.

10.3 FACILITATION SKILLS

Active listening: This means more than just listening. It means helping people feel that they are being heard and understood. Active listening encourages participation and a more open communication of experiences, thoughts, and feelings. In active listening, the person listening:

- Uses body language to show interest and understanding. In most cultures this will include nodding the head and turning the body to face the person speaking.
- Uses facial expression to show interest and reflect on what is being said. It may include looking directly at the person speaking. In some cultures such direct eye contact may not be appropriate until some trust has been established.
- Listens to how things are said by paying attention to a speaker's body language and tone of voice.
- Asks questions to show a desire to understand.
- Summarizes and re-phrases the discussions to check on an understanding of what has been said and asks for feedback.

Effective questioning: This is essential in training or facilitating as effective questioning increases people's participation in group discussions and encourages their involvement in problem-solving. In effective questioning, the person asking questions:

- Asks open ended questions, for example using the six key "helper" questions: Why? What? When? Where? Who? and How?
- Asks probing questions by following up people's answers with further questions that look deeper into the issue. Continually asking "but why...?" is useful for doing this.
- Asks clarifying questions to ensure they have understood. This can be done by re-wording a previous question.
- Asks questions about personal points of view by asking about how people feel and not just about what they know.

Facilitating group discussion: This increases the participation of all group members and ensures that a range of community perspectives and interests are included. Good facilitation skills help to improve the quality of group discussion and problem-solving. Facilitators can also help build consensus where necessary, and encourage participation and ownership of MNCH issues. When facilitating group discussions facilitators:

- Introduce themselves and the purpose and nature of the session to participants.
- Ask each person in the group to introduce themselves to each other.
- Ensure that everyone is comfortable and can see and hear each other.

- Agree with the participants on the aims of the session and how much time is available.
- Agree on 'ground rules' with participants, including the need to respect opinions and confidentiality.
- Agree with the participants on how the discussion will be recorded and what will happen to this record at the end of the session. Remember: this is 'their' process, not yours – allowing them to keep the drawings and diagrams from the session increases their sense of ownership in the process. However, taking notes and keeping copies may prove useful later.
- Help the participants to remain focused on the agreed aims of the session.
- Enable all group members to contribute to the discussion by paying attention to who is dominating discussions and who is not contributing (remember that people have different reasons for being quiet – they may be thinking deeply).
- Summarize the main points of the session and any action points that have been agreed upon.
- Thank the participants for their time and contributions and, if appropriate, agree on a time and place for a further meeting.

Parking lot: Introduce the concept of a 'parking lot'. Put a blank sheet or flip chart paper titled 'Parking Lot' at the front of the training room. Encourage participants to use the sheet to write/ post issues and questions that arise during group discussion or in any module sessions. The parking lot list allows space for other participants to discuss any listed issue during tea breaks, or lunch. Alternatively, information can be sought from other external experts or project heads and shared with all during morning recap time or afternoon evaluation periods. Ensure that all questions raised in the parking lot are answered during the training programme.

Using participatory methods and tools: Avoid didactic teaching (teacher-centred, telling facts, and assuming right and wrong answers). Instead, become familiar with participatory forms of learning. Some suggestions for including participatory methods and tools are:

For introductory sessions, when participants are just becoming acquainted, they experience tension, doubts and suspicions. A new place, new environment and new faces could inhibit their participation. So be sure to create a supportive, fun and encouraging training environment. Although participants possibly come from the same background and geographical area, and may speak the same language, they may only have a nodding familiarity with one another, and may show reluctance to acknowledge individual relationships. Therefore, a positive beginning of the training is vital for both participants as well as facilitators. It aims to bring out the background of all the participants; their interests, hobbies and talents. Without reducing this session to mere formality for eliciting the names and contacts of the participants, the facilitator should find an innovative way to conduct self-introductions so that everyone feels like they know each other and has a better understanding of the other participants. In Session 5: Getting Started, there are a number of suggested activities to start off each module.

For awareness-generating sessions introduce the topic, then use role-plays, small group discussion, case studies, simulation, and learning games to provide an opportunity to experience the concept, share reactions and observations, reflect upon implications, and consequences, discuss patterns and dynamics, develop practical and conceptual understanding and apply it to real life situations.

- Using a case study
  - Note that a case study is used to offer an opportunity to participants to understand and appreciate different MNCH issues and to facilitate discussions that help them reflect and analyse real life actions, events, episodes and experiences based on their own experiences. A case study can be used to identify what went wrong in the complex situations and gain insights on how these types of incidences can be avoided in future. Multiple cases on similar situations are used to expose the participants to different dimensions of the situation/ problem and learn new concepts. However, most situations have complex backgrounds and it is not expected that participants will be able to assess all the factors that could have contributed to a particular situation. The purpose of a case study is to generate probing questions about what might have happened and to find an empowering solution.

For knowledge-based sessions start by introducing the topic, find out what the current level of knowledge is using the brainstorming technique, then use mini-lectures to present the information, backed up with audio-visual aids such as flip-charts or PowerPoint presentations. Follow-up with an exercise to practice the knowledge that was presented, then provide a handout to recap all information.

- Using PowerPoint presentations
  - Use PowerPoint slides for a better visual impact and as a reference point and as a base for creating a better understanding in the participants. But do not limit yourself to what is presented in the slides. Explain the medical terms that are used in the presentation thoroughly, and ensure that the participants understand the pie charts or any other statistics.
  - Add as much extra information as possible to help participants understand how that point is important for them to understand in the context of their responsibility to motivate the ASHAs and JHAs to provide better service and ensure that the maximum number of pregnant women access the complete package of MNCH care services.

For skills-based sessions explain and describe the skills first, followed by a demonstration, and then hands-on practice time, either in pairs or small groups, followed by group discussion of success/ challenges with the process.

10.4 PREPARING FOR THE TRAINING

Before the training note that prior preparation is essential for effective facilitation. Note the four main aspects involved in conducting a training program: preparation, process management, resource management, and human relations management.

10.4.1 PREPARATION

Give yourself sufficient time to prepare for the workshop. Besides referring to the training materials, also take time to browse through relevant books, previous reports and articles to strengthen facilitation. Engage in research to keep you up to date with current issues linked to MNCH. A background study of a specific area where the Sukshema project operates in could lead to an awareness of existing gaps.

Be prepared for different skill levels of participants. Enlist the help of more proficient or literate participants to help those who are slower or who cannot write. If none of the participants can write, conduct the activity verbally and use pictorial representations or symbols to list their expectations.

10.4.2 PROCESS MANAGEMENT

Before the workshop the facilitator should read the entire module thoroughly to see how each session flows into the next and how all the activities are linked together to achieve the overall aim. If possible, conduct a small mock training program before the real workshop starts. Or, try to attend other training programs conducted by other facilitators. Make a note of how you would have facilitated the session in order to improve it and note the time keeping strategies and how to keep participants 'on track'.

In some sessions that use a 'mini-lecture' as a facilitation methodology, a facilitator 'script' is provided and the text is italicized and indented. Make sure you have read the background material on the topic so you will be prepared to answer any questions from the participants.

The facilitator should prepare materials and resources needed for each session well ahead of time. When you see that there is a PowerPoint Presentation (PPP) listed in the training materials, then a PPP can be prepared using the reading material in the annexures of the Tool Kit's Modules or the Information Guides in Module 6. Other materials to prepare might include flip charts, posters and handouts.

Each training session follows the same format and includes the following information:

- **Objectives:** What the facilitator hopes to achieve by the end of each session.
- **Methodology:** Teaching approaches and techniques used.
- **Duration:** Length of time for each session
- **Training materials:** Materials that the facilitator will use during the session
- **Tips for facilitators:** Gives extra information to help the facilitator have a successful teaching experience. These notes could include extra information on the session topic, reflection on how the session might proceed or what could be the potential questions/concerns that are likely to be asked by a particular audience and suggestions for replies
- **Process:** Step-by-step instructions on how to implement activities and run sessions.

To manage time, do not drag any session beyond the time allotted for it unless absolutely necessary. Frequently check to make sure the time schedule is being followed. If there is a lag in following the schedule, ask for participants support in getting back on track with the schedule and the topic. Use the "parking lot" to write and post issues that need to be considered later and not during the particular session.

10.4.3 RESOURCE MANAGEMENT

In good time before the workshop starts make sure all the logistical arrangements have been taken care of. Confirm an adequate training venue, accommodation, and food. Prior to the training make an observational visit to the venue to know more about the available facilities. If you find something lacking, you can bring it to the attention of the organizers. If you need any aides or assistants, make prior arrangements for their presence and also ensure task allocation well in advance. If any assistant facilitators or guest speakers are needed for any of the sessions, invite them early enough so they can plan and confirm their schedules.

10.4.4 HUMAN RELATIONS MANAGEMENT

Be aware that you will be the focus of attention during the training and be aware of your gestures and general conduct. During the training period, it is very important to get sufficient rest and sleep. Do not let problems or worries affect your peace of mind. Keep away from other work pressures and mentally fortify yourself to focus on the scheduled program. Begin the session with confidence and self-belief.

Starting the training program on a

a relaxed and positive note is an important first step. Many of the participants will have little or no previous experience of having attended any training program or workshop. Therefore it is only natural that they might be anxious or unsettled. Training programs are usually arranged in a secluded place to keep the participants from getting distracted. This means that the participants have to travel to get to the training site. The journey and the unfamiliar surroundings of the venue will probably add to their uneasiness. Therefore, it is essential that the participants must be in a proper frame of mind to be able to participate actively in the training sessions. They should be given time to refresh themselves physically and to prepare themselves mentally. The facilitators should strive to create a warm, cordial and relaxed environment so that the participants can feel at ease with their surroundings and with each other. This is just as important as the actual training that will follow. Interacting and building rapport with co-facilitators, Sukshema project staff and the participants as much as possible will prove very useful during the workshop.

Focus on building rapport with the participants by:

- Respecting participants' local knowledge and encouraging them to participate actively in small groups and make presentations.
- Acknowledging the value of the contribution by each participant.
- Listening carefully to what participants say and responding to questions, observations and remarks in a positive tone.
- Accepting even incomplete ideas and trying to develop the ideas further, or asking for clarification.
- Not pretending to know the answer of a particular question if you do not. Be frank and tell participants that you will get back to them with more information.
- Being alert to the possibilities of problems arising in the groups and being prepared to deal with them. Do not allow one participant to dominate the discussion, or interrupt it. Address this clearly, but without hurting the dominating participant. You might say: '"Let's give an opportunity to someone who has not spoken yet".
- Not becoming defensive, or ignoring the participant who interrupts. Instead, acknowledge the value of their input, but request them to keep their interruptions to the minimum, in the interest of the group. Suggest that the issues they raise could be discussed at length during lunch, or tea break, or once the session has ended.
- Avoiding a judgmental attitude.
- Establishing fresh rapport with the participants before starting a new session if each session is handled by different facilitators.

10.5 ENERGIZERS

The following activities and games can be used as energizers during the workshop to change the tempo of the day, keep people alert, help all participants mix with each other and make friends, revive interest levels and to help keep participants in a relaxed frame of mind. The facilitator should always ask everyone to participate, but stop the game or activity while the mood is still jovial, and make sure there is no negative competition among the participants. None of the energizers below require any materials.

Rhythmic Claps

As a relaxation exercise, this can be used to prepare the participants for the sessions, or it can be used for calling the participants attention after a break, or to bring silence whenever the proceedings become too noisy. Begin clapping after saying, "OK one, two, three clap". The group will begin by clapping their hands twice followed by three continuous claps and repeat the latter three times. Conclude with two short claps: (Tuk tuk- tuk tuk tuk; Tuk tuk- tuk tuk tuk; Tuk tuk- tuk tuk tuk; Tuk tuk!)

Dancing Index Finger

Ask participants to stand in a circle. The facilitator will tell the group to do as she does and say what she says. She will then lift up the right hand and draw attention to the index finger by folding the remaining fingers. Now twist and turn the index finger and tell the group that the finger is dancing. The entire group will follow suit to the accompaniment of the thakadimi-thakajanu tune and others will provide the chorus.

Next she will unfold the thumb and tell the group that the thumb is also dancing with the index fingers. This should be imitated by the group, again accompanied by singing of the thakadimi-thakajanu tune. Follow on with the left hand, first with the index finger and then the thumb joining in. After the group follows suit, the thumbs and index fingers of both hands should be dancing. Gradually let the body dance to the rhythm of the thakadimi-thakajanu tune.

Who is Your Favourite?

The participants will stand in a circle and each of them will draw a smaller circle around themselves. One participant must volunteer to stand in the middle of the large circle while the facilitator takes her place in the outer circle. The facilitator must now ask the participant in the middle the question, "Who is your favourite?" The participant must choose her favourite by indicating something worn by other participants. For example, she can say, "Those wearing watches are my favourite.", and all those participants wearing watches must change their place and go into someone else's place. Other favourites could include red saris and glass bangles. Each time, one participant will be left without a vacant spot and will assume the role of the facilitator in the middle to continue the game. Encourage participants to be quick in thinking and responding. If chairs are available they may be used for participants to play the game while seated instead of standing.

Rani's Choice

Invite one of the participants to come forward and declare her for the role of the Rani or Queen. The facilitator will act as the Minister to the Rani. Draw a fairly large

S. No	Energizer/game	When to be used	Number of participants	Time required
1.	Rhythmic Claps	This can be used to prepare the participants for the sessions, or it can be used for calling the participants attention after a break, or to bring silence whenever the proceedings become too noisy.	The entire group	5 minutes
2.	Dancing Index Finger	This can be used to break the monotony between sessions, or soon after lunch to enthuse the group.	30-35	10 minutes
3.	Who is Your Favorite?	This can be used to mix the group and to break the monotony between sessions, or soon after lunch to enthuse the group.	30-35	10 minutes
4.	Rani's Choice	This can be used after a demanding session to rejuvenate the group.	30-35	15 minutes
5.	Idli-vada-chutney-sambar	This is most appropriate as an introductory game to help participants get comfortable. This can be used to mix the group and to break the monotony between sessions, or soon after lunch to enthuse the group. It also helps in the formation of small groups.	30-35	10 minutes
6.	Imitation Game	This can be used to form small groups, or to mix the larger group and also to break the monotony.	30-35	10 minutes
7.	Game of Rules	This can be used to mix the group and to break the monotony between sessions, or soon after lunch to enthuse the group.	30-35	15 minutes
8.	Gandhi Thatha Game	This can be used to induce laughter among the participants and lighten the atmosphere.	30-35	5 minutes
9.	Basket on My Head	This can be used to make the participants alert and think up ideas and names.	30-35	5 minutes
10.	Follow the Leader	This can be used to break the monotony and helps the quieter participants to come out.	30-35	5 minutes
11.	In the River, On the Bank	This can be used in between post lunch sessions to energize the group.	30-35	5 minutes
12.	Number Acting	This can be used in between post lunch sessions to energize the group.	30-35	5 minutes
13.	Catch the Color	This can be used to help the participants to get familiar the surroundings.	30-35	5 minutes
14.	Chicken and Chimp	This can be used to get the participants physically active and to break the monotony between sessions.	30-35	10 minutes
15.	Blind Mice	This can be used in between post lunch sessions to energize the group and break the monotony.	30-35	5 minutes
16.	Chain Running	This can be used in between post lunch sessions to energize the group and break the monotony.	30-35	5 minutes
17.	Dance to the Beat	This can be used to help the participants open up and break the ice.	30-35	5 minutes
18.	What-ho, How-much?	This can be used to form small groups, or to mix the larger group and also to break the monotony.	30-35	5 minutes
19.	Chitty Chitty Bang Bang	This can be used to make the participants alert and break the monotony.	30-35	5 minutes

circle around the Rani and say that nobody is allowed to come inside that circle. The remaining participants will form 4 groups. They have to please the Rani by bringing simple objects desired by her and hand it over to the Minister. Each time the Rani desires something, the group bringing the desired object at the earliest will get a point. After playing the game for a while, analyse why a certain group got more marks while others got less. Explain the need for creativity combined with intelligence. Note: Before starting the game, the facilitator can brief the participant playing the Queen to start the game asking for simple things inside the room or hall. For example, one pink chart paper, four black hair clips, a pair of brown slippers and so on. Some of the commonly desired objects may be brought from outside the hall as well.

Idli-vada-chutney-sambar
Divide the participants into four groups and name the groups as Idli, vada, chutney and sambar, which are all types of south-Indian food. Ask the members of each group to hold hands and then form a circle. Now the facilitator narrates a story in which the names idli, vada, chutney and sambar are repeated randomly. Each time this happens, the particular group while continuing to hold hands, should also sit down and immediately get up. This should be repeated every time the name of the group figures in the narration of the story. This exercise is continued till the ice is broken and everyone is smiling. Note: This doesn't have to be a full-fledged story, but can also be a spur of the moment spiel. For example, "My wife, children and I went to a hotel and asked the waiter for the menu. He told us that they had idli, vada, chutney and sambar. My wife ordered idli, vada, chutney and sambar. My son ordered for two idlis, one vada and chutney, and my daughter ordered three vadas, but refused the idlis and asked only for the sambar, but not the chutney, while I ordered two idlis and chutney."

Imitation Game
The participants will form a circle and the facilitator will count off each participant from 1 – 6 giving each a name of an animal or a bird. Tell all the participants to start moving around the room and to imitate the cries and movements of the animals or birds they have been named after. For example, if it is fish, the participants must imitate swimming; in case of frogs, the participants will jump and so on. Now the participants will be asked find a partner belonging to the same group of animals or birds. For example, the facilitator will announce that all frogs must form themselves into pairs and participants with that name will jump like frogs towards other frogs and become pairs. Similarly the facilitator can ask different kinds of birds to form pairs and so on. Ensure that participants imitate the appropriate cries and movements throughout the period of exercise till pairs and subsequent groups are formed.

Game of Rules
Form two groups with equal number of members. Call two people from each group and ask them to stand on the spots already decided by the facilitator. Draw two lines a short distance away from the two spots and ask all other members of each group to stand behind these lines. Now ask the members on the two spots to stand facing each other and to then hold each other's hands and lift them up to form an arc wide enough to allow the other participants to run through it. When the facilitator announces "start", one participant from each group must run through the arc. Each participant in the group must complete their run, running back to their group to give a pass to the next member, who in turn must follow the same procedure. Continue till the last participant has completed the run. All participants are required to follow the following rules in this game:

1. They must run the course in front of their respective groups.
2. They should not touch anyone while running.
3. They must give a pass to the next group member in line.
4. All participants must stand behind their marked starting line.

Gandhi Thatha Game
The group is asked to form a standing circle and the facilitator should join the circle. It would be interesting if the facilitator could share a few thoughts on Mahatma Gandhi before starting the game. The rules are that the group must follow the cue provided by the facilitator. For example:
"Gandhi tata asks all of us to sit down."
"Gandhi tata asks all of us to remain standing."
"Gandhi tata asks all of us to do a slow jog."

Basket on My Head
All the participants must stand in circle. The facilitator should carry a basket on her head like a vegetable vendor and approach one of the participants and loudly announce her list of vegetables. The participant must instantly respond by naming the vegetables. If a participant fumbles while telling the names she has to carry the basket and continue the game. Now, she must go to another participant and announce that she is selling fruits and that participant will have to instantly come up with the right answers.

Follow the Leader
Select a leader from among the participants. She will start the game with an action or sound or both. Ask the remaining participants to imitate their leader. When the facilitator calls out "change", someone from the group will assume leadership and continue the game. Actions commonly include: dance steps, hunting gestures, or applying makeup. Stop the game after a couple of rounds. Encourage those who come forward when the change is announced. Continue the game until a sufficient number of participants get a chance to play the leader.

In the River, On the Bank
The participants will stand in two parallel lines, facing each other. Explain that all are standing on the riverbank and one step forward is the river. Participants will have to respond instantly to commands of "River" and "Bank". Start the game slowly and then increase speed as you vary the commands. Those who take a false step in response to the command will be out of the game.

Number Acting
Start the game by asking participants to speak aloud the numbers from 1 to 10. Next, the numbers will be written in the air by moving fingers, followed by arms, heads, and then the entire body, while both hands are placed on their waists!

Catch the Colour
The participants have to stand in a circle. The facilitator must loudly announce different colours one at a time. For each colour, the participants must rush towards their immediate surroundings and get something matching that colour. Those who fail to bring anything will be out of the game.

Chicken and Chimp
Divide the participants into two groups called Chicken and Chimp. Members of the two groups should form two parallel lines, standing about 5 feet apart. When the facilitator calls out "Chimp", the members from that group must run after the Chicken and catch them while they try to evade being caught. To make the game more interesting, the facilitator must keep suspense alive by starting with Chi.Chi.Chi…before saying either Chicken or Chimp! This not only creates confusion, but also makes participants more alert as they eagerly wait their turn either to catch or to run.

Blind Mice
Ask all the participants to close their eyes and slowly walk around like blind mice. They should not bang into each other. The facilitator must then ask the group to speed up their walking and finally ask them to run. Note: While playing this game, ensure that there are no obstacles on which participants can fall or hurt themselves.

Chain Running
Let all the participants stand apart and ask one to volunteer to start the game by running and touching another member. Now the other members must avoid being touched. Those who have been touched will hold hands and try to touch others. The chain will keep getting longer until the last person has been touched. Once a complete chain of the participants is formed, get them to sing a song while holding hands and moving around in a circle.

Dance to the Beat
Ask the participants if they would like to sing a song. Tell them that you will first start singing these words very softly: *daguchuku daguchuku daguchuku daguna dam dam dara dara dara dara dara dara dara*. Then ask the participants to raise their voice while singing these words. Then repeat the tune while holding their hands to be followed by head shakes. The activity should end with each member taking vigorous steps to the tune. All will join in the dancing and jumping with enthusiasm.

What-ho, How-much?
The participants will first stand in a circle and then jog clockwise. While they are moving, the facilitator in the middle should repeatedly ask them "What-ho, How-much?" while they respond with "As-much-as-you-say" while continuing to jog in the circle. Suddenly, the facilitator should say a number, for example 3. Instantly the participants have to break the circle and form a group with three members. Anyone who fails to do so will be out of the game before it starts again with a new number. Note: Try variations by saying "two and half" so that three members come together with two standing and one sitting.

Chitty Chitty Bang Bang
The participants stand in a circle and start saying numbers starting from 1. When it is the turn of the fifth participant, instead of saying 5, she has to say "Chitty Chitty Bang Bang", accompanied by a clap. This should be followed by every fifth participant (i.e., 5th, 10th, 15th, 20th and so on). If anyone just says "5", or "Chitty Chitty Bang Bang" without a clap, they have to leave the game. In that case, the next person is considered as the 5th person and is expected to follow the rules of the game.

10.6 RECAP SESSIONS AND EVALUATION ACTIVITIES

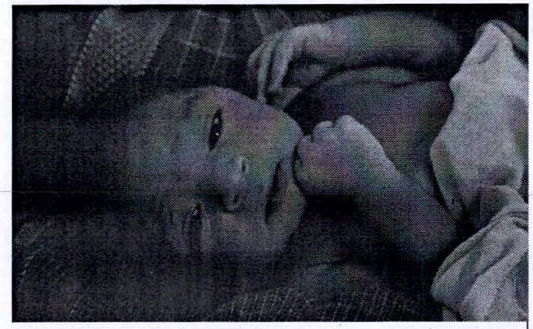
To ensure that the learning is lasting, at the start of each training day, recapture the previous day's learning. You can use a quiz format or any other interesting and innovative method for the recap.

Then after each day of training, conduct an exercise that can give the facilitator an idea about the extent of participants' understanding as a result of the day's information. One suggestion is to have a brainstorming session at the end of each day to gather insights from the participants regarding learning and to get their opinions on and reactions to what has been presented by the facilitator. The facilitator should try to analyse this feedback as soon as possible so that the participants' likes and dislikes can be taken into consideration for future sessions.

Longer-term evaluation activities enable participants to assess both the positive and negative effects of training, focused on modules or the entire workshop. Each of the modules can be evaluated through a process designed to assess the overall influence the sessions' messages had on the participants attitudes, knowledge and practice levels. A facilitator can ask participants to reflect on a number of items including: the relevance of the topics covered; facilitation style; facilitators' use of language; space to freely express one's opinions; methodologies used; scope/level of participation; handouts and materials; adequate breaks; food; and accommodation. Evaluation is also important in collecting suggestions for future training sessions.

In this Tool Kit, each module ends with a training evaluation and feedback session using a feedback form that gathers information on a number of the identified factors above.

11. GETTING STARTED



11.1 DOORWAY TO SUCCESSFUL TRAINING

Welcome Participants

Objective

To welcome participants to the training and allow the facilitator to introduce themself and briefly explain the relevance of the training, including the importance of the participants' roles.

Methodology
Mini-lecture

Duration
30 minutes

Training Materials

Welcome signs or banners

Tips for facilitators

The training facilitator makes an introduction and shares the relevance of the workshop so that the participants have a clear view of its importance.

Process

- Display a welcome sign, a banner, or a PowerPoint slide that reads 'Welcome to the Community Level Interventions for Improving Maternal, Neonatal and Child Health Training at the front of the training room as participants enter.
- Welcome the participants and any other guests who might be present to formally inaugurate the training workshop.
- Deliver a short lecture that gives information about the purpose in organizing the workshop.
- Encourage participants to ask questions for clarification.

Introduction of participants

Objective

To allow the facilitator to learn the names of participants and for the participants to become acquainted with each other in an enjoyable and relaxed atmosphere that builds trust and interest in each of the participants.

Methodology
Individual reflection and large group sharing

Duration
Approximately 45 minutes

Training Materials

As required depending on activity chosen

Tips for facilitators

It is important that everyone understands and respects each other as individual person with unique characteristics, so the introductions should not stop with only a name, but should be more intimate.

Process

- Start off by telling the participants that you would like to learn everyone's names, since you are going to be working together for several days.
- Initiate any one of the following activities:
  - **Activity 1:** The facilitator will ask the participants to pair up with someone seated close to them and introduce themselves to each other. Give each pair 15 minutes to share names, where the live, information about their family and any issues concerning their work or their community that is important to them. Ask each pair to prepare a very short skit, song or poem (2 or 3 minutes) on one of these topics. Then ask the pairs to introduce each other to the group and give their presentation. The facilitator should not make any comments on the skits, songs or poems as this is for entertainment, not judgement. However, if their presentation is too long, ask the pair to cut it short.
  - **Activity 2:** Each participant should be given a white postcard-sized piece of paper or card and a pen. Tell each participant to imagine that the card is a mirror. Ask them to draw an image of their face and hair on the card making it as life-like as possible, adding any distinguishing and individual features, such as moles, beards or eye glasses. Tell the participants that these cards will be collected and shuffled and then re-distributed to the group. The person getting the card then needs to find that person in the larger group. Once the two persons have found each other using the portrait cards give them 10 minutes to introduce themselves and get to know each other by asking and telling about their home town, profession, family, or friends. Have each pair introduce themselves to the larger group and tell how they managed to recognize that person from the drawing.
  - **Activity 3:** Participants are asked to introduce themselves by stating their name along with an adjective that describes them. The exercise can be modified by asking participants to choose an adjective that starts with the same letter as their name. (For example, I am Simple Sarita). All subsequent participants are required to repeat the names and adjectives of previous participants before stating their name and adjective. (For example, She is Simple Sarita and I am Macho Mohan). Continue until all participants have introduced themselves in this way.
  - **Activity 4:** Participants stand, or sit in a circle. Ask them to think about who they would like to be and why. They can be asked to choose from categories of famous people from history, sports, music, movies or characters who are known in the local community. Likewise they can be asked to choose their favourite fruits, colours, cartoon characters, etc. For example, if the selected category is movie actors, 'I would like to be Amitabh Bachchan because he is versatile'. If the selected category is flowers, 'I would like to be a Jasmine blossom because it smells wonderful'.
  - **Activity 5:** Ask a volunteer to stand at the front of the training room with their back to the other participants. Stick one of the participant's names on the back of the volunteer. Then tell the volunteer that he/she will need guess the name of the participant that has been pasted on his/her back by asking questions to the rest of the group to guess the name. The questions can only be answered with 'yes' or 'no' (for example, 'Is this person female?' or 'Is this person working in my area?'). The volunteer may guess at any time. If he/she is correct, then the person who answered the last question will have a new name stuck on their back, and the activity continues as before. If they are wrong, they have to continue to ask more questions. Before starting the activity, agree on either a time limit or the number of questions before you change participants.
  - **Activity 6:** Ask participants to run in a circle. Play music as they run. Ask them to stop when the music stops. Announce a number – for example 3, 4, 5. Participants should form groups of 3, 4 or 5, accordingly. Each time they meet in a group, they should share information about themselves. Encourage participants to form groups with new participants each time. The questions they ask of each other could include: name, designation, organization; favourite sweets; the person who motivates them the most; favourite colour and why, etc.
  - **Activity 8:** Read different statements. Those who agree with these statements should come forward, form a group and introduce themselves. These statements could be: I like to watch movies; I am always late to office; I have two children; I am a slow eater; I like formal clothes, etc.
  - **Activity 9:** Form two large circles with all participants - one inside the other. The participants in the inner circle should face the participants in the outer circle. Participants in the inside circle should walk in one direction and those in the outside circle should walk in the opposite direction. This way, each participant gets to face and meet a new person as the circle continues to move very slowly. When you meet a new person introduce yourself and share your area of interest.

Objectives of the workshop

Objective

To clarify the objectives of the workshop so that everyone has an understanding of the purpose and scope of the training.

Methodology
Large group discussion

Duration
30 minutes

Training Materials

Objectives listed on chart paper

Tips for facilitators

The particular module of the 'Community Level Interventions for Improving Maternal, Neonatal and Child Health Training Tool Kit' will determine which objectives the current workshop should be focusing on. For the relevant module, review each of the relevant session's aims that you intend to present in the current workshop and make a list of those objectives on flip chart paper.

Process

- Clarify that this workshop will cover material developed in the 'Community Level Interventions for Improving Maternal, Neonatal and Child Health Training Tool Kit' There are seven modules in the Tool Kit, all with a different focus.
- Display the objectives of this training on chart paper.
- Ask if there are any questions about any of the objectives.
- Display the objectives in the training room.

Hopes and Fears

Objective

To allow participants to voice their expectations and fears about participating in workshop.

Methodology
Reflection and large group discussion

Duration
45 minutes

Training Materials

Chart paper with two columns labelled 'Hopes' and 'Fears' and marking pens

Tips for facilitators

The participants may come up with a wide range of expectations, some of which may fall outside the scope of the training program. The facilitator will be responsible to clarify the scope and limitations of the workshop so that participants have a realistic view of the workshop's activities and outcomes.

Process

- Display the chart with two columns labelled 'Hopes' and 'Fears' at the front of the training room.
- Ask the group to brainstorm about what issues they want to put in each column.
- Notes their response on a flip chart.
- When the chart is filled up, go back and discuss each entry.
- Highlight any of the objectives that were discussed in the previous session and posted on the training room wall.
- Clarify any hopes that do not match with the objectives.

Ground rules for the workshop

Objective

To agree on a set of rules for the group during the training workshop.

Methodology
Large group discussion

Duration
30 minutes

Training Materials

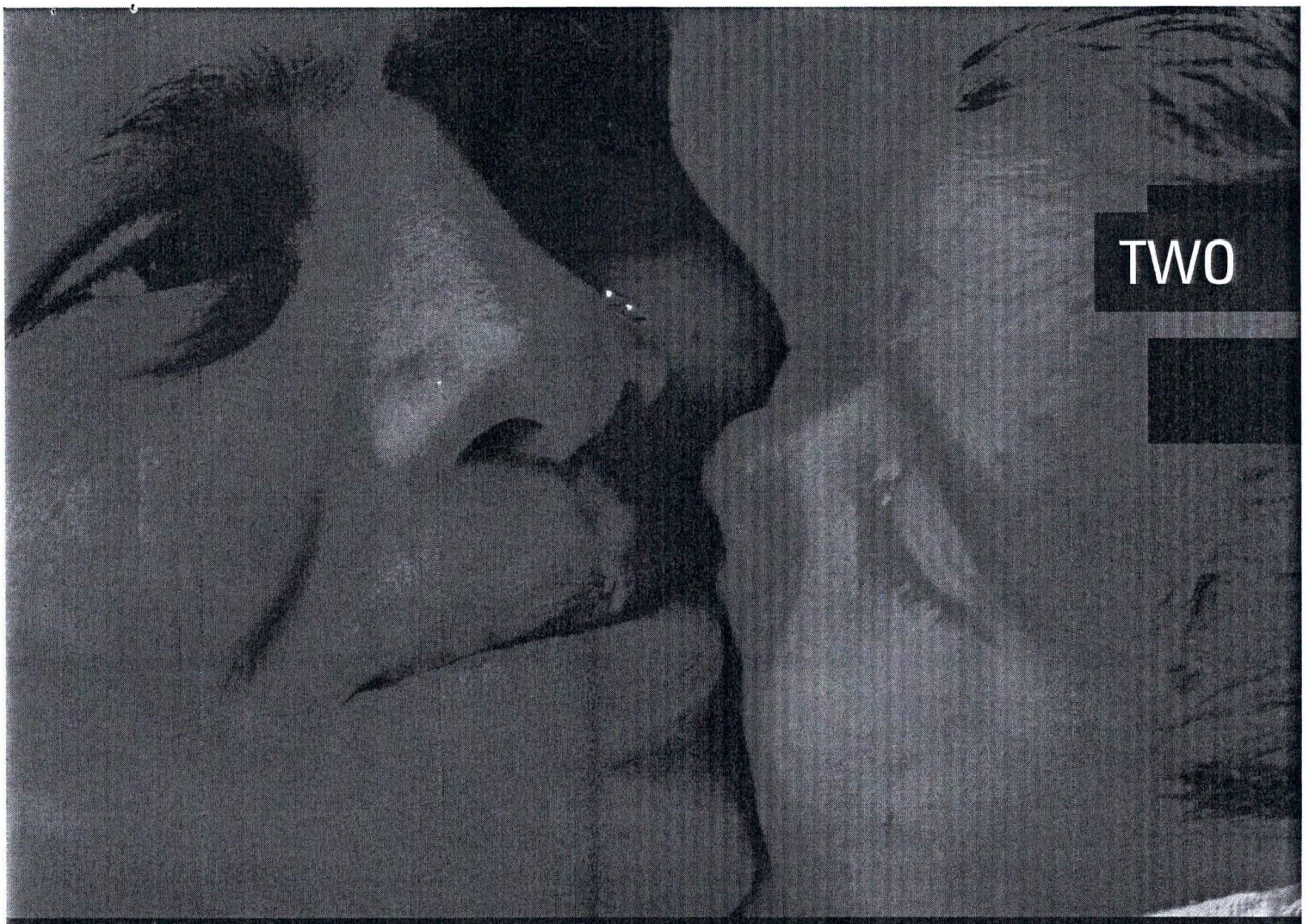
Chart paper and marker pens

Tips for facilitators

- A core list of ground rules could include:
- Need to be punctual
- Confidentiality
- Good listening practices with only one person talking at a time
- Avoiding interrupting others
- No mobile phones in training room, or at least kept on 'silent mode'
- Respect for what others are saying...not to judge or ridicule anyone
- All trying to take part actively in discussion
- Not doing things that hurt or harm others
- Accepting that each of us has a right to change our minds
- Realising that all questions are worth asking
- Regular attendance at all sessions

Process

- Tell participants that they should agree on some ground rules, or ways of preventing any group tensions or conflicts during the workshop.
- Ask for a volunteer to write down topics while participants brainstorm ideas that they would like to include.
- Once all the rules proposed by the group are on chart paper, review them again together for clarity. Read out the rules and quiz the group on how each rule will help prevent tension or conflict during the workshop.
- Ask for a show of hands that all ground rules are unanimously agreed upon.
- Ask two participants to volunteer during the workshop to help remind the group of ground rules throughout the training workshop.
- Ask them to also: help in maintaining group co-operation and discipline; act as time keepers; and to liaise with the training team in case of problems.



TWO

Community Level Interventions
For Improving Maternal, Neonatal
And Child Health: A Training Tool Kit

2 CORE CONCEPTS OF MATERNAL NEONATAL AND CHILD HEALTH

Community Level Interventions for Improving Maternal, Neonatal and Child Health Training Tool Kit: Core Concepts of Maternal and Child Health is the second module of the tool kit in a series of seven on enhancing community engagement for improving outreach, shaping demand and strengthening accountability to improve maternal, neonatal and child health outcomes in Karnataka.

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Karnataka Health Promotion Trust (KHPT)
University of Manitoba (UOM)

Dr. B M Ramesh, UOM
Dr. Krishnamurthy, UOM
Mr. Mohan HL, UOM
Ms. Prathibha Rai, KHPT
Ms. Navya R, KHPT
Dr. Suresh Chitrapu, KHPT
Mr. Balasubramanya KV, KHPT
Dr. Troy Cunnigham, KHPT
Mr. Arin Kar, KHPT
Mr. Ajay Gaikwad, KHPT
Mr. Nagaraj R, KHPT
Mr. Manjunath Dodawad, KHPT
Ms. Lakshmi C, KHPT
Ms. Sharada HR, KHPT

THE EDITORIAL TEAM:
Mr. H.L. Mohan, KHPT
Ms. Mallika Biddappa, KHPT
Ms. Dorothy L. Southern, KHPT Consultant

The photographs are by **KV Balasubramanya.** They have been used in the module with consent from the community.

Publisher:
Karnataka Health Promotion Trust
IT/ BT Park, 4th & 5th Floor
1-4, Rajajinagar Industrial Area
Behind KSSIDC Administrative Office
Rajajinagar, Bangalore- 560 004
Karnataka, India

Phone: 91-80-40400200
Fax: 91-80-40400300
www.khpt.org

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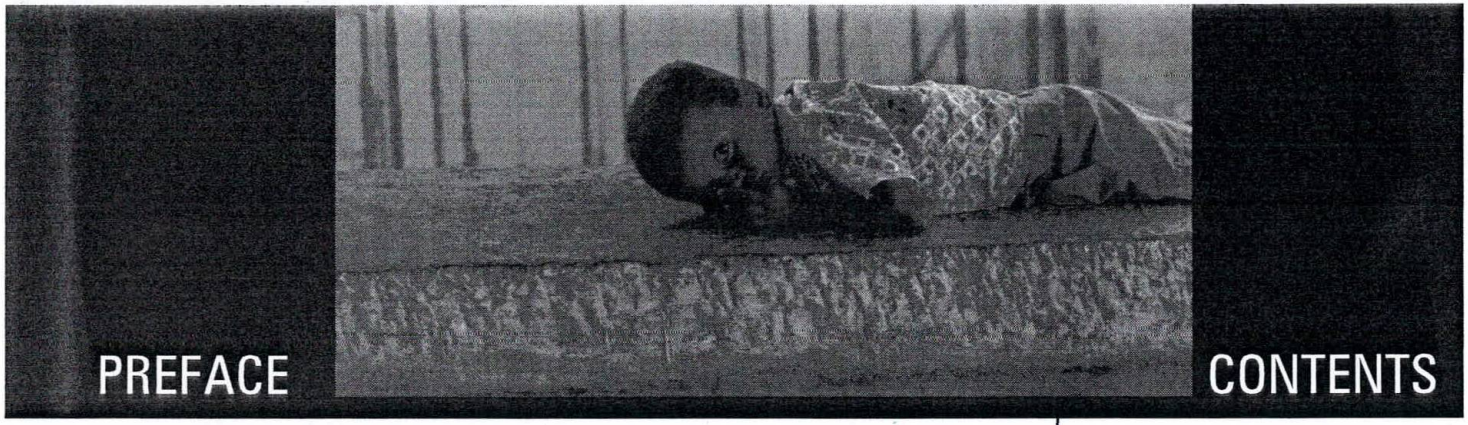
2

Community Level Interventions For Improving Maternal, Neonatal And Child Health: A Training Tool Kit

CORE CONCEPTS OF MATERNAL NEONATAL AND CHILD HEALTH

ಸುಕ್ಷೇಮ
sukshema
Improved Maternal, Newborn & Child Health

NATIONAL RURAL HEALTH MISSION



PREFACE

The Community Level Interventions for Improving Maternal, Neonatal and Child Health Tool Kit is a series of seven modules:

Module 1: Design, Planning and Implementation of the Sukshema Project
Module 2: Core Concepts of Maternal, Neonatal and Child Health
Module 3: Sukshema's Community Level Interventions
Module 4: Communication and Collaborative Skills for Front Line Workers
Module 5: Improving the Enumeration and Tracking Process
Module 6: Home Base Maternal and Newborn Care
Module 7: Supportive Community Monitoring

Module 2: Core Concepts of Maternal Neonatal and Child Health trains the resource persons (RPs) employed by the Sukshema project on technical information on the maternal neonatal and child health (MNCH) continuum of care. This continuum includes four stages: Antenatal care – care during pregnancy; Intra-natal care – care during the delivery and first two hours after the delivery; Post-natal care (mother and newborn) – care during the first 42 days; and Child care – care of the child up to year 5. The training sessions details critical issues in the MNCH continuum of care's four stages and lays the foundation and understanding of related concepts and medical terminologies among the front line health workers (FLWs), including the Junior Female Health Assistant (JHA), the Accredited Social Health Activist (ASHA), and the Anganwadi Worker (AWW).

CONTENTS

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
ARI	Acute Respiratory Infection
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BCC	Behaviour Change Communication
BEmONC	Basic Emergency Obstetric and Neonatal Care
BP	Blood Pressure
BPL	Below Poverty Line
CBO	Community Based Organization
CBR	Crude Birth Rate
CDR	Crude Death Rate
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CHC	Community Health Centre
CHW	Community Health Worker
DH	District Hospital
DOH	Department of Health
EDD	Expected Date of Delivery
EmONC	Emergency Obstetric and Newborn Care
FRU	First Referral Unit
FP	Family Planning
FWC	Family Welfare Centre
Hb	Haemoglobin
HbsAg	Hepatitis B Surface Antigen
HBNC	Home based Newborn Care
HBMNC	Home based Maternal Newborn Care
HIV	Human Immuno-deficiency Virus
ICDS	Integrated Child Development Services
ICU	Intensive Care Unit
IDD	Iodine Deficiency Disorders
IEC	Information, Education, Communication
IFA	Iron and Folic Acid
IMR	Infant Mortality Rate
IMNCH	Integrated Management of Neonatal and Childhood Illness
INC	Intra-natal Care
IPC	Inter Personal Communication
JHA	Junior Female Health Assistant
JSY	Janani Suraksha Yojana
LBW	Low Birth Weight
MDG	UN Millennium Development Goals
MMR	Maternal Mortality Rate
MNCH	Maternal, Newborn and Child Health
MNT	Maternal and Newborn Tetanus
MO	Medical Officer
NGO	Non-Government Organization
NID	National Immunization Day
NSS	National Sample Survey
NRHM	National Rural Health Mission
OPD	Out Patient Department
ORS	Oral Rehydration Salt
ORT	Oral Rehydration Therapy
PHC	Primary Health Centre
PNC	Postnatal Care
PPP	PowerPoint Presentation
PPPCT	Prevention of Parent to Child Transmission (HIV)
PPH	Post-partum Haemorrhage
PRI	Panchayat Raj Institution
RCH	Reproductive and Child Health
RKS	Rogi Kalyan Samiti
RTI	Reproductive Tract Infection
SBA	Skilled Birth Attendant
SC	Sub Centre
STI	Sexually Transmitted Infection
TBA	Trained / Traditional Birth Attendant
TH	Taluk Hospital
TT	Tetanus Toxoid
UIP	Universal Immunisation Programme
UNICEF	United Nation's Children's Fund
VHND	Village Health and Nutrition Day
VHW	Village Health Worker
VHSNC	Village Health and Sanitation Nutrition Committee
WHO	World Health Organization

GLOSSARY OF TERMS

Acute respiratory infections (ari)
The respiratory tract is an organ starting from the nose to the alveoli and organs such as the sinuses, middle ear cavity and pleura. Infection is the entry of germs or microorganisms into the human body and multiply, causing symptoms of illness and acute infection is an infection that lasts up to 14 days. Ari can be caused by viruses, bacteria or riketsia, while often a complication of bacterial infections caused by respiratory viruses, especially if there is any epidemic or pandemic. Respiratory infections are responsible for almost 20% of all under-five deaths worldwide. Any child who has a cough, is breathing faster than usual with short, quick breaths or is having difficulty in breathing, (excluding children that had only a blocked nose) should be presumed to have ari and taken to health care provider.

Amniotic cavity / sac
Amniotic cavity is the space within the uterus in which the foetus resides, bound by the amniotic membrane. The membranes which make up the sac may occasionally rupture naturally as labour begins, but usually remain intact until the end of the first stage of labour. The sac or 'bag of water' as is commonly called us filled with amniotic fluid in which the developing baby grows.

Amniotic fluid
The fluid within this amniotic cavity / sac is called the amniotic fluid. This is clear straw-coloured liquid sac helps the foetus to grow uniformly and develop bones and muscles. Babies breathe this fluid in and out of their lungs in the womb helping the lungs to grow as well. It also keeps the amnion (membrane) from sticking to the foetus.

It cushions the baby against pressure and knocks, allows the baby to move around and grow without restriction, keeps the baby at a constant temperature, and provides a barrier against infection.

Anaemia
Anaemia is the shortage of red blood cells in the body, leading to an inability of the blood to carry oxygen around the body. It is a condition rather than a disease itself. Anaemia occurs when you have a below-normal level of haemoglobin or haematocrit. Symptoms include weakness, lethargy, paleness and breathlessness. It may be caused by a lack of iron in the diet, blood loss, chronic illness, a genetic or acquired disease or defect, or it may be caused by a side effect of medication.

For any pregnant woman the haemoglobin level should be 11-16 gm hb/dl . If it is lower than this normal level it is diagnosed as anaemia. Anaemia is classified as mild, moderate or severe based on the concentrations of haemoglobin in the blood. Mild anaemia corresponds to a level of haemoglobin concentration of 09 to 10.9 g/dl for pregnant women moderate anaemia corresponds to a level of 7.0-9.9 g/dl, while severe anaemia corresponds to a level less than 7.0 g/dl.

Antenatal care
Medical care for a pregnant woman and her developing baby for the duration of the pregnancy

ASHA
An Accredited Social Health Activist (ASHA) is a community based health functionary in the rural areas. ASHAs are supposed to create awareness and provide information to the community on determinants of health such as nutrition, basic sanitation and hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilization of health and family welfare services.

Birth asphyxia
It is the medical condition resulting from deprivation of oxygen to a newborn infant that lasts long enough during the birth process to cause physical harm, usually to the brain. Hence the newborn infant fails to start breathing on its own in the minutes following birth.

Birth weight
It is the first weight of the foetus or newborn obtained after birth. For live births, birth weight should preferably be measured within the first hour of life before significant postnatal weight loss has occurred. At full term, the average baby will be about 20 inches (51 cm) long and will weigh approximately 6 to 9 pounds (2700 to 4000 grams). Any baby with a birth weight under 2500 grams is a low birth weight baby (LBW). LBW babies are usually premature as well. However, some LBW are full term, but undernourished and under-grown. LBW babies have increased risks of lung, heart and metabolic problems. They often require treatment in a special care nursery or NICU.

Caesarean section
Delivery of the baby through surgical extraction /an incision in the abdominal and uterine walls when delivery through the vagina/ birth canal is deemed unsafe is called Caesarean section.

Colostrum
A thin white opalescent fluid, the first milk secreted shortly after delivery and before mature breast milk is produced. It differs from the milk secreted later by containing more lactal-bumin and lacto-protein; colostrum is also rich in antibodies that confer passive immunity to the newborn and helps in resisting infection.

Congenital anomalies
Something that is unusual or different at birth.

Congenital malformation
A physical defect present in a baby at birth that can involve different parts of the body including the brain, heart, lungs, liver, bones, and intestinal tract is called congenital malformations. Congenital malformation can be genetic, it can result from exposure of the foetus to a mal-forming agent (such as alcohol), or it can be of unknown origin. Congenital malformations are now the leading cause of infant mortality (death) in many developed nations. Examples include heart defects, cleft lip and palate, spina bifida, limb defects, and Down syndrome.

Cord prolapsed
A condition when the umbilical cord falls through the cervix and possibly even into the vaginal canal, usually during labour or when water breaks ahead of the baby's head or other parts of the baby's body. Delivery or caesarean is usually performed immediately. A prolapsed cord is a serious emergency and can be very harmful to the baby. When the cord is compressed or squeezed (for example, between the baby and the wall of the uterus or vagina), the baby's supply of blood and oxygen is cut off. The lack of oxygen (birth asphyxia) can lead to severe damage or death if the problem is not taken care of within minutes.

Diarrhoea
Diarrhoea is a common condition that involves unusually frequent and liquid bowel movements. There are many infectious and non-infectious causes of diarrhoea. Persistent diarrhoea is both uncomfortable and dangerous to the health because it can indicate an underlying infection and may mean that the body is not able to absorb some nutrients due to a problem in the bowels. Treatment includes drinking plenty of fluids to prevent dehydration and taking over-the-counter remedies.

Diphtheria
Diphtheria is an acute infectious disease that typically strikes the upper respiratory tract including the throat. It is caused by infection with the bacteria Corynebacterium diphtheriae. Symptoms include sore throat and mild fever at first. As the disease progresses, a membranous substance forms in the throat, which makes it difficult to breathe and swallow.

Foetal distress
Foetal distress is a complication when during labour baby's heart beat becomes flat, or drops to a lower level repeatedly causing stress for the baby. Sometimes during labour and delivery the foetus may not get enough oxygen from the placenta and may become "distressed". When this happens, the foetal heart rate may show patterns consistent with oxygen deprivation.

Five cleans
A major factor contributing to neonatal and maternal infections is unhygienic delivery practices. Hence five cleans that are a must during delivery to ensure hygienic practices are:
- Clean hands - wash and wear gloves
- Clean delivery surface – take care that it is dry
- Clean cord cut – use sterile blades to cut the cord
- Clean cord ties – use sterile clips or ties and leave 2 finger length of the cord.
- Clean cord stump care – do not apply anything as there is a danger of infection / tetanus and subsequent death if proper care is not taken

Gestation
The period of foetal development from conception until birth is called gestation or pregnancy.

Total gestation period = 40 weeks
- **Full term** = 37-42 weeks
- **Pre-term** < 37 weeks
- **Post-dates** > 42 weeks

Total gestation period is divided into three trimesters –
- **1st trimester** = 0-12 weeks
- **2nd trimester** = 12-28 weeks
- **3rd trimester** = 28 to 40 weeks

Hepatitis
Inflammation of the liver from any cause is called Hepatitis. Depending on the type of virus, there are different types of Hepatitis.

Hydramnios
Hydramnios is an excess of amniotic fluid in the uterus during pregnancy.

Infant
A young baby, from birth to 12 months of age is called infant

Infant Mortality Rate
Infant Mortality Rate (IMR) is the number of deaths under one year of age occurring among live births in a given geographical area during a given year, per 1000 live births occurring among the population of the given geographical area during the same year. In other words it is the number of children dying at less than 1 year of age, divided by the number of live births that year.

Instrumental delivery
Term used to describe either a forceps or ventouse (vacuum) delivery

Kangaroo care
It means holding a baby in a skin-to-skin contact with the mother. The baby is placed on the mother's chest, dressed in a diaper and sometimes a cap. The baby's head is turned to the side so that the baby's ear is against the mother's heart. In this position the baby is able to find comfort in the mother's heartbeat and feel the mother's warmth. This procedure is limited to babies whose condition is not critical and facilitates bonding between mother and child. Kangaroo care can be done with any infant who is medically stable. Kangaroo care has been shown to have several benefits for premature babies and their mothers. It helps babies breathe and sleep better, gain weight more quickly, and have more stable temperatures. Mothers who practice kangaroo care have better milk supplies and less depression.

Labour
The process of delivering a baby and the placenta, membranes, and umbilical cord from the uterus to the vagina to the outside world is called labour.

False labour
Uterine contractions that are irregular, do not increase in frequency or severity, and do not efface or dilate the cervix are called false labour.

True labour
The labour pains are true when the contractions in the uterus cause discomfort or a dull ache in the back and/ or lower abdomen. There is pressure in the pelvis and

then the ache comes in front. Some women may also feel pain in their sides and thighs. Contractions become intense and frequent. The contractions come at regular intervals and last about 30-70 seconds.

Four stages of labour

- **1st stage** = onset of pain till full dilatation of cervix (10 cms); 12 hours in primi gravida and half time subsequently
- **2nd stage** = full dilatation of cervix to delivery of the baby; 2 hours in primi gravida and half time subsequently
- **3rd stage** = delivery of baby to delivery of placenta; 15 minutes in primi gravida and others
- **4th stage** = recovery stage (first one hour after delivery of placenta)

Live birth

According to WHO the definition of live-birth is 'Live birth refers to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life - e.g. beating of the heart, respiration, pulsation of the umbilical cord or definite movement of voluntary muscles - whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered to be live birth.

Lochia discharge

The normal uterine discharge of blood, tissue, and mucus from the vagina after childbirth is called lochia discharge. Lochia contains blood, tissue from the placenta, and mucus. It's how the body gets rid of the lining of the uterus (womb) after birth. The blood may come out in gushes or flow more evenly like a heavy period. It is also known as: postpartum bleeding, postpartum vaginal discharge, bleeding after childbirth. The blood changes colour and becomes lighter as uterus heals and returns to its pre-pregnancy size. At first the flow of lochia is heavy and bright red, and may have clots in it. Gradually, it changes to pink then brownish and, eventually, to yellow-white. Lochia has an odour similar to that of normal menstrual flow. If there is an offensive or abnormal odour during lochia, it is important to contact the physician for evaluation.

Mal presentations

Normally, the presentation of a foetus about to be born refers to which anatomical part of the foetus is leading, that is, is closest to the pelvic inlet of the birth canal. According to the leading part, this is identified as a cephalic, breech, or shoulder presentation. A mal presentation is any other presentation than a vertex presentation (with the top of the head first). If any part of the baby other than the top of baby's head or the buttock enters the pelvis first, it causes a complication during a vaginal delivery.

Cephalic (head-first) presentation

Cephalic presentation is considered normal and occurs in about 97% of deliveries. There are different types of cephalic presentation, which depend on the foetal attitude. Rarely, the foetus' head is extended back, and the chin, face, or forehead will present first depending on the degree of extension. This is a more difficult delivery, because this is not the smallest part of the foetus' head. It may result in a need for caesarean delivery. A caesarean delivery may be recommended for any of the foetal positions other than cephalic.

Breech presentation

Breech presentation is considered abnormal and occurs about 3% of the time. A complete breech presentation occurs when the buttocks present first, and both the hips and knees are flexed. A frank breech occurs when the hips are flexed so the legs are straight and completely drawn up toward the chest. Other breech positions occur when either the feet or knees come out first.

Shoulder presentation

The shoulder, arm, or trunk may present first if the foetus is in a transverse lie. This type of presentation occurs less than 1% of the time. Transverse lie is more common with premature delivery or multiple pregnancies.

Maternal Mortality Rate

The maternal mortality rate (MMR) refers to the number of deaths from puerperal causes occurring among the female population of a given geographical area during a given year, per 100, 000 live births occurring among the population of the given geographical area during the same year. In other words it is the number of registered maternal deaths due to birth- or pregnancy-related complications per 100,000 registered live births.

Measles

Measles is an acute and highly contagious viral disease characterized by fever, runny nose, cough, red eyes, and a spreading skin rash. Measles, also known as rubeola, is a potentially disastrous disease. It can be complicated by ear infections, pneumonia, encephalitis (which can cause convulsions, mental retardation, and even death), the sudden onset of low blood platelet levels with severe bleeding (acute thrombocytopenic purpura), or a chronic brain disease that occurs months to years after an attack of measles.

Meconium stained liquor

Meconium is a dark green liquid normally passed by the newborn baby, containing mucus, bile and epithelial cells. Meconium stained amniotic fluid / 'liquor' is when the baby opens their bowels inside the uterus, making the waters look green, yellow or brownish in colour. Meconium stained liquor is usually associated with a response from the baby to having a temporarily reduced oxygen supply at some point in time (usually during labour) or a slowly reducing level of oxygen over a period of time.

Multiple pregnancies

Multiple pregnancies are where more than one foetus develops simultaneously in the womb. The presence of more than one foetus in the uterus increases the likelihood of birth defects as well as problems during labour and delivery.

Multi-para

A woman who has given birth previously at least twice.

Grand Multi para

A woman who has given birth previously five or more times.

Neonatal

Of/or relating to newborn children.

Neonatal period

The first 28 days of life.

Early neonatal period

It is the period between 0-7 days.

Late neonatal period

It is the period between 8-28 days.

Obstructed labour

When a foetus cannot progress into birth canal due to some type of obstruction is called obstructed labour. Prolonged and/or obstructed labour accounts for about 8% of direct maternal deaths in developing countries. If a woman with prolonged and/or obstructed labour does not receive timely and effective management, she may die from rupture of the uterus or infection. Foetal deaths are also common if prompt treatment for obstructed labour is not undertaken.

Pallor

Pallor is a clinical manifestation consisting of an unnatural paleness of the skin.

Perinatal period

The perinatal period commences at 20/ 22 completed weeks (140/ 154 days) of gestation and ends 7 to 28 completed days after birth.

Perineum

The area of the body between the anus and vulva in females and between anus and scrotum in males is called perineum.

Pertussis

It is known as whooping cough; an infectious a communicable, potentially deadly illness disease caused by the bacteria called by Bordetella pertussis, marked by catarrh of the respiratory tract and peculiar paroxysms of cough, ending in a prolonged crowing or whooping respiration. It is characterized by fits of coughing followed by a noisy, 'whooping' indrawn breath. Immunization with DPT (diphtheria-pertussis-tetanus) vaccine provides protection against the disease.

Placenta

Placenta is a flattened circular organ in the uterus of pregnant eutherian mammals which permits metabolic interchange between foetus and mother and nourishes the foetus through the umbilical cord. It develops during pregnancy and permits the absorption of oxygen and nutritive materials into the foetal blood and the release of carbon dioxide and nitrogenous waste from it, without the direct mixing of maternal and foetal blood. It is expelled following birth.

Poliomyelitis

Popularly known as polio, Poliomyelitis is an acute viral disease usually caused by a poliovirus and marked clinically by fever, sore throat, headache, vomiting, and often stiffness of the neck and back; these may be the only symptoms of the minor illness. In the major illness, which may or may not be preceded by the minor illness, there is central nervous system involvement, stiff neck, pleocytosis in spinal fluid, and perhaps paralysis; there may be subsequent atrophy of muscle groups, ending in contraction and permanent deformity.

Post-neonatal period

It refers to the period from the fourth week after birth to the end of the first year.

Post-partum

Traditionally the postpartum period ends 6 weeks after birth. However, WHO has designated the first 28 completed days after birth of the infant as the neonatal period.

Post-partum haemorrhage (PPH)

This is excessive bleeding following delivery. It is defined as blood loss greater than 500 ml or of the amount that adversely affects the maternal physiology. It is categorized as immediate (within the first 24 hours after birth) or delayed (after 24 hours postpartum).

Pre-eclampsia and eclampsia

A condition in pregnancy characterized by abrupt hypertension (a sharp rise in BP), albuminuria (leakage of large amounts of the protein albumin into the urine) and oedema (swelling) of the hands, feet, and face is called preeclampsia. It is the most common complication of pregnancy. It affects about five percent of pregnancies. It occurs in the third trimester (the last third) of pregnancy. In preeclampsia, the woman has dangerously high BP, swelling, and protein in the urine. If allowed to progress, this syndrome leads to eclampsia. The preeclampsia-eclampsia continuum (also called pregnancy-induced hypertension or PIH). In this type of hypertension, high BP is first noted sometime after week 20 of pregnancy and is accompanied by protein in the urine and swelling.

Pregnancy outcomes (dead or alive)

- Live-birth
- Neonate = newborn
- Abortion < 20 weeks
- Stillbirth > 20 weeks

Pre-lacteal feed

Preceding the establishment of milk flow in the newly delivered mother; the newborn baby used to be fed with carbohydrate-electrolyte solutions to reduce initial weight loss until breast feeding is fully established. This feed is called pre-lacteal feed.

Pregnancy induced hyper tension (PIH)

There is a chance of hyper tension in pregnancy which is called pregnancy induced hyper tension (PIH) pregnancy induced hypertension (PIH) is a condition of high BP during pregnancy. It can lead to a serious condition called preeclampsia (also sometimes referred to as toxemia). The normal BP is 120 (systolic)/ 80 diastolic Mm/hg. If it is more, it is called hyper tension.

Preterm

An infant born between the 20th to the 38th week of gestation (134 to 266 days). Normal gestation is approximately forty weeks.

Primi gravida

A woman who is pregnant for the first time. If she is over 35 she may be referred to with the term 'elderly primi gravida.'

Multi gravida
A woman who has been pregnant two or more times.

Prolonged labour (Refer to obstructed labour)
Labour more than 24 hours duration is called prolonged labour. This may be due to a prolonged latent phase i.e. more than 20 hours in a primi gravida or more than 14 hours in a multipara, or due to a 'protraction disorder' in which there is protracted cervical dilatation in the active phase of labor and protracted descent of the foetus.

Sepsis
Sepsis is an infection. It signifies the presence of bacteria (bacteremia) or other infectious organisms or their toxins in the blood (septicemia) or in other tissue of the body. Sepsis may be associated with clinical symptoms of systemic (body wide) illness, such as fever, chills, malaise (generally feeling "rotten"), low BP, and mental status changes. Sepsis can be a serious situation, a life threatening disease calling for urgent and comprehensive care.

Stillborn
If the baby dies before delivery it is called as stillbirth. It usually refers to a pregnancy loss after 20 weeks of gestation or loss of a baby weighing 350 or more grams.

Tetanus
An often fatal infectious disease caused by the bacteria Clostridium tetani. It usually enters the body through a puncture, cut, or open wound. Tetanus is characterized by profoundly painful spasms of muscles, including "locking" of the jaw so that the mouth cannot open (lockjaw). C. tetani releases a toxin that affects the motor nerves, (the nerves which stimulate the muscles). DPT immunization provides protection to a child against tetanus.

Thalassaemia
Thalassaemia is an inherited disorder of red blood cells resulting from the absence or deficiency in one or more of the constituents of hemoglobin. The protein-iron complex in RBCs facilitates oxygen transport in our body. Depending on the defect, thalassaemia symptoms vary in intensity from unnoticeable to life-threatening, and include anaemia and instability of RBCs, treatable by regular blood transfusions. Thalassaemia is only curable by bone marrow transplants from compatible donors.

Tuberculosis
Tuberculosis (TB) is a chronic and highly contagious infectious disease caused by the closely related species of the bacteria. TB is more common in people with immune system problems, such as AIDS, than in the general population.

Umbilical cord
Umbilical cord connects the developing embryo or fetus with the placenta. Umbilical arteries and vein run through the cord. The substance of the umbilical cord is known as Wharton's jelly and is a rich source of stem cells. At birth the umbilical cord measures about 20 inches (50 cm) in length. The cord is clamped and cut after birth and its residual tip forms the umbilicus (bellybutton).

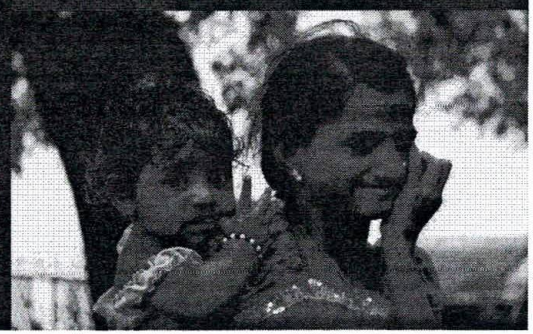
Uterus
The uterus (womb) is a hollow, pear-shaped organ located in a woman's lower abdomen between the bladder and the rectum. The narrow, lower portion of the uterus is the cervix; the broader, upper part is the corpus. The corpus is made up of two layers of tissue.

Vaccination
Injection of a killed microbe in order to stimulate the immune system against the microbe, thereby preventing disease is called vaccination. Vaccinations, or immunizations, work by stimulating the immune system, the natural disease-fighting system of the body. The healthy immune system is able to recognize invading bacteria and viruses and produce substances (antibodies) to destroy or disable them. Immunizations prepare the immune system to ward off a disease. To immunize against viral diseases, the virus used in the vaccine has been weakened or killed. To only immunize against bacterial diseases, it is generally possible to use a small portion of the dead bacteria to stimulate the formation of antibodies against the whole bacteria. In addition to the initial immunization process, it has been found that the effectiveness of immunizations can be improved by periodic repeat injections or 'boosters'.

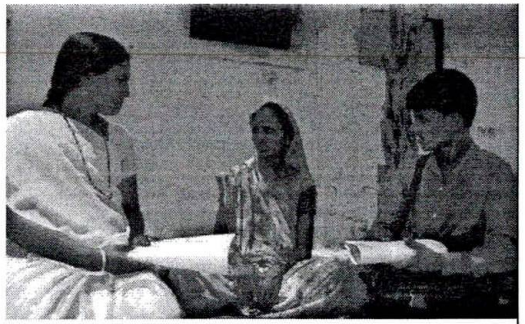
- **Infant** = birth to 1 year
- **Neonatal period** = birth to 28 days
- **Post-neonatal period** = 29 days – 1 year
- **Early neonatal period** = 0-7 days
- **Late neonatal period** = 8-28 days
- **Peri-natal period** = 28 weeks to 7 days

GETTING STARTED

The Doorway to Successful Training in **Part 11 of Module 1** should always be used to start a training workshop: initially if covering all modules at one time, or as a refresher if modules are scheduled over a period of time. The Doorway to Successful Training contains a detailed plan of sessions that sets the stage forthe workshop activities and logistics, covering welcome, introductions, objectives, hopes and fears, and ground rules.



SESSION 1: UNDERSTANDING MNCH CONTINUUM OF CARE



Objective

- To help participants understand the Maternal, Neo-natal and Child Health (MNCH) continuum of care to reduce child mortality and prevent maternal deaths
- Magnitude of MNCH related morbidity and mortality
- Major causes of maternal deaths and deaths in neonates and children under five
- Gaps in MNCH service delivery and utilization in the Sukshema project's operational areas
- MNCH continuum of care
- MNCH service provision structure
- Basic facts and definitions related to MNCH

Methodology

PowerPoint Presentation (PPP) and discussion

Duration

2.5 hours

Training Materials

Laptop, LCD projector, screen and pointer, PPP: Continuum of care, Background material 1: MNCH Care Continuum

Tips for facilitators

This is a critical session to make the field workers understand the rationale and need for a focused intervention package in ensuring care throughout the continuum cycle. This session will set the tone of the training and requires a technical co-facilitator who is a senior medical doctor with experience of handling MNCH issues. Read the background material carefully, especially with reference to the statistics, and understand all issues presented.

Process

1.1 INTRODUCTION

- Ask participants, 'What is health?'
- Encourage them to come up with ideas. Ask probing questions until you get some responses.
- Note their responses on a flip chart.
- Then write the complete definition of health as suggested by the World Health Organization (WHO): "Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity".
- Explain that health is holistic, not just the absence of illness and explain the meaning of each aspect of health - physical, mental and social.
- Ask them if they know the meaning of the acronym MNCH. If not, introduce the topic of Maternal, Neo-natal and Child Health. Tell them MNCH covers care of pregnant women, care during the delivery, care of the newborn/ child and the newly delivered mother.
- Tell them that the following topics will be covered in the session:
  - Magnitude of MNCH related morbidity and mortality
  - Major causes of maternal deaths and deaths in neonates and children under five
  - Gaps in MNCH service delivery and utilization in the Sukshema project's operational areas
  - MNCH care continuum
  - MNCH service provision structure
  - Basic facts and definitions related to MNCH

1.2 MAGNITUDE OF MNCH RELATED MORBIDITY AND MORTALITY

- Use PPP to provide the worldwide statistics on maternal and infant morbidity and mortality. Explain the scenario with reference to India and then more specifically with northern Karnataka.
- Explain the key terminology used in the session – MMR, IMR, live births, etc. and relate it with the Millennium Development Goals (MDGs). Refer to the list of acronyms in Module 2.
- Emphasize the key fact: Most deaths of infants occur during the first 24 hours after birth. A large percentage of these infant deaths are due to conditions that could be prevented or treated with access to simple, affordable interventions.
- Explain that this knowledge is used as a basis for planning MNCH services. Home visits are planned to identify any problems and to bring needed interventions to mothers, newborns and children to improve their health and chances of survival.

1.3 MAJOR CAUSES OF MATERNAL DEATHS AND DEATHS IN NEONATES AND CHILDREN UNDER FIVE

A. CAUSES FOR MATERNAL DEATHS

- Ask participants to brainstorm major causes of maternal deaths.
- Note their responses on a flip chart.
- Ask them to divide these causes into direct/immediate causes and indirect causes/factors that might influence the direct/immediate causes. Tell them that indirect causes could include social, cultural or economic factors.
- Stress that while both direct and indirect cause are important, this session will focus on direct causes as the overall objective is to work with the ASHAs and JHAs so they can take appropriate steps to address the direct causes of maternal deaths.
- Explain that while all the causes they have shared lead to maternal deaths, a number of studies and surveys have substantiated five major medical causes/factors that lead to most maternal deaths.
- Use PPP to show the primary five causes as:
  - Haemorrhage (37%)
  - Infection (Sepsis) (11%)
  - High blood pressure (BP) or hyper tension pregnancy-induced hypertension (PIH) or eclampsia (5%)
  - Obstructive labour or the failure to progress the delivery due to problems such as a mismatch between foetal size/presenting part of the foetus, and the mother's pelvis, position of foetal head, mal-presentations (5%)
  - Abortion (8%)
- Share the percentages of deaths due to each cause and note these statistics provide evidence-base decision making for policy makers when planning allocations of resources, both human and financial, to tackle this problem.

