स्वास्थ्य एवं
परिवार कल्याण मंत्रालय
MINISTRY OF
HEALTH AND
FAMILY WELFARE

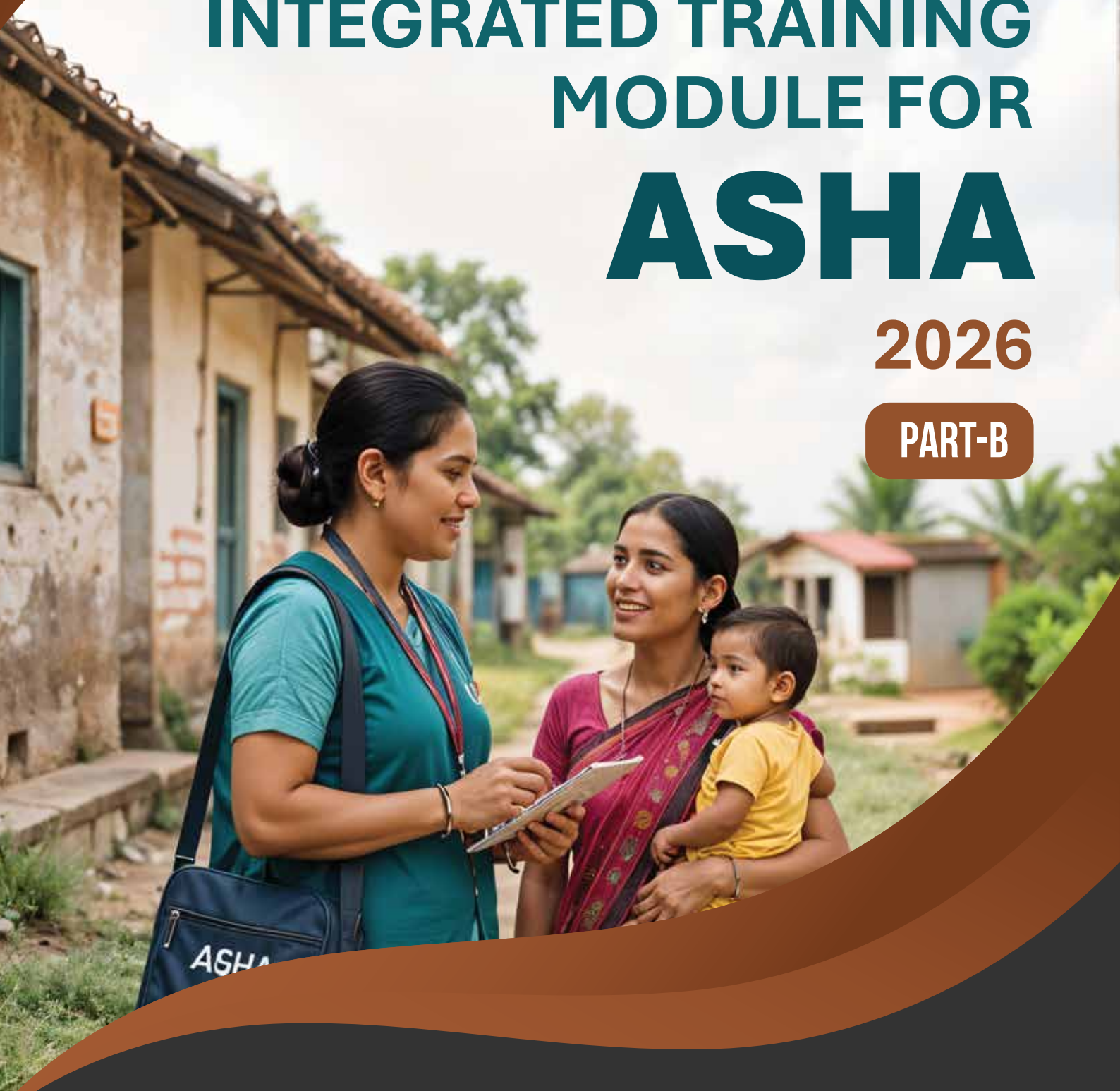
सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

INTEGRATED TRAINING MODULE FOR ASHA

2026

PART-B



PART B : HOLDING HANDS THROUGH DIFFERENT PHASES OF LIFE

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KEY ABBREVIATIONS

AAM	Ayushman Arogya Mandirs
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BMO	Block Medical Officer
BP	Blood Pressure
CBAC	Community-Based Assessment Checklist
CDR	Child Death Review
CHO	Community Health Officer
CPHC	Comprehensive Primary Health Care
COPD	Chronic Obstructive Pulmonary Disease
DEIC	District Early Intervention Centre
ENT	Ear, Nose and Throat
FAQ	Frequently Asked Questions
GERD	Gastroesophageal Reflux Disease
Hb	Haemoglobin
HBNC	Home-Based Newborn Care
HBNCC	Home-Based Newborn Care and Child Care
HBYC	Home-Based Young Child Care
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ICDS	Integrated Child Development Services
IEC	Information, Education and Communication
IFA	Iron Folic Acid
IHIP	Integrated Health Information Platform
IMNCI	Integrated Management of Neonatal and Childhood Illness
IMR	Infant Mortality Rate
IPC	Infection Prevention and Control

IUCD	Intra-Uterine Contraceptive Device
JAS	Jan Arogya Samiti
KMC	Kangaroo Mother Care
LASA	Look-Alike Sound-Alike
LBW	Low Birth Weight
LLINs	Long-Lasting Insecticidal Nets
MAM	Moderate Acute Malnutrition
MAS	Mahila Arogya Samiti
MCP Card	Mother and Child Protection Card
MO	Medical Officer
MOIC	Medical Officer In Charge
MNS	Mental, Neurological and Substance Use
MPA	Medroxyprogesterone Acetate
MPW	Multipurpose Worker
MR	Measles-Rubella
MUAC	Mid-Upper Arm Circumference
NBSU	Newborn Stabilisation Unit
NCD	Non-Communicable Disease
NDPS	Narcotic Drugs and Psychotropic Substances
NFFP	National Family Planning Programme
NMR	Neonatal Mortality Rate
NRC	Nutrition Rehabilitation Centre
NQAS	National Quality Assurance Standards
ORS	Oral Rehydration Solution
PHC	Primary Health Centre
PHQ	Patient Health Questionnaire
PM-JAY	Pradhan Mantri Jan Arogya Yojana
PMMVY	Pradhan Mantri Matru Vandana Yojana
PNC	Postnatal Care
POC	Point of Care
PPE	Personal Protective Equipment

PPH	Postpartum Haemorrhage
PRI	Panchayati Raj Institution
RBSK	Rashtriya Bal Swasthya Karyakram
RCH	Reproductive and Child Health
RDT	Rapid Diagnostic Test
RKSK	Rashtriya Kishore Swasthya Karyakram
RMNCAH+N	Reproductive, Maternal, Newborn, Child and Adolescent Health plus Nutrition
RR	Respiratory Rate
SAM	Severe Acute Malnutrition
SBCC	Social and Behaviour Change Communication
SHC	Sub Health Centre
SHG	Self-Help Group
SNCU	Special Newborn Care Unit
SpO_2	Peripheral Oxygen Saturation
SRS	Sample Registration System
SSBSK	Samagra Shishu Bal Swasthya Karyakram
STI/RTI	Sexually Transmitted Infection / Reproductive Tract Infection
SVR	Sustained Virological Response
TB	Tuberculosis
UACS	Upper Airway Cough Syndrome
UPHC	Urban Primary Health Centre
UPT	Urine Pregnancy Test
VHSNC plus	Village Health, Sanitation and Nutrition Committee plus
VHSND	Village Health, Sanitation and Nutrition Day
Vit A	Vitamin A
WHO	World Health Organization
WIFS	Weekly Iron and Folic Acid Supplementation
WRA	Women of Reproductive Age

B1

Infant and Child Health

PART B

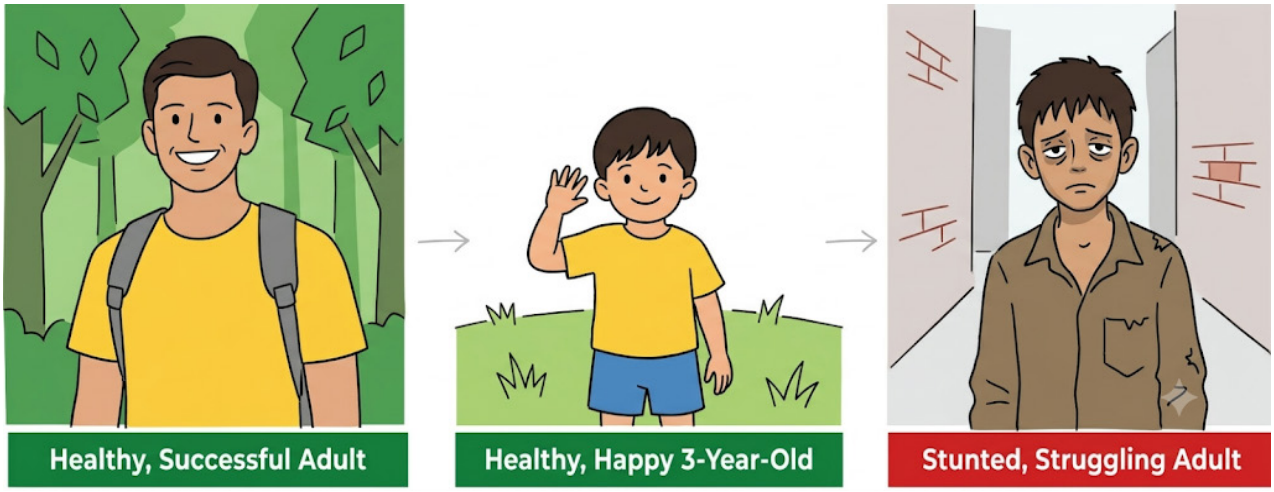
B1 Infant and Child Health

B.1.1 FIRST 1000 DAYS OF LIFE

First 1000 days of life From 9 months of pregnancy to child's 2nd birthday are extremely critical in an individual's life. Why is that so ?

The "First 1000 Days" of life are a period of rapid physical growth and accelerated mental development and offer a unique opportunity to build lifelong health and intelligence. Baby in the womb is dependent on the mother for nutrition as well as mental, physical and emotional growth. **Optimum nutrition, protection from illness and a warm loving environment in the early childhood make a difference for the rest of the baby's life. Each day of this journey is special and influences the way she/he develops, grows and learns – not just now, but for her / his entire life.**

This has become even more critical as the brain growth missed during this period cannot be corrected later. Height lost during childhood because of poor nutrition leads to stunting which is permanent and cannot be reversed .



In view of the early child development, the first 36 months are being prioritized in the SSBSK (Samagra Shishu Bal Swasthya Karyakram) program. The following section will equip you in your role as an ASHA for implementation of the same.

SSBSK - Samagra Shishu Bal Swasthya Karyakram (SSBSK) integrates Home-Based Newborn care (HBNC) and Home-Based care for Young Child (HBYC) programmes into a single continuum from birth up to 3 years of age

SSBSK includes following

- **One combined programme –** SSBSK brings HBNC and HBYC together to provide continuous care from birth to 3 years (36 months).
- **Identify "At-risk" children early –** Identify low-birth-weight/preterm babies, discharged sick newborns, children with poor growth, repeated illness, incomplete immunization or delayed development, and provide extra follow-up.
- **Use existing health contacts –** Use VHSND/UIP contacts at around 1.5 and 2.5 months for screening, weighing, feeding counselling, ECD and safety counselling.
- **Follow the revised home-visit schedule –** Give additional visits to "At-risk" newborns, including Day 3 and Day 7 joint visits with ANM/CHO, and extra follow-up for "At-risk" young children.
- **Extend home-based care –** Home visits continue at 18, 24, 30 and 36 months, focusing on growth, booster immunization and early childhood development.
- **Care for the mother's mental health –** Screen mothers for mental health problems, provide basic counselling and link them to AAM/Tele-MANAS when needed.
- **Support maternal nutrition –** During the postnatal period, counsel mothers on a diverse diet and IFA and calcium supplementation, along with child nutrition counselling.
- **Promote nurturing care and ECD –** Encourage responsive parenting, talking, playing, communication and early stimulation. Involve fathers, grandparents and other caregivers.
- **Work as a team (AAA model) –** ASHA works with ANM and AWW, along with CHO/MO and other health workers, instead of working alone.
- **Use digital tracking –** Use JANANI, U-WIN, RBSK 2.0, POSHAN Tracker and Shaishav App for child-wise tracking, referrals and follow-up.

At Risk Newborn - Low birth weight (<2.5 kg)
Preterm (<37 weeks)
Congenital anomalies
Not breastfed
Discharged from newborn care units (SNCU/NICU/MNCU and NBSU).
*Low weight for age
At-risk' young children (6 weeks to 36 months)
Growth faltering, low weight for age
Delayed milestones
Recurrent illness / hospitalization
Partial Immunization

Role of ASHA in SSBSK

You as an ASHA is the key community-level service provider under SSBSK. You provide home-based care to postnatal mothers, newborns and young children from birth to 3 years. Through regular home visits, You help families identify health problems early, follow healthy practices, and reach health services when needed.

