

Notes for ASHA Trainers

Induction Training for ASHAs in Urban Areas



Ministry of Health and Family Welfare
Government of India

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Introduction to the Trainers Notes

This Trainer Guide is intended for the use of trainers who are responsible for training newly selected ASHAs in Urban Areas. This guide aims to facilitate the trainers in transacting the induction round, that covers the content included in -“Induction Training Module for ASHAs in Urban Areas”.

The introductory chapter of this guide describes standard principles to be followed for conducting ASHA training workshops, and ways to ensure participatory training.

Using this guide the trainers will orient ASHA to their roles and responsibilities build skills of community rapport building and leadership, develop an understanding of the health system and a rights based approach to health. All these are covered in Sessions 1-4. Other basic concepts of health, hygiene and illness, understanding of common health problems and infectious and non-communicable diseases form a part of Sessions 6 and 7. As a part of this training, ASHAs are also introduced to key aspects of reproductive, maternal, new born, child and adolescent health and skills for vulnerability assessment and mapping. Sessions 8-14 have been designed so as to lay the foundation for learning complex skills which will be covered in subsequent trainings of ASHAs.

These notes draw substantially from the earlier Trainer Notes developed for ASHA Modules 5, 6 and 7.

Guidance for Trainers to Plan the ASHA training workshop

I) Review by Trainers and Programme Managers:

This will enable systematic planning for ASHA Induction Training. Following points need to be ensured as part of the review:

- Prior intimation to ASHAs about training venue and dates.
- Planning for the ASHAs arrival at training venue and welcoming them
- Departure on the last day: arrangement for payment and transport – (information about timings, other means to facilitate their return)
- Arrangement of food
- Workshop venue and setting: Building a positive environment
- Accommodation: cleanliness, basic comfort, security
- Preparation of study material
- Games and songs: identifying persons who can lead these sessions
- Emergency medical facilities
- Day care for the children
- Arrangements for recreation

II) Follow these tips for successful training:

☉ Make it Residential

- a. The training is residential and all ASHAs should be present for all the sessions of the training.
- b. Residential training is preferred as it gives ASHA an opportunity to build solidarity with the group and practice difficult skills after the formal sessions. Trainers should also stay at the training site to enable team building and provide additional practice time.

☉ Get the training aids ready as a prior exercise:

- a. Trainers need to read through the session and make sure they understand the training methodology and they are well prepared. The Training Aids required for a session, are included in each session chapter. Some training sessions include Notes for Trainers with additional suggestions which state how the activity should be implemented and give the information (knowledge) needed for the session. Trainers should plan to have posters and flip charts to be displayed ready before the start of the workshop, and these should be organized session wise.
- b. Trainers should ensure that there is a blackboard, coloured and white chalk, dusters and flip charts and markers available as most sessions require these.
- c. Some sessions require use of videos or films. If electricity is fluctuating, it is preferable to present these when steady power is assured, and the trainer should be able to ensure that the session runs smoothly.

- d. Study material and worksheets to be given to the ASHAs must be ready well before the training commences and should be distributed at appropriate time during the session. Trainers should check the material before distribution which will avoid chaos during session.

☉ **Make the training participatory, non- hierarchical, and build solidarity**

- a. Trainers should eat, sit, sing and play with the ASHAs which give them the feeling that they are the members of the group.
- b. ASHAs and the trainers should sit in a circle so that the trainers easily become part of the group. As the training involves role plays, group discussions, demonstrations etc. chairs and tables should be avoided.
- c. Trainers should understand the difficulties of the ASHAs and have sympathy for their problems.
- d. Songs and games should be used as relaxation techniques also to inculcate a feeling of solidarity and oneness with each other. The ASHA song is one good beginning, and local songs of inspiration and those celebrating women’s health and empowerment should be used.
- e. Ask the trainees to share the training schedule of each training workshop. There should be a definite plan for the events in the evenings. For certain events they may ask the ASHAs to share the responsibility. This develops organization capacity in ASHAs.
- f. Trainers and ASHAs should participate in keeping the training area clean.
- g. Trainers should also follow methods of Participatory Learning in Class Room

Table below details out the methods that are usually followed, highlighting the strengths, usage and weaknesses of each-

Type of Method	Key Points in Methods	Pros and Cons/Strengths and Weaknesses	When Best to Use
Presenta- tion	<ul style="list-style-type: none"> • Power point presentations, charts, posters or even writing on black board makes it easier to focus and recall. • Written text of paper should almost always be circulated and participants given time to read it. (Module text). • Needs good presenter and a good preparation. • Eye contact with as many participants is possible. • Interrupting flow of presentation for a few questions, jokes, visuals helps a lot. 	<ul style="list-style-type: none"> • Good for presentation of many facts. In large audiences – not much else can be done, • Could be impressive and inspiring but difficult to replicate and level of recall of what is said is very poor 	<ul style="list-style-type: none"> • Conveying facts or Information. • Organized presentation of overviews- where many sub- themes are linked to a single framework, like objectives of the workshop. • Large groups.

Type of Method	Key Points in Methods	Pros and Cons/Strengths and Weaknesses	When Best to Use
Demonstration	<ul style="list-style-type: none"> • Best for teaching skills: The activity is carried out by facilitator with all participants observing. • It could be repeated by each member or by each small group with facilitator observing, using a check list. • Use of mannequins and models and appropriate instruments essential for teaching of these specific skills. 	<ul style="list-style-type: none"> • Good for teaching skills. • Comes near – but is not the same as doing it in real situations. • Requires a lot of equipment and preparation. • Counseling skills- of one or two mothers in front of a whole group is effective but can be embarrassing to facilitator and to mother with child. 	<ul style="list-style-type: none"> • Useful for skill learning. • Counselling skills, counting breathing in a child using a mannequin, making ORS solution etc
Group discussion	<ul style="list-style-type: none"> • A topic is given to the group. Different persons are allowed to voice their understanding. A good moderator gives everyone time, and allows more time for those who have new insights to offer. • Moderator also sums up and draws the generalizations that are emerging. 	<ul style="list-style-type: none"> • It could be used to follow or intersperse with a presentation for making the presentation more participatory and interactive. • Not everyone gets to speak because the group is large. • Needs a skilled moderator. 	<ul style="list-style-type: none"> • Issues where there are differing viewpoints- mainly two or three contending view points where a consensus has to be built up. Like on the role of ASHA.
Small group discussion	<ul style="list-style-type: none"> • The participants are divided into small groups of 4 to 8 persons- usually about 5 to 7 person groups. • A set of tasks or questions is set to them which they would discuss in the group. The group may have to read the specific pages in the module first. Then each member in the group answers the questions and the consensus answers are written down in a chart paper or noted down and presented to the larger group/plenary.. The moderator of the larger group then facilitates the large group discussion. 	<ul style="list-style-type: none"> • The subject matter of the text gets revised thrice- when it is read out, when the questions are answered by each in the group and when they are again presented in the larger plenary. • Helps to give more attention to those with low literacy skills and who are slow in learning. • Can be conducted even with those with modest presentation skills. • Make take much more time, especially where the facilitators are not confident and dynamic. 	<ul style="list-style-type: none"> • Becomes the main form in which the modules are covered- when we are not in the experiential/ group learning mode. <p>This allows for the text to be read and internalized and prevents transmission loss.</p>

Type of Method	Key Points in Methods	Pros and Cons/Strengths and Weaknesses	When Best to Use
Role play	<ul style="list-style-type: none"> • Three steps: Briefing: A situation is given to a selection of participants. Roles of different characters are assigned to each. • Play: The situation is then acted out and allowed to develop towards a purpose. • Debriefing: the act is stopped and then the participants reflect on what they saw and learnt from the different roles. 	<ul style="list-style-type: none"> • Takes time. Needs careful and skilled facilitation to lead to required outcomes. Not useful for skills- but useful to question attitudes. • Risk of getting carried away with theatrics some of which could be more powerful with negative messages. Thus the text would be gender sensitive- but the gender insensitive character may act better and more convincingly. 	<ul style="list-style-type: none"> • Most useful for exploring attitudes and perceptions, especially where they act as constraints. <p>In ASHA training most role plays are more in the nature of case simulations which must be differentiated from role plays.</p>
Case simulation a. Oral with Handouts/ Posters etc. b. Video-based	<ul style="list-style-type: none"> • The facilitator plays the role of the pregnant woman or a woman with a young child simulating a real patient/ beneficiary. The ASHA asks questions or counsels this beneficiary. • Instead of facilitator playing this role orally, a video clipping could show such a child, or a poster or handout could describe such a case. • Best is the video –clipping with poster and handout as a back up – but if all else fails a good trainer could herself simulate the case. 	<ul style="list-style-type: none"> • Pros- next best to experiential learning for counseling skills – and without the embarrassment and ethical concerns of practicing with a real beneficiary. • Video clippings based case simulation best for seeing a wide variety of sick child and newborn situations. • Need to organize electronic material carefully. 	<ul style="list-style-type: none"> • For Counseling skills. • Also for learning to identify sick and severely malnourished children and other danger signs and complication requiring referral.

How to choose the appropriate TRAINING METHODS and TECHNIQUES

Kinds of Learning	Training Activities	Evaluation Activities
Facts/Information	Readings, Presentations, Audio-Visuals	Written exams, oral exams, role plays
Skills (Manual, Communication, decision-making, planning etc.)	Demonstration or simulations (Practice with feedback to correct mistakes)	Observation during practice or role play or on the job using checklist
Attitudes/Values	Discussion, Role plays, role modeling, clarification exercises	Observing behaviors on the job, during practice or during role plays

Undertake Training Evaluation:

- a. To be sure the training objectives have been met, it is important that trainers evaluate the ASHAs. Trainers can conduct an informal evaluation at the end of each session by giving questions for practice through case studies or questionnaires. Through questions and answers, the trainers should ask participants to explain the session, if they answer correctly; this will indicate that the session objectives have been met.
- b. A formal evaluation is conducted at the end of training programme when answer sheets for evaluation should be checked immediately and the scores should be shared with the trainees. The problems should be discussed with the trainees and misconception should be cleared. If this is not done immediately then the trainees proceed further in learning the content and confusion remains in the content. Trainers should share the result with the ASHA when her memory is still fresh. Never delay sharing the result.
- c. Demonstration exercises and practical tests are needed to evaluate specific skills. such as preparing ORS, nutrition counseling to mother of a malnourished child, how to conduct vulnerability assessment of households living in slums, how to measure temperature and weight of the newborn etc.
- d. The trainers should plan to spend time in the evening to give additional inputs to those ASHAs who have not performed well in the test.

Other Points to Note

- a. Considering the educational background of ASHAs they are not used to long hours of classroom teaching. The trainer should learn to understand when the group is losing interest in the session and should modify the session to ensure that the trainees regain concentration in the session. The trainer should keep the group engaged by asking questions which will promote active participation.
- b. Training should start each day at the stipulated time: If the trainers are delayed and the trainees are on time the trainees start rating the trainers as late comers. This may change the mood of the training and slowly nothing it seems that nothing is happening as planned. Trainers should manage the time for each session. Enough time should be given for discussion on important points. Try to stick to the time table of the day and avoid creating backlog which is difficult to manage afterwards.

Agenda for Induction TOT for ASHA Trainers

Session Details

Day -1

Introduction, Background to the Induction Module and Participatory Training Methods, Being an ASHA: ASHA Support and Supervision – UHND and Working Arrangements, What is a Healthy Community

Day-2

Understanding Rights and Right to Health- Preserving Women’s Right to Health: Understanding NUHM, Navigating Complex Public Health Facilities. Skills of ASHA- Leadership, Communication, Decision Making, Negotiation and Coordination Skills

Day-3

Skills of ASHA (continued): Convergence for Health, Understanding Vulnerability among Various Vulnerable Groups, Vulnerability Mapping and Assessment. Knowing about Health, Hygiene and Illness- ASHA’s Role in Promoting Rational Drug Use

Practice sessions (*Being an ASHA, Understanding Rights and Right to Health, Skills of ASHA- Leadership and Decision Making Skills, Knowing about Health, Hygiene and Illness*)

Day-4

Dealing with Common Health Problems, Role of ASHA in Management of Trauma and Injuries, Common Diseases - Tuberculosis, Leprosy, Malaria, Dengue and Chickengunya, Prevention of Vector Borne Diseases

Day -5

Maternal Health- Antenatal care, Delivery and Post Natal Care.

Newborn Care – Care of the Normal & High Risk Baby, Breastfeeding, Infant and Young Child Nutrition- Malnutrition and Immunization.

Day-6

Infant and young child nutrition (Cont.) – Common Childhood Illnesses and Adolescent Health

Day-7

Women’s Reproductive Health- RTI & STI, Preventing Unwanted Pregnancies & Safe Abortion.

Practice sessions (*Dealing with Common Health Problems, Role of ASHA in Management of Trauma and Injuries. Common Diseases - Tuberculosis, Leprosy, Malaria, Dengue and Chickengunia, Prevention of Vector Borne Diseases*)

Day-8

Practice sessions (*Maternal Health – Antenatal care, New Born Care, Malnutrition, Common childhood illness and Preventing Unwanted Pregnancies & Safe Abortion*)

Written Evaluation

Closing and way forward

Agenda for Training for ASHA in Induction Module

Day 1

Introduction & Background to the Module	2 Hours
Being an ASHA	5 Hours

Day 2

What is a Healthy Community?	2 Hours
Understanding Rights and Right to health	4 Hours
Skills of ASHA	1.5 Hours

Day 3

Skills of ASHA (Contd.)	5 Hours
Skills of ASHA (Understanding Vulnerability and its Assessment)	2.5 Hours

Day 4

Knowing about Health, Hygiene and Illness	2 Hours
Dealing with Common Health Problems	3 Hours
Common Disease -TB & Leprosy	2 Hours

Day 5

Common Diseases (Contd.)- Malaria, Dengue and Chickengunya	3 Hours
Common Diseases (Contd.) - Non-Communicable Diseases	1 Hour
Maternal Health – Antenatal and Delivery Care	3 Hours

Day 6

Maternal Health – Postnatal Care	1.5 Hours
New Born Health	3 Hours
Infant and Young Child Health and Nutrition	3 Hours

Day 7

Infant and Young Child Health and Nutrition (Contd.)- Diarrhoea and ARI	3 Hours
Adolescent Health	1.5 Hours
RTI & STI, Preventing Unwanted Pregnancies and Safe Abortion	2.5 Hours

Day 8

State Specific Programme Orientation	3 Hours
Evaluation	2.5 Hours

Session 1.1: Introduction of Participants

Aim: To introduce ASHAs in training workshop to one another. To make them feel relaxed, introduce them to the training workshop and build a team.

Method: Interaction and game

Material: One ball and/or small piece of papers 2"X2"

Time: 30minutes

Activities:

1. Welcome all participants to the workshop. You should begin the session by congratulating all participants on getting selected as an ASHA. This session should instill a feeling of being unique and would enable each of them recognize their talent and skills that helped them in getting selected as an ASHA for their area.
2. The trainer should throw the ball to a participant, who should catch it. Then the person who caught the ball should tell the group: her name, area from where she has been selected, person in her family or area who inspired her to become an ASHA and why does she think she was selected by her community to undertake the responsibilities of ASHA.
3. The first participant would throw the ball to any other person whom she knows the least and so on. Then she could throw the ball to anyone in the room, except the first two. This way the ball would proceed to every participant and everyone would have introduced themselves.
4. Then the trainer would collect the ball and again throw the ball to a participant, who should then catch it and tell the name of the person who threw the ball. If she does so that is good, if not she has to be helped by her neighbour and if still they cannot get the name the participant has to introduce herself again. If they are still unable to get the name, the participant has to reintroduce herself. Now the ball goes around and each person has to name the person from whom they receive the ball. Thus each person has to recollect the names of all those in the room.
5. Another way of introduction can be to distribute small piece of chart paper/card and felt pen to each person. In 5 minutes the participant draws on it, anything that they think represents her personality. It can be any object from daily life from nature or from animal world. Each participant explains her work of art to the whole group, as to what are the similarities between her and the object drawn. It can reflect her desires and thoughts. The 'identity cards' should be worn on a thread/ribbon around the neck for the duration of the workshop. It can lead to reflections over the 'self' and explorations of new ways of thinking and doing.
6. Once each participant is familiar with others name the game can be concluded.

Session 1.2 Main Roles and Tasks of an ASHA

Aim: By the end of this session the ASHAs will understand:

- What it means in her context to be a service provider, facilitator or an activist
- What are the broad activities through which she will fulfill her roles
- Expectation from different stakeholders
- Main job descriptions and essential tasks
- The importance of values to effectively perform the role of an ASHA

Method: Group Discussion

Material: Board, chart paper and marker pens.

Time: 120 minutes

Activity:

1. The trainer begins the session by telling the participants to look at picture on page 7 of the Induction Module. Trainer then gives a little time to the participants to read the section and resumes the discussion by asking: the ASHA has three types of roles, what are these?
2. Now ask the participants, what words like facilitator, activist, and provider or community health volunteer mean.
3. The trainer explains the various roles and expectations using the information given below
4. Use the poster (given on next page) on “An ASHAs Activities” to discuss the main roles and takes of an ASHAs

One is the role of an activist who sees health care as a right or entitlement- how can ASHA help the poor woman get treatment? Another is the role of a link worker-- how can the ASHA find out and inform the public about the near health facilities and free health services. The third is the role of service provider – what advice can ASHA offer to the mother of a child who has diarrhoea.

Since these ASHAs have not yet begun working, the trainer should explain different activities and explain her three roles in detail with some examples. The trainer should not impose any one answer as correct or mark the others as wrong- all three are acceptable – but the emphasis of each changes with the context of the area in which the ASHA works.

Role Clarity-

Given below are more examples of three types of roles that ASHAs already working are doing. We try to categorize them into three types. The trainer should note and point that it is not quite possible to separate these roles.

The Trainer could call out each role or write it up on a board and the participants could call out which of these three categories it belongs to, and whether they think they could perform this role, (Possible) whether this would make a difference to health outcomes, (effective) and whether they would like to perform it (desirable). ASHA could also say which other tasks they would like

included. Trainers must have clarity that this is only to stimulate discussion. It is not mandatory for ASHA to do all these activities. But they could volunteer to do some of these.

a. Link worker Role

- I inform those who are due for immunisation about which day the ANM would be visiting or conduction Urban Health and Nutrition Day (UHND).
- I hire a vehicle and take the pregnant woman with labour pains to the hospital.
- I inform the local ANM or medical officer about any outbreak of disease in my area.

b. Service Provision

- If any child has fever or cough, the family brings the child to me, for some advice and drugs and I decide whether they have to be referred.
- I visit homes with malnourished children to counsel them on feeding practices and prevention of infection.
- I act as DOTs provider for TB patients in my area.

c. Activist Role

- There are many small pockets of slums in my area where services were not reaching. I made intensive efforts with all concerned and improved service coverage in these slums.
- I went to the hospital with a patient and one staff member asked for Rs. 500 payment. I asked for a receipt to be given to the patient. Even though the staff member got angry with me, I persisted in asking for the receipt.
- There is no UHND held in my area. I led a meeting of the Mahila Aarogya Samiti to meet the block medical officer and we convinced them to start UHND in our area.

8. After explaining each of these roles it is important to ask the participants which of these roles they think is more important and ask them to give more examples of each type of role. Write the examples on the board. Allow an open ended discussion.

9. Summarize their responses and reinforce the fact it is important for an ASHA to perform all these roles as necessary with the balance between them changing as per the context.

10. Annexure 3 given on page 133 of Induction Module carries an interesting story about women's anti arrack movement. Trainer can ask one of the participants to read aloud this story, while the other participants are asked to listen carefully. This will help to build clarity on ASHA's role in community mobilization.

11. Now make the participants open the picture on "Activities of an ASHA" given on page 8 of the Induction Module. Ask the participants to take turns to read the text given below and explain each of these activities in detail one by one.

12. End the session by asking few participants to summarize in brief what they have learnt so far. Trainer can fill the gaps wherever necessary.



An ASHA's Activities



An ASHA is a **facilitator**, that is, she helps the village community to access health services provided by the government.



An ASHA is a **community mobilizer** who involves the community in securing their health rights to lead to better health.



In some cases, an ASHA is also the **health care provider**. For example, she counsels on child feeding or provides appropriate home care for diarrhoea and other common illnesses using her drug kit.



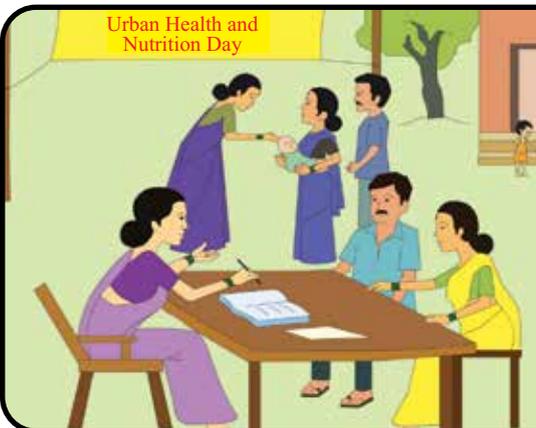
Making **home visits** to families in her area is one of the most important activities of an ASHA. This gives her an opportunity to communicate important health messages and to establish a rapport with the families living in the slum.



An ASHA's Activities



Such visits are absolutely essential if there is a **pregnant woman, newborn or a child below two** in a family. During these visits, she should assess the health status of the woman and child, and counsel the family about the care they need to take.



Apart from home visits, the ASHA also has to **attend the Urban Health and Nutrition Day** held every month. She should ensure that the people in her area also attend, and access the services provided, such as immunisation and check-up of pregnant women.



Occasionally, the ASHA has to **visit the health facility** (UPHC/CHC or district hospital), accompanying a pregnant woman for delivery or a child who needs urgent treatment.



The ASHA is expected to **hold slum level & meetings** regularly. She participates in meetings of the Mahila Arogya Samiti, and of women's groups. These are occasions for her to create awareness in the community about common health problems, and how they can be prevented and managed at the community level.

Session 1.3 Essential Tasks and Values of an ASHA

Aim: By the end of this session the ASHAs will understand:

- Expectation from different stakeholders
- Main job descriptions and essential tasks
- The importance of values to effectively perform the role of an ASHA

Method: Discussion

Material: Board, chart paper and marker pens

Time: 150 minutes

Activity:

1. Begin the session by asking the participants what is it they want to do for their community, what they think are expectations of the community and of frontline workers (ANM, AWW) and service providers from them. Make three columns for each on a board and write their responses.
2. The trainer should prompt them if there is any work or some outcomes have not been spoken about.
3. Now ask them to open page 9 of the Induction Module and read the box on essential tasks of an ASHA. They should read it loud and in turns. The trainer should write down what is being read out on a chart paper separately. The trainer should then ask the ASHAs to point out what has not appeared on the board and has now been included in the chart paper.
4. Now explain to the participants that to do these tasks there are certain skills that would be needed. Some of them would be taught to them in this training and some of them would be covered in subsequent trainings.
5. Since the ASHAs are new it is just not enough to tell them the key tasks they ought to do. Trainers should make an attempt to lay a strong foundation for these ASHAs from the beginning and explain why these tasks, outcomes or expectation have been defined for ASHAs across the country.
6. Use the information below for making a presentation on the contextual factors that define the essential tasks of an ASHA.

Step 1: Maternal Health

- In India about 46,000 women die each year during pregnancy and delivery. Most of these deaths can be prevented.
- Neonatal mortality in India accounts for 50% of deaths of all children under five. Three quarters of all neonatal deaths occur during the first week of life, and about 20% die in the first 24 hours. This is also the period when most maternal deaths take place.
- Maternal and neonatal mortality are higher among poorer, less educated and marginalised families.