B. CAUSES OF NEONATAL AND CHILD DEATHS:

- Ask participants to brainstorm the direct causes of neonatal and child deaths.
- Note their responses on a flip chart.
- If these causes are among those which are included in the top five causes, congratulate them for their understanding.
- Otherwise tell them that all the causes they listed do lead to neonatal/ child deaths, but are not among the top causes.
- Use PPP to show the top causes are as follows:

  Causes of the neonatal deaths
  - Sepsis/pneumonia (30.4%)
  - Birth asphyxia (19.5%)
  - Prematurity (16.8%)

  Causes of the child deaths
  - Neonatal conditions (33%)
  - Pneumonia (22%)
  - Diarrhoea (14%)
- Explain the new words and concepts such as Neonatal sepsis , birth asphyxia , premature births. Explain the signs and symptoms of sepsis and birth asphyxia and inform them that if a baby is premature the vital organs may not be fully developed and hence the baby can have breathing problems, infections and physiological defects. It can have a very low birth weight (less than 2.5 kg or 2500 grams). These babies are called low birth weight (LBW).
- Explain the importance of institutional delivery to prevent problems such as oxygen deprivation and infections due to lack of hygiene.
- Tell them that Bacillus Calmette–Guérin (BCG) vaccine can be given as per schedule if institutional delivery takes place and breast feeding of colostrum can be initiated.
- Ask when most neonatal and child deaths occur?
- Note their responses on a flip chart.
- Emphasize the key fact: Most deaths occur during childbirth and within 24 hours of birth due to delivery at home or during delayed transportation as immediate access to medical care is not available.

1.4 GAPS IN MNCH SERVICE DELIVERY AND UTILIZATION IN THE SUKSHEMA PROJECT'S OPERATIONAL AREAS IN NORTHERN KARNATAKA

- Ask participants if they have seen or have heard about any cases of maternal, neonatal or child deaths?
- Give two participants the chance to share details of their experiences. Ask the group to explore the situations and the outcomes by asking questions.
- Ask them why these deaths are still occurring when they can be prevented?
- Note their responses on a flip chart.
- Group these responses under the following headings:
  - Gaps in the community
  - Gaps in the service providers
- Use PPP to show the reasons for poor MNCH outcomes and discuss the gaps in the service delivery

and utilization in northern Karnataka.

- Explain that the gaps are evident from:
  - The demand side (i.e. gaps seen in the community in awareness about the MNCH care, danger signs, benefits of institutional delivery and availability of services, practices in accessing institutional care, accountability and community monitoring of services to bring about improvement).
  - The supply side (i.e. availability, accessibility and quality of services).
  - The interaction between health care providers (FLWs such as ASHA and JHA) and the community.
- Explain that these gaps impact in community losing trust in the health care sector, not accessing health services and thus increasing the maternal and infant mortality rates.
- Tell the participants that the Sukshema project aims to address these gaps by supporting the FLWs and VHSNCs, to rebuild the trust of pregnant women and their family members in the MNCH services and to access them.

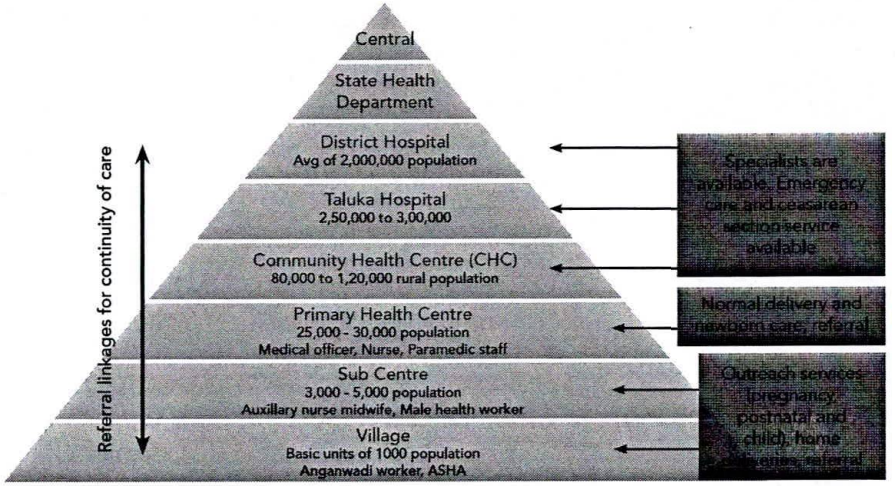
1.5 MNCH CARE CONTINUUM

- Introduce the important concept of the MNCH continuum of care.
- Ask them what they think the term MNCH continuum of care means.
- Note their responses on a flip chart.
- Use PPP to explain that the MNCH continuum of care starts from the inset of adolescence to pregnancy to delivery to post natal care to children under five and goes a full circle again.
- Brainstorm the different stages of woman's life.
- Note their responses on a flip chart.
- Discuss the different issues that women/ girls from rural areas face during each of these life stages and the dynamics behind these.
- Give examples from rural areas where girls do not get proper nutrition in childhood and adolescence and are forced into marriage at a young age. Elaborate how these conditions affect their reproductive health including closely spaced pregnancies, poor access to information about family planning and pressure to adhere to traditional practices.
- Emphasize that if a woman can receive MNCH services during each of her life stages, many reproductive disorders/health issues could be averted.
- Explain that MNCH services appropriate to each stage of a women's life cycle, such as nutrition, pregnancy guidance and care, delivery and post-partum care, immunization and proper family planning advice, could result into fewer complications and prevent most maternal, neo-natal and child deaths.
- Stress that the integrated MNCH continuum of care approach, instead of the piece-meal approach, is essential for mothers and children from pre-pregnancy to delivery, the immediate postnatal period, and childhood.
- Use PPP to explain how the access to effective interventions across the MNCH continuum of care can prevent maternal, neo-natal and child deaths.
- Explain that poor health, malnutrition and inadequate care of the pregnant woman results into premature deaths, sick newborns and low birth weight newborns. It also results in more infections and developmental problems in children.
- Highlight that as each component in the MNCH is linked with the other, they demand an integrated approach.
- Explain the MNCH continuum of care as
  - Antenatal care – care during pregnancy
  - Intra-natal care – care during the delivery and first two hours after the delivery
  - Postnatal care (Mother and newborn) – care during the first 42 days
  - Child care – care of the child up to age 5.

1.6 MNCH SERVICE PROVISION STRUCTURE

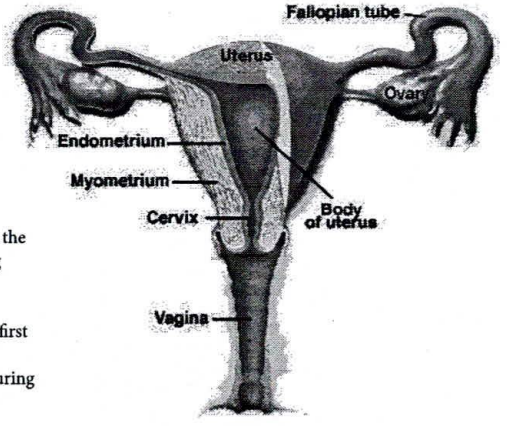
- Use PPP to explain the MNCH service provision structure from bottom level outreach services, which are available at the basic unit of 1,000 people by the ASHAs and AWWs, and for 3000 to 5000 people in SCs where JHAs and male health workers provide health care.
- Explain the other levels including: PHCs for 25,000 to 30,000 people where Medical Officers, Nurses and paramedical staff are on duty and normal delivery and newborn care, and referral services are provided; Community Health Centre (CHC) for 80,000 to 1,20,000 rural people; the Taluka Hospitals (TH) for 2,50,000 to 3,00,000 people; and District Hospitals for more than 20,00,000 people where specialists and emergency care and caesarean section services are available.
- Explain how the referral services/linkages ensure a MNCH continuum of care as the woman is able to get the complete package through any facility that is appropriate.

MNCH SERVICE PROVISION



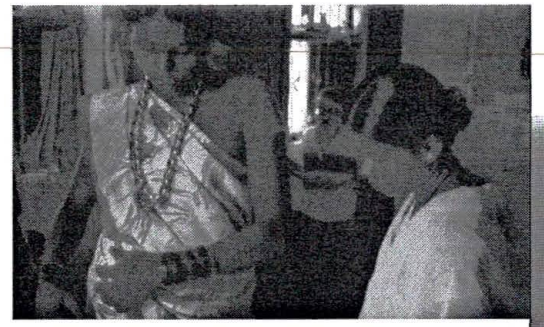
1.7 BASIC FACTS AND DEFINITIONS RELATED TO MNCH

- Tell them that it is important to understand the anatomical and medical terms related to pregnancy and child birth.
- Ask participants to explain the anatomy of uterus and the broad functions of the system.
- Use PPP to add/correct/explain and consolidate the learning to fully explain the anatomy of the reproductive organs of a women including:
  - Pregnancy (Gestation)
  - Total gestation period
  - Full term, pre-term and post-dates
  - Three trimesters
  - Labour and its four stages
  - Pregnancy outcomes and
  - Definitions of some terminologies



- Consolidate the information by highlighting that the MNCH continuum of care includes the following services:
  - **Antenatal care** – care during pregnancy
  - **Intra-natal care** – care during the delivery and first two hours after the delivery
  - **Postnatal care** (Mother and newborn) – care during the first 42 days
  - **Child care** – care of the child up to age 5

SESSION 2: ANTENATAL CARE (ANC)



Objective

- To understand ANC at all stages
- Importance of ANC
- Essential components of ANC
- High risk pregnancy
- Danger signs in pregnancy
- Birth preparedness for a safe delivery
- Key messages
- ASHA's role in ANC

Methodology

Case study, small group discussions and presentations in plenary, PPP and discussion

Duration

2.5 hours

Training Materials

Laptop, LCD projector, screen and pointer, photocopies of Tool 1: Case studies for ANC; PPP: ANC, Background Material 2: ANC

Tips for facilitators

This is an important session that provides a holistic understanding of the ANC stage, the care required at this stage, possible risks and dangers and signals that indicate urgent referrals to doctors. A senior medical doctor that has experience of handling MNCH issues should act as a technical co-facilitator. While consolidating the discussion on key issues ensure that all the points given in the background material are included in the discussion.

Process

2.1 IMPORTANCE OF ANC

- Divide the participants into five groups. Give one of the case studies to each of the groups.

Case 1: Savitha
Savitha is seven months pregnant and has never visited a hospital before. She had come to the hospital complaining of a severe headache for three days and blurred vision. When the nurse at the PHC checked her BP it was very high. She advised Savita's husband to take her to the District Hospital immediately.

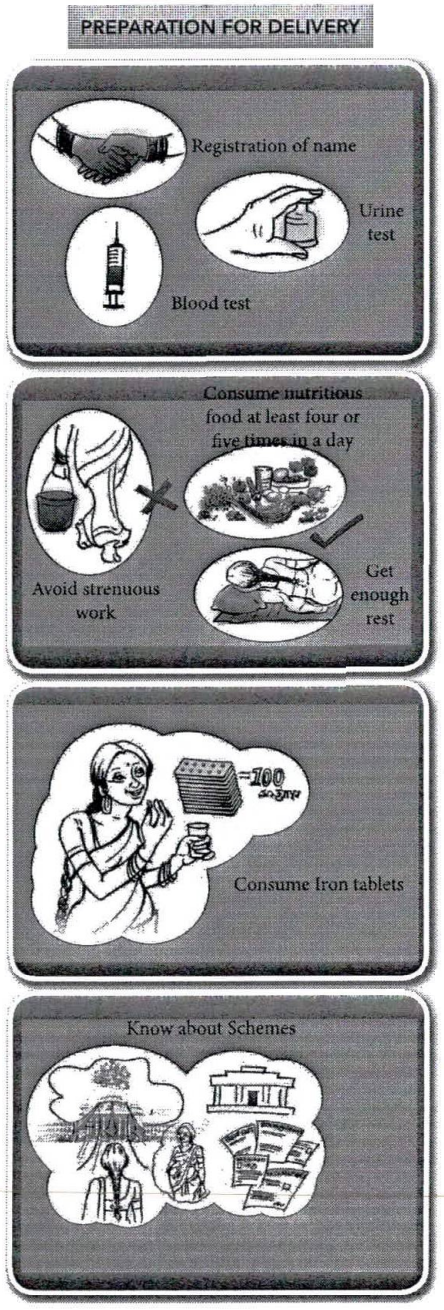
Case 2: Uma
Uma and her husband both work as agricultural labourers. Uma had not been having sufficient rest or food at regular intervals for the last two months because of the heavy work load. She had visited the SC when she was in her 5th month of pregnancy and was given a TT injection and iron tablets. Uma did not take half of the iron tablets as her aunt warned her that if she did, the baby would grow too big for her to have a normal delivery and it would result in a caesarean operation.

Case 3: Radha
24-year-old Radha was 9 months pregnant with his first child. She started having labour pains around midnight. After two hours her water bag broke and the water was clear. Suresh, Radha's father was not able to arrange for a 108 vehicle (Government ambulance) or a private vehicle to go to hospital for delivery. As the labour pains started getting strong, they called in the ASHA at 3:00 a.m. Radha's pressure started dropping and the ASHA had to fetch a JHA from home. With great difficulty they saved the lives of the mother and child.

Case 4: Vindhya
Vindhya was 6 months pregnant. She started bleeding unexpectedly. Her husband Srinivas had gone to visit a temple and would return only after 3 days. Although she was worried, she kept quiet and planned to go to the hospital when her husband returned. When her husband came back, he took her to the hospital. But it was too late, the baby had already died.

Case 5: Rani
Rani was a mother of three children and had two abortions in the past. She contributed to the family income by rolling papads. Her husband is a daily wage labourer. She ate only what was left after feeding her husband and children, which was not very much food. When she got pregnant again, she had no money to have any additional food or get any other help. She was very weak, but was still smiling when she was admitted at the hospital, but died during delivery.

- Ask group members to read their case study in the group, discuss and answer the questions below:
  - What do you think had gone wrong or right in this case study?
  - Why do you think this happened?
  - How do you think this could have been averted?
  - Is there anything more that should have been done?
- Allow 15 minutes for discussion. Ask a representative from each group to take 5 minutes to read out their case study and share their responses to the discussion questions.
- Ask other groups to share any other key information about the case study.
- Probe further and ask all participants these additional questions:
  - Were there any danger signals?
  - Were they ignored?
  - What could have been the appropriate action in each case?
- Continue with the next 4 case studies in the same manner.
- Consolidate the presentations and tell the groups that ANC stage requires careful care and adherence to good practices. If ignored, the life of the mother and child could be in danger.
- Explain that ANC is the particular form of medical care given to a pregnant woman and her baby starting from the time of conception up to the delivery of the baby.
- Tell them that every woman in her ANC stage needs to remember to:
  - Register for ANC services, preferably in the first trimester.



- Keep the ASHA informed about problems encountered at an early stage
- Take support from neighbours / VHSNC at an early stage
- Do birth planning and preparation in advance, including arrangement of money and vehicle to get to the hospital if necessary.
- Eat nutritious food, get adequate rest, receive required immunizations at the right time, and take any medicine as prescribed by doctor.
- Clarify all doubts/preconceived notions about pregnancy and actual delivery.
- Ensure the ASHA registers them, visits them regularly and advises the family on issues such as government schemes, family planning, birth planning, nutrition, and ANC services
- Recognize danger signs which require immediate and appropriate action such as:
  - ~ Headache and blurred vision
  - ~ Bleeding
  - ~ Breakage of water bag
  - ~ Convulsion / fits
  - ~ Loss of foetal movement

- Use PPP to explain that the ANC prepares the pregnant women for successful labour and delivery process by helping the mother maintain good health during pregnancy, informing the family members about pregnancy, labour and child care. More importantly, it provides a means of detecting problems with the pregnancy at an early stage when they are easily treatable and can avert maternal complications at delivery.

2.2 ESSENTIAL COMPONENTS OF ANC

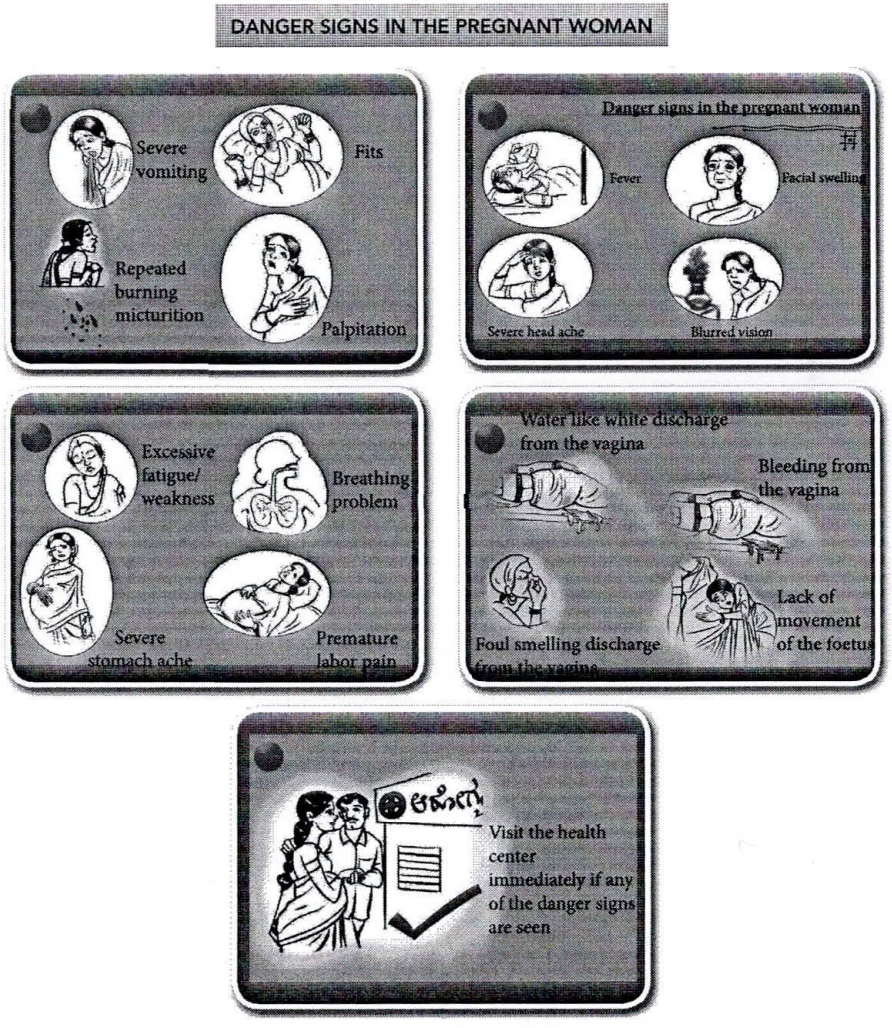
- Use PPP to continue the presentation on essential components of ANC
- Explain the necessity of:
  - Early registration (after confirmation of pregnancy)
  - ANC visits – Minimum 4 (including registration)
- Ask them what could be the advantages of early registration.
- Note their response on a flip chart.
- Add any missing information and modify/correct their responses if required.
- Consolidate the benefits of early registration.
- Ask them what could be the importance of ANC visits by ASHA/JHA.
- Note their response on a flip chart.
- Add any missing information and modify/correct their responses if required.
- Explain that ANC visits should be a minimum of four (including registration) or once a month in the case of high risk pregnancies.
- Tell them that ideally these visits should be during the following period:
  - **First visit:** 8-12 weeks
  - **Second visit:** 24-26 week,
  - **Third visit:** 32 weeks
  - **Fourth visit:** 36-38 weeks
- Explain the rationale behind the schedule of the ANC visits and regular and specific services given by the ASHA during the ANC visits.
- Consolidate the benefits of early registration and follow-through on all visits.
- Focus on preventive measures highlighted by health education, advice, and counselling on:
  - Nutrition - iron and folic acid tablets for 3 months
  - Vaccination - two doses of TT vaccine
  - Birth planning
  - Safe abortion
  - Family planning
  - Institutional delivery
  - Information about government schemes such as JSY, Madilu Kit, Prasooti Araike.
- Discuss:
  - Anaemia
  - Pregnancy induced Hyper tension (PIH)
  - Need for blood grouping[1]
- Ensure that participants know where ANC services are usually provided. Give specific locations if necessary.
  - **Community level**: ASHA, AWW, VHSNC and SCs.
  - **Facility level:**
    - ~ Level 1 – SC and non-24*7 PHC
    - ~ Level 2 – 24*7 PHC[2] and non FRU CHC
    - ~ Level 3 – FRU CHC, TH, DH

2.3 HIGH RISK PREGNANCY

- Ask the participants what is meant by the term high risk pregnancy.
- Note their response on a flip chart.
- Define high risk pregnancy as one in which some conditions puts the mother or the developing foetus, or both at a higher-than-normal risk of developing complications during or after the pregnancy and delivery.
- Explain that a pregnancy can be considered a high-risk pregnancy for a variety of reasons and complications can be divided into maternal and foetal.
- Highlight that high risk cases should be regularly monitored by the ASHA by planning monthly visits, encouraging regular check-ups where ANC services are available, watching for danger signals, and opting for institutional delivery.

2.4 DANGER SIGNS IN PREGNANCY

- Explain that one of the important steps in reducing the maternal and infant morbidity and mortality is to recognize the danger signals during the antenatal period.
- When danger signs are recognized it is crucial to immediately refer the case to the nearest ANC service facility.
- Emphasize that this is the responsibility of the RPs to be aware of these signs and to support the ASHAs and JHAs in their work to do the needful when necessary.
- Use PPP to list the important danger signals that require immediate hospitalization.
- Explain there are other signals that should be referred to ANC service facilities, but which are not emergencies that must be hospitalized immediately. These are:
  - Severe anaemia – shows iron deficiency
  - Night blindness – shows vitamin A deficiency
  - Fever – a sign of infection
  - White discharge - a sign of infection
  - Multiple pregnancies - requires special attention during delivery
  - Mal-presentations - requires special attention during delivery
  - Pain/burning when urinating – a sign of urinary infection



1 The blood groups are , A, AB, B, O and RH negative and positive
2 Services are available at the PHC on all seven days of the week and on all 24 hours of each day

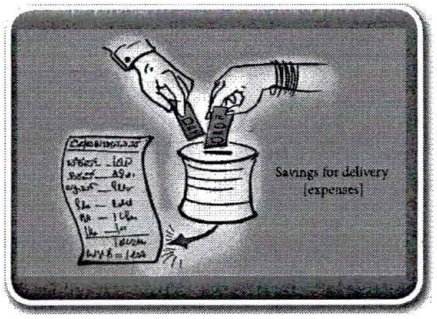
2.5 BIRTH PREPAREDNESS FOR A SAFE DELIVERY

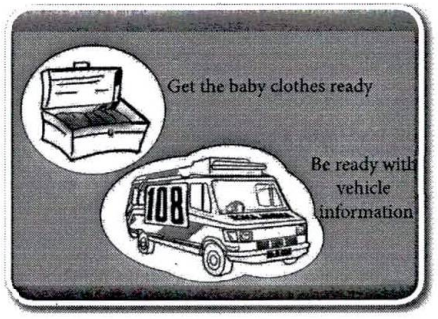
- Ask participants how women should begin to prepare for a safe delivery.
- Note their response on a flip chart.
- Use PPP to discuss birth preparedness.
- Explain that identifying the estimated delivery date (EDD) is important and includes both medical and non-medical aspects.
- The non-medical aspects include:
  - Arranging for the finances for the delivery process.
  - Identifying an accompanying person either among family or friends who can stay during delivery.
  - Knowing the contact numbers of ambulance / 108 van or any other available vehicle.
  - Knowing the contact numbers of the ASHA and JHA.
- The medical aspects include:
  - Checking for availability of correct blood type from a nearby blood bank, if it would be required.
  - Checking for availability of doctors/specialists and referral to FRU if there was any complications during delivery.

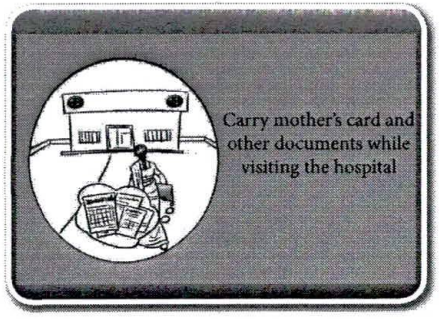
2.6 KEY MESSAGES

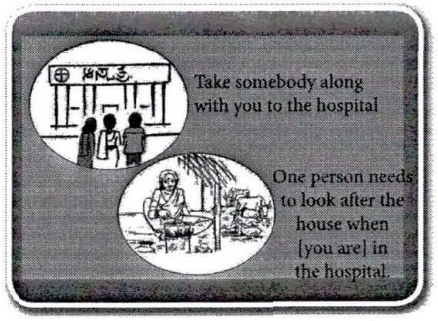
- Ask participants to sum up their learning to ensure that they remember all the information presented in Session 2.
  - Consolidate the key messages as:
  - Pregnant women need to register early for ANC services, preferably within the first trimester.
  - Pregnant women must have regular ANC check-ups – minimum four at regular intervals.
  - Pregnant women should eat a nutritious diet throughout their pregnancy, with a focus on iron-rich and high protein foods.
  - Birth planning should be done in advance to avoid last minute emergencies, including arranging for money, ambulance, blood transfusion, and specialist care.
  - Watch-out for danger signals if the pregnancy is high risk.
  - Pregnant women should be in regular contact with the ASHA who can give her appropriate advice.

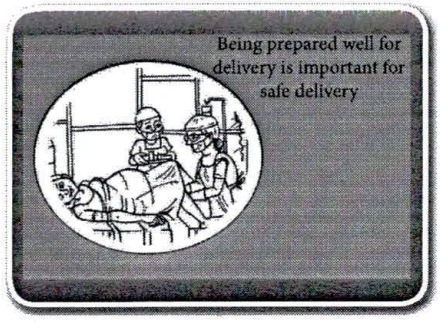
PREPARATIONS FOR HOSPITAL DELIVERY



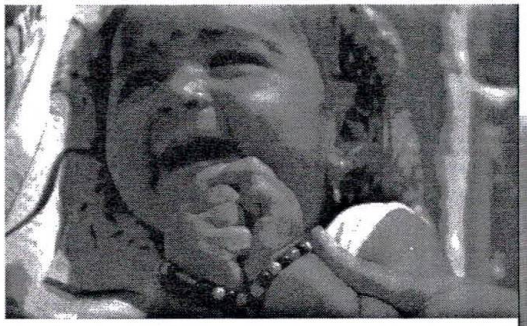








SESSION 3: DELIVERY / INTRA-NATAL CARE



Objective

- To help participants understand the importance of an institutional delivery
- Know how an institutional delivery can save the lives of mothers and babies
- Know the stages of delivery
- Know the danger signals during delivery
- Know the '5' cleans

Methodology

Case study, small group discussions and presentations in plenary, PPP, film and discussion

Duration

3 hours

Training Materials

Laptop, LCD projector, screen and pointer, photocopies of Tool 2: Case studies for Intra-natal care, PPP: Intra-natal care, Film 1: Stages of delivering a baby (There are several videos available on the internet).

Tips for facilitators

As this is a technical session, a senior medical doctor that has experience of handling MNCH issues should act as a technical co-facilitator. This session emphasizes the importance of institutional delivery to ensure that the RPs understand their responsibility to motivate the ASHAs to convince the pregnant women and their family members to access institutions for their deliveries.

Process

3.1 IMPORTANCE OF AN INSTITUTIONAL DELIVERY

- Divide the participants into five groups. Give one of the case studies to each of the groups.

Case 1: Smita

When Smita started labour pains at night, her grandmother conducted the delivery at home. They were all happy as both the mother and newborn were in good condition. After 1 hour, however, Smita started bleeding heavily. But her grandmother was not worried as she felt that such amount of bleeding is normal after delivery. At midnight, Smita became unconscious. Somebody from the community called 108 for ambulance. The PHC was 10 km away from Smita's house. Unfortunately Smita died in the ambulance.

Case 2: Lalitha

It was Lalitha's second pregnancy and her parents wanted her to deliver at home, and since there were no complications it would be OK. They had asked a traditional birth attendant to attend to her. Lalitha started having her labour pains at 8 p.m. The contractions were good, but the baby's head was not moving down. When they realised that there was a problem, they called for the local ASHA. The ASHA told them to take Lalitha to the hospital, but the family members did not take her immediately. Instead they waited until morning. Later that next morning, Lalitha delivered a dead baby.

Case 3: Shalini

Shalini delivered a female baby at night at her home. She had never gone to a JHA or any other health care provider during her pregnancy. The JHA who conducted her delivery saw that Shalini was bleeding heavily and called 108 for the ambulance to send her to the nearby PHC. The medical officer at the PHC looked at Shalini in the ambulance and sent her to the District Hospital. When Shalini reached there the doctor said that she required blood immediately. But Shalini did not know her blood group. It took around an hour to check her blood group. Her blood group was B negative, but unfortunately there was no stock of B negative blood at the hospital. Shalini died before the family could find another source of her blood type.

Case 4: Geeta

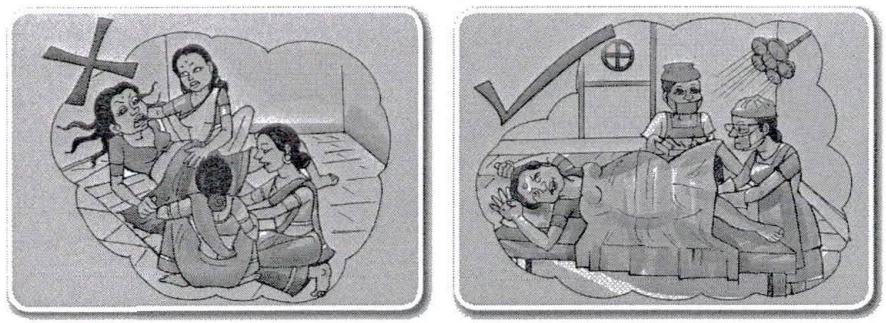
Geeta delivered a male baby at the PHC and the Medical Officer advised her to stay in the PHC for two days (48 hours). Her husband Gopal took her home two hours after the delivery saying that she was OK and didn't need to stay there. The next morning Geeta's family members gave honey and water to the baby and branded it on the chest and abdomen. In the evening the baby developed a high fever and had to be taken to a nearby private hospital. The baby was admitted for three days. The family had to spend about 5 000 rupees for the treatment.

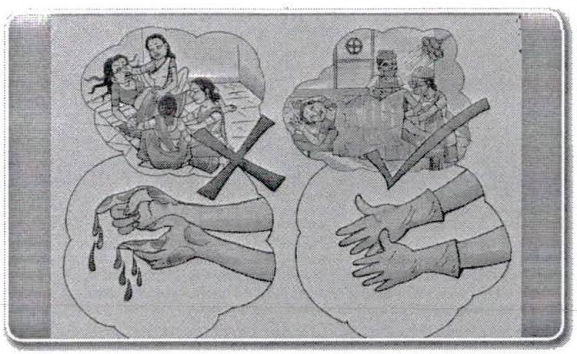
Case 5: Vandana

Vandana started having labour pains early in the morning. The pains gradually increased. She went to the SC in the afternoon. The JHA said that the contractions were good, but she said that she was not able to hear the foetal heartbeat. She advised them to consult the doctor at the PHC. The Medical Officer examined Vandana and found that the foetus was lying transversely and she needed a caesarean section. He referred Vandana to the Taluka hospital, but the specialist was not on duty, so Vandana was referred to the District Hospital, which was very far away. Despite being very late in the evening they set out. The baby was at very high risk and died.

- Ask group members to read the case study in the group, discuss and answer the questions below:
  - What do you think had gone wrong or right in this case?
  - Why do you think this happened?
  - How do you think this could have been averted?
  - Is there anything more that should have been done?
- Allow 15 minutes for discussion. Ask a representative from each group to take 5 minutes to read out their case study and share their responses to the discussion questions.
- Ask other groups to share any other key information about the case study.
- Continue with the next 4 case studies in the same manner.
- Consolidate the following points:
  - A large number of maternal and neo-natal deaths are avoidable or preventable.
  - If the delivery is done at home, chances are that no preparation is done prior to the delivery and the birth attendant (either from the family or from the community) is not well-trained.
  - Delivery at home may not always result in morbidity, but that does not mean that home delivery is a good option. In case of any danger sign or prolonged labour, it would be difficult to manage at home.
  - It is better to avoid the rush of a last-minute transfer to the hospital if medical problems arise and choose the option of institutional delivery.
  - Institutions have round-the-clock help for the mother and baby, for example, food, medical assistance, and are able to quickly respond during emergencies.
  - Institutional delivery is one of the safest options for the mothers-at-risk to address medical complications and avert the possibilities of maternal and infant deaths. Procedures such as caesarean sections and forceps deliveries offer solutions to dangerous situations that are available only at the institutions.
    - ~ It is important to convince the families to get every delivery done at an institution, but especially for high-risk cases, institutional delivery is the only option.
    - ~ Any danger sign requires immediate and appropriate action.
    - ~ To ensure availability at the time of delivery, finding out what blood group the pregnant woman is needs to be done in advance.
    - ~ It is very important for the woman to stay at the hospital/health facility for 48 hours to avail care for herself and for the newborn baby.
    - ~ This is a crucial period and ignorance/lack of adequate knowledge about handling the newborn can prove fatal.
- Use PPP to reiterate that at the institutions intra-natal services are provided by trained and Skilled Birth Attendants (SBA) that include the JHA, staff nurse and medical officer.
- Inform them that the intra-natal care is available at the same place where ANC is.
- Ask the participants to recall the facilities where intra-natal services are available.
- Ensure that participants know the specific locations where intra-natal services are available at all three levels:
  - **Level 1** –SBA (SC, non 24/7 PHC)
  - **Level 2** – BEmONC (24/7 PHC, non-FRU CHC)
  - **Level 3** –CEmONC (FRU-CHC, TH, DH)

IMPORTANCE OF HOSPITAL DELIVERY



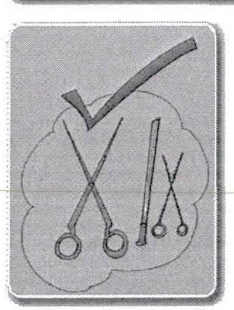


Hands could be dirty in home delivery
In a hospital delivery hands are covered with gloves

Dirty cloth
Tying the umbilical cord with dirty thread

Clean Thread
Tying the umbilical cord with clean thread

Rusted blade or scissors

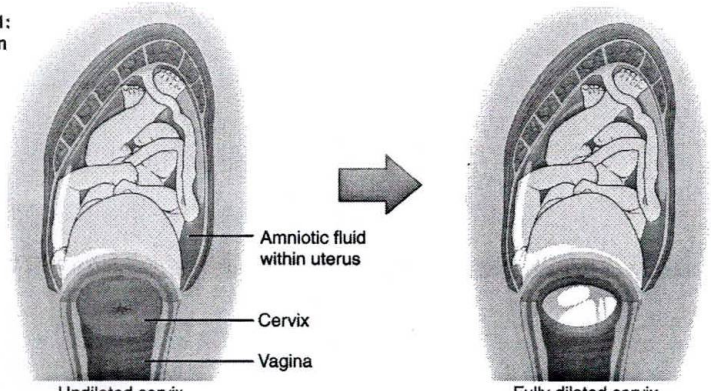


Sanitized blade and scissors

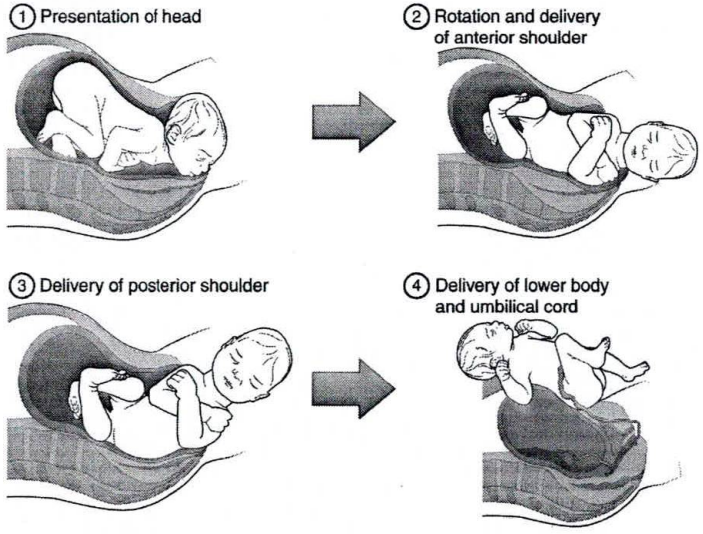
3.2 STAGES OF LABOUR

- Inform the participants that there are four stages in the delivery process.
- Show the film on 'Stages of delivering a baby' which is available online. http://www.babycenter.in/v1027490/inside-pregnancy-labour-and-birth
- https://www.youtube.com/watch?v=YlISC6KsYcc (National Geographic Documentary, 'In The Womb')
- Pause after each stage and explain the changed position of the baby and the process that is taking place.
- Explain that child birth is a very natural process and happens normally in most cases.
- However, some pregnant women in rural areas face several challenges during the entire phase of pregnancy/ delivery due to malnutrition and psychological pressures.
- Medical assistance by trained / skilled birth attendants can improve their chances of a normal/safe delivery.
- Use PPP to give an in-depth overview of a normal/safe delivery.

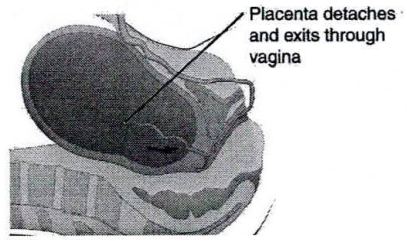
Stage 1: Dilation



Stage 2: Birth



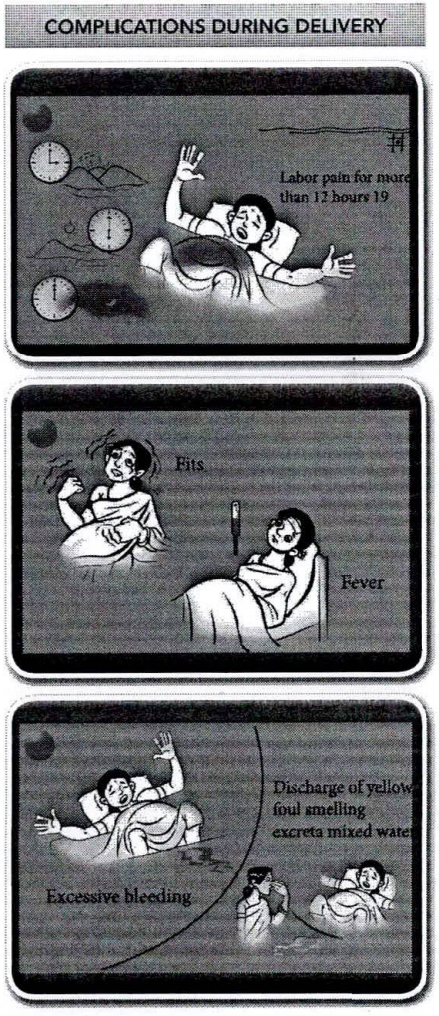
Stage 3: Afterbirth delivery

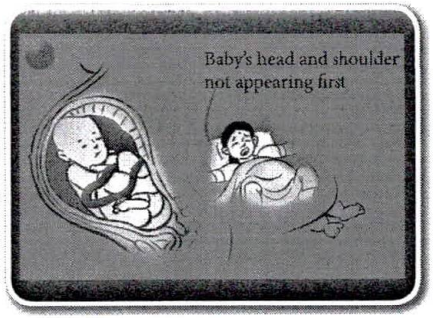


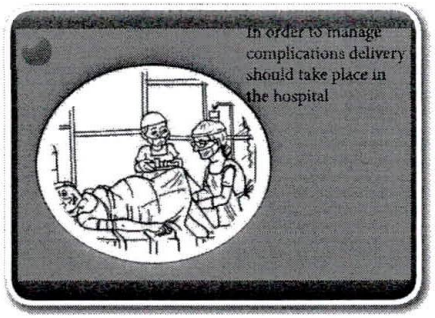
3.3 DANGER SIGNALS DURING THE DELIVERY PERIOD

- Tell the participants that just as there are danger signs that classify pregnancies to be high risk, there are also danger signs during the delivery period.
- Ask the participants to brainstorm some danger signs during delivery.
- Note their response on a flip chart.
- Use PPP to explain the danger signals during delivery:
  - Irregular/fast/very slow fetal heart beats[1] (Fetal distress)
  - Labour taking more than normal time in any stage (Prolonged labour)
  - Head or shoulders not coming out[2] (Obstructed labour)
  - Umbilical cord coming out before the baby (Cord prolapse)
  - Yellow or foul smelling liquor[3] (Meconium stained liquor)
  - Placenta not expelled completely[4] (Incomplete / retained placenta)
  - Fever
  - Fits
- Use PPP to explain the technical terms that were used in the film.
- Highlight that if any one of these signals is present during the delivery period, it is important not to wait for normal delivery. It is important for a doctor to decide if the pregnant woman should have the delivery by caesarean section and to take the doctor's advice.
- Tell them that waiting for normal delivery may distress the baby and lead to physical/psychological problems.

1 The normal range is 120 to 160 heart beats per minute
2 This could be result of different factors such as transverse position or bigger size if the baby or small size of the pelvis/ cervix not opening.
3 The foul smell indicates infections
4 If the placenta does not come and effort is made to remove it forcibly, there is a danger to lead to hemorrhage







3.4 THE '5' CLEANS

- Ask the participants if they can state the one key thing that is critical for ensuring a successful delivery.
- Note their response on a flip chart.
- Focus on the term cleanliness.
- Tell them that cleanliness during the delivery process is one of the most critical components for a safe delivery process.
- Ask participants to identify most critical five things that need to be clean for the safe delivery.
- Note their response on a flip chart.
- Consolidate the understanding by highlighting the '5' cleans.
  - Clean hands
  - Clean delivery surface
  - Clean cord cut
  - Clean cord ties
  - Clean cord stump care
- If the participant list other component that should be clean during delivery, agree, but tell them the above '5' cleans are most critical.

- Consolidate the main points of Session 3:
  - Knowing the advantages of institutional delivery
  - Knowing the stages of labour
  - Recognizing danger signs during delivery
  - Importance of maintaining cleanliness

SESSION 3: POST-NATAL CARE (PNC)

Training Materials

Laptop, LCD projector, screen and pointer, photocopies of Tool 3: Case studies for Post-natal care and PPP: Post-natal care

Tips for facilitators

The PNC period is one of the most critical periods in the maternal and neo-natal care continuum. Many maternal and infant deaths occur during this period. There are lot of misconceptions around how, when and what to feed a newborn, how to keep it warm, clean and safe. This session needs a technical co-facilitator who is a senior medical doctor who has MNCH experience and can emphasize the importance of post-partum care. The RPs must understand their responsibility to motivate the ASHAs to guide the nursing mothers and their families to access health care at the nearest institution if there are any danger signs.

Objective

- To help the participants understand post-natal care (PNC) and its importance
  - Importance of PNC
  - Essential components of PNC

Methodology

Case study, small group discussions and presentations in plenary, PPP and discussion

Duration

3 hours

Process

4.1 IMPORTANCE OF PNC

- Give one of the case studies to each of the six groups.

Case 1
A five day old newborn had bleeding from his umbilical cord. The grandmother applied some cow dung, a tradition in many villages as people believe it has antiseptic properties, to prevent the bleeding. But it did not stop. Then she tied a piece of cloth around the cord and the bleeding stopped. After few days, the baby developed high fever and there was pus on his umbilical cord.

Case 2
A newly delivered mother started breast feeding her baby after two days of delivery and therefore the baby was not fed with the colostrum. She also did not feed the baby regularly. After ten days, the new mother began to complain of pain in her breasts. She also started running a fever. She stopped feeding the baby as she felt that feeding would increase her pain.

Case 3
A grandmother started feeding a ten-day-old baby with sugar water, honey and cow milk along with the breast feeding as she felt that exclusive breast feeding would not help proper growth. A few days later the baby developed loose stools and vomited profusely. The mother stopped breast feeding thinking that it would increase the loose motions and the baby was given only sugar water.

Case 4
Kamala returned from her mother's house to her husband's house five days after her delivery. Soon after she started complaining of headache and blurred vision. Her husband got her some tablets for headache from a medical shop. Her headache subsided that day but came back the next day. Her husband then took her to a local quack who did not examine her but gave her some tablets and ointment for headache, advising them to not to worry. The next day, Kamala had convulsions and became unconscious.

Case 5
Parvathi delivered their 3rd daughter. The first two daughters were aged 4 and 2 years. The newborn baby only weighed 2 kg. Both Parvathi and her husband were disappointed at having another girl child, but decided that they will try again and maybe have a male baby next time.

Case 6
Bharati delivered at a PHC and returned home. After four days the JHA and the ASHA came to visit her at home. She reported heavy bleeding. Both JHA and ASHA tried to stop her bleeding, but when it was not under control, they called the ambulance (108) to take her to the nearby facility. Bharati was taken to the PHC where the Medical Officer gave her injections and tablets and the bleeding soon stopped.

- Ask group members to read the case study in the group, discuss and answer the questions below:
  - What do you think had gone wrong or right in this case?
  - Why do you think this happened?
  - How do you think this could have been averted?
  - If everything is all right, then suggest what advice you would give a new mother?
- Allow 15 minutes for discussion. Ask a representative from each group to take 5 minutes to read out their case study and share their responses to the discussion questions.
- Ask other groups to share any other key information about the case study.
- Continue with the next 5 case studies in the same manner.

- Consolidate the following points:
  - Soon after child birth it is very important for the mother to adhere to healthy and medically appropriate practices for herself and her newborn baby.
  - The umbilical cord should be cut with a sterile blade and tied with a clean cloth/clamp. The cord stump must be kept clean and dry. It should be allowed to dry naturally to prevent it from getting infected. Nothing should be applied to the cord stump, especially not cow dung. This could result into infection/pus and further complications.
  - The newborn and the mother should stay at the institution for 48 hours. If they cannot stay, the JHA and the ASHA should give them all the information about caring for the mother and the newborn. They must be told to contact the JHA or ASHA if there are any problems, even seemingly simple/small problems.

- Exclusive breast feeding is best for the infant. As the mother continues to breast feed, more milk is produced. The mother should not stop breast feeding the baby even if there are signs of loose stools. If the mother or family members feel that breast milk is not sufficient, they should consult the JHA or the ASHA to get help.
- If supplementary feeding is required, the mother needs to know what, when and how the baby should be fed and should contact the JHA or the ASHA immediately to prevent infant from getting sick or dying.

- Use PPP to explain that PNC refers to care of the mother and the baby after the delivery, up to 6 weeks (i.e. 42 days).
- PNC care is an important component of MNCH as a high proportion of deaths of mothers and newborns take place during this period.
- Repeat some of the statistics about IMR data from Session 1 and explain that good PNC can produce better outcomes.
- Explain the importance of PNC visits and adhering to the schedule. Home visits of the JHA and the ASHA are scheduled on the 3rd, 7th and 42nd day after birth for evaluation of the mother's health, and on the 14th, 21st and 28th day for the newborn. These visits are important to help the mothers understand the importance of breast feeding, keeping the baby warm, maintaining cleanliness and ensuring the completion of the immunization cycle for the baby.
- These home visits also help to assess the overall health conditions of mother and newborn and identify if there are any danger signs or problems such as heavy bleeding/infection. If there are problems, the ASHA or JHA can recommend that the mother or newborn is hospitalized.
- The home visits can also be used to provide appropriate counselling and advice and referral to appropriate clinics in case of any complications.

4.2 ESSENTIAL COMPONENTS OF PNC VISITS

- Use PPP to explain that the PNC visits should focus on the following components:
  - **Assessment of mother and newborn**
  - The baby has to be given thermal protection and ensure that the baby does not become either too cold (Hypothermia) or too hot (hyperthermia).
  - Explain the rationale behind keeping the baby warm.
  - If the newborn is low birth weight (LBW) it should not be bathed until it weighs at least 2.5kg as babies below this weight are prone to hypothermia.

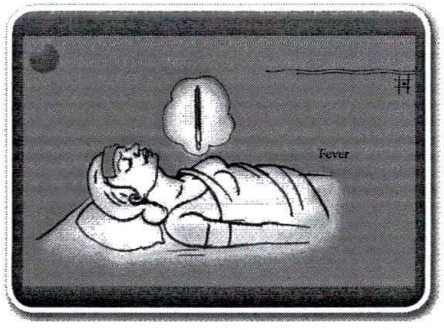
  - **Identification of danger signs in mother and newborn**
  - Identifying danger signs during the post-natal period is the responsibility of the JHA and the ASHA. They should check if any danger signs are present and if so, call for immediate medical assistance to prevent mortality and morbidity in both mother and infant.
  - Use PPP to present the important danger signs in mother and newborn.
  - Highlight that LBW infants have low immunity and their lungs are not fully developed. These infants need special care, such as 'kangaroo' care.
  - Use PPP to explain the advantages of 'kangaroo' care.

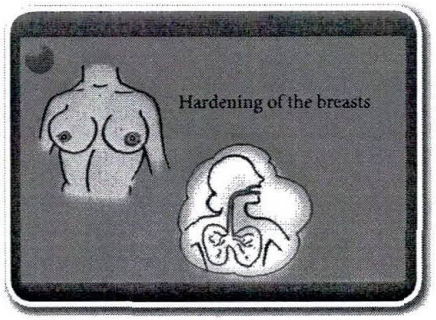
  - **Advice and counselling**
  - The new mother and her family need guidance on general health practices because there are misconceptions about nutrition, cleanliness and breastfeeding.
  - Information is also needed about types of immunizations, the prescribed schedule and birth registration.
  - Ask the participants to brainstorm topics on which the ASHAs should provide advice and counselling.
  - Note their response on a flip chart.
  - Use PPP to ensure that all the topics are fully explained.

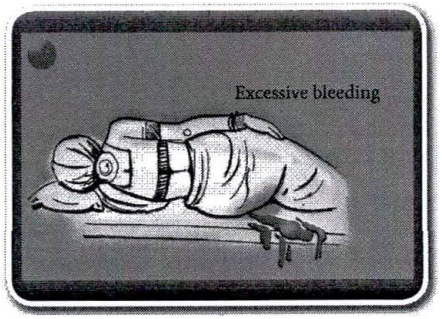
  - **Referral for complications**
  - If there are any danger signs/ complication the case needs to be referred to the nearest health care facility that offers an appropriate service.

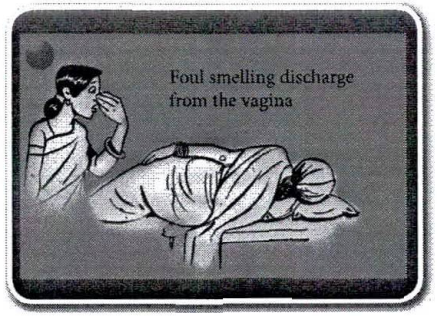
- Consolidate the main points of Session 4:
  - Importance of PNC
  - Essential components of PNC

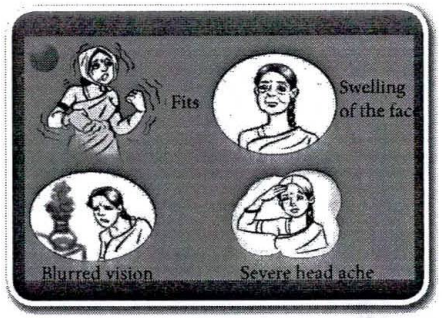
DANGER SIGNS IN THE NEWBORN MOTHER

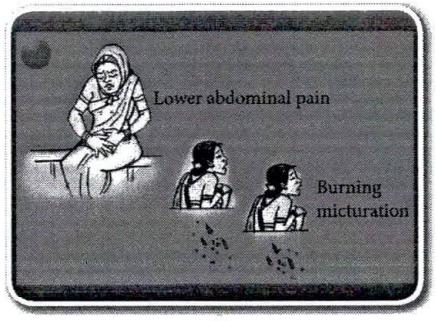


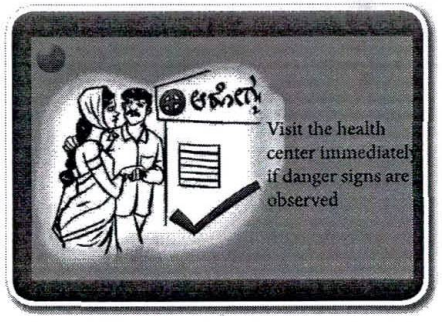




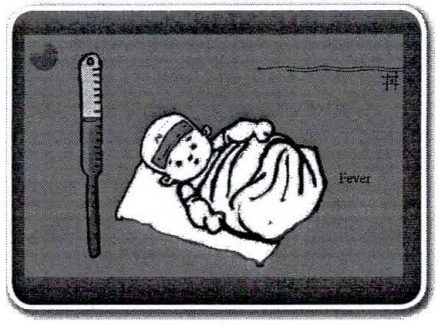


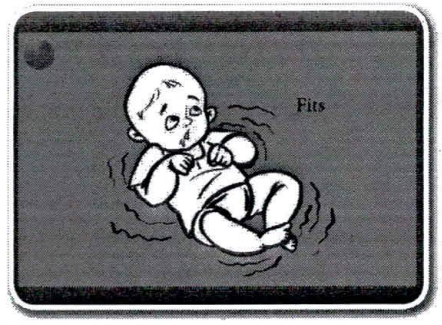


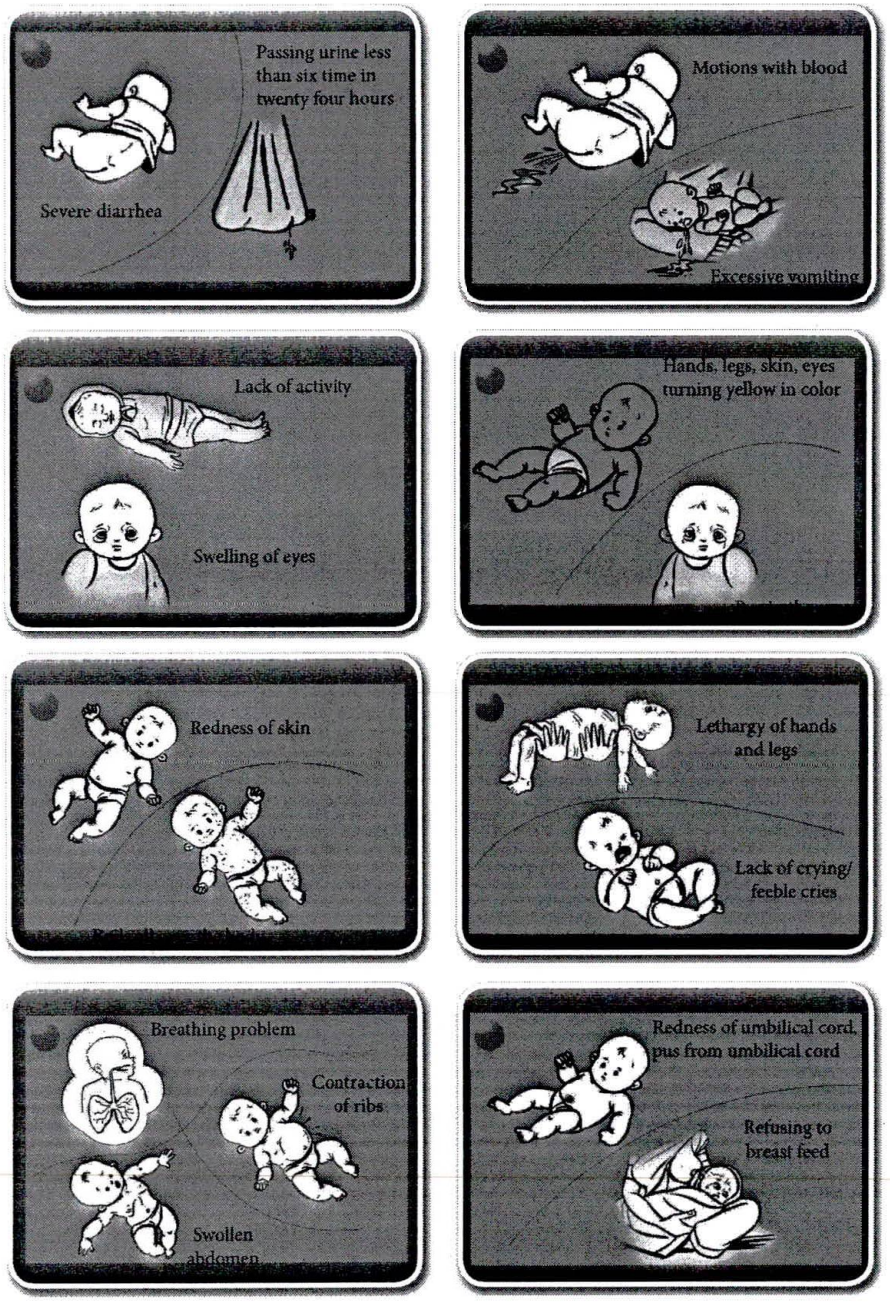




DANGER SIGNS IN THE NEWBORN INFANT







SESSION 5: CHILD CARE

Methodology
Case study, small group discussions and presentations in plenary, PPP and discussion

Duration
3 hours

Training Materials

Laptop, LCD projector, screen and pointer, photocopies of Tool 4: Case studies; and PPP: Child care

Objective

- To help participants understand the last stage in the MNCH continuum of care.
- The importance of proper child care.
- The importance and method of monitoring the growth and development of a child.
- The causes of malnutrition and ways to prevent it.
- The causes of diseases and illness and how to prevent and manage.

Tips for facilitators

Child care is the last stage in the MNCH continuum of care. Child care is crucial as most infant deaths occur during the first 24 hours after birth and most children die within the first year of their life. Wrong practices, misconceptions and poor awareness about breast feeding, external feeding, immunization and preventing/managing illness at this stage can damage a child's health in the long run and need to be corrected.

Process

5.1 IMPORTANCE OF CHILD CARE

- Define the last stage in the MNCH continuum of care as child care.
- Tell the participants that a baby who is 0 to 1 year old is referred to as an infant and from the first to five years is referred to as a child.
- Explain that the period from year 1 to year 5 is very important for the child's future health. During these years the growth and development of the child needs to be monitored closely to prevent long term health problems.
- Give one of the case studies to each of the five groups.

Case 1
Chanmu is an 8-year-old child studying in the 2nd standard. He had mild fever and weakness for few days. One day when he was playing, he suddenly fell down and could not stand on his feet. He started crying. Some friends carried him back to his home. When his parents saw him they took him to the Taluk hospital. The doctor said it might be polio.

Case 2
Shilpa and Aishwarya were sisters married into the same family. After one year, both of them gave birth to one child. The elder sister, Shilpa was beauty conscious and so she stopped breastfeeding the baby very early and fed her child with a bottle. Aishwarya, the younger sister preferred to breast feed her baby. As the children grew, Aishwarya's baby, which was breast fed longer, was healthier than Shilpa's bottle-fed baby, who frequently suffered infections.

Case 3
A 2-year-old baby was suffering with cough, fever and difficult breathing. His grandmother tried to treat him with home remedies using basil leaves and honey. After fifteen days, the cough and fever worsened, but they still continued with the remedies at home without consulting a doctor. When the baby became very ill they rushed him to a doctor. The doctor said the baby's condition was very serious and they should have brought him much earlier.

Case 4
Gayathri, a 2-month-old baby, had been having watery stools for 3 days. She was not fed properly due to the illness. When the baby didn't pass urine the whole night, the next morning the family approached the JHA at the SC. Seeing the baby's condition, the JHA referred the baby immediately to the FRU as she decided that the baby required glucose (IV fluids).

Case 5
Rafay is an 18 month old boy who was severely underweight. Rafay was not being breastfed, but given roti, dal and vegetables. He eats about half to one roti thrice a day. His mother complains that he does not eat a lot and has very poor appetite. He has frequent episodes of respiratory infections, but no other illness. His immunization schedule is complete.

- Ask group members to read the case study in the group, discuss and answer the questions below:
  - What is the health problem affecting the child?
  - What do you think caused the problem?
  - What could be done to improve the child's condition?
- Allow 15 minutes for discussion. Ask a representative from each group to take 5 minutes to read out their case study and share their responses to the discussion questions.
- Ask other groups to share any other key information about the case study.
- Continue with the next 4 case studies in the same manner.
- Use PPP to explain all issues raised in detail:
  - Dehydration is a serious condition and the child needs immediate medical care. To prevent the child being dehydrated, it is important that it is given enough liquids, especially when the child loses fluid due to vomiting/diarrhoea.
  - Continuing breastfeeding for as long as possible is very important for a young child. Breast milk is the ideal food as it contains a mix of enzymes and antibodies, making breastfed children less likely to have diarrhoea, ear infections, respiratory illness, allergies, intestinal worms, and colds. Extended breastfeeding can also reduce the risk of breast cancer.[1]
  - Some home remedies can be helpful, such as a mitigating measure for minor illnesses, but only using home remedies in the case of severe infections can be dangerous. Consulting a qualified medical doctor at the earliest time can reduce serious illness.
  - Mothers need to have correct information and knowledge about basic nutrition and how the right foods can ensure proper growth during all the developmental stages of the child. Mothers need to know who to contact so they can access this information.
  - The mother and family should also know that the child care health services are expensive in private hospitals, while in government hospitals MNCH child care services are available at a cheaper rate.
  - It is important to immunize the child according to the prescribed schedule of required vaccinations. Otherwise the health of the child, and the community, could be compromised.
  - When a child has episodes of diarrhoea it is important to continue to provide food and liquids. Give boiled and cooled water, warm and fresh foods, but avoid fatty foods.

1 Collaborative Group on Hormonal Factors in Breast Cancer; Lancet, 2002 Jul 20; 360 (9328): 187-95

- Highlight the fact that if there are any problems, MNCH child care services can control illnesses and diseases.
- Ask the participants to recall the facilities where child care services are available.
- Ensure that participants know the specific locations where child care services are available at all three levels:
  - **Level 1** –SBA (SC, non 24/7 PHC)
  - **Level 2** – BEmONC (24/7 PHC, non-FRU CHC)
  - **Level 3** –CEmONC (FRU-CHC, TH, DH)

5.2 CAUSES OF CHILD DEATHS

- Ask participants to brainstorm the direct causes of child deaths.
- Note their responses on a flip chart.
- If these causes are among those which are included in the top three causes, congratulate them for their understanding.
- Otherwise tell them that all the causes they listed do lead to child deaths, but are not among the top causes.
- Use PPP to show to highlight the top causes are as follows:
  - Neonatal conditions (33%)
  - Pneumonia (22%)
  - Diarrhoea (14%)
  - Highlight that pneumonia and diarrhoea are both common causes of child morbidity and mortality, but are avoidable with appropriate hygiene (washing hands with soap and water before eating and after defecation).

5.3 GROWTH AND DEVELOPMENT

- Use PPP to explain that regular growth monitoring helps in checking whether the child's growth and developmental milestones are appropriate for its age. It also helps in early detection and subsequent mitigation of any physical handicaps found in children, such as vision and hearing loss.
- Explain that the growth and development depends upon several inherent as well as external factors.
- Ask participants to brainstorm what factors could affect growth and development.
- Note their responses on a flip chart.
- Use PPP to emphasize that when delayed growth and development indicators are identified, then early referral to an appropriate health care provider can prevent more serious or future complications.
- Tell them that the AWW plots the growth of the child on a graph chart which helps diagram and illustrate a child's developmental progress.
- Display the proto type of the growth chart (See background material) and outline the parameters of growth and the normal values at different ages.
- Explain what the green, yellow and red bands on the growth chart mean. The red band shows severe malnourishment, yellow moderate malnourishment and green shows no malnourishment.

5.4 PREVENTING MALNUTRITION IN CHILDREN

- Show a picture of malnourished children to help participants understand how malnutrition affects a child's growth and development indicators.
- Use PPP to explain the key messages to prevent malnutrition.
- Highlight the importance of exclusive breast feeding, complementary feeding, feeding during illness, prevention of illness and access to health care and AWW services.

5.5 PREVENTION AND CONTROL OF DISEASES

- Ask the participants if they agree that children are more prone to diseases than adults.
- Note their responses on a flip chart.
- Some illnesses, which are not usually fatal if diagnosed early and treated properly, are diarrhoea, the common cold and acute respiratory infections caused by a number of respiratory viruses.
- Tell them that low immunity levels are the major cause of diseases. Immunity levels can be affected by different factors and practices. Though many of these diseases are dangerous they can be prevented to a large extent if the child is immunized. These diseases are called 'Vaccine preventable diseases' (VPDs).
- Explain that immunization is one of the most well-known and cost effective methods of preventing diseases. However, immunization has to be sustained to prevent VPDs.
- Ask the participants to brainstorm common vaccine preventable diseases.
- Note their responses on a flip chart.
- Share the list of the six most common vaccine preventable diseases:
  - Tetanus
  - Poliomyelitis
  - Diphtheria
  - Pertussis (whooping cough)
  - Measles
  - Childhood tuberculosis
- Stress that the vaccines must be given at the right age, right dose, right interval and the full course must be completed to ensure the best possible protection to the child against these diseases. The schedule that tells us when and how many doses of each vaccine are to be given is an immunization schedule. If a child is not given the right vaccines in time, it is necessary to get them started whenever possible and complete the primary immunization before the child reaches its first birthday.
- Present the national immunization schedule and emphasize that the booster doses are essential.
- Highlight that for school admission a certificate of complete immunization is required.

SESSION 6: CRITICAL MNCH ISSUES

Objective

- To review the MNCH continuum of care
- To identify seven issues that are critical to a MNCH intervention

Methodology

Small group discussion and plenary presentation and discussion

Duration

1 hour

Training Materials

Markers and brown sheets/ card sheets

Tips for facilitators

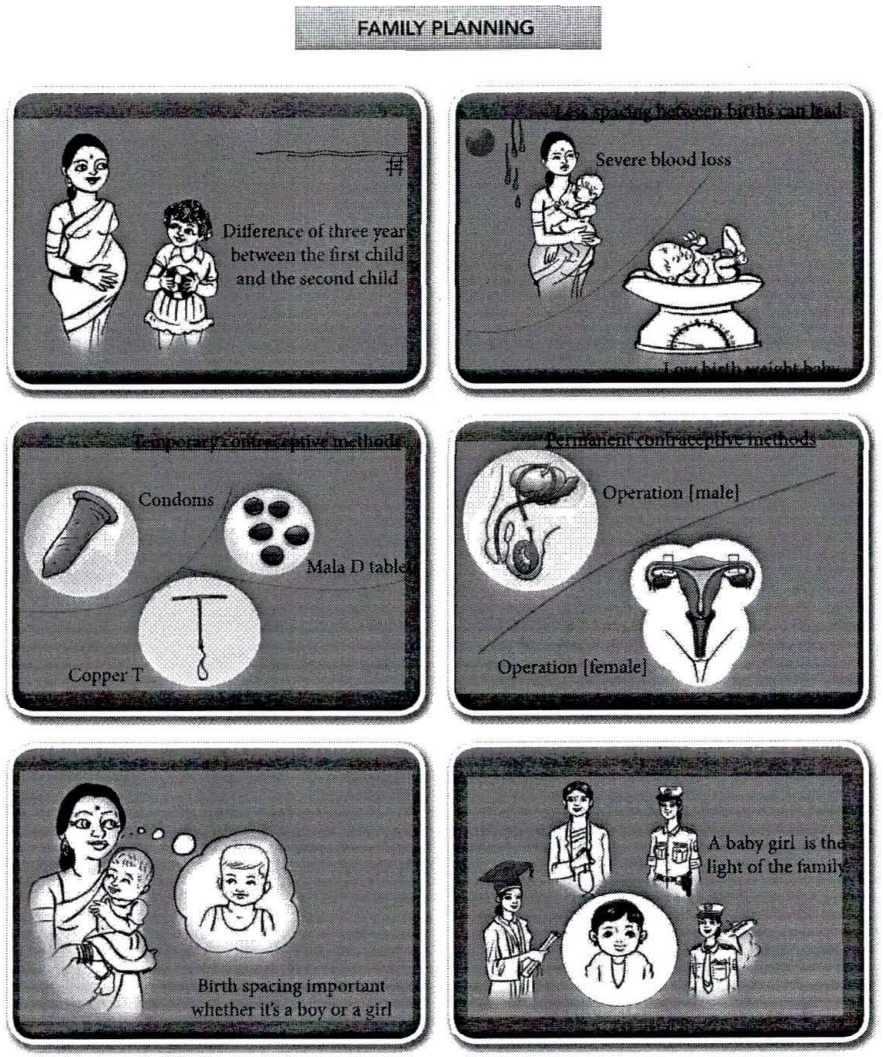
In this session the participants will review the different stages of the continuum of care and shortlist key themes that are critical to ensure the health of the mother and child. These key themes will form the key messages for a MNCH intervention. Although all issues are important, the participants will need to prioritize the most crucial issues for the intervention. The facilitator needs to help participants through this process of analysis.

Process

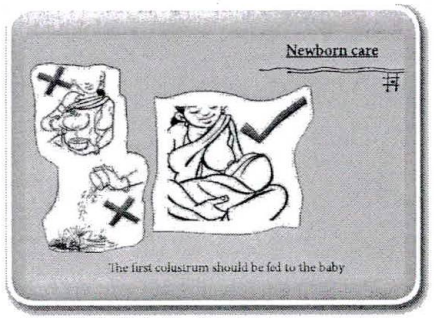
6.1 SEVEN CRITICAL ISSUES

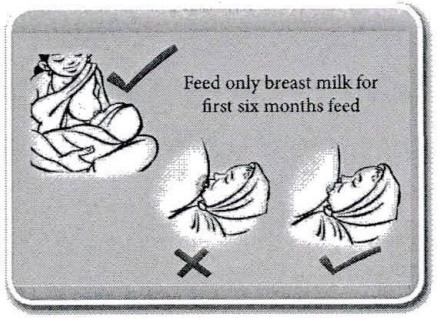
- Ask participants to recall the stages in the continuum of care:
  - **Antenatal care** – care during pregnancy
  - **Intra-natal care** – care during the delivery and first two hours after the delivery
  - **Postnatal care** (Mother and newborn) – care during the first 42 days
  - **Child care** – care of the child till year 5.
- Divide participants into these four groups.
- Ask each group to list the major issues in each stage on a flip chart.
- Allow 15 minutes for discussion.
- Ask a representative from each group to display their flip chart on the walls of the training room and to take 5 minutes to share their answers.
- Continue with the next 3 groups in the same manner.
- Ask all the groups to now consolidate all of the issues that have been identified by all the four groups and to pick the 7 most critical issues for the Sukshema project's MNCH intervention.
- Allow 10 minutes for each group to list the 7 most critical issues on a flip chart and then to display their flip chart on the walls of the training room.
- On a clean flip chart the facilitator should list the common most critical issues from each group. Use tally marks to decide in what order they are ranked.
- If there are disagreements about some issues, discuss with the group. Come to an agreement on 7 issues.
- Now display the list of 7 critical issues that have been identified by MNCH experts.