Key roles of ASHA

1. **Conduct regular home visits**

   You as an ASHA conduct scheduled home visits for newborns and young children. For healthy newborns, you conduct 4 visits after institutional delivery and 5 visits after home delivery. For an "At-risk" newborn, she conducts 9 intensive visits. The visit on day 3 and 7 to be conducted jointly with ANM and CHO. For young children, sou conduct visits at 3, 6, 9, 12, 18, 24, 30 and 36 months.

Category	Number of Visits	Schedule	Special Notes
Healthy Newborn (Institutional Delivery)	4 visits	Day 3, Day 7, Day 14, Day 28	Routine monitoring and counselling
Healthy Newborn (Home Delivery)	5 visits	Within 24 hrs, Day 3, Day 7, Day 14, Day 28	First visit within 24 hrs of birth
At-Risk Newborn	9 intensive visits	Day 1, Day 3, Day 7, Day 14, Day 21, Day 28, Day 35, Day 42, Day 60	Day 3 and 7 visits jointly with ANM and CHO
Young Child (3–36 months)	8 visits	3, 6, 9, 12, 18, 24, 30, 36 months	Focus on nutrition, growth, illness detection, early development

2. **Identify "At-risk" newborns and children**

   You as an ASHA identifiy babies and children who need extra care and follow-up, such as low-birth-weight or preterm newborns, babies discharged from newborn care units, children with poor growth, repeated illness, incomplete immunization or delayed development. You maintain and update the "At-risk" line-list.

3. **Assess the health of the mother and child**

   During each visit, You as an ASHA use the SSBSK home-visit checklist, asks key questions, observes the mother and child, monitors weight and looks for danger signs or other health problems.

4. **Promote breastfeeding and proper feeding**

   You as an ASHA will teach mothers the correct breastfeeding techniques, support exclusive breastfeeding, help with breastfeeding problems and explain responsive feeding. For young children, you will counsel families on complementary feeding from six months, dietary diversity and continued breastfeeding up to two years and beyond.

5. **Support newborn care and Kangaroo Mother Care (KMC)**

   For low-birth-weight and preterm babies, you as an ASHA will demonstrate and reinforce

home-based KMC, encouraging skin-to-skin contact for 8 hours a day or as much as possible, along with exclusive breastfeeding and family support. You also watch for danger signs and promotes timely referral.

6. **Monitor growth, nutrition and development**

   ASHA will monitors the child's weight, plots growth on the MCP Card and identifies growth faltering or malnutrition. You also check developmental milestones and refer children with developmental delays to the appropriate services.

7. **Promote nurturing care and Early Childhood Development (ECD)**

   You as an ASHA counsel families on responsive caregiving, talking, singing, reading, age-appropriate play, communication and gentle interaction. You will encourage fathers, grandparents and other family members to participate in the child's care and development.

8. **Provide postnatal care and support the mother**

   ASHA will look for postnatal complications, provide counselling on nutrition, hygiene, birth spacing, breastfeeding and KMC, and support the mother's overall well-being. You also assess maternal mental well-being during visits, provide first-line empathetic counselling and refer when needed.

9. **Identify danger signs and ensure timely referral**

   You as an ASHA will identify danger signs in mothers, newborns and young children, inform the ANM/CHO, counsel the family about the need for immediate care and facilitate referral to the appropriate health facility. You also follow up after referral.

10. **Support facility follow-up of "At-risk" children**

    You as an ASHA will help families attend scheduled follow-up visits after discharge from SNCU/NBSU/NRC/DEIC or other health facilities. You will remind caregivers about the follow-up schedule and help them reach the facility when required.

11. **Mobilize families and communities**

    You as an ASHA will mobilize families to attend VHSND/UHSND and other community platforms. You will work with ANM and AWW to promote feeding, growth monitoring, immunization, nurturing care, sanitation and access to social protection schemes.

12. **Provide counselling on safety, climate and new-age risks**

    You as an ASHA will counsel families to keep young children safe, limit screen exposure, encourage play and physical activity, protect children from extreme heat and reduce exposure to air pollution.

13. **Work as part of a team**

    As an ASHA you do not work alone. You will work with ANM, AWW, CHO and Medical Officer for joint visits, referral, follow-up, supervision and coordinated care. For "At-risk" newborns, joint visits with ANM/CHO are planned on Day 3 and Day 7; for "At-risk" young children, joint follow-up is planned during the 3rd and 6th months.

14. **Record and report services digitally**

    Being an ASHA you will record each SSBSK home visit in the Shaishav App. The app captures the visit, risk status, counselling, danger signs, referrals and follow-up. This supports child-wise tracking and continuity of care through the JANANI Portal.

Remember

ASHA's role in SSBSK is to:

Visit → Assess → Identify risk → Counsel → Refer when needed → Follow up → Record

Postnatal Care of the mother and baby : This is the care given to both mother and baby from birth in order to promote health of the mother and baby , reduce chances of complications , ensure their early detection and prompt management to prevent deaths .

This period starts from delivery up to 42 days after delivery (6 weeks). In institutional delivery first 48 hours are taken care of in the health facility . Once the mother returns from the health facility , you as an ASHA have a major role to play and Postnatal and SSBSK visits are amongst your **most important responsibilities** . Both mother and the newborn are vulnerable during period and the highest risk of complications in the mother and newborn is during this period.

To carry out these visits effectively and confidently, you must possess a combination of essential knowledge and essential skills. Both are equally important and complement each other.

In order to detect an abnormality / complication you being an ASHA must know the normal new-born and the normal course of progression in growth / development and normal course of recovery of a mother in first 42 days .

B.1.2 NORMAL NEW-BORN AND NEWBORN CARE

When you go on a home visit and see the new born for the first time what comes to your mind ?

Is the baby healthy and well .

- What is the **weight** of the baby ?
- Was the baby born at **its expected time** or early?
- Is the baby **active and alert**?
- Was the **breast feeding** started on time and is the baby accepting feeds well? Is it exclusive breast feeding?
- Is the baby **passing urine and stools** normally?
- Is the baby clad appropriately and is his/her **temperature normal**?
- The baby has **normal physical appearance** and is free from any apparent physical defects.

The normal newborn :

This information will help you in identifying normal babies and high risk babies .

It will also help in early identification of danger signs in a healthy or high risk baby.

Weight : The normal birth weight of a term newborn is 2.5 kg or more.

Term and Pre-term babies : A normal newborn is one who is born at term . A term baby is a baby who is born between 37 weeks and 42 completed weeks of pregnancy.

Babies born before 37 weeks are called preterm, and babies born after 42 weeks are called post-term, both of which require closer observation and care and therefore termed high risk babies.

Appearance:

- A normal newborn has a pinkish skin colour and looks well and active.
- The baby's head may appear slightly misshapen or swollen immediately after birth due to pressure during delivery; this is common and usually settles within a few days.
- The eyes are clear, There is no yellowness ,cloudiness, or discharge.
- The nose is open, the mouth appears normal, and the baby is able to suck well.
- The chest rises equally on both sides while breathing. The abdomen is soft,.
- The umbilical cord stump is clean, dry, and tied properly .
- The baby has normal arms and legs , moves all limbs actively, and the fingers and toes are well formed.
- The external genitalia appear normal for a boy or girl.
- The baby may have fine body hair, white coating on the skin, which are normal .

Visible Congenital Abnormalities

You may find **visible congenital abnormalities** that may affect feeding, breathing, or survival.

- Cleft lip or cleft palate, which may cause feeding difficulty
- Absent or malformed limbs, fingers, or toes
- Very large or very small head size
- Abnormal shape of the spine or swelling on the back

- Imperforate anus (no opening for passing stools)
- Abnormal swelling in the abdomen
- Abnormal external genitalia
- Neck swellings or large birth masses
- White eye or Congenital cataract

Breathing : During the first week of life, the respiratory rate usually remains within 40–60 breaths per minute. Not included in SSBSK in a calm, resting baby.

A normal newborn has a regular breathing pattern, without chest in-drawing or grunting.

You must watch carefully for the following danger signs at any age in the newborn period:

- **Fast breathing: more than 60 breaths per minute**
- **Slow or irregular breathing**
- **Severe Chest in-drawing (chest going in while breathing)**
- **Grunting sound while breathing(Not in SSBSK but its in IMNCI)**
- **Nasal flaring (SSBSK -No , IMNCI Yes)**
- **Bluish colour of lips, tongue, or face**
- **Pauses in breathing lasting more than 20 seconds**
- **Baby unable to feed or stops feeding due to breathing difficulty If any of these signs is present , refer immediately**

Temperature: The baby feels warm to touch, not cold or excessively hot. An axillary (under arm) temperature of 97.7–99.5°F(36.5*C to 37.5*C) is considered normal.

Passage of urine and stool: Normal newborn passes urine within the first 24 hours and passes stool (meconium) within the first 24–48 hours of birth. On an average the baby passes urine 6-8 times in the entire day.

Feeding: Baby is put to breast as soon as the cord is cut. The baby feeds well, shows a good suck, and breastfeeds 8–10 times or more in 24 hours.

Cord appearance and care of cord: Nothing is to be applied on the cord stump. It is to be kept clean and dry . It slowly dries up and falls off by 7 to 10 days. Any swelling , redness or discharge around it indicates infection and needs medical attention.

Breast feeding

Early Initiation of breast feeding (within one hour of birth) is extremely important for better bonding and early milk flow. Babies are normally very alert and responsive within one hour after delivery and are ready to suckle and attach to the breast easily. An early start also provides the benefits of colostrum (milk formed in first few days after delivery) to the baby.

What is colostrum?

Colostrum is the first thick yellow milk that comes from the breast when the child is born, and it is secreted in small quantities for the first 3-4 days. Although in small quantities, it is sufficient to meet the needs of the newborn baby.

This yellow milk (colostrum) is very nutritious.

- It acts as the first immunization for newborn.
- It has all the necessary nutrients in right amount for the baby's growth.
- It protects the baby against diarrhea, respiratory problems and other infections.
- It is richer in Vitamin A and K than normal breastmilk.
- It helps to prevent jaundice in the newborn.
- It helps to clean baby's intestine.

**Importance of breast feeding should be told to the mother / family right from the antenatal period. The benefits of breast milk:

For babies	For mothers
Breastfed babies are more intelligent than those fed with formula milk.They have better learning and reading ability.	It helps mothers regain their normal Weight after delivery
Breastmilk contains all nutrients necessary for the baby.It is easily digested and absorbed.	Protects mothers from anemia by reducing post-delivery bleeding
Protects the child from infections like diarrhea and pneumonia.	Helps mothers in family planning as it has contraceptive effect
It is at the right temperature, needs no preparation and is ready to serve whenever the baby needs.	Protects against breast and ovarian cancer
Saves the baby from respiratory problems, allergies, asthma and skin infections.	Early initiation of breastfeeding and frequent feeding saves mothers from the problem of breast engorgement
Fulfils emotional needs of the baby and inculcates a loving relationship between the baby and the mother.	Breast milk is readily available for the need of the baby
	Mothers are more relaxed and happier

Exclusive breastfeeding means giving the baby only mother's milk and no other food or drink to the baby, right from birth to six months of age. In addition to mother's milk, with the exception of syrup/drops of vitamins, minerals and medicines, expressed breast milk is also permitted.

Do not give the baby any sugar water, honey, ghutti, or herbal water (like saunf or ajwain) in the first 2-3 days. These prelacteal feeds stop good breastfeeding, block colostrum benefits, and can cause infections.

Artificial feeding means feeding the baby with other types of milk, food and drinks before 6 months of age . An artificially fed baby is more likely to have diarrhoea, pneumonia, ear, and other infections, is likely to suffer from nutritional disorders, mental development may get hampered, risk of chronic diseases such as diabetes, hypertension and obesity is increased when artificially fed babies become adults.

Babies on artificial feeding / Cow / Goat milk are more prone to develop allergies

Ms. R had delivered a baby yesterday afternoon . She has managed to learn the correct way of breast feeding and the baby has started sucking well at the breast . She wants to know as to how many times should she feed the baby ?

Responsive feeding:

- Mothers should breastfeed responsively and frequently—at least 8 times in 24 hours—by observing the baby's hunger and fullness cues. **Early hunger signs** include lip-licking, stirring, sucking on hands or clothes, rooting, and soft noises. **Late hunger signs** include frantic head movements and crying. Satiety signs include slowing down, unlatching, falling asleep, or turning away. **For sick babies,** encourage more frequent, shorter breastfeeding sessions, as they may have less appetite but still need breastmilk to maintain strength and recover from illness.

Babies should be exclusively breastfed for first 6 months of life

On completion of 6 months, appropriate complementary feeding should be started Children should continue to be breastfed up to 2 years of age or beyond

Important tip

Breastmilk production is dependent on frequent suckling by infants; the more the baby suckles, the more milk is formed. If the baby stops suckling, the breast soon stops secreting milk.

B.1.3 NORMAL RECOVERY OF THE MOTHER DURING POST PARTUM PERIOD :

As an ASHA you must know what is considered normal after delivery. This will help you in early detection of danger signs.