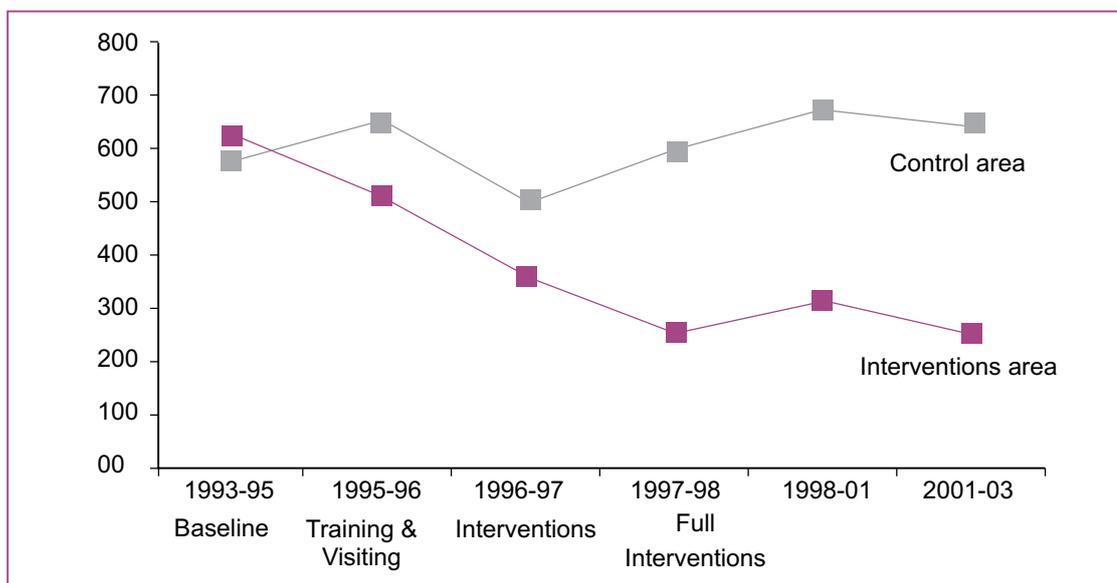
- Among children less than five years of age, the most important causes of death are diarrhoea, pneumonia, and malaria. Poor nutrition among children may not be a direct cause of death but is an underlying cause.
- Every pregnant woman should receive health education antenatal care and post natal care, and have a doctor/skilled birth attendant available for delivery preferably in a well equipped institution. The ASHA should help the mother in receiving all these services.
- Those pregnant women who have complications or for some reason may have a greater risk than other women should straight away be recommended to go to the hospital or an appropriate health facility. For this the ASHA should be aware of which are the services offered in nearby facilities, the cost of such services, how to arrange transport when needed and the skills to counsel a pregnant woman and help her make a birth plan. The home visit to the pregnant woman is also a useful occasion for counseling on family planning services. These services are potentially available for free, but many women who want to delay their next child or limit their family size are currently unable to avail of these services. The ASHA could help close this gap.
- Taken together all these activities are most important to reduce maternal mortality- which is one of the most important goals for the family, for the community and for the nation. This outcome is also easy to monitor by the ASHA trainer when she visits an area. She merely has to ask for the names of pregnant women who are going to deliver a baby or have done so within the month. She then visits two or three such homes and asks whether the pregnant woman has received all these services, and has/had made a birth plan. If these have happened, the contribution of ASHA is evident.
- There is some concern among some people, that if ASHAs are taught too many skills, they would become dais, or that the work of the ANM would be taken over. Is there such a danger? Explain how the ANM's work would also benefit because she would be covering more ante-natal cases, post natal cases and complications. The need for institutional delivery is so that risk is better managed by nurses who are trained to a higher level of skills. ASHA training is not sufficient to make her a good mid-wife and needs to be explained.

Step 2- Newborn and Child Health and Nutrition

- Saves lives: About one thirds to half of all deaths of children less than five years of age occur in the first month of life and of these a large number occur in the first day of life. There is enough evidence from all over the world that if appropriate newborn care is given from the moment of birth, almost all of these lives can be saved. After nine months of pregnancy, a mother and family are racked by sorrow and guilt if they lose this precious child, and society has to make every effort to prevent it.
- Importance of newborn care: One way of doing so is to promote institutional delivery- so that a trained nurse or midwife or doctor is available at the moment of birth. However nation-wide about 40% of births occurring outside institutions. There is enough evidence from all over the world and from India, that a well trained community health volunteer like ASHA can save a significant part of these lives if she were to be available in these critical hours. Even where there is institutional delivery, the mother and child leave for

home within one or two days and in the rest of the month, it is upto the ASHA to make the home visit. The graph below highlights the data from Gadchiroli, a urban area in Maharashtra where Community Health Workers such as ASHA were able to provide home based neonatal care (HBNC), resulting in a reduction in neonatal mortality and also a reduction in maternal illness.

Neonatal Mortality Rate



The major learning from this work was:

- ⦿ Home Based Newborn Care (HBNC) brings care to the home; all pregnant women and newborns in the community receive care.
 - ⦿ When a newborn is ill, having care at home is often more acceptable to areas.
 - ⦿ HBNC also includes giving health education to parents and assists them in giving better care to their infants.
 - ⦿ HBNC works in lowering the neonatal and infant mortality rates in poor areas in India, and improving neonatal health.
- **Newborn care is possible and acceptable:** Even in the current ASHA programme, even where ASHAs have not been trained for newborn care, most ASHAs are visiting newborns, quite spontaneously. Obviously there is a need and there are cultural factors behind this and one needs to provide ASHAs with the skills to make these visits more useful.
- **How far to go? How much to expect?** Sometimes a newborn is born and does not cry or it gives a cry and then stops. The babies are declared dead. If on the other hand there is a skilled nurse or midwife available they could try to resuscitate the baby with a bag and mask and a few of such babies can be saved. This is not to be tried by the ASHA unless she is, despite her best efforts, caught in a situation where she is the most skilled person available at the moment of birth. Also the community should not have too many expectations of the ASHA or even of the institution at such a point, since most such babies do not do well anyway. The importance should be to prevent birth asphyxia.

- **Breastfeeding promotion:** The promotion of timely and exclusive breastfeeding- requires more than preaching, it requires active support even in most advanced nations. ASHA could make a huge difference here, for no other single intervention has as much contribution to saving lives as this.
- **Care for the sick child - on the first day providing first contact care:** The other major life saver for lives of the young child is prompt and appropriate care- on the very first day – for a child with acute respiratory infection or diarrhoea. In an urban middle class context, if the child becomes ill with diarrhoea or has a persistent cold, the parents could consult the doctor in the evening or even wait to see if the illness progresses, and consult the doctor whenever they think it is serious. But for a mother in a area, where the family has to decide whether to lose the day’s wages for husband and wife, and incur the expenditure of a bus to a distant block town to see a doctor, the decision to see the doctor may be to put off until it is too late. On the other hand if an ASHA could help the family decides whether the child can be managed locally with a drug kit or home remedies or should rush immediately- this simple skill could save tens of thousands of lives. Since the ASHA is available at all times within the habitation, she could play this role best. From various field reports, it is clear that even though she is not yet trained in these skills many families with sick children already are coming to her.
- **Prevention of malnutrition and prevention of illness:** We know that from the sixth month of life onwards most infants and young children are at high risk for diarrhoea and respiratory infection and for slipping into malnutrition. This is also the age when the immunisation schedule should be complete. Yet simple measures like hand-washing or adequacy in complementary feeding, are not followed. Home visits and family counseling can make a huge difference in the prevention of malnutrition, anemia and many common recurrent illness of children. Most of this is based on advice, but there are a few drugs that can treat these conditions and these are provided in the ASHA drug kit for her use
- **Social Mobilisation:** One of the key roles that the ASHA plays is that of identifying and understanding the key target groups she has to work with. The way for her to reach these groups is primarily through home visits, and to establish rapport with stakeholders such as PRI representatives, members of the Area Health an Sanitation Committee, and Self Help Groups (SHG). Women and children from vulnerable and marginalised families are often higher risk of illness and death and the ASHA should ensure that every such family in the area is visited often.
- **Preventing Infectious and Non-Infectious Diseases:** Another major role that an ASHA would require to play is to identify people having symptoms of various infectious diseases like TB, Malaria, Dengue, Chickengunia and non-infectious diseases like Hypertension or Diabetes during her home visits. In such cases, she should encourage and help them to seek medical care from the appropriate health facility.

Since most of the tasks on ASHA involve health communication and undertaking counseling with the community, it is important that the trainer explains the difference between the counseling skill and health communication/teaching to ASHAs. Trainer should use the information below for doing so.

How does the skill of counseling differ from the skill of teaching/ health communication?

In health communication, a message is communicated. The communication process could be passive or active, it could be participatory or didactic, and it could be to a group or an individual. But counseling is focused on problem solving for an individual. One needs to actively listen to what is being said, analyze all the factors and then dialogue with the person so that, together, the right choices are made. Health communication is an important skill. But counseling is a more demanding skill.

Other skills like taking a temperature, or finding out the EDD or weighing the baby, or calculating grade of malnutrition are specific tasks, that can make a big difference to the health of mothers and children.

7. Social Mobilization is an important task of ASHA and would completely rest on role of ASHA as a health activist. It becomes important for the trainer to explain this task in relation to this role.

See Handout 1 - Laxmi's story for case study and discuss the constraints which make accessibility of health services difficult.

Hand Out 1 - ASHA as a Health Activist

Read the story given below. After reading the story let the participants agree upon the constraints of accessibility of health services.

Laxmi and her husband Ramu live in a slum area near a construction site. Laxmi married Ramu when she was 14 years old. Ramu was 18 then. He had passed the eighth grade. Laxmi was the eldest daughter-in-law. She had passed the second grade. Laxmi, with her mother-in-law and sister-in-law, worked very hard as a construction laborer. Her father-in-law did seasonal labour work and Ramu did wage labour in another area a little distance away.

Laxmi did not conceive for two years after marriage. Her mother-in-law took her to see a traditional healer, who gave her holy water.. Laxmi conceived at the age of 17 years. During the second month of pregnancy Laxmi had a miscarriage. The ANM requested Laxmi to visit the hospital which was 10 Km away from her area. Laxmi and Ramu went to the hospital for a check-up. The doctor informed Ramu that she was too young to be conceiving a child. She also had anemia. The doctor, therefore, advised them to use contraceptives. The doctor suggested the use of condoms to Ramu. Ramu refused to use condoms and asked Laxmi to either take contraceptive pills or insert an IUD. Laxmi took contraceptive pills for a year. The family pressurised her and Ramu to bear a child.

Laxmi discontinued her contraceptive pills and conceived within four months. She was doing construction work, besides the housework, as her ill father-in-law could not work regularly and needed regular medical care. Laxmi did not get herself checked by the ANM. Whenever the ANM came, she usually did not visit Laxmi's community as they were from a socially and economical backward class. Laxmi took iron- folic acid tablets irregularly. She took only one dose of tetanus injection(TT). No one followed up with Laxmi to see if she got proper antenatal care.

During the ninth month of her pregnancy, Ramu's father fell severely ill. He had to be admitted in a hospital. Ramu and Laxmi spent all the money that they had saved. They also had to borrow additional money.

Soon after, Laxmi experienced labour pain. The area dai of the area was called in to attend to her. The dai examined Laxmi and as she felt that the baby was not in correct position, advised Laxmi's mother-in-law to take Laxmi to the hospital. The mother-in-law waited for Ramu to return. Meanwhile, Laxmi's condition worsened. She was brought to the hospital in a very serious condition and the doctors had to work hard to save the baby girl and the mother. Ramu borrowed some more money, pawning Laxmi's gold earrings. Laxmi was advised rest, and the use of contraceptives to prevent an early second pregnancy. The baby girl used to fall ill often. Laxmi took her to the ANM. The ANM informed her that they should go to the Primary Health Centre (PHC), which was 3 km away. When Ramu got his wages they went to the PHC. They had to buy drugs from a chemist shop. Laxmi got pregnant again. She was scared this time due to her earlier experience. Ramu was also worried. He had large debts to clear. But the family wanted her to bear a son. Laxmi reluctantly retained the pregnancy, wishing it would be a boy. Ask the participants to list down all the barriers that Laxmi and her family faced in obtaining care.

They are: Social reasons, including gender discrimination, economic reasons and health system-related reasons

i. Social Reasons, including Gender Discrimination:

Health is not a priority for the community and, therefore, they do not easily/readily take action to improve their health. Generally, families do not value the life of a woman and, therefore, she neglects her health and delays the decision related to medical treatment. (Early marriage, low self-esteem, early pregnancy, low education among girls, economic dependence, low control on resources, etc. are some of the consequences of gender discrimination) Family members fail to recognise the symptoms and hence decisions are delayed. The community, which is socially and economically backward, does not usually have information about its rights and entitlements. Caste is a reality of Indian society. Some communities are marginalized because of their caste, some because of their ethnic or religious identities. This has a major impact on access to health services.

ii. Health Systems Related Reasons: The PHC may be located far away from the area, which makes it very difficult for the community to access the health services. At many PHCs the Medical Officer and other para-medical staff may not be available after 2:00 pm and for emergency services. This results in loss of faith in government health services. In many PHCs the medical/para medical staff is sensitive. They may ignore the people who are poor and socially backward. Due to the distance of a health facility, people have to incur expenditure on travel and forgo their daily wage to attend a health facility during its working hours.

iii. Economic Reasons Unemployment and exploitation of the poor community results in poor earnings. Due to this, disadvantaged and marginalized communities do not have proper nutrition and access to health services. The marginalized and disadvantaged communities do not usually earn enough to save money for emergency or health problems.

These topics are discussed more in the session on Right to Health.

Power of Togetherness

- Request the participants to share what needs to be done to improve the accessibility of health services for people like Laxmi and Ramu
- They may come up with several ideas. Ask them whether it is possible to accomplish all

these alone? Highlight the importance of working together and ASHA's role as an activist. Share the following points.

- To bring about a change in this situation we need to work with people. In our country there are many examples where women have come together and brought about major changes. The examples of the Anti Arrack Movement initiated by women activists in Andhra Pradesh and Chandrapur district of Maharashtra, and the earlier efforts of women in the Chipko Movement to save forest/trees in Himachal Pradesh are very inspiring. Similarly, the collective efforts led by Gandhiji during the freedom struggle and the struggle by Raja Ram Mohan Roy to eradicate the "Sati Pratha" are classic examples of activism for change.

"In its broadest sense, a community activist is one who works for social change in the community."

ASHA's role as an activist will give her the satisfaction of empowering the community and liberating the disadvantaged and marginalised.

- Based on discussion of the Anti-Arrack Movement earlier (Annexure 3 of Induction Module). Ask the following questions:
 - Who were involved in these movements?
 - Were they elite, rich, upper caste/class? Did they have any political support?
 - What made their collective efforts successful?

At the end of the discussion highlight that they were common people with uncommonly strong willpower to fight against difficulties and bring about change. Most important, they were women who are considered as the weaker section and as followers who have not been accepted easily in the role of leaders.

Notes for Trainers: Roles of ASHA as a Health Activist

Work "along with" the poor and oppressed, not "for" them. Development comes from a people's own understanding of their needs and rights. Hence, as an ASHA you need to encourage and help the community to identify, understand and analyse the issues concerning them and how to deal with it.

Working with people As an ASHA you must respect people's intelligence and understand that they too have rich life experiences. Draw out and build upon their strengths. Listen to them. You also are a member of the community so you will understand this better.

Help people grow As an ASHA you need to facilitate the process where people themselves decide and take ownership of their actions. This brings them dignity and builds their self-respect. Development effort should, therefore, start with knowing and building on people's potential, and proceed to their enhancement and growth.

Achievement is important because it builds confidence and makes subsequent steps possible. They need to be actively involved in planning, implementing, and in evaluating the decision-making processes.

Build up people's solidarity You need to encourage and create a feeling of solidarity among people, sharing and caring for one another, and marching together towards a new society where humanity is assured.

Build up the people's organisation People must take up activities which make their local community free of exploitation. For the poor and marginalised section to gain strength, they need to be organised. How will ASHA's work relate to the existing organisation of the weaker sections? How does ASHA's work promote their organisation? How will the ASHA's work promote their organised participation in all decision-making bodies at the local level?

8. Enrich the discussion by sharing the roles of an ASHA as a health activist and asking participants to read "**Reaching the Unreached**" brochure.
9. Now come to the second part of the session on Values of an ASHA. A trainer uses the information **below to initiate discussion on values.**
 - To work in the area of social transformation an ASHA has to work with the attitudes and behaviours of the community for positive change. Hence, it is important for an ASHA to review her own values and to address the values of individuals for social development.
 - For every individual, values are the central guiding force for their behaviour and attitudes. Culture, experience, education, religion, law, language and media influence one's values. Values are variable. While working on social issues, we are basically working with changing the attitudes and behaviours of the community and the programme implementer for positive, desired change. Hence, it becomes very important to address values of individuals for social development
 - Every individual has her/his own values. There is nothing like right or wrong. Generally, values are imbibed from our parents, our society and our environment.
 - Values shape our personality and identity and are directly connected with our vision of life. They guide us to decide our goal(s) and act on it. For example, when I know the destination that I have to reach, I can choose the correct path when I come to a crossroads. Without a clear sense of purpose and values, we are lost and confused. For example whether to spend time in gossiping or in working will depend on my values. Values remain in the subconscious mind and act like red and green traffic lights. They tell us what we should or should not do. Values are a set of beliefs about what is good and desirable. They are based on assumptions about how the world works. Our idea of what is the appropriate thing to do in a situation comes from values.

Some examples of values which are required for social development include:

Value of Equality

- In a patriarchal society women are viewed as submissive, weak and soft, and men as strong and powerful. Due to this, men are given more importance, power and respect in family and society whereas women are usually viewed in a supportive role. As a result, girls and women have less access to resources. For example, girls and women are given less food than boys and men of the family. Men and boys are given more scope to develop themselves, e.g., men are given more opportunity for basic and higher education. Men, also, usually inherit the properties of the family, while women usually do not get a share.

If you believe in patriarchal values you will not see anything wrong if a woman is ill-treated. If you believe in equality you will respect a woman as a person.

- In our society the structure of caste is very strong and people who are from a socially advantaged class are in favor of the caste structure.. As an ASHA, it is important to first understand the problems of the poor and marginalised communities. They need to be educated about their rights and entitlements. Empower them. Encourage them to share their views and feelings.

Treat each individual equally, irrespective of her or his class, caste, sex and religion.

Value of Responsibility

- Your behaviour should be responsible and should promote your own and your community's health. You may keep your own house clean but throw your garbage in the street, which is not responsible behaviour. As a member of the community you need to dispose of your garbage at a designated place so as to ensure hygiene and sanitation.
- The Mayor of your area has the power to make decisions for the development of your area. Many times people misuse this power and use it for their own benefit or benefit of their relatives and/or friends. Being responsible to yourself and to the power that you are designated with is very important. No system works effectively if all the designated members do not perform their duties efficiently in a coordinated manner.

Believe in People's Knowledge and Experience

- All people have experience and knowledge. It needs to be respected and valued while making any decision. Never view people as empty vessels needing to be filled with knowledge. They should not be viewed as passive recipients. They need to be active to sharing their views while making decisions. For example, if pregnant women are not coming forward to get their names registered you need to find out why they are not coming. Ask them to suggest strategies to increase registrations of pregnant women and how they will contribute to making the strategy work.

Values of Trust:

- When people honour each other, there is a trust established that leads to synergy, interdependence and mutual respect. Gaining the trust of those around you is not a difficult or unachievable task. Trust can be created by sharing feelings, thoughts, views and being transparent. Trust is like glue that holds people together. To experience the feeling of trust.

Activity- Trust Walk

- Step 1: Ask the participants to form pairs. Ask one member of the pair to blindfold the other. Chalk out a path which has obstacles, steps, bushes, stones, etc. Bring the participants who are not blindfolded in a group and inform them that as a facilitator they would be walking on a particular path and leading their blindfolded partner on that path. Another way of doing this is by asking one facilitator at a time to stand at the another end and guide the blindfolded partner (giving directions) leading to the point where he or she is standing
- Step 2: Lead the blindfolded partner on that path, by telling him/her where the obstacle is. Let them go to their partners. After finishing the walk reverse the roles.
- Step 3: Have a discussion on the following questions: How did you feel during the walk, both while being blindfolded and while being led? Were you confident about your partner? Was there a feeling of mistrust? When? Why? What are some of the actions and gestures which help you to develop trust on your partner?
- Step 4: Have a detailed discussion on the importance of the element of trust in community work.

You may highlight following points which helps them to develop trust -

- Accept people no matter who they are as they need assurance that they are truly accepted as they are. When the community people come to you they rely on you completely and therefore it is very important to develop and build the trust.
- Create a non-threatening and enabling environment where they can share their views and concerns openly without fear.
- Provide an opportunity to people to share information. For example, they may know an effective herbal treatment for some disease, or they know the reason for their poor participation in improving the health of the community but have not been able to analyze and articulate.
- Keep your words/promises. If you have promised to get a health check-up camp organized at the area level, try your level best to coordinate and organize it. If you fail, come back to the community and share your feelings and frustration. Accept their help to have it organized.
- Exhibit values of trust in all your actions.

While discussing these points ask them to share their life experiences, which helped them to build trust and the experience, which affected their trust. Conclude the session by discussing the values promoted by Mahatma Gandhi:

- Always speak the truth
- Believe in the power of non violence
- A person should not be treated on the basis of her or his caste/sex/religion. Everyone should be treated as a human being.
- If you have made a mistake never be ashamed to apologise or express regret and ask for forgiveness.
- Never misuse common resources like water, wood, etc. It belongs to every individual on earth and all persons need to have access to these resources.
- You can touch the heart of people if you are committed to serve them.
- Keep people at the centre of your activities and believe in the power of people. It is a fact that people who are conscious of their value-based priorities are more fulfilled and happier in their lives. They also make more effective decisions about their own and their community's growth and development.

To know your personal values is to be more aware of who you are, what you want and what you don't want. As an ASHA your work is very important. With that you should also value your family and their needs. You also need to think about what is more important to you and why.

Answering these questions for yourself can be revealing. In some situations the family may be important and in some it may be the work. One is actually a means to another. Working may enable you to support your family, providing you an opportunity to develop or having a family may provide support to work. Understanding your values enables you to move ahead and maintain for a balanced lifestyle.

Session 1.4: ASHA Support and Supervision

Aim: By the end of this session the ASHAs will understand:

- The concept of a collective support from other frontline workers (Mahila Aarogya Samiti) who will support them in their community work
- Their link with the two forums at community level: the Mahila Aarogya Samiti and the Urban Health and Nutrition Day.
- Time she is supposed to give for ASHA's work and other working arrangements?
- Tools for organizing her work.

Method: Interactive discussion, presentation and reading,

Material: Board, chart paper and marker pens, copy of area health register, an ASHA diary and drug kit stock card

Time: 90 minutes

Activity:

1. Start the session by asking ASHAs if it is possible for them to fulfill the tasks discussed in previous session all by themselves. A natural response to this would be "no".
2. Now ask them why do they think they would need support? Write their responses on the board.
3. Proceed to ask: Who in their opinion can support them? Try to classify their responses as-those within the area and those outside the area.
4. Ask the participants to open page 12 of the Induction Module and read the sub-sections of ASHA support and supervision by taking turns. Once a sub section-section has been read out, the trainer takes time to explain and then proceeds with the other participant reading the sub section ahead.
5. This way cover the role of each: Anganwadi Worker, ANM, ASHA Facilitator and Mahila Arogya Samiti.
6. Explain the working arrangements to ASHA and proceed to show them the tools which would help them in organizing their work. Trainers should have a copy of area health register, an ASHA Diary, Drug kit stock card and circulate them to the participants. The method to fill each of these is discussed briefly at this stage. Trainer should inform ASHAs to seek support from their ASHA Facilitator and further learn the method to maintain these tools.
7. Make a point to cover the details on UHND and drug kit stock card given as Annexure 1 and 2 on pages 131-132 of the Induction Module. List of incentives should also be discussed based on the state norms and then shared and distributed to all the ASHAs.

What is a Healthy Community

Session 2.1 Understanding your area and your community

Aim: By the end of this session the ASHAs will understand:

- What are the common health problems faced by her community
- What factors are responsible for ill health of the people
- What are the determinants of good health

Method: Discussion using illustrative charts

Material: Board, chart paper and marker pens,

Time: 120 minutes

Activity:

1. Display on a chart paper the illustration given on page 19 of the Induction Module depicting the common health problems faced by people..
2. Start the discussion by asking the participants what are the common health problems faced by people in their community.
3. Ask the participants to enumerate the possible factors that are responsible for ill health.
4. Summarize the responses. Explain the concept of health and the difference between good and ill Health as per the section below.
5. Ask the participants to read the section on Page 20 of the Induction Module describing the factors that contribute to good health, ask for doubts if any, explain all the factors in detail.
6. Now ask the participants about how each of the following factors are related to Ill Health:
 - Malnutrition
 - Unsafe Drinking Water
 - Unhealthy Living Conditions
 - Unhealthy Habits like tobacco and alcohol
 - Hard Labour
 - Mental Tension
 - Patriarchy
 - Lack of access to health services
 - Lack of Health Education
7. List their responses on the board, explain and summarize the session by asking them to read pages 20-22 of the Induction Module.

Understanding Rights and Right to Health

Session 3.1 Understanding Fundamental Rights

Aim: This session is particularly designed to sensitize ASHAs about their fundamental rights.

By the end of this session the participants will gain an understanding about the Fundamental Rights they enjoy as being citizens of India

Method: Discussion

Material: Board, chart paper and marker pens

Time: 60 minutes

Activity:

1. Introduce the topic of fundamental rights and tell the participants in brief what is the Constitution
2. Each fundamental right is further explained by giving appropriate examples.
3. The participants are asked to narrate the situations they have witnessed in area or elsewhere where they have observed fundamental rights been violated. Also ask them to name the particular type of right that has been violated and what do they think they could have done to act on the situation
4. Share the following example with the participants. Eg- There are two women in an area. One has passed 6th grade and the other is a graduate. Do you think the woman who is a graduate deserves more respect than the woman who has passed just 6th grade? Encourage the participants to share their views. End the discussion by saying that as human beings we all need respectful treatment.
5. Discussion on Fundamental Rights - As Indians we enjoy certain fundamental rights. These are mentioned in our Indian Constitution.