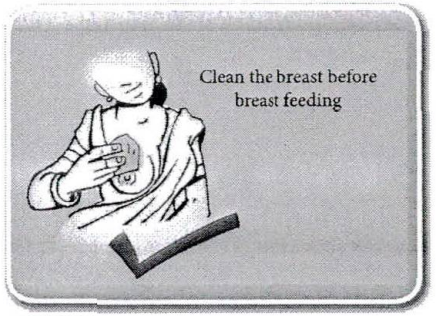
- Ask the group to compare their list with the list compiled by experts as follows:
  - ***Birth planning:*** This includes ensuring registration, receiving information about importance of institutional delivery, having JHA and ASHA contact numbers, arranging money and transport to go to the health care facilities, knowing blood group and arranging for blood before delivery, arranging clothes for the baby and preparing a care taker to accompany and care for the pregnant woman.
  - ***Nutrition:*** Importance of having nutritious food that include vegetables, fruits, sunflower or sesame seeds, supplemented by iron and folic acid tablets (normally 100 but 200 in case of severe anaemia), avoiding drinking too much tea or coffee, and maintaining basic hygiene at key times (washing hands before eating, after defecation and washing fruit/vegetables before eating).
  - ***Family Planning:*** Includes counselling on birth spacing and family planning methods appropriate to the profile and need of the pregnant woman.
  - ***Danger signs:*** Recognizing danger signs for mother and newborn during ANC, INC and PNC and knowing what to do/who to refer to.
  - ***Newborn care:*** Includes kangaroo care, breast feeding, thermal protection, the 5 'cleans', umbilical cord care, and giving the needed support to adjust to the new environment.
  - ***Government schemes:*** Information on government schemes, both state and central government that are MNCH related, with focus on *Madilu Kit, Bal Sanjivini, Thai Bhagya, JSY* and *Prasooti Arayike.*
  - ***Patients' Rights:*** Information about available health services and instilling a rights perspective among women in accessing the health care services in line with their needs.
- Tell the participants that these identified 7 critical issues will form the activities of the Sukshema project's MNCH intervention.

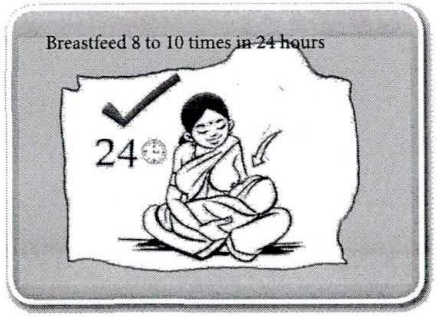


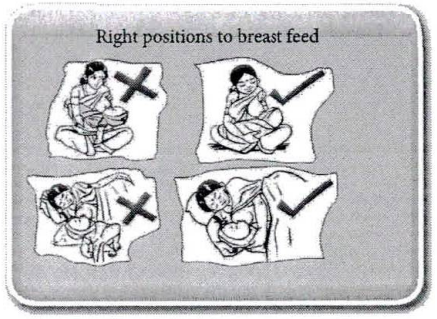
NEWBORN CARE

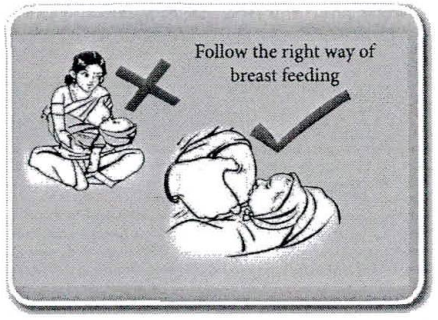


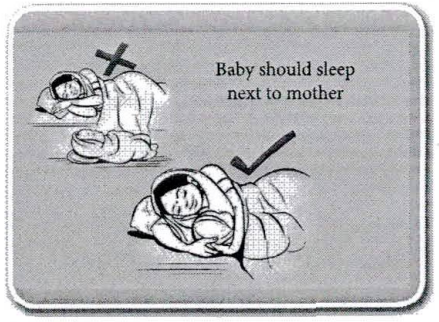


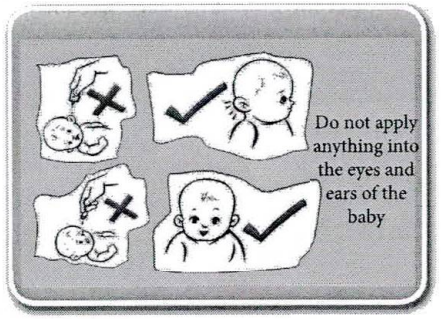


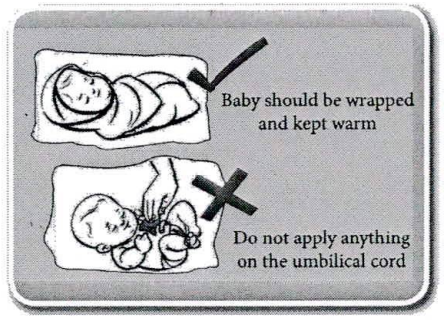


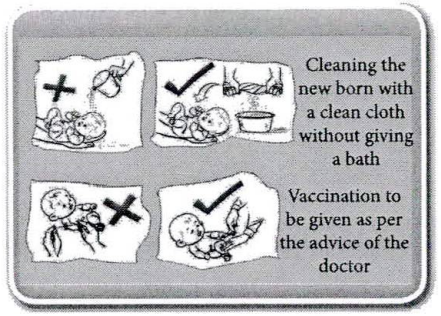


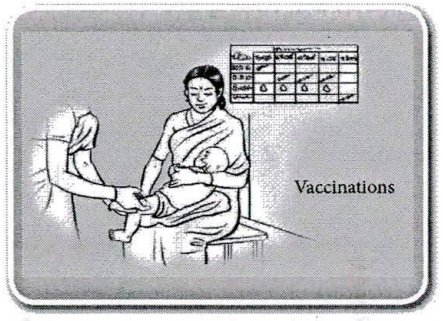


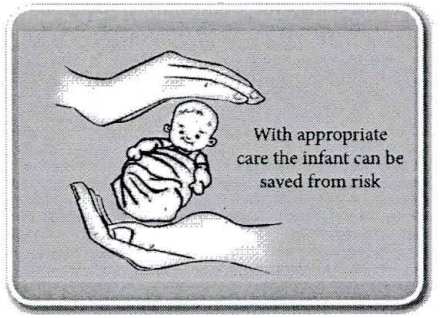


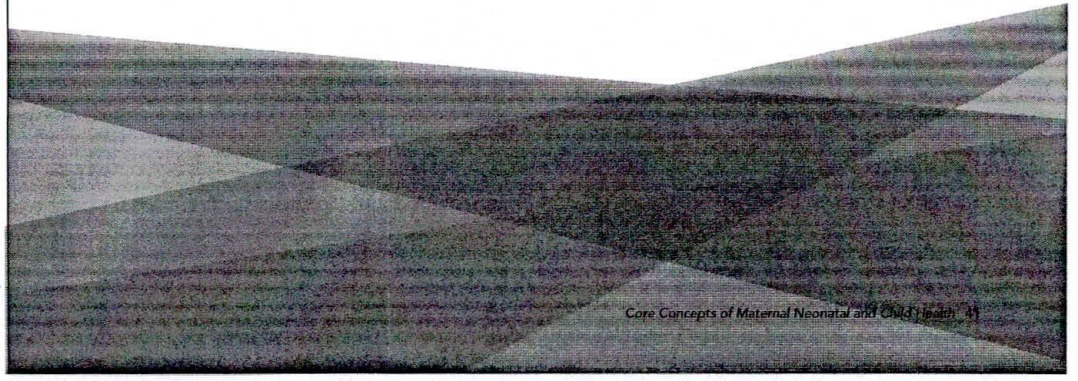




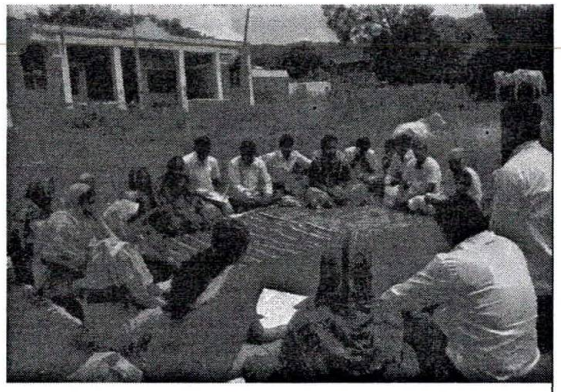








SESSION 7: POST-TEST AND TRAINING EVALUATION AND FEEDBACK



Objective

- To assess the extent to which the participants have understood the sessions' key messages.
- To assess what affect the module had on the participants' attitudes, knowledge and practice levels.
- To obtain feedback from the participants on the usefulness of the training and suggestions for enhancing future effectiveness.

Methodology
Reflection

Duration
30 minutes

Training Materials

Annexure 6 Post-test and Training evaluation and feedback form

Tips for facilitators

The post-test: will assess the extent to which the participants have understood the sessions' key messages. The seating arrangements can be changed to ensure that each participant does their own work so as to gauge how well they have understood the technical components and terms described through the module's sessions. This post-test can be modified based on the local training context. The post-test feedback can be either through sharing the marked tests, or through a group discussion about the best possible answers for each questions.

The training evaluation and feedback form: will assess what affect the module had on the participants' attitudes, knowledge and practice levels and obtain feedback on the usefulness of the training and suggestions for enhancing future effectiveness.

Process

- Assign a new 'classroom-like' seating arrangement for the participants, having them sit in rows that allow a space wide enough for the facilitator to walk through.
- Reassure them that this post-test is not for grading purposes, but to gauge the extent to which the training has been successful in highlighting the key themes and technical content.
- Give each participant a post-test and ask them to put their name at the top.
- Allow 20 minutes to complete it by choosing one correct answer from the multiple choices.
- After they finish, collect the filled questionnaires.
- Distribute the training evaluation and feedback form. Go over all the areas that they will need to think about while filling it in.
- Allow 20 minutes to complete it.
- While participants are completing the training evaluation and feedback form, the facilitators of the module should check the post-test papers and total the marks for each participant.
- Decide if the post-test results will be shared with the participants, or if a group discussion will be held on the correct answers.
- Collect the training evaluation and feedback forms from the participants.
- Either give back the post-tests and go over the correct answers, or hold the group discussion on the correct answers.
- Before the closing ceremony, ask the participants to share their feelings about the training: encourage anyone who is keen to orally share two positive aspects and two areas that need improvement.
- At the closing ceremony thank all the participants for their enthusiastic participation, congratulate them and wish hem the best as they go back to their own work areas and begin to initiate the intervention on the ground.
- Thank everyone else who contributed to the training program. This might have included administrative staff, venue owners, facilitators, guest speakers and the organizers.

TRAINING EVALUATION AND FEEDBACK FORM:

KARNATAKA HEALTH PROMOTION TRUST
Training Evaluation and Feedback Form

Name: _____ Designation: _____ Place of training: _____
Training dates: _____ Name of the PHC: _____

S.No.	Subject	Excellent	Good	Poor
1	Training content and sessions			
2	Training methodology and activities used			
3	Training skills of the facilitators			
4	Logistics at the training (Food, stay and comfort)			
5	Relevance and usefulness of training			

List the three aspects of the training that you found most useful.

1.
2.
3.

Name any session during the training that you did not understand properly/ or that was not communicated well.

1.
2.
3.

What are the three most important lessons that you can take back to your work place from this training?

1.
2.
3.

Please list suggestions for improved facilitation in future trainings.

1.
2.
3.

ANNEXURE 1 - Reading material on MNCH continuum of care

INTRODUCTION

Adopted by world leaders in the year 2000 and set to be achieved by 2015, the MDGs provide concrete, numerical benchmarks for tackling extreme poverty in its many dimensions and provide a framework for the entire international community to work together towards a common end – making sure that human development reaches everyone, everywhere.

Two of the health-related MDGs focus on reducing child mortality and improving maternal health. The global data substantiates provides the rationale for its inclusion in the MDGs. It says Worldwide:

- 530,000 women die from pregnancy related complications
- 4 million babies die within first month of life
- More than 10 million children die under age 5
- Nearly 99% of mother, newborn and child deaths occur in low and middle income countries

Most of these deaths are preventable if proper and timely care is made available. If we further analyse the data it shows that most of the deaths occur during the first five years: of which most happens in the first 24 hours.

Therefore, the MNCH programme under the NRHM, is envisaged to address complications during pregnancy and delivery and during neonatal and first five years, as universal coverage with key effective, affordable interventions: care for newborns and their mothers; infant and young children.

WHAT IS CONTINUUM OF CARE?

Continuum of care is a concept involving an integrated system of care that guides and tracks patient over a period through an intensive and comprehensive array of health services spanning the entire lifecycle from 'start to finish' in a seamless manner rather than a specific and unvarying list of services.

WHAT IS MNCH CONTINUUM OF CARE?

The 'MNCH Continuum of Care' includes integrated service delivery for mothers and children from pregnancy to delivery, the immediate postnatal period, and childhood. It recognizes that safe childbirth is critical to the health of both the woman and the newborn child and is based on the assumption that the health and well-being of women, newborns, and children are closely linked and should be managed in a unified way.

WHY THE APPROACH IS ESSENTIAL?

In the absence of the continuum of care approach, the policies and programs in the fields of maternal, newborn, and child health, would generally focus on one issue alone and address it with reference to only one of these groups. This approach would result into obscuring important linkages. When approached together and incorporated into integrated programs, these interventions can offer continuity of care and save millions of lives by building linkages, reducing missed opportunities, minimizing delays in care and treating the components as a continuum rather than separate parts.

This approach that groups the interconnected fields of maternal, newborn, and child health can help families access the benefits more easily. Linking interventions and delivering it as a package within the continuum of care can also avoid the duplication and make it more cost-effective. It thus can have a stronger impact and accelerate progress to improve the lives of families.

WHAT DOES IT INCLUDE?

The MNCH services under NRHM have adopted the continuum of care as one of its guiding principles to bring needed interventions to mothers, newborns, and children to improve their health and survival by saving children who die every year from preventable diseases.

This model demands the availability and accessibility to essential healthcare services and includes a package of:

- **Antenatal Care** – care during pregnancy
- **Intra-natal Care** – care during delivery of the baby
- **Post-natal Care** – care during the period starting from delivery up to 6 weeks
- **Child Care** – care of the child up to 5 years

ANNEXURE 2 - Reading material on antenatal care (ANC)

ANC is the medical care given to a pregnant woman and her baby starting from the time of conception up to the delivery of the baby and even goes beyond it. It plays an important role in achieving the aim of MNCH by preparing the pregnant women for a successful labour and delivery process by helping the mother maintain good health during pregnancy, informing the family members about pregnancy, labour and child care.

Pregnancy is a natural event in the life of women of reproductive age group. However, during pregnancy and childbirth some problems may arise which can threaten the life of the mother, baby or both. It is possible to identify women with some problems quite early if they have routine ante-natal check-up. This will enable them to access specialist care. Care during pregnancy is important to monitor progress and growth of the baby, detect complications at the earliest and treat them accordingly. During the visit the woman and her family should be advised proper nutrition, rest, exercise. They can make plans about where to deliver. This will help both the woman and baby to have a happy and healthy outcome. Minor ailments of pregnancy (e.g. vomiting, heart burn, constipation, backache etc.) are looked after during ANC period.

SCHEDULE OF ANC

- **The first visit is recommended as soon as the woman feels that she is pregnant. This is called registration of pregnancy, which ensures that all pregnant women receive care throughout pregnancy.**
- **In villages/districts where female foetuses are being eliminated before birth, it is further important that pregnancy is registered early.**
- **The second visit should be made between the fourth and sixth month.**
- **The third visit should be planned in the eighth month.**
- **An additional visit in the ninth month would help provide better care.**

If the health worker identifies health problems during these visits, a visit to a doctor will become necessary.

Advantages of early registration:

- Helps in assessing the health status of the mother and obtaining baseline information on BP, weight, etc.
- Helps in screening for complications/danger signals at an early stage and managing them appropriately by referral as and where required.
- Helps the woman recall the date of her last menstrual period for deciding EDD
- Helps in giving the woman the first dose of Tetanus Toxoid (TT) injection well within time (after 12 weeks of pregnancy).
- Helps the pregnant woman access facilities for an early and safe abortion if she does not want to continue with her pregnancy.
- Helps in building a good rapport with the pregnant woman and her family.
- Helps in starting the woman on a regular dose of folic acid during the first trimester.
- Helps in maintaining complete records in the Thayi card and for follow up.

What is done during pregnancy check-up and care?

A complete pregnancy check-up is carried out to detect problems and decide whether referral to doctor is required.

During the first check-up

- Take complete history of this pregnancy and previous pregnancies, if any and whether the woman has had any medical/surgical problem in the past.
- Weigh pregnant woman to see whether she is gaining adequate weight during pregnancy.
- Check BP to see if it is normal, high or low.
- Exam breasts/nipples to check whether they are normal.
- Exam abdomen to check growth/position of the baby.
- Test blood for anaemia (lacks blood/haemoglobin). If anaemic, how severe? If the woman has anaemia, prompt treatment helps prevent complications.
- Examine urine.
- Give first dose of TT injection.

During subsequent visits

- Details of any problem appearing since last visits are reassessed.
- BP, weight, and abdominal examination are repeated.
- Hundred iron and folic acid tablets (IFA) are given to all pregnant women.
- Treatment for anaemia depending upon the blood test results.

- Health education, advice, and counselling on
  - Nutrition
  - Birth planning
  - Safe abortion
  - Family planning
  - Institutional delivery
  - Information about government schemes such as JSY, Madilu Kit, Prasooti Araike.

HIGH RISK PREGNANCIES

It is important to identify the high risk pregnancies, with risk either to the mother and baby, and monitor them regularly by visiting them every month, watching for danger signals and convincing them to go for regular check-ups at the hospital and have an institutional delivery.

The following are considered high-risk pregnancies:

- Severe anaemia –possible need for blood transfusion during delivery.
- Young primi[1] (below 18 years) – possibilities of complications if the reproductive system is not fully developed (obstructed labour, ante-partum haemorrhage).
- Elderly primi (above 30 year) – there is risk of diabetes / High BP, chance of handicapped children.
- Elderly grand multiparas[2] - possibility of increased incidences of complications during pregnancy, labour and puerperium are likely to occur in these women.
- Short structured primi (140 cm) –There can be higher incidences of preterm birth and underweight babies. Also, these women are more likely to have a small pelvis, which can result in such complications during childbirth.
- Mal-presentations, (breech, transverse lie) etc. – Mal-presentation or mal-position of the foetus at full term increases the risk of obstructed labour and other birth complications.
- Ante partum haemorrhage, threatened abortion (bleeding) - chance of pre-term delivery.
- Pre-eclampsia & eclampsia.
- Twins, hydramnios.
- Previous C section or instrumental delivery/ prolonged labour/ stillborn/ intrauterine death/ manual removal of placenta/PPH.
- Excessive weight gain or not gaining enough weight.
- Family history of systemic illness - hypertensive, diabetes, h/o thalassaemia, delivery of twins and delivery of an infant with congenital malformation.
- Pregnancy associated with general disease.
- History of intake of habit-forming or harmful substances, such as alcohol, cigarettes.

Pregnant women with any of the following conditions has to be referred to a doctor

- Repeated neo-natal deaths, stillbirths, premature births or repeated abortions.
- Vaginal bleeding during present pregnancy.
- High BP or abnormal urine test indicating pregnancy induced hyper-tension (PIH).
- If the pregnant woman's previous delivery was through abdominal operation or she has had some other abdominal operation in the past.
- The pregnant woman has heart disease, anaemia, high BP, jaundice etc.
- If the pregnant woman has very big abdomen.
- If the woman is pregnant with twins.
- If the baby is upside down or in abnormal position inside the uterus.

Home care during pregnancy

- The woman's family and community have the key responsibility for making sure that the woman gets more food, takes rest and does not have to do heavy manual work during pregnancy.
- The pregnant woman needs extra energy from food, for the sake of her own health, for the growing foetus and for effective breastfeeding later on.
- During pregnancy a nutritious diet which is rich in iron, calcium and protein is required. For this, a pregnant woman should eat green, leafy vegetables, dal, milk, jaggery, eggs, fish, meat, etc.
- Taboos and restrictions on a pregnant woman's diet, such as not allowing certain vegetables, fruits, milk and ghee, might in fact harm her and the baby.
- Pregnant women are entitled to get food from the AWW centre.
- A pregnant woman should not fast. This deprives her and the growing baby inside the uterus of essential food.
- Pregnant women should not carry out heavy manual labour, like working on construction sites, famine relief, brick kilns, etc. Other members of the family and community should help to reduce her work burden.
- Pregnant, adolescent girls are especially likely to be under-nourished and are more likely to suffer problems during delivery. They need extra nutritious food and help for safe delivery at a health facility.
- Sometimes there are overweight pregnant women who need to avoid eating fat-rich food like oil, ghee, sugar, etc), but they should continue to eat vegetables, fruits, nuts and milk which are rich in iron, calcium, vitamins and minerals. They should also take regular exercise and consult a doctor.

1 Primi is a woman who is going to be delivering the baby for the first time

2 The term "multipara" applies to any woman who has given birth 2 or more times. A woman who has given birth 5 or more times is called a grand multipara.

EMERGENCY REFERRAL DURING PREGNANCY

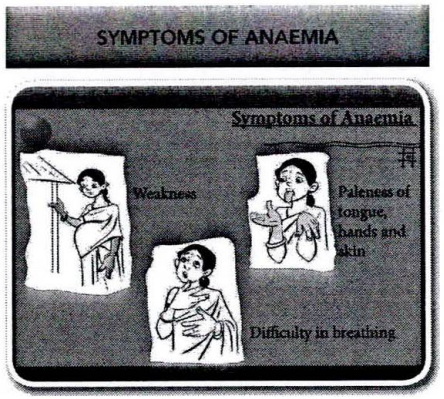
Danger signs in women	How to recognize	Action to be taken
Bleeding from the vagina	Bleeding- Any amount (bright red bleeding, or clots or tissue)	Refer to FRU/ Dist/ tertiary hospital
Loss of foetal movement	Absence of movement or kicking	Refer to FRU/ Dist/ tertiary hospital
Headache/ dizziness/ blurred vision	Severe headache and blurred vision or severe headache and spots before the eyes	Refer to FRU/ Dist/ tertiary hospital
Swollen face/ hands	Pitting oedema over back of the palm	Refer to FRU/ Dist/ tertiary hospital
Convulsions/ fits	Eyes roll, face and limbs twitch, body gets stiff and shakes, fists clinched	Refer to FRU/ Dist/ tertiary hospital

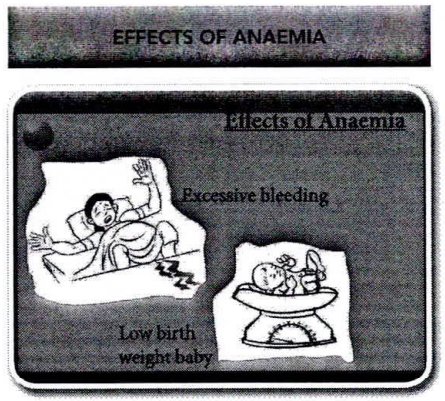
NON- EMERGENCY REFERRAL DURING PREGNANCY

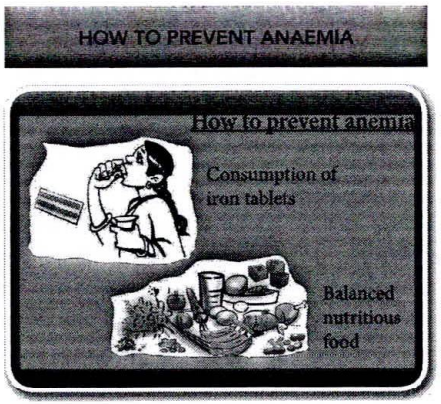
Problem	How to recognize	Action to be taken
Severe anaemia	Tongue very pale, weakness, general swelling on body	Refer to PHC/ dist/ tertiary hospital
Night blindness	Pregnant woman finds it difficult to see at dusk	Refer to JHA or PHC
Fever	Skin warm to touch. Temp > 100'C	Give paracetamol tab. If no relief after 48 hours, refer to PHC
Pain/ burning during urinating	Frequent urination & urgency, or pain/ burning when passing urine	Have mother drink two glasses of water in the morning, afternoon and evening. If no relief after 24 hours, refer to PHC
White discharge	Passage of white discharge by Vagina, itching in private parts	Teach mother to use genital violet; placed high in her vagina daily. If no relief after 5 days, refer to PHC
Itching/ scabies/ boil with pus on skin	Skin rashes with itching- could be present in other family members as well • Scabies • Presence of pus filled boils	For boils, advise woman to apply hot fomentations to the area thrice daily. If no improvement after 2 days refer to PHC
Bad obstetric history	Past history of abortion, still birth, neonatal death	Refer to FRU/ dist/ tertiary hospital
Multiple pregnancy	Suspicion/ knowledge	Refer to FRU/ dist/ tertiary
Malpresentation	Suspicion/ knowledge	Refer to FRU/ dist/ tertiary

Anaemia in pregnancy

- Lack of blood in the body is known as anaemia and is common in northern Karnataka. Anaemia in pregnancy leads to complications in pregnant women and can result in the death of mother and baby. A pregnant woman with anaemia looks pale, feels tired, complains of breathlessness on carrying out routine work, and might have swelling of the face and body. Anaemia can be prevented and treated completely if the woman follows the advice of JHA/doctor.
- Anaemia is treated with iron tablets, which have to be taken daily for many months during pregnancy or by giving injections. If the anaemia is severe, hospitalization and blood transfusion may be required.
- All pregnant women need to take one iron tablet daily, starting after three months of pregnancy to prevent anaemia.
- While giving iron tablets, the woman should be advised that some side effects might occur. However, they can be managed. These include:
  - Nausea or occasional vomiting - this can be prevented/avoided by taking the tablet after meals.
  - Constipation – this can be managed if the woman drinks more water and eats fruit.
  - Black stools or mild diarrhoea.
- The pregnant women should be advised that iron tablets should not be taken along with tea as that reduces its absorption.
- Pregnant women who have anaemia must have deliveries in hospital.







KEY MESSAGES

- All pregnant women should have early registration (12-16 weeks)
- All pregnant women should have a minimum of three ANC check-ups and hospital delivery in a health centre or hospital.

ROLES AND RESPONSIBILITIES OF ASHA:

- Visit every house in the community to make a list of all women who are eligible to become pregnant and children under the age of 5 years.
- Keeps records, registers and stock of supplies, equipment and medicines.
- Identify all pregnant women in the respective villages
- Help pregnant women in getting registered between 12-16 weeks of pregnancy and in getting the next three ante-natal check-ups.
- Ensure all requisite examinations/investigations are done for all pregnant women.
- Know the date and time of availability of JHA in Anganwadi Centre (AWC) in your village and inform all pregnant women about the same.
- Advise pregnant women regarding importance of balanced diet and ensure that undernourished pregnant women receive supplementary food from AWC.
- Attend to home deliveries and observe each woman during labour and delivery
- Recognizes early signs of newborn's sickness and manages it at home.
- Ensures that the baby gets necessary immunization on time.
- Actively collaborates with traditional birth attendant, JHA and supervisor.
- Track the drop-out pregnant women especially those who live in remote areas, are below poverty line, schedule caste/schedule tribe/migrants, etc. and help them in accessing health services.
- Help eligible pregnant women to get benefits under JSY.
- Advise the pregnant woman and her family about potential danger signs during pregnancy, delivery and after delivery, the post-partum period. If she has any of the following problems, she should be taken immediately to the nearest functional FRU directly. These include:
  - Any vaginal bleeding during pregnancy
  - Heavy vaginal bleeding during and following delivery, especially if the woman is feeling weak and faint
  - Severe headache/blurring of vision
  - Convulsions or loss of consciousness
  - Labour pains lasting more than 12 hours
  - Labour pains before eight months or 32-36 weeks of pregnancy.
  - Premature rupture of the bag of waters or leakage of water from uterus membranes, leaking
  - Failure of the placenta to come out within 30 minutes after delivery
  - Baby stops kicking inside the womb

ASHA should have the following information:

- The location of nearest FRU/hospital with obstetrician, anaesthetist, paediatrician, nursery, O.T. and blood bank.
- The mode of transport to reach facility should there be an emergency
- Approximate cost for Caesarean Section, blood transfusion and hospital stay, if it is a private hospital.

Note:
In case, it is a second pregnancy, when a couple already has a daughter, ASHA needs to be alert to the possibility that the family may reject another daughter and counsel accordingly.

ROLES AND RESPONSIBILITIES OF JHA:

- Cooperates with ASHA and informs her when women go into labour
- Attends to mothers during labour and delivers babies
- Practices clean and safe delivery methods
- Reinforces health education messages given by ASHA

ANNEXURE 3 - Reading material on delivery/ intra-natal care

WHAT IS INTRA-NATAL CARE?

Intra-natal care refers to the process of child birth. It is an extremely important process in every pregnancy. Quality intra-natal care can be the key to control the maternal mortality problem in India.

Delivery occurs normally after nine months of pregnancy. If delivery is before time special care for baby may be needed. As far as possible a pregnant woman should have the delivery in a health centre or hospital even if pregnancy is normal. This is mainly because during delivery, labour complications may suddenly occur which can threaten the life of mother, baby or both.

During delivery the time between starting of a problem to death of mother, baby or both is so short that it may not be possible to save the life of mother or baby if the pregnant woman is not already in a well-equipped health centre or hospital.

OBJECTIVE OF INTRA-NATAL CARE

Intra-natal care aims to provide

- Maintain the health and well-being of pregnant women and their offspring during the intra-natal period
- Closely observe the women in labour and avoid interference with natural process of delivery unless there is a valid reason to do so.
- Encourage and support women in labour and extend personal attention to them.
- Identify promptly any complications during the delivery process and institute immediate remedial measures including referral care.
- Ensure a safe delivery outcome in the form of healthy mothers and healthy babies.

During the intra-natal period it is important to maintain

- Clean and hygienic delivery conditions – five cleans that include
  - Clean hands
  - Clean delivery surface
  - Clean cord cut
  - Clean cord ties
  - Clean cord stump care.
- Safe delivery with minimum injury to the infant and mother
- Preparedness to deal with complications such as prolonged labour, ante-partum haemorrhage, convulsions, mal-presentations and prolapsed of umbilical cord etc.
- Care of the newborn baby

The intra-natal care includes

- Observation and assessment of the woman in labour, observation of the foetus, monitoring of labour, observation of the newborn in terms of appearance, pulse/ heart rate, reflexes, activity and muscle tone and respiration and weight recording.
- Care and attention in terms of prevention of infection, establishment of respiration of the newborn, prevention of heat loss and cutting of umbilical cord of the newborn.
- Education and counsel to feed colostrums, and develop an immediate bond between the mother and the newborn

STAGES OF LABOUR

1st stage- Starts from the beginning of pain until the mouth of the womb is fully open. This happens inside and cannot be seen. The bag of water also breaks. The fluid is usually clear but could also be yellow, green or red. This stage of labour usually lasts for about 8 to 12 hours.

2nd stage- Contractions push the baby out of the womb: the delivery of the baby. This stage of labour lasts usually for about an hour.

3rd stage- The contractions cause the placenta to peel off: delivery of the placenta. This lasts for about 20-30 minutes.

DANGER SIGNALS DURING INTRA-NATAL PERIOD

It is important to identify danger signals and refer the woman in labour to the appropriate health care facility especially in case of the home deliveries. These danger signals include:

- Irregular / fast / very slow fetal heart[1] **(Fetal distress)**
- Labour taking more than normal time[2] **(Prolonged labour)**
- Head or shoulders not coming out **(Obstructed labour)**
- Cord comes out before baby **(Cord prolapse)**
- Yellow or foul smelling liquor **(Meconium stained liquor)**
- Placenta not expelled completely **(Incomplete / retained placenta)**
- Fever
- Fits

1 The normal range of baby's heartbeats is 120 to 160 heart beats per minute

2 An 'average' length of labour for a woman having her first child is 12 to 18 hours. An "average" length of labour for a woman having her second or more children is considered to be about 7 hours. If the labour period extends to more than 24 hours, it is called a prolonged labour.

ROLES AND RESPONSIBILITIES OF ASHA:

- Counsel/advise the pregnant women and their families for institutional delivery.
- Identify the location of the hospitals, health centres, institutions near your village which provide delivery services round the clock, where delivery can take place and the cost for the same, if any and how to reach the hospital.
- Escort/ accompany the pregnant woman to the hospital for institutional delivery.
- Ensure the availability of transport to the FRU/ transport money available for the same, and how to access it in case of emergency and escort her.
- Find out the money/other provisions available under JSY for the area/ and what is the procedure to get it.
- If there is no functioning health centre or hospital within reach, or the family prefers a home delivery, advise the pregnant woman and her family to have the delivery conducted at home by a skilled birth attendant (SBA) such as JHA, staff nurse or doctor.
- In case a skilled birth attendant is not available, the delivery can be conducted by a trained TBA.
- Five cleans must be practiced during delivery: i.e. Clean hands, Clean surface, Clean new blade, Clean cord tie and Clean cord stump (do not apply anything on the stump).
- Place of delivery to be kept warm and free from draught.
- Help the mother in initiation of breast-feeding after delivery.

ANNEXURE 4 - Reading material on post-natal care (PNC)

WHAT IS PNC?

Post-natal period is the period of six weeks immediately after delivery, which is important both for the mother and the newborn. In this period, the changes, which have taken place in the organs/system during pregnancy in the woman, come back to normal, except the breasts. Mother and the newborn are susceptible to some problems which you should be aware of, so that they can be guided for treatment/referral. Postpartum care encompasses management of the mother, newborn, and infant during the postpartum period.

The time when effective PNC can make the most difference to the health and life chances of mothers and newborns is in the **early neonatal period**, the time just after the delivery and through the first seven days of life. However, the whole of the **neonatal period**, from birth to the 28th day after the birth, is a time of increased risk.

Deaths during the first 28 days of babies who were born alive is reported by all countries in the world as the neonatal mortality rate (the number of babies who die in the first 28 days) per 1,000 live births. Similarly, reports of maternal mortality include deaths of women from complications associated with postnatal problems, not just problems arising during the birth. Both these rates are important indicators of the effectiveness of postnatal care.

During the postpartum period the mother is at risk for such problems as infection, haemorrhage, pregnancy induced hypertension (PIH), blood clot formation, the opening up of incisions, breast problems, and postpartum depression.
Hence it is important for ASHAs/ JHAs to pay frequent home visits during the PNC to ensure that the newborn and mother are safe and check if there are any danger signals.

PRESCRIBED SCHEDULE FOR PNC VISITS

Home visits of ASHA and JHA are scheduled on

- 3rd, 7th and 42nd day for evaluation of mother's health
- 14th, 21st and 28th days for the newborn care

If birth occurs at home, the first visit should target the crucial first 24 hours after birth. In addition to the routine PNC visits the ASHAs and JHAs needs to do two / three extra visits to LBW babies.

Essential routine for PNCs

- Assessment of mother and newborn
- Identification of danger signs in mother and newborn
- Advice and counselling
- Referral for complications

Assessment for all mothers should include checking the following:

- Bleeding
- Convulsions or loss of consciousness
- Abdominal pain and fever
- Presence of any cyst/ swelling
- Tightness of stomach
- Cracked / inverted nipples
- Pulse, BP, temperature, pallor, breasts, abdomen, perineum, bleeding/foul smell /infection indicated by lochia discharge etc.
- Pus in the stitches
- Burning sensation while passing urine
- Anaemia

Assessment for all newborn should include checking the following:

- Loose motions/ fever
- Umbilical cord
- Breast feeding
- Comfortable breathing
- Weight
- Head protected and kept warm
- Eye movements
- Passing urine and stool

Extra care for low birth weight babies (LBW) or small babies and other vulnerable babies

- Identification of small babies / babies who need extra care.
- Assessment for danger signs and management or referral as appropriate.
- Extra support for breastfeeding, including expressing milk and cup feeding, if needed.
- Extra attention to warmth promotion, such as skin-to-skin care, or Kangaroo Care.
- Early identification and rapid referral of babies who are unable to breastfeed or accept expressed breast milk.
- Early identification and referral/management of emergencies for mother and baby.
- Appropriate detection, management, or referrals are necessary to save mothers and babies in the event of life-threatening complications.

Danger signs for the mother

- Excessive bleeding (Post-partum haemorrhage)
- Foul smelling vaginal discharge/ lochia (sign of sepsis)
- Fever with or without chills
- Severe abdominal pain
- Pus formation
- Excessive tiredness or breathlessness
- Swollen hands, face and legs with severe headaches or blurred vision
- Painful, engorged breasts (breast abscess) or sore, cracked, bleeding nipples
- Headache, blurring of vision
- Convulsions (Eclampsia)
- Difficulty in passing urine (Urinary Tract Infection)

Danger signs for the baby

- Convulsions
- Movement only when stimulated or no movement, even when stimulated (lethargy)
- Poor breastfeeding
- Fast breathing (more than 60 breaths per minute), grunting or severe chest in-drawing
- Fever (above 38°C) / Low body temperature (below 35.5°C),
- Very small baby (less than 1500 grams or born more than two months early)
- Bleeding
- Difficulty in breathing (chest in-drawing / grunting)
- Blood in stool
- Yellow palms and soles

BIRTH ASPHYXIA

One of the common causes of death among newborns is birth asphyxia. The foetus inside the mother's womb gets air from the mother's blood through the umbilical cord. Once the baby is out of the womb, it gets air by breathing. The cry is the first powerful breath. Most babies are born with a good cry and start to breathe vigorously on their own. A few babies do not. Babies who do not cry or breathe or have a weak cry or breath need help. This happens when the baby does not have enough air during the process of delivery and it suffocates. This affects the baby's brain and makes it appear dull at birth. When an asphyxiated baby is born, it appears limp and does not cry.

Definition

A baby who has at birth any one of the following symptoms is asphyxiated:

- No cry
- Weak cry
- No breathing
- Gasping
- Weak breathing

Consequences of asphyxia

Immediate (at birth):

- Still birth
- Drowsiness
- Unable to suckle
- Baby may die within the first few days

Long term:

If the baby survives it may have:

- Mental retardation
- Epilepsy (seizures and fits)
- Spasticity (Difficulty with walking or moving arms and hands)

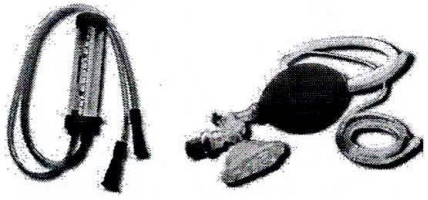
Warning of Asphyxia during labour:

- Prolonged or difficult labour
- Ruptured membranes with little fluid (dry delivery)
- Green or yellow colour thick amniotic fluid
- Prolapsed cord or tight cord around the neck
- Preterm labour (less than 8 months 14 days gestation)
- Breech presentation (or other abnormal presentation)

Addressing birth Asphyxia

If the baby does not cry or breathe or has a weak cry or breath, immediately dry and wrap the baby. Use a mucus extractor to clear the secretions in the airways (mouth, throat and nose) so that the baby can inhale freely. The cord need not be cut before the mucus extractor is used. If the mucus extractor does not result in the baby crying or breathing, start using the bag & mask immediately. ASHAs are trained to do this.

Mucus extractor ***Bag and Mask***



NEONATAL SEPSIS

Definition

In newborns the word 'sepsis' refers to any serious infection in the baby, whether in the lungs, brain or blood.

How big is the problem?

In India, nearly 1 out of every 10 newborns develops conditions suggestive of sepsis. Sepsis in the first month is very serious and can cause the baby's death. Without treatment many babies with sepsis die. With treatment, most live and grow up normally.

Causes of neonatal sepsis

- Mother has infection during pregnancy or delivery.
- During delivery, unclean techniques (poor hand washing, TBA putting hands inside the mother, using dirty blade and cord ties).
- Cord becomes infected from unclean cutting or putting dirty things on cord.
- Baby is weak; born pre term or with low birth weight (less than 2,000 gms).
- Baby becomes weak from poor feeding practices, including not giving breast milk early and exclusively.
- Baby comes in contact with an already infected person: mother, family members, visitors, TBA or ASHA.

How can sepsis be prevented?

- Good hygiene during and after delivery - frequent hand washing, clean clothes for the baby, clean blade during delivery.
- Keeping the baby warm.
- Breast feeding (early initiation and on demand).
- Keeping the umbilical cord clean and dry.

Advice and counselling

This is one of the important components of the PNC visits. The new mother and her family need guidance on several subjects, especially because there are number of misconceptions regarding the food to be given to the new mother, breastfeeding, and cord care, etc. More importantly, they need to know about the types and scheduling of required immunizations, and birth registration. The advice and counselling should include information on the following:

- Nutrition for mother
- Hygienic and warm environment (including personal hygiene for mother)
- Rooming in
- Registration of birth
- Cord care
- Colostrum feeding and exclusive breast feeding
- Immunisation
- Family planning (including spacing)
- Danger signs
- Follow up

General precautions the family must take with the newborn

The newborn is delicate and can easily fall sick if the family and mother are not careful. Some general precautions that the family should take are:

- **Bathing the baby:** Although it is recommended that the baby should not be bathed until the first seven days, many families bathe the baby on the first or second day. For a normal baby, if the family insists, the baby could be bathed after the second day. But in the case of LBW baby, you must insist on waiting for at least seven days. You should explain that bathing the baby and leaving it wet or exposed may cause it to get cold and fall sick. Thus, it is better to wipe the baby with a warm wet cloth and dry the baby immediately.
- People who are sick with cold, cough, fever, skin infection, diarrhoea, etc. should not hold the baby or come in close contact with the baby.
- The newborn baby should not be taken to places where there are other sick children.
- The newborn baby should also not be taken to places where there are large gatherings of people.

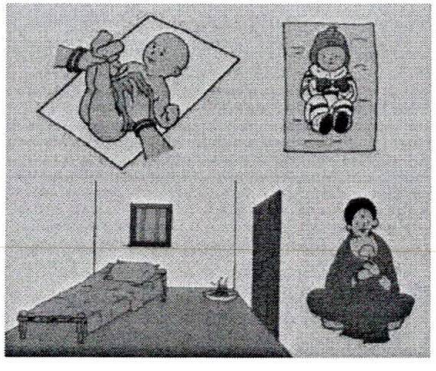
ROLES AND RESPONSIBILITIES OF ASHA

- Advise the woman at least one check-up within two weeks of delivery.
- Advise the women to visit the JHA for minor complaints e.g. sore breasts, cracked nipples, foul smelling discharge, pain in legs etc.
- Assist JHAs in conducting post-natal clinic and screening women and children with danger signals.
- Advise registration of birth.
- Counselling on exclusive breast-feeding for the newborn which:
  - Helps in better involution of the uterus.
  - Can produce lactational amenorrhea and thus act as natural contraceptive
- Counselling on contraceptive needs (temporary/ permanent) as required and help women/family to access them
- Ask mother to report if there is:
  - Excessive vaginal bleeding
  - Loss of consciousness
  - Fast or difficult breathing
  - Fever
  - Severe abdominal pain

Steps for you to take "just after" the baby is born

- Ask the mother about/observe the fluid after the waters break.

- If the fluid is yellow/green, as soon as the head is seen (even before delivery of complete baby), clean the mouth of the baby with gauze piece.
- As soon as the baby is born, note the time of birth and start counting time.
- Observation of baby at birth or within the first 30 seconds and at 5 after birth for movement of limbs, breathing and crying. The figure below will enable the assessment of whether the newborn should be recorded as a live or still birth. All six have to be "No" to declare a still birth. Even if one is "yes" the baby should be declared as live birth.
- If there is no cry or a weak cry, if there is no breathing or weak breathing or gasping, this condition is called Asphyxia. If the baby is asphyxiated (does not breathe at birth), and there is no doctor or nurse, you should try to help. This skill will be taught to you in Module 7. However, in many such newborns, your efforts may not make enough difference and you should not feel bad or blame yourself if the baby does not respond.
- Provide normal care at birth.
  - **Dry the baby:** Immediately after delivery, the newborn should be cleaned with a soft moist cloth and then the body and the head wiped dry with a soft dry cloth. The soft white substance with which the newborn is covered is actually protective and should not be rubbed off.
  - The baby should be kept close to mother's chest and abdomen.
  - The baby should be wrapped in several layers of clothing/ woollen clothing depending upon the season.
  - The room should be warm enough for an adult to feel just uncomfortable. The room should be free from strong wind.
- Weigh the newborn and decide whether the baby is normal or LBW.
- Determine whether the baby is term or pre-term.
- Measure newborn's temperature.



KEEPING NEWBORN WARM AND THE PROBLEM OF HYPOTHERMIA

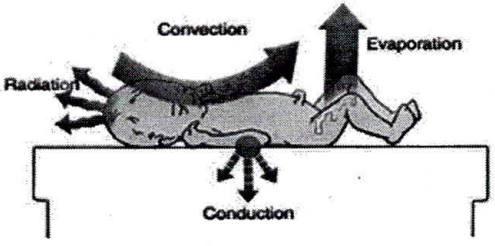
Why is it important to keep baby warm after delivery?

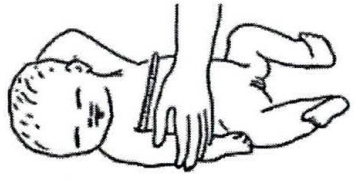
Babies have difficulty maintaining their temperature at birth and in the first day of life. They come out wet, and lose heat quickly. If they get cold, they use up energy, and can become sick. LBW and pre-term babies are at greater risk of getting cold.

When and why do most newborns get cold?

Most newborns lose heat in first minute after delivery. They are born wet. If they are left wet and naked, they lose a lot of heat to the air. A newborn baby's skin is very thin and its head is big in size compared to its body. It loses heat very quickly from its head. Babies do not have the capacity to keep themselves warm. If the newborn baby is not properly dried, wrapped, and its head is not kept covered, it can lose 2 to 4 degree Celsius within 10-20 minutes.

Example: If the baby's temperature was 97.7 degree Fahrenheit (36.5 degree Celsius [normal temperature]) at the time of birth and if there was a loss of 2.7 degree Fahrenheit because the baby was not properly dried and covered, the body temperature will become 95 degree Fahrenheit (35.0 degree Celsius [below normal temperature]).





What is the term for a situation when a baby's temperature falls below normal?

When a baby has a temperature below normal, it suffers from hypothermia.

What happens to a baby with hypothermia?

A baby who is cold, and has a low temperature (hypothermia) suffers from:

- Decreased ability to suckle at the breast, leading to poor feeding and weakness.
- Increased risk of death, especially in LBW and pre-term babies.

How can you tell if a baby is hypothermic?

- The early sign is cold feet.
- Then, the body becomes cold.

The best method is to measure the baby's body temperature. (This skill has already been taught to you)

How to keep newborns warm

- Before delivery, warm up the room (warm enough for adults).
- Immediately after delivery, dry the baby.
- Put a cap on the baby since a lot of heat could be lost though its head.
- Place in skin-to-skin contact with mother.
- Cover or put clothes on the baby, wrap it up with clean cloth, and place it close to its mother.
- Initiate early breastfeeding.
- Bathing for newborns:
  - It is best to wait until the second day to bathe the baby. One should wait seven days in case of LBW baby.
  - If the family insists on bathing the first day, please ask them to delay for at least six hours to give the baby time to adjust with its new environment.
  - For small and pre-term babies, do not give a bath until the baby gains weight (this could be few weeks) and weight of baby become 2,000 gm.
- To keep a small baby clean, you can give a light oil massage but making sure that the room is warm and the baby is not left uncovered for more than 10 minutes. DO NOT pour oil into any orifice, like the nose or ears at any time.
- Keep baby loosely clothed and wrapped.
- If it is very warm outside, make sure the baby is not too heavily clothed and wrapped; the baby can also get too hot.

BREAST FEEDING

Benefits for the baby

- Early skin-to-skin contact keeps the baby warm.
- It helps in early secretion of breast milk.
- Feeding first milk (colostrum) protects the baby from diseases.
- Helps mother and baby to develop a close and loving relationship.

Benefits for the mother

- Helps womb to contract and the placenta is expelled easily.
- Reduce the risk of excessive bleeding after delivery.

Important facts about breastfeeding

- Start breastfeeding immediately or at least within one hour after birth. Give nothing else, not even water.
- Baby should be put to the mother's breast even before placenta is delivered. It is useful for both the baby as well as the mother.
- Breastfeed as often as the baby wants and for as long as the baby wants. Baby should be breastfed day and night at least 8-10 times in 24 hours.
- Feeding more often helps in production of more milk. The more the baby sucks, more milk is produced.
- Baby should not be given any other liquid or foods such as sugar water, honey, goat's/cow's milk and not even water.

Why only breastfeeding?

Giving other food or fluid may harm the baby in following ways

- It reduces the amount of breast milk taken by the baby.
- It may contain germs from water or on feeding bowls or utensils. These germs can cause diarrhoea.
- It may be too dilute, so the baby becomes malnourished.
- Baby does not get enough iron from cow's and goat's milk and may thus develop anaemia.
- Baby may develop allergies.
- Baby may have difficulty digesting animal milk; the milk can cause diarrhoea, rashes or other symptoms. Diarrhoea may become persistent.
- Breast milk provides all the water a baby needs. Babies do not need extra water, even during the summer months.

BREASTFEEDING OBSERVATION TIPS

Signs of breastfeeding going well	Signs of possible difficulty
Mother's body relaxed, comfortable, confident, eye contact with baby, touching	Refer to FRU/ Dist/ tertiary hospital
Baby's mouth well attached, covering most of the areola, opened wide, lower lip turned outwards	Mouth not opened wide, not covering areola Lips around nipple
Suckling well, deep sucks, bursts with pauses Cheeks round, swallowing heard or seen	Rapid sucks, cheeks tense or sucked in smacking or clicking sounds
Baby calm and alert at breast, stays attached, mother may feel uterus cramping, some milk may be leaking (showing that milk is flowing)	Baby restless or crying, slips off breast; Mother not feeling cramping, no milk is leaking (showing that milk is not flowing)
After feed, breast soft, nipples protruding	After feed, breast full or enlarged, nipples may be red, cracked, flat or inverted

BREASTFEEDING

- Breastfeeding postpones mother's menstrual cycle, hence prevents pregnancy.
- Often a baby is breastfed only after the third day. This starves the baby and affects the milk flow.
- Immediate breast feeding within half an hour after birth is vital for the baby. It gives baby nutrition and immunity against illnesses. It shrinks the mother's womb and reduces bleeding. Milk flow is better with frequent suckling.
- Breast milk is the best food for the baby up to 6 months. No other food, including water, is necessary.
- Mother's breasts get prepared for producing milk during pregnancy. On delivery the breasts are ready to secrete thick milk called colostrum. The baby should be fed with colostrum as it protects the baby from germ-attacks. The colostrum should not be thrown away.
- Breast milk provides for all the needs of the baby. It also contains sufficient water for the baby's needs. No need for feeding water separately. More the baby suckles, the more milk is produced.
- Breastfeeding protects the baby from getting diarrhoea and pneumonia.
- Breastfed babies normally feed every two hours. Well-fed babies sleep quietly for 2-3 hours, and gain weight normally.

Breastfeeding Positions

Underarm Position *Side-lying Position* *Cradle Position* *Alternate Underarm Position*

MANAGING COMMON BREASTFEEDING PROBLEMS

Sore nipples

Causes:

- Poor latch-on or positioning at breast

Management:

- Improve attachment and/or position.
- Continue breastfeeding (reduce engorgement if present).
- Build mother's confidence.
- Advise her to wash breasts once a day with water, no soap.
- Put a little breast milk on nipples after feeding is finished (to lubricate the nipple) and air-dry.
- Wear loose clothing.
- If nipples are very red, shiny, flaky, itchy, and their condition does not get better with above treatment, it may be fungus infection. Apply gentian violet paint to nipples after each breastfeed for five days. If the condition does not improve, refer to a doctor.

Problem of not enough milk

Causes:

- Delayed initiation of breastfeeding; infrequent feeding; giving fluids other than breast milk; mother's anxiety, exhaustion, insecurity; inadequate family support.

Management:

- Decide whether there is enough milk or not:
  - Does the baby pass urine six times or more each day?
  - Has the baby gained sufficient weight? (During the 1st week there is usually a small weight loss, after that a newborn should gain 150-200 gm per week.)
  - Is the baby satisfied after feeds?
- Reassure the mother.
- If there is not enough milk, have the baby feed more often.
- Check breastfeeding process to observe mother attachment and positioning of the baby.
- Encourage rest. Encourage the mother to drink and eat more.

Signs that the baby is not getting enough milk

Poor weight gain

- Weight gain of less than 500 grams in a month
- Less than birth weight after two weeks

Passing small amounts of concentrated urine

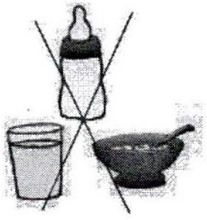
- Less than six times a day
- Yellow and strong smelling

Other signs are:

- Baby not satisfied after breastfeed and often cries
- Very frequent breastfeeds
- Very long breastfeeds
- Baby refuses to breastfeed
- Baby has hard, dry or green stools
- No milk comes when mother tries to express
- Breast did not enlarge
- Milk did not come in.

Mothers and families think that in the following situations, their milk is not enough, but in fact, these conditions do not affect the breast milk supply:

- Age of mother
- Sexual intercourse
- Return of menstruation
- Disapproval of relatives and neighbours
- Age of baby
- Caesarean section delivery
- Many siblings
- Simple, ordinary diet



ANNEXURE 5 - Reading material on child care

As most of the child deaths occur during the first five years of life, care of children below five years is one of the most crucial components in the MNCH continuum of care. The child care intervention has four important components:

- Monitoring growth and development
- Nutrition interventions
- Prevention and management of childhood illnesses
- Immunization

MONITORING GROWTH AND DEVELOPMENT:

The terms growth and development though used interchangeably, many times are two different concepts. Growth is the increase in size of the body – in height, weight, mid-arm circumference and other measurable areas. Development is the gaining of skills in all aspects of the child's life such as physical development, social and emotional development, intellectual development and communication and speech development.

The growth and development are both interlinked. Growth is the best general index of the health of an individual child, and regular measurements of growth permit the early detection of malnutrition, frequently associated with diarrhoea, and other illnesses/ developmental problems and take remedial action at the earliest. Monitoring growth and development helps in screening and diagnosing nutritional, chronic systemic lacunae and endocrine disease at an early stage and has the potential for significant impact on mortality. The remedial actions could include supplementary feeding, prophylaxis against vitamin A deficiency, control of nutritional anaemia and referral to medical services etc. to severely malnourished children.

Monitoring the growth of a child requires taking the same measurements at regular intervals, approximately at the same time of the day, and seeing how they change by plotting it on a growth chart.[1] If the child is not growing properly, it means the child is malnourished, i.e. under nourished.

NUTRITION INTERVENTIONS

Nutrition is required for a child to grow, develop, and remain active and to reach adulthood without illness. Nutrients such as carbohydrates, fats, proteins are required in large amounts (macro nutrients), while some nutrients e.g. Vitamins, Iron, Calcium, Iodine etc. are required in minimum amounts (micro nutrients).

Children should be give appropriate nutrition according to ages below:

0-6 months

During this period they should be given exclusive breastfeeding by feeding them at least eight times a day. Mothers should be encouraged to breast-feed on demand. Bottle-feeding should be discouraged and anxious mothers should be reassured by informing them that breast milk is the ideal food for young infants and it contains all nutrients. Chances of malnutrition in breast-fed infants are less and it prevents infection, as it is clean and free from bacteria. Breastfeeding enhances brain development Breastfeeding increases mother and child bonding and helps in better development of the child.

6-12 months

During this period, complementary feeding needs to start. Home based complementary foods after six months, given four or five times a day, in addition to continuing breastfeeding as often as the child wants is best. If the child is not breastfed, it may be given undiluted milk by a cup and complementary food five times a day. Food should be mashed and it should be freshly prepared. Washing hands before feeding is extremely important.

12 months-two years

Continue breastfeeding for two years or beyond. Give home based food four-five times a day

Two years onwards

Children should be given home-cooked food five-six times a day as they eat in small quantities.

1 Refer to Thayi Card to see the growth chart

MICRO NUTRIENTS (VITAMIN A, IRON, IODINE)

Vitamin 'A' Deficiency
Vitamin A is important for normal vision. Vitamin A deficiency is most common between six months and three years. It can even cause even blindness, with night blindness the earliest symptom. The government's policy on supplementation of micronutrient Vitamin A is:

- Regular consumption of dark green leafy vegetables or yellow fruits and vegetables
- Breastfeeding feeding with colostrums
- Oral prophylactic doses:
  - One dose of 100,000 IU to infants 6 – 11 months old
  - One dose of 200,000 IU to children 1 – 5 years old repeated every six months
- A child must receive a total of 9 oral doses of Vitamin A by the age of five years old.

For treatment of Vitamin A deficient cases:

- One dose of 200,000 IU immediately at diagnosis
- Follow-up dose of 200,ooo IU four weeks later

IRON DEFICIENCY ANAEMIA

Iron deficiency is the most common cause of anaemia. Iron deficiency anaemia occurs when the body doesn't have enough iron. Iron is important because it helps a person get enough oxygen throughout your body. The body uses iron to make haemoglobin. Haemoglobin is a part of the red blood cells. Haemoglobin carries oxygen through your body. If you do not have enough iron, your body makes fewer and smaller red blood cells. Then your body has less haemoglobin, and you cannot get enough oxygen. A person might have low iron levels because of not getting enough iron in food. This can happen in people who need a lot of iron, such as small children and adolescents. Anaemia in children is very common because of inadequate diet and recurrent infections and worm infestations. It is also common in pregnant women and those who have heavy menstrual bleeding.

FOLIC ACID DEFICIENCY ANAEMIA

Folic acid deficiency anaemia happens when your body does not have enough folic acid. Folic acid is one of the B vitamins, and it helps the body make new cells, including new red blood cells . The body needs red blood cells to carry oxygen. If you don't have enough red blood cells, you have anaemia, which can make a person feel weak and tired. So it's important that you get enough folic acid every day. Most people get enough folic acid in the food they eat. But some people either don't get enough in their diet if they don't eat enough foods that contain folic acid. These include citrus fruits, leafy green vegetables, and fortified cereals. Other people have trouble absorbing it from the foods they eat. Pregnant women who do not get enough folic acid are more likely to have babies with very serious birth defects.

The Ministry of Health and Family Welfare has revised the guidelines on IFA supplementation related to the National Nutritional Anaemia Prophylaxis programme. This is the outcome of a long process, initiated with different consultations on anaemia in adolescent girls. In 2003, the National Consultation on Micronutrients with the ICMR/MHFW began working with a committee chaired by the DG of the ICMR. They subsequently worked with the NRHM and various other groups on the 11th plan that includes:

- Infants between 6-12 months should also be included in the programme as there is sufficient evidence that iron deficiency affects this age also.
- Children between 6 months to 60 months should be given 20mg elemental iron and 100 mcg folic acid per day per child as this regimen is considered safe and effective.

National IMNCI guidelines for this supplementation to be followed.

- For children (6-60 months), ferrous sulphate and folic acid should be provided in a liquid formulation containing 20 mg elemental iron and 100mcg folic acid per ml of the liquid formulation. For safety reason, the liquid formulation should be dispensed in bottles so designed that only 1 ml cab be dispensed each time.
- Dispersible tablets have an advantage over liquid formulations in programmatic conditions. These have been used effectively in other parts of the world and in large scale Indian studies. The logistics of introducing dispersible formulation of Iron and Folic Acid should be expedited under the programme.

The current programme recommendations for pregnant and lactating women should be continued.
School children, 6-10 year old, and adolescents, 11-18 year olds, should also be included in the National Nutritional Anaemia Prophylaxis Programme (NNAPP).

- School children, 6-10 year old, and adolescents, 11-18 year olds, should also be included in the National Nutritional Anaemia Prophylaxis Programme (NNAPP).
- Children 6-10 year old will be provided 30 mg elemental iron and 250 mcg folic acid per child per day for 100 days in a year.
- Adolescents, 11-18 years will be supplemented at the same doses and duration as adults. The adolescent girls will be given priority.

IODINE DEFICIENCY

Iodine is a very important trace element. It is required for the normal growth and development of human beings. Its deficiency during pregnancy can lead to spontaneous abortion/still birth and cretinism/mental retardation in children.

Children should be given an iron and protein rich diet consisting of jaggery, milk, eggs, pulses, green leafy vegetables, guavas, apples, etc. Children have access to AWW Services where supplementary food is provided for the child up to the age of 5. Malnourished children are to be given additional food supplements.

PREVENTION AND MANAGEMENT OF CHILDHOOD ILLNESSES:

Major childhood illnesses include diarrhoea and Acute Respiratory Infection (ARI).

Diarrhoea is marked by liquid or watery stools passed more than three times in a day. Normally there are three types of diarrhoea:

- Acute watery diarrhoea which lasts not more than 14 days
- Dysentery is diarrhoea with visible blood in stools
- Persistent diarrhoea begins acutely but is of unusually long duration i.e. lasting more than 14 days.

Diarrheal diseases are a major cause of death and disease among children under five years. The majority of the diarrhoeal deaths are due to dehydration (loss of water and minerals). Golden rules to observe if a child has diarrhoea are:

- If the child is breastfed, continue breast-feeding more frequently.
- If the child has started consuming other foods, continue feeding small quantities of these items
- Give extra fluids
- Give ORS (Oral Rehydration Solution)
- Refer in case of danger signs
- After the child recovers and normal appetite reappears, the child may be given more food than normal to regain lost weight.

Diarrhoea can be prevented by:

- Exclusively breastfeeding for the first six months.
- Washing hands thoroughly before cooking food and feeding the child and keeping containers clean for preparing the food and for feeding the baby.
- Keeping the food and drinking water covered.
- Consuming freshly prepared food within one hour.
- Keeping the house and neighbouring area clean and proper disposal of waste so that houseflies don't breed.
- Constructing sanitary latrines for each household.

Acute Respiratory Infection
Acute Respiratory Infection (ARI) is an important cause of mortality and morbidity in children. Most children up to the age of five years are susceptible to ARI. If not treated in time, some of children develop pneumonia, which can result in death. Good nutrition, timely administration of Vitamin A, and avoiding exposure to cold, dust and smoke helps in preventing pneumonia.
The child might have ARI if it has some or all of the following symptoms:

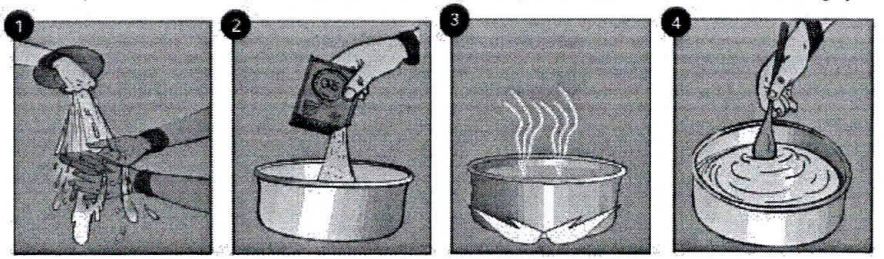
- Cough
- Running nose
- Fever
- Difficulty in breathing

Serious morbidity and death are preventable if it is identified early and treated/referred in time. When a child has suspected ARI do the following:

- Keep the child warm.
- Give plenty of fluids and continue breast-feeding.
- Give home remedies – ginger, honey, lemon, kadha, etc.
- Increase feeds after the child recovers.
- Help the child rest.
- Access NMCH services and get prompt treatment.

MANAGING MILD CASES OF DIARRHOEA AT HOME: PREPARATION OF ORS

1. Wash your hands with soap
2. Pour all the ORS powder into 1 litre
3. Pour 1 litre of drinking water (boiled and cooled)
4. Stir well until the powder is mixed thoroughly



Preparation of home made ORS:
Take one glass (200ml) of water, add a pinch of salt and a spoon of sugar

SIX IMPORTANT MESSAGES FOR PREVENTING CHILD MALNUTRITION

- **Exclusive Breastfeeding:** Up to the age of six months, give only breast milk; no water should be added.

- **Complementary Feeding:** At the age of six months, add other foods. Breastfeeding alone is not enough, though it is good to continue breastfeeding for at least one to two years more. There are five things to remember about complementary feeding:
  - **Consistency:** Initially the food has to be soft and mashed. But later, anything that adults eat can be given to the child, with fewer spices. Do not dilute food. Keep it as thick as possible, for e.g. 'give daal not daal ka pani'.
  - **Quantity:** Gradually increase the amount of such foods. Till at about one year, the child gets almost half as much nutrition as the mother.
  - **Frequency:** The amount of complementary foods given should be equal to about half what the adult needs in terms of nutrients. But since the child's stomach is small, this amount has to be distributed into four to five, even six feeds per day.
  - **Density:** The food also has to be energy dense, low in volume, high in energy, therefore, add some oil or fats to the food. Family could add a spoon of it to every roti/every meal. Whatever edible oil is available in the house is sufficient.
  - **Variety:** Add protective foods – green leafy vegetables. The rule is that the greener it is, or the redder it is, the more its protective quality. Similarly meat, eggs, fish are liked by children and very nutritive and protective.

- **Feeding during the illness:** Give as much as the child will eat; do not reduce the quantity of food. After the illness, to catch up with growth, add an extra-feed. Recurrent illness is a major cause of malnutrition

- **Prevent illness:** Recurrent illness is a major cause of malnutrition. There are six important things to remember which could prevent illness:
  - **Hand washing:** before feeding the child, before preparing the child's food, and after cleaning up the child who has passed stools. This is the single most useful measure to prevent recurrent diarrhoea.
  - **Drinking water** to be boiled. Though useful for everyone, it is of particular importance to the malnourished child with recurrent diarrhoea.
  - **Full immunization of the child:** Tuberculosis, diphtheria, pertussis and measles are all prevented by immunization and are the diseases that cause severe malnutrition. In malnourished children, these diseases are more common and life threatening, than in normal children.
  - **Vitamin A:** To be given along with measles vaccine in the ninth month and then repeated once every six months till five years of age. This too reduces infections and night blindness, all of which is more common in malnourished children.
  - Avoid persons with infections, especially with a cough and cold picking up the child, and handling the child, or even coming near the child during the illness. This does not apply to mother, but even she should be more rigorous in handwashing and more careful in handling the baby.
  - **Preventing Malaria:** In districts with malaria the baby should sleep under an insecticide treated bed net. Malaria too is a major cause of malnutrition.

- **Access to health services**
  - Seek prompt MNCH services. On the very first day of the illness, if you help the mother decide on whether it is a minor illness for which home remedy would be adequate, or to be referred to a doctor, such a decision could save lives. Early treatment would prevent malnutrition.
  - Access to contraceptive services is important. If the age of mother is less than 19, or the gap between two children is less than three years, there is a much higher chance of the children being malnourished

- **Access to AWW services that include:**
  - Food supplement for the child up to the age of 5. This could be a cooked meal, or in the form of take – home rations. Malnourished children are to be given additional food supplements. For children below the age of two, take – home rations are to be given. Pregnant women and lactating mothers up to six months are entitled to get food supplements.
  - Weighing the baby and informing the family of the level of malnutrition.
  - Conducting Village Health and Nutrition Day (VHND) activities. The JHA visits every month and the child is immunized, given Vitamin A supplements, paediatric iron supplements, Oral Rehydration Salts (ORS) packets or drugs as needed for illness management.

ANAEMIA IN CHILDREN UNDER FIVE YEARS OF AGE

Anaemia is important to diagnose because it commonly comes along with malnutrition. It may be a cause of poor appetite. Blood testing is essential, but even in its absence based on observation of pallor alone, treatment can be started.

Unusual paleness (pallor) of the skin of the soles or palms is a sign of anaemia. To see if the child has anaemia, look at the skin of the child's palm Children between 6 months to 60 months should be given 20mg elemental iron and 100 mcg folic acid per day per child as this regimen is considered safe and effective.
. Hold the child's palm open by grasping it gently from side to side. Do not stretch the fingers backward. This may cause pallor. Compare the child's palm with your own palm and the palm of other children. If the skin is paler than of others, the child has pallor.

Treatment for anaemia in children between 6 months to 60 months should be 20mg elemental iron and 100 mcg folic acid per day. For a child 2 years and above, also give one tablet of Albendazole for deworming once every six months. For a child less than two years, give half a tablet of Albendazole (Refer to Annexure 6). Iron rich foods are needed for the young child. If anaemia does not improve, the child must be referred to a doctor for more complete blood tests and treatment

HOW TO ASSESS A SICK CHILD FOR DANGER SIGNS?

Step 1: ASK: Is the child able to drink or breastfeed?
A child has the sign "not able to drink or breastfeed" if the child is not able to suck or swallow when offered a drink or breast milk. If the mother says that the child is not able to drink or breastfeed, ask her to describe what happens when she offers the child something to drink. For example, is the child able to take fluid into his mouth and swallow it? If you are not sure about the mother's answer, ask her to offer the child a drink of clean water or breast milk. Look to see if the child is swallowing the water or breast milk. A child who is breastfed may have difficulty sucking when his nose is blocked. If the child's nose is blocked, clear it. If the child can breastfeed after his nose is cleared, the child does not have the danger sign.

Step 2: ASK: Does the child vomit everything?
A child who is not able to hold anything down at all has the sign "vomits everything." What goes down comes back up. A child who vomits everything will not be able to hold down food, fluids or oral drugs. A child who vomits several times, but can hold down some fluids, does not have this general danger sign.

Step 3: ASK: Has the child had convulsions?
Ask the mother questions on whether the child has suffered from convulsions (local term) or not.

Step 4: LOOK: See if the child is lethargic or unconscious.
The lethargic child is sleepy when the child should be awake. A child who stares blankly and does not appear to notice what is happening around is also lethargic. The unconscious child does not waken at all. This child does not respond to touch, loud noise or pain.

Step 5: Ensure that the child is referred to a PHC/CHC immediately.