Vaginal Bleeding : After delivery, it is normal for a woman to have vaginal discharge called *lochia*, which changes in colour and amount as the body heals.

Colour	**Red discharge (Lochia Rubra)**	**Pink/Brown discharge (Lochia Serosa)**	**White/Pale Yellow discharge (Lochia Alba)**
Duration	Day 1 to Day 3–4	Day 4 to Day 10	Day 10 up to 4–6 weeks
Amount	Like or slightly more than a period	Less than earlier, gradually reducing	Very little
Meaning	Normal bleeding after childbirth	Uterus is healing	Healing almost complete

This gradual change from red to light colour and reduction in amount is normal.

Danger signs : Heavy bleeding at any time, foul-smelling discharge, large clots, or a return to heavy red bleeding after it had reduced are danger signs, and the woman should be taken to a health facility immediately.

Ms. G had delivered a baby girl three days back. When you as an ASHA didi came to visit her, you found that Ms. G had already changed 7-8 pads . She was looking pale and felt weak. Her husband said that he would take her to the centre the next day. What will you do as an ASHA?

Shrinkage of Uterus to its normal size :

After delivery of the baby and placenta, the uterus undergoes a natural process called uterine involution, through which it gradually returns to its normal, non-pregnant size.

- Immediately after delivery, the uterus is large, firm, and felt at the level of the umbilicus. Strong uterine contractions occur, especially during breastfeeding, which help reduce bleeding and shrink the uterus.
- By Day 1 after delivery, the uterus is usually the size of uterus of five months pregnancy, sitting below the level of navel. It weighs around 1 kg and is firm and hard in consistency. From this point onwards, the uterus reduces in size by approximately one finger breadth (about 1–2 cm) each day.
- By the end of the first week, it is usually midway between the umbilicus and the pubic bone.
- By around two weeks after delivery, the uterus has descended into the pelvis and is no longer felt on abdominal examination. By four to six weeks, the uterus returns to its normal pre-pregnancy size and weight.

Throughout this period, the uterus should feel firm and well contracted. A soft or poorly contracted uterus, increasing abdominal pain, heavy bleeding, or foul-smelling discharge are danger signs and require immediate referral.

Appetite and food intake :

After delivery, a woman's appetite usually improves gradually as the body recovers from labour. Once she is stable, she should be encouraged to start oral fluids and then take light, easily digestible food.

During the postpartum period, especially while breastfeeding, the mother requires adequate and nutritious food to regain strength, support milk production, and prevent anaemia. She should be encouraged to eat small, frequent meals that include cereals, pulses, vegetables, fruits, milk or milk products, and adequate protein sources. Drinking enough fluids is equally important.

Traditional food practices may vary, but unnecessary food restrictions should be avoided, as they can affect the mother's health and breast milk production. The mother should continue iron–folic acid and calcium supplementation as advised.

Danger signs :

- **No appetite or inability to eat for more than 24 hours**

- Repeated vomiting
- Severe weakness or dizziness
- Signs of infection such as fever along with poor intake of food

Improvement in strength and physical and mental well-being :

After delivery, the mother may feel weak and tired, which is normal. Her strength and well-being improve gradually with **adequate rest, good nutrition, enough fluids, and emotional support from the family.** She should be encouraged to sleep whenever the baby sleeps, avoid heavy work, and accept help with household tasks. **Eating nutritious food, continuing iron–folic acid and calcium tablets, and breastfeeding regularly** will help her recover faster. Gentle movement and light activity are helpful, but strenuous work should be avoided. **If the mother remains very weak, dizzy, breathless, or feels unwell despite rest and food, she should be taken to a health facility for evaluation.**

Mood changes such as feeling low, anxious, or tearful in the first few days are common and usually improve with rest, support, and reassurance.Family support, kind communication, and help with household work are very important for her emotional health. She should be encouraged to talk about her feelings and not feel ashamed or worried.

However, if the mother remains persistently sad, anxious, withdrawn, unable to sleep or eat, or expresses thoughts of harming herself or the baby, this is not normal and she should be referred to a health facility for further care.

Passage of Urine After Delivery

After delivery, it is important that the mother **passes urine within 4–6 hours**. Passing urine helps the uterus contract well and reduces the risk of heavy bleeding. Difficulty in passing urine may occur initially, especially after long labour, injections in the back, or stitches, but it should not be ignored.During the first **24–48 hours**, the mother should be able to pass urine normally without much pain.

Passing urine more frequently in the first few days is normal, as the body removes extra fluid collected during pregnancy. The urine should be adequate in amount and light in colour.

The mother should be advised to **drink enough fluids**, **not hold urine**, and **maintain cleanliness of the private area**.

Danger Signs – Refer Immediately

- No urine passed within 6 hours after delivery
- Severe pain or burning while passing urine
- Very little or no urine output
- Fever along with urinary complaints

Passage of stools and bowel movements in post partum period:

After delivery, it is common for the mother to have a **delay in passing stools for the first one or two days**, especially if she has had a long labour, stitches, or fear of pain. This is usually normal. Once bowel movements start, stools may be hard initially. The mother should be encouraged to **drink plenty of fluids, eat fibre-rich foods such as fruits, vegetables, and whole grains, and move around gently,** as this helps prevent constipation. Passing stools should not be very painful. Reassure the mother that passing stools will not harm the stitches if she eats well and does not strain.

Severe constipation, inability to pass stools for several days, severe abdominal pain, or bleeding from the anus are not normal and the mother should be referred to a health facility.

Breast changes and care of breasts :

After delivery, the breasts undergo normal changes as milk production starts. In the first few days, the breasts may feel full, heavy, warm, or slightly painful,which is normal and shows that milk is coming in. Early and frequent breastfeeding helps relieve fullness and prevents problems. The mother should be encouraged to breastfeed within one hour of birth and continue feeding on demand, ensuring correct positioning and attachment. Breasts should be kept clean by daily bathing; no soap or oil should be applied to the nipples, as this can cause dryness and cracks. Tight clothing should be avoided.

If the breasts become very painful, hard, red, or if there are cracked nipples, fever, or difficulty in feeding, these may indicate engorgement or infection, and the mother should be referred to the health facility.

At home, as their ASHA you have an extremely important role to play over next six weeks while you watch the mother and baby in their home setting through scheduled visits under SSBSK program.

During these home visits you observe and assist the normal post partum recovery of the mother and watch the well being and progress of baby while maintaining vigil for any signs of complications / danger signs.

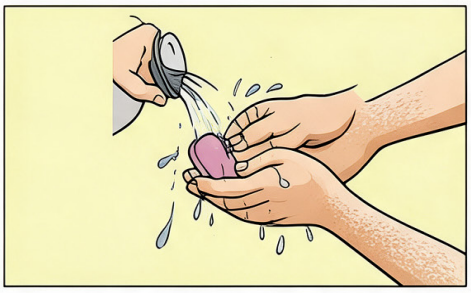
B.1.4 SKILLS REQUIRED FOR HOME VISITS :

Along with the knowledge given above you as an ASHA will also require certain skills before making home visits.

1. **Hand washing :** Learning how to wash hands correctly is extremely important as this protects the baby from infection and you must wash hands before touching the baby.

Procedure of Hand washing:

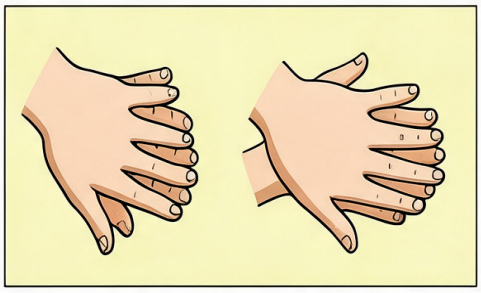
1. Remove bangles and wristwatch.
2. Wet hands and forearms up to elbow with clean water.
3. Apply soap and scrub forearms, hands and fingers (especially nails) thoroughly.
4. Rinse with clean water
5. Air-dry with hands up and elbow facing the ground.
6. Do not touch the ground, floor or dirty objects after washing your hands.



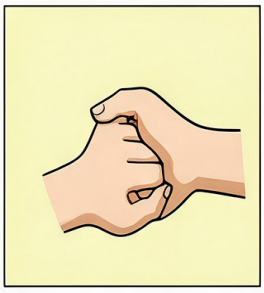
Remove rings, bangles, wrist watch or any other ornament or hands from both hands.

Roll the sleeves of garment up to elbow level. Wet hands and forearm up to elbow with clean water.

Apply soap properly on wet hands and forearm up to elbow to create good lather (foam).



Scrub your palms of both hands from the front and back and clean the area between your fingers.

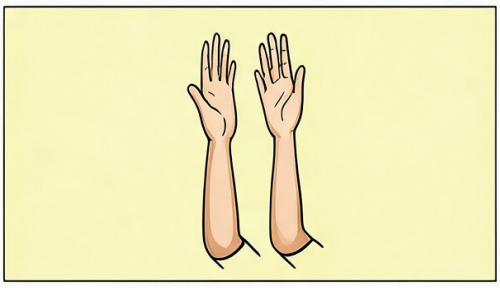


Scrub your knuckles of both hands.

Scrub your thumb of both hands.

Scrub your nails of both hands by rubbing against your palms.

Scrub both the wrists, by moving down slowly scrubbing both the forearms.



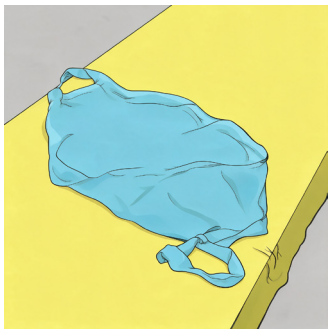
Wash your hands and forearms thoroughly with clean water.

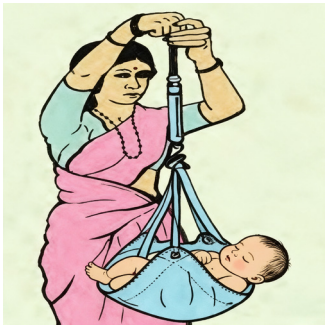
Air-dry with hands up, elbows facing the ground.

Do not use towel or any cloth to dry the hands and not touch the ground or dirty objects after washing hands.

During your household visit, check if the family has soap and clean water for handwashing. Show the mother and caregivers how to wash their hands. Explain why it is important to wash hands every time they touch the baby, and tell them how and when to do it.

2. Weighing the newborn





Steps
1. Place the sling on scale
2. Hold scale by top bar off the floor, keeping the adjustment knob at eye level.
3. Turn the screw until its top fully covers the red and 'O' is visible.
4. Remove sling on hook and place it on a clean cloth on the ground.
5. Place baby with minimum clothes on, in sling and replace the sling on hook.
6. Holding top bar carefully, as you stand up, lift the scale and sling with baby off the ground, until the knob is at eye level.
7. Read the weight.
8. Gently put the sling with baby in it, on the ground and unhook the sling.
9. Remove the baby from the sling and hand it over to its mother.
10. Record the weight.

Remember!!

1. Baby should be weighed within two days of birth and on subsequent home visits
2. It is important to weigh the baby after birth because babies with low birth weight may require special care. **
3. Use the colour-coded weighing machine meant for weighing newborn which indicates the weight as green, yellow or red.

- Weigh every newborn and record the actual weight in grams/kg.
- Birth weight <2500 g (2.5 kg) is considered Low Birth Weight (LBW) and is an "At-risk" newborn under SSBSK.
- An LBW newborn requires additional care and closer follow-up as per SSBSK.
- Do not use the colour of the weighing scale alone to classify or refer the newborn. Record the actual weight and follow the SSBSK risk-assessment and referral guidance.
- For an LBW newborn, promote KMC and support breastfeeding, and monitor weight gain during follow-up.

Monitoring weight :

Newborn :

Week 1:

Baby loses some weight (NORMAL) This is NORMAL(Remove as not part of SSBSK)

Day 10 to 14:

Baby regains birth weight

With proper breastfeeding, baby:

Stops losing weight

Starts gaining weight

Birth weight should be regained by 2 weeks

If not regained by 14th day ➔ baby is considered "At Risk" and needs assessment and additional followup visits

Weeks 3–4:

Baby gains weight steadily

This shows feeding is adequate

3. Measuring the temperature of baby

Skill- Measuring the temperature of the New-born Key Messages

- If temperature of newborn is between 36.5–37.5°C (97.7–99.5°F) then it is normal
- Different temperature scales: Fahrenheit and Centigrade (conversion shall be explained)
- Do not wash the tip, thermometer should be kept dry in the box
- Disinfect the thermometer with alcohol after use – the best method is to wipe the bulb with a cotton spirit swab

Steps	
1	Learning to measure temperature is also a useful skill in order to determine whether the newborn has fever or the newborn is cold. A cold newborn needs to be rewarmed immediately.
2	The trainer distributes the thermometer.
3	Take the thermometer out of its storage case.
4	This thermometer is used only at the armpit (axilla) not in the mouth or rectum. The trainer points out the parts of the thermometer including the 'tip' end.
5	Hold it at the broad end and clean the bulb with a cotton swab soaked in spirit.
6	Press the on/off switch once to turn on the thermometer . Look at the display. When the flashing numbers stop changing it is ready to use.
7	Check that the newborn's arm is by the side of the chest. Hold the thermometer and place the bulb at the apex of the axilla (ensure that it is dry), keeping it parallel to the body. Place arm against it. Do not change the position.
8	When the long beep is heard for the thermometer to indicate completion, remove the thermometer, and record the displayed temperature.
9	Note down the temperature and inform/counsel the mother.
10	Turn the thermometer off by pushing the on/off button once.
11	Clean the tip with cotton ball soaked in spirit (alcohol). Put the thermometer back in its case.