Fundamental Rights with key points

- **Right to Equality** - All citizens are guaranteed the right to equality. All citizens are equal in the eyes of law. No citizen can be discriminated against on the basis of religion, caste, sex or place of birth. For example, in a area every citizen has equal right to common resources such as water, land and public places. Similarly, government hospital, schools and colleges are open to all citizens.
- **Right to Freedom** - Under this right a citizen enjoys different kinds of freedom, e.g., a citizen can visit or live in any state. People from any area can go to the cities for work and choose to live there permanently. A citizen can adopt any profession of his or her choice. No one can refuse the son of a farmer the freedom to become a cook or a doctor's daughter the freedom to become a farmer. There is no law that restricts women only to domestic work or states that the man has to be the only earning member of the family.

- **Right against exploitation** - The law does not permit any citizen to exploit another citizen. Exploitation includes activities such as illegal bonded labour, child labour, sexual harassment and forced beggary.
- **Right to Freedom of religion** - The citizen has the right to follow any religion of his/her choice. If there is inter-religion marriage, e.g., a Hindu marrying a Sikh or Sikh marrying a Muslim, there is no legal compulsion on the wife to adopt her husband's religion.
- **Cultural and Educational Rights** - This right is particularly for the minorities. Through this right every community can promote their culture by means of special schools and institutions.
- **Right to Constitutional Remedies** - If any of the Fundamental Rights is violated, the citizen can approach the Supreme Court for the protection of her or his rights.
- **Right to Vote** - In India, all powers of the state rest in the hands of the people. All people have a right to vote.

At the end of the session, trainer reads out the following bullets and ask participants to assess each situation and share their views.

- My area is safe and secure. All members of the community receive equal treatment and information about different government schemes and opportunities.
 - My area provides equal access to resources, especially water, irrespective of one's caste, gender and religion.
 - When someone violates the rights of another person, the community takes note of it, discusses and makes the appropriate decision with the consent of all the community members and takes action.
 - All members of my area actively participate in decision-making processes related to community development.
 - No one in our area is subjected to degrading treatment or punishment.
 - My area's Mahila Aarogya Samiti has people from diverse backgrounds, religion and cultures. There are some women members in our Mahila Aarogya Samiti. There are 33% percent seats reserved in the Mahila Aarogya Samiti for women.
 - I can express my political, religious and cultural ideas and beliefs with my family and community without fear of discrimination.
 - The area members and the labourers are paid as per the minimum wage norms.
 - Both men and women are paid equal wage for equal work.
6. Conclude the session by asking them to develop two action plans to ensure that their community avails their Fundamental Rights.
 7. At the end of the sessions the participants are asked to narrate the situations they have witnessed in area or elsewhere where they have observed fundamental rights been violated. Also ask them to name the particular type of right that has been violated and what do they think they could have done to act on the situation.

Session 3.2: Understanding the meaning of Right to Health

Aim: By the end of this session the participants will:

- Gain an understanding of the right to health
- Be able to clearly identify the situations when right to health is violated

Method: Sub Group Discussion

Material: Board, chart paper and marker pens

Time: 45 minutes

Activity:

1. Divide the participants into small groups of 6-7 members each. Ask them to discuss the meaning of Right to Health. Give them 15 minutes for discussion. If the group is literate, ask them to write down the points on a flip chart or do an oral presentation.
2. Call all the participants together. Ask them to share their views. After listening to their input, enrich this discussion by sharing the information given in the Induction Module. While sharing, relate the points that emerged from their discussion.

The Right to Health –

Availability - The community has the right to have functional public health and healthcare facilities with adequate amount of drugs, equipment and effective implementation of comprehensive and gender-sensitive health programmes.

Accessibility - Health facilities and services need to be accessible to everyone without any discrimination. This can be explained as follows:

- **Non-discrimination** - Nobody should be refused treatment on the basis of religion, caste, economic status, gender, etc
- **Physical accessibility** - The health facility especially the public health facility, should be centrally located so that it can be reached at the earliest convenience. The health services should be affordable for majority of the people. In the public health system services are available free of cost.
- Information about the services that are available in the public health system should be accessible to all the community members. All members should be aware of their entitlements from the public health system.
- **Affordability** – The health care services should be made available to the community either free of cost or at a nominal affordable price. Cost should not be a barrier to healthcare.

Acceptability - All health facilities and services must be respectful of medical ethics and be culturally appropriate, sensitive to gender equality and life-cycle requirements, as well as designed to respect confidentiality and improve the health status of those concerned.

3. Right to Health also means that there is a space for public dialogue where people can lodge their complaints and obtain redressal.
4. At the end of the session ask the participants to share what challenges their communities face in accessing health care services from the Primary Health Centre or sub-centre.

Session 3.3 Preserving Women's Right to Health

Aim: By the end of this session the participants will be able to understand:

- The ways in which women in our society are not able to exercise their basic rights
- Why is it important that women in our society enjoy equal rights
- How discrimination against women in day to day life adversely affects their health
- Various health problems which women suffer in various stages of life

Method: Discussion, on real life experiences scoring exercise

Material: Pen and paper for the participants, chart, board, chart paper, drawing pins

Time: 45 minutes

Activity:

1. Start the session by asking the participants for their opinion about the status of women in our society? Do they feel that men and women, girls and boys enjoy the same/equal rights, and the same freedoms.
2. Ask participants to give examples from real life experiences where they have observed this unequal status of men and women.
3. Write their responses on the board and classify as unequal status for women in education, work, freedom of movement, selecting marriage options, treatment during illness, pregnancy, childbirth, income, food, health care, toilet facilities etc.
4. Now allow participants to narrate specifically real life experiences on discrimination in health. By now the participants would have built some clarity on this issue.
5. Trainer can also give a scoring exercise to the participants, where trainer asks the participants to open their notebooks and prepare score card for their family. Use these points: equal education of girls, sharing of women's work, rest in pregnancy, rest after childbirth, opinion about age of marriage, wife-beating, access to woman's income, enough food, timely health care, opinion on sex-selection before birth, bath and toilet facilities. If their family members have a positive attitude give one mark for positive attribute and zero for negative each. Discuss positive and negative attributes.
6. You can elaborate further on this by discussing the information given on page 28-30 of the Induction Module.
7. Display the chart on the table given on page 29 of the Induction Module highlighting the various health problems affecting women in various stages of their life. Explain to the group that most of these problems arise due to discrimination against women and also due to prevalence of patriarchy in our society. Use this opportunity to tell the participants that there future trainings will cover this topic more in detail.
8. End the session by asking participants to take turns to read the section on: ASHA's role in addressing these issues, while you explain each role in detail.

Session 3.4 Understanding NUHM and Our Healthcare Facilities

Aim: By the end of this session the participants will understand:

- The objectives of National Urban Health Mission
- Structure of the Health System, type of healthcare facilities in urban areas
- Service providers and their functions.
- Quality of health services

Method: Discussion using illustrative charts, card activity

Materials: Chart paper, display board and drawing pins, checklist on quality of services given in Annexure 4, page 135 of Induction Module to be given as handout, chart on structure of public healthcare facilities, given on page 26-27 of the Induction Module.

Time: 60 minutes

Activity:

1. Ask the participants of their perception of the National Urban Health Mission or National Health Mission.
2. Based on the experiences shared and information given at page 25 in the Induction Module explain the objectives of the National Urban Health Mission.
3. Now proceed to next section on structure of public healthcare facilities. This part is explained by giving a card activity to the participants. Display a set of cards with the following labels on the floor.
 - a. District level
 - b. District Medical Hospital/Civil Hospital
 - c. Ward/Block level
 - d. Urban-Community Health Centre
 - e. Urban-Primary Health Centre
 - f. Nursing Station/ Dispensary/Sub-Centre
 - g. Chief Medical Officer
 - h. Medical Officers
 - i. Staff Nurse
 - j. ANM
4. Ask 3-4 volunteers to come forward. Ask them to review the cards and develop a flow chart which explains the structure of the Public Healthcare Facilities. They need to depict which health facility is available at which level and who are the appointed health care providers at each of these levels.
5. Once they have completed the task ask other participants if they want to make any changes.
6. Once the group members agree on the final version, display the prepared chart on the healthcare facilities available at various levels. Let the participants compare it.

7. Discuss the various health personnel available at various levels with the health facilities and conclude the session by sharing the information on health care facilities as shown on Page 26 of the Induction Module.
8. As one of the main objectives of NUHM/NHM is delivery of quality healthcare services to the marginalized people living in urban areas, the trainer should emphasize that NUHM aims at: Improving the reach of health care services to the most vulnerable and marginalized groups among the urban poor, falling in the category of beggars, street children, construction workers, rickshaw pullers, migrant workers and other such groups.
9. The trainer asks participants to list key aspects of Quality of Care. He then discusses the following points with the given examples:

Quality Health Care

- A technically competent person has to take the case history and examine the patient.
 - Appropriate and rational treatment is given.
 - The patient is to be given appropriate/adequate information related to the diagnosis, treatment procedures and drugs prescribed.
 - The patient needs to be given time to share concerns. After listening to them, help them to make an informed decision regarding the treatment procedures (risk and safety factors) and choose the most suitable alternative, if there is a choice available.
 - Essential equipment, supplies and technical staff must be available at the facility. Patient/s must not be told that due to the unavailability of drugs or equipment being out of order s/he cannot get a treatment service.
 - Privacy, comfort, confidentiality and dignity of the patient are to be maintained- have curtains in the examination room, allow the attendant of a patient inside if she/he wishes, and keep registers/files locked.
 - Behaviour of the providers is courteous, non-discriminatory and reassuring.
 - Patient must feel motivated enough by the providers and the system to continue and complete the treatment.
10. Conclude the session by discussion the role of ASHA in enabling the community to obtain quality care by:

An ASHA must play a critical role in enabling the community to procure quality care by:

 - **Creating awareness about the meaning and implications of quality health care among the community members.**
 - **Informing them about their entitlements from the health providers and health services.**
 - **Mobilising Mahila Arogya Samiti members and informal and formal groups to conduct monitoring of health care services in their area, and take corrective action through the appropriate mechanism.**
 11. Trainer now reads the following situations to the ASHAs to enact a Role play

Situation 1:

The U-PHC, in an unused condition is situated outside the area. It is poorly maintained. The ANM does not stay in the area and does not visit regularly so even basic care is not available to the community. The role play needs to highlight the following points: An ASHA sends written complaints to the U-PHC and the Chief District Health Officer and discusses the problem with Mahila Aarogya Samiti members, who discuss the matter with the ANM. The Mahila Aarogya Samiti members and ASHA offer a place to the ANM to provide services in the area and use MAS funds to support this.

Situation 2:

One of the illegal slum areas where most of the households are involved in 'Beggary' is far away from the main area. The health camp is organised at the main area and this particular slum gets neglected for organization of any health camp or Urban Health and Nutrition Day activity. The people of the area find it difficult to avail services due to distance. As a result, they mostly depend on a quack who comes on a motorcycle, treats them in the area, even on credit. The role play needs to highlight the following points: The ASHA, being a witness to the situation, will write all the details related to what happened on one particular day. She takes the signatures of all the people present. She takes the copies of the letter and posts one copy to the medical officer, one to the Block Health Officer and one to the Chief Medical Officer. The government authority takes necessary actions.

Note: The detail of what needs to be highlighted in the role plays is given only for your reference. As a facilitator you need to guide the participants to make the situation as realistic as possible, keeping the local context in view.

12. Conclude the session by discussing the checklist on quality of healthcare service (Annexure 4 of Induction Module)

Session 3.5 Navigating Complex Public Health Facilities

Aim: By the end of the session, ASHAs would know what is their role in facilitating access to health facilities for patients in her community/area.

Method: Discussion and Role Play

Material: Black board, Marker pen

Time: 30 minutes

Activities:

1. Start the discussion by asking the participants, reasons why people from poor families hesitate to go the hospital despite the fact that government health facilities are quite centrally located, and are free of cost.
2. List their responses on the board. Circle responses related to access barriers that relate to unfamiliarity with the hospital, lack of knowledge of services available at the hospital; lack of awareness of the entitlements and free services; overcrowding and long waiting lines. If these have not emerged from the discussion, facilitate the discussion so that these are listed on the board, by asking leading questions, such as: "Is fear of the large hospital a problem", etc.
3. Now ask for 4-6 volunteers for the role play. Divide the volunteers in pairs. In each pair, ask one member to play the role of a patient like pregnant women, mother of a sick child, a patient with hypertension, a patient with trauma or injury etc. Another member will be playing the role of ASHA.
4. Then ask each pair to imitate 'how an ASHA will help these patients visiting a hospital i.e where she would refer them and what role she would play to facilitate their easy access to the services'. Give five minutes to each pair for the activity.
5. Give your feedback on the role play and summarize the session by highlight the role of an ASHA in helping the patients in navigating complex health facilities as: Helping the patients in registration at the hospital, guiding them to the right doctor/counter/department, informing them about the free services and entitlements at the hospitals and preventing any kind of harassment or 'under the table' payments.

Session 4.1 Leadership Skills

Aim: By the end of this session, the participants will understand

- The meaning of leadership, style of leadership and qualities, knowledge and skills required for the leadership role of an ASHA.

Method: Discussion, role play and leadership game

Material: Blank sheets of paper, sketch pens or board and marker pens, Handout for Snake and Ladder Leadership Game

Team: 60 minutes

Activity:

1. Trainers should conduct this session using a mix of discussion, role play and leadership game. It is important to emphasize to the participant that “Leadership” is a series of acquired skills. Most people have the potential to become leaders. In the slum a labourer and a woman domestic worker are also leaders. An ASHA is a leader too. She needs to know that leadership is about taking timely decisions which are for the common well-being and taking complete responsibility of converting them into action with courage and confidence in self, and encouragement and involvement of others.

Exercise 1: Skills and Qualities of a Leader:

Ask the participants to think of who is their favourite leader and why. Let them share their views. Now ask participants what are the skills that they observed among these leaders. The trainer lists the skills on the blackboard. The session can be summed up by sharing the following views on being a leader:

Qualities of a Leader

- Views problems as opportunities
- Able to get the cooperation of people
- Sets priorities according to community needs
- Focuses on the needs of the community
- S/he is courageous
- Creative thinking
- Has tolerance for things which are not explained clearly.
- Has positive attitude towards change

Skills of a Leader

- Clear Communication: shares information, debate, clarify and articulate values and beliefs;
- Listens to others
- Mobilizes the community, particularly the marginalized to access entitlements from the public health system
- Negotiate with stakeholders to ensure the rights of the community
- Ability to take a collective decision by involving the community
- Inspire people to follow
- Non-judgemental and transparent
- Show confidence, assertiveness, enthusiasm, passion and be accountable.
- Commitment and responsibility towards the community
- Trustworthy and Honest
- S/he is hard working
- Has a sense of responsibility

The trainer ends Step 1 by stating that there are certain skills like coordination, listening, communication and negotiation that every good leader has, and what an ASHA needs to learn. Actually all of us have those skills, but we just need to be confident that we have these skills and strengthen them by using all opportunities to exercise these

Exercise 2: Role Play on Leadership Style

- (i) The trainer calls for five volunteers. Ask one of them to play the role of an authoritarian leader, who does not listen to anyone and dominates. She puts forwards her views without listening to others and also takes decisions without consulting other members of the community. Also, she tends to be judgmental and regularly insults community members.
- (ii) Ask the other four to play the roles of the community members as given below.
 - Support whatever the leader says- Volunteer 1
 - Interrupt the discussion- Volunteer 2
 - Remain silent- Volunteer 3
 - Ask lots of questions- Volunteer 4

Make sure that you do not let each other know about the role you have allotted to them.

- (iii) Ask the group to discuss an Anganwadi which is not-functioning. Ask the leader to start the meeting. Let it continue for at least ten minutes.
- (iv) Call the participant who was playing the role of the leader aside and ask her now to play a role of a participatory leader wherein she has to get the views of the community on the reasons why the Anganwadi is not functioning. She has to involve all the community members in the decision-making process, respect the community members' experience and opinion, be proactive in letting the community members speak first, etc. Let the other volunteers continue

to play the same role. Give them ten minutes to perform the role play. At the end of both the role plays ask the following questions.

- What did the leader do in the first role play?
- How did the community members react?
- What did the leader do in the second role play?
- What were the differences?
- How did the community members react?
- Ask them to decide which style of leadership they follow.

Exercise 3: Leadership Game - Snakes and Ladders

- (i) Ask the participants about their views of different tasks they need to do as a participatory leader, and list them on the blackboard. Now divide the participants into small groups, of four members each.
- (ii) Photocopy the snake and ladder game given in Annexure 1. Give one copy to each group along with one dice. Give them 15 minutes to play. Once they finish the game call them in for a discussion. Ask them to share their learning from the game. Enrich the discussion by sharing the expectations from a participatory leader. (Ask Participants to read from the section on Leadership skills on Pages 31-33 in the Induction Module)

Session 4.2 Communication Skills

Aim: By the end of this session, the participants will understand:

- The meaning of communication and develop oral and written skills of communication to play the role of ASHA effectively

Method: Discussion, lecture, demonstration by participants, role play on assertive communication, practice exercises for writing.

Material: Note book, pens, board, chart paper, marker pens, three glasses of water, turmeric powder, ink,

Time: 90 minutes

Activity:

The trainer explains that Communication is an important part of the ASHAs role. For an ASHA to play her role effectively there is a need to communicate with community members and the stakeholders at the area level and with the health care providers.

Exercise 1: Effective Communication

- (i) Invite two participants as volunteers to perform the exercise. Give an identical set of articles to each volunteer (e.g. glass, pen, duster, handkerchief, paperweight, wooden block, etc, which are easily available.)
- (ii) Now ask the pair to sit back to back. The pair should decide who will be the “communicator” and who the “receiver”. The receiver should not speak but only follow the communicators’ instructions. Ask the communicator to organize the given articles in front of her on the floor by

speaking aloud about the arrangement. The receiver has to arrange the articles in the same way that she heard it.

- (iii) At the end of the exercise, ask the volunteers to share their experiences, and other participants in the room to share their observations
- (iv) Repeat the exercise by letting the receiver ask some questions and the communicator to explain the arrangement in minute detail. As a trainer you may demonstrate how to do it.
- (v) At the end of the exercise ask the participants to compare the outcome of both exercises and discuss the reasons.
- (vi) Explain to the participants that we often fail to achieve any change as a result of our work, because we communicate from one direction and do not include the community in the process. In the first part of the exercise, the communicator was the leader and the receiver the community who was not allowed to ask questions. Often, the leader assumes that the community does not have any worthwhile knowledge and he/she knows everything. An ASHA as a leader should be careful that she does not fall into this trap.

Exercise 2: Let us make a Green Colour!

Step 1: Take three transparent glasses. Fill half of one glass with blue liquid using ink and water, half of the second glass with yellow liquid using water and turmeric powder. Fill the third glass with a little water.

Step 2: Show the glass of clear water to the participants. Tell them that we often think that people do not have knowledge. They are like plain colourless water.

Step 3: Show the glass with blue liquid. This represents the knowledge that the community has. They have the knowledge gained from experience.

Step 4: Now show the glass with yellow liquid. This represents the information that as a leader we bring along with us.

Step 5: Inform the participants that when we share information with the community they listen to us as a leader and they compare it with their own information (i.e., the blue liquid mixes with the yellow liquid.). Pour yellow liquid into the blue liquid. Stir the mixture. Inform the participants that mixing represents thinking and the final product in the form of green liquid is new information.

Step 6: Show the green liquid to the participants and inform them that if we mix the right amount of both liquids we get the green colour. If we add more yellow, which represents our knowledge, the green colour of the liquid will be spoilt.

Step 7: Conclude the session by highlighting the following:

As an ASHA you need to keep the following points in view while communicating with the community:

- Never differentiate on the basis of caste and class while communicating with the community. Your tone and gestures should not change when interacting with socially and economically disadvantaged community members. Respect them.
- The community has immense knowledge and experience. Use them by giving people a chance to share it. Do not treat them like empty vessels.
- Never make any comment which emphasizes gender inequality. Your communication should be gender-sensitive.
- Do not react fast. Listen, assimilate, analyze and then react.
- Do not use a blaming tone.

Exercise 3: Understanding how we 'Communicate'

- Request two volunteers to come forward. Ask one of them to enact the role of a local leader like ward committee head/Self-Help Group leader/ Medical Officer of a U-PHC and the other to play the role of an ASHA. ASHA has to discuss the need for support to a pregnant woman for transportation to the health centre for a delivery.
- Ask the rest of the group to observe the following points:

Verbal communication

- Tone of the ASHA's discussion
- How she starts her dialogue
- What kind of information she provides to the other person to sensitize him about the issue. Give suggestions.

Non-verbal communication

- Whether she was maintaining eye contact
 - Whether her body posture depicted confidence
 - Whether her facial expression reflected that she was listening to the other person's point of view
- Make sure that when you are briefing the larger group about the observations the volunteers are kept out of the room.
 - Let the volunteers play the role assigned to them. After the role play let the group give feedback. Based on the feedback, let the volunteers play their role again.
 - Reinforce the points related to verbal and non verbal communication by asking participants to read the relevant sections from pages 33-35 of the Induction Module.

Exercise 4: How to Write Simply and Effectively

- As an ASHA you would need to write applications and letters to the authorities as the people's representative. There are several forms of letters depending on the purpose. It can also vary according to the target group. The purpose of a letter could be to:
 - To bring to the notice of the authorities some important facts

- To share some experience
 - To demand help or resources
 - To express gratitude
- (ii) Ask participants to read the section on Written Communication on page 34 and Annexure 5 of the Induction Module to understand how to write a simple letter
- (iii) If there is time during the session, you could ask some volunteers to write on the following topics and discuss them with the group :
- The ANM does not visit your area regularly
 - After the monsoon, the area is facing a sanitation problem
 - Request for extra Anganwadi in your area
 - Request for the repair of the U-PHC/dispensary.

Exercise 5: Listening is a Skill:

- (i) Call four volunteers. Ask three of them to go out of the room. Brief the one who is in the room that she will share one interesting life story with the other volunteers. Ask the person to recollect a life story. Brief the three volunteers outside the classroom:
- (ii) Tell the first Volunteer to:
- Look around the room while the person is telling the story
 - Interrupt and prevent the speaker from finishing his/her sentence
 - Change the subject
 - Laugh when the speaker is serious
 - Talk to the person sitting next to her while the person is telling her story
 - Do not make eye contact with the speaker
- (iii) Tell the second Volunteer to read any handout given during the training while the person is telling the story
- (iv) Ask the third Volunteer to listen carefully to the person telling the story and ask relevant questions.
- (v) Call the three volunteers back into the classroom Let the three volunteers sit opposite the “main” volunteer who will share her life story. At the end of the story-telling ask the person who was narrating about her feelings. Ask the rest of the participants to share their experiences and feelings when they have been listened to or when they have not been heard.
- (vi) Summarize the tips for good listening and ask participants to read the section on Active Listening from page 34-35 of the Induction Module.
- Maintain eye contact
 - Sit in a receptive position, lean forward
 - Look and be interested
 - Remove distractions
 - Understand non-verbal signals

- Make the environment and timing conducive to listening
 - Be courteous
 - Stop talking! No interruptions
 - Give time for listening and make it known to the person who is talking that they have your complete attention
 - Encourage the person who is talking by using positive gestures and words
 - Do not pass judgments/criticism mid-way
- (vii) Conclude the session by reading the sections on Communicating with stakeholders and summarize key points to take care while communicating on page 34 and 35 of the Induction Module.

Session 4.3 Decision Making Skills

Aim: By the end of this session, the participants will understand the meaning and importance of timely decision-making, and develop the skills of decision-making, needed by an ASHA.

Method: Discussion and role play

Material: Blank sheets of paper, sketch pens or board and marker pens

Team: 60 minutes

Activity:

The Trainer explains that as part of her work, an ASHA has to constantly make different decisions that affect the health of individuals, families and the community. She must remember that all people have the right to participate in decision making process especially related to their health and well being. An involved community that has had an active role in decision-making will support the effective implementation of the decision.

Exercise 1: Let us Decide

- (i) The Trainer describes the following situation to the participants and explains the key steps involved in decisions making:

Situation: As an ASHA you need to facilitate the process of deciding on a place for the public tap in your area. You know that several people in the area will have an interest in deciding on where to locate the source of drinking water. The better off families would like to have the source near their area. The poor and marginalized community would like it near their part of the area, but may not be able to voice this opinion. It may be possible that the municipal council/ward committee will take a decision at its own level and being powerful they can over-ride the opinions of others, especially the weaker sections.