NATIONAL IMMUNIZATION SCHEDULE

Immunization is one of the most well-known and cost effective methods of preventing diseases.
Many serious germ diseases in children can be prevented by immunization. These vaccines are given free to all children by the JHA and at the sub-centers and the PHC. Some vaccines need cold storage during transportation to retain their power. Although most of the Vaccine Preventable Diseases (VPDs) are now under controll, immunization has to be sustained, not only to prevent VPDs, but also to:

- Eliminate Tetanus,
- Reduce the incidence of Measles and
- Eradicate Poliomyelitis.

The six vaccine preventable diseases are

- Poliomyelitis (can be prevented by OPV)
- Tetanus (can be prevented by DPT)
- Diphtheria (can be prevented by DPT)
- Pertussis (whooping cough) (can be prevented by DPT)
- Measles (can be prevented by measles vaccine)
- Childhood tuberculosis / lung TB (can be prevented by BCG)

The vaccines must be given at the right age, right dose, right interval and the full course must be completed to ensure the best possible protection to the child against these diseases. The schedule that tells us when and how many doses of each vaccine are to be given is called immunization schedule.

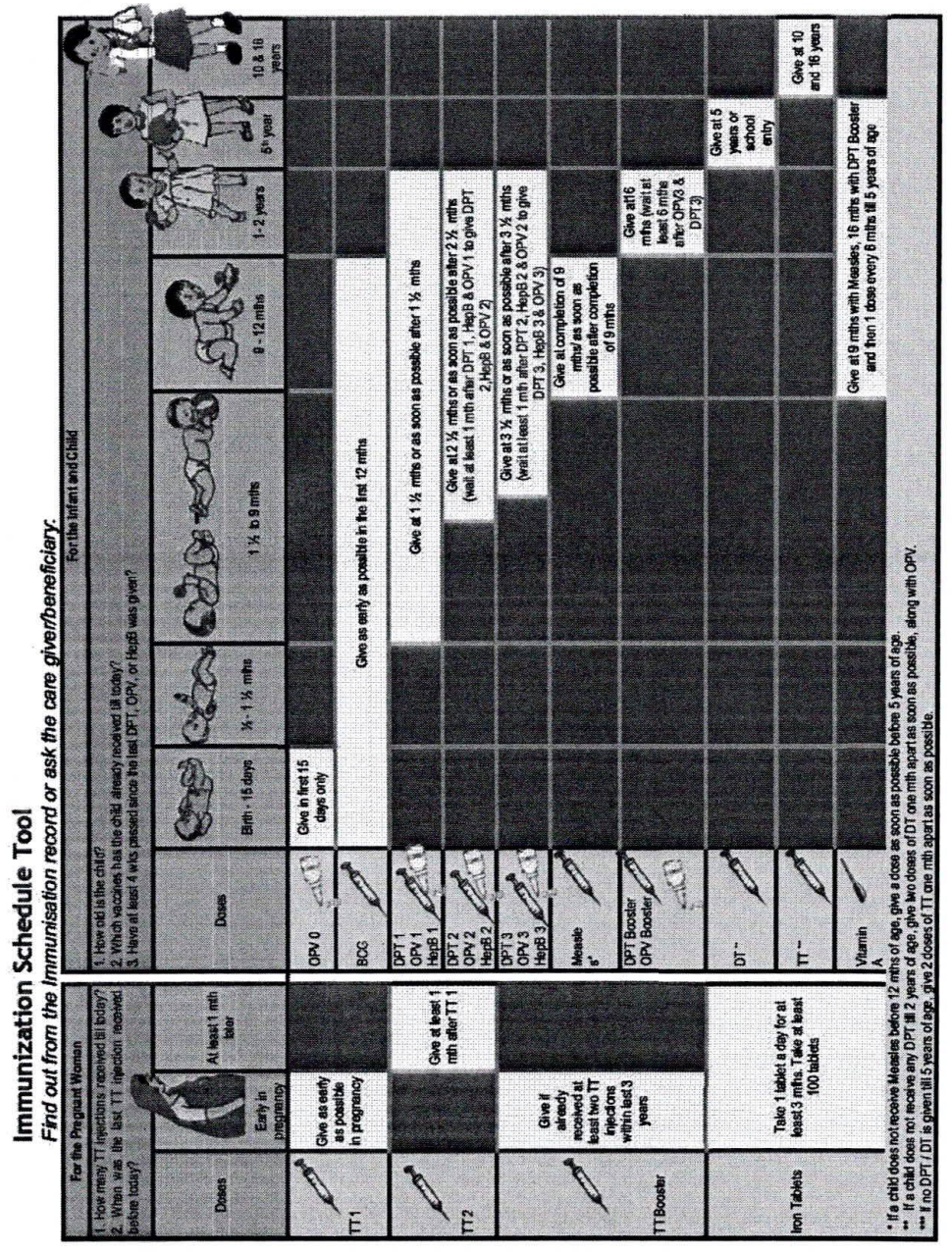
NATIONAL IMMUNIZATION SCHEDULE (NIS) FOR INFANTS, CHILDREN AND PREGNANT WOMEN

Vaccine	When to give	Dose	Route	Site
For Pregnant Women				
TT-1	Early in pregnancy	0.5 ml	Intra-muscular	Upper Arm
TT-2	4 weeks after TT-1*	0.5 ml	Intra-muscular	Upper Arm
TT- Booster	If received 2 TT doses in a pregnancy within the last 3 yrs*	0.5 ml	Intra-muscular	Upper Arm
For Infants				
BCG	At birth or as early as possible till one year of age	0.1ml (0.05ml until 1 month age	Intra-dermal	Left Upper Arm
Hepatitis B	At birth or as early as possible within 24 hours	0.5 ml	Intra-muscular	Antero-lateral side of mid-thigh
OPV-0	At birth or as early as possible within the first 15 days	2 drops	Oral	Oral
OPV 1,2 & 3	At 6 weeks, 10 weeks & 14 weeks	2 drops	Oral	Oral
DPT1,2 & 3	At 6 weeks, 10 weeks & 14 weeks	0.5 ml	Intra-muscular	Antero-lateral side of mid-thigh
Hepatitis B 1, 2 & 3****	At 6 weeks, 10 weeks & 14 weeks	0.5 ml	Intra-muscular	Antero-lateral side of mid-thigh
Measles	9 completed months-12 months. (give up to 5 years if not received at 9-12 months age)	0.5 ml	Sub-cutaneous	Right Upper Arm
Vitamin A (1stdose)	At 9 months with measles	1 ml (1 lakh IU)	Oral	Oral
For Children				
DPT booster	16-24 months	0.5 ml	Intra-muscular	Antero-lateral side of mid-thigh
OPV Booster	16-24 months	2 drops	Oral	Oral
Japanese Encephalitis**	16-24 months with DPT/OPV booster	0.5 ml	Sub-cutaneous	Left Upper Arm
Vitamin A*** (2nd to 9th dose)	16 months with DPT/OPV booster Then, one dose every 6 months up to the age of 5 years.	2 ml (2 lakh IU)	Oral	Oral
DT Booster	5-6 years	0.5 ml	Intra-muscular	Upper Arm
TT	10 years & 16 years	0.5 ml	Intra-muscular	Upper Arm

*Give TT-2 or Booster doses before 36 weeks of pregnancy. However, give these even if more than 36 weeks have passed. Give TT to a woman in labour, if she has not previously received TT.
** SA 14-14-2 Vaccine, in select endemic districts after the campaign.
*** The 2nd to 9th doses of Vitamin A can be administered to children 1-5 years old during biannual rounds, in collaboration with ICDS.
**** In select states, districts and cities.

Proposed Changes in the National Immunization Schedule: 2009-10

- DT Booster to be replaced by DPT Booster at 5-6 years of age.
- In select well-performing states, MR to be given with DPT Booster at 16-24 months (Dose: 0.5 ml; Route: Sub-cutaneous; Site: Right Upper Arm)
- DPT and HepB vaccines at 6, 10 and 14 weeks to be replaced by DPT-HepB-Hib (Pentavalent) vaccine.



ANNEXURE 6 - Post-exam for Module 1*

* Facilitator will need to update all questions that relate to population/census data or statistical measures for a given time period.

Name:

Place:

Date:

PHC name:

1. Based on current census data, what is the worldwide annual infant mortality rate (IMR) for children below the age of 5 years?
   a. 1 million
   b. 5 million
   c. 10 million

2. Based on current census data, what is the worldwide mortality rate of women who are pregnant and mortality rates of women due to complications during child birth and post natal complications?
   a. 5 lacs
   b. 5.3 lacs
   c. 4 lacs

3. How is MMR (maternal mortality rate) measured?
   a. No. of deaths per 100 pregnant women
   b. No. of deaths per 100000 pregnant women
   c. No. of deaths per 1000 pregnant women

4. What is the IMR (Infant mortality rate) according to current census data?
   a. 60/1000 live births
   b. 50/1000 live births
   c. 40/1000 live births

5. This is one of the most important reasons for the mortality of a mother. Choose the correct one from the below mentioned options
   a. Excessive Bleeding
   b. Malaria
   c. Typhoid

6. Who is called a newborn baby? Choose the answer from the below mentioned options
   a. 0 – 25 days of birth (actually 0-28 days)
   b. 0 – 6 months of birth
   c. 0 – 1 year of birth

7. In how many districts of Karnataka has the Sukshema program been implemented?
   a. 6
   b. 8
   c. 10

8. What will be the percentage of HB in cases of acute blood deficiency?
   a. <10%
   b. <7%

9. During pregnancy, in which trimester do the weeks 12 – 28 appear?
   a. 1
   b. 2
   c. 3

10. When does ANC begin?
   a. 3 months
   b. 5 months
   c. Immediately after sexual intercourse (As soon as the pregnancy is suspected)

11. How many times do mothers usually visit the health centre after registering for ANC?
   a. 3
   b. 4
   c. 5

12. What is the normal BP for a human being?
   a. 110/80
   b. 120/80

13. How many doses of TT injection should be administered to a first time pregnant woman (Primi)?
   a. 2
   b. 3
   c. 4

14. What symptoms can be pinpointed from a urine protein test?
   a. Blood deficiency
   b. Pre eclampsia (high BP)
   c. Heart condition

15. Which among the below mentioned options is the best permanent family planning option?
   a. Mala.D
   b. Condom
   c. Tubectomy

16. At the facility level, in which level do 24/7 PHC and non. FRU CHC appear?
   a. 1st level
   b. 2nd level
   c. 3rd level

17. For a woman who is in her first pregnancy, what height of this woman will indicate that she will have a risky pregnancy?
   a. 140 centimeters
   b. 160 centimeters
   c. 170 centimeters

18. How many iron supplement tablets are given to a pregnant woman as a precaution to guard against blood deficiency?
   a. 100
   b. 200
   c. 300

19. For a pregnant woman what is the time line for a full term pregnancy?
   a. 32 – 36 weeks
   b. 37 – 42 weeks
   c. 42 – 45 weeks

20. What is the duration of post natal care?
a. 42
b. 40

21. In which trimester of the pregnancy will a still birth occur?
a. After 28 weeks
b. After 20 weeks

22. What is intra partum care?
a. Pre natal care
b. Post natal care
c. Care during child delivery

23. Most mother mortality cases happen during the below mentioned instances?
a. PNC
b. INC
c. ANC

24. How many stages are there in a pregnancy?
a. 3
b. 4

25. For a first time pregnancy, what is the duration of the first stage of child birth?
a. 0 – 12 hours
b. 0 – 15 hours

26. How many times must a newborn baby be breast fed in a day?
a. 8 – 10 times
b. 3 – 4 times

27. The below mentioned options are the reasons for infant mortality – Tick the correct options
a. Diarrhea
b. ARI (Acute Respiratory Infection)
c. Measles
d. Typhoid
e. malaria
f. HIV/AIDS

28. How many times is DPT prescribed?
a. 5 times
b. 3 times

29. Which disease does BCG control?
a. Tuberculosis (TB)
c. Throat inflammation

30. At which stage is ETT implemented?
a. At the village level
b. At the sub centre level
c. At the PHC level
d. At the district level

31. We can reach the below mentioned sections through ETT?
a. Those living below the poverty line
b. Dalits
c. Migrants
d. All of the above

32. Whose information does the mother card contain?
a. Mother
b. Child
c. Pregnant woman
d. All of the above

33. Who enters details into the mother card?
a. JHA and RP
b. RP and doctor
c. ASHA and JHA
d. JHA and doctor

34. Who is the target audience for FFC?
a. Neighbours
b. Pregnant woman
c. Family members

35. How many important communication topics make up the FFC?
a. 12
b. 7
c. 8

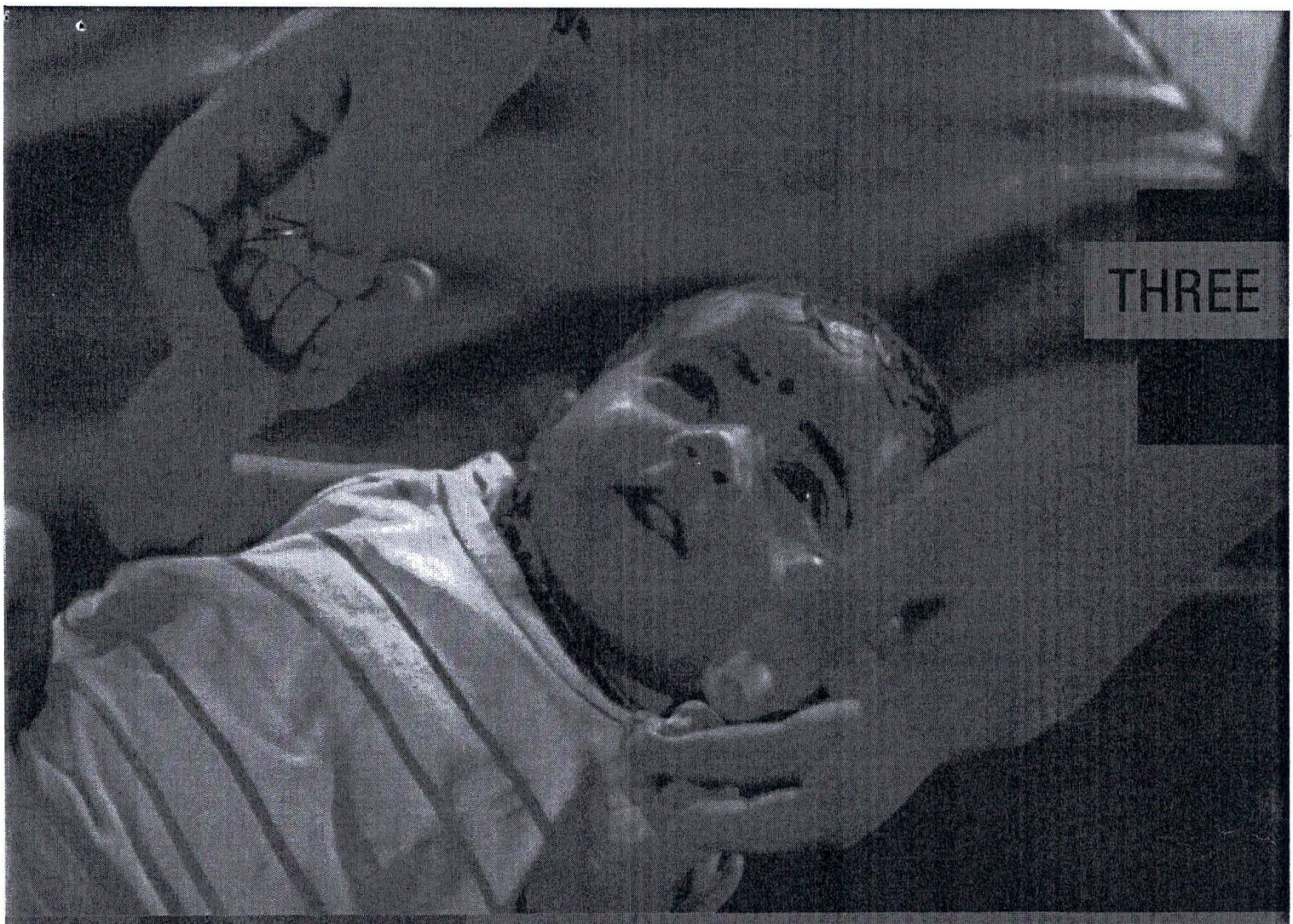
36. Who enters information into the HBMNC (Home Based Maternal & Newborn Care) tool?
a. JHA and RP
b. RP and doctor
c. ASHA
d. JHA and doctor

37. What is ARS?
a. Health safe guard committee
b. Health safe guard organization
c. Health safe guard armour

38. What is the main aim of community monitoring?
a. Guarantee services due to the community
b. Guarantee that the pregnant woman's family is accessing all health related services
c. All of the above

39. Which among the below mentioned options is a mid media activity?
a. Home visit
b. Street play
c. Counselling
d. All of the above

40. Which among the below mentioned options is the primary responsibility of an RP?
a. Entering information into the mother card
b. Support for ASHA workers
c. Home visits
d. All of the above



THREE

3

Community Level Interventions For Improving Maternal, Neonatal And Child Health: A Training Tool Kit

SUKSHEMA'S COMMUNITY LEVEL INTERVENTIONS

Community Level Interventions for Improving Maternal, Neonatal and Child Health Training Tool Kit: Sukshema's Community Level Interventions is the third module of the tool kit in a series of seven on enhancing community engagement for improving outreach, shaping demand and strengthening accountability to improve maternal, neonatal and child health outcomes in Karnataka.

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Karnataka Health Promotion Trust (KHPT)
University of Manitoba (UOM)

Mr. Mohan HL, UOM
Dr. Krishnamurthy, UOM
Ms. Mallika Biddappa, KHPT
Ms. Prathibha Rai, KHPT
Ms. Navya R, KHPT
Mr. Somashekar Hawaldar, KHPT
Dr. Suresh Chitrapu, KHPT
Mr. Balasubramanya KV, KHPT
Dr. Troy Cunnigham, KHPT
Mr. Arin Kar, KHPT
Mr. Ajay Gaikwad, KHPT
Mr. Nagaraj R, KHPT
Mr. Manjunath Dodawad, KHPT
Dr. B M Ramesh, KHPT
Dr. Krishnamurthy, KHPT
Dr. James Blanchard, UoM
Ms. Lakshmi C, KHPT
Ms. Sharada HR, KHPT

THE EDITORIAL TEAM:
Mr. H.L. Mohan, KHPT
Ms. Mallika Biddappa, KHPT
Ms. Dorothy L. Southern, KHPT Consultant

The photographs are by **KV Balasubramanya**. They have been used in the module with consent from the community.

Publisher:
Karnataka Health Promotion Trust
IT/ BT Park, 4th & 5th Floor
1-4, Rajajinagar Industrial Area
Behind KSSIDC Administrative Office
Rajajinagar, Bangalore- 560 004
Karnataka, India

Phone: 91-80-40400200
Fax: 91-80-40400300
www.khpt.org

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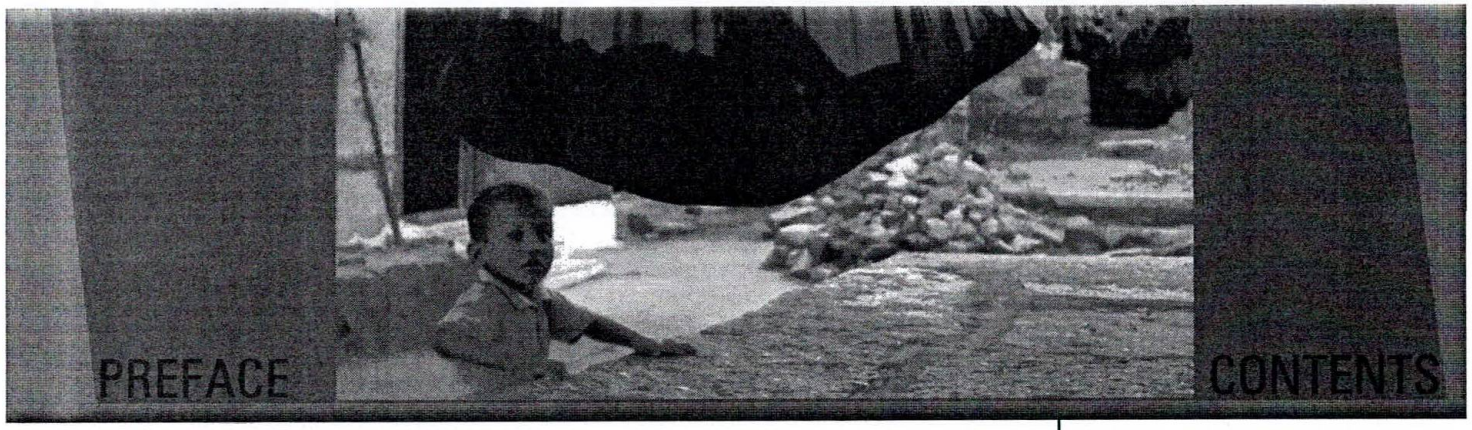
3

Community Level Interventions For Improving Maternal, Neonatal And Child Health: A Training Tool Kit

SUKSHEMA'S COMMUNITY LEVEL INTERVENTIONS

ಸುಕ್ಷೇಮ
sukshema
Improved Maternal, Newborn & Child Health

NATIONAL RURAL HEALTH MISSION



PREFACE

The Community Level Interventions for Improving Maternal, Neonatal and Child Health Tool Kit is a series of seven modules:

Module 1: Design, Planning and Implementation of the Sukshema Project
Module 2: Core Concepts of Maternal, Neonatal and Child Health
Module 3: Sukshema's Community Level Interventions
Module 4: Communication and Collaborative Skills for Front Line Workers
Module 5: Improving the Enumeration and Tracking Process
Module 6: Home Base Maternal and Newborn Care
Module 7: Supportive Community Monitoring

Module 3: Sukshema's Community Level Interventions is aimed at Resource Persons (RPs) to provide an overview of the community level interventions planned under the Sukshema project. Enhancing communication is highlighted in the family focused communication intervention and the enumeration and tracking intervention seeks to bridge the gaps that occur in the Maternal Neonatal and Child Health (MNCH) continuum of care. Two other tools are introduced: one to improve the quality of interaction during home based care, the Home Based Maternal Newborn Care (HBMNC) Tool; and the other to enhance planning, accountability and monitoring of health service delivery through the Supportive Community Monitoring (SCM) Tool. This module also gives participants the opportunity to clarity roles and responsibilities of a number of field level workers in the Sukshema project and in the Government of Karnataka (GoK) health service.

CONTENTS

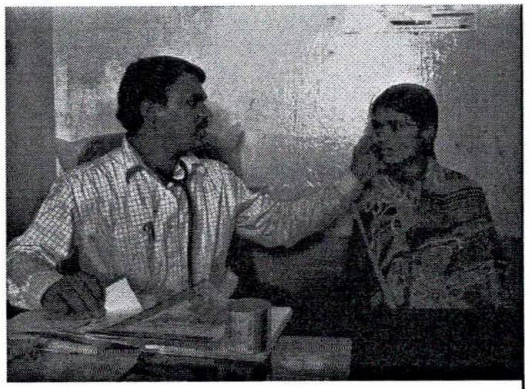
ACRONYMS

ANC	Ante Natal Care
ARI	Acute Respiratory Infection
ARS	Arogya Raksha Samitis
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BCC	Behaviour Change Communication
BPL	Below Poverty Line
CBO	Community Based Organization
CDL	Community Demand List (CDL1) Tool
DOH	Department of Health
EDD	Expected Date of Delivery
ETT	Enumeration and Tracking Tool (ETT1)
FLW	Frontline Health Worker
FP	Family Planning
FRU	First Referral Unit
GoK	Government of Karnataka
HBMNC	Home Based Maternal Newborn Care
IEC	Information, Education, Communication
IMR	Infant Mortality Rate
IPC	Inter Personal Communication
JHA	Junior Female Health Assistant
JSY	Janani Suraksha Yojana
JHA	Junior Female Health Assistant
KHPT	Karnataka Health Promotion Trust
MDG	UN Millennium Development Goals
MMR	Maternal Mortality Rate
MNCH	Maternal, Newborn and Child Health
NGO	Non-Government Organization
NRHM	National Rural Health Mission
PHC	Primary Health Centre
PNC	Post-natal Care
PRI	Panchayat Raj Institution
RP	Resource Person
SBA	Skilled Birth Attendant
SC	Sub Centre
SC/ ST	Scheduled Caste/ Scheduled Tribe
SCM	Supportive Community Monitoring
SHRC	State Health Resource Centre
SHS	State Health Society
SRS	Sample Registration System
TBA	Trained / Traditional Birth Attendant
TT	Tetanus Toxoid
VHW	Village Health Worker
VHSNC	Village Health and Sanitation Nutrition Committee

GETTING STARTED

The Doorway to Successful Training **in Part II of Module 1** should always be used to start a training workshop: initially if covering all modules at one time, or as a refresher if modules are scheduled over a period of time. The Doorway to Successful Training contains a detailed plan of sessions that sets the stage for the workshop activities and logistics, covering welcome, introductions, objectives, hopes and fears, and ground rules.

SESSION 1: UNDERSTANDING SUKSHEMA'S COMMUNITY INTERVENTIONS



Objective

- To help the participants understand the Sukshema project's MNCH interventions package as a whole.
- The circles of influence

Methodology
Discussion and group work

Duration
1 hour

Training Materials

Markers and brown sheets/ chart paper

Tips for facilitators

The circle of influence starts with family members including mother, father, husband, mother-in-law, father-in-law, grandmother, etc., but extends much further than the family. It reaches to the village elders, such as caste leaders, sanghas, Panchayat members, and then to community structures, such as the PHC and SC. Participants will need help to understand the extent of these influences on a woman's health making decisions. They will also need to see the link between the interventions as a whole, although they will be implemented separately in the Sukshema project's MNCH intervention.

Process

1.1 CIRCLES OF INFLUENCE

- Ask the participants, 'Who has the most influence on a woman's health making decisions?'
- Encourage them to come up with ideas. Ask probing questions until you get some responses.
- Note their responses on a flip chart.
- Ask if other people, groups and institutions also have an influence on woman's health making decisions?
- Probe further and ask who are the main influencers at the village level are.
- Tell them that in addition to all the influences they have listed, there are also larger influences such as religious leaders, media, political leaders/ policy makers and customs and traditions.
- Tell them that all these people/institutions at different levels have the power to influence MNCH related opinions and decisions both positively or negatively.
- Display the 'Circle of Influence' diagram at the front of the training room.

- Tell the participants that woman and child's health is determined by various factors beyond just medical factors.
- Start at the inner circle and explain that many external forces determine a woman's health making decisions or her ability to make those decisions.
- Working with all these different circles of influence is important to support both mothers and children.
- Divide the participants into five groups.
- Assign each group a 'circle' in the Circle of Influence and ask them to discuss what they could do to get support for mother and child access to MNCH continuum of care services.
- Allow 15 minutes for discussion. Ask a representative from each group to take 5 minutes to share their main discussion points.
- Ask other groups to share any other key information.
- Introduce the Sukshema project's MNCH interventions. These focus on the first three 'circles': the family, the FLWs and Community Structures:
  - Family focused communication – to address the family 'circle'.
  - Enumeration and tracking using the Community Demand List (CDL) Tool – to address the FLWs 'circle'.
  - Home Based Maternal Neonatal Care (HBMNC) Tool - to address the FLWs 'circle'.
  - Supportive Community Monitoring (SCM) Tool - to address the community structure 'circle'.
  - Arogya Mantap – to address all three 'circles'.
- Consolidate the main points of Session 1:
  - The focus of the community interventions is to build the skill of the FLWs and help them work better with the mothers, children and their families. The tools will enhance the skills, guide and improve the quality of work of the FLWs, which in turn will help enhance MNCH outcomes.
- Tell the participants that in the following sessions they will learn more about each of these interventions and how they are linked.

SESSION 2: ENHANCING COMMUNICATION AND COORDINATION USING FAMILY FOCUSED COMMUNICATION

Objective

- To help the participants understand the concept and importance of family focused communication
- To understand how gender and family influence the behaviour of pregnant women

Methodology
Role play, group work and discussion

Duration
2 hours

Training Materials

Markers and brown sheets/ card sheets

Tips for facilitators

This session highlights the family focused communication (FFC) intervention. It will help FLWs understand that the family is a very crucial component of gaining access to the MNCH continuum of care and to help them improve their communication skills. FLWs must understand why conveying MNCH messages to the pregnant woman alone will not be enough, but that they must involve key family members for the intervention to successful. They must also understand the concept of gender and how gender norms can influence a pregnant woman's health making decisions. For the role play, the facilitator could develop a script for each actor and give it to the volunteers ahead of the session so they could practice before performing.

Process

2.1 FFC COMMUNICATION

- Ask 6 participants to volunteer to act out the following role play. Tell them to make their own dialogues and develop the role play using their own experiences from the field.

  A woman is 8 months pregnant. The ASHA visits her house to tell her about the importance of institutional delivery and about birth preparedness. When the ASHA reaches her home, the mother-in-law refuses to let her in and tells a lie that the woman is sleeping. The ASHA takes the JHA along with her the next day to meet the same woman. This time the pregnant woman opens the door and looks scared and uneasy at the ASHA and JFA. They tell her about institutional delivery and birth preparedness. The woman refuses and says she is not interested and that she will deliver at home. The FLWs try to convince her. They ask her why is she not interested. After much probing the woman confesses that her grandmother is very against institutional delivery. The ASHA and JFA don't know what to do. They go back and discuss together. They decide to talk to the grandmother alone the next day. After much opposition, the grandmother agrees to hear them. They try to explain about the advantages of institutional delivery. After they finish, the grandmother tells that she has given birth to 10 children in her house and she doesn't need to be told anything. She asks the ASHA and JFA to leave without paying heed to their words.

- Ask the volunteers to present the role play for all other participants to watch and listen carefully.
- After the role play ask the following questions and discuss:
  - What happened in the role play?
  - What stopped the woman from making her own independent decision?
  - Who influenced her decisions?
  - Was the communication by the FLWs proper?
  - Did it result in making the right decision in favour of the woman?
  - Did it address the woman alone or the family?
  - What could have been done to make the communication more effective?
  - What can we learn from this role play that can be used in our intervention?
- Ask all the participants to share similar experiences that they know of in their families or in the course of their field work.
- Consolidate the role play and discussion:
  - A woman is not empowered to make her own decisions in our current rural context because of power issues.
  - A female is taught to be subjected to the decisions of elders in the family.
  - Decision makers are usually the men and the other powerful figures of the family.
  - Therefore, working only with the woman in isolation will not achieve access to the MNCH continuum of care services.
  - Communication with the entire family is key for behaviour change

- Divide the participants into three groups and give each of them one of the following situations:
  1. *The husband of a family living below the poverty line (BPL) is refusing to let his wife go for family planning. She is pregnant with her fourth child and has three daughters. What will your communication message be, for whom and using which method?*
  2. *The mother is not allowing her pregnant daughter to take iron and folic acid pills for fear that baby will become dark. The mother is illiterate. What will your communication message be, for whom and using which method?*
  3. *The woman does not want to breastfeed the baby because her mother-in-law has warned her that if she does then the baby will be cursed. What will your communication message be, for whom and using which method?*

- Allow 15 minutes to discuss and develop a communication message. Ask a representative from each group to take 5 minutes to share their message.
- Ask other groups to comment.
- Tell the participants that the FLWs need the skills to assess the situation, know whom to focus on, design an appropriate communication message, and communicate it effectively with a positive impact.
- The FFC intervention will train FLWs to communicate effectively using appropriate tools such as flipcharts, picture cards and other innovative methods.

2.2 FFC COORDINATION

- Ask the participants who the three key groups of FLWs are:
- Display a flip chart divided into three columns at the front of the training room.
- Note their responses in the first column of the flip chart.
- Ask them to define the duties of each of these groups: the ASHAs, the JFAs and the AWWs.
- Note their responses in the second column of the flip chart.
- Ask them how these three groups coordinate their work in the field.
- Note their responses in the third column of the flip chart.
- Ask them to share their perceptions and experiences, both positive and negative, on the nature of coordination between the three FLWs.
- Tell them that the FFC encourages the three FLWS to work together to achieve the same objective. Avoiding duplication and enabling data sharing can improve the quality of service delivery in the field.
- Consolidate the main focus areas of the FFC:
  - Family
  - Communication
  - Coordination between front line workers
- Details on the FFC intervention will be further explained in Module 4 of the Tool Kit, 'Communication and Collaborative Skills for Front Line Health Workers'.

SESSION 3: THE AROGYA MANTAP- PROVIDING SPACE FOR COLLABORATION AND DISCUSSIONS

Objective

- To let participants know about Arogya Mantap's role and activities in providing a collaborative forum for FLWs

Methodology
Brainstorming and discussion

Duration
30 minutes

Training Materials

Markers and brown sheets/ card sheets

Tips for facilitators

The *Arogya Mantap* is an activity of the Sukshema project to build a collaborative forum at the SC level. It offers space for all the FLWs and the VHSNC members to come together to discuss common issues and generate solutions. Engage the participants in brainstorming and discussions so that they will understand the concept of the *Arogya Mantap*, the need for this platform, and its importance.

Process

- Ask the FLW participants (ASHAs, JHAs or AWWs) to imagine they are working in a SC area.
- Ask them to think of one important thing they wish they had to work better and be more effective. For example, for a teacher might say, I wish I had the support of parents to ensure that all children come to school.
- Note their responses on a flip chart.
- Tell the group that in the field they need a space or a platform where they can meet together to share and discuss their work, as well as their personal lives so they can understand each other's issues and concerns.
- Tell them that in order to fill this gap, a forum called the Arogya Mantap has been developed where all the ASHAs, JHAs and AWWs, as well as VHSNC members in each of the SCs where there is an Arogya Mantap, can meet once a month. They can discuss the challenges they face in their work as well as enjoy a time of fellowship, perhaps planning entertainment activities.
- Meeting regularly in this forum will help them stay motivated and connected so they can function more effectively as a group.

SESSION 4:
BRIDGING GAPS IN THE MNCH CONTINUUM OF CARE THROUGH ENUMERATION AND TRACKING

Objective

- To help participants understand the usefulness and importance of enumeration and tracking using the Community Demand List (CDL) Tool in outreach work

Methodology

Case study, small group discussion, plenary presentation and discussion

Duration

1 hour and 30 minutes

Process

- Give one of the case studies to each of the five groups.

Training Materials

Copy of case studies, markers and brown sheets/ chart paper

Tips for facilitators

This session does not deal with the details of the Community Demand List (CDL) Tool, but helps the participants understand the concept of why the tool was developed and how it will help the ASHAs in the field to help all women access the MNCH continuum of care services.

Case 1:
The population of Herur village of Gangavati Taluk is around 1000, including 15 pregnant women. Nine of them work under a contractor. The contractor took these nine pregnant women to Rampura village for 15 days for some work. Five out of them are due for the first dose of Tetanus Toxoid (TT) injection and four of them are due for a booster dose of TT. In this situation, how should ASHA from Herur village ensure that all the pregnant women receive the TT injections as per the schedule?

Case 2:
A group of five to six migrant families returned to Mallapur from Mangalore. Three pregnant women are part of this group. One of them is in the first trimester and the other two are in the third trimester. One of them has a 10 year old child. None of these women are registered. What can the ASHA do to ensure that these three women receive the care that needs to be given at this period?

Case 3:
There are a total of 10 pregnant women in Bennur village. Four of them are due for delivery this month. While two of these four have registered in private hospitals, the other two have registered in the government hospital. All four have gone to hospital without any birth preparedness. What can the ASHA do to ensure they receive PNC services?

Case 4:
The findings of a survey conducted in Alvandi village on immunization found that out of the 16 children who had completed their first year, only 10 had received a complete package of immunizations. How will the ASHA ensure that all the children from Alvandi village are completely immunized?

Case 5:
In Mahalingpura village 10 women have recently delivered. How will ASHA ensure that all of them get complete PNC services?

- Ask group members to read the case study in the group, discuss and answer the question in each case study.
- Allow 15 minutes for discussion, then ask a representative from each group to take 5 minutes to read out their case study and share their responses to the case study's question.
- Ask other groups to share any other key information about the case study.
- Continue with the next 4 case studies in the same manner.
- Highlight that the ASHA is the main point of reference and link between women and the service providing facility.
- Ask the participants if a village had 1000 people with an ASHA in place and there were 25 pregnant women would all the pregnant women receive all MNCH services in the continuum of care?
- Note their responses on a flip chart.
- Ask them to share and discuss from their own experiences of working in the field.
- Consolidate the discussion by pointing out:
  - Pregnancy and delivery are very normal events.
  - Most of the women deliver normally without any problems, but other women and newborns are at risk for morbidity and mortality because they don't know about or have access to all MNCH services in the continuum of care.
  - If a pregnant woman misses even one service in the MNCH continuum of care, the continuum is broken.
  - Many times ANC registration is done so late that more than 50 % of MNCH services are not provided.
  - It is crucial that 100 % of ANC registration is done and continuum of care is given to all pregnant women without any gap.
  - Every woman needs information about services and access to ALL services on time and that the ASHA is responsible for this.
- Tell the participants that the following gaps have been noted in the field:
  - Some of the ASHAs don't recognize the importance of the "MNCH continuum of care" concept.
  - Some are unaware of all the MNCH continuum of care services and the timing of the services.
  - Some have no effective tools to support them in their outreach. Though they have many registers they do not have a means of identifying where the gaps exist and following up all the women in their area.
- Ask participants what the solution could be to fill in the gaps in the continuum of care?
- Note their responses on a flip chart.
- Ask them to share and discuss from their own experiences of working in the field.
- Consolidate the discussion:
  - ASHAs should be supported to build their capacity in knowing about the MNCH continuum of care services
  - ASHAs should be provided with tools that can help them plan their outreach in her area to ensure 100 % registration and 100 % continuity in MNCH care services to avoid any gaps.
- Tell the participants that the Community Demand List (CDL) Tool has been developed to plan and monitor their outreach. The tool:
  - Provides an overall picture of all women in a specific area to allow the ASHAs to enumerate and track them.
  - Shows who should be given what services and when the next service is due.
  - Maintains a record that shows the percentage of coverage.
  - Identifies gaps, analyses reasons for gaps and suggests solutions.
- The ASHAs will be trained to use the CDL Tool by the RPs.
- The CDL Tool will be explained in detail in Module 5 of this Tool Kit.

SESSION 5:
IMPROVING THE QUALITY OF INTERACTION IN PROVIDING HOME BASED MATERNAL, NEONATAL AND CHILD CARE

Objective

- To help the participants understand the concept, importance and usefulness of the Home Based Maternal, Neonatal and Care (HBMNC) Tool in monitoring the mother and newborn.

Methodology

Small group discussion and presentation

Duration

1 hour

Training Materials

Markers and brown sheets/ card sheets

Tips for facilitators

ASHAs have the important task of visiting women throughout the perinatal and post-natal period to seek information from the mother and the newborn that can help her screen them for any complications. The HBMNC Tool is an important tool to help the ASHA monitor them and to communicate the right messages at the right time.

Process

- Ask the participants what is the main responsibility of the ASHAs?
- Note their responses on a flip chart.
- Ask them to share and discuss the reasons and responsibility of visiting homes from their own experiences of working in the field.
- Note their responses on a flip chart.
- Consolidate the discussion by pointing out:
  - Doing home visits is the ASHAs key responsibility.
  - It is a crucial platform for communicating with the woman and her family during the MNCH continuum of care
  - One of the main aspects of a home visit is to check the condition of the woman during ANC and her child during PNC and suggest appropriate services and practices and steps to ensure that they are healthy.
- Ask the participants how home visits are conducted currently in the field and what the gaps are?
- Note their responses on a flip chart.
- Ask them to share and discuss the identified gaps.
- Highlight the gap of communication: either what to communicate or how to communicate.
- Tell the participants that for ASHAs to communicate well, they need to first understand all the aspects of the MNCH continuum of care thoroughly and to know the right messages at the right stage:
  - **Antenatal care** – care during pregnancy
  - **Intra-natal care** – care during the delivery and first two hours after the delivery
  - **Postnatal care** (Mother and newborn) – care during the first 42 days
  - **Child care** – care of the child up to 5 years of age.
- Tell them that the HBMNC Tool has been designed to address gaps in communication to help the ASHAs improve the quality of their interactions during home visits and help them plan interventions in cases where the health of the mother or newborn is at risk.
- Consolidate that the HBMNC Tool is essential in maintaining a detailed record of every woman and newborn across the MNCH continuum of care. It can guide the ASHAs on what to be looking for during each stage and helps them develop the right message at the right time: informing women and their families about high risk pregnancies, danger signs during ANC, delivery and PNC periods, and healthy practices in newborn care.
- The ASHAs will be trained to use the HBMNC Tool by the RPs.
- The HBMNC Tool will be explained in detail in Module 6 of this Tool Kit.

SESSION 6:
ENHANCING ACCOUNTABILITY THROUGH SUPPORTIVE COMMUNITY MONITORING

Objective

- To help the participants understand the concept of Supportive Community Monitoring (SCM)
- To help the participants understand the responsibility of the community to ensure the adoption of healthy behaviours and improve access to available services by women and family members and the community's responsibility to support the FLWs to be effective in the field.
- To inform the participants about the Supportive Community Monitoring (SCM) Tool.

Methodology

Discussion and group work

Duration

2 hours

Training Materials

Brown sheets and markers

Tips for facilitators

The focus of the session is to enable the participants to critically think about the concept of supportive community monitoring and its relevance to improving MNCH and general health status of the village. Some of the participants may not have worked with grass root community structures and might find this concept new. Take time to discuss and help them understand the role of the community to enhance health outcomes at the village level.

Process

- Give one of the case studies to each of the four groups.

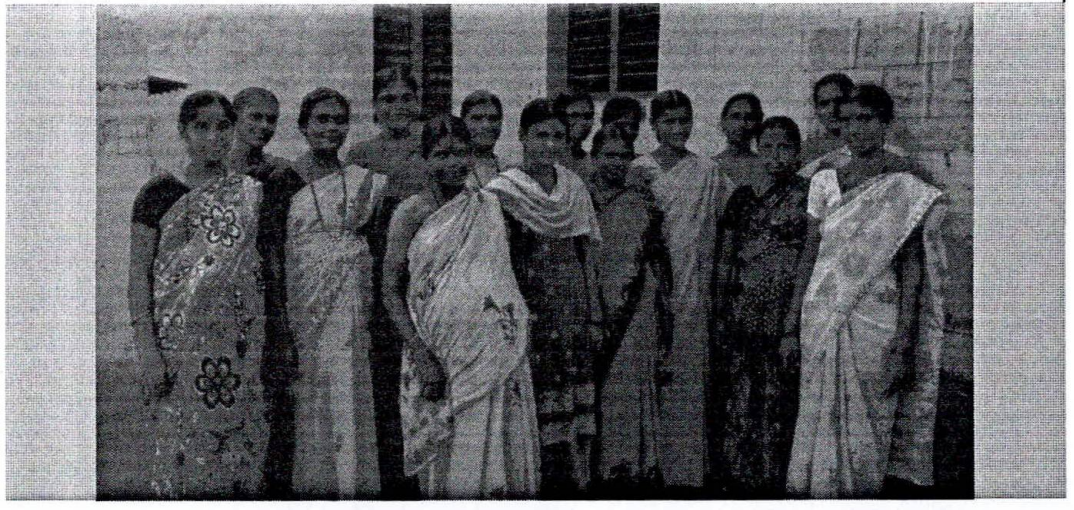
Case 1:
Repeated efforts by the ASHA and JFA have not been successful in convincing Ramappa to register and bring his wife for check-ups at the PHC despite it being her first pregnancy and she being underweight. Every possible attempt was made using communication materials, discussions with family members and even bringing the Medical Officer to their house. He refuses and accuses the FLWs that they force women only 'to fill their pockets'. What can be done?

Case 2:
In Mudhol village, 3 maternal deaths have happened recently. This village is known for child marriage, which is believed to be a traditional practice. FLWs have failed to convince families about the dangers of marrying a girl before she is 18. Early marriage leads to early pregnancy and delivery related complications. What can be done?

Case 3:
The Girinagar PHC has not received any Madilu kits for the past 6 months from the GoK and the women are demanding that they receive the kits. The villages are blaming the ASHA for this. What can be done?

Case 4:
An SC/ST woman in Kavalur village is highly anaemic. She is pregnant with her first child and her husband has alienated her. Her family has refused to accept her back into the house and she lives alone in a hut with no means to feed herself. Her earning as a daily wage labourer is very low. She needs a blood transfusion to save the life of the baby. It will cost her 1500 Rs. What can be done?

- Ask group members to read the case study in the group, discuss and answer the question in each case study.
- Allow 15 minutes for discussion, and then ask a representative from each group to take 5 minutes to read out their case study and share their responses to the case study's question.
- Ask other groups to share any other key information about the case study.
- Continue with the next 3 case studies in the same manner.
- Highlight any solutions that involve the villagers/ village heads/ Gram Panchayat members to resolve the case study problems.
- Tell them that the larger community has a very crucial role to play in ensuring the general health status of a village, but that very often this role is undermined.
- Ask the participants that if they agree that the community plays a crucial role in reducing maternal and child morbidity and mortality in rural villages and how this source of help can be improved?
- Note their responses on a flip chart.
- Ask them to share and discuss their own experiences of working in the field.
- Highlight any answers that involve the Village Health Sanitation and Nutrition Committee (VHSNC). Make sure all participants know about the committee and its role.
- Tell them that the NRHM has recognized the importance of community participation and involvement in maintaining the health of the village and have constituted the VHSNC to be in charge of offering support to all health related activities at the village level.
- One of the crucial roles of VHSNC is to support the efforts in reducing maternal and infant morbidity and mortality at the village levels.
- They can do this by supporting the efforts of the FLWs using supportive monitoring of MNCH continuum of care activities in the field.
- Divide the participants into two groups. Give each group one of the following questions to discuss:
  - What does supportive monitoring mean? What activities could it involve?
  - How can the VHSNC do supportive monitoring?
- Allow 15 minutes for discussion. Ask a representative from each group to take 5 minutes to share their answers.
- Ask the other group to contribute any other key information about that question.
- Consolidate the session saying that the key to effective community monitoring is "supportive" monitoring, not supervising. The spirit behind the intervention is 'fact-finding' and 'learning lessons for improvement' rather than 'fault finding'. Community feedback on the status of functioning of the healthcare system and service providers can facilitate corrective action and enhance accountability to the community among health care providers and community structures.
- Tell the participants that the SCM Tool has been designed to help the VHSNC members to assess the gaps in the field regarding access to and delivery of MNCH services across the continuum of care. It will then help them to strategize on what steps should be taken locally to address the gaps. Monthly use of the SCM Tool will help them understand the areas where they need to support the FLWs.
- The VHSNC members will be trained to use the SCM Tool by the RPs.
- The SCMT will be explained in detail in Module 7 of this Tool Kit.



SESSION 7: STAFF STRUCTURE, ROLES AND RESPONSIBILITIES AND DRAWING-UP AN ACTION PLAN

Process

7.1 STAFF STRUCTURE

- Divide participants into three groups. Give them each the following situations to role play:

  - *Seema is pregnant for the second time and is in her seventh month. During the first delivery Seema had obstructed labour. The ASHA and JFA from Seema's village are discussing how they would be able to ensure that Seema goes to the PHC for her delivery. What will the RP do to help?*

  - *Geetha is pregnant for the sixth time and has five daughters. Her mother-in-law thinks that since she has delivered for five times before there is no need for her to register so early. Geetha gets tired very quickly, but cannot take rest as she is the eldest daughter-in-law of the house. What are different issues that Geetha needs guidance on and how will the RP help?*

  - *In a village, eight girls below 18 were married off over the last three years. Three of them are pregnant now. The ASHA of the village is very concerned about them. What will the RP do to help?*

- Allow 15 minutes to prepare their role play.
- After each group has performed their role play, ask all participants to discuss the role of the RP.
- Display the 'Overview of MNCH staff' flowchart at the front of the training room.
- Explain the existing MNCH staff structure roles.
- Ask the participants to return to their role play group and to write down the roles of the FLWs based on the role play and their experiences in the field on a flip chart.
- Allow 15 minutes for group work then ask a representative from each group to display their flip chart on the walls of the training room and to take 5 minutes to share their answers.
- Consolidate by stating that every level/staff has clearly defined roles and responsibilities. Clarify that the ASHA, JHA and VHSNC will directly work with the community and it is their responsibility to create awareness, give the right message at the right time, and ensure that all services reach the women across the continuum of care.

Objective

- To help the participants understand the roles of the project staff at different functional levels.
- Help the draw up an action plan for the Sukshema project's activities.

Methodology

Group discussion

Duration

1 hour

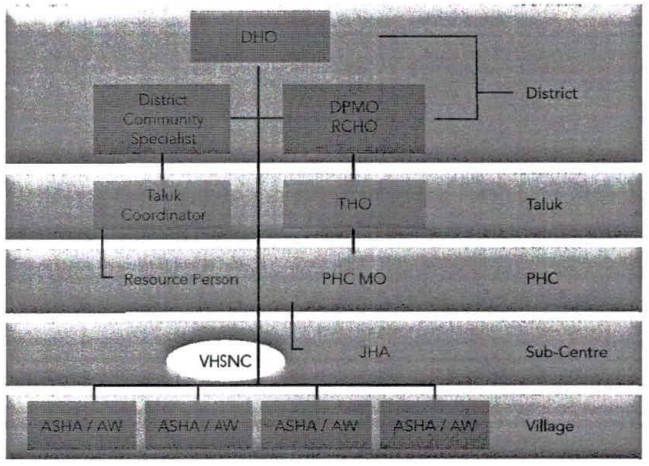
Training Materials

Briefs for the role-play, brown sheets, pen, pencils and sketch pens; Background material 9: Staff structure and responsibilities for under project Sukshema, format 5: Profile of PHC/ SC

Tips for facilitators

Note that the staff structure presented in this session is based on Sukshema's experience in the field. This session can be modified by users according to availability of resources, scale of project, funder support and the roll out plan. It is important to build role clarity so that the roles do not overlap. The RPs need to understand that they are not here to replace any existing position, but to motivate and support the ASHAs to do their work responsibly and efficiently. Their role is not supervisory, but supportive.

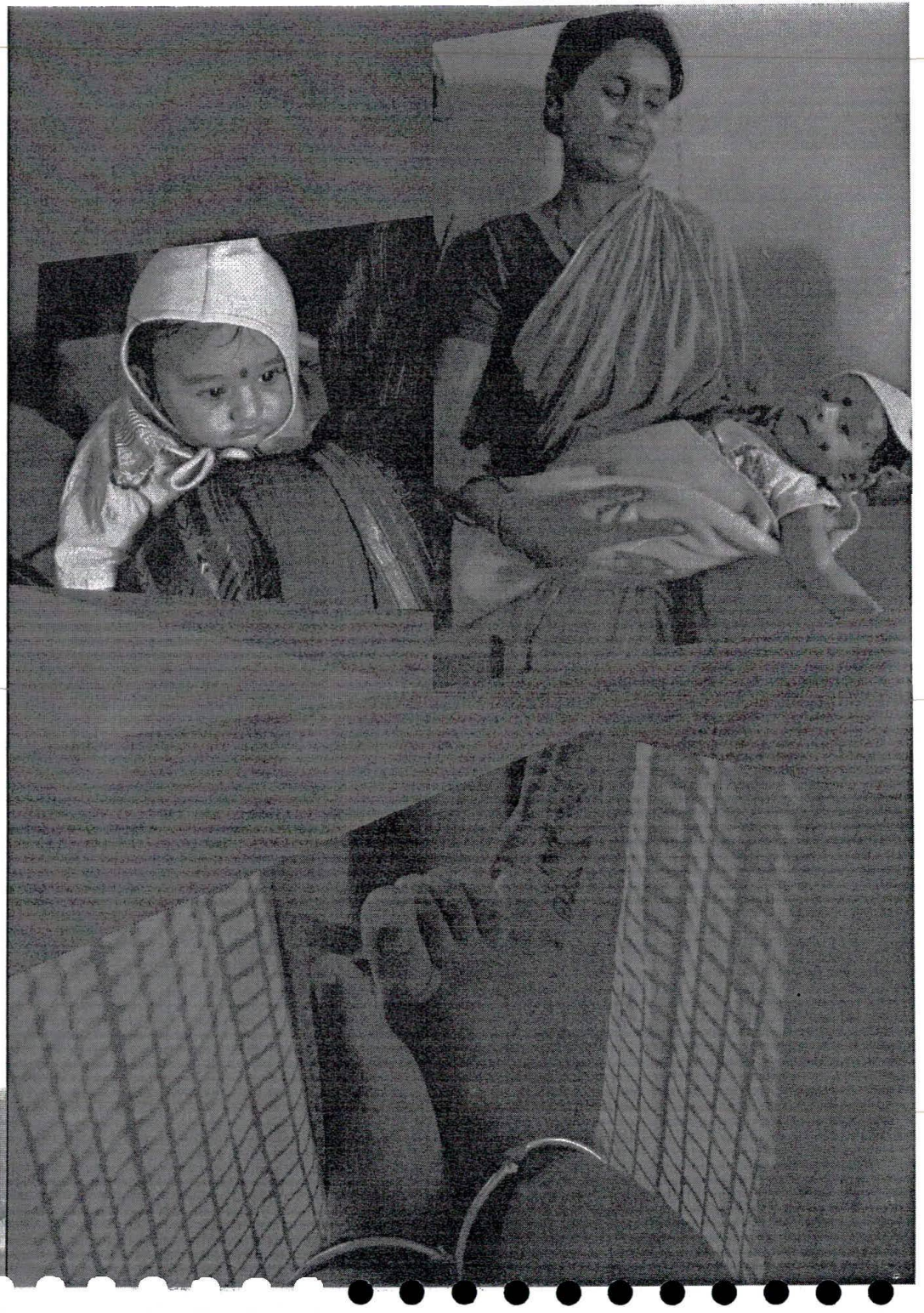
OVERVIEW OF THE KOPPAL MNCH 'SYSTEM'



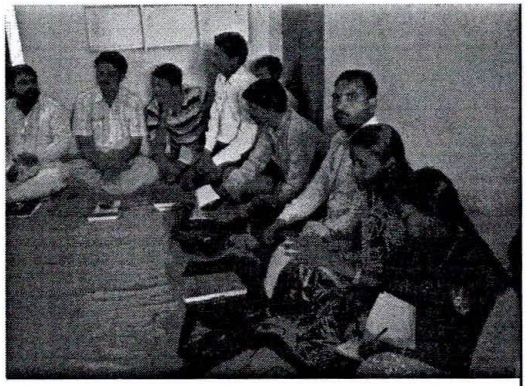
- Emphasize that the RPs role is to support them with information, tools and providing guidance in planning and NOT direct implementation. RPs should not do a policing job, but support the FLWs with affection, trust and team work.
- RPs will conduct trainings for them on the following community level interventions and support them to roll out:
  - Family focused Communication (FFC) Tool
  - Community Demand List (CDL) Tool
  - Home Based Maternal Neonatal and Care (HBMNC) Tool
  - Supportive Community Monitoring (SCM) Tool
- The RPs also have a responsibility to follow up with the FLWs and analyse the outcome of the use of these tools, the interventions on MNCH outcomes, and ASHA tasks. This includes:
  - Analysing the CDL Tool outcome through gap analysis and problem solving tools
  - Analysing the HBMNC Tool outcome and the manner in which it is helping the ASHA do home visits more effectively.
  - Analysing the SCM Tool outcome and supporting VHSNCs to implement the tool and take appropriate action steps to work more effectively with the FLWs.
- RPs will use checklists that have been developed to help them do these duties.

7.2 DRAWING ACTION PLANS

- Ask the participants to return to their role play group and to develop and write down on a flip chart their action plan based on their specific roles for the next three months in their respective areas.
- Allow 20 minutes for group work then ask a representative from each group to display their flip chart on the walls of the training room and to take 5 minutes to share their answers.
- If the training has a Taluk coordinator or a District coordinator let them sit with the groups and plan how they will initiate this process in the field.
- Their action plan can start with profiling their PHC areas, gathering information about all FLWs working in that area, rapport building with VHSNCs, PHC staff and FLWs, preparing for ToT, briefing health department officials about the project and its interventions, etc.
- Give inputs on their presentations and help them finalize their plans based on the stage that the project is in and the scale at which the activities are going to be launched.



SESSION 8: TRAINING EVALUATION AND FEEDBACK



Objective

- To assess what affect the module had on the participants' attitudes, knowledge and practice levels.
- To obtain feedback from the participants on the usefulness of the training and suggestions for enhancing future effectiveness.

Methodology
Reflection

Duration
30 minutes

Training Materials

Training evaluation and feedback form

Tips for facilitators

The training evaluation and feedback form will assess what affect the module had on the participants' attitudes, knowledge and practice levels and obtain feedback on the usefulness of the training and suggestions for enhancing future effectiveness.

Process

- Distribute the training evaluation and feedback form. Go over all the areas that the participants will need to think about while filling it in.
- Allow 20 minutes to complete it.
- Collect the training evaluation and feedback forms from the participants.
- Before the closing ceremony begins, ask the participants to share their feelings about the training: encourage anyone who is keen to orally share two positive aspects and two areas that need improvement.
- At the closing ceremony thank all the participants for their enthusiastic participation, congratulate them and wish them the best as they go back to their own field areas and begin to initiate the intervention on ground.
- Thank everyone else who contributed to the training program. This might have included administrative staff, venue owners, facilitators, guest speakers and the organizers.

TRAINING EVALUATION AND FEEDBACK FORM:

KARNATAKA HEALTH PROMOTION TRUST
Training Evaluation and Feedback Form

Name: _____ Designation: _____ Place of training: _____
Training dates: _____ Name of the PHC: _____

S.No.	Subject	Excellent	Good	Poor
1	Training content and sessions			
2	Training methodology and activities used			
3	Training skills of the facilitators			
4	Logistics at the training (Food, stay and comfort)			
5	Relevance and usefulness of training			

List the three aspects of the training that you found most useful.

1.
2.
3.

Name any session during the training that you did not understand properly/ or that was not communicated well.

1.
2.
3.

What are the three most important lessons that you can take back to your work place from this training?

1.
2.
3.

Please list suggestions for improved facilitation in future trainings.

1.
2.
3.

ANNEXURE 1 - Reading material on village health and sanitation nutrition committee (VHSNC)

On the 12th of April 2005 the Indian government started the "National rural health mission" (NRHM) to safeguard and improve the health of all its citizens especially the poor and those living in rural areas. Under the aegis of this mission the government has started several programs to improve the health of its citizens. The government has put local community members in charge of health services and has encouraged them to formulate and oversee them in order to give the people an opportunity to take decisions regarding their health and to play a pivotal role in safe guarding it. The supervision and planning of government's health plans have been handed over to the community so that their response to people's needs and also their effectiveness can be ensured. In this way the goal is to engender a sense of ownership in stakeholders including the government, community and NGOs.

PURPOSES:

1. For the government, Panchayat Raj institutions, and the community to work together to achieve the goal of ensuring equal partnership of the community in improvement of health services.
2. Create an atmosphere where it is clear that it is the community's right to access health services and it is the responsibility of the government and concerned departments to extend such services.
3. Identify the reasons why health services and various health benefits are not effectively reaching the community and importantly to women, children and the weaker sections of the society.
4. Ensure that there is transparency and accountability in the delivery system of health services and to encourage them to effectively use the constitutionally sanctioned platform of Grama Sabhas.
5. Clearly understand the intentions, goals, organizational structure and best practices of the mission and help the members with the knowledge, skills and methods necessary to adapt it.

A1. VHSNC/VILLAGE HEALTH PLAN AND MONITORING COMMITTEE:

- At the village level, the VHSNC will also function as the village health plan and monitoring committee.

Formation and selection of general members

- The VHSNC/Village health plan and monitoring committee will comprise of 15 Grama Sabha members. Out of this there should be a minimum of 8 women members and among the women members 3 of them should belong to SC/ST and 2 SHG members. Among the remaining 7 members, a minimum of 2 should be belonging to SC/ST.

Ex officio members

- The Junior Female Health Assistant (JHA), the Junior Male Health Assistant (JHA), the primary school teacher (preferably women), all Anganwadi workers (AWWs) and the Accredited Social Health Activists (ASHAs) of that particular village will be the ex officio members.

"Committee President"

- Only the local Gram Panchayat member can become the ex officio President of the Village health and sanitation committee/Village health plan and monitoring committee.
- If that member is already the President of the local Gram Panchayat, only he can become the ex officio President of the Village health and sanitation committee/Village health plan and monitoring committee.
- If the Gram Panchayat President is not a resident of the village, then a Gram Panchayat member who is a resident of the village can become the ex officio President of the VHSNC/Village health plan and monitoring committee.
- In case there are more than one Gram Panchayat member in the village, then the Gram Panchayat has to nominate one of them to be the ex officio President of the VHSNC/Village health plan and monitoring committee.
- If the Gram Panchayat is unable to decide on whom to nominate, the chief executive of the local Taluk Panchayat can select a suitable member from among the concerned Gram Panchayat members to be the ex officio President of the VHSNC/Village health plan and monitoring committee.
- In such a situation, the decision of the chief executive of the Taluk Panchayat will be final.

A2.4 COMMITTEE SECRETARY

A local ASHA worker who is the member of the committee will be the secretary of the VHSNC/Village health plan and monitoring committee. If there are no ASHAs in the village the Anganwadi member will be the member secretary. If there are more than one ASHA or Anganwadi Worker, than the VHSNC/Village health plan and monitoring committee is authorized to select the senior most and able among them to be the member secretary.

A2.5 MEMBERSHIP TENURE:

Among the 15 Gram Sabha members elected to the committee, 1/3rd of them will retire after the first year and will be decided by a lottery. 5 new members from the Gram Sabha will then be elected to take their place. Similarly the remaining 5+5 members will retire after the 2nd and 3rd years decided by the lottery and their places will be taken similarly by other Gram Sabha members. If the retiring member is from a reserved category then the incoming member will also have to be from the same category. The Gram Sabha will have the discretion of re-electing a retired member. But the members of the Gram Sabha should be aware of the purpose and that is to give every capable member of the village a chance to become the member of the committee. The retiring and re- electing of 1/3rd of its members should be repeated annually. The supervision of the retirement and re-election of the members must be jointly done by the secretary of the local Gram Panchayat and the doctor of the primary health centre

A3. RESPONSIBILITIES OF THE VHSNC VILLAGE HEALTH PLAN AND MONITORING COMMITTEE

- The VHSNC/Village health plan and monitoring committee should every year prepare an annual village health plan and a monthly report card and submit it to the concerned PHC's health plan and monitoring committee. In addition the committee will also have the following responsibilities:
  - Establish meaningful community monitoring systems as per the directions of the Indian government
  - Arrange a quarterly health related people contact program where there is a dialogue with the community about health department services and short comings if any, local solutions andsuggestions on how to further improve the services.
  - Engender an understanding in the community about health services and health related rights.
  - Prepare a village health plan to suit local realities and necessities.
  - Analyse current village health and care activities and supply information to its concerned workers/officers on how to make it better.
  - Submit the annual village health report to the Gram Sabha
  - Submit the authentic and qualitative information about the state of the health of the village to the health plan and monitoring committee of the PHC.
  - The management of the index numbers of the village health records and the health information board should be done regularly. The records and the board should not only carry information about services like pregnant women care and post natal services, care for new born babies, vaccinations, nutrition, etc., but also services aimed at people suffering from contagious diseases and life style related diseases and Madilu, birth protection scheme, post-natal care, mother's care, etc., and complete information about similar people oriented programs, which then should be regularly updated. Information regarding the visit dates of health workers to the village, venue, etc., should also be provided to the people.
  - Oversee the visit of health workers to the village on the specified date and ensure complete health care to the villagers.
  - Organize people awareness campaigns about the societal boundaries leading to forced abortions of female foetus.
  - Use of open funds: According to the periodic directions given to the state government, the open funds can be used and the monthly accounts have to be submitted to the doctor at the primary health centre and a copy of the accounts to the Gram Panchayat.
  - For the sake of village health related works every Gram health and sanitation/gram health plan and monitoring committee can accept help in the way of money or in kind from institutions, Panchayat and donors.

A.4 COMMITTEE MEETING:

- In the afternoon of the first Monday of every month the committee should compulsorily meet and conduct a meeting at any convenient place, for example the Gram Panchayat office building/sub centre/ Anganwadi Centre/school building/community hall. In an emergency, an extraordinary meeting can also be called.
- The committee secretary has to send a notice along with an agenda 3 full days before the date of an ordinary meeting. An extraordinary meeting can be called 24 hours after the notice has been sent.
- To conduct a meeting the quorum/members present should be 1/3rd the total number of members. Among the members present, at least 1/3rd should be women.
- If there isn't a quorum, the president should wait for

30 minutes. If there is still no quorum, the meeting should be postponed to a date convenient to everyone in the same month and a fresh notice sent intimating the new date.

- On the day of the meeting if the president is absent and if there is a quorum, then a unanimous choice from among the members present can function as the president and conduct the meeting.
- The proceedings and decisions of the meeting have to be recorded in an authentic book and the signatures of the members present has to be affixed in it and the copies of it have to be given to the PHC.
- The health plan and monitoring committee and the secretary will have the responsibility of properly maintaining the documents.
- The bank account of the VHSNC should jointly in the names of the president and the secretary.
- Every three months the VHSNC/village health plan and monitoring committee should submit a financial and program report to the Gram Panchayat standing committee.
- The village health and sanitation/village health plan and monitoring committee should be the successor to the Gram Sabha of the Gram Panchayat.
- According to the Karnataka Panchayat Raj order 1993 61-A, the VHSNC/village health plan and monitoring committee will have the position of a subcommittee to the gram Panchayat standing committee.

ANNEXURE 2 - Reading material on Government infrastructure related to healthcare

In the rural areas, the health care needs are primarily looked after by the outreach services which are available at the basic unit of 1000 people by ASHAs and AWWs. But the proper infra-structure of healthcare in rural areas has been developed as a three tier structure based on predetermined population norms which are as follows:

HEALTH CENTRE NORMS

	Population Norms	
Centre	Plain Area	Hilly/Tribal/Difficult Area
Sub-Centre	5,000	3,000
Primary Health Centre	30,000	20,000
Community Health Centre	1,20,000	80,000

Source: MHFW (2005), Population Norms (Census 2001), http://www.mohfw.nic.in

Sub-Centres (SCs)
The Sub-Centre (SC) is the most peripheral and first contact point between the primary health care system and the community. Each SC is required to be manned by at least one JHA and one Male Health Worker. The SCs are provided with basic drugs for minor ailments needed for taking care of essential health needs of men, women and children.

Primary Health Centres (PHCs)
PHC is the first contact point between village community and the Medical Officer. The PHCs were envisaged to provide an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care. As per minimum requirement, a PHC is to be manned by a Medical Officer supported by 14 paramedical and other staff. It acts as a referral unit for 6 SCs. It has 4 - 6 beds for patients. The activities of PHC involve curative, preventive, promotive and Family Welfare Services.

Community Health Centres (CHCs)
CHCs are being established and maintained by the State Government under Minimum Needs Programme (MNP) / /Basic Minimum Services Programme (BMS). As per minimum norms, a CHC is required to be manned by four medical specialists i.e. Surgeon, Physician, Gynaecologist and Paediatrician supported by 21 paramedical and other staff. It has 30 in-door beds with one OT, X-ray, Labour Room and Laboratory facilities. It serves as a referral centre for 4 PHCs and also provides facilities for obstetric care and specialist consultations.

First Referral Units (FRUs)
An existing facility (district hospital, sub-divisional hospital, community health centre etc.), in addition to all emergencies that any such healthy facility is required to provide, can only be declared a fully operational First Referral Unit (FRU) if it is equipped to provide round-the-clock services for:

- Emergency Obstetric Care including surgical interventions like Caesarean Sections
- Newborn Care
- Blood Storage Facility on a 24-hour basis.

For 2,50,000 to 3,00,000 people a Taluk hospital would provide the health service infrastructure, while for average of 20,00,000 people, this would be the District Hospital where specialists and emergency care and caesarean section services are available.

ANNEXURE 3 - Reading material on Government schemes for mothers and children

Under the National Rural Health Mission (NRHM) several programmes/schemes have been introduced to reduce the incidence of maternal and child morbidity and mortality. Several important programmes/schemes are:

1. *Janani Suraksha Yojane*
2. *Madilu Yojane*
3. *Prasuthi Araike Yojane*
4. *Universal Immunization programme*
5. *Thayi card*
6. *Thayi Bhagya Scheme and Thayi Bhaya plus scheme*
7. *Janani Shishu Suraksha Karyakrama*

1. JANANI SURAKSHA YOJANE

Objective:
To provide financial support for families living below the poverty line (BPL) and belonging to SC/ ST groups.

Primary programme components include:

- Early registration
- Micro / birth planning
- Referral transport (Home to Health Institution)
- Institutional birth
- Post-delivery visit and reporting
- Family planning and counselling

Eligibility of beneficiaries:

- Low Performing States (LPS): All pregnant women. Above Poverty Line women delivering in general wards of Government / Accredited Private Hospitals
- High Performing States (HPS): All BPL pregnant women, 19 years and above, up to 2 live births.
- LPS & HPS states: SC and ST women 19 years and above, 2 live births delivering in general

wards of Government or Accredited Private institutions.
- Home Deliveries: All BPL women of 19 years of age or above, up to 2 live births.

ASSISTANCE PACKAGE IN RUPEES:				
Category	Rural		Urban	
	Mothers	ASHA	Mothers	ASHA
LPS states	1,400	600	1,000	200
HPS states	700	-	600	-
	For two live births only			

In both LPS and HPS states provisions for caesarean section:
- Up to Rs. 1500/- per case for hiring services of experts from private sector
- If private doctors are not available, utilization permitted for providing honorarium/TA to Government specialists, if available in another Government facility provided s/he has the time to spare and empanelled.

Other relevant information:
- The scheme is supported by ASHAs or any other linked worker.
- Pregnant women have to register with the health worker to avail these services. If not, they have to have at least undergone three check-ups. They should have also had 2 Tetanus injections and the prescribed course of iron tablets.

2. MADILU YOJANE

Objective:
- To enable pregnant women with very low income, especially from BPL families, to access Government Hospitals for delivery

Eligibility of beneficiaries:
- Women from BPL families
- Women who have delivered in a Government Institution
- Women with only two children

Assistance package:
- Under this scheme, a post-natal medical kit containing 19 items for the safety and use of the mother and child up to 3 months after the delivery, is given as a 'Tavarige udugore' or gift from the mother. The kit includes bedspreads, bathing soap, detergent, etc. Mosquito nets are also supplied in malaria endemic districts.