Based on the newborn's temperature identification of fever or hypothermia

Normal temp:	36.5–37.5°C (97.7–99.5°F)
Cold/Hypothermia :	<36°C (96.8°F)
Fever/Hyperthermia :	≥37.5°C (99.5°F) or more

4. Counting the respiratory / breathing rate of the baby .

Counting the breathing rate of the baby :

STEP 1: Prepare the baby

- Make sure the baby is calm.
- Baby should not be crying, feeding, or moving a lot.
- Keep the baby comfortably positioned and calm and adequately clothed depending on the ambient temperature.

Never count breathing when baby is crying

STEP 2: Expose the chest and abdomen if its not visible through clothes

- Gently open clothes
- Chest and abdomen should be clearly visible
- Newborns breathe with the abdomen and not just the chest

STEP 3: Watch the breathing

- Look at up–down movement of chest and abdomen
- One breath = one rise + one fall

Do not count hiccups, sighs, or movements

STEP 4: Count for FULL 1 minute

- Use:
  - Watch with second hand or
  - Mobile stopwatch or
  - Count slowly up to 60

Always count for full 60 seconds (Newborn breathing is irregular)

STEP 5: Count carefully and note it

- Count every breath quietly

If baby moves or cries ➔ stop, calm baby, start again

Respiratory rate of 40–60 breaths per minute is considered within normal range for a newborn.

So far you have learnt :

1. How to wash hands correctly ?
2. How to weigh the baby ?
3. How to take temperature of the baby ?
4. How to measure respiratory rate of the baby ?

B.1.5 MAKING THE SSBSK HOME VISITS :

You as an ASHA are now familiar with what a normal newborn and how a mother normally recovers during the postnatal period and you have also learnt basic skills which will be required during your household visits. You are now ready to undertake your home visits to provide home based care to the newborn and the post natal mother .

Schedule of SSBSK Home visits : Post natal period , (starting from delivery up to 42 days after delivery (6 weeks)) is very important as the highest risk of complications to the mother and newborn is during this period .This home based care through structured visits helps to promote health of the mother and baby , enables early detection of any complications and helps you to pay extra attention to those at high risk.

In institutional delivery first 48 hours are taken care of in the health facility and your role begins when she returns home .

You must know:

- The exact days on which postnatal and SSBSK home visits are to be conducted
- This knowledge ensures that no visit is missed and that care is provided at the right time.

Newborn category	Institutional delivery	Home delivery	At-risk newborn	Neonate discharged from SNCU/ MNCU	Special provision
Home-visit schedule	6 visits: Day 3, 7, 14, 21, 28 and 42	7 visits: Day 1, 3, 7, 14, 21, 28 and 42	9 visits: Day 1, 3, 5, 7, 10, 14, 21, 28 and 42	At-risk schedule: Day 1, 3, 5, 7, 10, 14, 21, 28 and 42	Day 3 and Day 7: joint visit by ANM + CHO for at-risk newborns
Who conducts	ASHA	ASHA	ASHA-led intensified follow-up	ASHA-led follow-up after discharge	ANM + CHO jointly on Day 3 and Day 7

Post natal Care and Homebased Newborn Care

During the SSBSK visits both mother and newborn are examined as a unit . How will you schedule your visit ?

Example 1: If the baby is born at a facility (normal delivery) , on 1st of July. You will consider that as Day 1. Then on day 2, mother and child will be at the health facility. Once they come home, you will visit them on which days and how many visits will you make .

Answer:

- **1 July = Day 1 (day of birth).**
- Since this is an institutional delivery, the first home visit is after discharge.
- You will make **6 home** visits on:
  - **Day 3 – 3 July**
  - **Day 7 – 7 July**
  - **Day 14 – 14 July**
  - **Day 21 – 21 July**
  - **Day 28 – 28 July**
  - **Day 42 – 11 August**

Therefore, you will make a total of 6 home visits: Day 3, 7, 14, 21, 28 and 42.

Example 2: If the baby is born at home (normal delivery) , on 5th of July. You will consider that as Day 1. Then on day 2, mother and child will be at the health facility. Once they come home, you will visit them on which days and how many visits will you make .

Situation: The baby is born at home through normal delivery on 5 July.

- **5 July = Day 1 (day of birth).**
- The mother and baby are subsequently taken to the health facility on **Day 2** and return home after discharge.
- As this is a **home delivery,** you will make **7 home visits**.

Visit	Day	Date
1st visit	Day 1	5 July
2nd visit	Day 3	7 July
3rd visit	Day 7	11 July
4th visit	Day 14	18 July
5th visit	Day 21	25 July
6th visit	Day 28	1 August
7th visit	Day 42	16 August

Therefore, 7 home visits will be made on **Day 1, 3, 7, 14, 21, 28 and 42.**

Important: The Day 1 visit is counted from the **date of birth (5 July)**. If the mother and baby are taken to a health facility on Day 2 and subsequently return home, the remaining visits should continue according to the prescribed schedule.

Example 3 : If you have more than one neonate under care , you can mark in your calender : Chintu is born at home on Jan2 and Monu was born (normal delivery) on Jan 17.

Example:

- Chintu was born at home on 2 January.
- Monu was born through normal institutional delivery on 17 January.

Date	Chintu – Home delivery	Monu – Institutional delivery
2 Jan	**Day 1 – Visit 1**	**—**
4 Jan	**Day 3 – Visit 2**	**—**
9 Jan	**Day 7 – Visit 3**	**—**
16 Jan	**Day 14 – Visit 4**	**—**
23 Jan	**Day 21 – Visit 5**	**—**
30 Jan	**Day 28 – Visit 6**	**—**
13 Feb	**Day 42 – Visit 7**	**—**
20 Jan	**—**	**Day 3 – Visit 1**
24 Jan	**—**	**Day 7 – Visit 2**
31 Jan	**—**	**Day 14 – Visit 3**
7 Feb	**—**	**Day 21 – Visit 4**
14 Feb	**—**	**Day 28 – Visit 5**
28 Feb	**—**	**Day 42 – Visit 6**

Key learning: By marking both newborns on the calendar according to their **date of birth and applicable visit schedule**, ASHA can plan her visits in advance and ensure that **each neonate receives all scheduled visits on time.**

Making the SSBSK

During the Day 3 home visitWhat all will you observe , ask and examine :

Mother :

Observe	Ask about her	Examine You must wash hands before examination	Act
The surroundings of the mother/ baby for cleanliness.	How is she feeling?	Her face, nails for pallor	Reassure her if everything is fine. As per your assessment take appropriate action
Temperature of the room – Whether it is comfortable for the newborn / mother.	How is the bleeding ? How many pads did she change in last 24 hours ?	Face / hands or feet for any swelling	
Personal hygiene – is she dressed neatly, combed	What has she eaten in last 24 hours ? Has she taken milk and enough fluids ?	Take her pulse and temperature	Once again counsel her for adequate diet / milk and fluids.
Family's attitude towards her and her baby	Does she have any urinary complaints ? Has she passed stool?	Hydration	Ensure that she is continuing to take her IFA and calcium supplement
The appearance of the mother – tired but cheerful / weak / distressed or sad	Does she have any pain in the perineal region in or around stitches? Is she washing the area and keeping it clean?	Per abdomen to see if the uterus is well contracted.	Reiterate the importance of personal hygiene / care of perineum / clean surroundings / washing hands before touching the baby
The way she looks at or holds her baby	Does she have any foul smelling discharge?	Breast examination for milk flow / any engorgement / redness / swelling or hardness . Any cracks or fissures on or around nipples.	Reinforce the message of exclusive breast feeding.

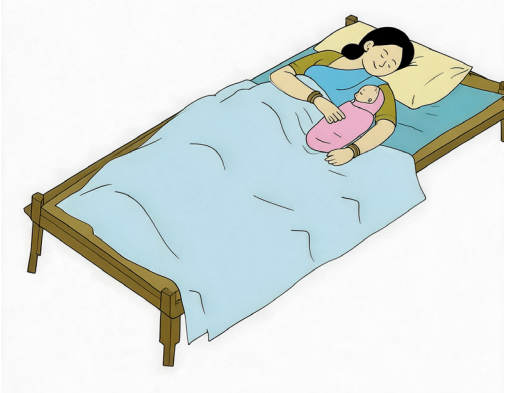
Observe	Ask about her	Examine You must wash hands before examination	Act
Breathing and talking normally or having any difficulty	Does she have any other complaints – fever / headache / dizziness / blurring of vision or any other complaint .		Remind her about the importance of adequate sleep and rest.
Colour – is she unduly pale	Is she able to breast feed well? Does she feed from the breast. Does she have any pain in breasts / nipples?		In case of any danger sign / complication, refer and facilitate her to access the linked higher health facility.
Any foul smell when you approach her	How many times did the baby pass urine in last 24 hrs. Is the baby passing stools normally?		Make her aware of the danger signs and what she should do.

Baby :

Observe	Ask about her	Examine You must wash hands before examination	Act
The surroundings of the baby for cleanliness.	How many times was the baby breast fed in last 24 hours. How long does the feed last. Is the baby sucking well Is the baby burped after the feeds	On the first visit examine the baby from head to toe for any visible birth defects	Emphasize the importance of exclusive breast feeding once again and dangers of top feeds. Having watched breast feeding, help in correcting the position to facilitate latching. Explain how to keep the nipples clean.

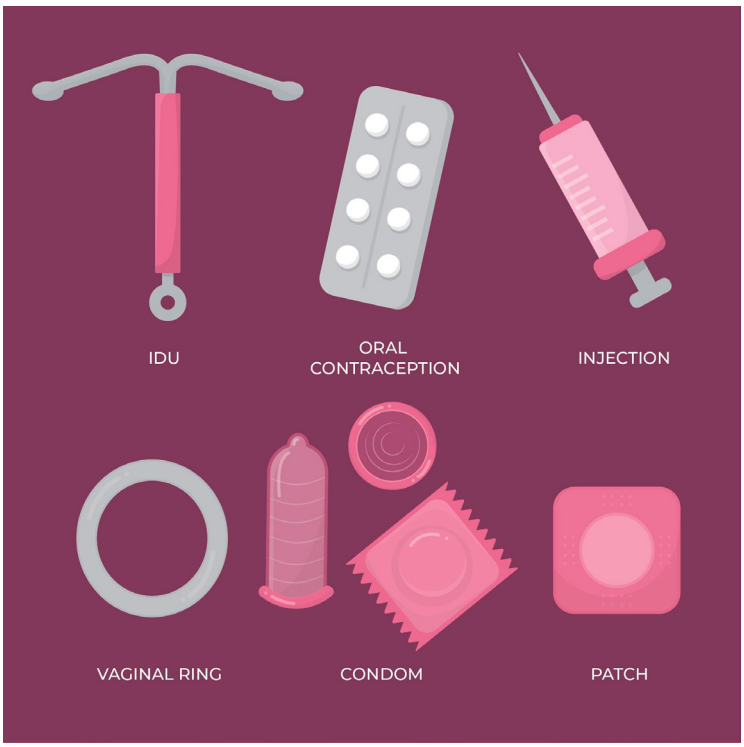
Observe	Ask about her	Examine You must wash hands before examination	Act
The clothing of the baby is clean and appropriate as per the room temperature	Is the baby being given any top feeds with bottle or otherwise	Take weight of the baby	Again counsel about proper cleaning and clothing of the baby. How the baby must be kept warm.
If the baby is sleeping observe the posture, regular relaxed breathing. Count the number of breaths per minute.	Is the baby sleeping most of the time or keeps crying.	Take temperature of the baby	Counsel about the cord care and that nothing should be applied on it.
If the baby is awake, watch the posture, activity, limb movements. If the baby is crying, is it a strong cry?	How many times did the baby pass urine in past 24 hrs. Is he / she passing stools normally	Look for jaundice / bluish discoloration / excessive pallor	Emphasize importance of hand washing before touching the baby and minimal handling by outsiders.
Watch the color of the baby -face / lips /fingers/ palms / soles (unduly pale or blue or yellow)	Vaccines administered in the health facility – Zero dose polio drops, Hepatitis B, BCG	Examine the umbilical cord, it should be dry and there should be no discharge	In case of any danger sign / complication, refer and facilitate to access to the linked higher health facility.
Observe the mother breast feed the baby. See the position of the baby and latching of the baby to the breast . See if the sucking is strong and sustained.	Any symptom / abnormality noticed by mother or attendant	Look for any pustules on the skin.	Educate the mother and care givers about danger signs.
		Check if there is any discharge from the eyes.	