- Since this decision affects all the areas you need to first discuss it with other relevant people. First, you should individually discuss with the marginalized community and take their opinion. You should listen carefully to what they are saying and why.
- Call a meeting of the community members. The members' meeting needs to be representative of all segments of the area, religions, and castes and have an equal number of men and women. If you think it is necessary to take a formal decision in a meeting of

all Mahila Arogya Samitis of the area, and then make sure that a proper meeting takes place with representation of all the areas. You may have to call a special meeting.

- During the discussion it may happen that the marginalized community will not openly share their opinion. Therefore, during the meeting you will need to share the opinion the marginalized community members have shared with you earlier. During the discussion you should bring forward the pros and cons of each opinion.
- Select the best option - avoid vagueness or a 'foot in both camps' compromise. We know what happens to people who stay in the middle of the road. They get run down. At the end of the discussion the best decision need to be taken which is agreeable to all or at least majority of the members. Sometimes it is very difficult to decide upon the best option. In that case, you need to take a vote. Try out different ways of voting, e.g., five persons from each community are given a chance to vote.
- Explain your decision to those involved and affected, and follow up to ensure proper and effective implementation of the decision taken. You need to explain the rationale behind the decision taken. The process does not stop here. You need to make sure that it gets implemented as decided.
- The trainer then sums up the session and asks the participants to read the section on Decision Making Skills given on the Induction Module on pages 36 and 37.

Session 4.4 Negotiation Skills

Aim: By the end of this session, the participants will understand

- The meaning of negotiation and develop negotiation skills which are required by an ASHA.

Method: Discussion and role play

Material: Blank sheets of paper, sketch pens or board and marker pens, and a purse, bottle and two books

Team: 60 minutes

Activity:

The Trainer explains that Negotiation is the process by which two or more persons with differing needs and goals, work out a mutually acceptable solution to an issue. During her work, ASHA will face this situation often, and has to resolve these differences to achieve the larger goals of the area health programmes. This session discusses the meaning of negotiation and types of negotiation processes.

Exercise 1: Learning Negotiation Skills

- (i) Ask the participants to divide themselves into three groups, and select a leader.
- (ii) Display three articles, a book, a purse, and a bottle on a table in the middle of the room, and ask the group leaders to choose one article each from those displayed on the table.
- (iii) The task of each group will be discuss and devise strategies to showcase their article and market it as the best deal, while the others have to negotiate to buy it at the lowest price. Allow fifteen minutes for the group work

- (iv) Ask the participants to share their experience and observations. (Five minutes each)
- Seller Group will share the strategy they used, whether they sold the article, are they happy with the deal, How much did they have to compromise, and to share the process of negotiation in brief.
 - Buyer Group will share the strategy did you use to finalize the deal, whether they are satisfied with the product, how much did they have compromise, and share the process of negotiation in brief.
- (v) Based on the observations, summaries the key points of negotiation:
- Try and use an approach that allows both parties to gain from the situation.
 - Be clear on what is important to you and why it is important.
 - Know what would be the best alternative to negotiate a solution.
 - Focus on the bigger goal and consider the other party's situation.
 - Generate a variety of possibilities before deciding what to do.
 - Understand the views of the other party by putting yourself in their place.
- (vi) The trainer asks participants to read the section on Negotiation Skills from the Induction Module, pages 35-37.

Exercise 2: Let Us Negotiate

- (i) Call two volunteers to perform a role play based on the situation to do this below:
- Situation: The ANM visits your area for the monthly Urban Health and Nutrition day to provide services for pregnant women, mothers and children. There is a cluster of households about two kms from the Anganwadi center. They belong to migrant families from another district. They are reluctant to access the UHND services. You want the ANM to extend her stay and accompany you to these households to convince these families. The ANM is reluctant to do this as she does not have the time.
- (ii) Ask one volunteer to play the role of an ANM and another that of an ASHA, and to negotiate the details.
- (iii) At the end of the role play, ask the group: Did both parties win or was the win one-sided? What would they do differently if they faced such a situation again,
- (iv) If there is time the trainer can call on two other participants to do a role play using another situation.

Session 4.5 Coordination Skill

Aim: By the end of this session, the participants will understand why coordination is necessary for effective health outcomes and how to practice holding a community meeting.

Method: Role Plays and discussion

Material: Chart paper, or board and marker pens,

Team: 60 minutes

Activity:

The trainer explains that in the course of all three roles that the ASHA has to perform she has to coordinate with various stakeholders and the community. Coordination can be done with individuals on a one to one basis, (for example, agreeing with the Anganwadi Worker at what time they need to start preparing for the monthly Urban Health and Nutrition Day) or through a group meeting (MAS meeting to discuss the next month's plan).

Exercise 1: Why and with whom to coordinate?

- (i) Ask the participants why they need to coordinate and write their responses on the board.
- (ii) The trainer then explains that coordination is necessary is to keep everyone informed about the activities being conducted, develop common understanding and to avoid misunderstanding, share information, take collective decisions, and to plan future actions.
- (iii) Ask participants about the key individuals/groups in her community with whom the ASHA needs to coordinate. List their responses on the board. You can draw it in the way it is shown on page 39 of the Induction Module. This chart can be different in different communities, so do not insist on it being the same as in the Induction Module. The main stakeholders (who are there in every situation: ANM, AWW, Mahila Aarogya Samiti members) need to be included.
- (iv) Every stakeholder has a key role and the ASHA needs to know the role that each stakeholder plays.
- (i) The trainer concludes the session by asking participants to The Trainer asks participants to read the section on Coordination on pages 39-40. Particular emphasis should be place on reading the Table on page 38 in which the roles of the ASHA, ANM and AWW are laid out with respect to the major activities of the ASHA.

Exercise 2:-Weave a Net

- (ii) Make the participants sit in a circle. Give a ball of thread to one participant. Inform them that they have to weave a net from the thread. Ask the participant to hold the end of the thread and throw the ball to another participant. The second participant also holds the thread with one hand and throws the ball to another person. Inform the participants that the woven net needs to look symmetrical. Encourage them to discuss who will throw the ball to whom so as to get a beautiful net at the end of the exercise. At the end all the participants need to have the thread in their hands.
- (iii) Ask them to hold the thread by pulling it slightly towards them. By doing this the net will look good. Ask one of them to loosen the grasp and hold the thread without pressure. Ask the participants to observe the change in the net. Ask them to relate it with the process of

coordination. Now ask two participants to let go of the thread they are holding. Again ask them to observe the changes and relate it with the process of coordination which results in an effective net. Networking also can be ensured through effective coordination.

- (iv) The Trainer now highlights that in the process of coordination each member plays an important role and therefore the ASHA must make sure that all concerned stakeholders are in contact with each other and are kept informed.

Exercise 3: How to conduct a meeting

- (i) The trainer informs the group that they need to hold a meeting to discuss the issue of environmental sanitation of the area. Ask ten volunteers to come forward. Let the group decide who will play the role of an ASHA to coordinate the meeting. Each of the other members plays the role of a stakeholder: ANM, AWW, SHG member, NGO Representative, etc. For identification they need to put a label on each member. They are given 15 minutes to conduct the role play. Other participants observe the process and list down their observations.
- (ii) At the end of the role play, the trainer asks participants to share their observations.
- (iii) The trainer then highlights the importance of documentation by asking two or three participants to prepare a documentation based on Annexure 6 of the Induction Module. This is reviewed by the rest of the group and the Trainer concludes the session by summarizing the key points on coordination.
- (iv) The trainer also explains to the participants that they will be trained later in the activities of Mahila Aarogya Samiti meeting and will be able to further develop their skills.

End the session with a narrative exercise: To build further clarity you can ask three participants to volunteer. One acts as an ASHA, one as an ANM and one as an AWW. Make them go through the chart on Page 41. For each activity- such as home visits etc., let each one come and narrate what their respective roles will be pertaining to a particular activity. For assistance also display the chart on the board. The other participants are asked to observe actively and prompt or add in case the volunteers get stuck or miss out few details.

Section 4.6: Convergence for Health

Aim: By the end of this session, the participants will understand why convergence between other departments is necessary for effective health outcomes, and how to facilitate this.

Method: Role Plays and discussion

Material: Chart paper, or board and marker pens

Team: 1 Hour

Activity:

1. In order to start the discussion on this issue, remind the participants of the content covered in Section 2. Ask them to list non health factors which also have an influence on health. The list should cover safe drinking water, anganwadi services for children, education and safe disposal of waste. If the list is not complete, the trainer adds them.

2. Explain that in the course of all three roles of ASHA, she has to coordinate with various stakeholders and the community. Coordination can be done with individuals on one to one basis, (for example, agreeing with the Anganwadi Worker at what time they need to start preparing for the monthly Urban Health and Nutrition Day) or through a group meeting (MAS meeting to discuss the next month's plan).
3. Ask participants to open Page 39 of the Induction Module which lists the major stakeholders with whom ASHA can meet and work for the goal of healthy community.
4. Now explain the role of an ASHA as given on Page 39 of the Induction Module. Explain that the ASHA with the help of MAS members will need to play an active role and advocate with the local authorities for taking necessary actions.
5. Divide participants into four or five groups. Allocate the following cases to each group. Give them ten minutes to prepare and ask each group to enact as a role play in ten minutes what they would do. After each role play ask the rest of the group to point out the strengths and weakness of each approach and what the outcome was likely to be.

Case Studies: Convergence for Health

Case Study 1: You live in a slum area of Lucknow. Near your area, a large amount of garbage has been dumped by the residents of nearby houses. Since the last ten days, there has been no collection by the municipality of this large pile. This has resulted in a foul smell spreading through the colony and flies and mosquitoes breeding just outside your colony. As an ASHA what would you do?

Case Study 2: There is a pocket of jhuggis near the railway line where head-load workers and their families live. Since this colony is not an authorized colony, there is no water supply by the municipality to this area. The municipality tanker of water does not fulfill the need of even half of the families. Therefore, people living in this colony, have to buy private water for their daily sustenance and incur heavy costs. This issue is raised in a Mahila Arogya Samiti meeting. What steps can you, as an ASHA suggest to MAS members to resolve this problem?

Case Study 3: One problem you have noticed is that there several children of age 6 to 8 years who do not attend school and roam around in the day time when both parents are out for their daily work. They look after their smaller siblings and manage household work. As an ASHA, what would you do?

Case Study 4: Hema is a young girl of 18 years, married to a man aged 30 years. He is an alcoholic and beats Hema daily. He runs a small tea stall and earns very little. She requests her husband for permission to join the local self help group (SHG) to get additional access to credit and livelihood skills. But he suspects her of having an extra marital affair and does not allow her to join the SHG. Hema tried to hide this matter from the neighbors but shared this problem with you. How will you as an ASHA help her?

Divide the group into three. Allot one case to each group. When one group performs the role play, other participants should watch and note down their observations. Give each group 10 minutes to perform. Then ask participants to respond to the way in which the role play was enacted, ensuring that positive feedback is provided before commenting on the gaps.

Notes for Trainers:

Explain to participants that the actions in each case would be different in different areas and there are no prescribed, correct answers. The importance of these role plays is that the group understands how an ASHA should be trained to assess the situation, her skills in explaining the issue to the MAS < How effective she is in allocating responsibilities within the MAS, facilitating written communication if required, and her judgement on who can be called upon for support within and outside her community. The trainer should explain that there are several challenges in urban areas. Sometimes MAS members may be too busy to come together. Sometimes they may face hostility. Government officers may be difficult to reach. ASHA and MAS must organize and ask other community members to join them. Young people are an important resource. While the response of each group would be different i.e in a well organized city, the MAS could call upon the Urban local bodies (ULB), in others, self help in the form of collective action may be the only way forward..

Trainer should always emphasize that in all the situations which require collective action for health, ASHA should meet MAS members or other community groups:

- Identify the immediate issues related to health care and other basic services in the slum/area
- Identifying the underlying causes for these problems
- Deciding the appropriate actions required to address the problem. It could be writing a letter, organizing meeting with concerned official or taking collective action with the community.
- Deciding the responsible persons to lead the action
- Deciding on any community level events to be organized to address the problem
- Fixing the timeframe for undertaking the action

Case Study 1

The trainer should look for the following in the participant's responses:

- ASHA meets with the members of Mahila Arogya Samiti Members and explains the situation.
- They jointly decide the most appropriate person whom they can meet or write to solve the situation.
- Allocate responsibilities: Contacting municipal corporation, talk to the community, writing a letter, find out the source
- Deciding for how much time will they wait
- Educate community on consequences if no action is taken
- To take collective action, they can then organize cleanliness drive and mosquito control measures involving MAS and community volunteers.

Case Study 2

Look for:

- If she has assessed the situation well- identifying the main issue and the immediate steps possible.

- Decided the responsible person to meet who can address the issue
- ASHA along with MAS members can decide to write and meet the concerned ward councilor
- They can also attend the Ward Coordination Committee meeting to present the problems of their area for appropriate solution.
- Apart from this, ASHA can also educate and inform community regarding safe drinking water practices and methods for household water treatment to prevent any water borne diseases.

Case Study 3

In such cases, your major role would be

- To highlight this problem to the MAS and then to community members especially mothers of the young children to understand causes and explain its implications on their children.
- You with the MAS members can then meet to anganwadi health workers and their supervisors (like C.D.P.O) of the area. Along with MAS members, you can carry out a quick survey of all those families, and organize regular non-formal pre-school activities in the anganwadi of children in the age group 3-6 years of age so that their elder sibling can attend schools.
- Support school enrolment of the older children by meeting local councils and school principal.

Case Study 4

Look for the following:

Individual Action and Building Solidarity

- First of all, ASHA should counsel Hema and provide her emotional support
- She should provide health advice and care to Hema and refer the ANM or PHC-MO for a checkup.

Build Solidarity:

- ASHA can inform Hema that community can take a collective effort to help her in this problem. With Hema's consent, ASHA can talk to MAS members and community leaders/opinion holders, who can talk to Hema's husband and convince him to allow her to join the self help group.
- As part of her core activity, they can regularly meet adolescent girls and women during her monthly meetings to aware them on various legal provisions and enable them to share any experience so that action can be taken.

The Trainers should again re-emphasize the points in the box-Notes for the trainer.

Session 4.7: Understanding Vulnerability among various Vulnerable Groups

Aim: At the end of the session the ASHA will be able to:

- List the different vulnerable groups
- Know the specific health problems and service needs

Method: Class room interaction and Group Activity

Material: Black board, Marker pen

Time: 2 hours

Activities:

1. Start the session by telling the participants that increasing numbers of people are coming to urban areas from rural areas in search of employment and better opportunities. But due to the lack of necessary infrastructure like housing, water and sanitation, and basic services like health and education, these people often have no other options but to live in clusters within the towns or cities and on the margins, called jhuggis or slums.
2. Ask the group to identify what are the geographic locations in which such people live. List these on the board. The list would include localities such as the roadside, under flyovers, railway platforms, bus stops, outside shops without shelter and in unsafe conditions.
3. Ask the group: to list out challenges that these people face in their day to day life. Lead the discussion by highlighting the fact these people struggle for those basic services (like safe drinking water, food, sanitation, health, education, safety and social security) which should be provided to them by the state. Note and list their responses on the board.
4. Now explain to the participants that these challenges have serious implications on their health. (Page 42).
5. Ask for a few volunteers from the group and have them read aloud from page number 42 of the Induction Module and enable them to make the link between where the urban poor live and particular health problems.
6. Explain three types of vulnerabilities i.e Residential, Occupational and Social Vulnerabilities as given on Page 43 of the Induction Module. Vulnerable populations include the homeless, rag-pickers, street children, rickshaw pullers, construction, brick and lime kiln workers, sex workers and temporary migrants. Categorizing the vulnerable urban groups based on the nature of their vulnerabilities can help the ASHA to better understand their specific needs so that she can provide the right kind of support.
7. Make three columns on the board and ask participants to first list out the groups in each category, as listed in the Box titled "Different vulnerable groups according to the vulnerability criteria". Then ask participants if this is appropriate to their context, and ask them to suggest additional groups based on their experience to expand the list. The participants can also add these in their copies of the Induction Module on page 43.
8. Conclude the section by highlighting the fact that the poor and vulnerable in urban areas, are the focus of the programme, and the ASHA must be specifically concerned about them. The first step is in knowing who they are and where they live. This is what has been covered in this section.

Session 4.8: Vulnerability Mapping and Assessment

Aim: By the end of the session:

- ASHA would know the basis and importance of “Vulnerability Assessment
- ASHAs would be able to identify different vulnerable groups through the use of the ‘Vulnerability Assessment Tool’.

Method: Class room discussion, group activity or field visit

Material: Black board, Marker pen

Time: 2 hours

Activities:

1. Start the discussion by highlighting that in order to identify, reach and work for the most marginalized and vulnerable groups in urban areas, a skill that the ASHA needs is to understand how to assess “Vulnerability” of the households/individuals in her area.
2. Explain that a tool called the “Vulnerability Assessment Tool” is designed to help the ASHA in identifying vulnerable households/individuals. [Ask the participants to open Annexure 12 on Page 150 of the Induction Module].
3. You must now explain each section of the tool to the participants- asking them to read out each part aloud one by one. Then explain each part to familiarize them with the Mapping Tool. The tool is divided into five sections. The first three sections contain 17 indicators/variables which assess the extent of residential, social and occupational vulnerability of the household. Section IV helps gather information on the health status and health seeking behavior of the households.
4. After every participant has understood the various indicators, explain how to calculate the scores and categorize the households in the categories listed in the tool:
 - ⦿ Each variable is given three scores as 0,1 and 2. Zero being the lowest/worst case.
 - ⦿ Then, the scores are added
 - ⦿ Based on the score, the household is categorized into one of three categories i.e –
 - 0 - 15: Most Vulnerable,
 - 16-30: Highly Vulnerable and
 - 31-42: Vulnerable.

Explain to participants that this categorization will help them in prioritizing their households and addressing the health needs of the individual/family in a more focused manner.

5. Mention that the last section simply lists the vulnerable groups, so that if the surveyed household/ individual belongs to any category, ASHA can tick and highlight the category directly for prioritization and follow up action.
6. Now distribute the hand out of the tool to all the participants. If possible, conduct a practical session for ASHAs in which the ASHA can go in the field and conduct the vulnerability assessment through the tool.

7. Once the discussion on the mapping tool is completed, explain to the participants, that the mapping tool helps them in prioritizing the households based on their vulnerabilities. This is only the first step. The ASHA will need to use skills such as communicating, motivating, counseling, coordinating and mobilizing to ensure that such families get access to the services they need.
8. Conclude the session by asking participants to read aloud from pages 44 to 45 of the Induction Module.

Checklist for assessing the skill for Vulnerability Assessment and Mapping

	Trainer should look for the following:	Yes	Partially	No
	COMMUNICATION			
1	An ASHA ask questions in clear and simple language			
2	Ensure that the family understands why and what she is saying			
3	Listen carefully to assess if family has any queries or doubts			
	TOOL ADMINISTRATION			
4	See whether ASHAs have understood all the components/ indicators of the tool			
5	See whether ASHAs are asking right questions and in right manner. Her questions should not make respondents feel disrespected or embarrassed			
6	Assess if she is able to appropriately rank the household under each indicator			
7	See whether she is able to add and do the cumulative coring correctly			
8	Look for accurate categorization of the household: vulnerable, highly vulnerable and most vulnerable			
9	Check whether she is able to recognize the vulnerability group of the household (under part V of the tool)			
10	Look whether she is able to correctly prioritize those houses categorized under highly and most vulnerable			

Knowing about Health, Hygiene and Illness

Session 5.1 Role of Diet and Food in maintaining Good Health

Aim: By the end of this session the participants will understand:

- Role of food in maintaining good health
- Various nutrients present in the body
- Concept of Balanced Diet
- What are good dietary practices?

Method: Demonstration and discussion

Material: Flip chart, pictures of new born, a toddler boy or a girl, adolescent girl, woman managing a shop, pregnant mother, and breastfeeding mother, women labouring on road, chart depicting constituents of balanced diet (food pyramid), and marker pens

Time: 30 minutes

Activity:

1. Start the discussion by telling the participants that: in our country there is a tradition of women fasting on various occasions. Some of them present here would also be doing so? How do they feel on days of fasting when they do not take food? Possible responses to this will be- we feel tired, feel less energetic to do physical work, some may even say we will feel irritated. You tell them that: they all know that all living beings need food to survive.
2. Now ask them to recall an image of a child in their area who looks very weak and small for his/her age. Evoke the participants to think about the reasons for the same. You may get responses such as: he/she is weak because he/she does not get enough food or some may also say that they are probably not given good quality food?
3. Now explain to the participants by relating to the discussion above that- from their responses it becomes clear that the human beings need food to-live, grow and work. Now show pictures of new born girl, a toddler girl, adolescent girl, pregnant mother, breastfeeding mother, old woman, woman managing a area shop and women labouring on road.
4. The first 6 pictures depict various stages of life of a woman and the remaining show women doing different kinds of work. Take the first six pictures and ask the participants: do they think that the food needs of each of these individuals in these various stages of life are same. Ask them to talk about the different food needs for each of them. Also ask about the food requirements for the women in the remaining two pictures. The discussion will help you to demonstrate that food requirements change with the age, depend on the physiological status and also vary according to the type of work we do.

5. Ask the participants to take turns to read the section on major constituents of balanced diet and their functions given at pages 47 and 48 of the Induction Module.
6. End the discussion by telling the participants to share their experience about the good dietary practices people follow in urban households. You can supplement more information at the end.

Session 5.2: Role of Personal Hygiene and Clean Surroundings in Keeping Good Health

Aim: By the end of this session the participants will understand:

- The relation between personal hygiene and clean surroundings with health
- Common measures adopted to ensure good health
- Measures to keep the surroundings clean

Method: Discussion using illustrative charts, demonstration

Material: Board, chart paper, marker pens, soap and bucket of water

Time: 30 minutes

Activity:

1. Start the discussion by asking participants how many of them wash their hands before cooking, serving, eating food, drinking or serving water? And why do they think they have adopted this practice. A likely response to this question would be-to maintain cleanliness.
2. Display the chart with illustration showing route of transmission of infections given on Page: 49 of the Induction Module
3. Explain using the chart the various modes of transmission of germs/infection.
4. Ask a few participants to share their views about the other personal measures they adopt to maintain personal hygiene. Continue the discussion by explaining the text given on pages 49-50 of the Induction Module.
5. Ask two participants to volunteer. One participant reads the steps on correct method of hand washing given on page 139 of the Induction Module, while the other participant demonstrates the correct method of hand washing to the participants as he/she reads on.
6. You can ask other participants to practice this method as an assignment for the evening.
7. Now talk about hygienic measures pertaining to surroundings. The discussion should involve generating responses from the participants regarding practices they adopt for safe handling of food and water and also about mechanisms which are usually adopted to keep area surroundings clean. Acknowledge the correct ones and enrich the discussion from the text given in the Induction Module and with information below*.
8. Talk about sanitary disposal of solid and liquid waste by making participants read the text given on 50-51.
9. End the discussion by making few participants to summarize what they have learnt in the session.

Notes for Trainers

*Discussion on preventing water stagnation in areas:

Think of an area without pools of stagnated dirty water? Who will help you in making this happen? All slums commonly have cesspools and streams of dirty water flowing through lanes, by lanes and roadsides. Even where drains are made by the municipalities, the water stagnates at places and overflows. One way of dealing with this problem is to ensure the disposal of the wastewater effectively by each household. You can be a catalyst in making your area free of cesspools or wastewater ditches. MAS members, multi-purpose worker, teachers and community level workers of other development departments can join hands and make this happen.

Session 5.3: What is Illness/Disease and Sickness?

Aim: By the end of this session the participants will understand:

- What is a disease?
- Various types of diseases
- How the human body tries to heal itself ?

Method: Discussion

Material: Board and marker pens, chart paper

Time: 30 minutes

Activity:

1. Start the session by asking about 5-6 participants to share experiences of illness in their families in the last six months.
2. This exercise will help you gather examples of various types of illnesses. They could be in the form of diarrhoea, malaria, common colds, injuries due to accidents, diabetes, hypertension, mental illness, etc. List them on the board.
3. Use these examples to establish the fact that disease is an abnormal condition affecting the individual. It could affect an individual physically or mentally.
4. Divide the board in two columns and ask the participants to classify these diseases as those which spread from one person to another and those which do not. You can prompt and provide clues wherever necessary. Use this discussion to explain about communicable and non-communicable diseases.
5. Now ask the participants to take turns to read aloud the section on page 52 of the Induction Module and build further clarity with explanation in between.
6. Discuss healing-how wounds and illnesses heal and explain in simple words the concept of immunity/body defense systems using the information given on page 52-53 of the Induction Module.
7. Recap the session using important points.