Other relevant information:
- Mothers who deliver in a private hospital are not eligible for this service
- Pregnant women have to register at the SC and in the local Health Centre well in advance
- BPL families that do not possess the BPL card have to get authorization letter from the Revenue Department Officer to avail of this service

3. PRASUTHI ARAIKE YOJANE

Objective:
- This scheme aims to address the nutrition deficiency in SC and ST families by giving financial assistance to encourage rest, provide access to nutritious food and medical care during first and second live births for BPL mothers.

Assistance package:
- Financial assistance of Rs.2000/- during Antenatal period for BPL women that is given in two instalments. The first instalment of Rs.1000/- is given during third trimester, and second instalment is given immediately after delivery.
- An information booklet is given to all pregnant women focused on the necessity of nutritious food.

Eligibility criteria:
- Pregnant women from SC and ST, BPL families, living in the districts already identified by the State Government are eligible, up to 2 live births.

Other relevant information:
- During every ANC visit, the women should get the signature, date and seal of the PHC/Government Hospital Medical Officer.
- The Junior Health Assistant (Female) has to provide

a document ascertaining the beneficiary's registration (ANC) and if it is the 1st or the 2nd delivery.
- The delivery has to be compulsorily conducted at the PHC/Government Hospital.
- The beneficiary has to provide the doctor with a photocopy of the caste certificate or a copy of the BPL card.

ANC REGISTRATION BOOKLET (THAYI CARD)

The Thayi card is a comprehensive ANC registration booklet. It encompasses all the mother and child health parameters from early ANC registration to post natal follow up, immunization records of the child, weight gain record, etc. These cards help in pregnancy tracking and the immunization and growth of the child and record the disbursement of the money for JSY/Prasuthi Araike Yojane as well as the disbursement of Madilu kits.

THAYI BHAGYA YOJANE

Objectives:
- Despite in-sourcing/hiring of obstetrics, anesthesia and pediatric specialists at FRUs, Karnataka is experiencing shortage. However, the private medical sector expertise is available and this scheme proposes to tap this valuable resource. Private providers are empanelled in identified districts to provide the delivery care package. The private providers must be screened by District Health Society. This scheme enables cashless transactions for rural BPL families to access delivery at recognized private hospitals.

Eligibility criteria:
- BPL women more than 19 years of age, for first two live births, who have regular ANC check-ups.

Package:
- Private providers are reimbursed Rs.3,00,000 for every 100 deliveries on a capitation basis i.e.RS.3000/- per delivery, out of which Rs.250 + Rs.75/- will go to transportation charges of the beneficiary and accompanying person.
- This scheme is extended to Government institutions up to FRU level. For Government institutions a threshold is fixed on the basis of number of deliveries conducted. This package is only applicable for deliveries above the threshold level. Rs.1,50,000 for 100 deliveries will be paid as a package for Government hospital i.e. Rs.1500/- per delivery.

JANANI SHISHU SURAKSHA KARYAKRAMA

Objective:
- This scheme is commonly known as JSSK and was introduced by the Government in September, 2011. It covers all women, with no difference linked to BPL or APL.

Package:
- Access to ANC services and newborn services up to 30 days.
- Consumables /drugs (normal delivery or C-Section), i.e., bandages, gloves, etc.
- Lab testing (ANC and newborn) i.e., X-Ray, blood check, scanning, etc.
- Hospitalisation if required during ANC with food when normal delivery for 2 days and C-Section for 7 days)
- Free vehicle support for transfer to higher facility
- No user charge in any Government institution.

ANNEXURE 4 - Checklists for Sukshema's project field staff

1) CDL RP ANALYSIS FORMAT

CDL RP ANALYSIS FORMAT 1 MONTH: MATERNAL, NEWBORN AND CHILD INDICATORS

S.No	PHC name	Sub Centre name	ANC reg	TT	IFA	ANC	Home delivery	PNC visits	Deaths		
									Maternal	Neonatal (0-28 day)	Post neonatal (29th day - 1 yr)

Formula to denote red, yellow or green mark across each of the indicator

Formula: Sum of Ach (Fulfilled)/Sum of Target (Client needs) * 100
If the percentage obtained is less than 50% in that sub centre mark red, if the percentage obtained is between 50%-75% in that sub centre mark yellow and if the percentage obtained is more than 50% then mark green. In case of home deliveries reported in that sub centre area mark red even if there was one home delivery reported. Mark green if there were no home deliveries reported. Similarly mark red even if there was one maternal death reported in that sub centre. Mark green if there were no deaths reported in that sub centre.

Red: Less than 50%	Yellow: 50-75%	Green: More than 75%

2) CDL RP ANALYSIS FORMAT

CDL RP ANALYSIS FORMAT 2

SUB CENTRE NAME:

Reasons for gaps in services	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
1. ASHA workers visiting pregnant women and newborn												
2. Ineffective communication between frontline workers & beneficiaries												
3. Unavailability of ASHA/ANM/AWW workers in the area												
4. Incomplete ANC services - IFA/TT injections												
5. Cultural practices and beliefs												
6. Families negatively influencing the pregnant women and mothers												
7. Poor health seeking behavior												
8. Male preference												
9. Inability to pay the delivery cost owing to poverty												
10. Others												

Instructions: Sub centres listed in the RP Analysis format 1 having 3 or more than 3 indicators with poor performing indicators (less than 50%) marked red are selected for further analysis in this format. The probable reasons for gaps in services are listed in this format which should be identified every month and marked (√) or else marked (×) if no reasons were identified. The issues identified should be discussed in the Arogya Mantapa meeting and the group should arrive at problem solving approaches.

3) HBMNC TOOL HANDHOLDING CHECKLIST

Name of the RP: _____ PHC: _____ Taluk: _____

ASHA Name	Sub centre Area name	Rapport established with the women	Interacted without looking at the tool word by word	Examined the Women/ newborn as required	Appropriate messages were identified through open ended questions	Suitable tool was used for effective communication	Message was focused on women & her family	Appropriate communication skills were used (Active listening, observatio, open ended questions, paraphrasing & other) skills have been used	Informed about the further follow up needed	Collected information & has been recorded in the prescribed tool	Color Green/ Yellow/ Red
1											
2											
3											
4											
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6											
7											
8											
9											
10											
11											
12											
13											
14											
15											

Scoring: If score is 8 & above (Green): Good, 5-7(Yellow): Average, 4 & < 4(Red): Needs further support

4) SCM TOOL HANDHOLDING CHECKLIST

Name of the RP: _____ PHC: _____ Taluk: _____

Name of the village	Members participation was open & free mind	Members sat in different groups & discussed freely	Discussion was conducted on the activity planned in the previous meeting	Microplanning was done after the meeting	Mutual cooperation was observed	All the columns are filled & abstract prepared	Members are discussion without the help of RPs	Discussion points are brought to the notice of the panchayat & followed up	SCMT meetings are conducted regularly	Tools are filled only after the discussion	Color Green/ Yellow/ Red

Scoring: If score is 8 & above (Green): Good, 5-7(Yellow): Average, 4 & < 4(Red): Needs further support

5) AROGYA MANTAPA HANDHOLDING CHECKLIST

Name of the RP: _____ PHC: _____ Taluk: _____

Name of the Subcentre	All the FLWs (subcentre level) were participated	All the members taking part freely	AM meting are being convened on rotation	Follow up discussions were held on the resolution of the previous meeting	Gap analysis was done by FLWs after updating & discussion	Prepared Action plan for the coming month	Innovative & interesting Activities conducted	Proceedings documented on rotation basis	Members are discussing without the help of RPs	VHSNC supporting this meeting	Color Green/ Yellow/ Red

Scoring: If score is 8 & above (Green): Good, 5-7(Yellow): Average, 4 & < 4(Red): Needs further support

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Community Level Interventions For Improving Maternal, Neonatal And Child Health: A Training Tool Kit

4 COMMUNICATION AND COLLABORATIVE SKILLS FOR FRONT LINE HEALTH WORKERS

Community Level Interventions for Improving Maternal, Neonatal and Child Health: Communication and Collaboration for Front Line Workers, is the fourth module of the tool kit in a series of seven on enhancing community engagement for improving outreach, shaping demand and strengthening accountability to improve maternal, neonatal and child health outcomes in Karnataka.

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IT/ BT Park, 4th & 5th Floor
1-4, Rajajinagar Industrial Area
Behind KSSIDC Administrative Office
Rajajinagar, Bangalore- 560 004
Karnataka, India

Phone: 91-80-40400200
Fax: 91-80-40400300
www.khpt.org

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Karnataka Health Promotion Trust (KHPT)
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Mr. Mohan HL, UOM
Dr. Suresh Chitrapu, KHPT
Dr. Seema Huddar, KHPT
Anna Schurmann, KHPT
Dr. Suresh Chitrapu, KHPT
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THE EDITORIAL TEAM:
Mr. H.L. Mohan, KHPT
Ms. Mallika Biddappa, KHPT
Mr. Suresh Chitrapu, KHPT
Ms. Dorothy Southern, KHPT consultant

The photographs are by **KV Balasubramanya.** They have been used in the module with consent from the community.

4

Community Level Interventions For Improving Maternal, Neonatal And Child Health: A Training Tool Kit

COMMUNICATION AND COLLABORATIVE SKILLS FOR FRONT LINE HEALTH WORKERS

ಸುಕ್ಷೇಮ
sukshema
Improved Maternal, Newborn & Child Health

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

PREFACE

The Community Level Interventions Training Tool Kit is a series of seven modules:

Module 1: Design, Planning and Implementation of the Sukshema Project
Module 2: Core Concepts of Maternal, Neonatal and Child Health
Module 3: Sukshema's Community Level Interventions
Module 4: **Communication and Collaborative Skills for Front Line Health Workers**
Module 5: Improving the Enumeration and Tracking Process
Module 6: Home Base Maternal and Newborn Care
Module 7: Supportive Community Monitoring

Module 4: Communication and Collaborative Skills for Front Line Health Workers focuses on the Junior Female Health Assistant (JHA), the Accredited Social Health Activist (ASHA), and the Anganwadi Worker (AWW), the three groups that are key front line health workers (FLWs) in the Sukshema's project. The module will lead them through sessions that will enhance their understanding about: gender and social issues related to the acceptability and access to Maternal Neonatal and Child Health (MNCH) continuum of care services; the importance of focussing on the family as a unit for bringing about desired changes related to MNCH practices; and addressing the gaps in coordination among FLWs in the field. Overall the module aims to improve communication skills during outreach and interactions with the pregnant woman, her family and the community through Family Focused Communication (FFC) Tools, which can help FLWs value themselves and their work, both when working independently or in a group.

CONTENTS

ACRONYMS

ANC	Ante Natal Care
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BCC	Behaviour Change Communication
BPL	Below Poverty Line
CHC	Community Health Centre
CHW	Community Health Worker
DPM	District Programme Manager
DPO	District Programme Officer
EDD	Expected Date of Delivery
FLW	Frontline Health Worker
FP	Family Planning
FRU	First Referral Unit
GoK	Government of Karnataka
IEC	Information, Education, Communication
IMR	Infant Mortality Rate
IPC	Inter Personal Communication
JHA	Junior Female Health Assistant
LBW	Low Birth Weight
MDG	UN Millennium Development Goals
MMR	Maternal Mortality Rate
MNCH	Maternal, Newborn and Child Health
MO	Medical Officer
NGO	Non-Government Organization
NRHM	National Rural Health Mission
PHC	Primary Health Centre
PNC	Post-natal Care
SBA	Skilled Birth Attendant
SC	Sub Centre
SC/ ST	Scheduled Caste/ Scheduled Tribe
SHG	Self Help Group
TBA	Trained / Traditional Birth Attendant
TT	Tetanus Toxoid
VHSNC	Village Health and Sanitation Nutrition Committee
WHO	World Health Organization

GETTING STARTED

The Doorway to Successful Training **in Part 11 of Module 1** should always be used to start a training workshop: initially if covering all modules at one time, or as a refresher if modules are scheduled over a period of time. The Doorway to Successful Training contains a detailed plan of sessions that sets the stage for the workshop activities and logistics, covering welcome, introductions, objectives, hopes and fears, and ground rules.

SESSION 1: UNDERLYING CAUSES OF MOTHER AND INFANT MORTALITY

Objective

- To help the FLWs understand the deeper social realities that lead to a high MMR and IMR.

Methodology
Brainstorming and discussion

Duration
1.5 hours

Training Materials

Picture of tree, markers and brown sheets/ chart paper

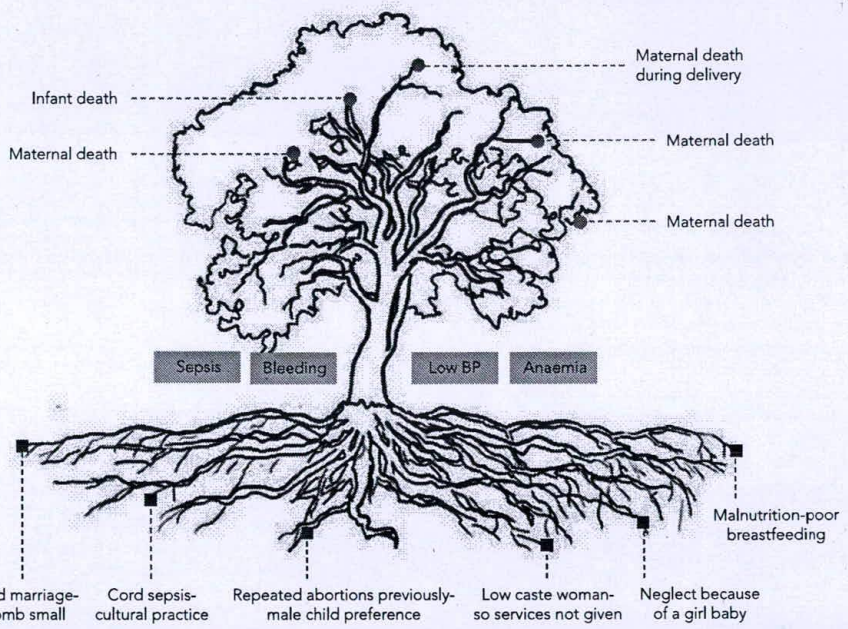
Tips for facilitators

This session focuses on helping the FLWs explore the underlying causes of maternal and infant illness and death using a socio-cultural lens. Some participants may not immediately agree with this approach, but take the time to use analytical reasoning so they understand that both medical and social causes have to be addressed using a holistic approach. Convince them that change needs to happen at the individual level, the family level and the societal level to improve MNCH continuum of care services in rural areas.

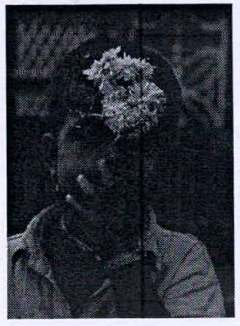
Process

1.1 CIRCLES OF INFLUENCE

- Ask the participants, 'Why do mothers and infants die during child birth in rural India?'
- Encourage them to come up with ideas. Ask probing questions until you get some responses.
- Note their responses on a flip chart.
- Highlight the four most commonly shared responses.
- Ask the participants, 'What could be the reasons behind these main causes?'
  - *For example, deconstruct anemia, the causes of which could be malnutrition, overwork, poverty, lack of awareness on nutritious food. Or deconstruct malnutrition, the causes of which could be a woman eats at the end of the meal when most of the food has been eaten.*
- Note their responses on a flip chart.
- Continue with the next two most common responses.
- Tell the participants that most of the reasons for causes for India's high MMR and IMR have their roots in gender discrimination and imbalances in society.
- Most of the time we tend to look at MNCH only from the medical point of view and ignore the deeper social and cultural realities that are responsible for MMR and IMR.
- Display the picture of the tree at the front of the training room.
- Explain the social and cultural realities in the Indian context using the picture.
- Ask all the participants to share similar experiences that they know of in the course of their field work.
- Consolidate the discussion:
  - When analyzed, every cause of maternal and infant death has social and cultural roots.
  - Change needs to happen at the individual level, the family level and the societal level.
  - This holistic understanding should lead to addressing both medical and social causes together to bring about improvement in MNCH in rural regions.
  - Healthy mothers and babies reflect a healthy social balance in the village.



SESSION 2: UNDERSTANDING FAMILY FOCUSED COMMUNICATION (FFC)



Objective

- To help FLWs understand the importance of communication focused on families.

Methodology
Brainstorming and discussion

Duration
1.5 hours

Training Materials

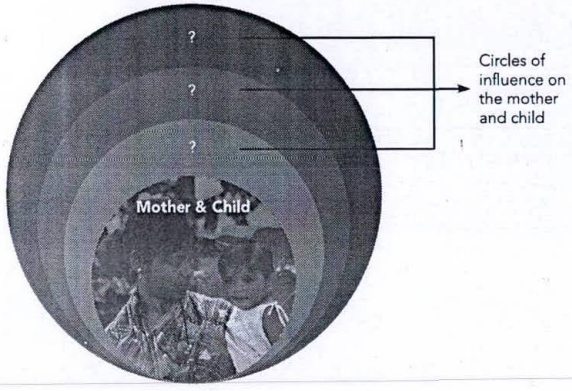
Markers and brown sheets/ card sheets

Tips for facilitators

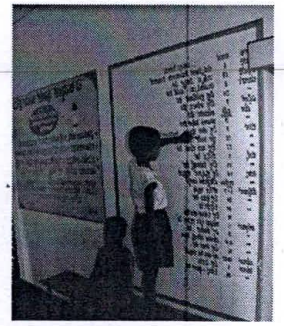
This session highlights the concept of FFC and its relevance to MNCH. The current priority of the FLWs is identifying family members who influence the pregnant woman. The FLWs must ensure that strategic and focused communication with these individuals takes place in a timely manner so that their opinions, views and beliefs are altered for effective behavior change, not just in the pregnant woman, but in the family as a whole. Encourage the FLWs to share experiences from the field at different stages of the session to make the discussions realistic. Help them understand that when communication is structured responding to real social realities within families, it is possible to change the decision makers behavior.

Process

- Share this story with the participants:
  Within a few hours after delivering a child Kamalakka dies on the way to the hospital due to severe bleeding. Her family had her deliver her baby at home. The grandmother believed the bleeding will take out all the toxins within the body. She wasn't fed properly during her pregnancy due to the fear that the baby may grow too big for a safe delivery. Her mother-in law made her do strenuous work to facilitate "easy child birth". Her husband wanted a male child, but she already had three daughters in the last 4 years. But Kamalakka died and now her children are motherless.
- Ask the participants why Kamalakka died.
- Note their responses on a flip chart.
- Ask them what wrong beliefs led to her death.
- Note their responses on a flip chart.
- Ask them where these wrong beliefs come from?
- Note their responses on a flip chart.
- Display the picture of the concentric circles at the front of the training room.
- Ask them who influences pregnant women/mothers the most. Tell them to fill in the circles with people/ groups/ organizations that have influence on a woman, her child and her health.
- Allow 10 minutes for discussion and encourage everybody to contribute.
- Make sure everyone gives reasons for the influence they have on the woman. For example, if they say husband should be in the innermost circle, ask them why they think so.
- Consolidate the discussion:
  - The closest circle of influence on the mother or the pregnant woman is her family.
  - It is in the family that beliefs are reinforced and practiced.
  - Working with women in isolation will not give the desired results.
- Ask the FLWs if they have ever worked with family members?
- Note their responses on a flip chart.
- Ask all the participants to share similar experiences that they know of in the course of their field work.
- Consolidate the discussion:
  - The decisions that surround the woman, her marriage, her pregnancy, delivery and child care are often taken by family members.
  - Behavior change communication should focus on prominent members of the family who have an influence on the pregnant woman and her decisions.
  - Working with family members is crucial to ensure they make the right decisions and to build a supportive environment for the woman.
  - Communication strategies for family members may be different and need new strategies.
    - ~ A mother in law may refuse to listen.
    - ~ A husband may not even believe in institutional delivery.
- Tell the participants that in the following sessions they will learn more about communicating with the family.



SESSION 3: ENHANCING COMMUNICATION SKILLS: FIVE ACTIVITIES FOR FLWS



Session 3 includes five activities/exercises to enhance the communication skills of FLWs to work with pregnant women and their families to improve the mother and child's health during the MNCH continuum of care. The activities aim to help the FLWs be confident enough to communicate intelligently and sensitively with persons with different personalities, beliefs and customs, and to find solutions for both expected and unexpected challenges in the families. All the activities in the session are linked together and should be conducted in one session. A key aspect of this session is to motivate FLWs to perceive their work not merely as a job, but as a commitment to the cause of saving mothers' and children's lives. These activities should help FLWs explore their personal strengths and channel them effectively so that their interactions with mothers and families are focused, relevant and powerful and that the FLWs realize their full potential.

Duration for all 5 activities: 4 hrs

ACTIVITY 1: LISTENING AND COMPREHENSION SKILLS

Objective

- To help improve the listening skills of the FLWs during interactions in the field.
- To know the difference between hearing and listening.
- To grasp information, remember what was said, and comprehend the meaning.
- To be able to design communication messages based on what they heard.

Methodology
Reading activity and discussion

Duration
30 minutes

Training Materials

One copy of a MNCH brochures for each group, e.g., project brochures, handouts or reading material on MNCH care. Markers and brown sheets/ chart paper

Tips for facilitators

Some of the participants may feel that 650 words per minute is impossible. Reassure them that to reach that limit they need to practice improving their listening abilities by continuous effort and concentration. Tell them that there is also a link between how well you can listen and how interested you are in the subject. A FLW who is not interested in a conversation with a pregnant woman during a home visit will not hear much. She won't be listening to what is being said. Communication will not be effective.

Process

- Divide the participants into four groups.
- Give each of the groups one copy of the brochure.
- Tell one person in each group to read aloud to the group what's written in the brochure for one minute. Ensure that she reads loud enough for all her group members to hear. Ask her to read with moderate speed.
- Signal when they need to start and when it's time to stop reading. The signal can be a bell or a loud "START" "STOP" announcement.
- Give each group a paper and marker. After one minute of reading, tell the groups to make a list of the words that they heard.
- Allow three minutes to write down the words. Ask a representative from each group to share some of the words their group heard.
- Highlight the importance of listening. Tell them that psychological studies have proven that the human brain is capable of listening to up to 650 words per minutes.
- Ask the participants why they thought the exercise was important?
- Note their responses on a flip chart.
- Highlight the difference between hearing and listening. Hearing is merely the ability to perceive sound Listening is something one consciously chooses to do. Listening requires concentration so

that the brain processes meaning from words and sentences. Listening leads to learning and retention and therefore generates effective responses.

- Ask all the participants to share similar experiences of how listening helps in their work in the field?
- Consolidate the activity:
  - First learn to be an effective listener.
  - Make an effort to reach the maximum ability to listen to 650 words per minutes.
  - Only when you listen can you internalize and understand each situation.

ACTIVITY 2: USING NON- VERBAL COMMUNICATION AND BODY LANGUAGE FOR EXPRESSION

Objective

- To help participants understand that body language is important for effective powerful communication in their field work.
- Non-verbal communication can be effective in helping the women/families remember NMCH messages better.
- The body language of the FLWs can be utilized to make the listeners comfortable and make the communication powerful.

Methodology

Group activity and discussion

Duration

45 minutes

Training Materials

Black and white/colour pictures/ photographs of some event with a group of people doing something

Tips for facilitators

Participants should be encouraged to communicate in such a way that other people won't forget. To ensure this, they can improve their body language, use pictures, perform a role play, or use interactive activities to build interest in the topic and to help women/families improve their retention of the information.

Process

- Ask the participants if any of them can recollect a picture or a photograph that they have always remembered.
- If yes, give one or two of them a chance to share what they remember about that picture.
- Ask them why they remember it so well.
- Let other participants share their reactions about why we remember some things, but don't remember others.
- Divide the participants into four groups.
- Give each group one photograph that has captured some human activity.
- Tell all members of the group to try look at the picture for 10 seconds without batting an eyelid or blinking.
- Say START and after 10 seconds, say STOP.
- Now ask all the members in each group to close their eyes.
- Ask them if they can still see the picture in their mind's eye.
- Tell them to open their eyes.
- Tell them that scientific studies have shown that information absorbed by the right side of the brain will remain permanently with the individual and 80% of this information is grasped from non-verbal forms of communication such as pictures, photos and body language. This type of visual communication is permanently stored in one's memory and many people find it easier to remember information gained from pictures, colors, music or postures, rather through verbal communication.
- Tell each group to discuss what they thought was happening in the photograph; the situation, who the group of people were, what they might have been saying, etc.
- Allow 5 minutes for discussion and then tell each group to plan how to create a pose similar to what they saw in their picture with their group members.
- Ask one group to come to the front of the training room and to pose as in the picture.
- Ask the other participants to guess what the situation might be about.
- Continue with the next 3 groups.
- Ask them what they have learnt from this session.
- Note their responses on a flip chart.
- Consolidate the activity:
  - Communication can be powerful without saying a single word.
  - The use of our body to communicate is called body language.
  - A person's body language can either make other people comfortable uncomfortable.
  - Positive body language can generate a healthy atmosphere for communication.
  - Use of pictures and diagrams can be an effective means of communication as pregnant women and their families can comprehend/respond to a picture or a photograph faster than to words.

ACTIVITY 3: IMPROVING ABILITY TO EXPRESS THROUGH WORDS

Objective

- To help the participants understand that different kinds of verbal communication can be more meaningful and a variety of expressions improves the effectiveness of communication.

Methodology

Group reading activity and discussion

Duration

45 minutes

Training Materials

A brochure with any written material on MNCH

Tips for facilitators

Tell the participants that just like a human has the ability to listen to 625 words in a minute, a human can also speak 125 words in a minute. Speaking using different pronunciations, tones and modulations can make the communication interesting and captivating. Having a variety of tones/ expressions will be helpful and effective while conversing with a group of pregnant women or their family members. Every family or pregnant woman has unique situations and communication has also got to be uniquely tailored for them. Health related information should be interspersed with colloquial language to make the communication effective.

Process

- Divide the participants into four groups.
- Give each group one brochure and highlight one paragraph of text that should be read
- Start with Group 1. Ask one member to read that text aloud. Whisper to that person to read without showing any emotions at all.
- After the reader from Group 1 finishes reading, ask the participants what they felt about this kind of reading and why.
- Encourage discussion.
- Move to Group 2. Ask one member to read that text aloud. Whisper to that person to read using a heavy colloquial/local dialect.
- After the reader from Group 2 finishes reading, ask the participants what they felt about this kind of reading and why.
- Encourage discussion.
- Move on to Group 3. Ask one member to read that text aloud. Whisper to that person to read using a very high pitched fast voice.
- After the reader from Group 3 finishes reading, ask the participants what they felt about this kind of reading and why.
- Encourage discussion.
- Move on to Group 4. Ask one member to read that text aloud. Whisper to that person to read using a very low pitched slow voice.
- After the reader from Group 4 finishes reading, ask the participants what they felt about this kind of reading and why.
- Encourage discussion.
- Ask the participants what they felt about the four kinds of reading and why.
- Go back to Group 1: ask the reader to read in a very sad voice.
- Go to Group 2: ask the reader to read in a very happy voice.
- Go to Group 2: ask the reader to read in a very frightened or scared voice.
- Go to Group 2: ask the reader to read in a very triumphant or heroic voice.
- Ask the participants what they felt about the four kinds of reading and why.
- Ask the participants which of these kinds of reading might be most effective in the context of their work in the field.
- Ask them what they have learnt from this session.
- Note their responses on a flip chart.
- Consolidate the activity:
  - Verbal communication should be tailored differently for different people.
  - Using a variety of ways to make verbal communication interesting can enhance retention among listeners.
  - FLWs often fail to impress their target audience with their conversations because they do not make it attractive.
  - An FLW who communicates well will be more confident of reaching out to the community.

ACTIVITY 4: OVERCOMING BARRIERS TO COMMUNICATION

Objective

- To help the participants learn how to overcome barriers to communication in the field and use them to their advantage.

Methodology

Role play and group discussion

Duration

1 hour

Training Materials

None

Tips for facilitators

FLWs should be mentally and physically prepared before any home visit or interaction with pregnant women and their family members. The must know the specific MNCH continuum of care stage that they are dealing with and all related information. If something goes wrong during a home visit, they must remember to remain calm and composed even when faced with adverse reactions from the pregnant woman, family members or the community. They should seek out people who support them and who can influence family members if necessary. Patience and a positive attitude will help FLWs to overcome communication barriers.

Process

- Ask participants to share some personal challenges they face in the field.
- Note their responses on a flip chart and display at the front of the training room.
- Divide participants into 4 groups:
  - Ask group 1 to discuss challenging situations that they faced while addressing an ANC case, then to choose one and prepare a 5 minute role play for the larger group that highlights actions to overcome the challenge and turn it into their advantage.
  - Ask group 2 to do the same using the topic of handling a delivery.
  - Ask group 3 to do the same using the topic of handling a PNC case.
  - Ask group 4 to do the same using the topic of a rift between ASHAs, JHAs or AWWs in the field.
- Allow 20 minutes for discussion and role play preparation then ask a representative from each group to introduce the role play and then have the group perform the role play.
- After each role play ask the participants watching it to identify ways in which the challenge had been addressed and if they thought this would be useful in a field situation.
- Encourage participants to share any different ideas about how the challenge could have been overcome.
- Continue on with the next 3 groups.
- Go back to the list of the challenges faced in the field that they shared at the beginning of the activity.
- Ask them if these situations can be overcome by appropriate use of both verbal and non-verbal communication. Discuss each situation as a group.
- Consolidate the activity:
  - Don't be stressed out or taken aback by any setback in communication or a regressive incident in the field.
  - Barriers can be non-cooperative family members, negative attitudes, people with different personalities, beliefs, thought patterns, strange situations, patriarchal family systems, etc.
  - Get support from other FLWs or community members.
  - Having a calm and quiet demeanor, using supportive body language, the right choice of words, and correct knowledge can help to overcome barriers.
  - Barriers can be overcome and turned into an advantage, but this process sometime takes continuous effort with a patient and positive attitude.

ACTIVITY 5: MOVING FROM A SELF-CENTRIC TO A PEOPLE-CENTRIC APPROACH

Objective

- To help participants examine their motives and intentions in the work that they engage in.

Methodology

Group question activity, game and discussion

Training Materials

None

Duration

1 hour

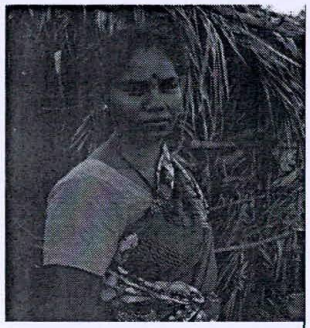
Tips for facilitators

This activity is only a beginning of moving from a self-centric to a people-centric approach. It sows the seeds of thought about changing their perspective from the natural disposition of being self-centred, into being more of a person that is guided by social responsibilities. After the circle game, make it clear that finding a place in the circle should not have been the priority. They became competitive instead of using this opportunity to meet all the group members. Highlight that their job responsibilities as FLWs is to reach out to target groups and not focus on themselves.

Process

- Ask the participants whom do they feel they are working for.
- Note their responses on a flip chart and display at the front of the training room.
- Tell the participants that they will take part in an activity that involves a series of questions that they need to respond honestly to.
- Ask the participants, 'If humans were now living on the planet Mars, and there was a fight between those people living on Mars and those of us here on Earth, who would you support?' The majority will probably answer Earth.
- Ask them why? The group might say, 'Because it is ours'.
- Ask them, 'Now what if there was a fight between India and Pakistan. Who would you support?' The majority will probably answer India. Ask them why?
- The group might say, 'Because it is ours'.
- Continue asking the questions:
  - *"If there is a fight between north India and south India?"*
  - *"If there is a fight between Karnataka and Tamil Nadu?"*
  - *"If there is a fight between our district and the neighboring one?"*
  - *"If there is a fight between our town and the neighboring one?"*
  - *"If there is a fight between our street and the next one?"*
  - *"If there is a fight between our house and our neighbor?*
  - *"If there is a fight between our father and our mother?"*
- Although they probably had no problems answering all the previous questions, now there might be a dilemma.
- Insist on them answering the question, choosing between their father or their mother. The majority will probably answer mother.
- Ask them why? The group might say, 'Because she is like us'.
- Now ask if there were to be a fight between you and your mother, who would you support? Most likely the answer will be, "Me".
- Remind them what they told you at the beginning of the activity when they said that they worked for mothers and children. Ask them if they are contradicting themselves.
- Tell them that they need to reflect about who is it they truly work for? They need to move from thinking about themselves to truly believing about helping mothers and children.
- Introduce a game that should clarify how a people-centred approach will benefit them in the context of their MNCH work with the communities.
- Divide the participants into two groups. One group participates in the activity and the other group forms the spectators.
- Ask the spectator group to sit down around the room.
- Ask one member of the group playing the game to volunteer to step aside for the moment.
- Ask all of the other game participants to stand in a circle with everyone facing inside.
- Now tell the volunteer to start walking around the circle in the clockwise direction. Tell her after about 1 minute to touch somebody standing in the circle on the back.
- The person who is tapped on the back needs to step out of the circle and start walking anti-clockwise around the circle. The people still in the circle should not move, but leave that space empty.
- Tell them that when they both meet, they need to introduce each other by giving their name, where they live and which area they work in.
- Then they should try to get back to the one empty spot in the circle.
- The participant who arrives first to the empty place gets to take the place. The other participant continues the game, by tapping a new person on the back each time.
- Play the game until all participants have a chance, then ask all participants to sit down.
- Ask the spectator group what they observed during the game, giving three or four people the opportunity to respond with different reactions. They might say that they saw the participants were in a hurry to get to the empty place first, so they rushed through the introductions.
- Ask the group that played the game why the place in the circle became more important than introductions, giving three or four people the opportunity to respond with different reactions.
- Consolidate the session:
  - There is a difference between just a job and a profession you feel passionate about.
  - You must be committed to see change in the lives of mothers and children.
  - Actions can be driven by selfish motives.
  - During work the focus should not be on personal objectives, but on the needs of pregnant women, their families and their communities.
  - Becoming a people-centred individual is ultimately an expansion of one's own personality.
  - It is important to develop an outlook that focuses on peaceful co-existence and to building good and lasting relationships with the mother, families and communities.
  - Use every opportunity to be a "people person" rather than a "me-my life and myself" person.

SESSION 4: UNDERSTANDING WOMEN AND THEIR STATUS IN THE SOCIETY



Objective

- To help the participants critically analyse the situation of women in northern Indian society

Methodology
Group work and discussion

Duration
1.5 hours

Training Materials

Picture of tree, markers and brown sheets/ chart paper

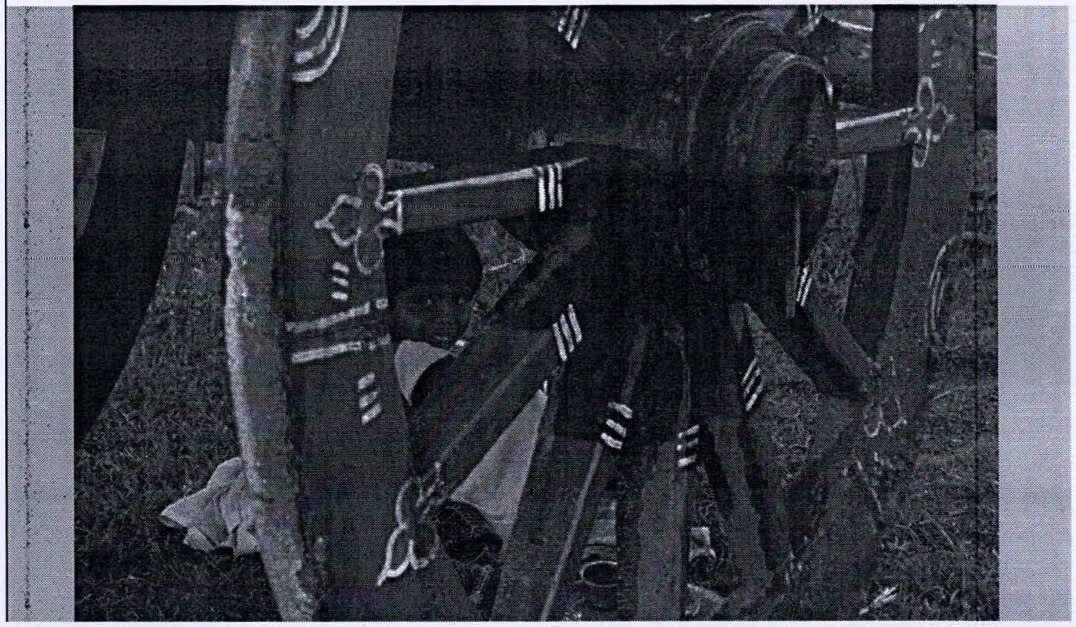
Tips for facilitators

The participants should develop a deeper perspective about the challenges faced by pregnant women, including the issue of maternal deaths. For a FLW, an unnatural death of a pregnant woman, a woman who has just delivered a child or of a new born baby might seem to be the fault of the woman herself, relatives, the medical team. However, this assessment is superficial and fails to examine the deeper prevailing social norms and practices that put women in a vulnerable situation. A closer look can reveal that prevailing regressive social trends are responsible for a lack of knowledge, acceptability and access to services throughout the MNCH continuum of care. This session should encourage women to think about the realities surrounding a woman's life in the northern Indian society, especially in rural areas. Some women will find it difficult to break out of their own social conditioning and may not accept that anything is wrong at all. The picture cards will present real life examples that might convince them that there is inequality, and that this can sometimes be very visible, or sometimes can manifest itself in subtle ways.

Process

- Divide participants into 4 groups.
- Give each group 5 scenes, one from each category (social, financial, religious, cultural and political).
- Ask the groups to think about and discuss the scenes in detail.
- Tell them to answer the following questions for each of the scenes:
  - *What situation does the stated scene illustrate?*
  - *Could this situation happen in your field site?*
  - *Share a similar incident that you have witnessed in your field site.*
  - *Why does this situation happen?*
- Allow 20 minutes for discussion. Ask the group to share the scene they thought was most important to them. Ask a representative from that group to share the scene and the answers to the question.
- Encourage all participants to share any different ideas about the situation.
- Continue on with the next 3 groups, asking them to choose a scene from a different category.
- Facilitate a plenary discussion:
  - Are women lagging behind in many spheres of life? Why?
  - What are the major reasons for women being in this situation?
  - How deep is the society's indifference towards women? What have been the adverse effects of this indifference upon their lives?
  - What is the overall opinion of the group on the current state of women? Why?
- Encourage the freedom to debate, express and talk.
- Consolidate the session:
  - Society at large has been indifferent to the inequality faced by women.
  - In order to empower women to access MNCH services as their right, they need to understand the maze of rituals, practices, customs and traditions that surround a woman's life.
  - FLWs should not reinforce negative beliefs and practice, but should try to sensitively enlighten pregnant women, their families and their communities to whatever extent possible.

SCENES FOR DISCUSSION				
Social	Financial	Religious	Cultural	Political
A boy or girl primary student caring for an infant or young child	Male wages are more than female wages	A woman banished to the cowshed during her menstrual cycle	Modern day magazine advertisements as opposed to rural cultural appropriate dress.	A woman Panchayat president sidelined and her powers usurped by her husband
A drunken husband beating up his wife	A woman who works both in the fields and at home	A widow with a tonsured head	A tragic heroine film star who is weeping	A woman's program with the dais filled with men
Mother-in law, father-in law and husband pestering the wife for dowry	Women in a family that is migrating for work	A new mother and her new born baby outside the house because they are impure	A woman breaking her bangles after her husband's death	Men controlling the self-help groups (SHGs)
A child being married to an older man	A female sex worker	A Devadasi woman	A woman immolating herself on her husband's pyre	A picture of a situation where the majority of the agitators are SC/ST women
A lower caste woman working at a menial task for an upper caste woman.	Women are dismissed from the jobs for asking for leave of absence to have a child/care for a child	A woman being 'punished' by throwing coloured water	A woman jumping into a lake	Woman being told by her husband whom to vote for



SESSION 5: UNDERSTANDING WOMEN AND THEIR STATUS IN THE SOCIETY

Objective

- To help the participants understand how pregnant women and their children have been systematically excluded from opportunities to access MNCH continuum of care services.
- To help FLWs understand how significant their role is in linking women to services.

Methodology

Power walk activity

Duration

1.5 hours

Training Materials

Identification badges with the roles written or drawn on them, safety pins to attach these badges onto the saris/ dresses, list of questions written down for the facilitator to call out

Tips for facilitators

Once FLWs understand and accept the unequal status of women in Indian society, they can understand how this inequality manifests itself through the lack of opportunities to access MNCH continuum of care services. Not all FLWs will initially agree that women are marginalized, but through the real examples in the Power Walk activity, they should be enlightened as they realize that it was the men and influential people who were able to access the 'government benefits', while the women and marginalized groups could not reach the 'goal line'. Encourage lots of discussion to highlight that FLWs are not solely responsible for women not accessing MNCH services, as many other factors are at play.

Process

- Select 18 volunteers from the participants. Ask the others to act as spectators who take note of what is happening during the Power Walk activity.
- Ask the 18 volunteers to stand in a horizontal line in a large spacious room.
- Mark a 'goal' close to the end of the room, which ideally would be about 20 full steps away from where the volunteers are standing.
- Place about 5 books on the 'goal line'. Tell the volunteers that these books represent the 'government services' that all people should have access to and benefit from.
- Give each of the volunteers an identification badge that tells them who they represent as in the table provided.

Roles for participants in the Power Walk activity
1. Married woman working as daily wage labourer
2. Rich woman living in a village
3. Illiterate woman from the village
4. Financially backward pregnant woman
5. Woman working as a domestic maid
6. Dalit woman
7. Old woman
8. Teenage Girl
9. Taluk panchayat member
10. Village headman
11. Daily wage labourer at a construction site
12. Male politician
13. Newspaper reporter
14. Village elder
15. Social worker
16. Farmer
17. Rich trader
18. Male government officer

- Tell the volunteers to attach the badges on their saris/ dresses using a safety pin.
- Tell the volunteers that:
  - **One:** Whoever reaches the 'goal line' will be able to pick up a book that represents access to 'government services' that will benefit their lives.
  - **Two:** To reach the 'goal line' they will have to answer a series of questions. If the answer to that question is a YES, then they can take one step forward. If the answer to those questions is NO, then they need to take one step backwards.
- Before you start asking questions:
  - Demonstrate the size or length of an average step to ensure fairness.
  - Ensure that all the participants understand and have internalized the roles that they are playing.
- Start asking with the questions in the table provided. Ask them slowly, one by one, to allow the volunteers to think about each and then decide to either take a step forward or backward.

QUESTIONS FOR THE POWER WALK ACTIVITY
Is it easy for you to deal with the system in government offices?
Are you earning any money every day?
Do you read the newspaper every day?
Do you openly express your opinions at home?
Does anyone question you if you come home at 8pm?
Do you have to come home and work even though you are employed outside?
Is it possible for you to spend the money you earn the way it pleases you?
Have you got any personal savings in the bank?
Is it possible for you to access immediate medical care as and when you fall ill?
Is your decision final with regard to your marriage?
Have you got the right to take decisions regarding your family?
Can you dress up according to your wishes?
Is it possible for you to take decisions regarding the things that are dear to you?
Is it possible for you to visit the places that catch your fancy whenever you want?
Is it possible for you to take up higher studies?

- As the questions are being answered everyone will see that the 18 volunteers are standing at different lengths away from the 'goal line'.
- When the final question has been asked, perhaps only one or two volunteers have reached the 'goal line' and have collected a book of 'government services'.
- For the remaining volunteers who are still standing, tell them at the count of three to run towards the 'goal line' and try to get a book.
- Count one, two and three. The participants who were nearer to the 'goal line' will probably get the remaining book.
- Ask everyone to sit down.
- First ask the spectators to share their experience of the activity.
- Then ask the volunteers who were able to access the books to come forward and tell the other participants what role they had in order of first, second, third, etc.
- Ask the participants to discuss why each person was able to reach the 'goal line' and get access the 'government services'.
- Ask the volunteers who did not access the 'government benefits' to the other participants what role they had in order of who was last, second to last, third to last, etc.
- Ask all the participants if they think this situation represents what happens in the field.
- Ask them what they can do as FLWs to help improve the access of mothers and children to services.

- Consolidate the session:
  - Basic rights of people are being denied because of their marginalized status.
  - It is crucial that MNCH continuum of care service reach marginalized women
  - The reasons why women and other groups are marginalized are complex and linked to wider societal issues.
  - To ensure that benefits reach needy beneficiaries instead of only those that are powerful and influential takes continuous effort and commitment.

SESSION 6: DEVELOPING DIFFERENT PERSPECTIVES

Objective

- To help participants keenly and intensely observe a situation and be able to see different perspectives and attitudes with an outlook free from personal prejudices

Methodology

Games and discussion

Duration

45 minutes

Training Materials

A transparent glass half filled with water, white sheet of paper with a black dot drawn in the middle, the two squares, a tea cup with a handle, and markers and brown sheets

Tips for facilitators

This session has four activities that will help participants understand that most of their decisions are shaped or influenced by previous experiences, prejudices or social conditioning in their lives. This hinders them from taking an objective decision and examining a situation thoroughly and analyzing it, thinking through possible options, and using their best judgment. While working with pregnant mothers, their families and the community, it is best to free themselves of bias and prejudices. Although this is not possible in the short term, it needs practice and encouragement.

Process

ACTIVITY 1:

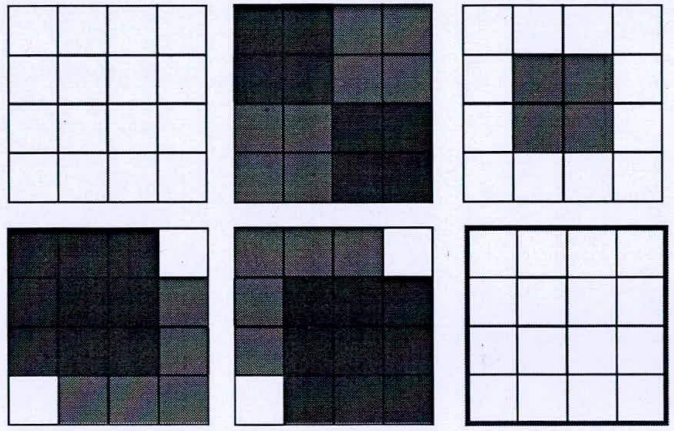
- Fill up one transparent glass half full of water and display at the front of the training room.
- Ask the participants, "What do you see?"
- Note their responses on a flip chart and discuss.
- Ask them what they have learned from the discussions.
- Tell them that the same glass has been perceived by different people differently. If they see it as a half- filled glass then they have the opportunity to take the responsibility to fill it up fully, just the same as if we see gaps in MNCH services in the field, we need to fill them and not expect somebody else to do it.

ACTIVITY 2:

- Display the A3 sized white sheet of paper with a black dot drawn in its corner at the front of the training room.
- Ask the participants, "What do you see?"
- Note their responses on a flip chart and discuss.
- Ask them what they have learned from the discussions.
- Tell them that there are different perspectives of the same thing. There is not always only one way of understanding a situation. We need to open to explore different ways of seeing the same situation. If they only see the small black spot, they are blinded to the much larger white space. When they are in the field, they cannot allow one negative incident to ruin all their efforts. They need to take all experiences, good or bad, in their stride, while learning from every experience.

ACTIVITY 3:

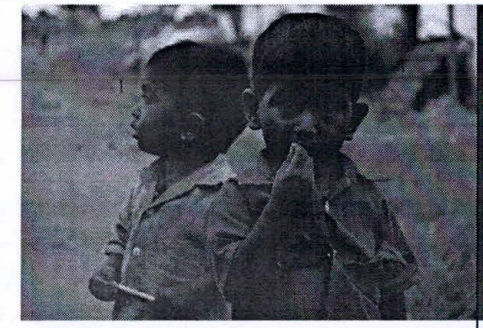
- Draw 16 squares on the board as shown and display at the front of the training room.
- Ask the participants to count the number of squares and call out there answers.
- Most will count 16 squares.
- Tell them that there are more than 16.
- Ask volunteers to come up to the board and try finding them. Give 3 or 4 participants a chance to find them.
- Tell them that there are 26 squares in total
- Discuss as a group.
- Ask them what they have learned from the discussions.
- Tell them that many times in many situations they have to look carefully to find things that are not initially obvious. Tell them this is especially true when we work with pregnant women, their families and communities.



ACTIVITY 4:

- Make all the participants sit in a circle on the floor and place the tea cup in the middle of the circle.
- Ask each of the participants which side is the handle of the cup facing. Some of them will say right, some left and some centre and some behind.
- Discuss as a group.
- Ask them what they have learned from the discussions.
- Tell them that the truth is not only what is initially obvious. They need to develop a holistic outlook or perspective of situations. Then we they encounter interactions in the field with pregnant women, their families and communities, they will be able to effectively communicate with them.
- Consolidate the session:
  - What they see might not always be true.
  - Their prejudices can influence their communication negatively.
  - Their outlook may not be holistic unless they probe into situations deeply and objectively.
  - They should learn to take negative situations as an opportunity to improve.

SESSION 7: MATERNAL AND CHILD CARE: THEN AND NOW



Objective

- To help the participants understand the value of the services and the assistance provided by FLWs.

Methodology
Group work and discussion

Duration
1 hour

Training Materials

Chart paper and marker pens

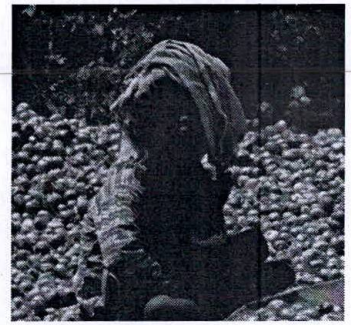
Tips for facilitators

This session should help the FLWS understand the history and development of services and benefits provided by the MNCH continuum of care and the positive impact ensuring access has had on the lives of mothers and children in rural India. In the past when pregnant women gave birth, especially in rural areas, there were hardly any services available and maternal, infant and child deaths were on the increase. Although we can be critical of government services, there have been a number of advancements made to improve MNCH conditions. The FLWs should realize the tremendous role they play in ensuring access to MNCH continuum of care services and how they are linked to every advancement to date.

Process

- Divide the participants into two groups.
- Give each group a chart paper and markers.
- Tell group 1 that they will explore 'THE SITUATION THEN'. Ask them to discuss and answer the following questions:
  - What was the situation of mothers and children in our villages ten years ago?
  - What were the services, benefits available for them then?
  - What was the reality in the field surrounding pregnancy, delivery and child care?
  - What were the advantages and disadvantages of the situation then?
- Tell group 2 that they will explore 'THE SITUATION NOW'. Ask them to discuss and answer the following questions:
  - What is the situation of mothers and children in our villages now?
  - What are the services, benefits and systems available for them now?
  - What is the reality in the field surrounding pregnancy, delivery and child care?
  - What are the advantages and disadvantages of the situation now?
- Allow 20 minutes to discuss their topics and then ask a representative from each group to display their chart paper at the front of the training room and to share the answers to the questions.
- Encourage all participants to share any different ideas about the situation.
- Continue on with the next group.
- Ensure that all important changes that we see today in relation to MNCH care are covered as below:
  - Mother and child mortality rates were higher because of shortage of benefits and services, superstitions, false beliefs, etc.
  - Then there were no ambulance services
  - There was no system of knowledge dissemination
  - There was no distribution of nutritious food or medicine
  - There were no ASHAs
  - There were no tools to help FLWs work better
  - There was no stress on institutional delivery
  - There were no equipment in PHCs and SCs
- Ask them if maternal deaths and infant deaths have stopped after all these positive changes. They will say no, but highlight that the role of the FLWS is crucial in ensuring that these developments are used to the maximum in the field until there is a significant decrease in the MMR and the IMR.
- Consolidate the session:
  - Though people criticize the government, there have been positive efforts to improve the lives of mothers and children in the past decade.
  - The existing benefits and services that have been introduced throughout the MNCH continuum of care have been fully discussed.
  - One of the biggest achievements has been the presence of ASHA, JHAs and AWW in the field.
  - The role of the FLWs is critical.

SESSION 8: COORDINATION AND COLLABORATION IN THE FIELD



Session 8 includes six activities/exercises to enhance the coordination and collaboration of FLWs in the field. Identifying existing challenges to working together and having a clear idea of their vision and purpose can improve their interactions with pregnant women, their families and the community. The activities aim to help the FLWs be able to coordinate their roles and responsibilities with all groups under the umbrella of FLWs so they can find strength in unity. A forum that they can establish to empower their future activities is outlined and plans laid for operationalization.

Duration for all 6 activities: 4 hours and 30 minutes

ACTIVITY 1: THE THREE SISTERS

Objective

- To help participants understand the importance of working together in the field.

Methodology
Screening of a short film, or narration of the film's story and discussion

Duration
1 hour

Training Materials

Copy of the film on a cd, LCD and screen, laptop, speakers, brown sheets and markers

Tips for facilitators

This can be a sensitive session to handle as the ASHAs, JHAs and AWWs may take it personally and jump to their defence. They may attempt to deny that there are any problems with working together in the field. Be tactful, keep calm and reassure them that this session is not intended to blame anyone, but to point out gaps that have been noted during observations in the field. Even if they have not experienced these problems, the suggestions for positively working together can be beneficial to all.

Process

- Screen the short film after ensuring that all participants can see the screen and can hear the volume.
- If there is no provision for screening the film, then read the story script slowly in a loud, clear voice.

Story of the three sisters

Thimmakka is in a good mood while eagerly waiting at the door for the arrival of her three daughters. She stood by the door reliving all her past: the struggles she faced in bringing up the girls after their father had died when they were very young; how her eldest daughter Suma began to help her at a very early age; the strong bond between the three siblings; their joy at having completed their studies; how each one got a job; their marriage; and the pain of seeing them leave her to be somebody else's wife. All of this flashed before her mind's eye.

The eldest girl Suma, even though she wanted to study, had dropped out of school to help her widowed mother. After completing her SSLC she took up the job of an ASHA worker to support the family and let her other two sisters complete their studies. The second sister Rama barely completed her SSLC and refused to continue her studies and became an Anganwadi teacher in a neighboring village. The youngest Uma, with the assistance of her two older sisters, completed her PUC and also the health assistant course. She took up the post of a JHA in a distant village. Thimmakka managed to find boys for each of her

girls from the villages where her girls were working and got them married off there. All her daughters usually come home twice a year and spend a few days with her. The girls arrived home and there was a lot of chatter in the house with each one sharing all the news in their lives.

They finally sit down for dinner and begin to share about the struggles each of them have been facing at work. Suma, the eldest girl, relates the problems she faces as an ASHA worker. She talks about the disdain shown by the family of the pregnant woman towards her, the non-cooperative older Anganwadi workers in her area who refuse to even acknowledge her presence in the village, the pressure that the JHAs put on her to give them the information and do reports at the end of every month, the unhelpful doctors. To top it all off, they are all suspicions of her husband's family and the insecurities of her husband. Suma says that her work experiences were making it very difficult for her to continue her job as an ASHA.

The Anganwadi teacher, Rama also talks about the problems she faces. Departmental pressure, the difficulty in managing all the children in her Anganwadi centre, the non-cooperative ASHA workers, the pressure from her mother-in law to bring nutritional supplements form the centre to their home on the sly, and the proud JHA in her village who gives her no respect.

Uma, the youngest girl who is a JHA talks of the problems she has with the ASHA workers and how so many of them can barely read or write and never give her reports on time, the pressure form the medical officer, non-cooperative doctors, irresponsible family members of the pregnant women, and all of the times she gets blamed for everything that happens in a PHC and the 'ungrateful' villagers. She also tells the others that all these pressures are forcing her also to think of quitting her job and be at peace. Echoing her sentiments all of them agree that this might be the best option for them. Thimmakka is disappointed at hearing this and wonders what to tell them.

- Divide participants into three groups.
- Tell group 1 to discuss Suma's story and to answer the following questions on a chart paper:
  - Is it right or wrong for that sister to quit her job? Why or why not?
  - Would that sister have been able to solve their problems if all the sisters were in the same village? Why or why not?
  - What would they suggest that this sister do to solve her problems and begin to enjoy her work?
- Tell group 2 to discuss Rama's story and to answer the same questions on a chart paper.
- Tell group 2 to discuss Uma's story and to answer the same questions on a chart paper.
- Allow 20 minutes and then ask a representative from group 1 so display their answers at the front of the training room and to share their discussions.
- Allow other groups to share their comments about Suma.
- Continue with the next 2 groups in the same manner.
- Consolidate the session:
  - Despite differences FLWs need to work together in the field.
  - Respect and trust can build a good work atmosphere.
  - Only collaborative efforts can improve access to MNCH continuum of care services in the field.

ACTIVITY 2: OUR WORK AND VISION

Objective

- To help the participants understand their common goal and vision

Methodology
Storytelling and discussion

Duration
45 minutes

Training Materials
Copy of the story

Tips for facilitators
This session can be sensitive as all the participants might want to identify with and compare themselves with the 3rd worker. They might deny that they could feel like worker 1 and worker 2. Point out that aspiring to always realize the important role they play in ensuring access to MNCH continuum of care services should make it easier for them to have a positive vision, a good attitude, to enjoy their work and respect their work colleagues.

Process

- Tell the participants to listen carefully while you share a story.

A reporter working on a piece for his magazine, about "what drives hard workers", visits a stone quarrying pit. There he watches workers toiling in the sun on the different levels of the quarrying pit. He has the conversation with a few workers he meets there.

***Reporter to worker 1:** What work do you do here?*
***Worker 1:** Me? It's my horrible fate that I landed here. My only choice is to work here as a stone mason to feed myself.*

The reporter speaks to the next worker.
***Reporter to worker 2:** What work do you do here?*
***Worker 2:** Me? I am working here to feed my family.*

The reporter speaks to the next worker.
***Reporter to worker 3:** What work do you do here?*
***Worker 3:** Me? I am working to build the most beautiful mansion in town. It's a tough job, but then when we are done, the building will make me proud.*

- Ask the participants what is the difference between the three workers' answers?
- Discuss each of the workers' answers.
- Ask them what their goals and sense of vision are?
- Discuss each role if there are different categories of FLWs in the workshop.
- Consolidate the session:
  - The three workers were working towards the same goal, but only the 3rd worker had a sense of vision.
  - The worker with a sense of vision also had the right attitude towards his work and enjoyed and respected what he did.
  - FLWs should understand that their work is important and that they should respect each other for doing this job.

ACTIVITY 3: ROLES AND RESPONSIBILITIES OF FLWS

Objective

- To help the FLWs understand their specific roles and responsibilities, the commonalities and differences between other categories of FLWs and to see the benefits in supporting each other towards a common goal.

Methodology
Group work and discussion

Duration
45 minutes

Training Materials
Brown paper, markers and tape

Tips for facilitators
This session, focused on identifying commonalities and differences, can help the FLWs feel more confident about what they do. They will now know of practical ways in which they can support each other in the field.

Process

- Divide participants into three groups made up of the ASHAs, the JHAs, and the AWWs.
- Give each of the groups brown sheets and markers
- Tell them to discuss and list down all their roles and responsibilities.
- Allow 15 minutes to make this list and then ask the ASHAs to display their list at the front of the training room and to share the items they feel are most important.
- Continue on with the JHAs and the AWWs.
- Now ask the whole group to look at all three lists and to see if they can find some roles and responsibilities that are repeated, or that overlap.
- Allow 10 minutes for all groups to highlight the common roles by underlining them with a different coloured marker.
- Discuss if these roles and responsibilities should be duplicated or overlapping.
- If so, discuss how to find ways to prevent duplication of activities, to cooperate and support each other in the field, and to generate the collection of uniform data.
- Consolidate the session:
  - Roles and responsibilities have been discussed and clarified
  - Importance of avoiding overlap has been highlighted
  - FLWs are able to see the benefit of supporting each other in the field to carry out overlapping activities.

ACTIVITY 4: COORDINATION AND COOPERATION FOR PROGRESS

Objective

- To help participants understand the importance of coordination and cooperation among themselves to achieve their goals in the field.

Methodology
Activity and discussion

Duration*
30 minutes

Training Materials

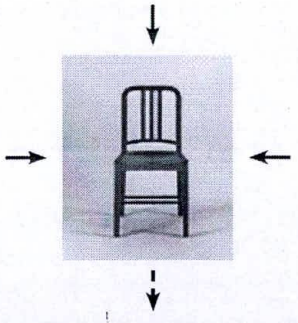
A chair

Tips for facilitators

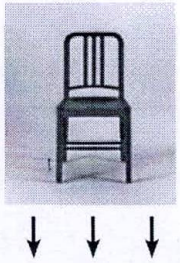
FLWs face several challenges in the field, including lack of cooperation by co-workers, indifference by village health committees, and mistrust by family members. Ensure that the participants are able to link this session to their situations in the field. They will find that their work duties are easier if they cooperate among themselves in order to collectively face these challenges.

Process

- Ask the participants to define the terms cooperation and coordination.
- Note their responses on a flip chart.
- Display these definitions at the front of the training room:
  - **Coordination:** Co-ordination is the unification, integration, synchronization of the efforts of group members so as to provide unity of action in the pursuit of common goals and purpose. It is a hidden force which binds all the other functions of any given group.
  - **Cooperation:** The act of working together by giving and receiving active assistance from each other that builds trust, belief and a peaceful work environment.
- Ask one ASHA, one JHA and an AWW to volunteer to take part in an activity. Tell the other participants to watch.
- Place a strong chair before them and ask them to stand on the three sides of the chair facing inside so they can see each other faces (behind, on its left and on its right).
- Now tell them to push the chair towards the direction of the fourth side (forward) without changing their positions.



- They will not be able to do it.
- Ask the participants watching to explain why they were struggling.
- Discuss with the group.
- Now ask the three volunteers to turn and change the direction that they face. Let all three of them face towards the front.



- Now tell them to push the chair towards the direction they are facing (forward) without changing their positions.
- They will be able to do it.
- Discuss with the group why they could do it.
- Consolidate the session:
  - In the first instance there was no possibility of coordination because they could not collectively channel their efforts. Their efforts were opposing.
  - In the second instance they had a common vision and could coordinate and help each other move together towards that goal.

ACTIVITY 5: UNITY IS STRENGTH

Objective

- To help the participants understand that working together brings strength and enjoyment.

Methodology
Activity and discussion

Duration
45 minutes

Training Materials

None

Tips for facilitators

This game can get noisy and messy. Don't worry, but make sure that the participants follow the rules. And ensure that the message from this game is elicited clearly from them after the game. The participants need to understand that when they paired up, they became stronger and were able to get more and more people to join them.

Process

- Ask the participants to walk around the training room, making sure they do not bump into anyone.
- If they do, then they should join hands and continue walking around.
- Allow a couple of minutes and then ask everyone to increase their pace/speed of walking.
- If they bump into either a single person or a group holding hands, they must join them.
- Allow a couple of minutes and then ask everyone to increase their pace/speed of walking again.
- As the groups holding hands get bigger, more and more people will bump into each other and join those groups.
- When any one group reaches the target number of 8 people holding hands stop the activity.
- Ask all the participants to stand together in the respective groups they were holding hands with.
- Ask them what connection they can make between this activity and working together in the field.
- Discuss with the whole group.
- Consolidate the session:
  - When workers are united they are strong
  - When workers are united and strong, the job duties become more enjoyable.

ACTIVITY 6: AROGYA MANTAP: BUILDING COLLABORATIVE FORUMS OF FLWS

Objective

- To help participants understand the need and the purpose of a collaborative forum for FLWs and how to operationalize an Arogya Mantap.

Methodology
Brainstorming and discussion

Duration
45 minutes

Training Materials

Chart paper and marker pens

Tips for facilitators

This session is an introduction to the Arogya Mantap concept. The follow up would be to ensure that at least one project staff facilitates an Arogya Mantap in the field. In the Sukshema's project in northern Karnataka, the Arogya Mantaps are held at the SC level and all the ASHAs, JHAs and AWWs that work under this SC participate. However, this arrangement could vary in different contexts. (See Annexure 1)

Process

- Ask the participants what they think they need most to ensure that they can put the learning of this training into practice.
- Note their responses on a flip chart.
- Highlight any responses linked to "meeting together often to discuss work issues".
- Use that response to bring in the concept of the *Arogya Mantap*.
- Tell them that the *Arogya Mantap* is a collaborative forum that is intended to offer FLWs a space to meet, discuss and to share their learning, experiences and challenges and work together to address and generate joint solutions.
- Ask them why they need to come together.
- Note their responses on a flip chart.
- Divide participants into four groups. Ensure that each group has some ASHAs, JHAs and AWWs in it.
- Tell each group to discuss the *Arogya Mantap*:
  - What will its purpose and function be?
  - Who should be part of it?
  - When and where should members meet?
  - How can it be useful to FLWs?
  - What activities can it undertake to make it more interesting?
  - How should it be made operational?
  - Who should be responsible for it?
- Allow 20 minutes for discussion then ask a representative from each group to take 5 minutes to

share their most important points.

- Continue on with the next 3 groups in the same manner.
- Encourage discussion on all points in the plenary.
- Distribute the *Arogya Mantap* concept note in Annexure 1 and read it together.
- Ask the FLWs to decide on a date to begin the *Arogya Mantap* meeting and choose either a SC or a health facility as a venue.
- Tell them that one of the project field workers will be present to facilitate the first *Arogya Mantap* meeting in each of the SCs on the dates that have been decided by the groups.
- Consolidate the session by noting that the *Arogya Mantap* is:
  - A collaborative forum that is intended to make the work duties of the FLWs less stressful and more productive by bringing FLWs together.
  - Able to evolve according to the members' need and objectives.

SESSION 9: TRAINING EVALUATION AND FEEDBACK

Objective

- To assess what affect the module had on the participants' attitudes, knowledge and practice levels.
- To obtain feedback from the participants on the usefulness of the training and suggestions for enhancing future effectiveness.

Methodology

Reflection

Duration

30 minutes

Training Materials

Training evaluation and feedback form

Tips for facilitators

The training evaluation and feedback form will assess what affect the module had on the participants' attitudes, knowledge and practice levels and obtain feedback on the usefulness of the training and suggestions for enhancing future effectiveness.

Process

- Distribute the training evaluation and feedback form. Go over all the areas that the participants will need to think about while filling it in.
- Allow 20 minutes to complete it.
- Collect the training evaluation and feedback forms from the participants.
- Before the closing ceremony begins, ask the participants to share their feelings about the training: encourage anyone who is keen to orally share two positive aspects and two areas that need improvement.
- At the closing ceremony thank all the participants for their enthusiastic participation, congratulate them and wish them the best as they go back to their own field areas and begin to initiate the intervention on ground.
- Thank everyone else who contributed to the training program. This might have included administrative staff, venue owners, facilitators, guest speakers and the organizers.

TRAINING EVALUATION AND FEEDBACK FORM:

KARNATAKA HEALTH PROMOTION TRUST
Training Evaluation and Feedback Form

Name: _____ Designation: _____ Place of training: _____

Training dates: _____ Name of the PHC: _____

S.No.	Subject	Excellent	Good	Poor
1	Training content and sessions			
2	Training methodology and activities used			
3	Training skills of the facilitators			
4	Logistics at the training (Food, stay and comfort)			
5	Relevance and usefulness of training			

List the three aspects of the training that you found most useful.

1.
2.
3.

Name any session during the training that you did not understand properly/ or that was not communicated well.

1.
2.
3.

What are the three most important lessons that you can take back to your work place from this training?

1.
2.
3.

Please list suggestions for improved facilitation in future trainings.

1.
2.
3.

FIVE

5

Community Level Interventions For Improving Maternal, Neonatal And Child Health: A Training Tool Kit

IMPROVING THE ENUMERATION AND TRACKING PROCESS

Community Level Interventions for Improving Maternal, Neonatal and Child Health: Improving the Enumeration and Tracking Process is the fifth module of the tool kit in a series of seven on enhancing community engagement for improving outreach, shaping demand and strengthening accountability to improve maternal, neonatal and child health outcomes in Karnataka.

Publisher:
Karnataka Health Promotion Trust
IT/ BT Park, 4th & 5th Floor
1-4, Rajajinagar Industrial Area
Behind KSSIDC Administrative Office
Rajajinagar, Bangalore- 560 004
Karnataka, India

Phone: 91-80-40400200
Fax: 91-80-40400300
www.khpt.org

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Karnataka Health Promotion Trust (KHPT)
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Mr. Mohan HL, UOM
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Dr. Navya R, KHPT
Mr. Vinod Kumar, KHPT
Mr. Raghavendra Kamati, KHPT
Dr. Rajeshwari, KHPT
Ms. Salima, JHA, Koppal
Ms. Renuka R, JHA, Koppal
Ms. Renuka, ASHA worker, Koppal
Ms. Gayathri, ASHA worker, Koppal
Ms. Rukmini, ASHA worker, Koppal
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THE EDITORIAL TEAM:
Mr. H.L. Mohan, KHPT
Ms. Mallika Biddappa, KHPT
Dr. Navya R, KHPT
Ms. Dorothy Southern, KHPT consultant

The photographs are by **KV Balasubramanya**. They have been used in the module with consent from the community.