On subsequent visits :



- You as an ASHA will watch for and examine the same things.
- Encourage the mother to rest for at least 6 weeks after delivery.
- Encourage her to eat more food than usual. She can eat any kind of food but high protein food such as pulses, legumes and nuts are more beneficial. She should drink plenty of fluids.
- Ensure that she is taking her IFA and calcium supplements.
- Ensure exclusive breast feeding.
- Care of episiotomy : If the mother has cut at the opening of vagina or has had stitches during delivery, she should keep the area clean.
- Ensure well being of the baby.
- Monitor the growth and development of the baby.
- Be vigilant for any danger signs in both mother and baby.
- Family Planning counselling :
  - Discuss with the mother the need of contraceptives services.
  - Caution her on the risk of unprotected sex and the high chances of conceiving again.
  - You will assist the couple in choosing and adopting the most suitable contraception.

On your first visit and on every subsequent visit you must ensure that parents know the importance of keeping the baby warm and continuing exclusive breast feeding. Counsel and build their capacities for the same .



B.1.6 TEMPERATURE MAINTENANCE OF BABIES :

Babies are small and lose heat fast and they cannot make heat easily. Premature, low-birth-weight and sick babies are at greater risk of becoming cold. Heat escapes easily from skin , just like a small cup of hot tea cools faster. Babies have very little body fat which acts as natural blanket and keeps older individuals warm. They cannot shiver and produce heat .Therefore there is risk of their body temperature falling below normal (hypothermia) . It is a dangerous condition and may lead to death. Sick small babies lose heat even more easily .

Prevention of hypothermia : It is extremely important that the mother and the caregivers understand the importance of keeping the baby warm.

Clothing : In summers also baby should be clad in a light loose cotton clothes- sleeveless or half-sleeve vest + diaper/nappy, one thin layer is enough, head uncovered indoors (cover only if windy or when going outside).Do not keep the baby directly under or in front of the fan or a blast from a window or a door.

In winters, there should be one extra layer (more than adults) or as many layers as per weather condition, Soft inner cotton clothes and warm outer layer/s , Cap, socks, mittens. Baby should be wrapped in light but warm blanket, not heavy quilts. For a small or low-birth-weight baby, give skin-to-skin contact (Kangaroo Mother Care/KMC) as advised by the health worker .The room should be kept warm, free from any wind currents /draft. Bath should not be given before 48 hours. In pre term infants it is deferred even beyond this.

Wrapping the baby : As an ASHA, you teach the parents, how to wrap their babies

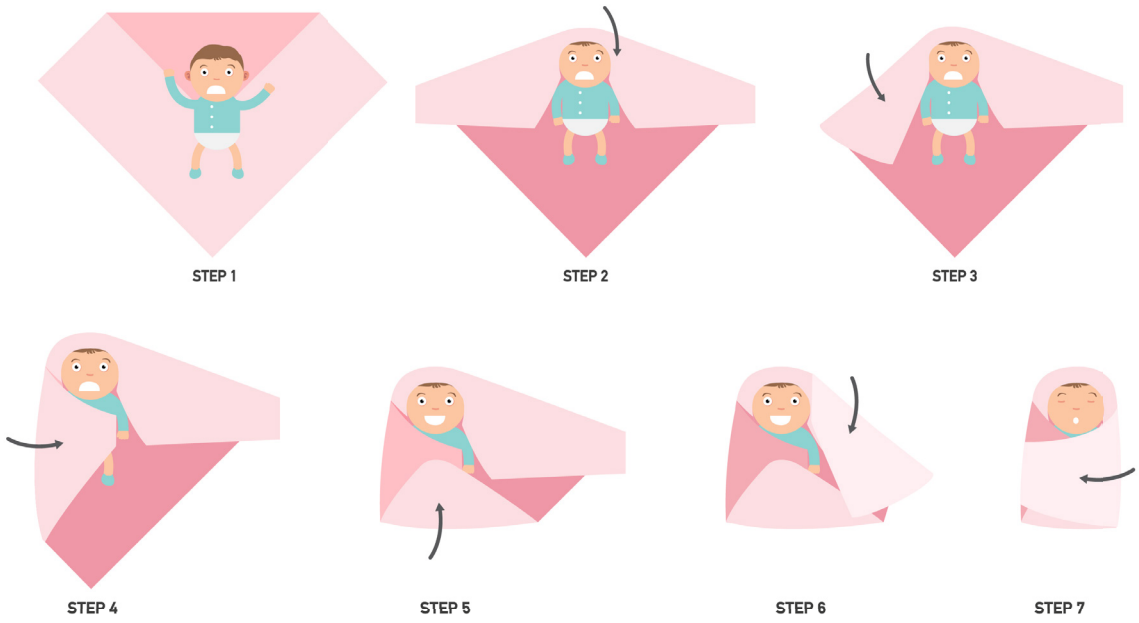
Steps	ASHA's Learning Point:
Step 1: Check Readiness of the Newborn Before wrapping, ensure that: • The newborn is dry • The baby is properly dressed • Head, ears, chest, abdomen, and soles of the feet are covered	A wet or poorly dressed baby loses heat quickly.
Step 2: Prepare the Wrapping Area • Spread a clean blanket on a flat, clean surface in a diamond (kite) shape • Place a clean cotton cloth on top	Clean surface and clean cloth prevent infection.
Step 3: Fold the Blanket • Fold the top corner inward the baby's head and ears.	This fold will support
Step 4: Position the Newborn • Place the newborn in the centre of the blanket • Ensure the head is near the folded top corner	Correct positioning makes wrapping safe and comfortable.
Step 5: Cover the Head and Ears • Bring the folded top part over the head, forehead, and ears • Gently tuck both sides under the chin using fingers	Head and ears must be covered, but the face must remain Ensure the face remains uncovered open.

Step 6: Cover the Feet • Fold the bottom corner upward to cover the feet and lower body	Cold feet mean the baby is losing heat.
Step 7: Wrap the Sides • Wrap one side of the blanket across the baby • Fold the other side over it • Ensure the wrap is snug but not tight	Baby should feel secure but should breathe comfortably.

“Dry the baby, dress the baby, wrap the baby, keep the baby warm.”

Key Messages

- Wrap the newborn day and night
- Re-wrap after bathing or cleaning
- Keep baby warm, dry, and close to the mother
- Combine wrapping with skin-to-skin care whenever possible



Based on the newborn’s temperature identification of fever or hypothermia

Normal temp: 97°F–99°F (36.1°C–37.2°C)

Cold/Hypothermia: 95°F–<97°F:; : <95°F (35°C);

Fever/Hyperthermia: >99°F (37.2°C) or more

If the Newborn is Extremely Cold and the Body Temperature is Below 95°F (35°C)

Danger signs of Hypothermia:

- Feels **cold to touch**, especially feet and abdomen
- Baby is **not feeding well** or refuses feeds
- Baby is **very sleepy and less active**
- Baby has **slow or fast breathing**
- Baby has **weak cry** or no cry
- Skin may appear **pale or bluish**

Refer immediately if any of these danger sign is present .

- Place the baby in the Kangaroo Mother Care (KMC) position on the chest of the mother or a family member, ensuring skin-to-skin contact. Both the mother and the baby should be dressed warmly, with the baby's head and feet covered and covered with blanket to maintain optimal warmth.
- Refer the baby urgently to health facility in KMC position.

You would be surprised to know that we hardly loose any babies due to hypothermia in areas with sub zero temperatures like Ladakh because of better parental preparedness and traditional practice of carrying their babies in close contact with their bodies and protecting them from cold air and living in heat-retaining houses.

Hypothermia-related neonatal deaths are more common in regions with moderate cold and poor preparedness than in regions with extreme cold and strong cultural adaptation.

B.1.7 KANGAROO MOTHER CARE (KMC) FOR LBW BABIES

KMC is a simple method of care for low-birth-weight infants that includes early and prolonged skin-to-skin contact with the mother (or a substitute caregiver) and exclusive and frequent breastfeeding

KMC for all preterm or LBW newborns: KMC should be initiated as soon as possible after birth for all preterm or LBW newborns and is recommended as routine care for all preterm or LBW newborns. KMC can be initiated in a health facility or at home and should be given for ***8–24 hours per day (as many hours as possible).***

Involve the whole family. KMC works best when both parents and other family members are involved. They can help with holding the baby, household tasks, and emotional support.

Counselling: Effective counselling for the initiation of KMC is a pre-requisite to overcome socio-cultural barriers and anxiety towards handling a low-birth-weight infant by the mother.

Explain the benefits of KMC:

- KMC significantly reduces newborn deaths, hypothermia, infections, and hospital stay while improving breastfeeding, growth, and physiological stability.
- Better bonding between mother and newborn

- It supports long-term brain development and better learning outcomes.
- Families experience stronger bonding, lower maternal stress, and greater confidence, while health workers, facilities, and health systems benefit from higher satisfaction and lower costs.

How to Provide Home based KMC?

Demonstrate the KMC technique, including skin-to-skin contact in the correct position; breastfeeding; changing nappies (diapers) and breastfeeding while maintaining skin-to-skin contact.

Clothing: Mother: She can wear any front-open, light dress suitable to local culture, not mandatory to have any special dress.Infant: Dressed in cap, socks, disposable diapers and front-open sleeveless shirt or 'Jhabala' made of a soft natural fabric like cotton

Skill- Kangaroo Mother Care (KMC)

Key Messages

- Eligibility criteria for KMC- all stabilized low birth weight babies (below 2500 gms)
- The two components of KMC are: Skin-to-skin contact and Exclusive breastfeeding

Duration of KMC

- Effectively for 8 hours or more, as much as possible.

Steps of Kangaroo Mother Care (KMC)	
1	Counsel the mother, providing privacy to the mother. Request the mother to sit or recline comfortably
2	Undress the newborn gently, except for cap, nappy and socks
3	Place the newborn prone on mother's/family member chest in an upright position with the head slightly extended, between her breasts in skin-to-skin contact in a frog-like position
4	Turn newborn's head to one side to keep airway clear
5	Support the newborn's bottom with a sling/binder
6	Cover the newborn with mother's 'pallu' or gown; wrap the newborn-mother duo with an added blanket or shawl depending on the room temperature
7	Advise mother to breastfeed the newborn frequently

8	Ensure the room is warm by using a room heater if necessary (26–28°C)
9	Advise the mother to provide KMC for at least 1-2 hour/ session. Skin-to-skin contact should be maintained as long as possible

High Temperature

If the body temperature is 99°F or higher, it is considered a fever. In the summer, if the newborn's temperature rises, follow the steps below to determine whether the elevated temperature is due to overdressing or an actual fever:

- Uncover the newborn and remove any hats or caps.
- Open windows and doors to allow cool air to circulate.
- Encourage the mother to breastfeed.
- If there is a heat source in the room (such as a fire), turn it off.
- Wait for 30 minutes and recheck the newborn's temperature. Refer to a health facility if fever persists.

If a newborn does not get enough breastmilk, the baby may become dehydrated. After the first few days of life, a baby who is getting enough breastmilk usually passes urine at least 6 times in 24 hours. Passing urine less often than usual, especially fewer than 6 times in 24 hours after the first few days, or passing very little, dark or strong-smelling urine, may indicate that the baby is not getting enough breastmilk. During the first 3–5 days after birth, urine output is normally lower. Fever in a newborn is a danger sign. Do not assume that fever is only due to inadequate feeding or dehydration. The baby should be assessed and referred promptly in case of fever or poor feeding or inability to feed

Monitor baby's health including body temperature and watch for danger signs (e.g. poor feeding, difficulty with breathing, less movement, fever, cold to touch). Get help immediately if any of these signs appear.

On your second SSBSK visit to Mrs. B house, you found that the baby's feet were cold to touch. As an ASHA what would you do?

Mrs. S had delivered yesterday. This is her first baby. Upon home sit you found that Mrs. S is tired and frustrated. She has been trying to breast feed her baby but is unable to do so. Although the baby comes to breast eagerly, it is unable to suck properly and is crying a lot. She is on the verge of initiating a bottle feed. AS an ASHA what is to be done ?

B.1.8 ENSURING EXCLUSIVE BREASTFEEDING :

Exclusive breastfeeding is to be given up to 6 months of age and with complementary feed as long as possible not less than 2 years of age. There can be different reasons for a baby not being able to breast feed . In a normal and healthy baby, a common reason is poor attachment to the breast due to incorrect positioning especially in a first time mother.