Session 5.4 Treatment for Diseases

Aim: By the end of this session the participants will understand:

- Common ways to treat an illness
- Role of ASHAs in promoting rational drug use

Method: Discussion and experience sharing by the participants

Material: Writing board and marker pens

Time: 30 minutes

Activity:

1. Start the session by asking participants where do they normally go when ill or if there is somebody ill in the family? Many will answer: "To a doctor/hospital". Further ask: do they always visit a doctor who prescribes modern medicines or sometimes seek any form of alternate treatment with home based remedies or certain other traditional ones.
2. Now tell the participants: Thus there are two methods of treating an illness: modern and traditional
3. Talk about modern medicines. Show some medicines from the ASHA drug kit and tell in brief about their respective uses. Use this opportunity to inform ASHAs that for their benefit, information about usage, doses, side effects and precautions for drugs in their drug kit has been provided in Annexure 8 on page 140-144 of the Induction Module. Specify that they will learn about the use of each drug in subsequent training sessions as and when the particular topic is being taught to them.
4. Discuss the role of ASHA in promoting rational drug use as per the text on page 54 of the Induction Module. Ask for a volunteer to read aloud this section in the class.
5. End the session with a recap asking ASHA in the group to list some key facts.

Dealing with Common Health Problems

Session 6.1: Fever

Aim: By the end of this session the participants will understand:

- What is fever and why does it occur ?
- What is the normal body temperature and how to measure it ?
- How to manage fever ?

Method: Demonstration and Discussion

Material: Thermometer, piece of cloth and mannequin to demonstrate tepid water sponging

Time: 30 minutes

Activity:

1. Start by discussing with participants that all of them must have experienced having fever. We all perceive fever to be an increase in body temperature. Sometimes it gets cured on its own in short course while in certain other cases people seek treatment, when it is associated with a serious disease like malaria or flu. You can ask the participants to add examples of illnesses from their personal experience when they sought treatment for fever for themselves or their family members.
2. Explain to the participants that fever is a common symptom of a disease and not a disease in itself.
3. Show the participants a thermometer and tell them that this is the device used to measure body temperature and they must have seen it before. Tell them about the normal body temperature. Briefly demonstrate how the temperature is measured and tell the participant that they will learn the skill of measuring temperature in their next training.
4. It is important to tell the ASHAs that in case they are approached for managing fever in pregnant women, new borns and children below five years of age they should advise referral to an ANM or to the closest health care facility. They should attempt management of fever in all these cases only after it has been taught to them in detail in their next round of training.
5. Tell them that it is important to look for danger signs such as: cough, ear discharge, chills, stiff neck, rash and diarrhea etc. These signify an acute illness that needs immediate referral. Trainers should show them how to look for stiff neck.
6. For children above five years of age and adults they can manage as per the text described in Page 56 of the Induction Module.
7. Discuss the management of fever associated with self- limiting infections as per the section on fever in Induction Module (Page No. 55). Trainer can also demonstrate tepid water sponging on the mannequin.

8. Discuss the doses of paracetamol for individuals 5 years of age and above given on page 140-141 of the Induction Module. Discuss and drill what is the dose of paracetamol they would need to give for different age groups. You could actually distribute a few tablets and make them wrap the correct dose for a particular age group in a piece of paper. In a high malaria area chloroquine or equivalent drug will need to be given. Tell the participants that Malaria will be covered in subsequent sessions.

Section 6.2 Pain, Common Cold and Cough

Aim: By the end of this session the participants will understand:

- What is pain and what does it signify ?
- What is ASHA's role in pain relief ?
- How to deal with common cold and cough ?

Method: Discussion

Material: Board, marker pen and notebook

Time: 30 minutes

Activity:

1. Start the session by asking participants about how they perceive pain. Their response would be that it is an unpleasant sensation and often makes them alert that there is something wrong inside the body.
2. Ask them to write down from their memory what are the types of pain they have experienced in their life and what did they do about it? Tell some of them to share their experience about pain. Try to gather information on different kinds of pain.
3. Discuss pain by relating to discussion above and using the text given in the Induction Module.
4. Use this session to make the participants practice management of pain with paracetamol. They should be told not to manage pain in cases of pregnant mother, newborns or children under five years of age as has been recommended earlier in case of fever.
5. Trainer should also talk of other non-drug remedies of pain that can be suggested such as massaging with oils such as eucalyptus oil for headaches etc.
6. Write situations* of pain for different age group and make the participant write the management of pain either as: refer immediately, manage using paracetamol and undertake non-drug based management. Tell the participants to specify the dose wherever they recommend use of paracetamol.
7. The worksheets are then collected for evaluation to see if they have understood the management.

*Situations of pain:

Situation 1: A 55 year old woman approaches you with complain of moderate pain in the back since two days.

Situation 2: You are informed about a 60 year old man complaining of severe chest pain

Situation 3: A 11 year old boy fell, has hurt his foot and complains of discomfort.

8. Now discuss the management of cold and cough by asking participants to share their knowledge as to how they manage such episodes with home remedies. Subsequently supplementing this with information given in the Induction Module on page 56-57. It is important to inform the participants that management of cold and cough in children less than two years of age will be taught to them in subsequent trainings. Until then they should refer such cases to ANM or to a hospital.

Session 6.3 Wound Care

Aim: By the end of this session the participants will learn about:

- Types of wound
- Management of wound with no bleeding
- Management of wounds with bleeding
- Care of infected wounds

Method: Demonstration and hands on practice for the participants

Material: Bandages, antiseptic solution and ointment, gauze piece, cotton, clean cloth, soap and water, illustrations on wound care

Time: 30 minutes

Activity:

1. Start the session by asking the participants to share their knowledge about the different types of wounds. Support them by giving hints like minor cuts, bruises, deep wounds, etc.
2. Describe the three types of wound by relating to what they have shared
3. Discuss the management of the three types of wound using illustrations and conducting a demonstration for management.
4. Trainer should ask participants to work in small groups to practice management of each type of wounds
5. Participants should read the instruction given on pages 57-59 of the Induction Module.
6. Summarize the session using key points.

Session 6.4: Animal Bites

Aim: By the end of this session the participants will learn about:

- Effects of dog bites and other animal bites
- Signs of rabies
- ASHA's role in managing cases of dog bites/other animal bites
- ASHA's role in raising community awareness about prevention of rabies

Method: Discussion

Material: Board and marker pens

Time: 30 minutes

Activity:

1. Start the discussion by telling the participants that dog bites are the most common types of animal bites seen in India and all of them must have come across it in their life.
2. Ask the participants whether they have seen a case of rabies or hydrophobia. Tell them that dog bites are common but hydrophobia is not so common as every dog bite does not give rabies. It leads to rabies which is a fatal disease if not prevented on time. Rabies has no cure but timely treatment can save it by preventing the germs from reaching brain.
3. Tell the participants to read section on Dog bites given on page 59 and 60. Explain using the details in the book.
4. Explain the role of an ASHA in case of dog bites and other animal bites and end the session by discussing what they can do to build community awareness on rabies.

Section 6.5 Burns

Aim: By the end of this session the participants will understand:

- Common causes of burns
- Types of burns and what is the specific care needed for each type
- Do's and don'ts for burn care which should be told to the individuals
- What safety measures can be adopted by the community to avoid burn related accidents

Method: Discussion

Material: Board and marker pens

Time: 30 minutes

Activity:

1. Start session by asking the participants to recall who in their areas have been affected with burn related injuries, major or minor in their families in the last six months. Give them some time to think and share. Write at least 10-15 examples on the board. The examples will help in establishing that mostly it's the women and children who are the burn victims.
2. Now ask them to enumerate the common causes of burns and write the responses on a board
3. Elaborate using the text given on page 61 of the Induction Module.
4. Discuss about various types of burns and discuss each type as per the text given in Induction Module.
5. Ask one of the participants to read aloud the section on: Informing individuals about burn care, given in page 62 of the Induction Module while you explain each bullet in detail.
6. Ask the participants to share what are the safety measures that should be adopted to prevent burns. Write their responses on the board.
7. Ask the participants to compare both so as to ensure that all of safety measures have been covered.
8. End the session by summarizing the important points.

Session 6.6: Role of ASHA in Management of Trauma and Injuries

Aim: By the end of this session, participants will understand:

- Types of traumas and injuries
- Role of ASHA in prevention or management of such cases

Method: Discussion

Material: Black board and Marker pen

Time: 30 minutes

Activities:

1. Start the session by explaining to the participants that ASHA could come across cases of injuries or traumas, in which she would be required to provide first level care, help or correct referral.
2. Explain the meaning of injury and trauma briefly: Injury is a damage or harm caused to the body by an outside agent or force. This may be physical or chemical, and either by accident or intentional. Injury can be minor or severe.
3. Now, read page 63 of the Induction Module and explain various types of injuries. Explain that common causes are Traffic Accidents, Falls, Fire, Burns, Natural Disasters, Drowning, Fall of objects, Intentional Self Harm, Floods or Earthquakes etc.
4. Ask the participants about the possible roles an ASHA can play in these cases. List their responses on the board.
5. Highlight that in such cases ASHA can help the people by providing first aid for wounds with or without bleeding.
6. Mention that there could be situations where people would require emergency care which can prove life saving for them. For instance, if the person is not breathing properly then timely referral to the hospital is life saving. In such emergency cases, ASHA should reach out to the patients, call for ambulance and help in transferring the patient to the nearest hospital.

Session 7.1 Tuberculosis (TB)

Aim: At the end of the session the participant will:

- Understand what TB is and how it spreads
- Learn to identify possible cases of TB
- Learn what DOTS is
- Learn the possible side effects of TB drugs and action to be taken
- Learn how TB may be prevented
- Understand ASHA's role in TB diagnosis, treatment, prevention and management

Methods: Presentation, group work, demonstration

Materials: Chart/board, DOTS drugs, sketch pen and charts for presentation

Time: 60 minutes

Activities:

1. Start the session by making a presentation of 10 minutes on what is TB, how it is spread and what are its symptoms. Explain how to identify possible cases of TB. Discuss who all are at risk of getting the disease and dying of the disease. Remember to discuss in relation to malnutrition, living conditions, poverty and access to health services.
2. Make a brief presentation on how TB is diagnosed (how many times sputum is tested and time period). Ask the trainees about problems faced by people in going for diagnosis. Discuss issues in access to health facility, awareness about TB, differential access of men and women to TB diagnosis, and cost involved. Discuss how the ASHA can help to resolve the problems.
3. Present what is DOTS and show the trainees the DOTS drugs. Explain what may be some of the side effects of common TB drugs. Also present what action ASHA should take if a patient shows any of the side effects. Make the participants read out Table B in Annexure 11 of Induction Module.
4. Read aloud pages 65 and 66 of Induction Module. Ask the participants if they have any questions. Clarify and discuss them.
5. Group work: Divide the participants into groups of five each and tell them to read out pages together. Give each group the task to discuss regarding what the role of ASHAs should be in diagnosis, treatment, prevention and management of TB. Let them present and discuss with relation to what is written in the book.
6. Summarize the session using the poster given on next page.



Tuberculosis Treatment and Management: An ASHA's Role



Educating the community about measures for tuberculosis prevention and treatment, including the importance of a nutritious diet, personal hygiene, and the need for prompt and complete treatment



Serving as the DOTS provider in the village



Motivating tuberculosis patients to take appropriate and complete treatment



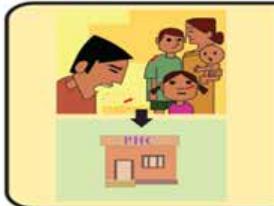
Helping patients access drugs from the health facility and deal with any side effects



Encouraging patients to take adequate rest and a nourishing diet during the course of treatment



Counselling patients and their families about the precautions to be taken to prevent the spread of TB in the family



Monitoring health of patients' family members and ensuring prompt referral if any signs of TB are observed



Ensuring that all newborns are immunised in time



Informing the health facility about any previous treatment taken by a patient who has a relapse



Counselling women about the need to take contraceptive measures during the course of treatment, and advising them on what methods would be appropriate

Notes to the trainer:

It is expected that the trainer will discuss the way TB is considered a social stigma and the ASHA's role in changing this perception. Also, the ASHAs should clearly understand the precautions to be taken for pregnant women.

Session 7.2 Leprosy

Aim: At the end of the session the participant will:

- Understand what Leprosy is and how it spreads
- Learn to identify possible cases of leprosy
- Learn about Multi Drug Therapy for leprosy
- Understand ASHA's role in detection and management of Leprosy

Methods: Presentation

Materials: Chart/board and pens

Time: 60 minutes

Activities:

1. Start the session by making a presentation of 10 minutes on what is Leprosy, how it is spread and what are its symptoms. Explain how to identify possible cases of leprosy. Discuss the two types of Leprosy and if possible show the photographs of each of these types.
2. Discuss in brief what is Multi Drug Therapy for leprosy is.
3. Read aloud ASHA's Role in leprosy given on 67 and 68 of Induction Module. Ask the participants if they have any questions. Clarify and discuss them.
4. Summarize the session by emphasizing the key points.

Session 7.3 Malaria

7.3a) Knowing about malaria

Aim: At the end of the session the participants will

- Understand what causes malaria, and how it spreads
- Be able to identify the signs and symptoms of malaria

Methods: Presentation, demonstration

Materials: Chart/board, poster blood slides, lancet, cotton wool, spirit, RDT kits.

Time: 90 minutes

Activities:

1. Ask the participants-"have they heard about malaria? How is it caused?" Write the responses on the board. Trainer explains and discusses the correct answer. The Trainer also explains the two types of malaria.
2. Ask the participants have they observed ever got a chance to observe what are the symptoms of malaria and how to suspect malaria. Write the responses on the board. Trainer explains and discusses the correct answer. The trainer also discusses ways to confirm malaria. Explain the difference between diagnosis through blood slides and rapid diagnostic tests.
3. The trainer then asks who are more susceptible/likely to get malaria and discusses as to why they are more susceptible. Discuss in the context of nutrition, pregnancy and children. Let the

trainees read out pages 68 and 69 of Induction Module till the part 'Managing malaria.' Ask the participants if they have any questions.

Notes for the Trainers: Decision to teach ASHAs the skills of blood slide preparation and diagnosing malaria through Rapid Diagnostic Kit in the induction round itself will be contextual and will depend on the prevalence of malaria in a given region. It is important to teach ASHAs these skills in malaria endemic areas for which persons from the department should be engaged as trainers. In other areas, it will suffice to give ASHAs a demonstration of these skills in induction round, provided a separate training on malaria is arranged to master and cover these skills in greater details.

Session 7.3b Treating Malaria

Aim: By the end of the session, the participants will

- Learn how to treat malaria
- Learn how to bring down fever of the patient

Methods: Presentation, discussion, demonstration

Materials: Poster with treatment guidelines, full dosages of Chloroquine, Primaquine and ACT.

Activities:

1. Make a 10-15 minute presentation on the how to treat malaria using power point or posters. Introduce the 3 kinds of medicines (Chloroquine, Primaquine and ACT) and discuss when to give which one. Present the treatment guidelines in a chart and go through in detail the Age-wise guidelines for Chloroquine, Primaquine and ACT. Show the actual drugs/blister packs. Also discuss how to bring down fever and the importance of taking full dose of medicine for three days. Explain and show how to do sponging and why. Let the participants read out Table C in Annexure 8 given in Induction Module showing the treatment guidelines.
2. Ask questions on dosages for different age groups and drugs. Let the participants volunteer to give answer and make them take out the dose in their hand and give it to you. For example:
 - I am 6 years old, and I have fever with chills. I have tested negative through RDT. What drugs will you give me and what advice should I follow?
 - I am 13 years old and tested positive through RDT. What drugs will you give me and what advice?
 - I am 32 years old and have fever with chills. No tests are available. What drugs will you give me and what advice?
 - I am a pregnant woman with symptoms of malaria. What drugs will you give me and what advice?
 - I am 3 years old with symptoms of malaria and very high fever. What drugs will you give me and what advice?
3. After this, once again make them repeat the treatment guidelines together as given in Table C of annexure 8.

Notes for the Trainer:

After this session the participants should also be able to answer the following questions:

- What to do in case of a pregnant woman?
- Why is it necessary to take full course of the drugs?
- How to give ACT to children

Session 7.3C: Key Skills in Diagnosis of Malaria

Aim: At the end of the session the participants will be to understand:

- Method to make blood slides
- Method to perform rapid diagnostic test

Skill 1: Making a blood slide -

Methods: Demonstration, practice

Material: Photocopies of Worksheet Skills checklist, Blood slides and disposable lancet for all participants, cotton, and spirit or cotton swab for cleaning the finger, lead pencil.

Activities

1. Hold up all the items one by one and tell ASHAs about each of them, discuss how each one of the items will be used.
2. Ask for two volunteers. Ask one participant to read out step by step from Annexure 9 of Induction Module. Demonstrate each step as she reads it, with the other participant. Now ask the volunteer to repeat the steps with the trainer. You can call a few more participants to demonstrate in front of the whole group. Ask the participants whether anyone has any questions.
3. Divide the trainees into pairs. Have each ASHA practice making a blood slide while the partner follows along with the checklist and records on the Worksheet skills checklist.
4. Trainers have to go to each pair and check whether each trainee is able to make the blood slide correctly. Make each ASHA make at least two blood slides.

Notes for the Trainer: Please ensure that there are enough numbers of Blood slides and lancet for each ASHA to practice at least twice. While showing the demonstration, ensure that it is visible to all trainees. Please remember that this may be the first time that the trainees have had to prick a person and take out drops of blood. There may be some reluctance to do so. In order to overcome this, it would be necessary to give some encouragement and instill confidence. You have to ensure that at the end of the session that each trainee is able to make a blood slide correctly.

Handout 3- Skill checklist: Making Blood Slide for Malaria

1. Record the details of the patient in the appropriate form.
2. Select the second or third finger on the left hand and clean it with spirit and cotton swab.
3. The site of the puncture is the side of the ball of the finger, not too close to the nail bed. Puncture with the lancet.
4. Allow the blood to come up automatically. Do not squeeze the finger.
5. Take a clean slide and hold the slide by its edges. Note that the size of the blood drop is controlled better if the finger touches the slide from below. Touch the drop of blood with the clean slide and collect three drops for preparing the thick smear.
6. Touch another drop of blood with the edge of another clean slide for preparing the thin smear.
7. Spread with corner of another slide, the three drops of blood in a circle or square of about 1 cm, to make the thick smear.
8. Bring the edge of the slide carrying the second drop of blood to the surface of the first slide, wait until the blood spreads along the whole edge. Holding it at an angle of about 45 degrees push it forward with rapid but not too brisk movement.
9. Write with a pencil the slide number on the thin film. Wait until the thick film dries before handling or transporting it.

Remember

- The blood should not be excessively stirred. Spread gently in circular or rectangular for 3 to 6 movements.
- The circular thick film should be about 1 cm (1/5 inch) in diameter.
- Allow the thick film to dry with the slide in the flat, level position protected from flies, dust and extensive heat.
- Label the dry thin film with a soft lead pencil by writing on the thinner film the blood slide number and date of collection.
- Dispose off the lancet and cotton swab

Worksheet 1: Skills checklist of making blood slide

	Skills	Tick if done correctly
1	Records details of patient	
2	Selects correct finger and cleans it	
3	Punctures correctly	
4	Touches the drop of blood with a clean slide and collects three drops of blood for the thick film	
5	Touches the edge of a new slide with a drop of blood	
6	Makes the thick smear	
7	Makes the thin smear	
8	Writes the slide number and date of collection on the thin smear and waits for the thick smear to dry	
9	Dispose off the lancet and swab	

Skill 2: Performing Rapid Diagnostic Test

Methods: Demonstration

Material: Photocopies of Annexure 10 in Induction Module, spirit, cotton swab, disposable lancet, capillary tube, test strip, multiple well plastic plate, test tube, buffer solution or reagent solution, desiccant.

1. Hold up all the items one by one and tell the participants about each of them. Discuss how each one of the items will be used.
2. Ask for two volunteers. Ask one participant to read out step by step from Annexure 10. Demonstrate each step as she reads it, with the other participant. Now ask the volunteer to repeat the steps with the trainer. You can call a few more trainees to demonstrate in front of the whole group. Ask the participants whether anyone has any questions. Discuss if any.
3. Divide the trainees into pairs. Have each ASHA perform a rapid diagnostic test on the partner who follows along with the checklist and records on the Worksheet skills checklist. Trainers have to go to each pair and check whether each trainee is able to perform the test correctly. Make each ASHA do the test at least twice.

Notes to the trainer: Please ensure that there is enough material for each ASHA to practice on at least twice and for demonstration. While showing the demonstration, ensure that it is visible to all trainees. You have to ensure that at the end of the session that each trainee is able to perform the test correctly and dispose off the materials properly.

Refer to Annexure 10: Performing Rapid Diagnostic Test on page 147 of Induction Module

Handout 4 Skill checklist: Performing Rapid Diagnostic Test

Tick if done correctly

	Skills	Tick if done correctly
1	Test desiccant is blue	
2	Read instructions on the kit	
3	Take out and keep ready all the materials to be required	
4	Test desiccant is blue	
5	Clean finger	
6	Prick with lancet	
7	Get drop of blood to come up in the tube/loop	
8	Place the blood on the test strip in the correctly	
9	Pour 4 drops of buffer solution in test tube and place the test strip properly in it	
10	Read result correctly after 15-20 minutes	
11	Properly dispose off all materials used	

Session 7.4: Dengue

Aim: By the end of this session, the participants will understand:

- What is Dengue, how does it spread ?
- Be able to identify its signs and symptoms
- Understand prevention and management

Method: Discussion

Material: Chart paper, board and marker pens

Time: 30 minutes

Activity:

1. Ask the participants about their knowledge of Dengue- in terms of cause, seasonality, signs and symptoms, and care seeking behaviours list their responses in the board.
2. Now discuss the responses and explain the two forms of Dengue.
3. The trainer then asks who are more susceptible/likely to get Dengue and discusses as to why they are more susceptible. Discuss in the context of nutrition, pregnancy and children. Highlight the fact that Dengue / DHF can affect all age groups & both sexes. Emphasise that younger children are more affected by Dengue and deaths due to DHF are also more in younger children than older children and adults.
4. Ask participants to read aloud from pages 70 and 71 of the Induction Module.
5. Discuss methods of prevention listed on page 72-74. Since this is a mosquito borne infection, the trainer can use this as an opportunity to review prevention related measures for all mosquito borne diseases.

Session 7.5: Chikungunya

Aim: By the end of this session, the participants will understand:

- What is Dengue, how does it spread
- Be able to identify its signs and symptoms
- Understand prevention and management

Method: Discussion

Material: Chart paper, board and marker pens

Time: 30 minutes

Activity:

1. Ask the participants about their knowledge of Dengue- in terms of cause, seasonality, signs and symptoms, and care seeking behaviours. List their responses in the board.
2. Now discuss the responses and explain how it spreads.
3. Ask participants read out aloud from page 72 of Induction Module.

4. Mention that in cases where symptoms suggestive of Chikungunya are present, ASHA should immediately refer the patient for early diagnosis and treatment.
5. For all vector borne diseases, the trainer should emphasize the importance of the ASHA's role in prevention, early identification of those with symptoms that could be suggestive of these conditions, and facilitating referral. The role of the Mahila Arogya Samiti should also be emphasized.
6. An important aspect of the sessions on vector borne diseases control (in Section 7) is the importance of recognizing where the mosquito breeding sites are located. The ASHA and MAS should use community fora to explain how the closeness of such sites to where people live, is likely to cause infections such as malaria, dengue and chikungunya. Prevention and control with participation of local community and convergence with other departments is a must. An important step in prevention is to reduce the number of natural and artificial water-filled container in which mosquitoes can breed. During outbreaks, insecticides may be sprayed to kill flying mosquitoes, applied to surfaces in and around containers where the mosquitoes land, and used to treat water in containers to kill the immature larvae.

NOTES FOR TRAINERS: Trainers should realize that the sections on 'Infectious Diseases' are content heavy sessions. Trainers should try to make these sessions as interesting and interactive as possible. Trainer should emphasize on reading the module repeatedly. S/He should read the sections aloud in the class and then ask ASHAs to read the sections themselves. Trainer should also make the participants revise the content after each session. He can do this in quiz manner also.

Session 7.6: Prevention of Vector Borne Diseases

Aim: At the end of the session, participants will

- Understand how to prevent vector borne diseases
- Be able to identify possible breeding sources for mosquitoes
- Be able to plan for controlling mosquitoes in the area

Method: Discussion, Group work

Materials: Sheets of paper and pen

Time: 30 minutes

1. Ask the trainees "Where do mosquitoes breed?" Take the responses. Emphasize on the fact that they breed in clean water and not dirty water. Present the two ways of controlling vector borne diseases - by not allowing mosquitoes to multiply and not allowing them to bite.
2. Explain the utility of bed nets, especially for children and pregnant women and discuss what may be the barriers to the use of bed nets. Discuss how the ASHA can counsel families on the use of bed nets, especially for pregnant women and children. Introduce the concept of impregnated bed nets and discuss its availability.
3. Ask the participants to read out pages 72-74 of Induction Module.
4. Case Study: Making a area level malaria plan: Divide the trainees into groups of five and give them 20 minutes, to list different areas of the area or the places where they find stagnant

water and discuss action to be taken to correct it. Refer to 'Ways of controlling malaria' on page 73. Once they finish, let them present what they saw, describing the area of stagnant water (whether it is a pond, rock pool, broken matka/pot in a courtyard, area around the handpump). They also have to say what corrective measures could be taken to reduce mosquitoes in that area. After all the presentations, summarize and discuss how to make an area level malaria plan. Discuss the role of ASHAs, MAS : Home visits and counseling, area meetings, awareness about malaria, information about drugs with ASHA etc.