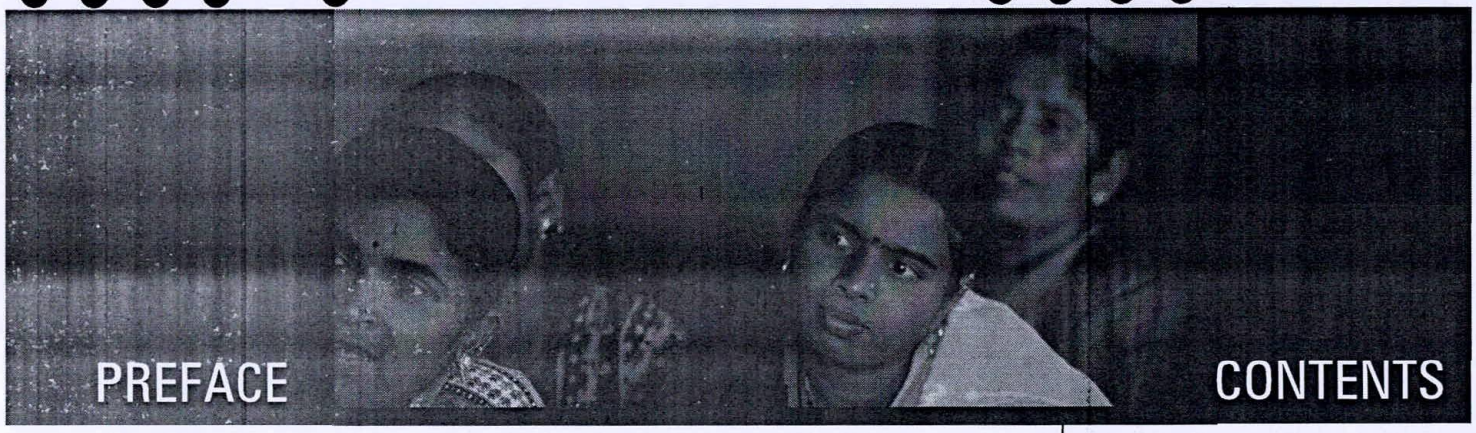
5

Community Level Interventions For Improving Maternal, Neonatal And Child Health: A Training Tool Kit

IMPROVING THE ENUMERATION AND TRACKING PROCESS

ಸುಕ್ಷೇಮ
sukshema
Improved Maternal, Newborn & Child Health

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन



PREFACE

The Community Level Interventions for Improving Maternal, Neonatal and Child Health Tool Kit is a series of seven modules:

Module 1: Design, Planning and Implementation of the Sukshema Project
Module 2: Core Concepts of Maternal, Neonatal and Child Health
Module 3: Sukshema's Community Level Interventions
Module 4: Communication and Collaborative Skills for Front Line Workers
Module 5: Improving the Enumeration and Tracking Process
Module 6: Home Base Maternal and Newborn Care
Module 7: Supportive Community Monitoring

Module 5: Improving the Enumeration and Tracking Process enhances the capacities of the Accredited Social Health Activist (ASHA) and the Junior Female Health Assistant (JHA) to identify, register and track all pregnant women in her area across the Maternal Neonatal and Child Health (MNCH) continuum of care. One of the key challenges identified in the field was the absence of effective enumeration and tracking tools. This led to gaps in the number of pregnant women accessing the full extent of services throughout the MNCH continuum of care service. The Community Demand List (CDL) Tool was developed specifically to identify which women in a specific area should be given what services and when the next service is due. The practical hands-on introduction to this tool should improve utilization of all MNCH services by all pregnant or recently delivered women and their newborns.

CONTENTS

ACRONYMS

ANC	Ante Natal Care
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BP	Blood Pressure
BPL	Below Poverty Line
CDL	Community Demand List (CDL) Tool
EDD	Expected Date of Delivery
FLW	Front line health worker
FRU	First response unit
IFA	Iron and Folic Acid
IMR	Infant Mortality Rate
JHA	Junior Female Health Assistant
LBW	Low Birth Weight
MMR	Maternal Mortality Rate
MNCH	Maternal, Newborn and Child Health
MO	Medical Officer
NRHM	National Rural Health Mission
PHC	Primary Health Centre
PNC	Post-natal Care
PPH	Postpartum Haemorrhage
SBA	Skilled Birth Attendant
SC	Sub Centre
SC/ ST	Scheduled Caste/ Scheduled Tribe
TBA	Trained / Traditional Birth Attendant
TT	Tetanus Toxoid
VHSNC	Village Health and Sanitation Nutrition Committee

GETTING STARTED

The Doorway to Successful Training **in Part 11 of Module 1** should always be used to start a training workshop: initially if covering all modules at one time, or as a refresher if modules are scheduled over a period of time. The Doorway to Successful Training contains a detailed plan of sessions that sets the stage for the workshop activities and logistics, covering welcome, introductions, objectives, hopes and fears, and ground rules.

SESSION 1: UNDERLYING CAUSES OF MOTHER AND INFANT MORTALITY

Objective

- To help participants understand the concept of outreach and related activities linked to the MNCH continuum of care.

Methodology
Group work

Duration
1 hour

Training Materials

LCD Projector, chart paper and markers

Tips for facilitators

This session clarifies exactly what outreach is linked to the MNCH continuum of care. This is critical for the ASHAs as they are the 'experts' on the ground and take the lead in delivering services.

Process

- Divide participants into four groups. Ask them to discuss and answer the following questions:
  - How would you define outreach?
  - What are the objectives of outreach activities in the context of the MNCH continuum of care?
  - What are the current challenges in outreach?
- Allow 15 minutes to discuss, then ask a representative from each group to share the main points.
- Continue on with the next 3 groups.

- Display the following definition of MNCH continuum of care at the front of the training room:
  - **Antenatal care (ANC)** – care during pregnancy
  - **Intra-natal care** – care during the delivery and first two hours after the delivery
  - **Post-natal care (PNC)** – (Mother and newborn care during the first 42 days
  - **Child care** – care of the child up to 5 years of age.
- Display the following definition of outreach on a flip chart at the front of the training room:
  Outreach is providing health education and services related to the MNCH continuum of care that can be accessed by pregnant women, recently delivered mothers, and mothers of children under 5 years old, along with their families and the community.

- Reinforce the need to providing continuous MNCH continuum of care services.
- Highlight the factors which determine a complete MNCH continuum of care:
  - All pregnant women in a village should be registered
  - All pregnant women registered should have received all the ANC care services.
  - All the new mothers and newborns should have received all the PNC care services.
  - All the children up to 5 years of age should have received all the Child care services.
- Ask the participants what are the most common MNCH services that rural women do not have access to?
- Discuss the reasons for this gap in service delivery.
- Discuss the gaps related to current challenges in providing outreach.
- Ask which health care workers are responsible for reaching people in rural areas/villages to provide health related information focused on MNCH?
- Discuss roles and responsibilities of FLWs, focusing on ASHAs.
- Highlight the importance of ASHAs fulfilling their key responsibility by delivering comprehensive MNCH outreach.
- Consolidate the activity:
  - A common understanding/definition of MNCH community outreach was agreed
  - Providing outreach related to the MNCH continuum of care was acknowledged as challenging, yet crucial.
  - ASHAs were recognized as the most important FLWs in terms of reaching people in the village and providing MNCH related information.

SESSION 2: CRITICAL ROLE OF JOB AIDS AND TOOLS IN OUTREACH

Objective

- To help the participants understand the need for job aids and tools that will contribute to the planning of outreach and to critically review the current job aids and tools in use and identify the gaps.

Methodology
Case study, small group discussion, plenary presentation and discussion

Duration
1 hour

Training Materials

Copy of case studies, markers and brown sheets/ chart paper, Job aides and registers used by FLWs (Annexure 1)

Tips for facilitators

The facilitator needs to engage the ASHA in a critical thinking process so that they recognize the need for job aids and tools that can help them do their job more effectively and efficiently.

Process

- Give each group one of the two case studies.

Case study 1:
A 24 year old married woman named Kamala had a child after one year of marriage. The ASHA in the village visited Kamala and described different family planning methods to the married couple. The couple decided to try the copper T method of family planning for birth spacing between their next planned for child. After three years, the couple decided to have their second child. Therefore, Kamala had the copper T r intrauterine device removed and she conceived again. The ASHA took Kamala to the JHA to be ANC services. Kamala's last menstrual period (LMP) was on 20/5/2011. The first ANC check-up was done by the JHA. However, Kamala missed the next ANC check-up. Kamala went into labour close to her due date and delivered at home. However, two hours after she gave birth she experience postpartum haemorrhage and died. The ASHA recorded Kamala's death and registered the newborn infant for PNC services, including immunisations.

Case study 2:
A 24 year old woman, Gauramma, was married on 1st January 2011. Her menstrual periods stopped after three months on 1/4/2011. She was taken to the JHA by family members to have a urine pregnancy test (UPT). Her pregnancy was confirmed. The JHA registered the woman and provided the Thayi card on 3/7/2011. The Thayi card number provided was 9800821. The first ANC check-up was done and Gauramma received a TT1 injection and iron and folic acid tablets. Gauramma had a normal delivery on 20/1/2012 at the closest PHC to her home. The ASHA in her village did the first PNC visit on 23/1/2012. After one and half month the ASHA visited again and the infant was given the first dose of Diphtheria, Tetanus Toxoids and Pertussis (DTP), oral polio vaccine (OPV) and Hepatitis.

- Ask group members to read the case study in the group, discuss and answer the following questions:
- What registers do you use to fill in the information of this case?
- How do you develop a follow-up plan to provide MNCH continuum of care services?
- Do the current registers help to plan your outreach? How?
- What changes in the registers would improve outreach?
- Allow 20 minutes for discussion, then ask a representative from each group to take 5 minutes to read out their case study, share their responses to the case study's question, and share the list of registers that they are currently using.

- Ask the other group to share any other key information about the case study.
- Continue with the next case studies in the same manner.
- Distribute Annexure 1 Job aides and registers used by FLWs.
- Highlight all the job aids and tools that have been identified as being used by the ASHAs.
- Add or delete according to the participants' context in the field.
- Consolidate the session:
  - Gaps of the job aids and tools have been identified.
  - Suggestions have been made for changes in the job aids and tools to improve outreach.

SESSION 3: CHALLENGES IN OUTREACH

Objective

- To identify critical challenges faced by ASHAs in conducting outreach

Methodology
Group work and presentation

Duration
1 hour

Training Materials

Copies of the Job aides and registers used by FLWs (Annexure 1), chart paper and sketch pens

Tips for facilitators

Ensure that the discussions are connected to the core topic of improving outreach. FLWs may share personal grievances such as issues around salary payment or other factors which may not be directly under the control of the project. Keep the group focused on outreach.

Process

- Divide participants into two groups.
- Ask each group to review the job aides and registers commonly used during outreach work as identified in Session 2. (See Annexure 1)
- Ask group members to discuss the following question:
  - What are the current problems and challenges in ensuring complete entry and continuity of all MNCH services to the target populations?
- Allow 20 minutes for discussion. Ask a representative from each group to take 5 minutes to share their answers in plenary.
- Ask the other group to share their answers and compare key information.
- Highlight the challenges they face.
- Brainstorm what they think is essential to meet these challenges and improve outreach.
- Note their responses on a flip chart.
- Consolidate the session:
  - Gaps in outreach can be overcome by developing a plan for ensuring entry of continuum of care services for all target groups at the village level.

SESSION 4: INTRODUCTION AND PRACTICE OF THE COMMUNITY DEMAND LIST (CDL1) TOOL

Objective

- To introduce the Community Demand List (CDL1) Tool to the participants and to facilitate a participatory practice session of entering details of pregnant women and newborns into CDL1 Tool.

Methodology
Group work and discussion

Duration
2 hours

Training Materials

Copies of the CDL1 Tool (Annexure 2) and Guidelines (Annexure 3)

Tips for facilitators

Before this session, thoroughly review the training materials, including Annexures 1, 2 and 3, to be able to lead this participatory hands-on exercise. Do not expect the participants to understand the tool completely at this juncture. Assure them that they will be able to acquaint themselves more through practical exercises in the field.

Process

- Discuss the purpose and uses of the CDL1 Tool.
- Some of the uses are:
  - Reduces workload of the ASHA: reduces time in filling in multiple formats
  - ASHAs may not need to refer to as many registers to get information about one beneficiary
  - Tool is easy to carry from one place to other
  - Less educated ASHAs can also use this format easily
  - Helps in providing timely health services to all target populations
  - Can track women who migrate
  - Can help plan outreach as the CDL1 Tool gives information about all beneficiaries and all important indicators in one place.
  - Helps prepare monthly plans for follow-up based on the understanding of who is due for what services.
  - Enables ASHA to prepare a list of beneficiaries requiring services
  - Helps track the services due and the services received by every registered person from pregnancy to delivery and until the baby is 18 months old.
  - Helps ASHA self-evaluate and reflect upon her own performance.
- Distribute the CDL1 Tool to every participant (See Annexure 2).
- Distribute Guidelines on how to fill-in the CDL1 Tool. (See Annexure 3)
- Review the CDL1 Tool by reading through each section and explaining every indicator in each of the sections/ columns in the tool.
- Demonstrate the entry of pregnant woman and newborn details in each column of the tool based on the example provided in the tool.
- Divide the participants into four groups.
- Ask each group to pick one case of a pregnant woman entered in their earlier job aides and registers. Tell them to transfer the details of that case into the CDL1 Tool.
- Allow 20 minutes for group work and discussion.
- Ask a representative from each group to take 5 minutes to share the case they were using and the process of transferring the details into the CDL1 Tool.
- Continue with the next 3 groups in the same manner.
- Clarify any misunderstandings.
- Consolidate the session:
  - The CDL1 Tool will ensure complete entry and continuity of MNCH care by helping the ASHAs to develop a plan for tracking pregnant women in the village.
  - The four sections of the CDL1 Tool: Identification details; ANC details; PNC details and Immunization details need to be filled in completely for every pregnant woman in the ASHAs area.

SESSION 5: INTRODUCTION AND USE OF THE COMMUNITY DEMAND LIST 2 (CDL2) TOOL

Objective

- To introduce participants to and provide hands on experience of using the Community Demand List 2 (CDL2) Tool

Methodology
Group work and discussion

Duration
1.5 hours

Training Materials

Copy of the CDL2 Tool (Annexure 4) and Definition of Indicators (Annexure 5) and Demonstration of using CDL2 (Annexure 6)

Tips for facilitators

Before this session, thoroughly review the training materials, including Annexures 4, 5 and 6 to be able to lead this participatory hands-on exercise. Resource persons (RPs) should assist the groups with practicing the use of the CDL2 Tool.

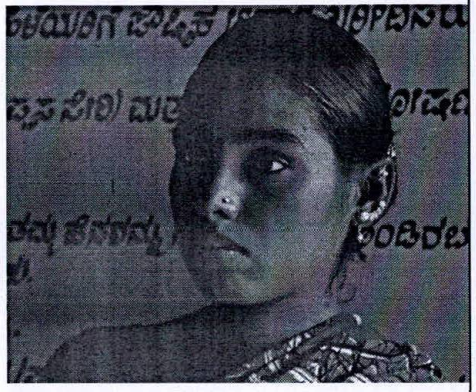
Process

- Distribute the CDL2 Tool to each participant (Annexure 4).
- Highlight the objectives and uses of the CDL2 Tool focussing on the importance of self-planning and self-review.
  - *Serves as a self-reflection and review tool. It has a list of 16 indicators derived from the CDL1 Tool. It helps the ASHA to identify and list only those indicators that are very critical to MNCH care such as registration of the pregnant woman, TT injection, PNC visits, family planning, etc. The CDL2 Tool is designed to help the ASHA carry out self-assessment of the progress she has made on these critical indicators, develop a plan to effectively address the gaps seen, evolve her monthly action plan, reinforce her personal targets, and engage in constructive reflection of her performance and challenges.*
  - *Provides the ASHA with information about beneficiaries due for services during the month as well as tracks those who have received services during that month. CDL1 Tool has the list of the names of the beneficiaries. However, CDL2 Tool only has the*

corresponding serial numbers. Therefore the ASHA does not need to write the names of the beneficiaries each time that she identifies their service due in this format. The CDL2 Tool is expected to be filled in by the ASHA the 21st of every month as her reporting period is from the 21st to the 20th of the next month. The process involves transferring the details of pregnant women and newborn from the CDL1 Tool to the CDL2 Tool.

- Distribute the Definition of Indicators to each participant (Annexure 5).
- Explain that for every indicator in the CDL2 Tool, there are defining targets and achievements. These are a standardized process and all indicators are listed.
- Divide the participants into pairs. Tell each pair to transfer the details of at least 10 to 15 pregnant woman from the CDL1 Tool to the CDL2 Tool.
- Allow 20 minutes.
- Distribute Demonstration of using CDL2 (Annexure 6) to each participant.
- In plenary, use the example provided in the demonstration tool as a reference for cross checking this documentation exercise.
- Ask the participants about their views on the CDL2 Tool: how does it help them to improve outreach of MNCH services?
- Consolidate the session:
  - The CDL2 Tool documents beneficiary information and serves as a self-reflection and self-review tool to assess performance for that month and identify strategies to fill gaps.

SESSION 6: VULNERABLE GROUPS: IDENTIFICATION AND PROBLEM SOLVING



Objective

- To help participants identify the reasons for gaps in the service provision, to identify vulnerable groups, and to suggest solutions to the problems.

Methodology

Group work and discussion

Duration

2 hours

Training Materials

Filled in CDL1 Tool and CDL2 Tool, chart paper and marker pens, copies of the Gap Analysis Exercise (Annexure 7)

Tips for facilitators

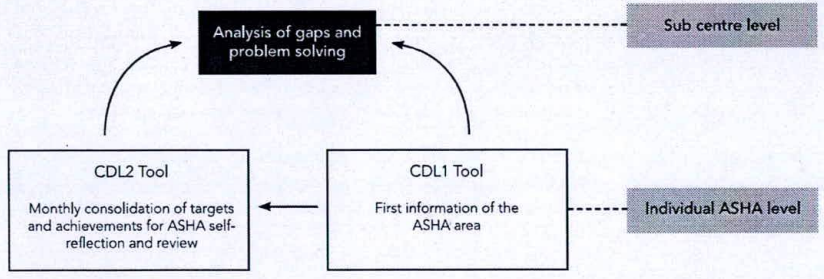
This session can be facilitated at various levels: it can be carried out with a group of ASHAs in the village, but it is recommended that this session be presented at the SC level so that the FLWs can understand the overall SC's performance in terms of service provision. This session demands close engagement of the facilitator. The participants could feel frustrated at the sudden emphasis on formats and numbers which is analytical and demands close attention. The ASHAs probably have never engaged in this type of exercise before. Ensure that you allow them to freely express their doubts and fears. Be patient and engage them in energizers if they are fatigued.

Process

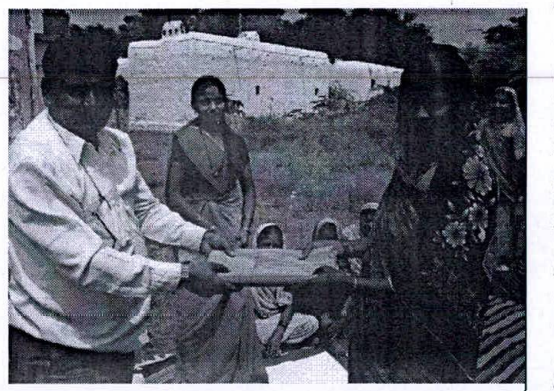
- Ask them to review their filled in CDL1 Tool and CDL2 Tool.
- Ask them which pregnant women have missed services?
- Tell them that women who often miss out on services are called vulnerable groups.
- Ask them who might be considered vulnerable in their areas.
- Note their responses on a flip chart.

- Highlight that the following women could be considered vulnerable:
  - Pregnant women who have not been registered and are already in the second trimester at the time of tracking.
  - Pregnant women with more than three gravida and poor birth spacing with the age of last child within 12 months.
  - Pregnant women who belong to SC/ST category and have a Below Poverty Line (BPL) status.
  - Pregnant women below 18 years.
  - Pregnant women who have repeatedly missed scheduled ANC services which include TT injections, IFA tablets and ANC check-ups
  - Pregnant women with a previous history of complications in pregnancy/delivery.
  - Pregnant women with complications in the current pregnancy.
  - Mothers who have not received counselling and PNC care post-delivery.
  - Mothers who have currently delivered at home.
  - Newborns who have missed the scheduled immunisation doses.
  - Any woman with a reported infant death(s) in the remarks section.
- Display the Flowchart for using the CDL1 Tool and CDL2 Tool and explain the process.
- Divide participants into four groups.
- Distribute one copy of the Gap Analysis Exercise (Annexure 7) to every group.
- Ask the groups to fill in the form listing the vulnerable groups and specifying the possible reasons for each gap. Tell them to categorize the reasons as either:
  - **External** (if the reason for gaps in services is due to the poor health seeking behaviour of the pregnant woman and her family); or
  - **Internal** (if the reason for gaps in services is due to lapses from service provider's side.
- Then ask them to analyse the gaps in services and to suggest solutions for these problems.
- Allow 30 minutes for discussion. Ask a representative from each group to take 5 minutes to share their most important points and solutions.
- Ask other groups to share any other key information about those vulnerable groups.
- Continue with the next 3 groups in the same manner.
- Highlight that possible solutions identified can be linked to different Sukshema community interventions such as family focused communication (FFC); home based maternal and newborn care (HBMNC) and discussion of issues pertaining to maternal and infant death in community platforms such as the VHSNC committee. The learning from FFC trainings could be used as a probable solution to minimize the gaps in communication with the families, which is also an internal reason for a gap in service utilization.
- Consolidate the session:
  - The importance of identifying vulnerable groups, identifying gaps, analysing the reasons for them and identifying solutions to the problems.
  - FLWs should now be able to link all the benefits of the CDL1 Tool and CDL2 Tool and begin to analyse the situation in the field.

FLOWCHART FOR USING THE CDL1 TOOL AND CDL2 TOOL



SESSION 7: TRAINING EVALUATION AND FEEDBACK



Objective

- To assess what affect the module had on the participants' attitudes, knowledge and practice levels.
- To obtain feedback from the participants on the usefulness of the training and suggestions for enhancing future effectiveness.

Methodology
Reflection

Duration
30 minutes

Training Materials
Training evaluation and feedback form

Tips for facilitators
The training evaluation and feedback form will assess what affect the module had on the participants' attitudes, knowledge and practice levels and obtain feedback on the usefulness of the training and suggestions for enhancing future effectiveness.

Process
- Distribute the training evaluation and feedback form. Go over all the areas that the participants will need to think about while filling it in.
- Allow 20 minutes to complete it.
- Collect the training evaluation and feedback forms from the participants.
- Before the closing ceremony begins, ask the participants to share their feelings about the training: encourage anyone who is keen to orally share two positive aspects and two areas that need improvement.
- At the closing ceremony thank all the participants for their enthusiastic participation, congratulate them and wish them the best as they go back to their own field areas and begin to initiate the intervention on ground.
- Thank everyone else who contributed to the training program. This might have included administrative staff, venue owners, facilitators, guest speakers and the organizers.

TRAINING EVALUATION AND FEEDBACK FORM:

KARNATAKA HEALTH PROMOTION TRUST
Training Evaluation and Feedback Form

Name: _____ Designation: _____ Place of training: _____
Training dates: _____ Name of the PHC: _____

S.No.	Subject	Excellent	Good	Poor
1	Training content and sessions			
2	Training methodology and activities used			
3	Training skills of the facilitators			
4	Logistics at the training (Food, stay and comfort)			
5	Relevance and usefulness of training			

List the three aspects of the training that you found most useful.

1.
2.
3.

Name any session during the training that you did not understand properly/ or that was not communicated well.

1.
2.
3.

What are the three most important lessons that you can take back to your work place from this training?

1.
2.
3.

Please list suggestions for improved facilitation in future trainings.

1.
2.
3.

ANNEXURE 1 - Job Aides and Registers used by FLWs

1. Pregnancy register
2. Delivery register
3. Birth and death register
4. Immunization register
5. Survey register
6. Daily work diary
7. High Risk pregnant women's register
8. Blood examination register
9. Eligible couple register
10. RTI/STI and ICTC test register
11. Certification register for providing support in delivery
12. Drug storage register
13. Birth and death register
14. Family Planning register
15. CNA survey format
16. Larvae survey
17. VHSNC register

ANNEXURE 2 - CDL1 Tool

COMMUNITY DEMAND LIST - CDL-1 (ETT-1)

Estimated number of pregnant women: ASHAName: ASHAArea Name: Village Name: Sub Centre Name: Code:

1	Chan-dramma. Nanjun-dappa A+ve	9 9 / 10	808659 9 9 / 10	9731918060	26	Others	V	G2, P1,A0	1		303	X	18 5 / 10	25 2 / 11	3	9 9 /-10	6 1 / 11	3 2 / 11		6 10 / 10	6 11 / 10		30 6 10 / 10	30 8 11 / 10	40 10 1 / 11	X

	Identification details														Ante-natal care details													
	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27
	S. No.	Women's Name & Husbands Name/ Blood group	Date of Registering Women in CDL-1	Registration done by JHA: Thayi Card No. & Date	Phone Personal (P), Neighbour's (N)	Age in Years	Caste SC/ST / Others	BPL if received card tick v if not mark X	Gravida (G) Para, (P) Abortion (A)	No. of Living Children (L) Boy	No. of Living Children (L) Girl	Age of the last child months	Previous pregnancy/ delivery complica-tions Yes v No X	L.M.P First day of last Menstrual period	E.D.D. L.M.P +7 days +9 months (Date)	Pregnancy in months at the time of registration	ANC check ups Date and type of facility --> PHC/ Private/ Other Govt. Facilities 1st checkup	2nd checkup	3rd checkup	4th checkup for high risk	TT 1st Visit	2nd Visit	3rd Visit	IFA tablets Number and date of receiving it 1st Dose Date	2nd Dose Date	Booster Dose Date	Pregnancy complica-tions Yes v / No X) --> Refer to the tool guidelines f or details
	1																										
	2																										
	3																										
	4																										
	5																										
	6																										
	7																										
	8																										
	9																										
	10																										
	11																										
	12																										
	13																										
	14																										
	15																										

General Instructions: (1) This toll is used to document and ensure everey pregnant woman in your area enters and stays in the MNCH care continuum through her pregnancy, delivery, postnatal care and child immunizationa services till the child is 18 months old. (2) This tool is also useful to identify gaps in service utilization, and prioritize women for outreach. (3) The information recorded here, except most part of the childhood immunization section, comes from the HBMNC tool that you use for every pregnant and recently delivered woman. An example of filling the tool has been provided above.

Delivery complications - * Ante partum hemorrhage, severe anemia during pregnancy (Hb ‹ 7 gm%), pregnancy induced hypertension, pre eclampsia, eclampsia, pre mature delivery, pre mature rupture of amniotica sac, lack of fetal movement, malpresentation and if the pregnant woman had a c-section or complicated delivery, mark (¥"). If the pregnant woman had a normal delivery without any complications mark (x)

PHC Name: Code: Taluk: Code: District: Code:

	Private 28 2/11	Normal	Gowri (F)	2800	3 3/11	7 3/11	14 3/11	21 3/11	28 3/11	64 4/11	X	√	28 2/11	28 2/11	28 2/11	13 4/11	13 4/11	13 5/11	13 5/11	13 6/11	13 6/11	10 12/11	10 12/11	10 12/11	20 9/12	20 9/12	20 9/12	8 1/11	30 4/11	30 4/11	
Post-natal care details																									Immunization details						
28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59
S. No.	Date of delivery and type of facility PHC/ Private/ Other Govt facilities	Type of delivery Normal/ Assisted/ C section	Name of the child Sex M/F	Weight at birth grams	PNC Visits (as per HBNC guidelines)						Family planning		BCG	Birth Dose		1st Dose		2nd Dose		3rd Dose		Measles 1st dose	Vita-min A	JE 1st dose	BD		Measles 2nd dose...	JE 2nd dose	Migration Write all the dates of moving out/in..		Remarks Maternal & infant deaths, highlight the reasons
					3 (0-5)	7 (6-10)	14 (11-12)	21 (18-24)	28 (25-35)	42 (36-42) and above	Tem-porary Yes √, No x	Perma-nent Yes √, No x		OPV	HEP B	OPV	Penta-valent	OPV	Penta-valent	OPV	Penta-valent				DPT	OPV			Out	In	
1																															
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14																															
15																															

** If DPT and Hep B vaccines were admsinistered then write that date, if Pentavalent vaccine was adminsitered instead of DPT and Hep B then write that date in the same column.

ANNEXURE 3 - Guidelines for using the CDL1 Tool

The CDL1 Tool developed for the ASHA's has been broadly divided into four major sections: identification details, ANC details, PNC details and immunization details. The top portion of the tool consists of a column which mentions the estimated number of pregnant women in the area. The ASHA's should enter the number of estimated pregnant woman after referring to the eligible couple register (ECC). This helps the ASHA enter all the details of the women/children in her area of work and track them through their service cycle ensuring that no one missed any specific across the ANC, delivery and PNC up to the age of 18 months of the new born. The tool filling instructions for each of the columns are specified below:

SECTION 1: GUIDELINES TO FILL THE IDENTIFICATION DETAILS

Column 1 – Serial number- Serial numbers have to be used. E.g.: 1, 2, 3

Column 2 – Enter the names of the woman and her husband as also her blood group. E.g.: Chandramma, Husband – Nanjundappa, A +ve.

Column 3 – ASHA registration- Record name of pregnant woman, mother and children; should also include the date of registration/entry,e.g.: 9/ 9/ 10

Column 4 – Number/ Date on the Thai card- The serial number present in the Thai card and the date when it was issued should be note. E.g.: 808659; Date: 12/10/10

Column 5 – Telephone number- The telephone number of the pregnant woman has to be recorded. If it is a personal number identify it as (P) and neighbor's phone as (N). E.g.: 9731918060 (P)

Column 6 – Age- Record the completed age of the woman. E.g.: 26 years

Columns 7 – Caste group- If the woman belongs to the scheduled caste or tribe record it as SC or ST. If not record it as "Other"

Column 8 – BPL status of the pregnant woman-If the family has a BPL card affix a (√) mark against the place if issued or else affix a (×)

Column 9 – Pregnant (G), Delivery (P), Abortion(A)- Pregnancies (Current + Previous) have to be recorded as G1, G2 and so on. Previous deliveries have to be recorded as P1, P2, and so on. If there has been no previous delivery mark it as P0. If there has been a spontaneous (miscarriage) or induced abortion during any previous pregnancy, then record it as A1, A2, and so on. If there has been no previous instance of any miscarriage or induced abortion, then record it as A0.

Column 10 and 11 – Number of living children - Record the number of children currently alive under the sub column 'boy' and 'girl'

Column 12 – Age of the youngest child- The name and the age in completed months of the youngest child has to be recorded here.

SECTION 2: ANC DETAILS

Column 13 – Complications experienced during the previous pregnancy/delivery- Affix a (√) symbol if there have been any complications in the previous pregnancy/ delivery and affix a (×) mark if there have not been any complications and it has been a normal delivery. *Commonly seen danger signs/ complications during pregnancy and delivery are provided as head notes in the tool.*

Column 14 – Date of the Last Menstrual Period (LMP)- Record the date of the first day of the last menstrual period. E.g.: 18/05/2010

Column 15 – Expected delivery date or EDD- On the basis of the LMP, the EDD can be calculated. Expected Delivery Date is calculated by summing up date of first day of LMP +7 days+9months. To fill this, use the EDD table of calculation. E.g.: If the LMP is 1st of January the corresponding EDD will be October 8th.

Column 16 – Period of pregnancy at registration- Indicate which month of pregnancy the woman was in at the time of registration by JHA. E.g.: 3 months

Columns 17, 18, 19, 20 – Number of ANC checkups conducted before delivery- Record the date of the first ANC checkup in *column 17*, 2nd in *column 18*, 3rd in *column 19* and if it is a complicated pregnancy, the date of the 4th ANC check up should be recorded in *column 20*.

Columns 21, 22, 23 – TT injection- Record the date of the 1st TT injection in *column 21*, date of 2nd TT in *column 22* and the date on which BD (Booster Dose) was taken has to be recorded in *column 23*.

Columns 24, 25, 26 – IFA tablets- Record the date and number of IFA tablets taken in the above mentioned columns.

Columns 27 – Complications associated with the current pregnancy- If there are any complications seen in the pregnant woman then affix a (√) symbol, otherwise affix (×) symbol. *Commonly seen danger signs/ complications during pregnancy are provided as head notes in the tool.*

SECTION 3: PNC DETAILS

Column 28 – Record the serial number given to the pregnant woman

Column 29 – Date of delivery and place- Record the date in the form date/month/year. E.g.: 12/03/2012. Place of delivery can be PHC/other government hospital/ private hospital. If it is not an institutional delivery record it as a home delivery.

Column 30 – Mode of delivery- The mode can be recorded as normal, cesarean or assisted delivery.

Column 31 – Name and sex of the baby- The name of the child and the sex 'M' for male and 'F' for female

Column 32 – Weight of the baby- Record the weight of the baby in grams. E.g.: If the weight of the baby is 2 kilograms, record it as 2000 grams.

Columns 33, 34, 35, 36, 37 and 38 – PNC visits (As per HBMNC guideline)- The visits on the days 3, 7, 14, 21, 28 and 42 are to be recorded with date of visit.

Columns 39, 40 – Family planning- Temporary/ Permanent- affix a symbol (√) in column 39 if the couple are practicing any temporary method, else mark (x), and if she/husband adopted any permanent method of contraception (Tubectomy/ Vasectomy) affix a (√) in column 40, else mark (x)

SECTION 4: IMMUNIZATION DETAILS

Column 41 – BCG- Record the date on which the BCG vaccine was administered. E.g.: 13/2/2011

Columns 42, 43 – 0 dose- Record the date on which OPV0 and HepatitisB0 were administered.

Columns 44 and 45 – First dose (OPV and Pentavalent)- Record the date on which the first dose of OPV and Pentavalent were administered

Columns 46 and 47 – Second dose (OPV and Pentavalent)- Record the date on which the second dose of OPV and Pentavalent were administered

Columns 48 and 49 – Third dose (OPV and Pentavalent) - Record the date on which the third dose of OPV and Pentavalent were administered

Column 50 – Measles (1st dose) - Record the date of administration of the measles vaccine

Column 51 – Vitamin A- Record the date on which Vitamin A was given

Column 52 – Brain fever (1st dose) - Record the date on which brain fever (JE) vaccine was administered

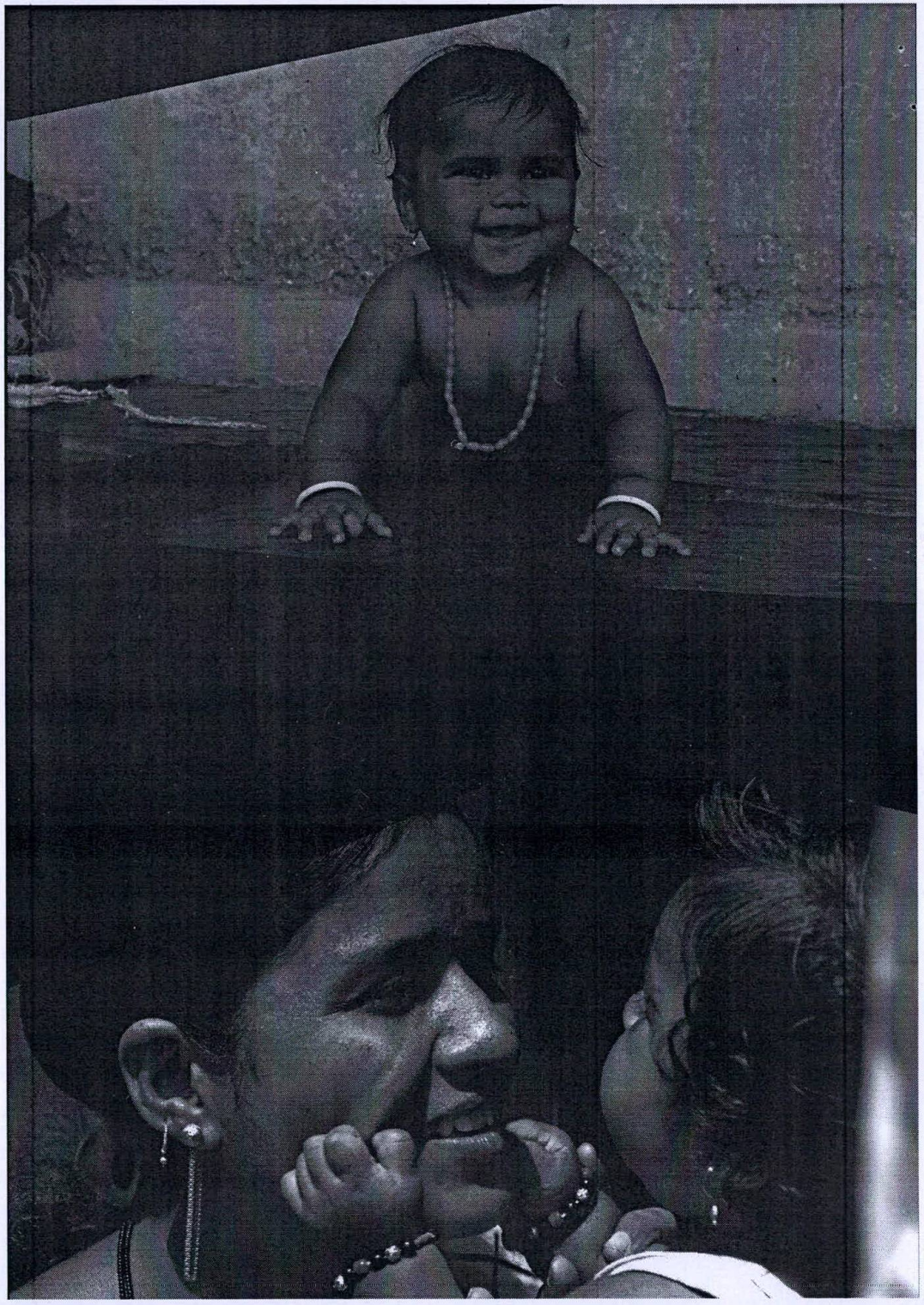
Columns 53 and 54 – Booster dose (DPT, OPV) - Record the date on which the booster dose injections DPT & OPV were administered in respective columns

Column 55 – Measles (2nd dose) - Record the date on which the 2nd dose of measles vaccine was given

Column 56 – Brain fever (2nd dose) - Record the date of administering the 2nd dose of the brain fever vaccine (JE)

Columns 57 and 58 – Migration- During the follow up period in the out migration column, record the date on which the pregnant woman/mother left the area and in the in migration column, record the date on which a pregnant woman/mother has come to this area. If a particular pregnant woman has migrated multiple times all the dates have to be recorded.

Column 59 – Reasons for mother and child mortality- The date along with reasons for the death of the pregnant woman/mother or child as recognized by the ASHA has to be recorded in this column.



ANNEXURE 4 - CDL2 Tool

COMMUNITY DEMAND LIST CDL2 TOOL

Month:
(To help ASHA to prepare her monthly action plan and to self-reflect on her own performance)

ASHA Name: Sub Centre: PHC:

S.No	Services	Eligible women/ children (Ref # of cdl-1)	Actual Target	Presently Staying in the village	Service Accessed	Performance -1 (% to Actual target)	Remarks
1	Total Registration [ ], Registration this month [ ], Pregnant women registration this month [ ]						
2	Thai Card Issuing (Column # 4)						
3	ANC Check-up (Column # 17,18,19 & 20)						
4	TT (Column # 21,22 & 23)						
5	IFA (Column # 24,25 & 26)						
		List of those who received 100/200 IFA tablets					
6	EDD (Column #15)						
7	PNC Services (Column # 33,34, 35, 36, 37 & 38)						
		List of those who completed all PNC visits					
8	Family Planning (Column # 39 &40)						
9	Family Planning (Those who are not listed in CDL1) (Column # 39)						
10	BCG (Column # 41)						
	0 Dose - OPV (Column # 42)						
	0 Dose - Hep B (Column # 43)						
11	1st Dose - OPV (Column # 42)						
	1st Dose - Pentavalent (Column # 43)						
12	2nd Dose - OPV (Column # 46)						
	2nd Dose - Pentavalent (Column # 47)						
13	3rd Dose - OPV (Column # 48)						
	3rd Dose - Pentavalent (Column # 49)						
14	1st Dose - Measles (Column # 50)						
	Vit A (Column # 51)						
	JE (Column # 52)						
15	Booster Dose - DPT (Column # 53)						
	Booster Dose - OPV (Column # 53)						
	2nd Dose - Measles (Column # 55)						
	2nd Dose - JE (Column # 56)						
	Measles - 2nd Dose (Column # 55)						
16	ASHA's performance in providing services to all (Total numbers)						

JHA Signature	ASHA Signature

ANNEXURE 5 - Definitions of Indicators for using CDL2 Tool

INDICATOR	TARGET	ACHIEVEMENT
ANC registration	This is a constant number every month –Estimated number of pregnant women as per the recent CNA/12, rounded off to the nearest integer	# of pregnant women issued Thayi card in the reporting month, based on the date of registration in CDL1 Tool
TT injection	# of pregnant women who have not received any TT injection so far irrespective of the month of pregnancy PLUS # of pregnant women who had received the first TT a month ago AND have not received the 2nd TT	# of pregnant women who received TT injections (either TT1 or TT2 or TT Boóster) in the reporting month
IFA 100	# of pregnant women in their 4th to 9th month of pregnancy who have so far received <100 IFA tablets PLUS # of severely anaemic pregnant women in their 4th to 9th month of pregnancy who have so far received <200 IFA tablets	# of pregnant women who reached a cumulative of 100/200 IFA tablets in the month
ANC check-up	# of pregnant women in their 3rd to 6th month of pregnancy who did not receive any ANC check-up from a medical doctor (either in a government or a private facility) PLUS # of pregnant women in their 7th to 8th month of pregnancy who received <2 ANC check-ups from a medical doctor (either in a government or a private facility) PLUS # of pregnant women in their 9th month of pregnancy who received <3 ANC check-ups from a medical doctor (either in a government or a private facility)	# of pregnant women who received ANC check-up from a medical doctor (either in a government or a private facility) in the reporting month
Delivery	# of pregnant women who are due for delivery in the reporting month, based on the EDD	This has two parts: 1. # of women who delivered at home in the reporting month 2. # of women who delivered in a facility (government or private) in the reporting month
PNC visits	# of delivered women who have received <6 PNC visits (based on PNC visit dates) within 42 days of delivery (based on date of delivery)	# of delivered women who received 6+ PNC visits in the reporting month
BCG	# of children age <12 months who did not receive a BCG vaccination	# of children age <12 months who did not receive a BCG vaccination
OPV (can be given anytime within 5 years of age)	# of children under age 15 days who have not received OPV birth dose PLUS # of children age 45 days and above who have not received the 1st dose of OPV PLUS # of children age 75 days and above who have not received the 2nd dose of OPV PLUS # of children age 105 days and above who have not received the 3rd dose of OPV	# of children age <12 months given OPV vaccination in the reporting month
Hep B [Can be administered only during the first year of life and should only be given along with DPT; thus if a child age <12 months has already received three doses of DPT but missed any dose of Hep B, the child cannot be administered Hep B and would move out of target]	# of children within 24 hours after birth who have not received Hep B birth dose PLUS # of children age 45 days and above who have not received the 1st dose of Hep B # of children age 75 days and above who have not received the 2nd dose of Hep B # of children age 105 days and above who have not received the 3rd dose of Hep B	# of children age <12 given HepB vaccination in the reporting month
DPT [Can be administered till attainment of two years of age]	# of children age 45 days and above who have not received the 1st dose of DPT # of children age 75 days and above who have not received the 2nd dose of DPT # of children age 105 days and above who have not received the 3rd dose of DPT	# of children age <12 months given DPT vaccination in the reporting month
Pentavalent vaccine	# of children age 45 days and above who have not received any dose of pentavalent vaccine and any dose of Hep B,DPT and OPV	# of children age <12 months given pentavalent vaccine in the reporting month
Measles	# of children age 9 months and above who have not received measles vaccine	# of children age <12 months given measles vaccination in the reporting month
Family planning	Local resident women listed in the CDL1 Tool who are not currently using any family planning methods	# of local resident women who are currently using any family planning method, separately for permanent and temporary methods

ANNEXURE 6 - Demonstration of CDL2 Tool

Below is a brief demonstration of filling in the CDL2 Tool. This exercise is focused on the first two indicators, which have numbers inserted as per CDL1 Tool. This will help the ASHA to prepare her monthly action plan and to self-reflect on her own performance.

COMMUNITY DEMAND LIST CDL2 TOOL

Month:
(To help ASHA to prepare her monthly action plan and to self-reflect on her own performance)

ASHA Name: Sub Centre: PHC:

S.No	Services	Eligible women/ children (Ref # of cdl-1)	Actual Target	Presently Staying in the village	Service Accessed	Performance -1 (% to Actual target)	Remarks
	1	2	3	4	5	6	7
1	Total Registration [ ], Registration this month [ ], Pregnant women registration this month [ ]						
2	Thai Card Issuing (Column # 4)						

1.1- Services- This section indicates which information the ASHA needs to derive from the CDL1.

1.2- Eligible women/ children-
Total registration- In this column the ASHA has to record the serial numbers of all the women registered so far. This is a cumulative count.
Registration this month- this refers to the serial numbers of pregnant women/mothers registered in the current month alone. These are new entries.
Pregnant women registration this month- this refers to the serial numbers of the new pregnant women the ASHA herself registered in her area in the current month.

1.3-Actual target refers to the total numbers of those that require services and not the serial numbers of women.

1.4- Presently staying in the ASHA area- In this column the ASHA record this number- Of the total target, how many are currently residing in the ASHA area

1.5- Service Accessed- In this column the ASHA will record this number- Of the numbers staying in the village, how many she was able to give or link to services. This indicates the achievement.

1.6- Performance- This % refers to:
The number recorded under the service accessed column _____ X 100
The number recorded under presently staying in the ASHA area

1.7- The remarks column allows for the ASHA to record reasons for not being able to achieve the target.
Example 2- Thai Card issuing

2.1- Refer to CDL1, column # 4 for this indicator- This refers to the women who have been issued Thai card

2.2- Eligible women/ children- this refers to the serial numbers of women who have received Thai card. It is a cumulative count.

2.3- Expected Beneficiary- refers to the total numbers of women to be issued Thai card in the current month.

2.4- Presently staying in the village- In this column the ASHA record this number- Of the total expected beneficiaries, how many are currently residing in the village/ ASHA area

2.5- Service Accessed- In this column the ASHA will record this number- Of the numbers staying in the village, for how many she could manage a Thai card. This indicates the achievement.

2.6- Performance- This % refers to:
The number recorded under the service accessed column _____ X 100
The number recorded under presently staying in the ASHA area

2.7- The remarks column allows for the ASHA to record reasons for not being able to achieve the target.
Indicator number 16 which is the last in CDL2, is a consolidation of the targets and achievements of all the previous 15 indicators. The ASHA adds up the total numbers under the three columns- Expected Beneficiaries, Presently Staying in the village and Service accessed based on which she then calculates her % performance. This indicator is used by the ASHA to carry out a self reflection and self assessment of her performance during the month. She does this every 21st during the ASHA meeting. Below this the concerned ASHA should affix her signature and get the signatures of the ASHA facilitator and Junior Female health Assistant as well every month.

ANNEXURE 7 - Gap Analysis Exercise

Pregnant women and newborn in the vulnerable list	Gaps Identified	Reasons for gaps		Solutions identified
		Service seekers* (External)	Service providers** (Internal)	

* Service seekers: Mother and newborn, ** Service providers: Health system and the health workers.

SIX

Community Level Interventions For Improving Maternal, Neonatal And Child Health: A Training Tool Kit

6 HOME BASED MATERNAL AND NEWBORN CARE

Community Level Interventions for Improving Maternal, Neonatal and Child Health Training Tool Kit: Home Based Maternal and Newborn Care, is the sixth module of the tool kit in a series of seven on enhancing community engagement for improving outreach, shaping demand and strengthening accountability to improve maternal, neonatal and child health outcomes in Karnataka.

Publisher:
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Karnataka, India

Phone: 91-80-40400200
Fax: 91-80-40400300
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DPMO of Koppal and Bagalkot districts
Deputy Director, Women and Child Department of Koppal and Bagalkot

All the taluk coordinators, resource persons, medical officers and all the front line health workers in Koppal and Bagalkot Districts contributed to the process of developing, piloting and rolling out the Tool Kit.

THE EDITORIAL TEAM:
Mr. H.L. Mohan, KHPT
Ms. Mallika Biddappa, KHPT
Ms. Prathibha Rai, KHPT
Ms. Dorothy L. Southern, KHPT Consultant

The photographs are by **KV Balasubramanya.** They have been used in the module with consent from the community.

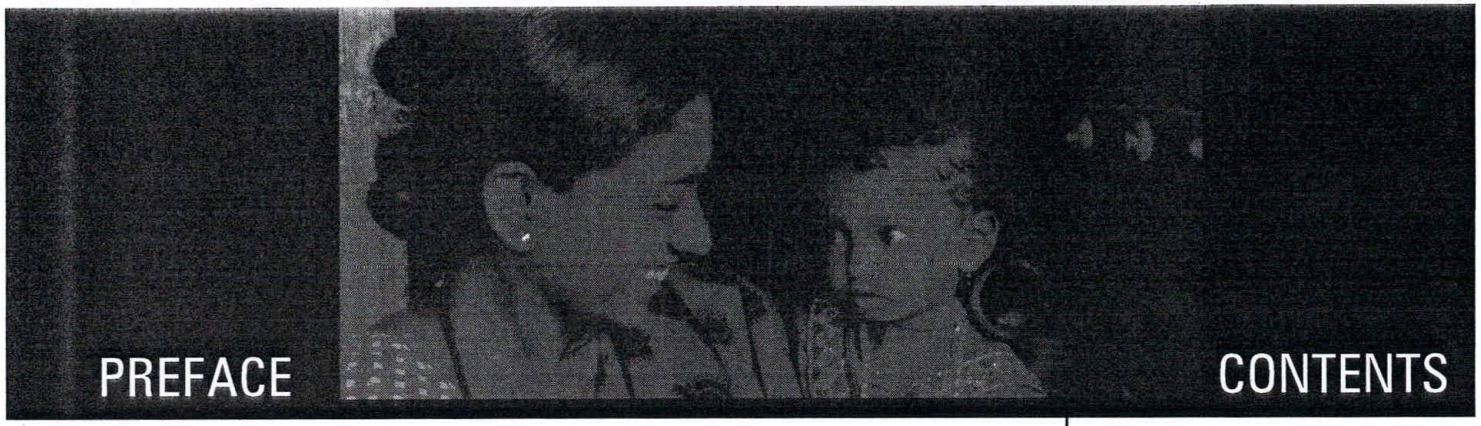
6

Community Level Interventions For Improving Maternal, Neonatal And Child Health: A Training Tool Kit

HOME BASED MATERNAL AND NEWBORN CARE

ಸುಕ್ಷೇಮ sukshema
Improved Maternal, Newborn & Child Health

NATIONAL RURAL HEALTH MISSION



PREFACE

The Community Level Interventions for Improving Maternal, Neonatal and Child Health Tool Kit is a series of seven modules:

Module 1: Design, Planning and Implementation of the Sukshema Project
Module 2: Core Concepts of Maternal, Neonatal and Child Health
Module 3: Sukshema's Community Level Interventions
Module 4: Communication and Collaborative Skills for Front Line Health Workers
Module 5: Improving the Enumeration and Tracking Process
Module 6: Home Base Maternal and Newborn Care
Module 7: Supportive Community Monitoring

Module 6: Home Based Maternal and Newborn Care is a training module for Accredited Social Health Activists (ASHAs) developed to enhance their communication skills and quality of homes visits. Once the ASHAs complete the enumeration and tracking of their area, they have the responsibility to ensure that all services reach the beneficiaries. It is the ASHAs' prerogative to reach out to the mother and child through home visits to deliver information, create awareness, identify symptoms of risk early and make timely referrals. In this context the quality of home visits conducted by the ASHAs need to result in bridging the information gap to a greater extent and bring about the expected results mentioned above. This module aims to specifically improve the capacities and the skills of the ASHA to conduct effective home visits by using the Home Based Maternal Newborn Care (HBMNC) Tool.

CONTENTS

ACRONYMS

ANC	Ante Natal Care
ARI	Acute Respiratory Infection
ARS	Arogya Raksha Samitis
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BCC	Behaviour Change Communication
BP	Blood Pressure
BPL	Below Poverty Line
CBO	Community Based Organization
CDL	Community Demand List (CDL1) Tool
CMR	Child mortality rate
DOH	Department of Health
EDD	Expected Date of Delivery
FLW	Frontline Health Worker
FP	Family Planning
FRU	First Response Unit
GoK	Government of Karnataka
HBMNC	Home Based Maternal Newborn Care
IEC	Information, Education, Communication
IFA	Iron and Folic Acid
IMR	Infant Mortality Rate
IPC	Inter Personal Communication
JHA	Junior Female Health Assistant
JSY	*Janani Suraksha Yojana*
KHPT	Karnataka Health Promotion Trust
MDG	UN Millennium Development Goals
MMR	Maternal Mortality Rate
MNCH	Maternal, Newborn and Child Health
NGO	Non-Government Organization
NRHM	National Rural Health Mission
PHC	Primary Health Centre
PNC	Post-natal Care
PRI	Panchayat Raj Institution
RP	Resource Person
SBA	Skilled Birth Attendant
SC	Sub Centre
SC/ ST	Scheduled Caste/ Scheduled Tribe
SCM	Supportive Community Monitoring
TBA	Trained / Traditional Birth Attendant
TT	Tetanus Toxoid
VHW	Village Health Worker
VHSNC	Village Health and Sanitation Nutrition Committee

GETTING STARTED

The Doorway to Successful Training **in Part 11 of Module 1** should always be used to start a training workshop: initially if covering all modules at one time, or as a refresher if modules are scheduled over a period of time. The Doorway to Successful Training contains a detailed plan of sessions that sets the stage for the workshop activities and logistics, covering welcome, introductions, objectives, hopes and fears, and ground rules.

SESSION 1: MATERNAL, INFANT AND CHILD MORTALITY

Objective

- To engage ASHAs in a discussion around the core issue of maternal, infant and child mortality and the root causes.

Methodology
Q & A and discussion

Duration
30 minutes

Training Materials

PPP, markers and brown sheets/ chart paper and copies of Information Guide for Session 1

Tips for facilitators

Encourage the participants to think critically about the issues and have them cite local examples from the field to increase their understanding.

Process

- Set the scene by sharing the current MNCH situation with respect to maternal, new born and the infant mortality in India and within the state/ region. Share data and other facts about the trends seen in MNCH.
- Ask participants the following questions:
  - What is abortion?
  - What is still birth?
  - What is maternal mortality?
  - What is maternal mortality ratio (MMR)?
  - What is infant mortality?
  - What is infant mortality rate (IMR)?
  - What is child mortality?
  - What is child mortality rate (CMR)?
- Use the pre-prepared chart 'Information Guide for Session 1' to correct definitions and provide explanation for the above questions.
- Ask participants probing questions on the causes for maternal, infant and the child mortality to understand at what stages there are higher occurrences of mortality. For example, delivery at home, during shifting the woman to the hospital, during delivery and within 42 days post-delivery.
- Use PPP/ posters to explain the medical and social causes for maternal, infant and child mortality.

- Consolidate the session:
  - Medical definitions of maternal, infant and child mortality are not sufficient.
  - Unless the root causes of mortality and the circumstances that pose high risk to women and children are understood, FLWs will not be able to effectively address the problem of MMR, IMR and CMR.

INFORMATION GUIDE FOR SESSION 1

- **Abortion:** The termination of pregnancy by the removal or expulsion from the uterus of a foetus or embryo prior to viability i.e. < 20 weeks of pregnancy
- **Still birth:** Death of the foetus more than 20 weeks of pregnancy or death during the delivery, birth of life less foetus weighing 1000 grams and measuring over 35 cms.
- **Maternal Mortality:** Death of the mother during pregnancy/ during delivery/ during abortion/ or within 42 days of delivery, because of the complication during pregnancy and its management and NOT due to accident, trauma or any other reasons
- **Maternal Mortality Ratio:** Number of death of mothers per 100000 live births in a specific area, in a year
- **Infant Mortality:** The death of child within 28 days from the birth
- **Infant Mortality Rate:** Number of child deaths per 1000 live births in a year
- **Child Mortality:** The death of child within a year of birth
- **Child Mortality Rate:** The number of death of the child within a year of birth per 1000 live births

CAUSES AND INSTANCES OF RISK OF MATERNAL, INFANT AND CHILD MORTALITY

- **Social causes:** Attitudes in the society with respect to the woman's status at home, religious, caste and creed based discrimination, the systems and customs followed at home, decision making/influencing authority regarding home based care and their information levels/beliefs, the education level of the family members. These are indirect causes that determine whether or not healthy practices are followed for the benefit of the woman and child.
- **Service delivery systemic causes:** Distance to hospital, shortage of medical staff and facilities, attitude and behaviour of medical staff, delay in service delivery.
- **Medical causes:** Causes for maternal mortality include excessive bleeding, infection, high blood pressure, repeated and unsafe abortions.

- Causes for child mortality include infection, Pneumonia, pre mature delivery, low body weight.
- Please note that there may be several other causes apart from the ones mentioned above.
- Most of the maternal and infant deaths occur during delivery and within 2 hours of delivery.

SESSION 2: STAGES OF SERVICE DELIVERY

Objective

- To help ASHAs gain clarity about specific services available at different stages of the MNCH continuum of care.

Methodology
Group work and discussion

Duration
1 hour

Training Materials

Markers and brown sheets/ chart paper and copies of Information Guide for Session2

Tips for facilitators

Encourage participants to cover all the services, even those which might seem unimportant. Services could be available at multiple facilities. In that case, list all the probable facilities/ individuals from where services can be accessed.

Process

- In the MNCH continuum of care, ask them which stages they are responsible for.
- Note their responses on a flip chart.
- Divide the participants into three groups and distribute chart paper and markers to each group.
- Assign group 1 to report on ANC services; group 2 to report on delivery services; and group 3 to report on PNC services.
- Ask them to:
  - List all the services that need to be given to the women/ new born under their group's stage
  - Identify where/ which facilities these services could be accessed.
- Allow 20 minutes to complete the exercise, then ask a representative from each group to take 5 minutes to share their responses.
- Ask other groups to contribute any other key information.
- Continue with the next 2 groups in the same manner.
- Use the pre-prepared chart 'Information Guide for Session 2' to wrap-up all the presentations.
- Consolidate the session:
  - Understanding the stages of service delivery stages and the available services at those stages will ensure the FLW is able to perform effectively and efficiently.

INFORMATION GUIDE FOR SESSION 2

ANTENATAL CARE		
LEVEL 1 Skilled Birth Attendant (SBA) Level	LEVEL 2 Institutional (Basic Level)	LEVEL 3 Institutional (Comprehensive Level)
Delivery by SBAs (Sub centre, PHCs not functioning as 24x7 and home deliveries conducted by SBA	PHC – Basic Obstetric and Neonatal care (24X7 PHCs, CHCs other than FRUs)	FRU – comprehensive Obstetric and Neonatal care (DH,SDH,RH,CEmONC, selected CHCs)
ANC session should include: • Registration (within 1st trimester) • Physical examination + weight+BP+abdominal examination • Identification of danger signs and appropriate higher care referrals • Ensuring consumption of at least 100 IFA tablets (for all pregnant women) 200 (for anaemic women). Severe anaemia needs referral • Essential lab investigations (HB%, urine for albumin/sugar, pregnancy test) • TT immunisation(two doses at interval of one month) • Counselling on nutrition, birth preparedness, safe abortion and institutional delivery) • Assured referral linkages for complicated pregnancies and deliveries	**All services mentioned under in Level 1 and the following:** • Blood grouping & Rh typing, Wet mount(saline/KOH), RPR/ VDRL • Management and provision of all emergency obstetric and new born care for complications other than these requiring blood transfusion or surgery • Linkages with nearest ICTC/ PPTCT centre for voluntary counselling and testing for HIV and PPTCT services	**All services mentioned under in Level 1 and the following:** • Blood cross matching + management of severe anaemia • Management of complications in pregnancy referred from Levels 1 and 2
INTRANATAL CARE		
LEVEL 1 SBA Level	LEVEL 2 Institutional (Basic Level)	LEVEL 3 Institutional (Comprehensive Level)
Delivery by SBAs (Sub centre, PHCs not functioning as 24x7 and home deliveries conducted by SBA	PHC – Basic Obstetric and Neonatal care (24X7 PHCs, CHCs other than FRUs)	FRU – comprehensive Obstetric and Neonatal care (DH, SDH, RH, CEmONC, selected CHCs)
• Normal delivery with the use of partograph • Active management of third stage of labour • Infection prevention • Identification of danger signs and appropriate higher care referrals • Pre – referral management for obstetric emergencies, e.g. eclampsia, PPH, shock • Assured referral linkages with higher facilities • Essential new born care will include: • Neonatal resuscitation • Warmth • Infection prevention • Initiation of breast feeding within an hour of birth and exclusive breast feeding there after • Screening for congenital anomalies • Weighing of newborns	**All in Level 1 and Availability of following services round the clock** • Episiotomy and suturing cervical tear • Assisted vaginal deliveries like outlet forceps, vacuum • Stabilisation of patients with obstetric emergencies, e.g. eclampsia, PPH, sepsis, shock • Referral linkages with higher facilities • Essential new born care as in level 1 + • Antenatal Corticosteroids to the mother in case of pre-term babies to prevent Respiratory Distress Syndrome (RDS) • Immediate care of LBW newborns (>1800gm)	**All in Level 2 and** • Availability of following services round the clock • Management of obstructed labour • Surgical intervention like Caesarean section • Comprehensive management of all obstetric emergencies, e.g. PIH/Eclampsia, Sepsis, PPH retained placenta, shock etc. • In-house blood bank/blood storage centre • Referral linkages with higher facilities including medical colleges • Essential new born care as in level 2 + • Care of LBW newborns <1800gm
POSTNATAL AND NEWBORN CARE		
LEVEL 1 SBA Level	LEVEL 2 Institutional (Basic Level)	LEVEL 3 Institutional (Comprehensive Level)
Delivery by SBAs (Sub centre, PHCs not functioning as 24x7 and home deliveries conducted by SBA	PHC – Basic Obstetric and Neonatal care (24X7 PHCs, CHCs other than FRUs)	FRU – comprehensive Obstetric and Neonatal care (DH,SDH,RH,CEmONC, selected CHCs)
• Minimum 6 hours of stay post delivery • Counselling for feeding, nutrition, family planning, hygiene, immunisation and PN check-up • Home visits on 3rd, 7th and 42nd day, both for mother and baby are needed. Additional visits are needed for the new born on day 14, 21 and 28. further visits may be necessary for LBW and sick newborns • Timely identification of danger signs and complications and referral of mother and baby **New born care** • Warmth • Hygiene and cord care • Identification, management and referral of sick neonates, low birth weight(LBW) and pre-term newborns • Referral linkages for management of complications • Care of LBW newborns <2500gm • Zero day immunisation OPV,BCG, Hepatitis B	**All mentioned in Level 1 and the following:** • 48 hours of stay post delivery and all the postnatal services for zero and third day to mother and baby • Timely referral for woman with postnatal complications • Stabilisation of mother with postnatal emergencies,e g.PPH,sepsis, shock, retained placenta • Referral linkages with higher facilities **New born care as in Level 1 and the following:** • Stabilisation of complications and referral • Care of LBW newborns >1800gm • Referral services for newborns <1800 gm and other newborn complications • Management of Sepsis	**All mentioned in Level 2 and the following:** • Clinical management of all maternal emergencies such as PPH, Puerperal Sepsis, Eclampsia, Breast Abscess, post surgical complication, shock and any other postnatal complications such as RH incompatibility etc.colleges **New born care as in Level 2 and the following:** • In district hospitals through Sick Newborn Care Unit (SNCU) • Management of complications • Care of LBW newborns <1800 gm • Establish referral linkages with higher facilities

SESSION 3: FRONTLINE HEALTH WORKERS: PROVIDING MNCH CONTINUUM OF CARE SERVICES

Process

- Divide the participants into three groups and distribute chart paper and markers to each group.
- Ask the participants who are some of the most important FLWs related to the MNCH continuum of care?
- Note their responses on a flip chart.
- Assign group 1 to report on ASHAs; group 2 to report on JHAs; and group 3 to report on AWWs.
- Ask them to:
  - Discuss the respective roles and responsibilities in providing MNCH continuum of care services.
- Allow 20 minutes to complete the exercise, then ask a representative from each group to take 5 minutes to share their responses.
- Ask other groups to contribute any other key information.
- Continue with the next 2 groups in the same manner.
- Use the pre-prepared chart 'Information Guide for Session 3' to wrap-up all the presentations.

- Consolidate the session:
  - Clarity of roles is essential to avoid confusion or overlapping of service delivery on the ground.
  - Clearly understanding the roles and responsibility of other FLWs is crucial for mutual support in the field.
  - There may be common responsibilities among the three. Let them know that some commonalities/overlaps are fine as long as there is shared work and cooperation to deliver services.

Objective

- To clarify the roles and responsibilities of frontline health workers (FLWs) such as Accredited Social Health Activist (ASHA), Junior Female Health Assistant (JHA), and Anganwadi Worker (AWW) in providing MNCH continuum of care services.
- To help participants know the importance of other FLW roles and responsibilities in improving MNCH services.

Methodology

Group discussion

Duration

1 hour

Training Materials

Markers and brown sheets/ chart paper and copies of Information Guide for Session 3

Tips for facilitators

Although the HBMNC Tool has been designed for use by the ASHA, as part of Sushema's current training strategy all three FLWs are involved in the training. Understanding all of their responsibilities is important to ensure mutual support and role clarity.

INFORMATION GUIDE FOR SESSION 3

The roles and responsibilities of the three frontline health workers in HBMNC are as follows:

- **Accredited Social Health Activist (ASHA):**
  1. Conduct home visits and enlist expected pregnancies and children up to the age of 5.
  2. Meet a pregnant woman at least 3 times and conduct necessary health education or counselling sessions.
  3. Offer support to conduct the pregnant women's meeting.
  4. Take the pregnant woman to the hospital for delivery and those with possible risks to higher centres well ahead of the due date.
  5. Conduct post-delivery follow up home visits and impart needed health messages.
  6. Identify the danger signs among the pregnant, nursing mother and newborns, providing first aid and referring to higher care
  7. Provide care for the newborn-immunisation within 2 years.

- **Junior Female Health Assistant (JHA):**
  1. Enrolment of the pregnant women
  2. Administration of TT injection and measuring BP of the pregnant woman, checking the weight of the child after delivery and administration of FS tablets after 5 months of delivery.
  3. Filling of "Thayi" card during the registration of the woman.
  4. Imparting education on nutritious food, hygiene and institutional delivery to the woman
  5. Provide Information to the pregnant woman on scanning and its benefits
  6. For the 1st and 2nd delivery, provide information about the government schemes available like JSY, Prasoothi Araike and Madilu Kit.
  7. Explain the immunisation process to new mothers
  8. Refer pregnant women with complications to higher care centres.
  9. Educate the family about home based care needed for the new born baby especially with low birth weight.
  10. Provide information to nursing mothers about precautions to be taken to avoid infection.
  11. Collection of blood samples for testing if the pregnant woman or the nursing mother runs fever
  12. Inform the women about the side effects of immunisation, importance of breast feeding, maternal and newborn care at home, permanent and temporary family planning options
  13. Conduct deliveries in case of emergencies in the sub centres
  14. Referral services for higher care
  15. Immunisation
  16. Conduct home visits with the ASHA and examining the formats filled by the ASHA
  17. Provide guidance and information to the ASHA on HBMNC
  18. Train the ASHA at the PHC level

- **Anganwadi worker: (AWW)**
  1. Conduct the mother's meeting and provide health education
  2. Conduct home visit to pregnant, nursing mothers & children between the age group of 6 months to 3 years. The purpose of this visit is to counsel women and families on the issues of nutrition.
  3. Keep track of the children's weight and send the graded children to higher centres
  4. Identify Grade children (malnutrition cases) and enrol for Bhagyalakshmi scheme (only for the BPL card holders)
  5. Identify healthy children and conduct baby shows
  6. Conduct the Balavikasa Samithi meetings
  7. Encourage and motivate people to seek institutional delivery and adopt family planning methods
  8. Identify the children with sickness and refer for higher treatment under the "Bala Sanjeevini" program
  9. conduct Nutrition camps and distribute nutritious food for the children between the age groups of 6 months to 3 years and pregnant women and nursing mothers
  10. Mobilize pregnant women for immunisation camps
  11. Register the child post delivery

SESSION 4: THE HBMNC TOOL: PROVIDING QUALITY MNCH CONTINUUM OF CARE SERVICES

Process

- Divide participants into four groups to prepare role plays.
  - *Group 1 to enact the 1st home visit with pregnant woman*
  - *Group 2 to enact the 2nd home visit with high risk pregnant woman*
  - *Group 3 to enact the 3rd home visit with healthy baby born at PHC*
  - *Group 4 to enact the 4th home visit with sick baby born at home*

- Ask them to first discuss key aspects of their home visits and to emphasise key messages that need to be given during the home visit.
- Allow 15 minutes to prepare their role play.
- After each group has performed their role play, ask participants to recall different messages that were given. Ask spectators if there were components that the ASHA missed out during the home visit, for example, identifying danger signs, or counselling, etc.
- After all groups have performed, ask how home based care can be given without missing any components and providing all messages.
- Note their responses on a flip chart.
- Tell them that the HBMNC Tool attempts to help the ASHA make her home visits very specific and guide her through important indicators to look for during the home visits.
- Distribute copies of the HBMNC Tool to all the participants (Annexure 1). Tell them to keep their copy of the HBMNC Tool available for use during all the sessions of Module 6.
- Briefly go over the key sections of the HBMNC Tool and some of the important indicators.
- Tell participants that in future sessions they will learn more details of the HBMNC Tool.

- Consolidate the session:
  - Home visits lack direction and critical messages are often forgotten if the ASHAs lacks a job aid or tool to help them remember everything that need to do or say during a home visit.
  - A job aid or tool can make home visits more effective.

Objective

- To enable ASHAs to see the gaps in home visits in the field
- To help ASHAs see the relevance of the HBMNC Tool in providing quality HBMNC

Methodology

Role play and discussion

Duration

1 hour

Training Materials

Markers and brown sheets/ chart paper, and copies of the HBMNC Tool (Annexure 1)

Tips for facilitators

The role plays will help the participants to explore all the necessary components that must be included in a home visit and ways to improve the content and communication skills will be explored together.

SESSION 5: USING THE HBMNC TOOL – SECTION 1 IDENTIFICATION

Objective

- To help participants understand the importance of timely identification of pregnant women and nursing mothers.
- To introduce participants to Section 1 of the HBMNC Tool.