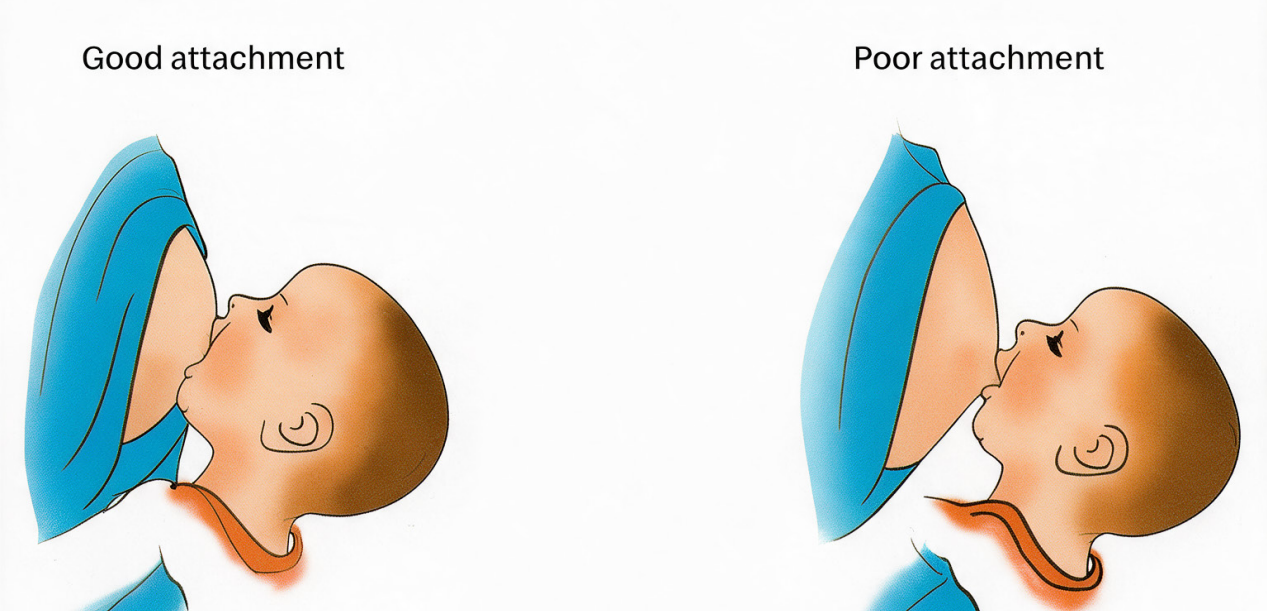
Correct positioning and latching (attachment) for breastfeeding

To obtain the maximum benefits of the breast feeding, baby should be held in a correct position as given below:

- While holding the baby, the mother should support the baby's bottom and not just the head and shoulders.
- Mother should hold the baby close to her body
- The baby's chin should touch the breast.
- Baby's mouth should be wide open.
- Baby's lower lip should turn outwards.
- We can see more of the areola above the baby's mouth and less below.

Correct position and correctly held

Incorrect position and incorrectly held



Attachment

Poor Attachment

Common causes of poor attachment are: use of feeding bottles, inexperience and lack of skilled support

Disadvantages of poor attachment are

- Pain and damage to mother's nipple. She may have sore nipples or fissures in nipple.
- Engorgement of the breast due to incomplete emptying of breasts.
- Baby remains hungry and frustrated, cries often.
- Less milk is produced in the breast because baby is not able to feed properly.
- Poor weight gain.

HOW TO HELP A MOTHER TO POSITION HER BABY

Greet the mother and ask her how breastfeeding is going. Observe her as she breastfeeds the baby. Assess a breastfeed. Explain what might help, and ask if she would like you to help her in positioning the baby

Make these key points clear:

- Baby turned towards mother and his ears, shoulder and buttock should be in a straight line
- His face should face the breast, with nose opposite the nipple
- Mother should hold the baby close to her.
- For a newborn, mother should support the babies bottom with hand, and not just his head and shoulders.

Explain the mother how to support the breast, with her hand, while offering it to the baby

- With her fingers and palm placed on her chest wall below the breast; so that her first

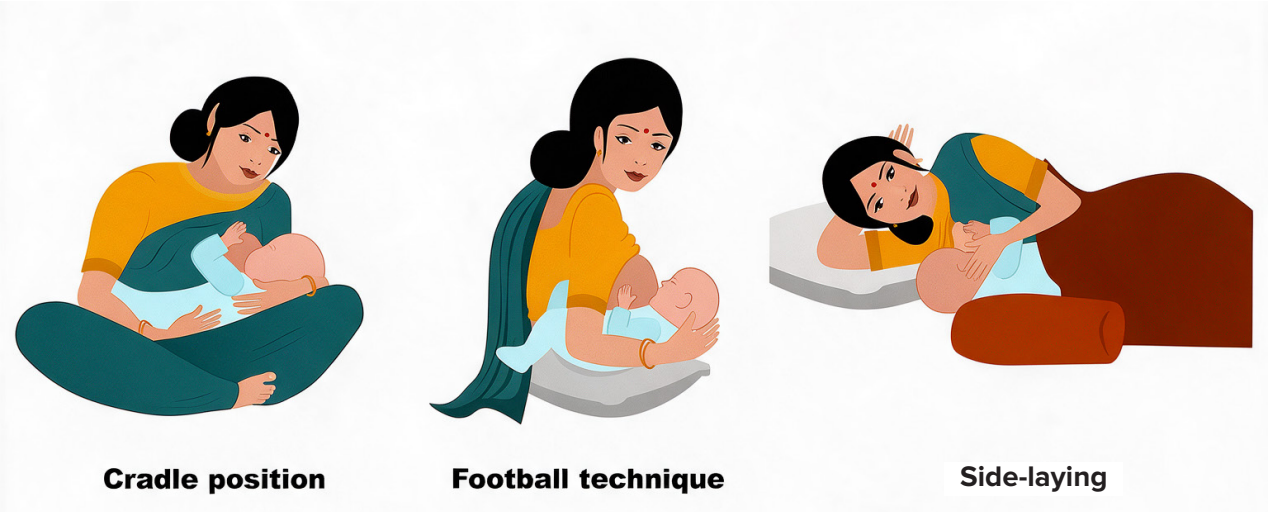
finger forms a support at the base of the breast

- With her thumb pressing on the top of the breast, so that it is easier for her baby to attach well.

Explain or show her how to bring the baby to the breast:

- Touch baby's lips with her nipple
- Wait until baby's mouth is wide open
- Move the baby quickly onto the breast from below.

Positioning the baby at the breast



Key Messages

- If a mother thinks lovingly of her baby, hears sounds of baby and makes Skin-to-skin contact with the baby (touch), this helps in improving production and flow of her milk to baby.
- Relaxed state of mind is important in making breastfeeding a success as anxiety and fear suppress adequate milk production and its flow.
- It is the baby's suckling which makes the breasts produce more milk.
- Appropriate positioning of the mother and child during lactation is most important to make breastfeeding a success.
- Burp the baby by gently rubbing the back.
- Mother's diet/nutrition and comfort is extremely important for successful breastfeeding.

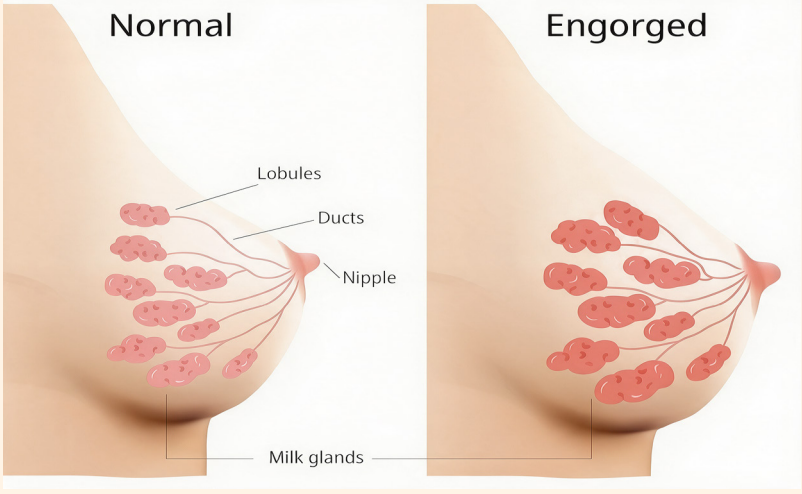
Counselling tips

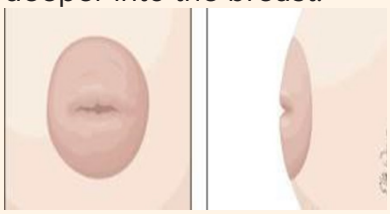
- Helpful non-verbal communication makes a mother feel that you are interested in her, so it helps her to talk to you (Sit by the side of the mother, Give time to listen to her, show affection and empathy)
- Open questions are very helpful, as in answering them a mother can give you some information. Open questions usually start with “How? What? When? Where? Why?” For example: “How are you feeding your baby?
- Use responses and gestures that show interest
- Reflect back on what the mother says
- Try to avoid following words which sound judgemental- Right, wrong, well, badly, good, enough, properly
- Accept what she thinks and feels. Recognise and praise the right things she does for her baby
- Practical help given at the appropriate time increases confidence of a mother.
- Give information which is of immediate relevance.
- Do not give commands, instead gently give suggestions.

B.1.9 MANAGING COMMON BREAST-FEEDING PROBLEMS:

Now let’s understand what are the potential difficulties with breastfeeding and their management :

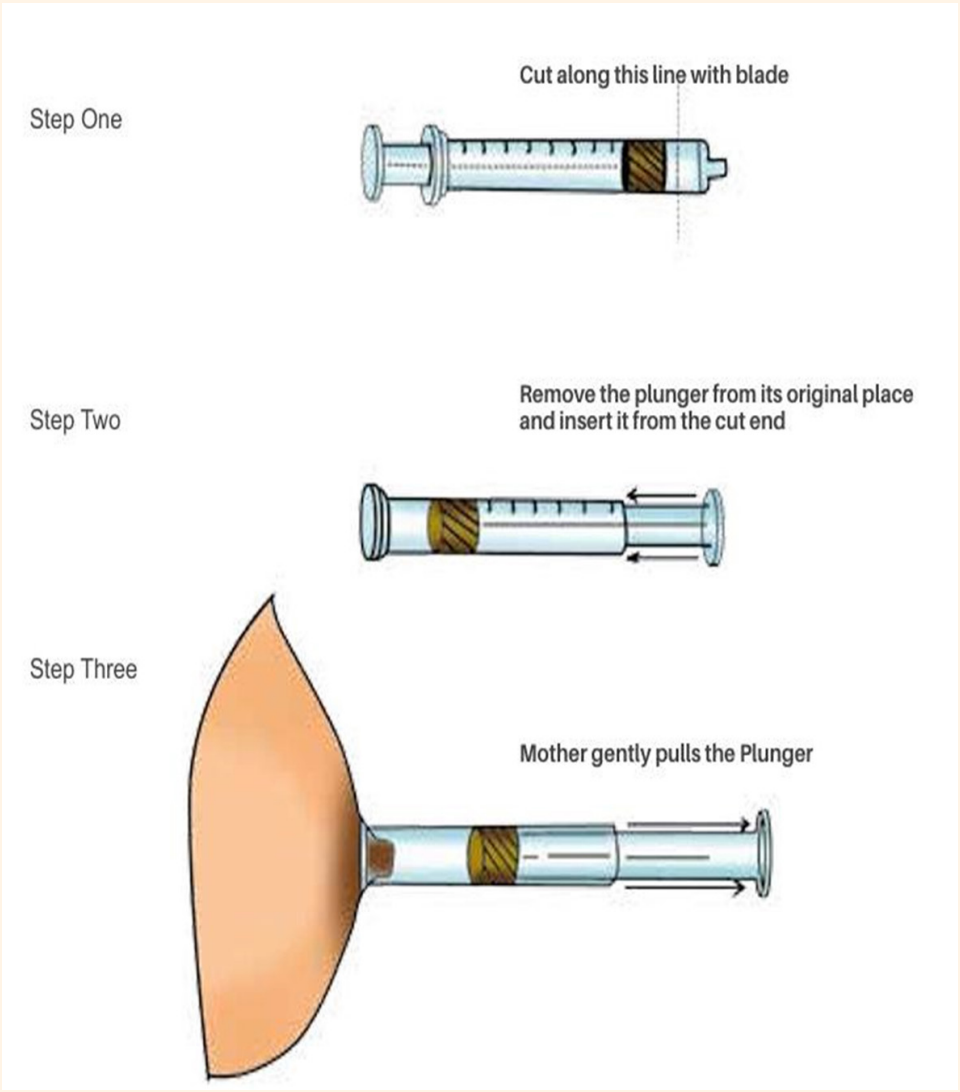
S.no	Problems	Management
1	**Perception of milk insufficiency**	Mothers and/or family members may be worried that breastmilk is not sufficient for the child’s needs. • Explain to mother and family the signs of baby getting enough milk i.e. ✓ After first few days The baby passes urine 6 times or more during the day. ✓ Baby gaining weight adequately. ✓ The baby feeds actively and appears satisfied after feeds. ✓ These are useful signs that the baby may be getting enough breastmilk. ✓ Reassure the mother. • Mother’s breast may not feel full, this is normal after the first few weeks. ▪ Advise the mother to relax and take a rest.