Notes to the Trainers: In the plan be sure to include-

- Identification of all possible breeding sites in the vicinity of the area
- Action on controlling breeding of mosquitoes
- Action on personal protection, including availability of bed nets, mosquito repellent
- Availability of medicines and materials for diagnosis for vector borne diseases with ASHA
- Availability of referral transport for severe cases
- Person/s responsible for each activity



Malaria Prevention and Treatment: An ASHA's Role



Creating awareness in the community about prevention and treatment of malaria, during house visits and village meetings.



Supporting the Village Health and Sanitation Committee and other village groups in taking measures for malaria prevention, such as spraying insecticide, preventing water stagnation and enabling cultivation of Gambusia fish in ponds and wells.



Persuading people with suspected malarial fever to get themselves tested at the health centre.



Screening those who are unable to go to the health centre for malaria, using RDT and blood slides; and sending negative slides to the laboratory.



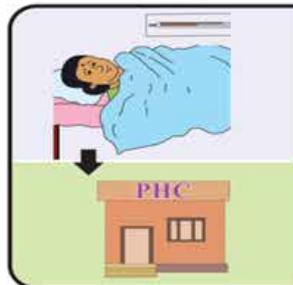
Treating those who test positive for malaria, with chloroquine or ACT drugs, followed by primaquine for radical treatment.



Maintaining appropriate records and registers, and ensuring that blood slides are properly transported to the laboratory.



Ensuring that a pregnant woman in a high malaria area uses an insecticide treated mosquito net during pregnancy, and also after delivery for herself and the baby.



Referring a pregnant woman with fever and chills immediately to a doctor, and starting appropriate treatment if there is any delay in doing so.

Session 7.6: Addressing Non-Communicable Diseases

Aim: By the end of this session, the participants will understand:

- What are non-communicable diseases (NCDs)
- What are the risk factors for non-communicable diseases
- What Healthy Behaviors can prevent NCDs

Method: Group activity, Case Study Discussion

Material: Chart paper, or board and marker pens

Time: 60 Minute

Activity:

1. Start the session explaining to the participants the difference between communicable and non-communicable diseases.
2. Ask participants to list common non-communicable diseases in their community.
3. List the four most common non-communicable diseases given on Page 74 of the Induction Module. Now explain the two types of Risk Factors i.e Hereditary and Lifestyle related risk factors and how life style related risk factors can be modified so as to prevent the disease.
4. Ask the participants to read aloud, in turns, the section on 'Addressing Non-Communicable Diseases' on Page 74 and 75 of the Induction Module.
5. Emphasize the critical role of ASHA in addressing these diseases- ASHAs should regularly identify and monitor those who are overweight, hypertensive, smoke or drink alcohol during her home visits and mobilize them to go for screening camps which are held periodically at their nearest health centre.
6. Divide the participants into four groups. Allocate one case study to each and ask them to convert their interaction into a role play.
7. Each group presents the role and ask the remaining participants to comment on whether the key messages have been communicated in a convincing way.

Case Studies: Addressing Non-Communicable Diseases

Case Study 1: Rakhi is 25 year old lady who works as a domestic worker. Her husband is a taxi driver. He is an alcoholic and does not have a regular job. They have two children of six year and four years. What advice an ASHA can give to Rakhi and her husband?

In this case, ASHA can communicate to Rakhi and her husband that alcohol is a risk factor for many diseases. This can lead to chronic illnesses which can make increase the cost of health care. She should refer him to see the doctor and attend Drug-De-addiction centre and follow up with them regularly.

Case Study 2: Madhu is 55 year old female, lives in a jhuggi with her family of six individuals. Her son and daughter-in-law work as construction laborers. She looks after household work. Since last two years, she is suffering from Diabetes. She purchases medicines for Diabetes from a nearby

pharmacy. Since last few months, she is facing problem of low vision. But due to her son and daughter's work, she could not go the public hospital for further treatment. What can an ASHA do in this case?

ASHA should meet with Madhu's children and explain them that Diabetes, if not treated properly can lead to various health problems. Therefore, they should not avoid this and advice that one of them should take her to the health centre. She can also inform that all the tests and medicine can be available to them for free of cost at public health facility. ASHA herself can accompany them to the health centre and help in getting her monthly dose of medicines from the health centre.

Case Study 3: Aman is a married man of 35 years, working in a mall as computer assistant for a lifestyle showroom. Most times, he eats at a fast food shop (with plenty of fried foods). He smokes and consumes alcohol occasionally. He recently visited the doctor for fever. The doctor told him he had high blood pressure and advised low fat, low salt food and regular exercise. But he did not follow up for medications. What advice can an ASHA give to Aman.

In this case, ASHA can inform Aman that high blood pressure is one of the biggest risk factor for many non-communicable diseases like heart attack and brain hemorrhage. Moreover, sedentary life style, junk food, smoking and drinking add to the risk of development of these diseases. Therefore, he should immediately visit the nearest appropriate health centre for proper treatment and follow up.

Case Study 4: Lata is a 60 year old woman. She has three children. Her youngest son of 25 years gets fits frequently since his childhood which has affected his mental abilities. Due to this medical condition, he behaves differently, can't work and is dependent on the family. Her family believes that this is due to some evil spirits and has not taken him to a doctor. What can ASHA can do in this situation?

ASHA should counsel the family that it is a medical condition that could have other ill effects. This can happen to anyone and is not related to spirits. If treated properly, this can be controlled. She should motivate the family to seek medical help and refer them to the appropriate health facility.

Please note that in all the above situations, ASHA along with MAS Members and other community stake-holders, can try to conduct awareness campaigns on Non-Communicable Diseases to promote the healthy lifestyles. It will sensitize the community regarding the risk factors of the chronic diseases and motivate them to go for regular check-ups for screening and timely treatment.

Session 8.1 Care during Pregnancy/ Antenatal Care

Aim: By the end of this session the participants will understand:

- Method to diagnose pregnancy using Nischay Kit
- Registration of pregnancy and its importance
- Key components and schedule of ante natal check-ups
- Importance of regular and complete ante natal care
- Where the services for ANC are provided: UHND or in a health care facility
- What is MCP card
- What are the danger signs during pregnancy and what complications can occur during pregnancy
- What is anaemia, its prevention and management during pregnancy
- Role of ASHA in pregnancy

Method: Discussion, demonstration, group exercise

Material Needed: Board, chart paper and marker pens, MCP Card, Nishchay kit and urine sample Situation Cards

Time: 90 minutes

Activity:

1. The trainer explains that one of the tasks of ASHA is to know at a particular time who in her area is pregnant and who is likely to get pregnant (newly weds, couples with one child where the child is past two years of age). The way the ASHA will need to reach out to these women is through home visits, in particular visiting houses where a marriage has taken place recently, or visiting families who have migrated into the area from outside. She should also ask families to inform her if an eligible woman gets pregnant, and emphasize early diagnosis.
2. Discussion on importance of early diagnosis: Ask group to list the various ways in which women confirm pregnancy. List the methods on a chart as they call out.
3. Demonstrating the use of the Nischay kit:
 - (a) This can be done by using a sample of urine from a pregnant woman. This can be brought from the ANC clinic in the nearby health facility. It is important for the group to see a positive and negative pregnancy test.

The trainer must emphasize the importance of maintaining confidentiality. The ASHA should read from page 77 of Induction Module and Annexure 11 on page 149 that describes how to conduct the Nischay test.

4. Tell the participants that once the pregnancy is confirmed the next step is pregnancy registration. Explain the importance of pregnancy registration and what is ASHA's role in pregnancy registration?
5. The trainer explains the participants' schedule and components of ANC care. Then the participants are asked to read aloud, taking turns this section given on 78 of Induction Module.
6. Distribute copies of Maternal and Child Protection Card as Handouts to the participants. Discuss using the card the schedule of visits, services that are provided in ANC clinic/UHND, why these services are important and how the information in MCP card is filled.
7. The trainer then lists each item of ANC section on the board asks clarificatory questions to assess if ASHAs have been able to understand.
8. It is important for trainers to emphasize here that all four complete check-ups are needed as by doing so the ANM will be able to detect problems and decide on referring woman to a doctor.
9. Now tell the participants that In addition to ensuring the ANC check-ups, ASHA should herself be alert on identifying danger signs during pregnancy when she visits pregnant women. Once she notices the danger signs she should refer the woman to a health facility for appropriate treatment.
10. The trainer then asks participants to share from their own experience the likely danger signs during pregnancy. List them on the board.
11. Trainer now discusses about High Risk Pregnancies by using the information given on page 79 of Induction Module. Participants are then asked to take turns to read the same.
12. The participants are then asked to read section on anaemia given on page 79 of the Induction Module. The trainers will tell the ASHAs that the haemoglobin level of pregnant women will be confirmed by the ANM. This information should be communicated to ASHA or ASHA should ensure that she knows the Hb level of pregnant women.
13. Tell the participants about the normal haemoglobin, mild or moderate and severe anaemia and what should be advice for pregnant women in each of these cases.
14. Build further clarity on this aspect. Make two columns on the board. One mentioning the values and category of anaemia and other specifying the advice. Now let the participants take turns to call out the advice for each of these situations while you write the responses on the board.
15. Based on the discussion so far, you can now tell the participants role of ASHAs in pregnancy or in ante natal care. Ask them to read, by taking turns the roles on page 80 of the Induction Module. Ask for doubts, provide clarification and move to the next exercise which I a group work.
16. Divide the participants in groups of four: To each group distribute the situation cards on: Educating the women on pregnancy care (Annexure II - Situation Card 1 to 4). Each card

has a situation for the group to discuss. Give about 10-15 minutes to the participants to discuss how they will transact different situations. Let two people from each group to come and present while others participants can supplement at the end of the presentation.

17. Wrap up the session by summarizing the key details.

Session: 8.2: Delivery Care

Aim: By the end of this session the participants will understand:

- The importance of safe institutional delivery
- What to do in cases when home birth is unavoidable
- Five cleans that are to be followed for home delivery
- Important health schemes of the government for the mothers and the new borns.

Method: Discussion, story based analysis

Material: Board, marker pens and Handouts

Time: 90minutes

Activity:

1. Start the session by telling the participants that they all would be familiar with the fact that delivery normally occurs after nine months of pregnancy. Ask them why they think it is important for pregnant women to go to a hospital.
2. List their responses on a board and enrich the discussion by telling the participants that certain complications occur suddenly during labour and delivery and need prompt attention. These may require referral to a higher level hospital also. Ask participants: do they have some idea about the complications of delivery? Listen to their responses and provide the correct answers which include: Excessive bleeding at any time, fits, long labour, and retained placenta.
3. Discuss that the ASHA is asked to escort the woman for delivery in the institution. Where ever possible it is also desirable but not mandatory that the ASHA stays with the woman in the hospital for delivery. This role is the Birth Companion role. The required skills to play this role effectively will be covered in great details in subsequent trainings. Until then she should seek the help of her ASHA Facilitator, who would undertake birth planning and support her in motivating women for safe institutional delivery. Facilitator should communicate the appropriate place of referral to ASHA or ASHA should ensure that she notes it down in her diary.
4. Divide the participants in groups of two: Distribute Situation card 5 and 6 on "Supporting a pregnant woman on delivery care". Give 10-15 minutes to the participants to discuss and make presentations. Now ask the participants to read the section on delivery care given on page 81 of the Induction Module.
5. Now ask the participants to share a real story they must have heard about difficulties families face while taking a pregnant woman having complications for delivery to a hospital.
6. Display on a board the specific entitlements of Janani Suraksha Yojna (JSY) and Janani Shishu Suraksha Karyakram (JSSK). Tell the participants that to overcome such problems and to help

these families government has introduced two specific schemes. Start discussing them in detail one by one.

7. Discuss the role of ASHA in relation to these schemes and ensuring these entitlements.
8. Ask the participants to read this section on page 83 of the Induction Module.
9. Now tell the following stories to the participants and analyze them one by one as per the notes below. (Handout 5)
 1. Tell the story of Neetha. Trainers must prepare before the session by reading the story, then tell the story to participants (try not to read it from the paper). After telling the story, the trainer asks the following questions.
 - Why did Neetha die? Ask for the cause of death as well as the social and economic factors. Listen to the answers and list them on the flip chart (immediate cause: she was bleeding excessively (Post Partum Haemorrhage), then got cold (a sign that there is loss of blood. It is a sign that she will die if emergency medical care is not received immediately). Social and economic factors: Neither the TBA nor Neetha recognized the risk, because there was no planning during pregnancy for emergencies, the family was not prepared and took too long to find money and transport etc.).
 - Ask if any woman if they have seen this kind of problem? Listen to the stories and analyze them as was done with the previous example.
 2. Trainer now tells another story, the story of Geetha. As with the previous story, trainer should prepare beforehand by becoming familiar with the story so they can tell it as a story and not simply read it.

Ask

- How did the ASHA help Geetha's family plan for the delivery? Listen to the answers and write on the flip chart (The ASHA motivated her for ANC, identified anaemia, and alerted the ANM, helped Geetha and her family to plan the birth so was happy about it, Geetha prepared for emergency by saving money, was able to rush to the hospital in time, ASHA and Geetha recognized the bleeding as a danger sign, Geetha also is a member of the self-help group and has self –confidence, and a belief in being able to control her life).
- Display both the lists from the stories of Neetha and Geetha. Ask the trainers what made difference? Why did Neetha die and how was it that Geetha could be saved? Encourage the participants to discuss the differences between the stories. List main points on the flip chart (Main differences: recognition of danger signs, emergency readiness including saved funds for transport, family understanding need for referral, general differences, Geetha a member of self-help group, more self-confidence, and wanting to take control of her life, etc.).
- Has any woman in your area been saved due to timely help? Listen to the answers and analyze any stories.
- Ask them what is necessary to save the life of pregnant women and child?

Handout 5- Story-telling and discussion

Story of Neetha :

Neetha lived with her husband in a slum area resided at the outskirts of the city. Her husband was poor farmer and they did not have much money or land. Neetha had one baby daughter. She did not want more children as it was hard managing even the one she already had. Yet, she became pregnant again. Neetha received one ANC where one injection and a few tablets were given to her. No other examination was done. She was also often exhausted, breathless and pale. One morning Neetha woke up and started having labour pains. She sent word for the ANM, but before the ANM could come, the waters broke and the husband rushed to call the local dai, who came and delivered a little girl. The baby was given gur-water, because the mother was considered too weak to feed the baby. After the delivery, Neetha started bleeding. When Neetha became cold, and continued to bleed, the local dai said she could not do anything more to help and said that they should go to the hospital. It took about three hours for the family to find money and transport to take Neetha to hospital. By the time they reached the hospital, Neetha was unconscious, and soon afterwards, she died.

Story of Geetha :

Geetha lived with her husband in a area. Geetha was pregnant. She was member of a self –help group. She had a little money and her husband owned a small plot of land. She used to meet didi (ANM/ASHA) and learnt about family planning from her. Geetha and her husband planned to have two children. Soon, Geetha became pregnant with her second baby. She went for regular ANC. During the ASHA's home visit, Geetha learnt about danger signs that could occur during pregnancy or delivery, or after delivery (postpartum or postnatal period) and how to plan to move to the hospital quickly. In the ANC the ASHA requested the ANM to get Geetha's blood checked for anaemia, since the ASHA was worried that Geetha had the signs of anemia. The ANM advised Geetha to take two tablets of IFA every day. The ASHA made a point of including Geetha's husband and mother-in-law in the discussion with Geetha on taking the IFA regularly, on the right foods to eat, knowing possible danger signs and the need to get to the hospital quickly, should they occur. One day Geetha woke up with labour pains. Since she and the ASHA had already made a birth plan, Geetha's husband knew which jeep owner had to be called. The ASHA also accompanied Geetha to the U-PHC that they had selected. A healthy baby girl was delivered. But after the delivery, Geetha bleeding seemed to increase. The ANM and doctor were busy attending to other patients, but the ASHA recognized at once that this was a complication. She immediately called the doctor. Geetha and her baby spent the night in the hospital under observation.

Session: 8.3 Post natal Care

Aim: By the end of this session the participants will understand:

- Importance of care to the mother during the post natal period
- What are the two main tasks of ASHAs during this period
- What are the important messages ASHA should give the mothers during this period

Method: Discussion

Time: 90minutes

Activity:

1. Start the discussion by telling the participants what post natal period is and why is it important that the mother and the new born are given special care during this period.
2. Discuss the tasks of ASHAs during this period: which are home visits and equipping mothers and families with key information on various aspects of care during this period.
3. Discuss the schedule of home visits needed during this period
4. It is important to tell the participants that there are several activities that need to be done by ASHAs during this period for mother and the new born so as to provide the right care at the right time. The skills for undertaking these will be covered in greater details in their next round of training.
5. Discuss the important messages for post natal mothers given on pages 83 and 84 of the Induction Module and elaborate on each of them.
6. Explain in brief the complications during the post-natal period.
7. End the discussion by summarizing the role of ASHA for mothers during this period.

Session 9.1 New Born Care

Aim: By the end of this session the participants will understand:

- The type of care needed for the normal new born
- What is the normal care at birth for the new born
- Schedule of home visits for the new born
- Who is a high risk baby
- Care for the high risk babies
- Danger signs in a new born
- Precautions to be taken for new born care

Method: Discussion and reading and demonstration using video clippings

Material: Video Clippings

Time: 90 minutes

Activity:

1. Start the discussion by explaining the participants what does immediate new born care consists of. It is important to tell them about birth asphyxia in brief especially in case of home delivery where there is no SBA. Since in these cases ASHA would need to refer the baby to the nearest health facility as time to save the baby is really short.
2. Discuss the importance of drying and ensuring warmth, early initiation of breastfeeding, avoiding pre-lacteal feeds and weighing the baby. Specify here that skills for ensuring warmth, wrapping and drying the new born will be covered in detail in their next round of training.
3. Discuss the schedule of home visits for the new born. You can summarize role of ASHA during home visits using the poster on: Role of ASHA in postnatal period for new born care, which has been displayed from the previous session.
4. Show the video clippings on new born care for demonstration (Nanhi Si Jaan and Skill CD). Visuals will clarify the concept and lay foundation for learning these skills in next round of training.
5. Explain what are high risk babies and why do they need extra care.
6. Ask one of the participants to read aloud this section given on pages 86 and 87 of the Induction Module.
7. You can give exercise to fill the worksheet given below on assessment of High Risk Baby.

Exercise for practice: Worksheet:

Sign in new born	Assessment: High Risk/Normal
A new born weighs 1.8 kg	
A new born could not feed on first day of birth	
A new born was born in 8 months 28 days	
A new born was born in 8 months 7 days	
A new born weighs 2.5 kgs	
A new born weighs 2000 gms	

8. Ask the participants to take turns to read aloud the care for high risk newborns. You can show them a video on care for the high risk newborns to build further clarity.
9. Display on a chart paper in one column the danger signs and normal signs in a newborn listed all together in one column. Ask the participants to call out for which sign they would ask the mother to take the immediately to a hospital. Write the correct responses in second column against the particular sign.
10. Explain the precautions during referral and other precautions to be taken for new born care.
11. End the session by summarizing the important points.

Session 9.2 Breastfeeding

Aim: By the end of this session the participants will understand:

- The importance of early initiation of breastfeeding; colostrum feeding
- Important facts about breastfeeding that should be told to the mothers
- Correct positions of breastfeeding
- What are common problems faced by mothers during breastfeeding
- How can an ASHA help in overcoming these problems

Method: Discussion and demonstration

Time: 90 minutes

Activity:

1. Start the session by asking participants to share from their experience why is breastfeeding important and why should a mother breastfeed exclusively for six months. List out the reasons on a board and add in if they miss out anything.
2. Ask the group-have they heard about "colostrum" feeding. Explain the importance of early initiation of breastfeeding.
3. Ask the participants what in their opinion is the most common reason for mother not breastfeeding. Their responses would include "not having enough milk". Emphasize that it is the effort and stimulus of suckling that is most important and the more the baby suckles the more milk is produced. Trainer explains this to the participants by explaining in brief how milk is produced by using the information given below.

4. Ask the group to read: “Facts about breastfeeding” given on page 88-89 of the Induction Module. Each participant reads alone. Now ask about four participants to volunteer. Each participant is given the task to tell the group two facts about breastfeeding which they just read. You write their points on a board. At the end you can ask other participants to correct or add any missing information. You can briefly explain all the points again to build clarity using the poster on Breastfeeding.
5. Display the correct positions of breastfeeding and describe each one in detail. You can also use video clippings to demonstrate these positions
6. Explain the steps to be followed by mothers while breastfeeding and ask the participants to read aloud these steps.
7. Describe the common problems of breastfeeding as per the related section on this given at page 78 of the Induction Module.
8. Trainer conducts a role play to demonstrate how a mother should be advised for breastfeeding. Here the main message is to help the mother with the position of breastfeeding and build her confidence that she is getting it right. The role play demonstration should bring out:
 - How to praise and build confidence
 - All important facts about breastfeeding
 - Steps that mother should follow to breastfeed
 - How would ASHA respond to in case the mother shares some common problems of associated with breastfeeding
 - Minor worries and problems of breastfeeding.

How milk is produced:

- Toward the end of pregnancy, the body is getting ready to feed the newborn. The breasts get bigger so that milk can be produced. Milk is produced when the gland tissue in the breast is stimulated. Before delivery, a signal is sent from the mother’s brain to ‘make milk’. In response to this stimulus, the first milk, called colostrum, is made and becomes present at the time of birth.
- When the baby suckles at the breast, the mother’s brain gives a stimulus to the breasts to produce the usual breast milk. The baby’s suckling controls the amount of milk produced so if the baby suckles more, more milk is produced. The baby’s suckling also makes the uterus contract (Which is why some women feel a tightening in abdomen when they breastfeed) This helps limit blood loss from uterus after delivery.
- How a mother feels while feeding her baby, can affect milk flow. If the mother is not giving time for feeding the baby or is tense less milk is available for baby. When the milk is in the reservoirs, the baby compresses the dark region (areola) of the breast with its upper mouth (palate) and tongue, squeezing the milk reservoirs and causing the milk to flow out of the nipple into the baby’s mouth. When the baby suckles, a message is sent to make more milk for the next feed.
- The baby gets the milk out by compressing the areola; not by sucking on the nipple alone which will only make the nipples sore.

Infant and Young Child Feeding

Session 10.1: Counseling for Malnutrition

Aim: By the end of the session the participants will:

- Understand the determinants of child malnutrition
- Have the skills to analyze and understand the causes of malnutrition in a given child
- Have the skills to counsel families to prevent and manage mild degrees of malnutrition in a specific child.

Methods: Presentation and Group discussion, Role Play: How to ask questions to assess causes of malnutrition in an individual child, Group task: Giving Advice to a family with a malnourished child.

Materials: Trainee check lists, Trainer check sheets

Time: 60 minutes

Activities

1. Short Presentation of 15 minutes. Use a power point if available or else posters. Explain the importance of addressing child malnutrition and the major social as well as proximate causes of child malnutrition. The quality of the presentation should be measured by the ability of the group to later answer the five questions given below.
2. Let the trainees break into five groups each and read out pages 91-93 of the Induction Module upto Counselling on Malnutrition. Fifteen minutes to read this is adequate.
3. After reading these pages each group should answer the following questions which should be written up on a chart paper. Then call each group to present the answer to one of the five questions- and the others to correct it if they have left out anything. If there is time, all five groups should answer all five questions. Though the answers to these five questions were given in the presentation and in the text, there could be different emphasis and views that come forth. The facilitator should be able to judge and take in the positive suggestions and correct false or wrong positions.

The key Questions are

- “Poor families require money for purchasing food. Educating them on improved nutrition is not going to solve the problem of malnutrition.” How would your group respond to this comment
- How does malnutrition affect the child? Is the ASHAs time spent on counselling for child nutrition well spent? How does her contribution complement or differ from that of the Anganwadi worker and the ANM on this task.