Methodology

Group discussion

Duration

1 hour

Training Materials

Markers and brown sheets/ chart paper, and copies of the HBMNC Tool (Annexure 1)

Tips for facilitators

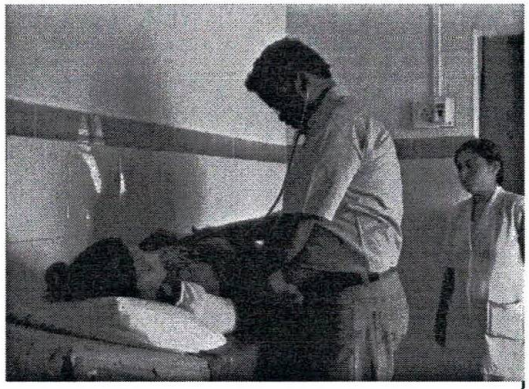
Before this session, thoroughly review Annexure 1. The participants will have the opportunity to have guided hands-on experience to fill in Section 1 of the HBMNC Tool so be prepared for detailed questions about where to get the information and where to put the information.

Process

- Ask participants how to identify eligible pregnant women and nursing mothers.
- Note their responses on a flip chart.
- Ask them what is the basic information that they need to provide comprehensive ANC services?
- Note their responses on a flip chart.
- Now tell them to look at Section 1 of the HBMNC Tool.
- Read through each of the components in Section 1 aloud and explain how and why this section is important. Clarify any doubts that the participants may have.
- Tell each participant to use an example of the most recent home visit they conducted. They can refer to their registers to obtain the woman's details if they cannot recollect it on their own.
- Allow 10 minutes to fill in Section 1 of the HBMNC Tool using that information.
- Verify if all the entries are correctly filled in by individually looking at formats randomly among the group.
- Select one filled format randomly from the group and discuss if it has been filled in correctly by going over each of the indicators in plenary.
- Ask if there are any questions about how to fill in Section 1.

- Consolidate the session:
  - The eliciting and recording of basic information of the woman during a home visits is crucial.

SESSION 6: PROVIDING ANC SERVICES



Process

- Divide the participants into four groups and distribute chart paper and markers to each group.
- Ask them to answer these questions:
  - What are components of care that needs to be provided to pregnant woman?
  - What are the symptoms of a complicated pregnancy?
  - What is the impact on the woman and child if these symptoms are not identified in time?
  - What are the danger signs that are observed during pregnancy?
- What is the role of the ASHA in providing ANC services?
- Allow 20 minutes for discussion, and then ask a representative from each group to take 5 minutes to share their responses.
- Ask other groups to share any other key information.
- Continue with the next 3 groups in the same manner.
- Use PPP and the pre-prepared chart 'Information Guide for Session 6' to wrap-up all the presentations and provide a complete picture of ANC services to the participants.

- Consolidate the session:
  - Continuous ANC services provided by the ASHA from pregnancy to delivery is crucial.

Objective

- To help participants identify ANC services that can be accessed during pregnancy to delivery.
- To understand the importance of identifying pregnant women with danger signs and possible complications and referring them to the next level of care.

Methodology

PPP and group discussion

Duration

1 hour

Training Materials

Markers and brown sheets/ chart paper and copies of Information Guide for Session 6

Tips for facilitators

Medical terminology may not be always understood by the participants so clarify the difference between terms such as complicated pregnancy and danger signs during pregnancy. Use suitable examples and local alternative words.

INFORMATION GUIDE FOR SESSION 6

Maternal mortality occurs during pregnancy, delivery and post-delivery due to excessive bleeding, infection/ sepsis, obstructed delivery, BP, unsafe abortions and also due to anaemia, heart ailments, malaria and hepatitis. The infant mortality mainly occurs due to Pneumonia/ infection, breathing difficulty, and pre mature delivery.

But by providing correct health education/counselling on the necessary care to be availed during the MNCH continuum of car, paying special attention to any danger signs and taking needed actions, most of the problems above can be prevented.

Necessary care to be given to pregnant women in the ANC period covers the following:

- ANC registration (Thayi card)
- Information on ANC testing facility at PHC or higher centre
- Providing TT immunisation
- Pre delivery / birth preparation
- Testing of blood and urine
- Weight, abdominal testing , foetal heart beat examination
- Information on nutrition
- Supplements of iron and folic acid tablets
- Promotion of breast feeding and importance of feeding colostrums immediately after birth
- Information on personal hygiene
- HIV testing and counselling on family planning
- Information on VHND and mothers meeting
- Information on birth gap
- Information on facilities provided by the government

Information on a complicated pregnancy and impact of unidentified symptoms:

- Anaemic – HB lower than 7gm
- First pregnancy within 18 years of age and after 30 years of age
- First time pregnancy and the dwarf (lesser than 140cms)- Short primi gravida (First pregnancy and height <4'10"
- Displacement of baby in the womb
- Bleeding during pregnancy
- Undergone more than 3 deliveries
- Swelling in the face/hands, seizures, High blood pressure during/because of pregnancy
- Pre-Eclampsia/Eclampsia
- RH incompatibility
- Previous surgery use of IUD/prolonged delivery/still birth/ death of foetus in womb/ artificial removal of placenta/PPH

All the above components are very crucial and even a slight negligence can lead to death of the mother or child. In such cases, immediate further investigation in higher centres is needed.

Information on the danger signs in pregnancy:

- Fever
- Head ache and blurred vision
- Excessive vomiting
- Fits / seizures / Epilepsy
- Difficulty in urination or less urine output
- Pain in the stomach
- Pre mature (within 37 weeks) labour pain
- Watery vaginal discharge / rupture of membrane
- Vaginal bleeding
- Vaginal discharge with foul smell
- Weak or no foetal movements
- Breathing difficulty even while resting or while conducting smaller day to day activities
- Severe weakness/ tiredness
- Palpitations

These symptoms may be visible at any stage in pregnancy. Even if at least one of these symptoms is observed one must consider it seriously and refer to the nearest health care centre. Educate the pregnant woman and the family members on how to identify these signs and ask them to be prepared to visit the nearest hospital if any of these signs are observed.

Pre delivery/ birth preparedness (plan) :

The pregnant woman and the family members must make a plan and be prepared for a safe and comfortable delivery as well as for post-delivery care. ASHAs should counsel the pregnant woman and the family members during the ANC follow up visits to:

- Choose a centre and a doctor who is able to provide quality service and care to the pregnant woman.
- Ensure that the pregnant woman is registered in the first trimester
- Have information on the EDD date
- Complete a minimum of 3 check-ups at the health centre
- Ensure that sufficient finances are arranged for the delivery time
- Choose the appropriate mode of travel to the hospital (Not to use bicycle, bullock cart) well ahead of the EDD date and ensure that prior discussions are done with the concerned so that vehicle reaches the house well on time
- Prepare and keep the necessary clothes clean and ready to be used for the nursing mother and baby
- Knowledge of danger signs during pregnancy and referral opportunities to higher care centres

SESSION 7: USING THE HBMNC TOOL – SECTION 2 ANC

Objective

- To introduce participants to Section 2 of the HBMNC Tool.

Methodology

Group discussion and presentation

Duration

1 hour

Training Materials

Markers and brown sheets/ chart paper, and copies of the HBMNC Tool (Annexure 1) and HBMNC Tool filling guidelines (Annexure 2)

Tips for facilitators

Encourage the participants to clarify any misinformation or doubts at this stage of the training.

Process

- Ask participants what hinders them from making their home visits more effective.
- Note their responses on a flip chart.
- Tell them that the HBMNC Tool supports their efforts to overcome home visit challenges.
- Now tell them to look at Section 2 of the HBMNC Tool.
- Read through each of the components in Section 2 aloud and explain how and why this section is important. Clarify any doubts that the participants may have.
- Tell each participant to use an example of the most recent home visit they conducted. They can refer to their registers to obtain the woman's details if they cannot recollect it on their own.
- Allow 10 minutes to fill in Section 2 of the HBMNC Tool using that information.
- Verify if all the entries are correctly filled in by individually looking at formats randomly among the group.
- Select one filled format randomly from the group and discuss if it has been filled in correctly by going over each of the indicators in plenary.
- Ask if there are any questions about how to fill in Section 2.
- Consolidate the session:
  - Understanding how to correctly fill the information in Section 2 of the HBMNC Tool is crucial.

SESSION 8: PROVIDING INTRA-NATAL (DELIVERY) CARE SERVICES

INFORMATION GUIDE FOR SESSION 8

Why is delivery care important?
The risk of mortality is the highest during and after delivery for both mother and child.

How many stages are there in delivery and what are they?
There are 4 stages of delivery. They are:
1st stage: From the starting of labour pain till the complete opening of the mouth of the womb (10cm dilation)
2nd stage: From the opening of the mouth of the womb till the baby comes out
3rd stage: From the time of baby has come out of the womb till the placenta is discharged.
4th stage: First two hours after the delivery

What are the danger signs during the delivery?
- Prolonged and obstructed delivery (More than the regular time required for a normal delivery, taking more than 12 hours)
- Inconsistent/ very fast/ very slow heartbeat of the foetus (stressed foetus/foetal distress)
- Inability of the child to push the head and shoulders way out (obstructed labour)
- Bleeding during pregnancy/ rupture of membrane in premature delivery/ or non-ruptured membrane
- Infection/sepsis
- Umbilical cord comes out first (Cord Prolapse)
- Yellowish or foul smelled, excreta mixed womb water oozing out (Meconium stained liquor)
- Partial or non-discharge of placenta (incomplete/ retained placenta)
- Fever, Fits, Excessive bleeding

Key things to observe during delivery care:
- It is very important to have the baby delivered by a skilled doctors and assistants.

The '5 Cleans':
1. Clean space /place: The delivery room should have sufficient ventilation and light. This helps in infection prevention and keeps the child warm and clean
2. Clean hands: Helps in infection prevention
3. Clean/sterile blade: Prevents sepsis
4. Clean/sterile thread: Prevents infection and pus formation
5. Clean cord - Do not apply anything on the umbilical cord to prevent infection/septic/pus and bleeding

Objective

- To help participants understand the care needed during delivery and the complications that may arise.

Methodology

PPP and discussion

Duration

1 hour

Training Materials

Markers and brown sheets/ chart paper, and copies of Information Guide for Session 8

Tips for facilitators

This is a crucial session as correct information given by FLWs regarding delivery care, and problems that may arise during and after delivery, could motivate the pregnant woman and family members to seek institutional delivery.

Process

- Divide participants into three groups and ask them to answer each of these questions:
  - What are the stages in delivery?
  - What are the danger signs during the delivery?
  - What is the 5 things that must be clean before, during and after delivery? Why is this important?
- Allow 15 minutes to discuss, and then ask a representative from each group to take 5 minutes to share their responses.
- Ask other groups to share any other key information.
- Continue with the next 2 groups in the same manner.
- Use PPP and the pre-prepared chart 'Information Guide for Session 8' to wrap-up all the presentations and provide a complete picture of delivery care to the participants. Use pictures of danger signs to confirm the awareness levels of the participants. (Refer to Module 2)

- Consolidate the session:
  - Delivery care takes prominence as the risk of mortality for both mother and child are the highest during and after delivery.
  - It is very important to have the baby delivered by a skilled doctors and assistants.
  - As soon as a woman knows she is pregnant she should start preparing for delivery.

SESSION 9: USING THE HBMNC TOOL – SECTION 3 DELIVERY

Objective

- To introduce participants to Section 3 of the HBMNC Tool.

Methodology
Discussion and presentation

Duration
1 hour

Training Materials

Markers and brown sheets/ chart paper, and copies of the HBMNC Tool (Annexure 1) and HBMNC Tool filling guidelines (Annexure 2)

Tips for facilitators

Encourage the participants to clarify any misinformation or doubts at this stage of the training.

Process

- Ask the participants to look at Section 3 of the HBMNC Tool.
- Read through each of the components in Section 3 aloud and explain how and why this section is important. Clarify any doubts that the participants may have.
- Tell each participant to use an example of the most recent home visit they conducted. They can refer to their registers to obtain the woman's details if they cannot recollect it on their own.
- Allow 10 minutes to fill in Section 3 of the HBMNC Tool using that information.
- Verify if all the entries are correctly filled in by individually looking at formats randomly among the group.
- Select one filled format randomly from the group and discuss if it has been filled in correctly by going over each of the indicators in plenary.
- Ask if there are any questions about how to fill in Section 3.
- Consolidate the session:
  - Understanding how to correctly fill the information in Section 3 of the HBMNC Tool is crucial.

SESSION 10: PROVIDING PNC SERVICES

Objective

- To help participants identify postnatal and newborn care services and the danger signs possible during this stage

Methodology
PPP/posters and group discussion

Duration
1 hour

Training Materials

Markers and brown sheets/ chart paper and copies of Information Guide for Session 10

Tips for facilitators

This is a crucial session as it deals with the vital components of maternal and new born care. ASHAs need to be very clear the information and the message they give at this stage to ensure the home visits are effective.

Process

- Divide participants into three groups and ask them to answer each of these questions:
  - What are danger signs and symptoms in a nursing mother?
  - What are detailed steps to take to address these signs and symptoms?
  - What are danger signs and symptoms in the newborn?
  - What are detailed steps to take to address these signs and symptoms?
  - How many times should an ASHA conduct a home visit to a nursing mother and newborn?
  - What are the key things she should observe during these visits?
- Allow 20 minutes to discuss, and then ask a representative from each group to take 5 minutes to share their responses.
- Ask other groups to share any other key information.
- Continue with the next 2 groups in the same manner.
- Use PPP/posters and the pre-prepared chart 'Information Guide for Session 10' to wrap-up all the presentations and provide a complete picture of PNC care to the participants. Use pictures of danger signs to confirm the awareness levels of the participants. (Refer to Module 2)
- Consolidate the session:
  - The first 42 days after delivery is a very crucial stage for both mother and child.
  - There is an increased risk for both mother and newborn in the first week that may lead to death.
  - Many mothers and newborn among the rural poor in the eight priority districts in northern Karnataka do not have access to PNC services.

INFORMATION GUIDE FOR SESSION 10

What do we mean by nursing mother and newborn baby care? What is its importance?
Once the placenta is discharged from the body during delivery the next 6 weeks is termed the post natal care or PNC stage. Since there is an increased risk of mortality of mother and infant during this stage it is important that they receive PNC services.

What are the necessary services that should be provided during the PNC? When and at what frequency should the ASHAs make home visits?
From the time of delivery till the 6th week, i.e. on the 3rd , 7th ,14th,21st,28th and 42nd day after the delivery ASHAs should make home visits. The purpose is to observe any danger signs, counsel the woman and family, and if necessary make referrals to higher care.

Danger signs in the nursing mother:
- Excessive bleeding and tenderness in the womb
- Painful and with foul smell lochia discharge
- Sepsis and infection of the nursing mother
- Fever/shivering with or without the swelling of face and limbs, severe head ache and blurred vision
- Difficulty in breathing or heavy breathing
- Breast abscess and infection
- Swelling and infection in the space between vagina and anus
- Sense of burning during urination

Danger signs in the newborn:
- Poor appetite for breast milk or unable to properly breastfeed
- Limited activity of the child
- Child suffering from fever or cold skin
- Difficulty in breathing or chest in-drawing/ grunting
- Child doesn't cry or makes a feeble cry
- Swelling in the stomach
- Limbs hanging or weak
- Bubbles filled with pus all over the body
- Child's armpits and skin folding in the thighs turning red
- Eyes swollen and filled with pus
- Belly button turns reddish and pus formed
- Seizures and fits
- Blood contaminated excreta
- Limbs turned yellowish

These signs and symptoms may quickly manifest in the nursing mother or the newborn. Even if there is only one sign visible this should be considered serious and the mother or newborn taken to a health facility.

PNC services include:
- Registering the child
- Providing home visits for regular care for the nursing mother and the newborn
- Counselling the nursing mother on nutrition (suggest intake of food with higher calorie and iron content)
- Identifying danger signs in both mother and newborn and immediate referral for higher care
- Promoting exclusive breast feeding in the first 6 months
- Immunising newborn
- Providing family planning information and services

SESSION 11: USING THE HBMNC TOOL – SECTION 4 PNC

Objective

- To introduce participants to Section 4 of the HBMNC Tool.

Methodology
Group Discussion and presentation

Duration
1 hour

Training Materials

Markers and brown sheets/ chart paper, and copies of the HBMNC Tool (Annexure 1) and HBMNC Tool filling guidelines (Annexure 2)

Tips for facilitators

Encourage the participants to clarify any misinformation or doubts at this stage of the training, especially related to the terminology used in Section 4 of the HBMNC Tool.

Process

- Ask the participants to look at Section 4 of the HBMNC Tool.
- Read through each of the components in Section 4 aloud and explain how and why this section is important. Clarify any doubts that the participants may have.
- Tell each participant to use an example of the most recent home visit they conducted. They can refer to their registers to obtain the woman's details if they cannot recollect it on their own.
- Allow 10 minutes to fill in Section 4 of the HBMNC Tool using that information.
- Verify if all the entries are correctly filled in by individually looking at formats randomly among the group.
- Select one filled format randomly from the group and discuss if it has been filled in correctly by going over each of the indicators in plenary.
- Ask if there are any questions about how to fill in Section 4.
- Consolidate the session:
  - Section 4 was designed to facilitate early detection of danger signs and symptoms among the nursing mother and newborn by the ASHAs in the designated area.
  - Early detection enables speedy and effective referral linkages to higher care.
  - Understanding how to correctly fill the information in Section 4 of the HBMNC Tool is crucial.

SESSION 12: PNC HOME VISITS: HEALTH EDUCATION AND COUNSELLING

Objective

- To help the ASHA understand where, when and how counselling should be done during PNC home visits.

Methodology
Role plays, question and answer session and discussion

Duration
1 hour

Training Materials

Markers and brown sheets/ chart paper, copies of case studies and copies of Information Guide for Session 12

Tips for facilitators

Encourage ASHAs not to be discouraged if they have had unsuccessful attempts trying to change behaviour among families of pregnant or newly delivered mothers. Tell them to share their experiences, but to listen to suggestions from other participants on how to successfully counsel that family. Create opportunities through the session for cross sharing and learning among the participants.

Process

- Give one of the role plays to each of the two groups.

Role Play Scenario 1:
Radha is 25 yrs old and is pregnant for the 2nd time. She is in the 8th month of pregnancy. Her first child is 2 years old and was delivered at home. She with her husband had gone to Bangalore for work and returned to the ASHA's area just one week ago. During her first ANC check-up she was diagnosed with severe anaemia. Today is your second home visit to Radha's house. Perform a role play of your home visit.

Role Play Scenario 2:
Pavithra is 28 years old. She delivered a baby girl 3 days ago in a PHC. Delivery was normal and the baby weighed 2.5 kg. She stayed in the PHC for 48 hours after which she got discharged and went back home. Today the ASHA is planning to do the first PNC visit to Pavithra's place. Perform a role play of your home visit.

- Allow 15 minutes for the group members to read it, discuss and prepare the play.
- Ask each group to perform their role play.
- Ask the participants to think about the role play that they watched and share what they felt about the way the ASHA conducted the home visit.
- Ask the participants if they saw any gaps in the interaction between the ASHA and the new mother or her family.
- Note their responses on a flip chart.
- Ask the participants if the ASHA could have done anything else to make the counselling more effective and focused?
- Note their responses on a flip chart.
- Ask the participants what skills does the ASHA need to identify problems and offer solutions or corrective measures through counselling?
- Note their responses on a flip chart.
- Use the pre-prepared chart 'Information Guide for Session 12' to review tips for successful PNC counselling during home visits.
- Consolidate the session:
  - Delivery and child birth related beliefs and customs and lack of access to correct information stop nursing mothers and their families from adopting good health practices.
  - Challenging these beliefs becomes a key focus of most of the counselling sessions that the ASHA has during her PNC home visits.
  - Education and awareness among families and mothers through the ASHA is the only way to put an end to such practices.

INFORMATION GUIDE FOR SESSION 12

1. Rapport / relationship building
This is the foundation for a good relationship between the ASHA and the pregnant woman. Always try to make the pregnant women comfortable by greeting her with appreciating words, motivational gestures such as a smile on your face, patting on the hand, etc. Any home visit has to begin with exchanging greetings between the ASHA, woman and any other family members present.

2. Assessing the knowledge of the pregnant women family members
In every home visit (1st visit or follow up visits, it is important to assess what the woman knows. For example, what does she knows about having nutritious food during pregnancy? What did she understand from the ASHA's last visit. For example, did she follow any of the advice given? Based on this understanding, the ASHA can plan to provide additional messages.

3. Screen for danger signs
It is important to quickly screen the woman or newborn during every home visit for any of the danger signs. Always observe, examine and inquire if everything is OK. "See", "Touch" & 'Ask" are the three key words in home visits to identify any danger signs or complications.

4. Dialogue/ asking open ended questions
By initiating dialogue you can elicit or gather the information using open ended questions Open ended means not just a simple 'yes' or 'no' question, but asks 'who', 'where', 'when', 'why', 'what' or 'how'. By asking open ended questions you will able to gather information in more than one or more sentences.

5. Using right IEC materials
To make your communication more effective it is important to use appropriate IEC materials in every home visit and as needed. Try to use pictures.

posters, pamphlets to make people curious and to start a dialogue. See Session 13 in Module 6.

6. Counselling

Provide correct information, breaking down difficult tasks or ideas, into smaller steps that can be easily understood or followed.

7. Focusing on the family

Each family has a different structure. By developing a rapport with the woman and with other family members you will be able to identify who is the decision maker in the family, or possibly find there are several people that have the power to make judgments about social of financial issues. These decisions or judgments could influence the woman's health seeking behavior. Through your dialogue with the woman and her family members identify the decision makers. Then focus your messages on these family members. For example, if a woman's grandmother is the reason for taking decision to have a home delivery, have dialogues with the grandmother to convince her about the benefits of an institutional delivery. Home visits can be more effective if you join up with an AWW, JHA or a VHSNC member.

8. Communication skills

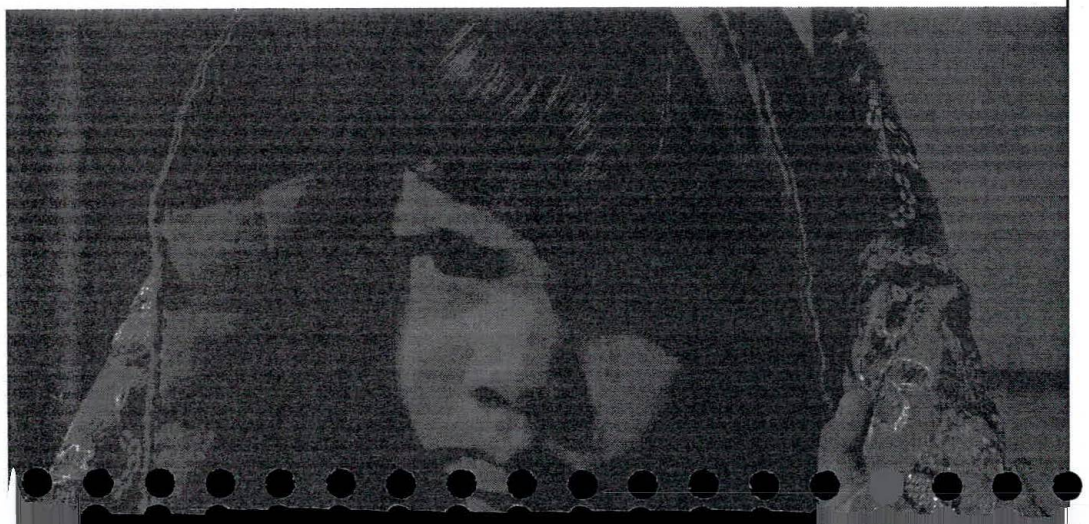
Probing, listening, paraphrasing/summarizing are all important skills to use while communicating with the woman and her family members. Paraphrasing means that after you gather information you then re-state the words said by the person. For example, you might say, 'I think you said that you are afraid of having a home delivery because if something went wrong there is no transportation available to take you to a health facility. Is this correct?' This will help her to understand that you were listening and want to continue the conversation. You can also ask the woman to reinstate the messages given by you in her own words. This will help you to assess that she has understood.

9. Follow up

Always give a follow-up date and time for your next home visit. If the woman has to make a follow-up visit to a health facility, always make sure that the date and time is convenient for her and that there is no misunderstanding about the purpose. Ask her to repeat what she understood by the details of the follow-up appointment and to recollect any action she needs to take. This is critical and will help you to see any trend in behaviours over time so you can plan your home visits accordingly.

10. Filling the results of the home visit in the HBMNC checklist

Once you completed the home visit, record the results in the checklist while you are still at the house. This should help you to remember any messages if you have forgotten during the interaction. If you wait too long to fill in the HBMNC form, you might forget some critical information.



SESSION 13: INTRODUCING IEC MATERIALS

Objective

- To help the participants understand the importance of IEC materials for effective communication during home visits

Methodology

Demonstration of reminder cards

Duration

30 minutes

Training Materials

ASHA reminder cards (Annexure 3)

Tips for facilitators

Demonstrate the use of these cards by giving examples. The cards should assist the ASHA to be a more effective communicator, and not hinder her communication during home visits.

Process

- Ask the participants how they could make their communication more effective during home visits.
- Note their responses on a flip chart.
- Highlight any responses related to using appropriate IEC materials to be more effective.
- Ask them for some examples of IEC materials.
- Give one set of reminder cards each to the participants (Annexure 3).
- Tell the participants:
  - These illustrated reminder cards were developed based on the messages given in the HBMNC checklist.
  - The HBMNC checklist will help an ASHA to identify the issues, and the reminder cards will help an ASHA to communicate the correct message.
  - ASHA should always carry the reminder cards with her, which is easy as they are the size of visiting cards.
  - Illustrations were developed based on 8 themes and linked with the messages provided in the HBMNC checklist, including birth planning & preparedness, danger signs in pregnancy, anaemia, danger signs during delivery, danger signs in newly delivered mother, danger signs in newborn, newborn care and family planning.
  - Cards are colour-coded based on the 8 themes. An ASHA can easily find the correct cards depending on what she wants to communicate. For example, if she identifies the need for counselling women on family planning, she will use the green coloured cards.
  - The cards can be used like a flip chart if there is a small group of people she is counselling.
- Demonstrate how to handle the cards. Ask the participants to hold the card so the information is available and to flip the card over without dropping it.
- Ask if there are any questions about using the cards.
- Consolidate the session:
  - Reminder cards can make home visits more effective and interesting.

SESSION 14: PRACTICAL USE OF THE HBMNC TOOL

Objective

- To provide hands-on experience in filling in the HBMNC Tool

Methodology

Field work and home visits and group work and discussion

Duration

2 hours

Training Materials

Markers and brown sheets/ chart paper, and copies of the HBMNC Tool (Annexure 1) and HBMNC Tool filling guidelines (Annexure 2)

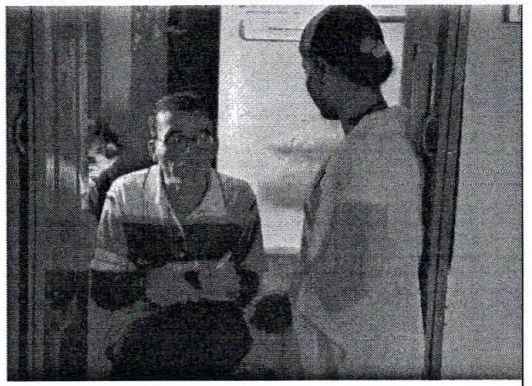
Tips for facilitators

Make plans for the field work and home visits in advance and ensure that there is no confusion during the home visit or any kind of inconvenience to the mother, baby or other family members. Encourage every participant to fill in the Tool during the visit.

Process

- Plan a short field visit in the nearby village/ SC or PHC area.
- Identify three houses that either have a pregnant woman, a recently delivered mother and newborn, or a PNC case available.
- Make prior arrangements so the visit is planned at a suitable time with the family's approval and cooperation. Confirm the arrangements close to the date and time.
- Divide the participants into 3 groups and distribute one copy of the HBMNC Tool and one copy of the guidelines to each person.
- Arrange for one project staff to accompany each of the three groups to each of the three houses.
- On reaching the house, the ASHA will introduce the purpose of this exercise to the woman and her family.
- Then the ASHA will conduct the home visits as per the guidelines.
- The participants in the group will fill the HBMNC format while listening to the conversation between the woman and the ASHA.
- At the end of the home visit each group will return t the training site.
- On returning, ask them about their experience in the field.
  - Was the home visit a positive experience? If yes, why? If no, why not?
  - Did the HBMNC Tool assist them during the home visit?
  - Were there any sections that they could not fill in?
- Let everyone have a chance to share.
- Select one filled format randomly from the group and discuss if it has been filled correctly by going over each of the indicators in plenary.
- Collect all the filled formats and verify some of them. Make the needed corrections.
- Consolidate the session:
  - Participants will gain hands-on experience in using/ filling the HBMNC Tool during their home visit.

SESSION 15: TRAINING EVALUATION AND FEEDBACK



Objective

- To assess what affect the module had on the participants' attitudes, knowledge and practice levels.
- To obtain feedback from the participants on the usefulness of the training and suggestions for enhancing future effectiveness.

Methodology
Reflection

Duration
30 minutes

Training Materials

Training evaluation and feedback form

Tips for facilitators

The training evaluation and feedback form will assess what affect the module had on the participants' attitudes, knowledge and practice levels and obtain feedback on the usefulness of the training and suggestions for enhancing future effectiveness.

Process

- Distribute the training evaluation and feedback form. Go over all the areas that the participants will need to think about while filling it in.
- Allow 20 minutes to complete it.
- Collect the training evaluation and feedback forms from the participants.
- Before the closing ceremony begins, ask the participants to share their feelings about the training: encourage anyone who is keen to orally share two positive aspects and two areas that need improvement.
- At the closing ceremony thank all the participants for their enthusiastic participation, congratulate them and wish them the best as they go back to their own field areas and begin to initiate the intervention on ground.
- Thank everyone else who contributed to the training program. This might have included administrative staff, venue owners, facilitators, guest speakers and the organizers.

TRAINING EVALUATION AND FEEDBACK FORM:

KARNATAKA HEALTH PROMOTION TRUST
Training Evaluation and Feedback Form

Name: _____ Designation: _____ Place of training: _____
Training dates: _____ Name of the PHC: _____

S.No.	Subject	Excellent	Good	Poor
1	Training content and sessions			
2	Training methodology and activities used			
3	Training skills of the facilitators			
4	Logistics at the training (Food, stay and comfort)			
5	Relevance and usefulness of training			

List the three aspects of the training that you found most useful.

1.
2.
3.

Name any session during the training that you did not understand properly/ or that was not communicated well.

1.
2.
3.

What are the three most important lessons that you can take back to your work place from this training?

1.
2.
3.

Please list suggestions for improved facilitation in future trainings.

1.
2.
3.

ANNEXURE 1 - HBMNC Tool

Project Sukshema | Department of Health, Government of Karnataka | National Rural Health Mission

HOME-BASED MATERNAL AND NEWBORN CARE TOOL FOR ASHAs

(Use one Form for each mother contacted during pregnancy and for EACH home visit within 42days after delivery. If you meet the woman outside her home, do not consider that as a home visit)

SECTION 1: IDENTIFICATION

A. ASHA IDENTIFICATION (Complete this section at your first home visit to the pregnant women)

1.District _____ 2.Taluka _____ 3.PHC Location_____

4.Subcentre Location_____ 5.Village Name_____

6.ASHA Name_____ 7.ASHA Area Name_____

B. WOMAN'S BACKGROUND INFORMATION (Complete this section at your first home visit to the pregnant women. Ask the woman and or refer to the Thayi card. If you have not filled all the information in the first visit, fill the remaining information in the subsequent visits. If you are meeting the woman for the first time after delivery, complete the section and skip to Section 3)

8.Name_____

9.Husband's name _____

10.Age ☐☐ yrs

11.BPL Y☐ N☐ **Caste/Tribe** SC☐ ST☐ Other☐

12.**Permanent address** Same village ☐
Other village within PHC area ☐
Other village outside PHC area ☐

13.Phone number ☐☐☐☐☐☐☐☐☐☐

14.Thayi card number ☐☐☐☐☐☐☐☐☐☐

15.Date of registration Day ☐☐

Month ☐☐ Year ☐☐

16.Place of registration Within PHC area ☐
Outside PHC area ☐

18.Total pregnancies ☐

19.Total live births ☐

20.Total abortions ☐

21. Total living children ☐

22. Age of the last child ☐☐ months

23. Any complications in previous pregnancies?
Y☐ N☐

24.Any previous C-sections/assisted delivery?
Y☐ N☐

25.Any of the previous home deliveries?
Y☐ N☐

26.LMP Day ☐☐ Month ☐☐ Year ☐☐

27.EDD Day ☐☐ Month ☐☐ Year ☐☐

28.Gestational type Single pregnancy ☐
Multiples ☐

SECTION 2: ANTENATAL HOME VISITS

A. VISIT DETAILS (Record details at each ANC home visit in the corresponding column. The first visit corresponds to the day on which you meet the pregnant woman. You are advised to make subsequent home visits at 4th, 8th, and 9th months of pregnancy. Additional visits are necessary for high-risk pregnant women. There is provision for documenting 5 visit details. If additional visits are made, use additional form)

	ANC home visit number				
	1	2	3	4	5
1.Visit date (dd/mm/yy)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
2.Gestational age (in months)	☐☐	☐☐	☐☐	☐☐	☐☐

B. COMPLAINTS (During each visit, ask the woman if she has any of the following complaints. Put a Y on Y box if present and a Y on N box if not present. For each complaint. If any complaint is present, refer her immediately to the nearest PHC/Health facility)

	1	2	3	4	5
3.Fever	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
4.Swelling of face	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
5.Headache	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
6.Blurred vision	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
7.Vomiting	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
8.Fits/seizures	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
9.Difficulty in passing urine/ less urine	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
10.Palpitation	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
11.Severe weakness/tiredness	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
12.Breathlessness at rest or on mild exertion	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
13.Pain in abdomen	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
14.Contractions	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
15.Watery discharge per vagina/ rupture of membranes	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
16.Bleeding per vagina	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
17.Foul discharge per vagina	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
18.Decreased/no foetal movement	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
19.Any other (specify)					

	Home visit number				
	1	2	3	4	5

C. TESTS (Ask or check the Thayi Card and record if the woman has completed the following tests. Put a Y on Y box if the test was already done and a Y on N box if not done, for each test. If any test is not done during the pregnancy, refer her to the nearest PHC/Health facility for these tests. Note that the test need not be done during every visit. Ensure the test at least once during pregnancy)

	1	2	3	4	5
20.Haemoglobin	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
21.Blood group/Rh	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
22.	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
23.	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
24.HbsAg	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
25.Urine for protein	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
26.Urine for detection of infection	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
27.	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
28.Other(Specify)	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐

D. ANC CHECKUPS (Check the Thayi Card or ask the women and record if she has received the following anytime before your first home visit or between your home visits. Put a √ on Y box if received and a √ on N box if not received)

29.ANC check up done? If yes record the date	Y☐ N☐ Date __/__/__	Y☐ N☐ Date __/__/__	Y☐ N☐ Date __/__/__	Y☐ N☐ Date __/__/__	Y☐ N☐ Date __/__/__
30.Place of ANC check done (Tick the place)	☐ PHC ☐ CHC ☐ TH ☐ DH ☐ Pvt ☐ Other	☐ PHC ☐ CHC ☐ TH ☐ DH ☐ Pvt ☐ Other	☐ PHC	☐ CHC ☐ TH ☐ DH ☐ Pvt ☐ Other	
31.TT injection dose	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
32.TT injection booster	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
33.IFA tablets	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
34.Was weight recorded?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
35.Was BP recorded?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
36.Was abdominal examination recorded?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
37.Was foetal heart rate recorded?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐

E. RISKS DURING PREGNANCY (Check the Thayi Card or other available test results and record if she has the following pregnancy complications. Put a √ on Y box if the complication is present and refer the woman to the nearest PHC/health facility. Put a √ on N box if not present. Put a √ on DK box if the condition cannot be determined)

38.Short primigravida (First pregnancy and height <4'10")	Y☐ N☐				
39.Severe anaemia (<7gms%)	Y☐ N☐ DK☐	Y☐ N☐ DK☐	Y☐ N☐ DK☐	Y☐ N☐ DK☐	Y☐ N☐ DK☐
40.Pregnancy induced hypertension/ eclampsia	Y☐ N☐ DK☐	Y☐ N☐ DK☐	Y☐ N☐ DK☐	Y☐ N☐ DK☐	Y☐ N☐ DK☐
41.Previous caesarean section/still birth/ abortion/ preterm birth	Y☐ N☐				
42.Grand multi parity (3+)	Y☐ N☐ DK☐				
43.					
44.Ante partum haemorrhage	Y☐ N☐ DK☐	Y☐ N☐ DK☐	Y☐ N☐ DK☐	Y☐ N☐ DK☐	Y☐ N☐ DK☐
45.					
46.					
47.Pregnancy with HIV/ diabetes/heart disease/ other health complaints	Y☐ N☐ DK☐	Y☐ N☐ DK☐	Y☐ N☐ DK☐	Y☐ N☐ DK☐	Y☐ N☐ DK☐

F. COUNSELING (Put a √ if provided counselling on the following topics at some point during the ANC home visits, not necessarily at one time. Refer Thayi card for information on most items. For the same item, counselling may be done in more than 1 visit)

48.Birth planning and preparedness-Promotion of delivery in a facility	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
49.Antenatal checkups in a facility	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
50.Blood and urine tests	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
51.Nutrition and rest during pregnancy	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
52.Signs and symptoms of anaemia	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
53.Prevention and treatment of anaemia including consumption of IFA tablets, Side-effects of IFA tabletsV	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐

Pregnancy outcome: Abortion ☐ Delivery ☐

[illegible]

A. DELIVERY DETAILS

1.Delivery date day ☐☐ month ☐☐ year ☐☐

2. Place of delivery SC ☐ PHC ☐ CHC ☐ TH ☐ DH ☐ PVT ☐ Home ☐ Other ☐

3.Name of institution ______________________________

4.Delivery outcome Live birth ☐ Still birth ☐ Newborn died ☐

5.Delivery type Normal ☐ C-section ☐ Assisted ☐ **6.Sex of the child** Male ☐ Female ☐

7.Birth weight ☐☐☐☐ gms **8. Date returned home** day ☐☐ month ☐☐ year ☐☐

9.Complications during delivery and postpartum period None ☐ Mother died ☐ Obstructed labour ☐ Postpartum haemorrhage ☐ Pre-eclampsia ☐ Eclampsia ☐ Mother developed infection ☐ Child died ☐ Child developed infection ☐ Preterm birth ☐ LBW (<2500 gms) ☐ Asphyxia ☐ Other ☐ (Specify) ______________________________

[illegible]

A. VISIT DETAILS (Record details of each PNC home visit in the corresponding column. The first visit corresponds to the day on [illegible])

	PNC home visit number					
	1	2	3	4	5	6
1.Visit date (dd/mm/yy)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
2.# of days since delivery	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐

B. COMPLAINTS : MATERNAL (During each visit, ask the woman [illegible] any of the following complaints. Put a √ on Y box if present and a √ on N box if not present [illegible])

3.Record her temperature in Celsius. **If the temperature >37.5 degrees Celsius, administer the first dose of paracetamol and refer to a health facility**	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐

	PNC home visit number					
	1	2	3	4	5	6
4.Are her breasts hard/ nipples hard or broken/ experiencing pain in the breasts or the nipples? **If YES, counsel her on right positioning and attachment of baby to the breasts, before referring to a health facility**	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
5.Does she experience difficulty in breathing?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
6.Is her uterus soft and does she have excessive bleeding? **If YES, provide uterine massage and advise breastfeeding before referring to a health facility**	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
7.Does she have pain and foul-smelling lochia discharge from the vagina?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
8.Is she experiencing fits?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
9.Is she experiencing severe abdominal pain?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
10.Does she have burning micturition? **If YES, advise more fluids before referring to health facility**	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
C: COMPLAINTS – NEWBORN (During each [illegible] complaints about the child and [illegible] are present, the latter may have a certain [illegible] require additional steps/[illegible] to warm the infant by skin to skin contact if the infant is cold [illegible]						
11.Record the baby's temperature in Celsius. **If the temperature >37.5 degree Celsius or <36.5 degrees Celsius, refer to a health facility**	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐
12.Does the baby have fits?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
13.Is the baby passing urine less than 6 times a day?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
14.Is the baby having diarrhoea?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
15.Is there blood in baby's stools?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐

16.Is the baby in-active?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
17.Are the baby's eyes swollen and discharging pus?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
18.	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
19.Are the baby's skin folds in arms and thighs red?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
20.Does the child have boils filled with pus?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
21.	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
22.Is the baby not crying at all or has a feeble cry?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
23.Is the baby's tummy bloated/ distended?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
24.Is the baby vomiting?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
25.Does the baby have difficulty in breathing and chest in-drawing?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
26.Is the baby breastfeeding poorly. **If YES, determine if the issue is positioning and attachment and provide counselling. If breastfeeding does not improve with counselling, refer to a health facility for further assessment." Although poor breastfeeding can be due to latch/attachment, it can also be a sign of sepsis.**	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
27.Is there redness or pus at the cord stump?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
	Home visit number					
	1	2	3	4	5	6
D: DIET/NUTRITION [illegible]						
28.# of full meals (and drinks) she had in the past 24 hours. **If <3, discuss with her the reasons, and advise her or link her to other schemes/ facilities as required.**	☐	☐	☐	☐	☐	☐
29.Does the mother avoid any food and fluids? **If YES, counsel her on balanced diet**	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐

30.# of times the baby breastfed in the past 24 hours. **If <7-8 times, advise her on the importance of breastfeeding discuss the reasons and advise her accordingly.**	☐	☐	☐	☐	☐	☐
31.Is she feeding the baby anything other than breast milk, including water, honey, sugar etc.?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
32.Has something been applied to the cord stump?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
33.Is the baby kept warm?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
34.Has the baby been given BCG?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
35.Has the baby been given Polio 0?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
36.Has the baby been given Hep B 0?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
E. COUNSELING [illegible]						
38.Keeping the baby warm	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
39.Cord care	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
40.Cleaning/bathing the baby	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
41.Care for baby's eyes and ears	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
42.Maternal danger signs: a.Fever	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
b.Convulsions	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
c.Blurred vision/severe headache	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
d.Increased bleeding	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
e.Foul discharge or odour	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
f.Breathing difficulty	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
g.Swollen/ red/ tender breasts	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
h.Pain/ difficulty in passing urine	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
i.Worsening abdominal pain	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
j.Worsening perineal pain	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
a.Breathing difficulty	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
b.Feeding problems	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
c.Convulsions	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
d.Diarrhoea/vomiting	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐

43.Newborn danger signs: e.Hypo/hyperthermia	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
f.Icterus/ yellow skin	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
g.Stiff (body arched) or sloppy	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
h.Irritability/ lethargy	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
i.Pustules on skin or boil	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
j.Not passing urine at least 6 times a day	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
k.Pus/ inflamed red umbilicus	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
l.Blood in stool	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
44.Childhood immunizations	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
45.Breastfeeding - right positioning and attachment of the baby to the breast	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
46.Breastfeeding - exclusive breastfeeding	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
	PNC home visit number					
	1	2	3	4	5	6
47.Breastfeeding - timely complementary feeding	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
48.Nutrition – increased calorie uptake, iron supplementation and plenty to drink	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
49.Counselling on care of the newborn during ARI/ breathing problems/ fever	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
50.Counselling on care of the newborn during diarrhoea and vomiting	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
51.Family planning	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
[illegible]						
52.Woman/child referred to a health facility?	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
53.Facility referred to	☐ PHC ☐ CHC ☐ TH ☐ DH ☐ Pvt ☐ Other	☐ PHC ☐ CHC ☐ TH ☐ DH ☐ Pvt ☐ Other	☐ PHC ☐ CHC ☐ TH ☐ DH ☐ Pvt ☐ Other	☐ PHC ☐ CHC ☐ TH ☐ DH ☐ Pvt ☐ Other	☐ PHC ☐ CHC ☐ TH ☐ DH ☐ Pvt ☐ Other	☐ PHC ☐ CHC ☐ TH ☐ DH ☐ Pvt ☐ Other
54.Reasons for referral						
55.Next follow-up visit date (dd/mm/yy)						

ANNEXURE 2 - HBMNC Tool filling guidelines

Project Sukshema Department of Health, Government of Karnataka National Rural Health Mission

INSTRUCTIONS FOR FILLING UP HBMNC TOOL

Use one Form for each mother contacted during pregnancy and for EACH home visit within 42days after delivery. If you meet the woman outside her home, do not consider that as a home visit.

A. VISIT DETAILS (Record details of each ANC home visit in the corresponding column. The first visit corresponds to the day on which you meet the pregnant woman. You are advised to make subsequent home visits at 4th, 6th, and 9th months of pregnancy. Additional visits are necessary for high risk pregnant women. There is provision for documenting 5 visit details. If additional visits are made, use additional form)

	ANC home visit number				
	1	2	3	4	5
1.Visit date (dd/mm/yy)	Ex. Each time record the date of home visits in the respective column Ex: 16/08/10				
2.Gestational age (in months)	Record the completed months of pregnancy on the date of your visit Ex. 2,4,8 etc.				

B. COMPLAINTS (During each visit ask the woman if she has any of the following complaints. Put a √ on Y box if present and a √ on N box if not present, for each complaint. If any complaint is present, refer her immediately to the nearest PHC/Health facility)

3.Fever	• Use the BCC tool and educate on the danger signs that may be observed in pregnant. Also inform about the need for immediately go to the health centre and ensure that they go • Ask /examine if any of the mentioned symptoms are present. Inform her/family members about the need to go to the health centre. • In case if the pregnant is tensed ensure that you instil courage to her/family members
4.Swelling of face	
5.Headache	
6.Blurred vision	
7.Vomiting	
8.Fits/seizures	
9.Difficulty in passing urine/ less urine	
10.Palpitation	
11.Severe weakness/tiredness	
12.Breathlessness at rest or on mild exertion	
13.Pain in abdomen	
14.Contractions	
15.Watery discharge per vagina/ rupture of membranes	
16.Bleeding per vagina	
17.Foul discharge per vagina	
18.Decreased/no foetal movement	
19.Any other (specify)	

C. TESTS (Ask or check the Thayi Card and record if the woman has completed the following tests. Put a √ on Y box if the test was already done and a √ on N box if not done, for each test. If any test is not done anytime during the pregnancy refer her to the nearest PHC/Health facility for these tests. Note that the test need not be done during every visit. Ensure that test at least once during pregnancy)

- Every pregnant woman must have availed the major check-ups and examinations. If NOT find out the reasons
- Chart a plan for availing proper treatment if it is in accessible
- If the proper treatment has not been availed because of carelessness either of family members or the pregnant, discuss the reasons. Counsel them and ensure they seek treatment immediately
- Verify the "thayi card" or talk to the junior female health assistant to understand if the weight, BP and the foetal heart beat is normal. If NOT normal then refer them for higher care at higher centres

20.Haemoglobin	This test is done to check if the woman is anaemic
21.Blood group/Rh	If you know the blood group and RH beforehand, it becomes easy to arrange for blood in case of urgent necessity. RH tells us if the blood group is either negative or positive
22.	
23.	
24.HbsAg	This helps to identify presence of jaundice
25.Urine for protein	If there is presence of higher levels of protein, there is possibility of issues eclampsia / pre eclampsia / fits. understand the status and take treatment if needed
26.Urine for detection of infection	This test is done to find out if there any Urinary tract infection
27.	
28.Other(Specify)	Apart from the problems mentioned here if there any other tests are done (sputum , malaria, bilirubin) record in "Others" column

D. ANC CHECKUPS (Check the Thayi Card or ask the woman and record if she has received the following anytime before your first home visit or between your home visits. Put a √ on Y box, if received and a √ on N box if not received)

29.ANC check up done? If yes record the date	• Educate about the pregnancy check ups • In case if the pregnant has not done any check-ups , explore reasons and counsel appropriately with the pregnant and family members • Ensure that the pregnant does in time pregnancy check ups • Knowing the place of check-up helps in following up with the health centre
30.Place of ANC check done (Tick the place)	
31.TT injection dose	• This is administered to prevent Tetanus infection
32.TT injection booster	
33.IFA tablets	• There can be excessive bleeding because of being anaemic • Tell her about the importance of taking IFA tablets • Ensure that she takes these tablets. If NOT discuss the reasons and counsel accordingly • Give attention in this regard in every visit
34.Was weight recorded?	• The pregnant should check her weight in every visit. During pregnancy the body weight should increase at least by 10-12 Kgs
35.Was BP recorded?	• There is a possibility of danger to the pregnant because of low or high blood pressure. so it's important have regular check-up and monitoring
36.Was abdominal examination recorded?	• This helps understand the status of position(if it is slanted) in which the child is in the womb
37.Was foetal heart rate recorded?	• This is very crucial to know the health status of the child

E. RISKS DURING PREGNANCY (Check the Thayi Card or other available test results and record if she has the following pregnancy complications. Put a √ on Y box if the complication is present and refer the woman to the nearest PHC/Health facility. Put a √ on N box if not present. Put a √ on DK box if the condition cannot be determined)

38.Short primigravida (First pregnancy and height <4'10")	• Educate on the symptoms of obstruction / complications • If there are any symptoms educate her on the need of in time check-ups, additional examinations and care. Ensure that that these are done and followed up • In case if the pregnant is tensed ensure that you instil courage to her/family members
39.Severe anaemia (<7gms%)	
40.Pregnancy induced hypertension/ eclampsia	
41.Previous caesarean section/still birth/ abortion/ preterm birth	
42.Grand multi parity (3+)	
43.	
44.Ante partum haemorrhage	
45.	
46.	
47.Pregnancy with HIV/ diabetes/heart disease/ other health complaints	

F. COUNSELING (Put a √ if provided counselling on the following topics at some points during the ANC home visits, not necessarily at one time. Refer Thayi card for information on most items. For the same item, counselling may be done in more than 1 visit)

48.Birth planning and preparedness- Promotion of delivery in a facility					
49.Antenatal checkups in a facility					
50.Blood and urine tests					
51.Nutrition and rest during pregnancy					
52.Signs and symptoms of anaemia					
53.Prevention and treatment of anaemia including consumption of IFA tablets, Side-effects of IFA tabletsV					
	ANC home visit number				
	1	2	3	4	5
54. Danger signs during pregnancy — a.Severe anaemia					
b.Fever					
c.Bleeding					
d.Headache/ blurred vision/ vomiting/ fits					
e.Water discharge/ leaking membrane					
f.Labour pain >12 hours					

55.Breastfeeding – early initiation and colostrum feeding					
56.Counselling to undergo HIV test					
57.Contraceptive counselling					
58.Government schemes					
59.Danger signs during labour					
60.VHND					
61.Thayandira Sabhe					
62.If moving out of the area, how to remain in the care continuum					

G. REFERRAL

63.Pregnant woman referred to a health facility?					
64.Facility referred to					
65.Reasons for referral					
66.Next follow-up visit date (dd/mm/yy)					

Pregnancy outcome: Abortion ☐ Delivery ☐

SECTION 3: DELIVERY DETAILS

A. DELIVERY DETAILS (Record detailed depth during the 1st postnatal home visit)

1.Delivery date day ☐☐ month ☐☐ year ☐☐

2. Place of delivery SC ☐ PHC ☐ CHC ☐ TH ☐ DH ☐ PVT ☐ Home ☐ Other ☐

3.Name of institution _____

4.Delivery outcome Live birth ☐ Still birth ☐ Newborn died ☐

5.Delivery type Normal ☐ C-section ☐ Assisted ☐ **6.Sex of the child** Male ☐ Female ☐

7.Birth weight ☐☐☐☐ gms **8. Date returned home** day ☐☐ month ☐☐ year ☐☐

9.Complications during delivery and postpartum period None ☐ Mother died ☐ Obstructed labour ☐ Postpartum haemorrhage ☐ Pre-eclampsia ☐ Eclampsia ☐ Mother developed infection ☐ Child died ☐ Child developed infection ☐ Preterm birth ☐ LBW (<2500 gms) ☐ Asphyxia ☐ Other ☐ (Specify) _____

SECTION 4: POSTNATAL HOME VISITS

A. VISIT DETAILS (Record details of each PNC home visit in the corresponding column. The first visit corresponds to the day on which you first met the woman after her delivery. You are required to make 6 PNC home visits within 42 days after delivery – on 3rd, 7th, 14th, 21st, 28th and 42nd day)

- 1st visit: The first visit to be conducted on the 3rd day of the delivery. Even if you are making the 1st visit within 5th day of delivery, record the same in the 1st visit column
- 2nd visit: The second visit to be conducted on the 7th day of delivery. Even if you are making the home visit anywhere between 6th to 10th day of delivery, mention the same in the 2nd visit column

- 3rd visit: The second visit to be conducted on the 14th day of delivery [illegible] anywhere between 11th to 17th day of delivery, mention the [illegible]
- 4th visit: The second visit to be conducted on the 21st day of delivery [illegible] anywhere between 18th to 24th day of delivery, mention the same in the 4th visit column.
- 5th visit: The second visit to be conducted on the 28th day of delivery [illegible] anywhere between 25th to 35th day of delivery, mention the same in the 5th visit column.
- 6th visit: The second visit to be conducted on the 42nd day of delivery. Even if you are making the home visit anywhere between 36th to 42nd day of delivery, mention the same in the 6th visit column.

	PNC home visit number					
	1st visit (0-5)	2nd visit (6-10)	3rd visit (11-17)	4th visit (18-24)	5th visit (25-35)	6th visit (36-42)
1.Visit date (dd/mm/yy)	• Mark the date of every home visit at the respective space Eg: 13.11.11					
2.# of days since delivery	• Please write the details of every post natal care home visit in the respective space provided. • Count the number of days since delivery till the home visit and mark the same Eg: 3					

B. COMPLAINTS - MATERNAL (During each visit, ask the woman [illegible] the following complaints. Put a √ on Y box if present and a x on N box if not present, for each complaint. [illegible] nearest PHC/Health facility. Note that some may have additional [illegible])

- If there is any affirmation please mark (√) where YES is mentioned [illegible] mentioned. Do the same to each of the above mentioned questions/ observations [illegible] observations are answered with YES, immediately refer her to the nearest [illegible] you may need to give instruction on first aid as well.
- Use the BCC Tool and educate on the danger signs [illegible] the need for immediately go to the health centre [illegible]
- Ask /examine if any of the mentioned symptoms are present. Inform her/family [illegible] to the health centre.
- In case if the pregnant is tensed ensure that you instil courage to her/family [illegible]

3.Record her temperature in Celsius.	• If the temperature >37.5 degrees Celsius, administer the first dose of paracetamol and refer to a health facility
4.Are her breasts hard/ nipples hard or broken/ experiencing pain in the breasts or the nipples?	• If YES, counsel her on right positioning and attachment of baby to the breasts, before referring to a health facility
5.Does she experience difficulty in breathing?	
6.Is her uterus soft and does she have excessive bleeding?	• If YES, provide uterine massage and advise breastfeeding before referring to a health facility
7.Does she have pain and foul-smelling lochia discharge from the vagina?	
8.Is she experiencing fits?	
9.Is she experiencing severe abdominal pain?	
10.Does she have burning micturition?	• If YES, advise more fluids before referring to health facility

[illegible]

11.Record the baby's temperature in Celsius.	• In each of the follow up visits kindly mark the following either through questioning or through observations • If there is affirmation of problem then mark (√) and if NO then mark (X). If you notice any one of the symptom/ problem, then think that there may be any infection and immediately refer to the nearest PHC or other health centres. • Instruct the care takers on first aid if needed. If the child's body temperature is cold (lesser than 36.5 degree Celsius) instruct the how the child can be kept warm by skin to skin contact with mothers body. Also suggest on the need to keep the baby warm en route to hospital
12.Does the baby have fits?	
13.Is the baby passing urine less than 6 times a day?	
14.Is the baby having diarrhoea?	
15.Is there blood in baby's stools?	
16.Is the baby in-active?	
17.Are the baby's eyes swollen and discharging pus?	
18.	
19.Are the baby's skin folds in arms and thighs red?	
20.Does the child have boils filled with pus?	
21.	
22.Is the baby not crying at all or has a feeble cry?	
23.Is the baby's tummy bloated/ distended?	
24.Is the baby vomiting?	
25.Does the baby have difficulty in breathing and chest in-drawing?	
26.Is the baby breastfeeding poorly.	
27.Is there redness or pus at the cord stump?	

	Home visit number					
	1	2	3	4	5	6
D. BEHAVIOURS (Ask the mother and put a √ on Y box if followed and a √ on N box if not present, for each behaviour. If any of these behaviours are not followed, counsel her appropriately on the same)						
28.# of full meals (and drinks) she had in the past 24 hours. **If <3, discuss with her the reasons, and advise her or link her to other schemes/ facilities as required.**	• Enquire how frequently in a day the nursing mother takes full meals • Educate on the importance of intake of nutrition food by the nursing mother • If the nursing mother is taking food less than thrice a day , enquire the reason and counsel on the same • If there any lack of finance for availing nutrition food, ensure that they receive support from VHNSC or other organisations • Give attention in this regard in every visit					
29.Does the mother avoid any food and fluids? **If YES, counsel her on balanced diet**	• Nursing mother should intake have both solid and liquid from time to time. Enquire about the same and educate on the importance of doing so. • If you observe non adherence , discuss the reasons and deliberate on the same with mother and family members • Give attention in this regard in every visit					
30.# of times the baby breastfed in the past 24 hours. **If <7-8 times, advise her on the importance of breastfeeding discuss the reasons and advise her accordingly.**	• Discuss how many times in a day the mother is breast feeding the baby • If it is lesser than 7-8 times per day, discuss the reasons and educate on the importance breast feeding and motivate them increase the frequency. Suggest according to the problems they have. • Give attention in this regard in every visit					
31.Is she feeding the baby anything other than breast milk, including water, honey, sugar etc.?	• Explain the importance of breast feeding. Stress on the fact that nothing else should be given other than breast milk • Give attention in this regard in every visit					
32.Has something been applied to the cord stump?	• Examine if anything is been applied on the umbilical cord • Let them be known about the problems arising out of applying oil or other things • Ensure nothing is applied / motivate not to • Give attention in this regard in every visit					
33.Is the baby kept warm?	• Check if the baby is been kept warm during your visit • If NOT discuss the reasons and advice appropriately • Give attention in this regard in every visit					
34.Has the baby been given BCG?						
35.Has the baby been given Polio 0?						
36.Has the baby been given Hep B 0?						
E. COUNSELING (Put a √ if provided counselling on the following topics in some phase during the PNC home visits, not necessarily all on the first visit. Refer to Thayi card for information on most items)						
38.Keeping the baby warm						
39.Cord care						

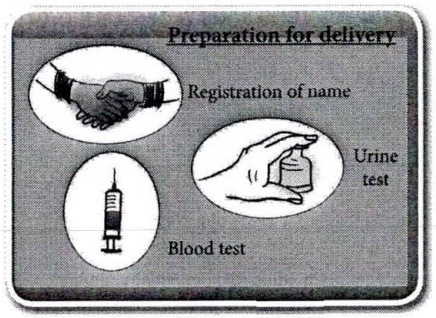
40.Cleaning/bathing the baby			• Give the following instruction during counselling: Do not give bath to baby for the first two days. If it's necessary in summer give sponge bath. During winter do not even give sponge bath
41.Care for baby's eyes and ears			• Make it very clear during counselling that nothing should be applied or no drops be put without doctors' advice
42.Maternal danger signs	a.Fever		
	b.Convulsions		
	c.Blurred vision/severe headache		
	d.Increased bleeding		
	e.Foul discharge or odour		
	f.Breathing difficulty		
	g.Swollen/ red/ tender breasts		
	h.Pain/ difficulty in passing urine		
	i.Worsening abdominal pain		
	j.Worsening perineal pain		
43.Newborn danger signs	a.Breathing difficulty		
	b.Feeding problems		
	c.Convulsions		
	d.Diarrhoea/vomiting		
	e.Hypo/hyperthermia		
	f.Icterus/ yellow skin		
	g.Stiff (body arched) or sloppy		
	h.Irritability/ lethargy		
	i.Pustules on skin or boil		
	j.Not passing urine at least 6 times a day		
	k.Pus/ inflamed red umbilicus		
	l.Blood in stool		
44.Childhood immunizations			
45.Breastfeeding - right positioning and attachment of the baby to the breast			
46.Breastfeeding - exclusive breastfeeding			

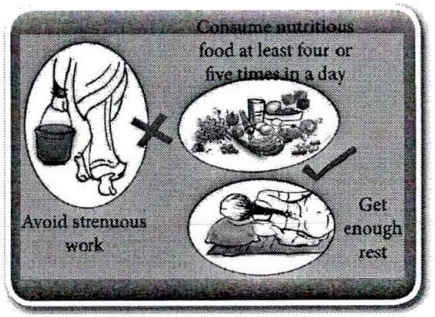
	PNC home visit number					
	1	2	3	4	5	6
47.Breastfeeding - timely complementary feeding						

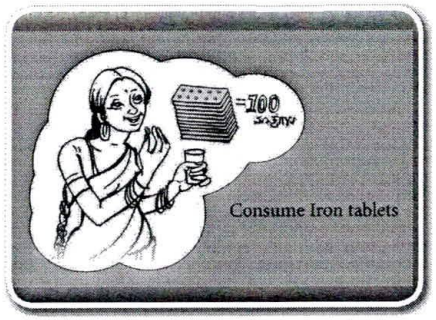
48.Nutrition – increased calorie uptake, iron supplementation and plenty to drink						
49.Counselling on care of the newborn during ARI/ breathing problems/ fever						
50.Counselling on care of the newborn during diarrhoea and vomiting						
51.Family planning						
F. REFERRAL						
52.Woman/child referred to a health facility?						
53.Facility referred to						
54.Reasons for referral						
55.Next follow-up visit date (dd/mm/yy)						