S.no	Problems	Management
		■ She should have an adequate amount of fluids in her diet like milk, Butter milk, flavoured water, sattu, soup, jeera water etc. Encourage the mother to drink fluids according to thirst and eat a varied, adequate diet. ■ To support breast milk production, a new mother should eat at least one extra meal every day compared to her diet before pregnancy. Her meals need to include a healthy mix of local foods, such as grains, dals (lentils), fresh fruits and vegetables, and milk, eggs, or meat. Along with this varied diet, she must continue taking the Iron, Folic Acid, and Calcium tablets provided by her local health worker (ASHA or ANM) to ensure she gets all the necessary nutrients.
2	**Breast engorgement** –Due to partial emptying, If the baby does not suckle the breast frequently. • If there are long intervals between feeds. • If breastfeeding is delayed the breasts can become overly full and painful.	• Continue breastfeeding. • Baby should be breastfed frequently in correct position. • If the baby is able to suckle, mother should feed the baby frequently. • If the baby is not able to suckle, help the mother to express her milk manually and feed the baby. • Before feeding or expressing milk, put on a warm cloth or have a warm shower. Lightly massage the breasts. • After the feed, put on a cold pack or cloth on the breasts. • Pain relieving medicines (paracetamol) are of help if required.
		

S.no	Problems	Management
3	Blocked duct A painful lump in the breast may be because of: Infrequent breastfeeding and not breastfeeding at night. • Tight clothing. • Nipple fissure.	• Correct suckling position. • Encourage frequent breastfeeding. • Gentle massage of the lump towards the nipple during breastfeeding. • Wear loose clothes.
4	**Mastitis/Swollen breast** It is due to inflammation after blocked duct or engorgement of breast. Mother has fever and the breast is red, hot, swollen and painful.	• Frequent breastfeeding in good position from affected breast and continue feeding from the unaffected side. • Pain relieving medicine. • Expression of milk manually. • If she does not improve in a day, refer to the nearest health centre
5	Inverted/retracted nipple – is when the nipple pushed inside the areola. If you try to pull it out it goes deeper into the breast.  During ANC visits, the health worker should examine a woman's breast for any such sign. (Details of ANC Visit are given below in table)	• Flat nipples 'come out' when pulled with the help of a finger and thumb or with the help of a blunt syringe and a plunger. Explain to her how it is to be used . • After delivery help mother to position baby at the breast correctly. Explain to the mother the baby needs to take a large mouthful of the breast so that by stretching her breast nipple will come out.Help her to make nipple stand out more prominently with massage. • If the baby can't suckle effectively in the first 1-2 weeks then she should express the breastmilk and give it to the baby. • Use a syringe pump. • Express breast milk and feed with cup.

Visit	Timing	Key Details
1st Visit	Within 12 weeks	Register the pregnancy and receive the first exam (ideally as soon as pregnancy is suspected).
2nd Visit	Between 14 and 26 week	Routine antenatal check-up.
3rd Visit	Between 28 and 34 week	A check-up performed by a doctor (Medical Officer) at the Primary Health Centre is highly recommended.
4th Visit	Between 36 weeks and term	Final routine check-up before delivery.

S.no	Problems	Management
		Show the mother the syringe, and explain how you cut off the adaptor end of the barrel. ● Put the plunger into the cut end of the barrel (that is, the reverse of its usual position). ● Use a model breast, and put the smooth end of the barrel over the nipple. » Gently pull the plunger to maintain steady but gentle pressure. » Do this for 30 seconds to 1 minute, several times a day. » Push the plunger back to decrease the suction, if she feels pain. (this prevents damaging the skin of the nipple and areola.) » Push the plunger back, to reduce suction, when she wants to remove the syringe from her breast. » When nipple stands out put the baby on to the breast.



S.no	Problems	Management
6	Cracked nipples/ Nipple fissures / Sore nipples - When baby pulls the nipple in and out while in an incorrect suckling position, it damages the skin, resulting in cracks (fissure), wounded and sore nipples which are painful. Frequent washing of breasts with soap might also result in sore nipples.	• Correct positioning for breastfeeding. • Expose the affected area to air and sunlight for sometime. • Wear loose clothes. • Avoid medicated lotions and ointments. • Rub the hind milk i.e, the milk that flows towords the end of feeding or pumping session, on the nipples and areola after each feed as it has higher fat content. • Apply vaseline, ghee, oil if needed • Also, it is easier for a baby to attach well when the breasts are still soft. There is less chance of nipple damage. • If the crack increases or is not healing please consult ANM/ CHO / MO.

Expressing breast milk :

There may be situations when the mother might require to express breastmilk . These are:

- To get relief from engorgement.
- To feed a sick baby who cannot suckle.
- To feed a low birth weight baby or a weak baby by cup as they are unable to suckle.
- To maintain the milk supply, when the mother or baby is ill.
- To feed a baby in conditions, where she is unable to breastfeed.
- To store expressed breastmilk, when she is going out for work.

Manual expression of milk by the mother:

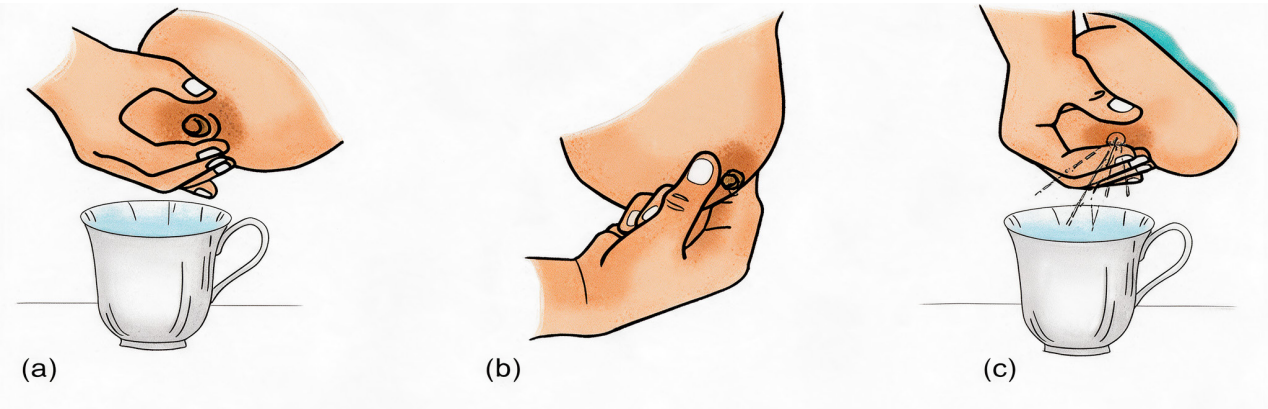
This is one of the easiest and safest methods to express breastmilk.

1. **Build a mother's confidence :** If possible keep the baby in the mother's lap and ask the mother to think lovingly about her baby. Try to reduce any source of pain and anxiety.
2. **Preparation of the vessel/container :** Ask her to choose a cup, glass, bowl / katori with a wide mouth. Wash the cup with soap and water.
3. **Prepare mother for expression of milk:** Advise the mother to sit quietly in a separate room with a supportive friend/helper. Tell her to wash breasts with luke warm water and wash hands thoroughly. Guide her to massage the breast lightly and to stimulate her nipple to activate the oxytocin reflex.
4. **Expressing by hand**
    - Advise the mother to put her thumb on her breast **ABOVE** the nipple and areola, and her first finger on the breast **BELOW** the nipple and areola, opposite the thumb. Tell

her to support the breast with other fingers

- Ask her to press her thumb and first finger slightly inwards towards the chest wall and she should avoid pressing too far, because that can block the milk ducts
- Tell her to apply pressure and release alternatively and multiple times till the flow of milk starts.
- Advise her to press the breast in same way from all sides so that milk flows from all **segments**.
- Express milk from one breast for at least 3-5 minutes then express from the other side and then repeat the process. Explain to the mother that generally it takes about 20-30 minutes to get enough milk for the baby.

How to store expressed breastmilk:



DO NOT

- **Squeeze the nipple.**
- **Express milk quickly.**
- **Rub or slide thumb and finger along the skin**

- Tell the mother to collect breastmilk in a clean covered container for storage.
- Expressed milk can be kept in a covered container at room temperature for up to 6 hours. Use it sooner in case of hot whether.
- Keep the container in the coolest place available. Can be stored in the main compartment of a regular refrigerator (<4 °C) for 24 hours.
- Bring the milk to normal temperature before feeding the baby.

How to feed expressed breastmilk:

- Use a small cup with a rounded brim without any sharp edges or a cup with a spout / paladi or use katori or spoon to feed.
  - Hold the baby in semi upright position, head tilted back and supported by one hand.
- Rest the edge of the cup lightly on the baby's lower lip.
- Tilt the cup enough to let the milk touch the lip.
- Do not pour milk into the baby's mouth

- Let the baby suck the milk by him/herself.
- Do not feed forcefully, if baby does not want the feed.

When the baby may not be getting enough milk :

1. Poor weight gain : • Less than 500gm in a month. • Less than birth weight by around 2 weeks of age.	**2. Passing small amount of concentrated urine** Less than 6 times a day, yellow and strong smelling
3. Few other Signs • Baby not satisfied after breastfeeds and cries often. • Very frequent breastfeeds and short duration breastfeeds • Baby refuses to breastfeed • Baby has hard, dry or green stools • Mother reports difficulty expressing milk or feels that her milk supply is inadequate. • Breasts did not enlarge (during pregnancy) • Milk did not 'come in' (after delivery)	

Evaluate why baby is not getting enough milk : Common reasons could be :

- Lack of motivation and confidence
- Delayed initiation of BF
- Incorrect position
- No night feeding, infrequent feeding
- Separating mother and baby
- Starting complementary feeding early
- Giving bottle and pacifier

Remember following conditions do not affect the milk supply :	
• Age of mother and / or baby • Resumption of sexual intercourse • Return of menstruation • Delivery by C-section • Having many children	• Simple diet. Absence of exotic or expensive foods in diet. • Disapproval of relatives and neighbors. • Returning to a job (if baby continues to suckle often).

Help the mother to give her baby more breastmilk, and to believe that she can produce enough.

Accept her ideas about breastmilk supply and her feelings about breastfeeding and her baby.

Reassure and encourage that she is still breastfeeding and that her breasts are good for making milk.

Give practical help by correct positioning and improved attachment of baby to the breast.

Give relevant Information Explain how baby's suckling controls milk supply and explain how baby can get more breastmilk.

Use simple language "Breasts will make more milk if baby takes more"

Suggest (as appropriate)

- Breastfeed more often, longer, at night.
- Stop using bottles or pacifiers (use cup or katori-spoon if necessary).
- Do not give any other food if baby is less than 6 month of age.
- Give ideas to reduce stress, anxiety and offer to talk to family.

If the baby is ill or abnormal refer the baby to the health center.

If the mother is taking estrogen pills or other medications refer her to Health center for the needful.

Dispel the common myths and misconceptions about breast feeding

Myth and Misconception	ASHA's Explanation should be
Colostrum should be discarded	Colostrum is rich in Immunoglobulins antibodies and helps baby to gain immunity in first few days of life. It is called babies first immunisation.
Mother is not given cereals for 6 days after childbirth After delivery, mother is given sumptuous amounts of ghee	Mother should be given a wholesome diet consisting of cereals / pulses and vegetables, fruits. Balanced diet with extra calories Giving extra ghee should be discouraged as it adds weight without providing the nutrients required for the recovering mother and good quality milk for baby. At this time, more stress should be given on diet comprising of pulses , milk , egg along with vegetables especially green leafy vegetables.
Breastfeeding will make them lose their figure and their breasts will sag	This belief should be changed. Breastfeeding is the most natural way to keep the body in shape. Weight gained during pregnancy gets reduced as a result of adequate breastfeeding.

Myth and Misconception	ASHA's Explanation should be
Pressing the breast yields more milk	This is a misconception. Frequent breast feeding and suckling by the baby is what increases the quantity of milk.
If the mother is ill, then babies should not be breastfed	If a mother is in position to breastfeed her child, then she must do so. This will not make her child ill, infact, breastfeeding protects the baby from illnesses.
If the child is sick, then also s/he should not be breastfed	A child should be breastfed during illness, as breast milk provides the required nutrition and energy to alleviate child's illness.
Many people rely upon khas-khas, lassan, adrak, dry nariyal, zeera and fruits for increasing the quantity of breastmilk	Only frequent breastfeeding during day and night helps in increasing milk production.
Increased intake of milk by mother will yield more breastmilk	Giving extra milk alone does not yield more breastmilk. Instead give a wholesome diet which includes milk.
Breasts of small size cannot produce adequate quantity of milk.	This is a misconception, as size of the breast is related to fats that lie beneath the skin, whereas milk is formed in special glands which are present in sufficient numbers in all women. All mothers are capable of producing enough milk for their baby.
Failure to breastfeed first child, will yield same result for second child	If a mother was unable to feed the first child, even then, she can be successful in breastfeeding her second child.

Breastfeeding low birth weight babies and twins :

Low birth weight babies weighing less than 2.5 kg at birth or babies born before time or at the time of birth they are weak. Low birth weight babies require more breastfeeding than normal babies. For such babies, mother's milk is most suited and essential. LBW babies who are clinically stable and able to suckle should be put to the breast as soon as possible. Some LBW/preterm babies may initially be unable to breastfeed directly. Some babies may have to be fed expressed breastmilk by cup. Babies born during 30-34 weeks and less than 1.5 kg body weight should be referred to district hospital.