- If malnutrition is as high as 46% of all children – why are we not so aware of this problem. Should we focus on all children or should we address some of these children more rigorously?
 - What are the most important messages related to feeding practices of the young child?
 - What are the main messages related to prevention of illness and access to services? Which are the services that are meant to reach the malnourished child and where there should be a special effort to facilitate access?
 - When must a malnourished child be referred for medical advice? Where must she be referred? What is severe acute malnutrition? This whole activity may take anywhere for about 30 to 45 minutes- should not let this discussion proceed for very long.
4. Now introduce the need for counseling and why counseling is a special skill. Take them through pages 94-97 of the Induction Module. Have the participants read this section aloud, taking turns.
 5. Role play on counseling and management of mother with a malnourished child. Please note this is not a drama – and trainer and participants should not get carried away with the theatrics. Some role plays are meant to bring out the relationships and perceptions of different people. This is not such a role play. In this role play, the trainer plays the role of the mother with a malnourished child, and a trainee to play the role of the ASHA. The purpose of this role play is on teaching the trainees which questions to ask and how it is to be asked, and enable them get the opportunity to use the skills learnt thus far

The trainees are given information on the child’s age and grade of malnutrition, and a rough idea of the family’s socio-economic status (which the ASHA can assess through observation without asking questions). Prompt the trainee if any question is left out till all the areas are covered. Then ask the trainee to present a brief analysis of what the causes of malnutrition are in that child. See box on page 96 of Induction Module for two examples of such a presentation. The whole exercise takes about 60 minutes and it is done about three or four times with one of the trainees volunteering to be the ASHA each time.

Check against this list as to whether all the following topics were covered in the questions- the order does not matter.

- a. On feeding:
 - i. What did the child receive to eat? in the last 24 hours.
 - ii. Was there an effort to assess the exact quantity of each food that the child was given.
 - iii. What special/protective foods does the child get in the last week? Especially was the amount of proteins, the amount of fats and oils and greens that the child got assessed?
 - iv. Was frequency of feeding assessed?
 - v. Was feeding during recent illnesses assessed?
 - vi. What were the constraints explored in each of the above- did the mother have the knowledge of the correct feeding issues.
 - vii. Is there expenditure on tonics, health foods, vitamin tablets, etc.
- b. On illness
 - i. Was the history of recent illnesses and their frequency assessed? Was diarrhoea, ARI and measles specifically asked for?
 - ii. What treatment was given? By whom? What were the expenditures?
- c. On access to services
 - i. Is the child immunised on schedule?
 - ii. Has the child received vitamin A? Deworming tablets/Paediatric iron tablets?
 - iii. Is the child getting rations from the anganwadi? Attending anganwadi?
- d. On family and economic context?
- e. Is mother able to give time on feeding, on child care? Who takes care of the child for much of the day?
- f. Could they afford protective foods like egg, meat, milk, fruit etc?
- g. What is the order of this child?
What is the spacing with earlier child?
- h. Is the mother using any spacing methods/limiting methods?

Presentation of the understandings could be written up as five or six case studies and distributed, so as to prepare for the third session.

Session 10.2: Assessment of Malnutrition

Aim: At the end of this session the participants will:

- Learn to identify the presence of malnutrition in a child
- Be able to measure the extent of malnutrition in a child
- Be able to communicate the extent of malnutrition to a family

Method: Introduction and then practice drill on measuring malnutrition using a chart.

Materials: Malnutrition/Growth charts, Salter weighing machine (can weigh children upto 25 kg) or its picture

Time : 60 minutes

Activities

1. Present identification of malnutrition from page 99-102 of the Induction Module.
2. Emphasize that an underweight child need not have any of the mentioned signs. Tell them about weighing the child using the Salter weighing machine. This is available at the Anganwadi Center. Emphasize that unless they are taught the skill of weighing in tier next round of training it is NOT part of the ASHAs work responsibility to measure the weight of the child regularly, but that she needs to know where the weighing machine is available. Once she is trained there may be times where a child needs to be weighed by her.
3. Give the weights and age of a number of 10 children in a worksheet. Each group has to fill up the grade of malnutrition. Describe new reference scale that is used in this module.
4. Ask how the weight of the child and the severity of being underweight are to be conveyed to the family. What would be the words used? Work out what is culturally appropriate but at the same time conveys adequately the seriousness of being underweight.

Notes for the Trainers

You need to know that the chart shown is called WHO standards. On the field health and ICDS staff may be using the earlier standards which classified malnutrition in grade normal, moderate and severe. Broadly what is marked as below the red line corresponds to level moderate and that which is below the last line corresponds to severe malnutrition.

Hand out 6- Work sheet of Severity of Malnutrition Calculation Drill

Age of child	Sex of the child	Weight in Kgs	Grade of malnutrition
1. 2 months	M	7	
2. 6 months	F	8	
3. 9 months	M	8	
4. 11 months	F	6	
5. 14 months	M	7	
6. 22 months	F	9	
7. 22 months	M	9	
8. 2 and half years	F	13	
9. 2 years 7 months	M	13	
10. 12 months	F	7	
11. 12 months	M	7	

Each individual has to do this and the small group has to check it and correct it in each group till everyone has learnt to calculate it.

Session 10.3: Learning Skill of Counseling and Behavior Change for Malnutrition

Aim: At the end of the session the participants will be able to:

- Learn how to counsel the mother and the family on infant and young child feeding.
- Become skilled in community mobilization for UHND, immunization and child health.

Methods: Role Play and Group discussion

Material: Five case studies

Time: 60 minutes

Activities

1. Circulate the case studies. Depending on time trainer can all five stories to a group of participants or select one or two to be given as role plays. Trainer asks the selected groups to counsel a family in this situation. Work it out as a role play with the facilitator playing the role of the family again. Take about half an hour to complete this. Use the check list given at the end of this session to check whether all aspects have been covered.
2. Then ask – what more is needed other than such interpersonal communication or counselling to make for a change in feeding practices? In particular what should be the community level action and how should we use the area health and nutrition day?

Hand out 7- Case-Studies of Malnutrition

- Banu was a nine month old girl with moderate malnutrition. She is being breastfeed and only this month was started on complementary foods. She eats rice and dal from her parents' plate while they are eating, once at about 10.00 am and then at about 6.00 pm. No other complementary food is given. She had diarrhoea once, one month ago, but no other illness. You gave her ORS and she became alright with it. She does not go to the anganwadi or get rations from there. Her immunisation is on schedule. How would you counsel this family?
- Rafay is an 18 month old boy who is severely underweight. He has no odema, but there is some wasting. He cannot go to the hospital because his mother cannot leave her younger child and she also has to go to work as she is the only earning member. Rafay is not being breastfeed, but gets to eat roti, dal and vegetables. He eats about half a roti or one roti thrice a day. But his mother complains that he does not eat a lot and has very poor appetite. He has frequent episodes of respiratory infection but no other illness. His immunization schedule is complete. How would you counsel this family?
- Akila is a 3 month old girl. The girl is of low birth weight. Now the weight is 4 kg. She gets breast-feeds but since last few days, she is being given water to drink also. There is no illness now, though in the second month there had been fever treated with antibiotics. No services from the anganwadi are accessed. One dose of DPT and one dose of BCG and one dose of polio have been given. How would you counsel this family?
- Krishna is a 12 month girl weighing 7 kg. This girl has stopped receiving breastfeeds and is on complementary feeds. The parents complain that though they try to feed him adequately, the child refuses feeds. The family's knowledge about complementary feeds is adequate. Immunisation is complete. The child has recurrent diarrhoea and is pale. It is a poor family and the earlier child is three years old. The mother goes out to work daily leaving the two children with the aging grandmother. What advice would you give this family?

- Naresh is a child of 14 months who is 7 kg. The child was normal till 10 months when it started lagging behind in the weight curve. The child was given adequate rice- but there was no variety in the diet and the child was only fed twice or thrice a day. The child had fever with a rash one month back and since then has been weaker. The child has completed immunization except for measles. What would be the advice for the child

	Check–List: Participants/Trainee did the following -	Yes	Partially	No
1.	Introduced herself and the purpose of the visit			
2.	Was able to estimate the age of the child adequately			
3.	Was able to ask about breastfeeding adequately-especially about exclusive breastfeeding if child is in first six months.			
2.	Was able to ask about amount, variety and frequency of complementary food adequately			
3.	Was there feeding in illness			
4.	Was history of illness taken			
5.	Was family situation assessed			
6.	Was access to services determined			
7.	Did the participant demonstrate active listening.			
8.	Did the participant follow the flow while asking questions- or was it like reading off a list? Was an active conversation established			
9.	Did counselling start with praise and reinforcement of good practices			
10.	Did participant resist the temptation to immediately respond negatively to any wrong answer – or make negative or derogatory remarks			
11.	Did participant resist giving gratuitous advice – like be clean, eat healthy food, take proper care of children etc.			
12.	Did participant place her advice as suggestions and discuss with the mother/ family whether they could adopt these suggestions- instead of merely pre-cribing advice			
13.	Did participant counsel on prevention of disease			
14.	Was counselling done on access to services			
15.	Were there any indications for medical referral for this child? If so was re-ferral advice given?			
16.	Was the family thanked and follow up visit indicated before the session closed.			

Use the following tips to assess the role play and give feedback:

Steps for Good Counselling-

- An ASHA asks questions and listen.
- See whether ASHAs have covered all the facts related to nutrition
- Whether advice given by ASHA is based on the local context and family’s situation
- Her language is clear and simple.
- While giving advice regarding inappropriate practices, she has not used words or language that may hurt community/family feelings.

How should ASHA ask and listen

- Ask questions in clear and simple language. Ensure that the family understands what you are saying.
- Listen carefully to assess if family has any queries or doubts.
- If you listen, you will know the doubts and fears that the family may have. You will also know which behaviours need to be changed.
- Ask appropriate questions.
- Praise behaviours that are good.

Ensure that the family has understood the facts

- Ask the family what they have understood and ascertain what needs to be explained further.
 - Praise the family for their good understanding.
 - Ask questions that require detailed responses. Your question should start with words like why, what, where, when, how many, how much and how.
 - Give the family some time to think and formulate the answer.
3. Ask participants to read out page 103-104 of the Induction Module on **role of ASHA in Immunisation**. Discuss- in practice what happens in your area. What should happen? Participants can take turns to present their views. The first six activities given in the list relate to what most would understand as the facilitation of services. But the five activities given under g. would be understood by most as the role of ASHA as activist. Compare and contrast the skills and support needed for these roles.

Session 10.4: Diarrhoea

Aim: At the end of the session the participants will learn:

- What is diarrhea
- Types of diarrhea
- How to counsel a family where a child has recurrent diarrhea.
- Decide between home based care and need for referral in a child with diarrhea.
- How to provide treatment for children.

Methods: Presentation and Group discussion

Materials: Chart paper, board and marker pens

Time: 90 Minutes

Activities:

1. Start the discussion by asking what their perception of Diarrhoea is. After listening to their responses explain the definition of diarrhoea.

2. Describe the three types of diarrhoea in detail and ask the participant to read this section on page 93 of the Induction Module.
3. Discuss the causes of diarrhoea in detail. Discuss on: Routes of transmission of infection shown during the session on illness and hygiene. The link between fecal contamination of drinking water and diarrhoea should be emphasized as the only cause of this problem.
4. Ask the participants to recall from the session on hygiene and call out what would be the preventive measures that the family and community could take. Make sure the importance of hand washing is stressed. Also discuss the safe disposal of feces and how to ensure safe drinking water.
5. Explain that there are families with children having recurrent diarrhoea. Because of this, they are also losing weight. Though preventive measures against diarrhoea are relevant to every family there is urgency about preventing this recurrent diarrhoea in such families.
6. The signs of dehydration should be taught, by showing the video clip and asking participants to write down whether the child is dehydrated or not.
7. You can briefly tell the participants that Depending on the signs of dehydration the child could be categorized into one of four groups- Diarrhoea with Severe dehydration, Diarrhoea with some dehydration, Diarrhoea with no dehydration and Dysentery. Make sure that this is understood by the participants. You can use the case studies given below and ask them to categorize the child. This is for practice.
8. Now discuss Treatment for diarrhoea: First discuss which categories need to be referred to hospital- at once. Then discuss what you would do in the other categories. This is given in page 107 of the Induction Module. Participants should read out in the small groups and discussed.
9. Discuss how to make ORS solution. Divide the participants in to groups and let each small group make such a solution using the packet and using sugar and salt and taste it. It is important to get them to make it. Emphasize that it is always preferable to make the ORS using the packet supplied because one is sure of the right proportions- but if that is not available, they should not hesitate to use home-made substitutes. List all possible home based substitutes. This is given in Page 93 of Induction Module.

Notes for Trainers

Case Studies for categorization of diarrhoea exercise: For each child let participant work out the categorization and then later tell the type of treatment.

- i. Kumkum aged 6 years has diarrhoea for last 15 days. Her stools are semi-solid and she passed stools four to five times a days. There are no signs of dehydration and there is no blood in the stools.
- ii. Pappi aged one has diarrhoea for three days. The stools are very watery and passing frequently. The child has passed much urine twice in last six hours, but of dark yellow colour. The child is irritable and the skin when pinched up goes back slowly. Mouth is dry. Child is very thirsty and drinks water eagerly.
- iii. Chintu aged three years has diarrhoea for one day. The stools are watery and passing frequently. Child has passed almost no urine in last six hours. It does not show any interest in

drinking water and when forced drinks poorly. The skin gets pinched up and goes back slowly. There is no blood in stools.

- iv. Rekha aged six months is having diarrhoea for last three days. Stools are watery and there is no blood. Child is otherwise normal, passing urine frequently and breastfeeding well.
- v. Ramesh aged 5 years is having diarrhoea for last two days, and there is blood in the stools. There are no signs of dehydration

Session 10.5 Acute Respiratory Infections

Aim: By the end of this session the participant will learn:

- What is ARI and why is it important in the Indian context
- What cases of ARI need immediate referral
- What is the care needed for children with ARI

Method: Discussion, video simulation

Material: Video clippings

Time: 90 Minutes

Activity:

1. Trainer starts discussion by introducing the concept of Acute Respiratory infections.
2. Use the video clippings to tell about the signs and symptoms of ARI. Start with the milder forms of ARI which include the commonly occurring cold and coughs and then proceed to show the signs of the severe form.
3. Ask one of the participant to read the related section for this on page 95 of the Induction Module.
4. Explain the type of care that is to be given during this illness.
5. Discuss what is the advice to be given for the child who has to receive home remedy for cough and cold. This is given in page 107 but one could also discuss what practices are being followed in the community and recommend those which do not have any harmful effects. Do not encourage any practice where oil is put into nose or ears. That is harmful. Most of these conditions are self-limiting and needless expenditure could be avoided. Include advice on feeding during an illness and the importance of it.
6. Discuss the conditions for referral. It is important to emphasize here that more extensive management of Acute Respiratory infections will be taught to ASHAs in their next round of training.
7. End the discussion by summarizing the important details.

Session 11.1

Aim: Aim: By the end of this session the participants will understand:

- What is adolescence and what are the main developmental changes that are seen in girls and boys during this period
- Why is it important to focus on the health of adolescents
- The major health concerns and related care for adolescent girls
- Role of ASHA pertaining to menstrual hygiene
- Specific concerns of adolescent boys
- What is nutritional anaemia and how can ASHA help in preventing nutritional anaemia
- What are the behavioural changes seen during adolescence and what role can ASHA play in addressing them

Method: Discussion, reading, role play

Material: Board, chart paper, marker pens

Time: 90minutes

Activity:

1. Trainer starts the session by asking the participants as to what they understand by adolescence.
2. By relating to their responses the trainer explains in brief what is adolescence?
3. Now ask what are main changes seen in the body during this period. Let them call out the changes in girls and boys separately. Write their responses on a flipchart. Now display the chart which you have prepared for these changes in boys and girls
4. Using the chart explain the these changes
5. Ask the participants what is the time around which these changes are noticed in boys and girls. Based on their responses explain- normal time of onset and the concept of "Puberty".
6. Discuss briefly why it is important to focus on adolescent health.
7. Display the diagram given on page 111 of Induction Module to explain what is menstruation and why does it occurs. Ask the participants to take turns to read the related section in Induction Module
8. Display chart on menstrual cycle to further build clarity on how menstruation occurs
9. Ask the group to list the possible questions that young girls may have regarding menstruation.
10. Make a list of their questions on a flip chart. Encourage the participants to try and answer the questions. Intervene only when you think they are not able to get to the answer or an incorrect response has been given.

11. Discuss the major problems during menstruation such as: Painful, heavy and irregular periods, and Premenstrual syndrome. Ask the participants what is generally done for these problems. Be sure that the solutions are not something that should not be done, for example “taking a Baraligan tablet, or using hot water bags directly on the skin, or fasting during periods.” The trainer builds further clarity on this topic by explaining the information given in Pages 111-112 and Induction Module.
12. Ask the participants to take turns and read aloud the sections staying clean during menstruation, important facts related to menstrual hygiene and role of ASHA pertaining to menstrual hygiene. Keep stopping them in between to explain these sections in details.
13. Trainer can conduct a role play here to reinforce the concepts that have been learnt so far.

Notes for Trainers:	
For role play situations, the trainer may use other issues. A few examples are given here. The facilitator can give one or all these situations and ask the participants to prepare an extempore play of 15 minutes. Listen carefully to the dialogues to point out the different counseling steps when this is done.	
Situations for role play:	
a) Girl is refusing to go to school as she has her periods and is embarrassed that her clothes may stain	
b) A young girl is taken to the PHC to meet the doctor as she has got a rash and itching in her private areas. The doctor advises on use of the sanitary napkin	
c) Two friends discuss how they are scared of going out during their periods, they are overheard by the ASHA who then counsels them	
Use the tips discussed in the nutrition counseling situation to assess the role play and give feedback: <ul style="list-style-type: none"> • See whether ASHAs have covered all the facts related to menstrual hygiene as have given on page 113. 	
Assessment of understanding	
Good Questions	Questions to be avoided
How will you take care of yourself during your menstrual period.?	• Do you remember how to take care of your menstrual health?
• Why will you wash your hands with soap?	• Do you wash your hands with soap?
• How will you dispose of the sanitary napkin?	• Do you know how to dispose of the sanitary napkin?
• What will you do in case you do not have a sanitary napkin?	• Do you know what to do if you do not have a sanitary napkin?
• Can you tell me what precautions you need to take when you are using a cloth napkin?	• Do you remember the precautions to take when you use a cloth napkin?

14. Describe the concerns of adolescent boys.
15. Trainer makes a brief presentation about nutritional anemia.
16. Participants are asked to take turns to read the section on role of ASHA in preventing nutritional anaemia, while the trainer explains each bullet in detail.
17. Ask the participants have they noticed in their families or area any behavioral changes amongst adolescent boys and girls. What do parents generally do about it?
18. By relating to their responses explain the section on behavioural changes given on page 116 of Induction Module. Describe what an ASHA can do in these situations.
19. End the session by consolidating learning form the session.

Reproductive Tract Infections and Sexually Transmitted Infection

Aim: By the end of this session the ASHA will be able to:

- Understand RTI/STI and HIV/AIDS; prevention, management and treatment.
- Counsel women on protection from RTI/STI and HIV/AIDS.
- Guide women to appropriate facilities for testing and management

Method: Group Discussion, Worksheet

Time: 60 minutes

Activities:

1. The trainer begins the session by giving a brief presentation about on the RTI, STI. The presentation on RTI/STI should aim to introduce the topic by telling the concept of white discharge and highlight the fact when the white discharge is normal and when is it regarded as abnormal.
2. Ask the participants why do they think very few women seek treatment for these infections. Relating to their responses you can explain why these diseases are not addressed.
3. The participants are asked to take turns to read pages 117 and 118 of the Induction Module, while the trainer explains each of these in details to strengthen their understanding.
4. The trainer then explains the group difference between RTI, STI, and HIV/AIDS
5. Describe the role of ASHAs in managing and preventing RTI/STI.
6. The trainer distributes the following cases studies as handouts and gives time (10 minutes per case) to the participants to prepare a list of steps an ASHA should follow in each of these cases.
7. Discuss each case one by one. Ask the participants call out the steps, while you write the responses on the board. Display the correct responses for each case and point the incorrect/missed ones.
8. Explain HIV/AIDS as per the information given in Induction Module. Ask the participants to read individually this section on Page 117-119 of the Induction Module.
9. You can give the worksheet verbally quiz them on HIV/AIDS to assess their understanding.
10. Identify the gaps, clarify doubts and end the session by summarizing key details.

Handout 8- Case Studies for discussing: Prevention and Management of RTI/STI

- a. Swarna comes to you one day and complains that she is having abdominal pain and also an itchy feeling in the genital area. She has a discharge which is greenish yellow, and foul smelling. Her husband is a migrant labourer. What advice would you give her?
- b. Nithya is a married woman, 21 years old. She has a two year old daughter. Her husband is a school teacher. She comes to you with a complaint of white discharge, but with no other symptoms. What would you ask her? What is the diagnosis?
- c. Sarala is 35 years old, and has three children. She has had a sterilization operation five years ago. Her husband is an alcoholic and often stays away from home. She complains of foul smelling discharge with itching in her genitalia and burning urination. She says this is the third time she has had such a condition. What would you advise her to do? What methods of local relief would you advise?

Correct Responses for the Case studies: Prevention and management of RTI and STI

- a. Swarna comes to you one day and complains that she is having abdominal pain and also an itchy feeling in the genital area. She has a discharge which is greenish yellow, and foul smelling. Her husband is a migrant labourer.

What advice would you give her?

- Advise her to go to the U-PHC since she may have an STD.
 - Ask her to ensure that her husband should also take the treatment which is given to her
 - Ask her to complete the treatment and not stop the, medication
 - Ask her to ensure that she uses a condom for every sexual encounter and not have unprotected sex
- b. Nithya is a married woman, 21 years old. She has a two year old daughter. Her husband is a school teacher. She comes to you with a complaint of white discharge, but with no other symptoms. What would you ask her? What is the diagnosis?
 - Ask for the colour of the discharge?
 - Ask if there are other symptoms such as burning, itching,
 - Ask if there is a rash or swelling, or lower abdominal pain
 - Since she has no other symptoms, this is most likely normal white discharge, but you should ask her to visit the U-PHC to get an internal examination done.
 - c. Sarala is 35 years old, and has three children. She has had a sterilization operation five years ago. Her husband is an alcoholic and often stays away from home. She complains of foul smelling discharge with itching in her genitalia and burning urination. She says this is the third time she has had such a condition. What would you advise her to do? What methods of local relief would you advise?
 - Advise her to go to the U-PHC and if possible take her husband with her.
 - Advise her to negotiate with her husband to avoid unprotected sex.
 - For local relief advise her on steps she can take at home:
 - Sit in a pan of clean, warm water for 15 minutes. Add lemon juice to the water.
 - Do not have sex until she feels better.

- Try to wear cotton next to the skin.
- Wash undergarments every day.
- Pour clean water on genitals after passing urine.

Worksheet: Quiz on HIV/AIDS

1. HIV is transmitted through all except:
 - a. From mother to baby
 - b. From infected needles
 - c. Through unprotected sexual intercourse
 - d. Through sharing the same utensils
2. None of the following can transmit HIV except:
 - a. Kissing
 - b. Mosquito bites
 - c. Sharing clothes
 - d. Mother to baby
3. Which of the following are at higher risk of getting HIV:
 - a. Truck drivers
 - b. Commercial sex workers
 - c. Men who have sex with men
 - d. Migrant labourers
 - e. All of the above
4. HIV can be prevented by all except:
 - a. Using a condom during sexual intercourse
 - b. Avoiding sex with multiple partners
 - c. Using sterile needles
 - d. Preventing mosquito bites
 - e. Ensuring safe blood for transfusion
5. True or False:
 - a. Persons with HIV are not at greater risk of getting TB
 - b. Women whose husbands have multiple sexual partners are at higher risk of getting HIV
 - c. Babies born to mothers who are HIV + are at higher risk
 - d. Men who have sex with men are not at risk of getting infected with HIV
 - e. The test for HIV is available at the district hospital

Worksheet 2: Responses to HIV/AIDS Quiz

1. d
2. d
3. e
4. d

Preventing Unwanted Pregnancies – Family Planning

Aim: By the end of this session the participants will be able to:

- Develop line lists of eligible couples for identification and follow up
- Understand the side-effects of the methods so as to counsel the woman to continue with the method or seek appropriate assistance.
- Assess which methods are suitable for couples/individuals based on their marital status, number of children, child bearing intentions, and the mother's health status, and counsel for method use based on informed choice.

Methods: Group discussions, Role plays, Worksheet

Material: Samples of Copper T, Oral Pills, Emergency Pills, Condoms,

Time: 60 minutes

Activities:

1. For this session, the trainer should be familiar with the contents of page 121-124 of the Induction Module, and the Notes to the Trainer given in this guide.
2. The trainer asks the participants to share from their experience what the commonly used methods of family planning in their community are and which are the various categories of women that they think require family planning.
3. The trainer asks participants what are the key constraints women face in accessing family planning methods. These are written up on the blackboard.
4. The trainer then lists the major categories of women that are in need of family planning and states why it is important to address them. (Notes to the Trainer). Other questions for discussion are:
 - How many marriages are held in your area within one marriage season?
 - Will it be easy to visit and advice young brides to be?
 - What all will you advice young and newly married brides and grooms about?
 - Is the onus of family planning on the woman only?
5. The trainer then discusses with the group how they would identify and list women in the community that belong in any of these categories. The ASHA are asked to do this as an exercise for their community practice, after the training round before the fourth round of training.