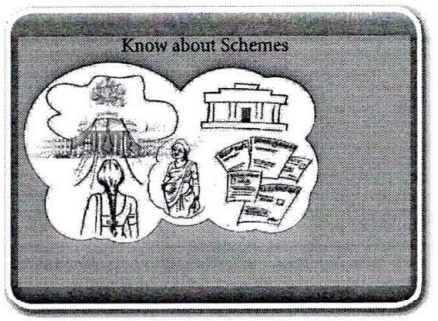
ANNEXURE 3 - ASHA Reminder Cards

PREPARATION FOR DELIVERY

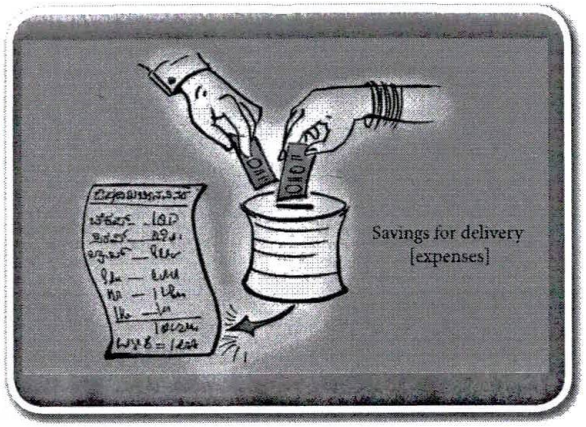


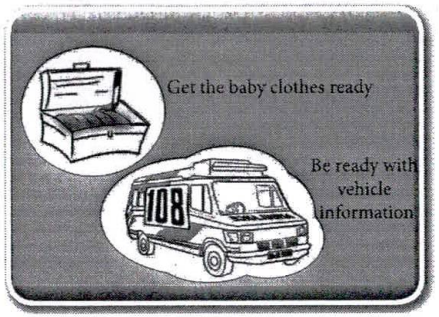


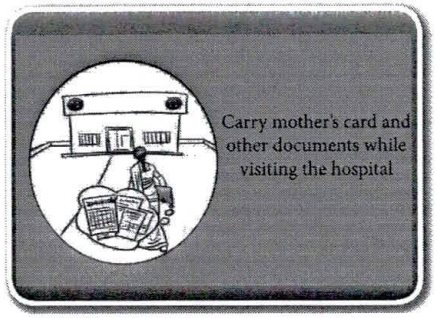


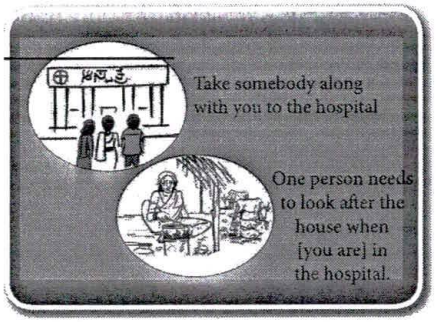


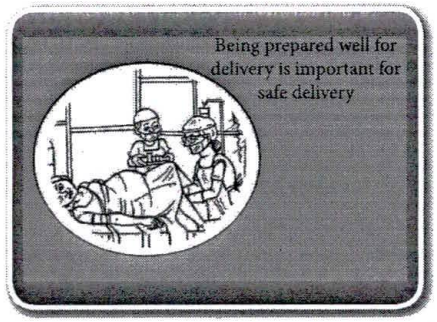
PREPARATIONS FOR HOSPITAL DELIVERY



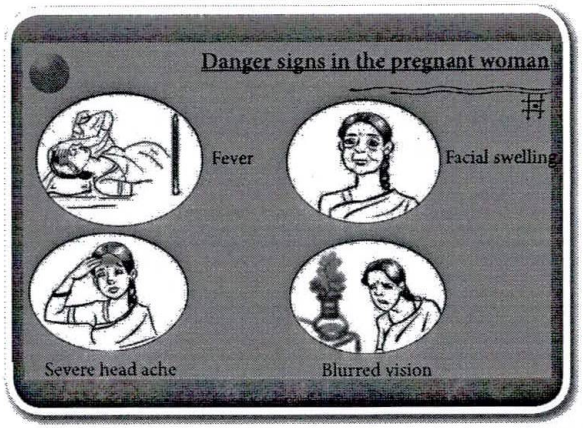


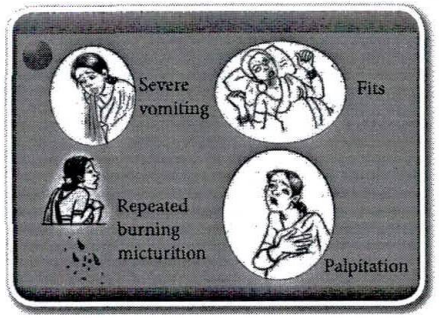


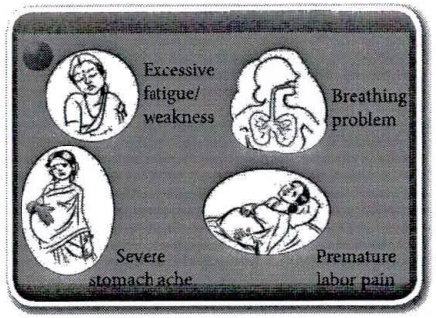


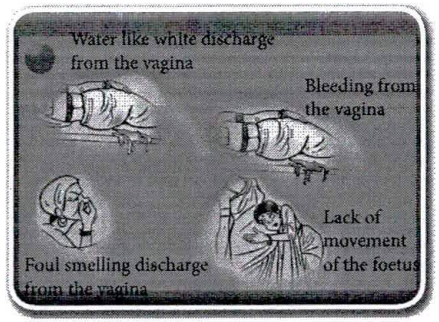


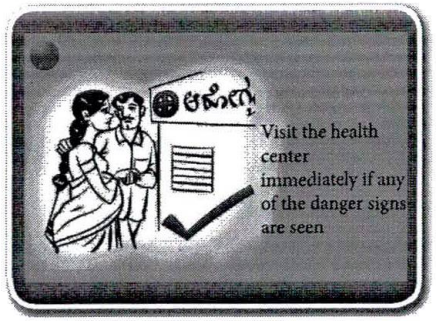
DANGER SIGNS IN THE PREGNANT WOMAN



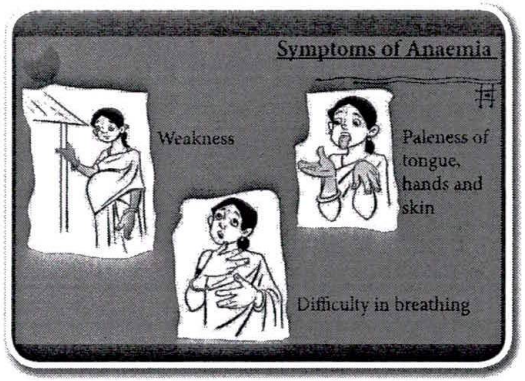


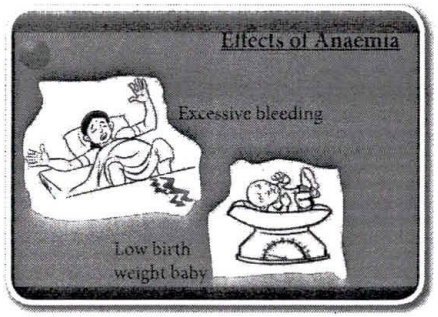


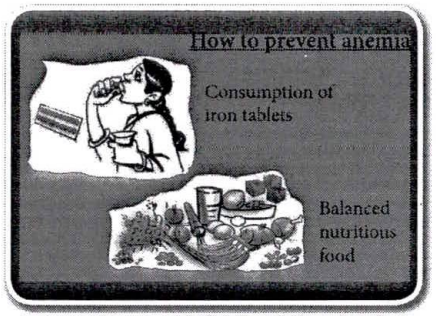




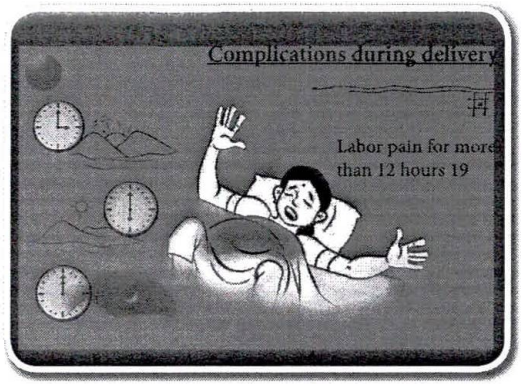
SYMPTOMS OF ANAEMIA

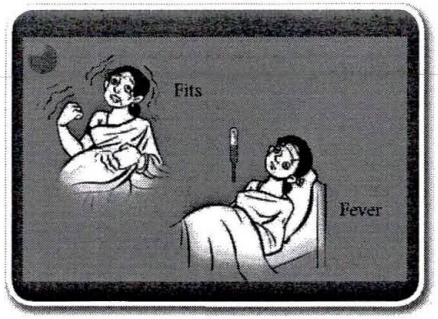


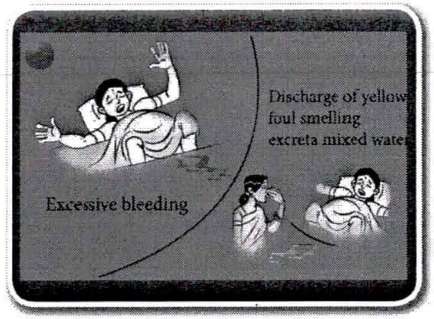


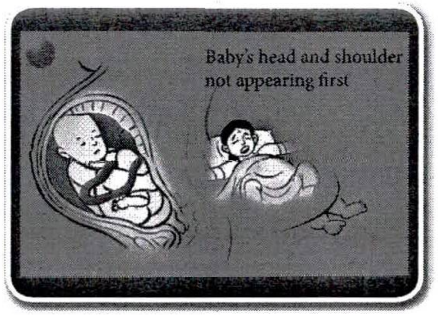


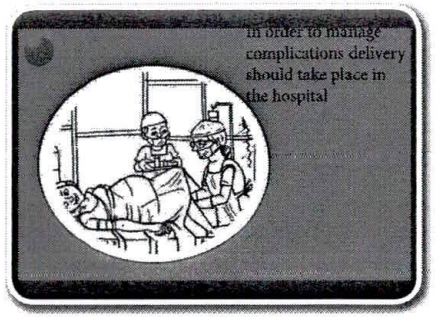
COMPLICATIONS DURING DELIVERY



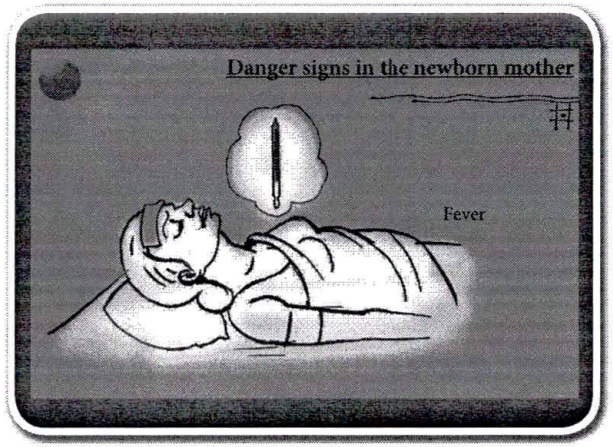


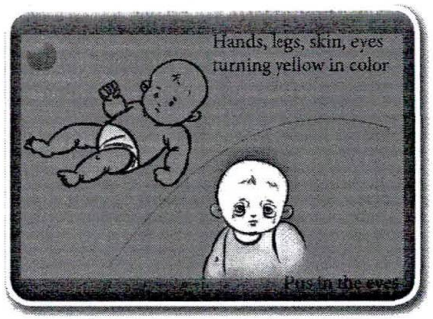


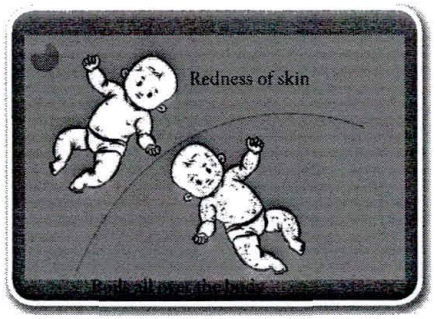


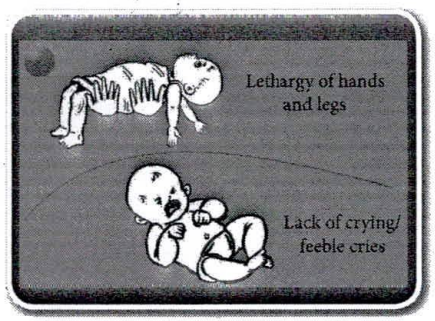


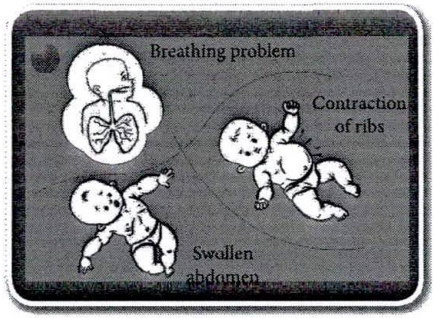
COMPLICATIONS DURING DELIVERY

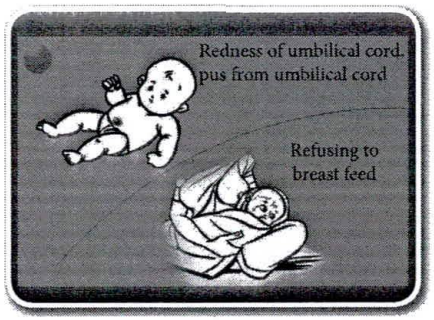




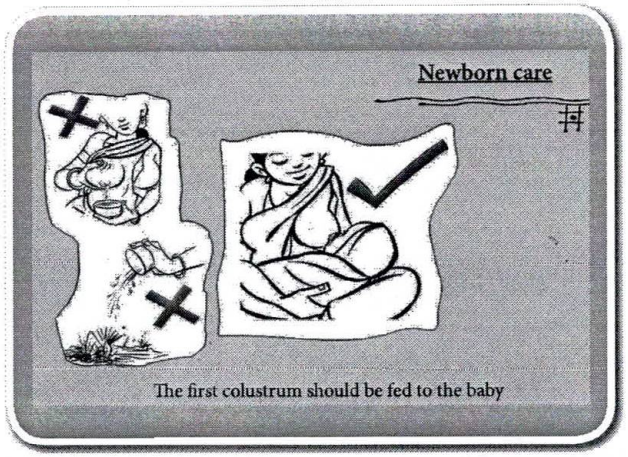


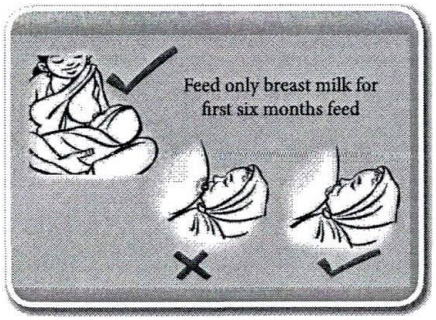


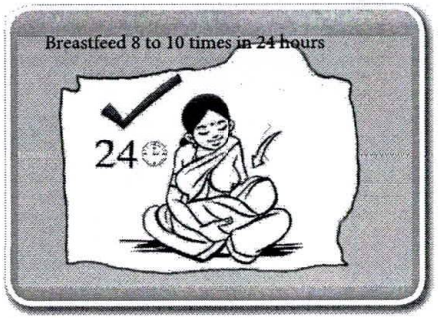


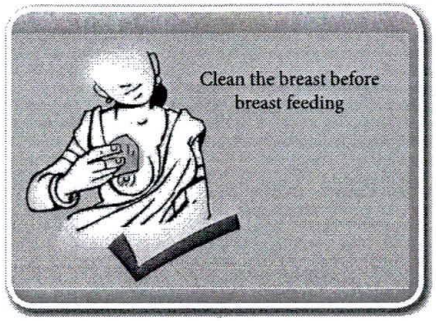


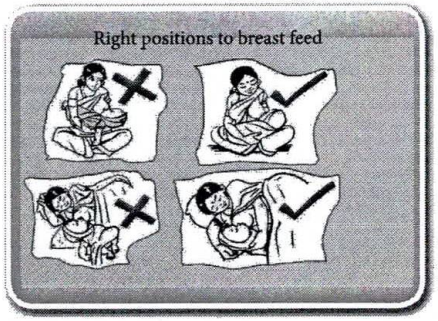
NEWBORN CARE

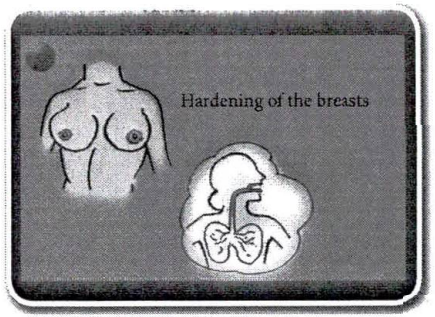


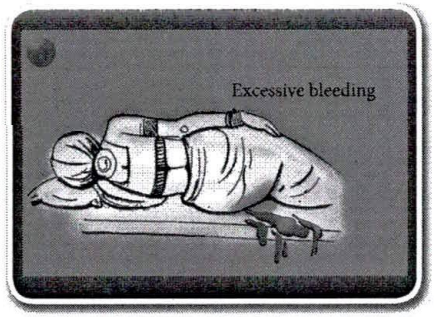


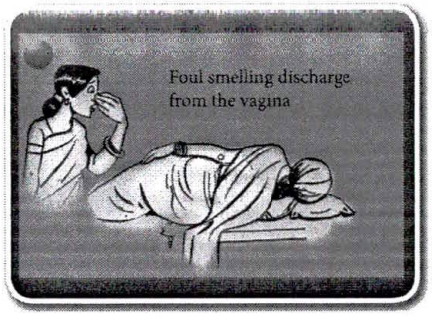


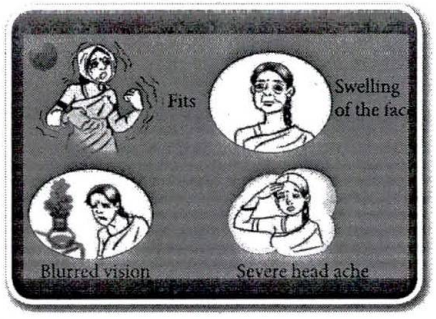


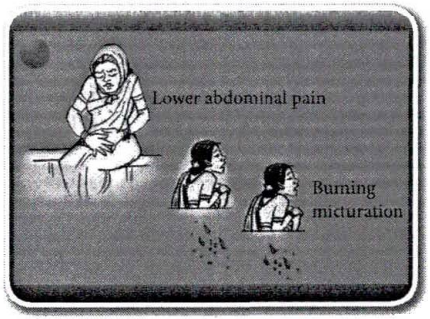


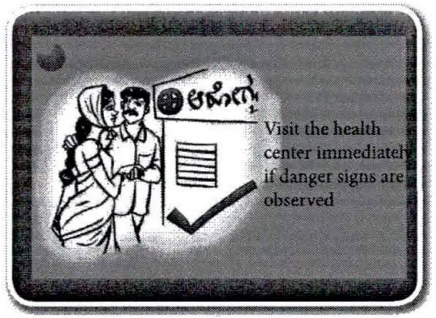




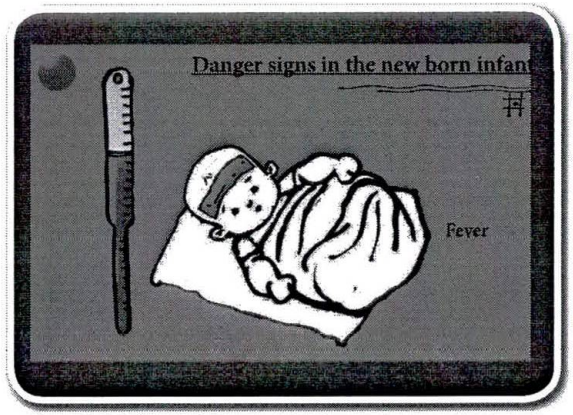


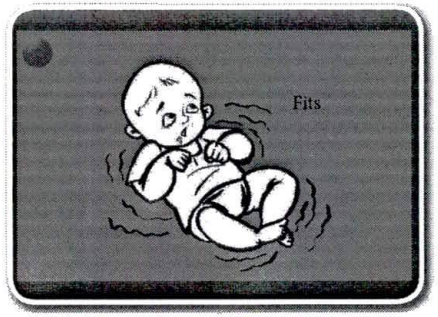


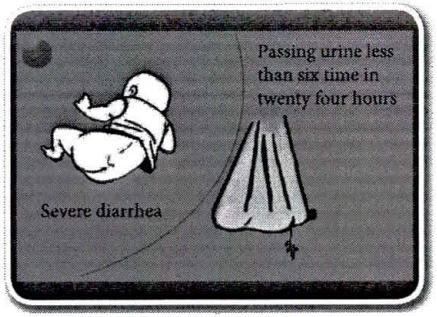


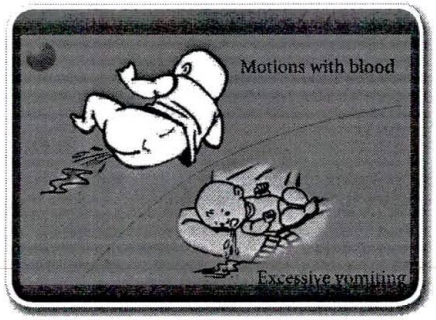


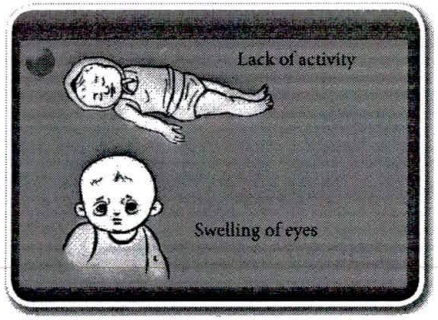
DANGER SIGNS IN THE NEW BORN INFANT





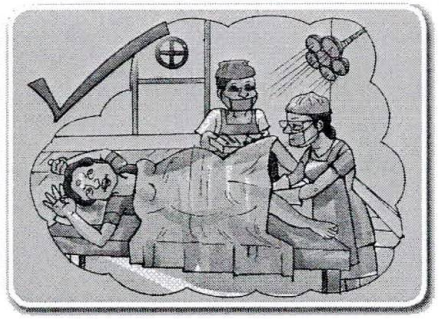




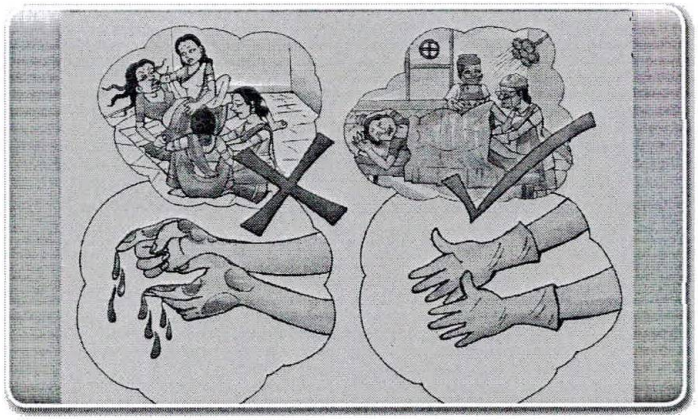


IMPORTANCE OF HOSPITAL DELIVERY

Why like this?
Home delivery

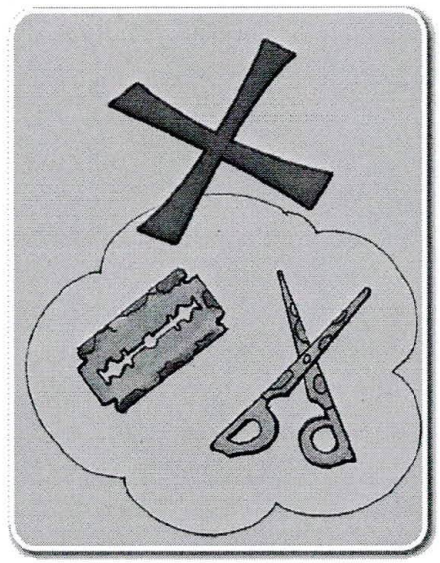


Let it be like this
Hospital delivery

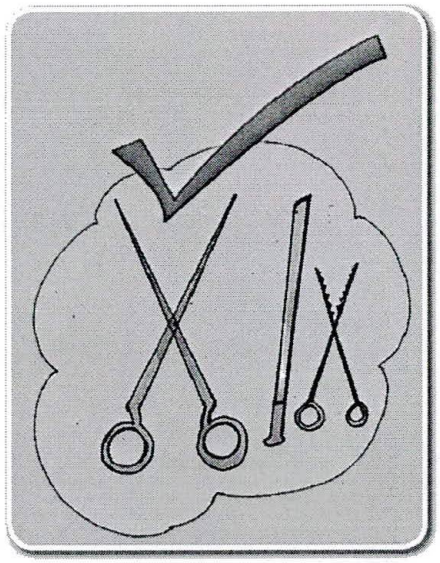


Hands could be dirty in home delivery
In a hospital delivery hands are covered with gloves

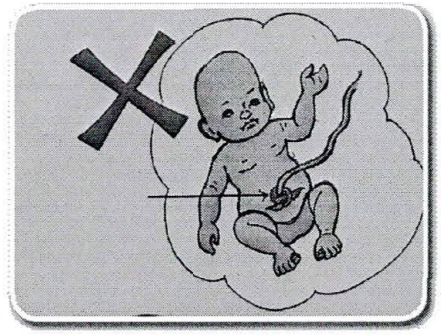
IMPORTANCE OF HOSPITAL DELIVERY



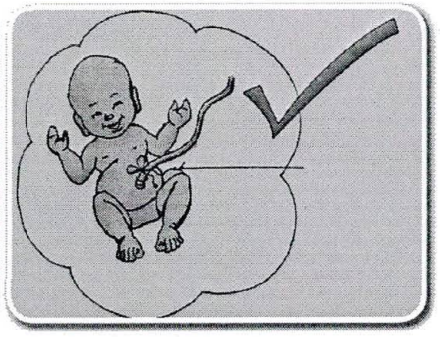
Rusted blade or scissors



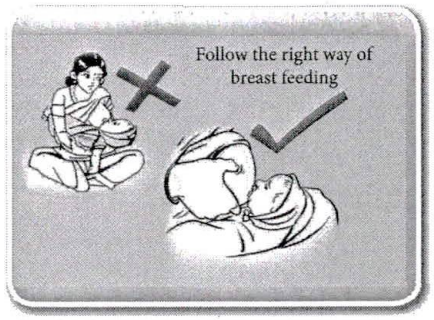
Sanitized blade and scissors

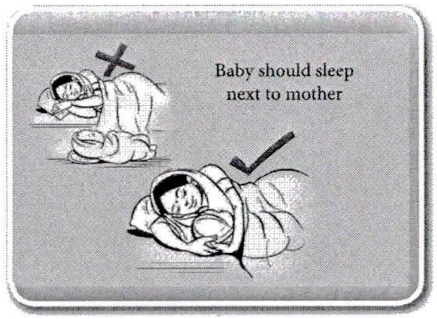


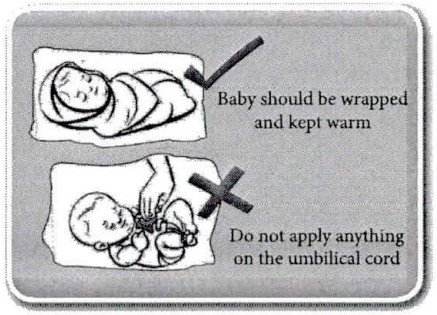
Dirty cloth
Tying the umbilical cord with dirty thread

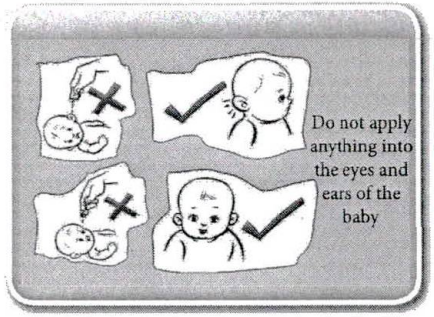


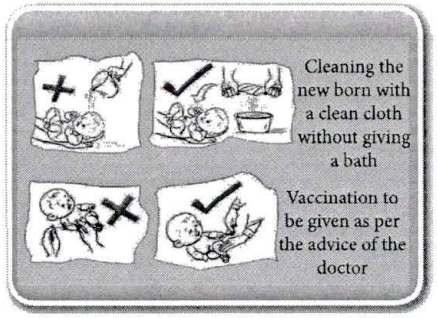
Clean thread
Tying the umbilical cord with clean thread

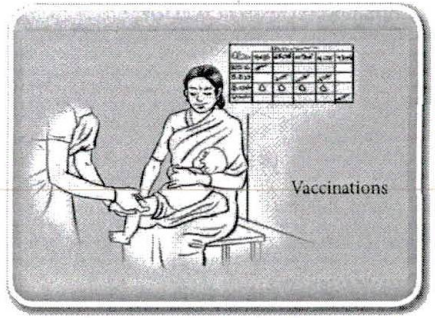


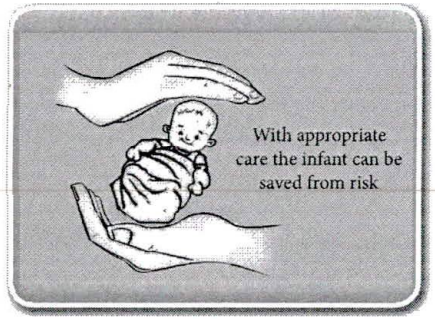




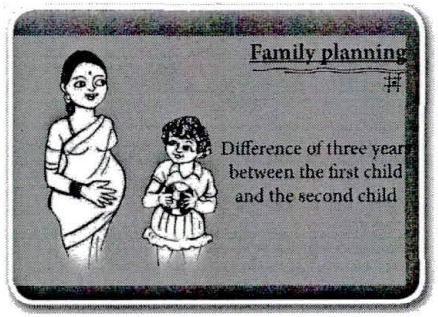


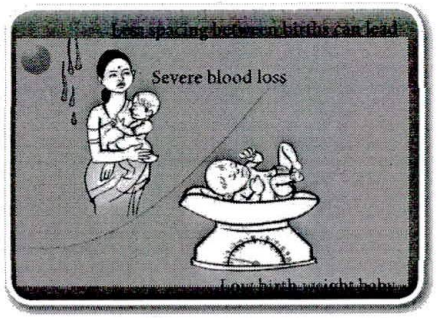


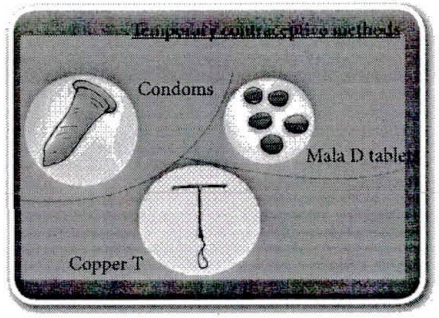


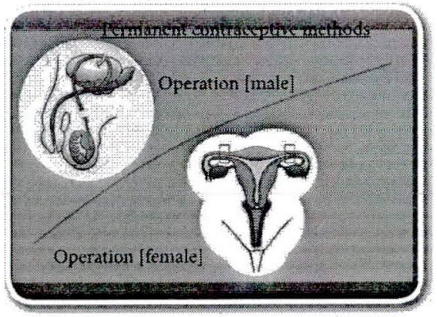


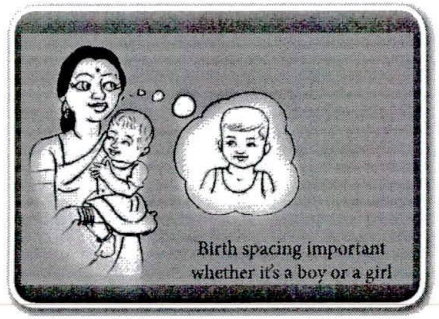
FAMILY PLANNING

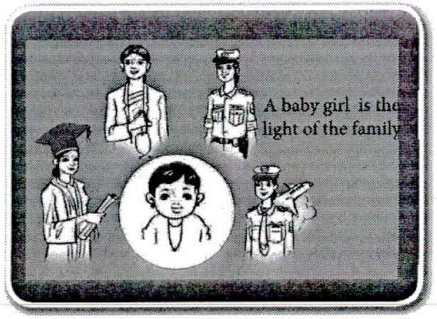


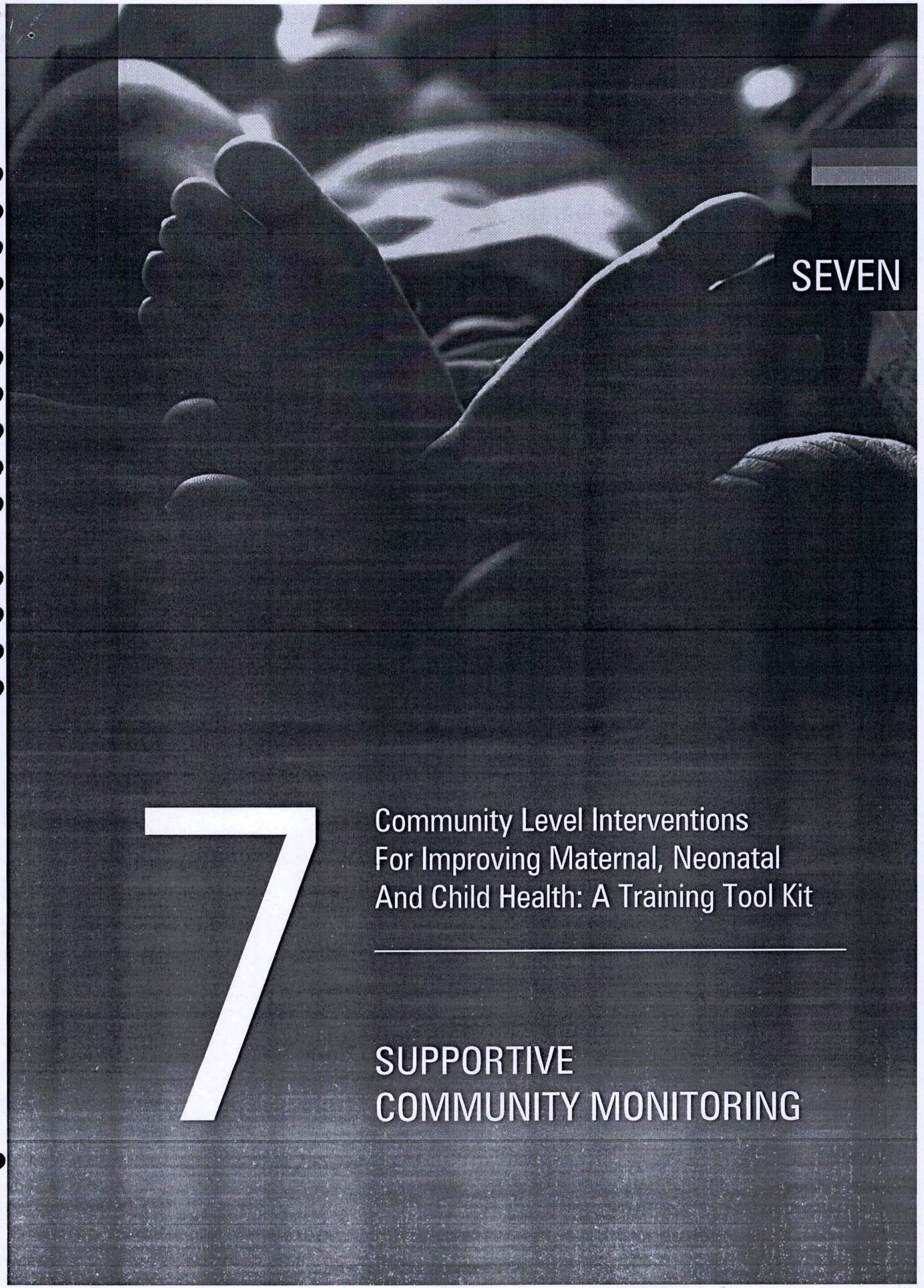












SEVEN

7

Community Level Interventions For Improving Maternal, Neonatal And Child Health: A Training Tool Kit

SUPPORTIVE COMMUNITY MONITORING

Community Level Interventions for Improving Maternal, Neonatal and Child Health: Supportive Community Monitoring is the last module of the tool kit in a series of seven on enhancing community engagement for improving outreach, shaping demand and strengthening accountability to improve maternal, neonatal and child health outcomes in Karnataka.

Publisher:
Karnataka Health Promotion Trust
IT/ BT Park, 4th & 5th Floor
1-4, Rajajinagar Industrial Area
Behind KSSIDC Administrative Office
Rajajinagar, Bangalore- 560 004
Karnataka, India

Phone: 91-80-40400200
Fax: 91-80-40400300
www.khpt.org

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Mr. Mohan H.L , UOM
Ms. Mallika Tharakan, KHPT
Ms. Prathibha Rai, KHPT
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Mr. KV Balasubramanya, KHPT
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Ms. Rekha Basapura, KHPT
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Mr. Basavanta Kamble, VHSNC President, Mudhol taluk, Bagalkot
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THE EDITORIAL TEAM:
Mr. H.L. Mohan, KHPT
Ms. Mallika Biddappa, KHPT
Mr. Somashekar Hawaldar, KHPT
Ms. Dorothy L. Southern, KHPT Consultant

The photographs are by **KV Balasubramanya**.
They have been used in the module with consent from the community.

7

Community Level Interventions For Improving Maternal, Neonatal And Child Health: A Training Tool Kit

SUPPORTIVE COMMUNITY MONITORING

ಸುಕ್ಷೇಮ
sukshema
Improved Maternal, Newborn & Child Health

NATIONAL RURAL HEALTH MISSION

PREFACE

The Community Level Interventions Training Tool Kit is a series of seven modules:

Module 1: Design, Planning and Implementation of the Sukshema Project
Module 2: Core Concepts of Maternal, Neonatal and Child Health
Module 3: Sukshema's Community Level Interventions
Module 4: Communication and Collaborative Skills for Front Line Health Workers
Module 5: Improving the Enumeration and Tracking Process
Module 6: Home Base Maternal and Newborn Care
Module 7: Supportive Community Monitoring

Module 7: Supportive Community Monitoring (SCM) aims to develop the capacity of the members of the Village Health and Sanitation Nutrition Committee (VHSNC). These members are tasked with providing support to the front line health workers (FLWs) in their village, monitor service access and delivery, as well as participate and share responsibility to improve the Maternal Neonatal and Child Health (MNCH) outcomes and general health status of their village. The module is intended to help the VHSNC Members understand the concept of supportive community monitoring as opposed to authoritative supervision. It aims to help VHSNC representatives engage the community in planning and monitoring health service delivery to enhance the availability, accessibility, quality and use of the public health system. Through the formation of a smaller group of active Supportive Community Monitoring (SCM) Members who are trained to carry out specific roles and responsibilities, this can be achieved. These SCM Members will be trained to use a SCM Tool that allows them to conduct a regular joint reflection process, leading to community monitoring and evaluation of health delivery systems on the ground.

CONTENTS

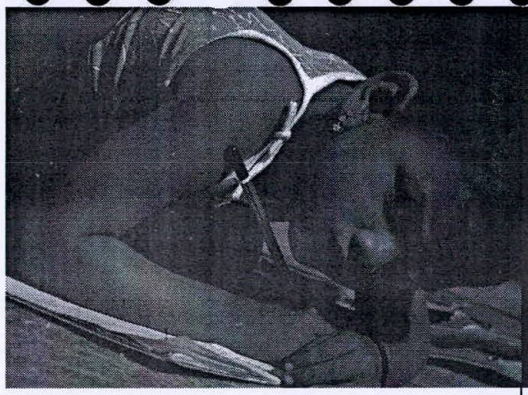
ACRONYMS

ANC	Ante Natal Care
ARI	Acute Respiratory Infection
ARS	Arogya Raksha Samitis
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BCC	Behaviour Change Communication
BP	Blood Pressure
BPL	Below Poverty Line
CBO	Community Based Organization
CDL	Community Demand List (CDL1) Tool
CMR	Child mortality rate
DOH	Department of Health
EDD	Expected Date of Delivery
FLW	Frontline Health Worker
FP	Family Planning
GoK	Government of Karnataka
HBMNC	Home Based Maternal Newborn Care
IEC	Information, Education, Communication
IFA	Iron and Folic Acid
IMR	Infant Mortality Rate
IPC	Inter Personal Communication
JHA	Junior Female Health Assistant
JSY	Janani Suraksha Yojana
JHA	Junior Female Health Assistant
KHPT	Karnataka Health Promotion Trust
MDG	UN Millennium Development Goals
MMR	Maternal Mortality Rate
MNCH	Maternal, Newborn and Child Health
NGO	Non-Government Organization
NRHM	National Rural Health Mission
PHC	Primary Health Centre
PNC	Post-natal Care
PRI	Panchayat Raj Institution
RP	Resource Person
SBA	Skilled Birth Attendant
SC	Sub Centre
SC/ ST	Scheduled Caste/ Scheduled Tribe
SCM	Supportive Community Monitoring
SCMT	Supportive Community Monitoring Team/Tool
SHG	Self-help group
TBA	Trained / Traditional Birth Attendant
TT	Tetanus Toxoid
VHW	Village Health Worker
VHSNC	Village Health and Sanitation Nutrition Committee

GETTING STARTED

The Doorway to Successful Training **in Part 11 of Module 1** should always be used to start a training workshop: initially if covering all modules at one time, or as a refresher if modules are scheduled over a period of time. The Doorway to Successful Training contains a detailed plan of sessions that sets the stage for the workshop activities and logistics, covering welcome, introductions, objectives, hopes and fears, and ground rules.

SESSION 1: SHARING KNOWLEDGE AND PURPOSE



Objective

- To help the Village Health and Sanitation and Nutrition Committee (VHSNC) Members understand that training needs to be transferred to others and they must be prepared to speak up and share their knowledge.

Methodology
Storytelling and discussion

Duration
30 minutes

Training Materials

Copy of story of the three dolls

Tips for facilitators

During the course of the discussion, do not enforce the need to be a doll worth Rs. 15 on everybody. Be open to listening to their choices.

Process

- Tell the participants the following story of 'The Three Dolls',

A family of three, Mallappa (Father), Mahadevi (Mother) and Suchithra (daughter) who lived in a village went to the neighbouring village to attend a fair. First they visited the temple and then went to the fair to get something to eat. The daughter saw some dolls on sale and pestered her parents to buy her one. The father went to the shop selling dolls and asked 'How much?' for a doll. The salesman showed him three similar dolls and quoted prices of Rs. 5, Rs. 10 and Rs. 15. The father then asked the salesman, "Why are you quoting different prices for the dolls that are so similar to each other?" The salesman replied, "Sir, the dolls may look similar, but they have different personalities". So the father asked him, "Please explain the personality of the dolls to me". The salesman took a thin string and put it through one ear of the Rs. 5 doll and it came out the other ear. He then put a thin string through the ear of the Rs. 10 doll and it did not come out at all. He then put the string through the ear of the Rs. 15 doll and it came out of the doll's mouth. The father decided to buy the doll worth Rs 15.

- Ask the participants why they think the father bought the Rs. 15 doll.
- Note their responses on a flip chart.
- Ask them which doll they would prefer and why.
- Allow several participants to share their choices and reasons.
- Note their responses on a flip chart.
- Highlight any responses that focus on the different types of people who make up any community. For example, some people hear things, but it goes in one ear and immediately out the other; they don't really listen. Others listen to everything, but never say anything out loud to others. Still others listen carefully and then speak up, which makes for an interesting personality.
- Ask the participants if there were dolls for sale, how much would they be worth? The answers might be Rs.15.

- Consolidate the session:
  - Participants need to open up, talk and participate freely in the training.
  - Learning from this training needs to be transferred to others.
  - When they return to their respective villages, they should tell their colleagues and friends about what they learnt from the other VHSNC Members.

SESSION 2: CRITICAL MNCH ISSUES

Objective

- To help participants understand the seriousness of the MNCH situation in India as a whole and in Karnataka State.
- To help them understand the deep causes of high MMR and IMR.

Methodology
Storytelling and discussion

Duration
1 hour

Training Materials

Chart paper, marker pens and pre-prepared information chart with details about the IMR and MMR, reasons for deaths and other important aspects of the MNCH continuum of care.

Tips for facilitators

The main focus of this session is to help the VHSNC Members think deeply about MNCH issues. Most of them associate high MMR and IMR with medical reasons and overlook the social causes that manifest in the form of negative attitudes/ myths and harmful cultural practices.

Process

- Tell the participants the following story of ' Kythamaranahalli:

Doddegowda and his wife Gowdashyani lived in Kythamaranahalli village. Doddegowda was the village head for his and 10 other neighbouring villages. His was the last word in all these villages. His only worry was that he did not have any children even after 8 years of marriage. He had taken vows to please several gods and finally he was blessed with a son whom he named Ramegowda. Years went by and Ramegowda grew up to be a fine young man. His parents got ready to find a suitable partner for him so he could marry. When he was 16 years old and studying in the 10th standard his parents decided to marry him to a younger cousin of his, Ramakka. She came from a good family, which meant that the alliance was immediately sealed.

This news of the planned marriage reached the local ASHA. She requested Doddegowda and Gowdashyani to postpone/stop the marriage since the girl was very young. However, she was angrily rebuffed by Doddegowda. The ASHA, along with the Anganwadi teacher and other officials, did not want to give up, so they continued to make attempts to convince the parents not to marry the young children. Their pleas fall on deaf ears.

As planned Doddegowda celebrated the marriage of his son and with god's blessings Ramakka became pregnant within 3 months. The ASHA visited their house as soon as she heard about Ramakka's pregnancy to enquire about her wellbeing and give her information. Ramegowda's father, Doddegowda did not think the ASHA had the knowledge to guide his daughter-in-law. So he didn't listen to her and sent her on her way. This happened again during her second visit. After that the ASHA did not visit their house again.

Meanwhile, the Ramakka's parents visited them to take their daughter home for the delivery as is the usual practice. When they arrived Ramegowda's parents told the in-laws that Ramakka is like a daughter to them and that they would like to have her there when she delivers her first child. They mention that there are no amenities in the parent's village. So Doddegowda told the in-laws to go home and he promised to have the delivery done at the village hospital. So the in-laws left Ramakka with her husband's family. Ramegowda is unable to speak in front of his parents, so he sat there as a mute spectator. As the date of delivery drew near there was a discussion regarding the pregnant woman

delivering her child at the hospital. Then talk veered to the fact that all the 12 deliveries in the past were conducted by the family mid-wife at their own home and that the mid-wife had proved to be lucky to the family. So Doddegowda and Gowdashyani decided that this delivery would also happen at their home with the assistance of the mid-wife Rangamma.

Ramakka wanted to have a hospital delivery. But what could she do? As her opinionated in-laws wouldn't listen to her parents, she decided to simply trust god and stay silent. Ramakka's pains begin and when the pain became unbearable the family sent for Rangamma, the mid wife. A ghee lamp was lit in front of the family deity and Rangamma assured everyone that everything was fine. But soon she told everyone that the baby's head was facing the wrong way and this was the first time she had seen this happen. She said she was not capable of helping Ramakka and to take her to the doctor to at least save the life of the mother. After a lot of searching the family located some transport and managed to take the pregnant woman to the hospital. It was 4pm when they finally reached the hospital. The doctor had just left the hospital to catch a bus home. The resident nurse there advised the family to take the pregnant woman to the Taluk hospital. By the time they reached the Taluk hospital it was 7.30 in the evening. The doctor there said that only one life could be saved, either the mother or the child, and the family decided to save the life of the mother.

- Divide the participants into four groups. Ask them to discuss the following questions:
  - What are the 4 major incidents in the story?
  - Have similar incidents taken place in your village?
  - Who plays the main roles in the story?
  - Why did the death happen?
  - Could it have been stopped?
  - At what different times could the baby's death been avoided?
  - Who are the individuals who could have stopped this death?
  - Who took the decision of whether the mother's life should be saved or that of the child? Why?
  - What did the mother feel at that juncture?
  - Did anyone at that point of time try to understand her feelings?
  - What might have been her decision?
  - If that child could talk what would it have said?

- Allow 20 minutes for discussion, than ask a representative from each group to take 5 minutes to share the main points of their discussion.
- Encourage other groups to share any other key information.
- Continue with the next 3 groups in the same manner.
- Use the pre prepared chart to highlight the current situation of maternal and child health in India as a whole and in Karnataka State.
- Consolidate the following points:
  - The MMR and IMR in India and in Karnataka State are very high.
  - The reasons behind the high MMR and IMR are linked to negative effects of social practices such as child marriage and gender inequity.

SESSION 3: UNDERSTANDING THE IMPORTANCE OF THE SCM TEAM

Objective

- To help participants understand the need and relevance of the Supportive Community Monitoring SCM Team

Methodology

Storytelling and discussion

Duration

1 hour

Training Materials

Chart paper and marker pens

Tips for facilitators

This session is a critical one as VHSNC Members may have questions about their roles and responsibilities. Even if they are not a member of the smaller SCM Team, all VHSNC Members need to understand their role is significant in improving the delivery and access of the MNCH continuum of care services. If there is any confusion, reassure them that the following sessions will provide clarity about the SCM Team and SCM Tool.

Process

- Tell the participants that in Session 2 they heard a story about the causes of maternal and infant deaths and the seriousness of the issue. Now they need to explore the possible solutions to address the causes.
- Tell them the following story.

A farmer in a village reared a cow and took it to his field every day for grazing. A few months later the cow delivered a calf and so the farmer kept the cow tied in the cowshed and brought grass for it from the field so it could get enough rest. A few days later the farmer wanted to begin taking the cow out to the field so that it could freely graze as much as it needed. When he tried to do so, the cow would take a few steps forward and then come running back to the cowshed. No amount of goading by the farmer and his family members changed the behaviour of the cow.

- Ask the participants why the cow wasn't ready to go to the field.
- Note their responses on a flip chart.

- Continue with the story:
  One day when the farmer returned after working in the town, he was pleasantly surprised to see his cow grazing in the field with its calf.

- Ask the participants what might have made the cow decide to return to the field.
- How do they think the calf found its way to the field?
- Note their responses on a flip chart.

- Continue with the story:
  The farmer's 8 year old daughter saw that her father was unhappy with the situation so she had devised a plan. She had seen her father milk the cow and leave the milk at the doorstep. So that morning, the girl dipped her little finger in the milk and held it near the calf's mouth. The calf began to suckle at her fingers. The girl continued to do this for a couple of days and the calf become used to this. On the third morning she dipped her fingers in the milk, and started walking to the field, stretching out her fingers to the calf. It soon followed her to the field.

- Ask the participants who the farmer represents in this story.
- Note their responses on a flip chart.
- Highlight any answers that focus on the role of provision of health service, such as a doctor, JHA or the ASHA.
- Tell the participants that in the story the farmer

represents the health department, the cow represents the community, the calf represents the VHSNC, the daughter is the SCM Team, the little finger represents the SCM Tool and the field represents the MNCH continuum of care services.

- Discuss these roles in detail with all the participants.
  - What services are extended by the health department to the community?
  - Are community members accessing all these services?
- Tell the participants that even though the health department (the farmer) extends a range of services through the ASHA and JHA, and despite repeated requests by doctors to come to the hospital for a check-up, undergo a HIV test, or take iron tablets, we do not access the services (like the cow).
- Ask the participants to tell you what they know about the VHSNC and its role.
- Note their responses on a flip chart.
- Tell the participants that as VHSNC Members they should come together to discuss any issues at the village level.
- Tell the participants that the SCM Team is a small team within the VHSNC that is assigned to provide support and to monitor the delivery and access of MNCH continuum of care services at the village level. Just like the girl's fingers in the story, the SCM Team has access to a tool to carry out this responsibility in an effective way.
- Consolidate the session:
  - The SCM Team is necessary and relevant.
  - In order to streamline the activities, this smaller team, comprising of 6 members, will be formed within the VHSNC that will take the lead in using the SCM Tool every month.

SESSION 4: MODALITIES, ROLE AND RESPONSIBILITIES OF THE SCM TEAM

Objective

- To clarify the modalities, role and responsibilities of the SCM Team

Methodology

Rain claps game and discussion

Duration

1 hour

Tips for facilitators

This session is critical in order to help the members understand the vision and purpose of the SCM Team. If they have questions related to how they would carry out their responsibilities, assure them that the next session will clarify that.

Process

- Tell the participants to play the 'rain claps' game.
- Tell each participant to clap with one finger (strike with one finger – index finger of one hand on the palm of other hand).
- Then ask them to use 2, 3, 4 and 5 fingers, and finally use the entire hand to clap.
- Ask the group to explain the difference between clapping with one finger and clapping with the entire hand.
- Note their responses on a flip chart.
- Now ask an ASHA to stand up and to continue to clap with one finger. Next, ask a self-help group (SHG) member to stand up and to continue to clap with 2 fingers. Then ask an SC/ST woman to stand up and to continue to clap with three fingers. Next ask a youth club member to stand up and continue to clap with 4 fingers. Then ask a person interested in mother and child health to stand up and continue to clap with 5 fingers. Finally ask the President of the VHSNC to stand up and clap with both hands.
- When all 6 members are now standing up, explain that this 6 member group is called the Supportive Community Monitoring Team (SCM Team). This team will try to strengthen and motivate the remaining VHSNC Members to assess, support and monitor the MNCH service delivery system in the village.
- Ask the SCM Team to brainstorm the roles and responsibilities for its members.
- Note their responses on a flip chart.
- When all points have been noted, share the list below for discussion.
- Tell the participants that in addition to the points listed, the SCM Team will be conducting a monthly assessment and self-reflection exercise using the SCM Tool to understand the status of MNCH service delivery in their village.

LIST OF ROLES AND RESPONSIBILITIES OF THE SCM TEAM MEMBERS

Role and responsibilities of the ASHA worker:

1. Extend MNCH services, such as TT injections, iron tablets and vaccines for babies in the community.
2. Provide information regarding critical symptoms during house visits and follow-up with each of the MNCH continuum of care cases, i.e., ANC, Delivery and PNC.
3. Organize the monthly meeting of the VHSNC.

Role and responsibilities of the SHG Member:

1. Create awareness about MNCH services with any pregnant woman, recently delivered and nursing mother living in the same lane or road as the member.
2. Utilize a portion of the VHSNC's untied fund towards improving MNCH services.
3. Take preventive measures against child marriages.
4. Raise a voice against discriminative, ignorant and repressive practices prevalent in the village.

Role and responsibilities of the SC/ST Member:

1. Ensure that the children living in the same lane or road as the member are all vaccinated.
2. Ensure that all child deliveries are conducted at the hospital by linking the beneficiaries.
3. Convey health related information to the community.
4. Ensure that the beneficiaries come forward to access the services offered.

Role and responsibilities of the Youth Club Member:

1. Donate blood to pregnant women delivering a child when required.
2. Accompany or send critical patients to the hospital.
3. Help the people understand the importance of maintaining cleanliness in the village.
4. Support actions to prevent child marriages such as informing higher authorities about potential offenders.

Role and responsibilities of the person interested in mother and child health:

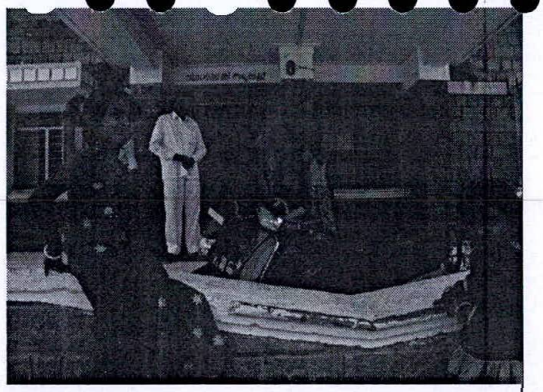
1. Inform the community about the advantages of nutritious food.
2. Inform the community about the advantages of health and cleanliness.
3. Support the prevention of child marriage.
4. Keep track of the health status of pregnant women and nursing mothers.
5. Help resolve conflicts and problems within the community around health issues.

Role and responsibilities of the VHSNC president:

1. Ensure that the services due to the community are extended to them.
2. Ensure that cleanliness is maintained in the village.
3. Take preventive steps to stop the spread of contagious diseases.
4. Organize and preside over the monthly VHSNC meetings.
5. Ensure that the VHSNC untied funds are utilized for the benefit of mothers and children.

- Consolidate the session:
  - Participants are aware of the role and responsibilities of the SCM Team.
  - Participants are motivated to work together to improve the MNCH continuum of care services.

SESSION 5: UNDERSTANDING THE SCM TOOL



Objective

- To introduce and explain in detail the SCM Tool to all the participants.
- To ensure participants have practical experience in using the SCM Tool and in analyzing its findings.

Methodology

Reading, discussion, group work

Duration

2 hours

Training Materials

Copies of the SCM Tool (Annexure 1), chart paper and markers

Tips for facilitators

Give the participants examples of villages where members of the SCMT have played a very active role in promoting MNCH services. For example ensuring that families listen to the instructions given by an ASHA or that poor pregnant women are taken to institutions for delivery using money from the untied funds to support their transportation costs. The groups may take a while to grasp how to fill in the tool and then how to use it. Be patient and explain again until everyone has thoroughly understood it.

STAGE 1 – IN-DEPTH STUDY OF THE SCM TOOL

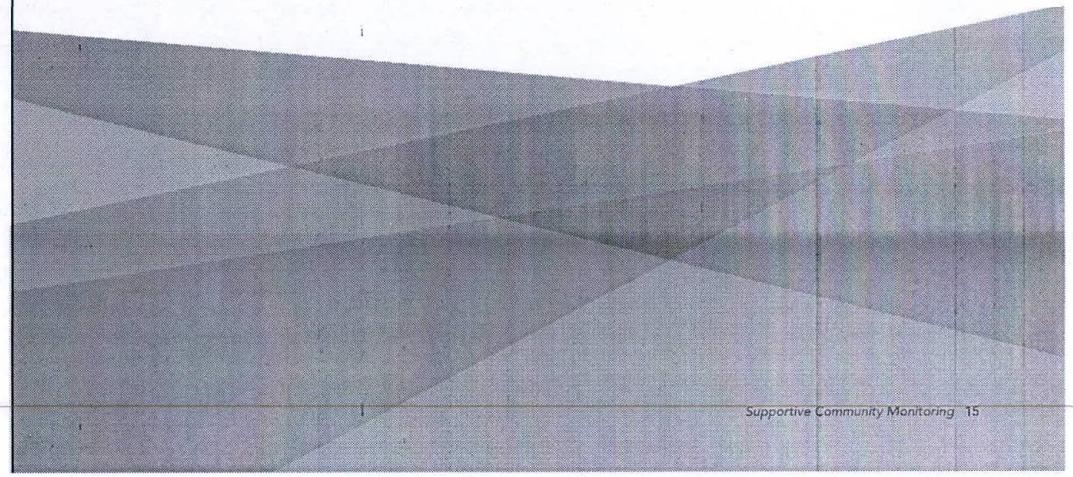
Process

- Distribute copies of the SCM Tool to each of the participants (Annexure 1).
- Read and review all the information.
- Ask the participants to share their views about the SCM Tool.
- Note their responses on a flip chart.
- Highlight and discuss the following points:
  - It helps to provide space for VHSNC Members to understand, assess and monitor health situations.
  - It helps to evolve local and joint solutions for MNCH issues and to supports efforts of FLWs.
  - It helps to enhance accountability and sustainability of health activities at village level.
- Tell them that the SCM Tool will support them as a team to assess the status of MNCH service delivery and access in their villages.

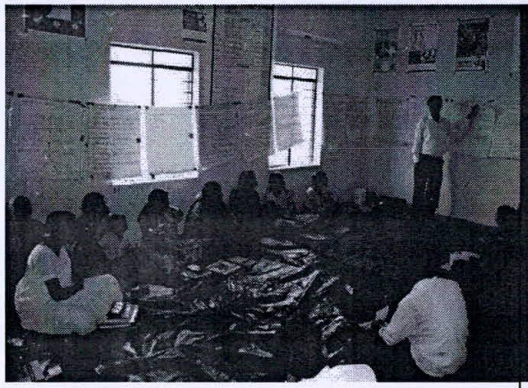
STAGE 2 – USING THE SCM TOOL

Process

- Divide the participants into four groups. Give them one section of the SCM Tool.
- Ask them to read and discuss their section and answer the following questions:
  - What is the main focus?
  - What are the main points?
  - How will the SCM Team Members gather the required information?
  - How will this information help the SCM Team Members?
- Allow 20 minutes for discussion, then ask a representative from each group to take 5 minutes to share their answers.
- Ask the other groups to share any other key information about that section.
- Continue with the next 3 groups in the same manner.
- Now ask the groups to enact an interaction with individuals as instructed in the SCM Tool. For example:
  - Group 1 needs to carry out discussions with the ASHA in the village and fill in the Tool.
  - Group 2 needs to conduct discussions with AWWs in the village and fill in the Tool.
  - Group 3 needs to have a discussion with the VHSNC Members and fill in the Tool.
  - Group 4 needs to carry out general enquiries and fill in the Tool.
- Make sure that everyone has read and understood the scoring process and the consolidation table and that everyone know how to fill that section in.
- Assist each of the 4 groups to analyze the outcome of the interactions.
- Assist them in scoring the status of the village.
- Tell them that when they do this exercise every month, they will be able to see whether the village is making progress on the tool's indicators, or not. This will help them to know what kind of corrective measure is needed and when to take action.
- Consolidate the session:
  - The SMC Tool is a mirror of the MNCH status of the village. After using the SMC Tool each month, the data can be analyzed to either highlight progress or to note when progress is not being made and additional activities need to be implemented.
  - The SCM Tool is not intended to supervise or identify gaps in service delivery of individual FLWs, but to help the SCM Team and VHSNC Members to understand their village and the issues around MNCH and offer support to the FLWs in carrying out their responsibilities.
  - The SCM Tool is not a standalone exercise, but a means to carry out a supportive monitoring role focused on MNCH in the village on a regular basis.



SESSION 6: SELECTION OF A SCM TEAM CONVENER



Objective

- To help the participants understand the importance of choosing an effective convener to steer the SCM Team

Methodology
Storytelling and discussion

Duration
45 minutes

Training Materials

Chart paper and markers

Tips for facilitators

Ensure that the participants from each village work together during this session so that they can engage in discussions together and create a common ownership of the intervention.

Process

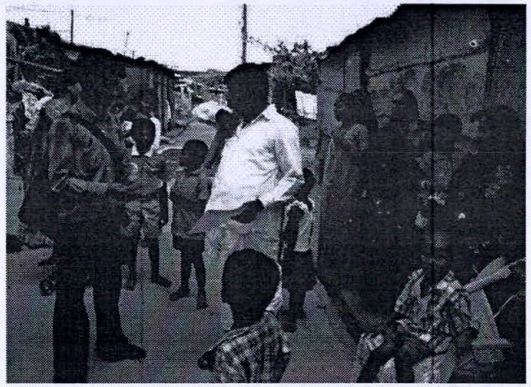
- Ask the participants to sit with their own SCM Team Members from their own village.
- Share the following story:

  Two friends owned a boat. One day they went out fishing and caught a lot of fish. They moored the boat near the dock and took all their catch to the market, sold it, and earned lots of money. Overjoyed by the windfall they decided to go back to fish again to see if they could catch even more fish. When they finally returned to the place where the boat was moored, it was early in the morning, and the sun was just rising. They began to pull in the fish nets from the water, but unfortunately there was not a single fish in the net.

- Ask the participants why the friends could not catch a lot of fish the second time.
- Note their responses on a flip chart.
- Highlight any responses that link the poor catch with the fact they had not set the boat free from its moorings so it was still in shallow water. If they had been in deeper water, they might have caught more fish.
- Tell them that similarly VHSNC Members seemed to have settled down in the comfortable chairs. They have not taken any proactive steps to take the village forward. The have hammered a stake to the ground and tied themselves to it.
- Tell them that they need to identify a SCM Team Convener who will take the lead in getting the group together and keep everyone motivated.
- Divide the participants into 3 groups.
- Allow 15 minutes for each group to choose their SCM Team Convener and then to introduce each person chosen to the larger group.

- Consolidate the session:
  - The SCM Team Convener is chosen by a team that understands the importance of this role.
  - The SCM Team Convener's role is to streamline activities and ensure that the SCM Team's responsibilities are carried out smoothly.

SESSION 7: RESPONSIBILITIES OF THE SCM TEAM MEMBERS



Objective

- To ensure that SCM Team Members are clear about their responsibilities and are committed to fulfilling them

Methodology
Group discussion

Duration
30 minutes

Training Materials

Chart paper and markers

Tips for facilitators

Make sure that the SCM Team Members are not too ambitious about planning activities. They need to be realistic and practical.

Process

- Ask the participants to sit with their own SCM Team Members from their own village. Give them chart paper and markers.
- Ask each team to discuss what kind of activities they should conduct.
- Allow 20 minutes for discussion and then ask the SCM Team Convener to display their activities in front of the training room and share them.
- In plenary, check which of the activities are feasible or realistic, or not.
- Have each group decide on a list of possible activities in a given timeframe.

- Tell the participants that the main responsibilities of the SCM Team Members are:
  - Conducting the monthly VHSNC and SCM Team meetings
  - Filling the SCM Tool every month and analyzing it to keep track of the village's progress on MNCH issues.
  - Following-up on the necessary measures to put into place based on the gaps identified with the SCM Tool.
  - Taking proactive steps to safeguard the health of the villagers.
  - Participating in the proceedings of the 'Arogya Mantapa'.
  - Being involved in all the health related activities that are implemented by the GoK Department of Health.
  - Offering all needed support to the FLWs.
  - Intervening when families refuse to admit a pregnant woman for institutional delivery.

- Consolidate the session:
  - A SCM Team's role is more supportive in nature.
  - It must not take on roles and responsibilities that duplicate those of the FLWs.

SESSION 8: ELECTING SCM TEAM REPRESENTATIVES AND DEVELOPING AN ACTION PLAN

Objective

- To help the SCM Team Members elect competent representatives and develop a 1 year realistic action plan.

Methodology

Discussion, voting, group work

Duration

1 hour and 15 minutes

Training Materials

Card sheet, chart paper and markers

Tips for facilitators

Ensure that everyone is involved in the selection process and that everyone knows the importance of identifying the right individuals for the SCM Team positions without any bias.

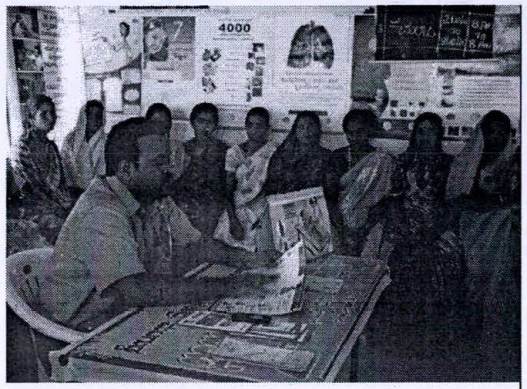
Process

- Ask the participants to sit with their own SCM Team Members from their own village.
- Tell them to democratically select two of their group members to be SCM Team Representatives: one male and one female, but the ASHA is not allowed to be a representative.
- When all groups have elected their new SCM Team Representatives, introduce them in plenary.
- Allow 40 minutes for each team to develop a one year action plan using the format below.
- Ask for both of the newly elected SCM Team Representatives from each group to take 5 minutes to share their action plans.
- Ask the other groups to give comments and suggestions.
- Continue on with the other groups in the same manor.

S.No	Activity	Responsibility and support	Timeline

- Consolidate the session:
  - When choosing a SCM Representative, priority should be given to creative individuals and those with leadership traits.
  - Action plans must be based on facts and with a realistic timeline.

SESSION 9: QUIZ AND TRAINING EVALUATION AND FEEDBACK



Objective

- To assess what affect the module had on the participants' attitudes, knowledge and practice levels.
- To obtain feedback from the participants on the usefulness of the training and suggestions for enhancing future effectiveness.

Methodology

Quiz and reflection

Duration

30 minutes

Training Materials

Quiz (Annexure 2), training evaluation and feedback form

Tips for facilitators

The training evaluation and feedback form will assess what affect the module had on the participants' attitudes, knowledge and practice levels and obtain feedback on the usefulness of the training and suggestions for enhancing future effectiveness.

Process

- Ask the participants to sit with their own SCM Team Members from their own village.
- Tell them that you will read out a question and if any one of the SCM Team Members from any group knows the answer they should shout it out. If correct, that team gets a point.
- The team with the most points wins the quiz.
- Ask the winning team to all stand up and be congratulated!
- Distribute the training evaluation and feedback form. Go over all the areas that the participants will need to think about while filling it in.
- Allow 20 minutes to complete it.
- Collect the training evaluation and feedback forms from the participants.
- Before the closing ceremony begins, ask the participants to share their feelings about the training: encourage anyone who is keen to orally share two positive aspects and two areas that need improvement.
- At the closing ceremony thank all the participants for their enthusiastic participation, congratulate them and wish them the best as they go back to their own field areas and begin to initiate the intervention on ground.
- Thank everyone else who contributed to the training program. This might have included administrative staff, venue owners, facilitators, guest speakers and the organizers.

TRAINING EVALUATION AND FEEDBACK FORM:

KARNATAKA HEALTH PROMOTION TRUST
Training Evaluation and Feedback Form

Name: _____ Designation: _____ Place of training: _____
Training dates: _____ Name of the PHC: _____

S.No.	Subject	Excellent	Good	Poor
1	Training content and sessions			
2	Training methodology and activities used			
3	Training skills of the facilitators			
4	Logistics at the training (Food, stay and comfort)			
5	Relevance and usefulness of training			

List the three aspects of the training that you found most useful.

1.
2.
3.

Name any session during the training that you did not understand properly/ or that was not communicated well.

1.
2.
3.

What are the three most important lessons that you can take back to your work place from this training?

1.
2.
3.

Please list suggestions for improved facilitation in future trainings.

1.
2.
3.

ANNEXURE 1 - SCM Tool

Project Sukshema Department of Health, Government of Karnataka National Rural Health Mission

COMMUNITY SUPPORT MONITORING TOOL			
Name of the village		Village code	
Name of sub-center		Sub-center code	
Name of the Primary Health Center		PHC code	
Taluk		District	

NAMES OF THE MEMBERS OF THE SUPPORTIVE COMMUNITY MONITORING COMMITTEE

1	2	3
4	5	

STEPS TO FIND OUT THE PERCENTAGE (%) FOR EACH INDICATOR

- For every indicator there will be a target and achievement, for the month.
- Target indicates the number of women to be given service for each ASHA area.
- Achievement indicates the number given service for each ASHA area.
- Look up for the target and achievement in the abstract for ASHAs in ETT abstract.
- Each ASHA tells her Achievement and Target for her area.
- Add up the target and achievement for all ASHAs under that VHSNC.
- For example, there are four ASHAS under one VHSNC. Then target for that VHSNC= Targets of ASHA 1 + ASHA 2 + ASHA3 + ASHA4 . similarly Achievement for that VHSNC= Achievements of A1 + A2+ A3 + A4.
- Divide the achievement by target, and multiply quotient by 100. (A/Tx100). This gives the % for each indicator.
- If the achievement is 75% and above mark a 'happy face', if less than 75% mark 'sad face'
- There are certain indicators for which the answer could be 'yes' or 'no'. In such cases mark 'happy face' for 'yes' and 'sad face' for 'no'.
- In the last section of the tool "Significant Issues" if the answer is 'no' mark 'happy face' and if it is 'yes' mark 'sad face'

PROCESS GUIDELINES FOR THE SUPPORTIVE COMMUNITY MONITORING TOOL

1. **Constitution of the Committee - There will be 5 members nominated from the VHSNC**
   i. Chairperson of the VHSNC – Member of the Gram Panchayath of that village, who will preside over all meetings
   ii. ASHA – Member Secretary
   iii. Woman representative of the SC/ST community
   iv. Member of the Self Help Group
   v. Member of Youth Group

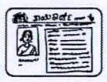
2. **There are four sections in this tool**
   i. Mother and child health
   ii. Anganwadi Services
   iii. VHSNC
   iv. Other significant issues of the village

3. **Process**

- The Committee will monitor the issues in two groups of 3 and 2 members each. One group will meet up with the ASHAs of the village and discuss about the ANC and PNC services rendered by them.
- The other group will discuss with anganwadi workers about the services provided by them such as nutrition, health education, mothers meeting, village health and nutrition days.
- Based on the discussions the tool will be filled by each group respectively and the consolidation done.
- The challenges or problems that emerge from the discussion are classified under 3 categories – a. Family based b. Social practices c. Systemic inadequacies
- Each group, based on the problems or challenges and the reasons identified, will work out strategies and action to be taken to address them.
- All 5 members of the SCMC will present their discussion and feedback to the VHSNC, and also discuss with the members on the village health issues and the support given to the front line health workers.
- The VHSNC will also discuss other significant issues such as child marriage, death of child/mother or community member etc.
- The outputs of the discussion of the two groups and the VHSNC are consolidated to arrive at the health status of the village for the particular month.

The decisions taken and recommendations in the VHSNC are presented at 3 levels –, at Sub-center level, Panchayath and PHC and also for follow-up action.

Sl.No	SERVICE RELATED TO PREGNANT WOMEN, JUST DELIVERED MOTHERS AND NEO-NATAL CHILDREN (This is to be filled based on consolidation of the target and achievement abstract of ASHAs of the village. If the achievement is above 75% of the target then mark the 'happy face', and if less mark the 'unhappy face' for each indicator as explained in the previous session.

1		% of pregnant women registered		5		% of institutional deliveries	
2		% of pregnant women received TT		6		% of PNC visits (completed)	
3		% of pregnant women received IFA		7		% of children immunizations (% of children immunized 0-11 months)	
4		% of pregnant women received ANC services		8		% of married women practicing family planning	

Please count the total number of happy and unhappy faces and fill in each box

PROBLEMS / CHALLENGES/ REASONS

DECISIONS TAKEN BASED ON THE DISCUSSIONS WITH ASHAS

Sl. No	DETAILS OF THE ANGANAWADI SERVICES Please fill in this page of the tool based on the discussions with Anganwadi workers of the village Source : Anganwadi Registers and Abstract of the ASHAs. Please mark the 'happy face' if the answer is 'yes' or % is above 75%	Grade

1		% of mothers' monthly meetings		4		% of children under 3 yrs weighed	
2		Is the Village Health and Nutrition day observed in the month?		5		% of malnourished children under 3 yrs who received nutritious food	
3		% of pregnant and delivered mothers received nutritious food					

Please count the total number of happy and unhappy faces and fill in each box

PROBLEMS / CHALLENGES/ REASONS

DECISIONS TAKEN BASED ON THE DISCUSSIONS WITH ASHAS

Sl. No	INFORMATION ON VHSNCS PERFORMANCE Please fill in this page based on the discussions with VHSNC members Please mark the 'happy face' if the answer is 'yes' or else 'unhappy face', or % is above 75% The number of ASHAs and AWWs together should be added and % collected

1		Testing and purification of the safe drinking water sources	☺ ☹
2		% of ASHAs and AWWs functioning in the village?	☺ ☹
3		% of ANM visits to the village	☺ ☹
4		Have the immunization programs been organized regularly?	☺ ☹
5		Have the pregnant women and delivered mothers been given any support by VHSNC (nutritional, monetary for medicine or vehicle support) or has the VHSNCs supported FLHWs?	☺ ☹
6		Is the fogging done regularly to control mosquitoe	☺ ☹

Please count the total number of happy and unhappy faces and fill in each box

☺ ☹

PROBLEMS / CHALLENGES/ REASONS

DECISIONS TAKEN BASED ON THE DISCUSSIONS WITH ASHAS

Sl. No	SIGNIFICANT INFORMATION Please fill in this page based on the discussions with VHSNC members Please mark the 'happy face' if the answer is 'yes' or else 'unhappy face'.

1		Has there been any child marriage in the village?	☺ ☹
2		Has any child less than 1 yr / recently delivered mother fallen sick and hospitalized seriously?	☺ ☹
3		Has there been any death of a child below one year?	☺ ☹
4		Has there been death of a recently delivered mother reported in the village?	☺ ☹
5		Has there been any death in the community reported, for any other reasons?	☺ ☹

Please count the total number of happy and unhappy faces and fill in each box

☺ ☹

PROBLEMS / CHALLENGES/ REASONS

DECISIONS TAKEN BASED ON THE DISCUSSIONS WITH ASHAS

ANALYSIS OF ALL THE SERVICES IN THE VILLAGE

ASHA Services rendered to mother and child ☺ ☹

AWWs services ☺ ☹

VHSNCs performance ☺ ☹

Sl. No	MONTHLY CONSOLIDATIONS There are 24 questions in the tool. Add up the number of 'happy faces' and the number of 'sad faces' for all the 3 services.	
1	If the number of 'happy faces' exceeds 18, then mark 'happy face' for that month,	
2	'Happy faces' are between 12-18, then mark the 'poker face'	
3	'Happy faces' less than 12 then mark 'sad face'	
	Consolidated village health status for the month	

Consolidation for the year

	Section	January	February	March	April	May	June
1	ASHA Services						
2	ANGANAVADI Services						
3	VHSNC Performence						

	Section	July	August	September	October	November	December
1	ASHA Services						
2	ANGANAVADI Services						
3	VHSNC Performence						

Consolidation for the year

	Section	January	February	March	April	May	June
	Health status of VHSNC						

	Section	July	August	September	October	November	December
	Health status of VHSNC						

ANNEXURE 2 - Quiz questions for Session 9

1. How many members make up the SCM Team?
2. From which committee have the SCM Team Members been chosen?
3. Who are the 6 SCM Team Members?
4. Who is the secretary of VHSNC?
5. Who selects the ASHA?
6. What do we mean by maternal mortality?
7. What do we mean by child mortality?
8. Who is the president of the VHSNC?
9. What do we mean by a happy face?
10. How much funds does the NRHM transfer to the VHSNC?
11. How many fatal diseases attack children? Which are they?
12. Which is the legally marriageable age specified by the government?
13. In SCM Tool specify the one criterion that if it is classified as a weepy face then the entire village is classified as a weepy face village?
14. Who are all responsible for health care?
15. In the Kyathamaranahalli story what character dies?
16. How much does the doll cost which listens through its ears and speaks through its mouth?
17. What does "Our village healthy village" mean?
18. What does "NRHM" mean?
19. Which is more, 1 kg of iron or 1 kg of cotton?
20. Our district should be rid of ----------and ----------deaths
21. Describe the SCM Tool.
22. What is the color of the new born smiling teeth?
23. What do you mean by ASHA?
24. What is the total number of checkups for a pregnant woman?
25. What are the symptoms that indicate that a pregnant woman is in a serious condition?
26. How many times does an ASHA visit a woman who has delivered a baby? Give the days on which she visits?
27. What is the frequency of VHSNC meetings?
28. In how many districts is VHSNC present?
29. How many members make up the VHSNC?
30. Which are the tablets that a pregnant woman must take? How many?