6. The trainer then asks the participants to read aloud, in turns, page from 121-124. Since there is lot of information here, the trainer, interrupts the reading as each bullet is completed and reviews and repeats the key points in the section.

The key sections are:

- Women's needs for family planning,
 - The Oral Contraceptive Pill,
 - Emergency Contraceptive Pills,
 - Condoms,
 - Intrauterine Contraceptive device,
 - Sterilization, (male and female), Under each head the trainer reviews the side effects, indications for use of the method, availability of method at various service levels.
- ◎ The trainer now displays the following four situations.
- Newly married woman (aged 19 years)
 - A woman who had her first baby about four weeks ago
 - A mother of three children who does not want any more children
 - Unmarried girl asking for contraception

For each of these situations the trainer asks the participants to write in their notebooks

- Key counselling message: as to why should they adopt a family planning method
 - Which method should they adopt
 - Key questions they will ask to elicit information regarding the conditions where a particular family planning is to be avoided
 - What are the side effects
 - Where can they avail this method from
7. The participants should be encouraged to use the chapter on Family Planning in Induction Module while writing this information
 8. Trainer asks the participants to take turns to call out the five responses for each situation. Write the correct responses on the board and clarify doubts in case of the incorrect ones.

Notes to the Trainer:

Family Planning is one of the oldest programmes in India. The trainer should use this session to provide ASHA with an understanding of the importance of family planning for the health of the mother and child and also what methods are most appropriate at various stages of a woman's reproductive life. Family planning is important for many reasons: to protect women's health from early and frequent childbearing, to help couples decide the interval between marriage and the first childbirth, and finally to decide the interval or space between successive children to ensure the survival and health of the children and the health of the mother.

In India family planning is often considered only after the woman has had all the children she wants. Counseling couples who are about to be married and those who are newlywed for family planning is important so that they are aware of the risks of childbirth (where the woman is less than 21 years of age), and to the importance of ensuring that the couple has time to get to know each other well enough to become parents. The programme emphasizes female methods over male methods of contraception (condoms, male sterilization)

How Can Family Planning Save Mothers?

By adopting family planning methods, women can protect themselves from unplanned pregnancies and their consequences, e.g., abortion and its possible complications.

- Family planning can prevent highrisk pregnancies and protect women from serious complications which they may have to face due to pregnancy when they are too young, too old, and with too many pregnancies and/or pregnancies with less than two years interval.

How Can Family Planning Save Infants?

Spacing of births by at least two years could prevent at least 50 percent of infant deaths.

By adopting family planning, couples can ensure at least a two year interval between births and ensure proper health, nutrition and well being for the baby and for herself.

Principles of family planning:

The couple has the right to choose a contraceptive method, without any pressure or coercion from the service provider. The couple must be enabled to make a decision of which method to choose. The women and man should be informed about all the methods available, how they work, their advantages, disadvantages, common side effects and effectiveness, correct use, health risks, warning signs and symptoms, information on return to fertility once the method is stopped, the extent to which it protects from STIs, including HIV/AIDS, so as to be fully informed before making a choice. Men should be encouraged to take responsibility for family planning by using condoms or adopting sterilization.

Aim: By the end of this session the participants will be able to:

- Advise on method, based on duration of pregnancy.
- Understand the risks of unsafe abortions, and know where safe abortion services are available in her area.
- Help women in need of such services to access safe abortion services.
- Be able to identify signs of post abortion complications and advise appropriate referral.
- Counsel for appropriate post abortion contraception.

Methods: Group discussion,

Material: Board, marker pens, poster on safe abortion

Time: 30 minutes

Activities:

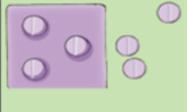
1. The trainer asks the participants what are common reasons that women in the community seek abortion, the period of pregnancy during which abortion is sought and where abortion is sought. These are listed on a flip chart or board
2. The trainer then asks the ASHA to read aloud from pages 125-127 of Induction Module.
3. The trainer then asks the participants to correlate what they have just learned with the material on the board and identify any incorrect facts and corrects the gaps in knowledge.
4. The trainer must emphasize to the participants that women in the community who seek abortion, would often confide in ASHA if she is seen as a friend to them. The ASHA must respect the confidentiality of women who come to them seeking information on abortion related services.
5. For further practice you can display the case studies given below without the correct responses. Discuss each case one by one, Give ten minutes per case to the participants to read and write the answers in their note book. Now let the participant call out the responses. List them on a board and now show the correct responses.
6. Clarify why a particular response is incorrect.
7. End the session by summarizing important details by using the poster given on next page



Safe Abortion



Methods for Safe Abortion



Medical Abortion

- Can be done in less than 7 weeks after LMP
- Under supervision of medical provider



Manual Vacuum Aspiration

- Can be done up to 8 weeks of pregnancy
- Woman needs to stay in the health facility for a few hours



Dilatation and curettage (D and C)

- Can be done up to 12 weeks of pregnancy
- Is associated with a higher risk of complications

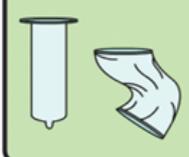
Post-Abortion Care



Avoid sex for 5 days post-abortion



Drink plenty of fluids



Use contraception always

Post-Abortion Complications



Heavy Bleeding



High Fever



Severe pain in the abdomen



Fainting and Confusion

ASHA's Role in Safe Abortion



Counsel women on abortion service



Conduct home visits on days 3 & 7 after abortion



Provide Information on signs of complications



Motivate use of contraception post-abortion

Case Studies for discussion: Safe Abortion

- Lata is a married woman of 25. She has an eight month old baby and is breastfeeding. She restarted her period when the baby was six months old, i.e. two months ago. She has not got her periods since then. She is worried that she is pregnant and wants an abortion. What would you do? What method of abortion is appropriate for her? Why did you choose this method? What are the other methods and why did you not select those other methods?

 - Use Nischay kit to confirm that she is pregnant
 - Determine weeks of pregnancy (about eight weeks)
 - Method of choice: MVA
 - Ask her to go to U-PHC for a safe abortion
 - Medical abortion can only be done upto seven weeks, and D and C is a risky procedure.
- Kusum has three children, and is thirty five years old. Her youngest child is four years old. Her LMP was August 10, 2014. She comes to you on September 18, 2014, saying that she has missed her period. She does not want to have another child. What will you do? What method of abortion is appropriate for her? Why did you choose this method? When would you visit her after the abortion? List four key messages that you would give her on post abortion care.

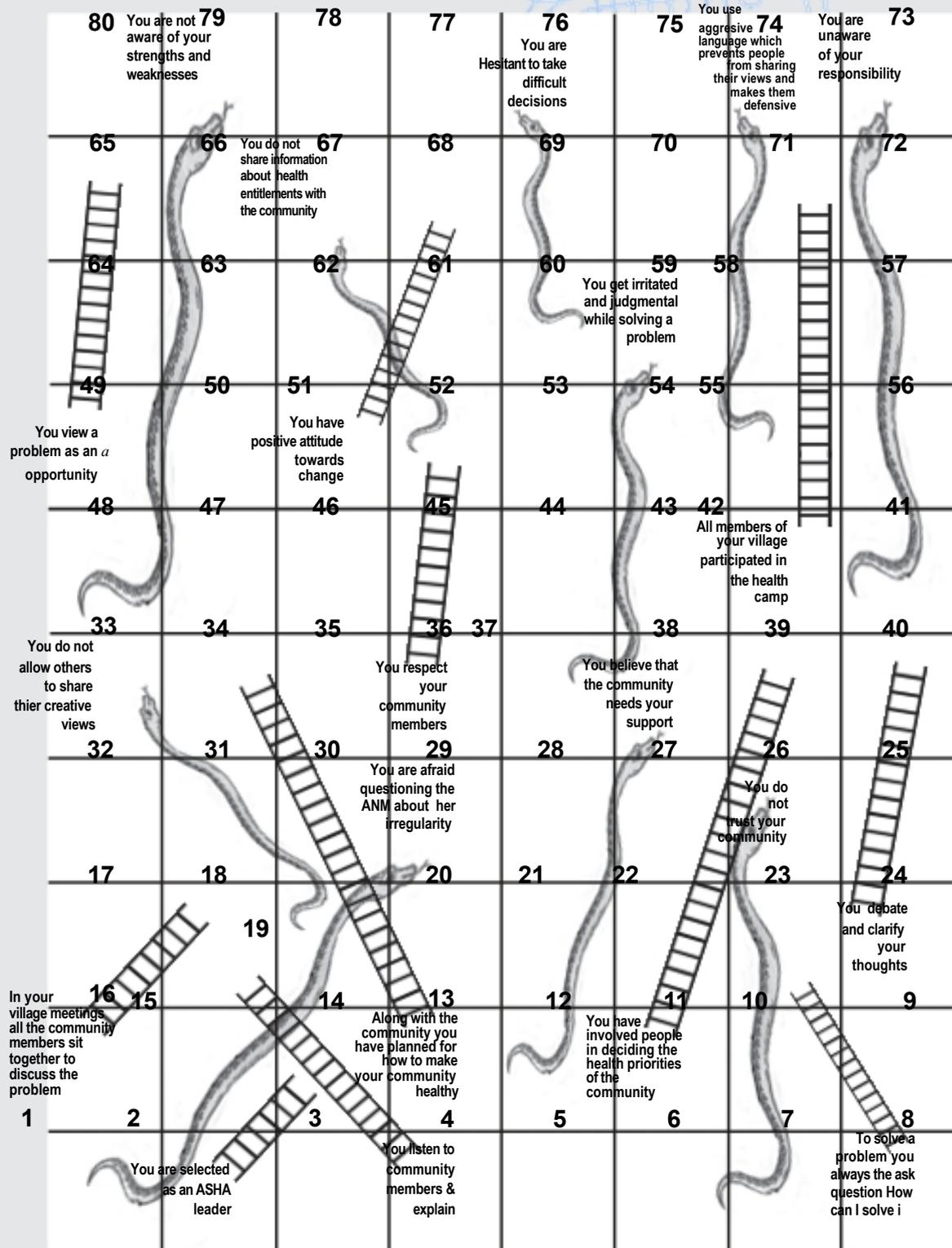
 - Use Nischay kit to confirm that she is pregnant
 - Determine weeks of pregnancy (about six weeks)
 - Ask her to go to U-PHC for a safe abortion
 - Method of choice: Medical Abortion
 - Medical abortion can be done upto seven weeks, and is a safe method that does not require any surgery. However two visits to the doctor/U-PHC are required
 - ASHA should visit her on Days 3 and 7.
 - Four key messages on post abortion care (page 126, Induction Module)
 - Abortion is not to be used a method of family planning – all forms of abortion have some side effects and it is best to use a method of family planning to prevent pregnancies.
- Leena is 19 years old, and was married eight months ago. Her husband calls you one day as she is bleeding heavily, and has fever. Leena tells you that she had missed two monthly periods. Three days ago, she went to an untrained provider in the next town for an abortion since she did not want anyone in her house to know. What is your first response? What do you think happened to Leena and why? What should she have done? What advice would you give her after she returns from the hospital?

 - Immediately ask the husband to arrange transport to take her to the nearby 24/7 U-PHC
 - Leena did not want a child so early and could not share this with her husband and in-laws she had to get the abortion done in secret, and she did not know who to go to.
 - She should have gone to a U-PHC where she could have had a safe abortion using an MVA.
 - Counsel Leena and her husband to delay pregnancy for six months at least, to give her body time to heal. You should counsel the use of condoms or oral pills, and a check up by the doctor in the PHC.

Annexures

Annexure - 1

Leadership Game



Annexure - 2

Situation Cards





Situations for Analysis 1 (Educating Women on Pregnancy Care)

Shanti is the fourth and youngest daughter-in-law in the family. She and her husband live with his parents, his three brothers and their wives and children. Shanti is now pregnant with her first child, and ASHA Sunita has ensured that the pregnancy is registered. Sunita has just been talking to Shanti about the need for adequate nutrition and rest. Shanti suddenly interrupts her, saying, "Sunita didi, where is the time to rest here? You know ours is a large family and there is always so much to do. And who's going to convince my mother-in-law and sisters-in-law?"

What can the ASHA do in this situation?

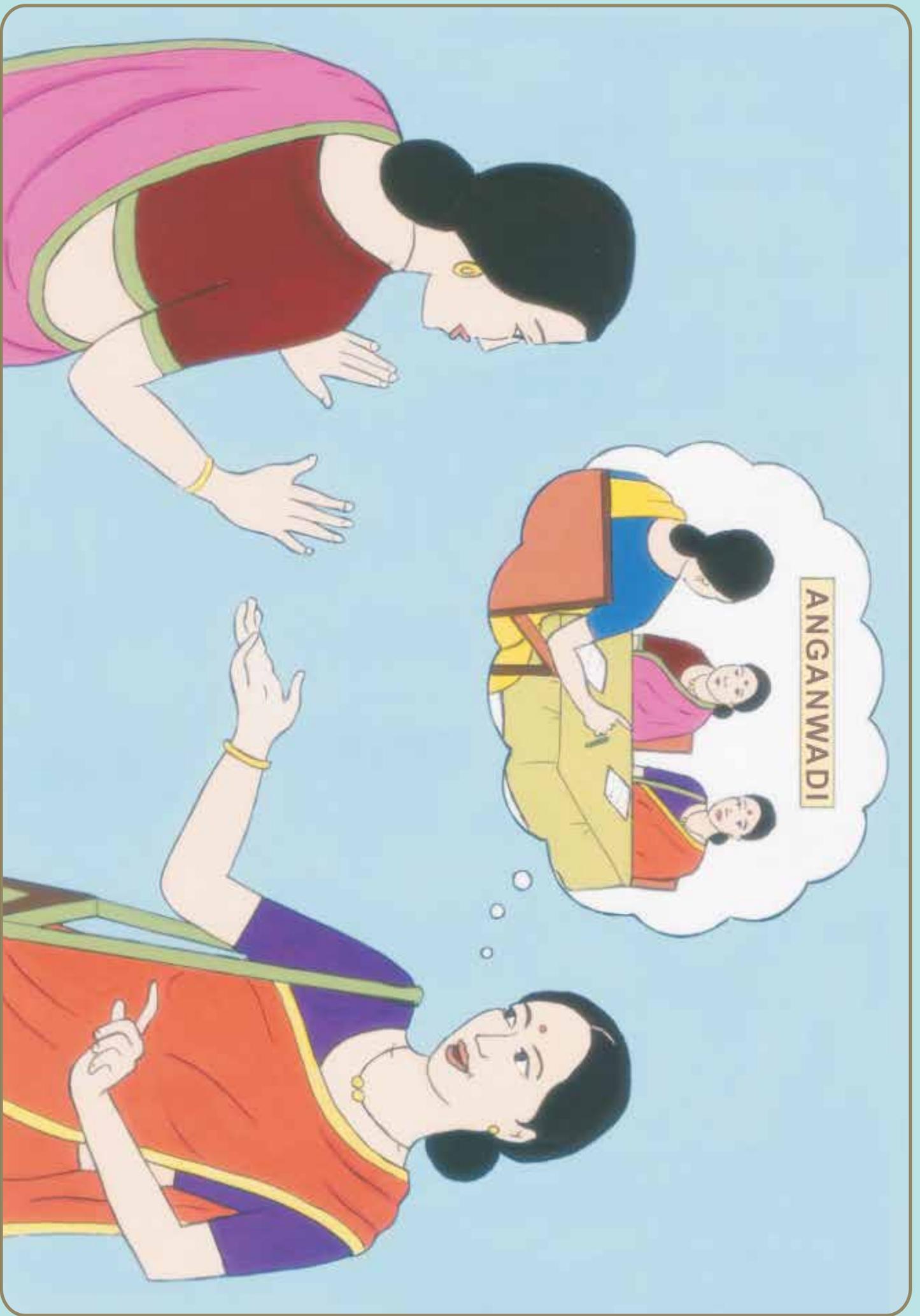




Situations for Analysis 2 (Educating Women on Pregnancy Care)

Rasila and her mother-in-law have been listening keenly to ASHA Parvati as she shows them the book on the care required during pregnancy. Suddenly, Rasila's mother-in-law interrupts Parvati, saying, "She's not the first woman in our family to become pregnant. In our days, we didn't need any medicines when we were pregnant. All this talk about taking iron-shiron is nonsense! After all, my daughter-in-law gets enough food to eat; what else does she need? These tablets will only spoil her health."

What can the ASHA do in this situation?

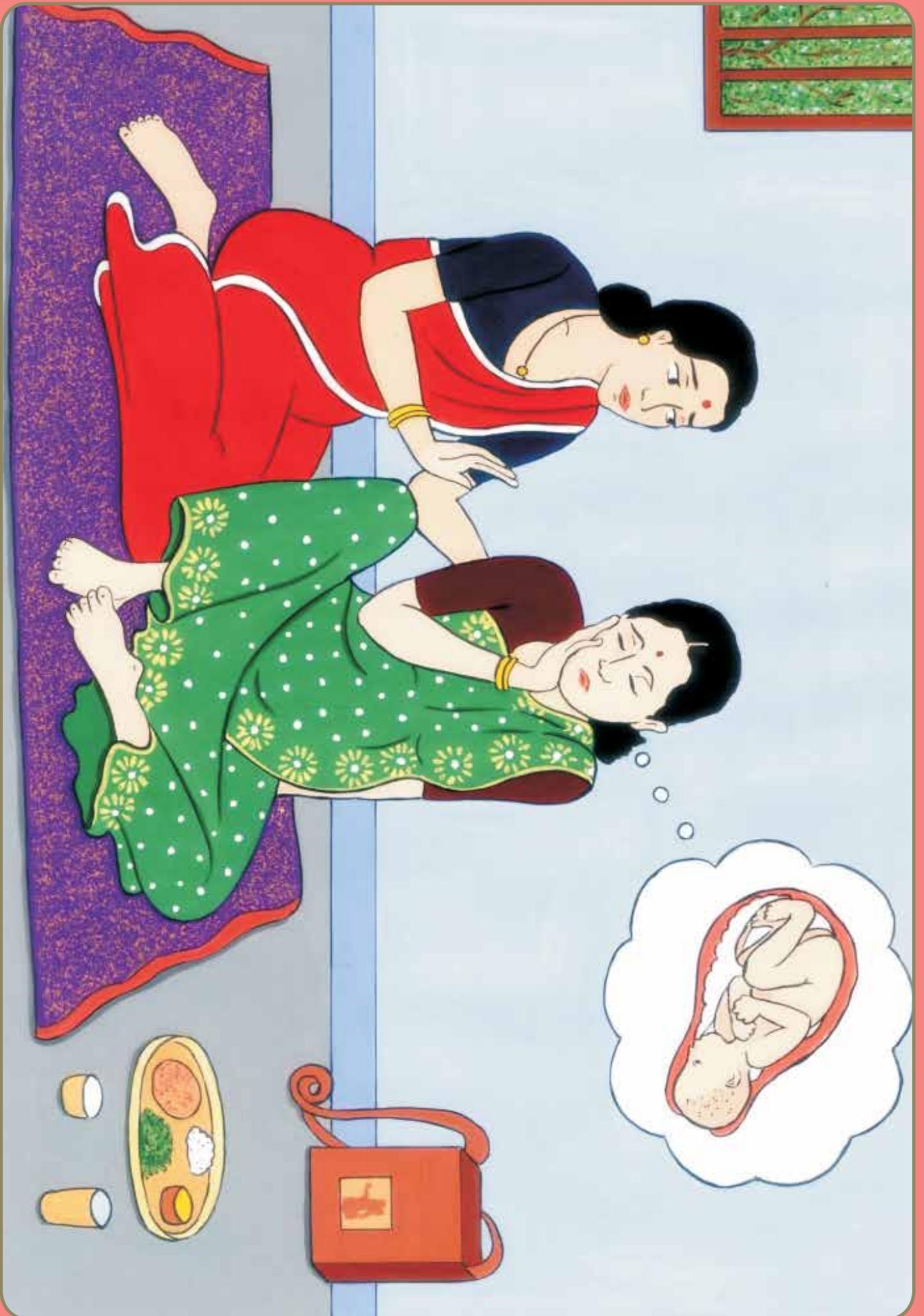




Situations for Analysis 3 (Educating Women on Pregnancy Care)

Simran has been married for ten years. She is now pregnant with her first child, and is really happy. ASHA Neetu is visiting Simran today to talk to her about the care she needs to take. Neetu finds, to her surprise, that while Simran is quite happy to take her advice about eating well and taking enough rest, she does not want to visit the ANM and register the pregnancy. She explains that she is afraid of the 'evil eye'; she has been wanting a baby for so long, and has got pregnant after all these years. What if something happens to spoil it all?!

What can the ASHA do in this situation?





Situations for Analysis 4 (Educating Women on Pregnancy Care)

ASHA Dona has just been talking to Madhu about the care she needs to take. Madhu, who is small and delicate-looking, is pregnant with her first child. She has been listening attentively to all that Dona has been saying. After a few minutes, she asks Dona hesitantly, “Didi, my mother is quite worried for me. She says I’m small-built and might have a difficult pregnancy. She says I should not eat much, otherwise the baby will grow too big and I’ll have a tough time during delivery. Now I’m nervous too, and don’t feel like eating at all.”

What can the ASHA do in this situation?

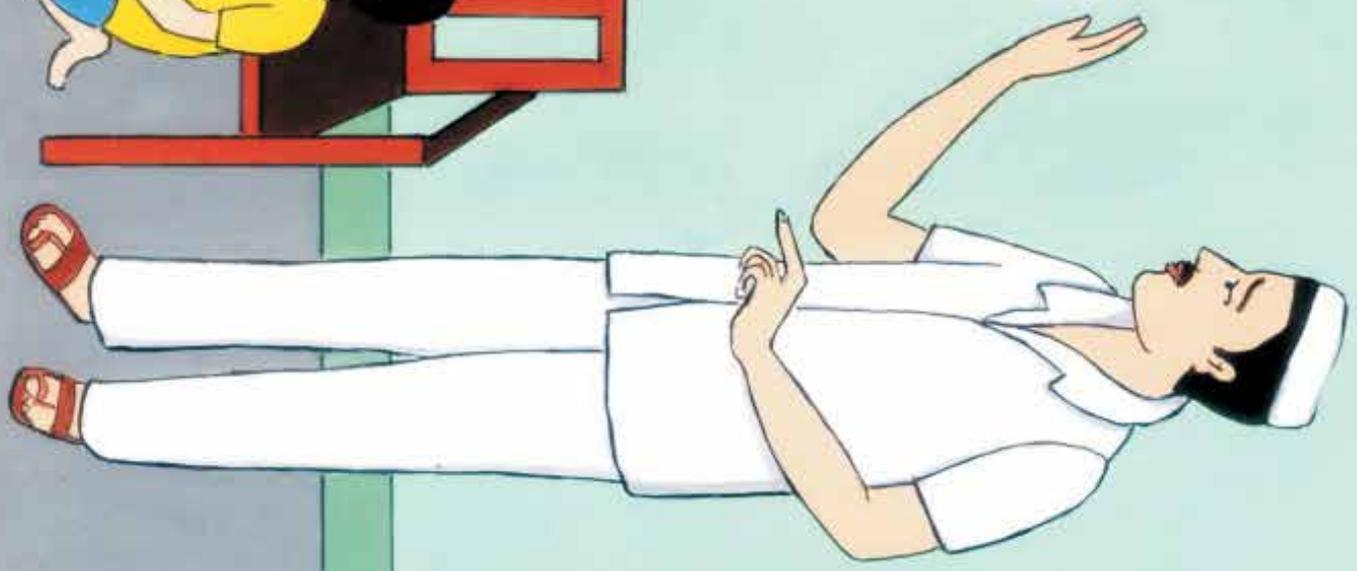




Situations for Analysis 5 (Supporting a Pregnant Woman During Delivery)

Lalita has started working as an ASHA only recently. Teresa is pregnant and her family insists on having a delivery at home in spite of Lalita explaining the advantages of having a delivery at a health facility. On a visit to Teresa's place, she finds that Teresa's labour pains have begun and her mother-in-law has called the SBA as planned. The SBA has just arrived. Lalita is worried as this is the first time she is assisting in delivery and hopes everything will go well. What should Lalita's role be at this time?

HOSPITAL





Situations for Analysis 6 (Supporting a Pregnant Woman During Delivery)

Leena is a young and enthusiastic ASHA. But at the moment she is rather upset. She has accompanied Naseem, a second-time mother, to the hospital. Naseem is having a rather difficult time and has thrown up twice. Leena has tried to tell the hospital staff to clean up and do something to make Naseem comfortable, but her requests have been ignored. In fact one of the attendants even told Leena to clean up the place herself, if she was so worried. What can Leena do?