- Most mothers have enough breastmilk to feed twins.
- Mothers may need support and encouragement to be able to and believe that they can breastfeed both of them.
- Some mothers feed both twins at the same time; some feed first one twin, and then the other.
- Encourage her to make sure that the weaker gets enough breastmilk.
- Both the babies can be fed together.

- One way to breastfeed twins together is to hold the babies with their bodies and legs going under the mother's arms.
- Talk to her husband and other family members about how they can help her with other work so that she is free to breastfeed the babies

Some babies may have to be fed expressed breastmilk by cup. How to feed a baby by a cup

- Hold the baby sitting upright or semi-upright in your lap.
- Hold a small cup of milk to the baby's lips.
- The cup rests lightly on the baby's lower lip, and the edges of the cup touch the outer part of the baby's upper lip.
- Tilt the cup so that the milk just reaches the baby's lip.
- The baby becomes alert, and opens his mouth and eyes.
- A low birth weight baby starts to take the milk into his mouth with his tongue.
- A full term or older baby sucks the milk, spilling some of it.
- When the baby has had enough, he closes his mouth and will not take any more.

Precautions

- DO NOT pour the milk into the baby's mouth (just hold the cup in such a way that milk touches his lips and let him take it himself).
- DO NOT feed while baby is crying.
- DO NOT feed a baby when s/he is not alert .
- DO NOT feed a baby when s/he is lying in the bed.

Attitude

- As an ASHA you should build confidence by accepting her ideas and praising what she has been doing as good.
- Help her in breastfeeding in correct position.
- Be empathetic. Give advices like a friend, make them comfortable, so that they can ask any question.
- Always advise for family planning to keep a gap of at least 2-3 years between two children.
- If the mother is taking contraceptive pills or medication, she should take doctor's advice.

Refusal to Breast feed and crying :

Sometimes babies refuse to take feed and keep crying which is source of great concern to the mother and care givers. Remember there are other causes which can lead to this :

- This may be due to the discomfort felt by a baby who is wet or feeling hot / cold.
- A baby who wants to sleep and is being continuously disturbed by visitors is also irritable .
- Baby who is hungry but unable to take feed because of poor attachment , not enough milk , too much milk flow or a blocked nose etc keeps crying before getting tired and exhausted.
- Sometimes certain foods / drugs mother is taking can reach baby through breast milk and can cause irritability – caffeine , cigarettes and other drugs .
- Colic is another common reason for babies crying .
- Sickness in the baby – pain in the ear , fever, sore mouth, vomiting, diarrhoea etc can make baby cry and refuse feeds .

In such a situation of breast refusal and crying, the frontline worker should help mothers and suggest the following:

- If the baby is sick, then refer to nearest health facility.
- If a baby is unable to suckle, give expressed breast milk by cup.
- If a baby has a blocked nose, clear the nostrils by cotton wick, soaked in salt water

Give practical help

Explain to mother and other family members that the best way to comfort a crying baby is to hold him/her close, with gentle movement and gentle pressure on his/her abdomen.

Show the mother how to burp the baby. She should hold him/her upright on her shoulder and pat the back of the baby.

B.1.10 DANGER SIGNS IN NEWBORN AND POSTNATAL MOTHER :

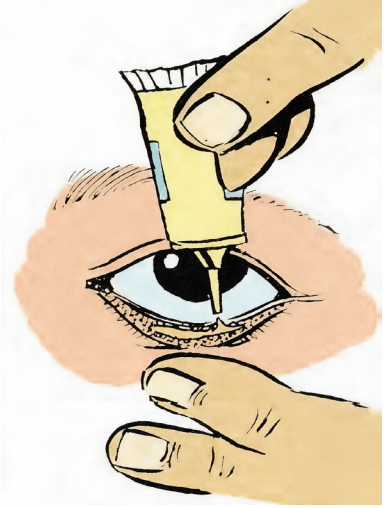
Danger signs in newborns

- Difficulty in breathing, indrawing of chest.
- Jaundice , palms / soles are yellow Yellow discoloration of palms and/or soles. Jaundice appearing within the first 24 hours of birth requires urgent referral.
- Fast breathing (more than 60 breaths / min)
- Inability to suck milk.
- Inability to pass stools and urine.
- If baby develops fever or is cold to touch.
- Seizures
- Dull and lethargic baby.
- Has blood in stool.
- Umbilical cord is swollen , red or has pus discharge.
- More than 10 pustules over body or one large boil.
- Diarrhoea
- Eyes are red and infected.
- For a home-delivered newborn, assess for newborn danger signs and risk factors, including birth weight and feeding. If any danger sign or high-risk condition is identified, immediately facilitate assessment/referral to the appropriate health facility and inform ANM/CHO.

Report immediately to CH0/ MPW if any complication is seen.

Timely treatment saves life of baby.

Baby with eye discharge : Any baby having eye discharge should be seen by the ANM / CHO or if required by the MO in PHC . This might be infection and certain eye drops or eye ointment might be prescribed which will need to be put in baby's eyes .



How to put antibiotic ointment:

Gently pull the baby's lower eyelid down.

Squeeze a thin line of ointment moving from the inside corner to the outside of the eye.

Do not touch the baby's eye with the tip of the tube.

If the tube touches the baby's eyes, it should not be used again.

Put the ointment / drops at frequency and number of days prescribed by the CHO / MO.

Danger signs / Complications after delivery in the mother :

Some women can develop complications after the delivery, these women required immediate referral to the health facility. The symptoms of these major complications are given in table below:

Table 1: Complications after delivery

S. No	Complication	Advice
1	**Excessive bleeding**	• Ask the women if the bleeding is heavy. • If the woman is using more than 5 pads a day or more than one thick cloth in a day, she is having a heavy bleeding. • Advice the mother to begin the breastfeeding immediately, that should help to reduce the bleeding. • Refer immediately to the appropriate health facility.
2	**Puerperal sepsis (infections) Fever, foul smelling discharge, pain lower abdomen**	• If the discharge is foul smelling, then there are chances of infection. • Fever with chills and pain in abdomen with foul smelling discharge make infections even more likely.

S. No	Complication	Advice
3	**Convulsions**	• Convulsions with or without sweeling of face, hands, severe headache and blurred vision • These patients need immediate referral. • If CHO/ANM is available within 15 minutes, they should stabilise the patient before referral. • Convulsions
4	**Anaemia**	• You should check if the mother is pale and enable the mother to get her Hb test done.
5	**Perineal swelling and infection**	• If there is a pain, swelling and discharge from the cut (stitch line) with or without fever, this indicates infection and refer to the facility.
6	**Breast engorgement/ Mastitis infection**	• Explained above in earlier section
7	**Post-partum mood changes**	Some women may suffer from mood changes after childbirth. They need counselling and family support. The changes usually disappear after a week or so. If not, then refer to the health facility for treatment.
In case you find any of the above mentioned danger signs, refer and facilitate shifting of the woman to the nearby health facility for further management.		

If the woman was already having pre-existing conditions / complications during pregnancy or childbirth you must in addition , keep in mind the instructions given at the time of discharge . These might include extra visit to the health facility , certain investigations or certain medications to be taken by the mother or baby . You must inform the ANM / CHO and facilitate compliance by the woman / family.

Danger signs during post-natal period:

1	Excessive bleeding, i.e. soaking more than 2–3 pads in 20–30 minutes after delivery	9	Urinary burning along with pain and swelling in lower limbs
2	Yellowness of urine, skin or eyes	10	Severe abdominal pain
3	Pale skin or eyes, giddiness or weakness	11	Difficulty in breathing
4	Cracked and painful nipples	12	Inability to pass urine after delivery

5	Convulsions	13	Abnormal behaviour such as Confusion, severe behavioural change, hallucinations, or other abnormal mental behaviour – urgent assessment/referral.
6	Fever	14	Swelling on face, hands and legs
7	Easy fatiguability /not feeling well	15	Foul-smelling lochia
8	Incontinence of stool		

Post Partum Depression : It's normal for new mothers to feel emotional highs and lows during the first few days after delivery. Post-partum depression is a well-known entity, it usually begins in the first week after delivery, but it usually subsides within two weeks. However, as an ASHA you should provide additional care to the mother and support for breastfeeding.

As an ASHA will counsel family on following points to provide emotional and psychosocial support to the mother during PNC period and this is crucial for mother and newborn bonding.

- ✓ **Be a good listener:** Be there to listen and support if the recently delivered new mother is feeling overwhelmed or emotional. Encourage her to express her feelings without judgment, and remind her that it's okay to experience a wide range of emotions.
- ✓ **Encourage self-care:** Help her focus on self-care.
- ✓ **Family/ Husband to help** with household work, taking care of the newborn or other children and cattle.
- ✓ **Tell her how well she's doing:** This can boost her confidence and mental health.
- ✓ **Keep checking in**: Check in with her by phone, video call
- ✓ **Encourage her to connect with other mothers:** Help her to connect with other mothers / find a mother support group if possi b l e and provide teleconsultation if required

If the mood swings, indifference to baby, depression persists being an ASHA you should inform ANM / CHO, refer the mother to nearest AAM or take **TELE MANAS consultation on 14416.**

On third day of her delivery a new mother is still struggling with the breast feeding. This is her first baby, and the baby is hungry and reaches for nipple but then after few sucks starts crying. As an ASHA how will you help her?

B.1.11 TAKING EXTRA CARE OF THE "AT RISK" BABIES

Why do we need to identify newborn and child who are 'at risk':

- 'At-risk' newborns are more vulnerable to illness, growth faltering and developmental delays. With timely and appropriate care, their outcomes can be significantly improved.
- It is essential to ensure close monitoring, proactive support, and timely linkage to appropriate health and nutrition services.
- As frontline health workers you are to prioritize these newborns and their families for additional follow-ups and intensified interventions, thereby optimizing the impact of available resources.

Difference between the "AT RISK" BABIES and babies who develop danger signs :

- 'At-risk newborns' should not be misunderstood as 'Newborns with danger signs'
- 'At-risk newborn' refers to infants who require closer observation and follow-up because of biological vulnerability and are more likely to have inadequate growth, delayed milestones and common childhood illnesses.
- Families of these babies need enhanced counselling, frequent home visits, and growth monitoring to prevent complications.
- In contrast, newborns with danger signs present with acute symptoms (like convulsions, not feeding well etc) as described in the MCP card and require urgent referral and treatment at an appropriate health facility.

Criteria for identification

- Birth weight is less than 2500 grams OR is preterm (born before 37 weeks of pregnancy)
- Newborns who are not initiated on breastmilk / or not breastfeeding
- Newborns requiring hospitalization / discharged from Special Newborn Care Unit (SNCU)
- Low weight for age*
- Visible congenital malformations that are life threatening; or hamper feeding such as cleft lip and/or palate

**ANM and CHO Joint visits / MO can use these additional criteria to identify "At-risk" infants:*

- *Newborns not regained birth weight by Day 14 of life*
- *Newborns not gaining weight in two consecutive visits after 14 days of life*

How do we identify 'At-Risk' newborn and child?

Role of ASHA for "At-Risk" Newborns :

- **Prepare the line list:** At-Risk" newborns must be identified at home during the first home visit by you as an ASHA. The number of "At-Risk" newborn and children under each ASHA should be clearly recorded (line listed) and should also be listed with the ANM / CHO for actions at their level.
- **Additional home visits for "At Risk" newborn :** As per SSBSK guidelines, the visit schedule is as follows: Day 1/ within 24 hours of discharge, 3rd day, 5th day, 7th day, 10th day, 14th day, 21st day, 28th day and 42nd day.

Remember

- "At-Risk" newborns do not needs to be observed however no not need immediate referral to the health facility unless they show any danger sign.
- These babies should receive joint visits by the ANM and the CHO on day 3 and 7.
- The decision for referral should be jointly made by the ASHA, ANM, CHO, and the family. The CHO should first conduct a full assessment and refer only when specialist care is needed.

Recognising Life-Threatening Situations: In a new-born or infant, the following signs indicate an emergency and need urgent medical attention:

1. **Baby is unusually sleepy , lethargic , or unconscious and limp .**
2. **Baby is not accepting feeds or vomiting everything .**
3. **Baby is having fits .**
4. **Baby has fever or is hypothermic (temperature is below normal)**
5. **Baby has fast breathing > 60 breaths per minute ,**
6. **Baby has grunting and /or severe chest indrawing**

Provide appropriate guidance to parents of "At-Risk" Newborns :

Check temperature, count respiratory rate, Heart Rate and for any blue/yellow coloration Assess Temperature:

If newborn weighs <2500 gms

- Promote, counsel and demonstrate KMC to mother/ care giver (Skin to skin contact for ≥8 hours/day or as much as possible) to keep baby warm.
- Provide 2-layer clothing with head and feet covered, and protect from direct airflow, Demonstrate baby Wrapping to family.
- If newborn is SNCU discharged, ensure medication as per discharge ticket, continue KMC, and keep baby warm as advised.
- If further referral needed, refer mother and baby to the nearest health facility and advise mother to continue KMC and breastfeeding during transport.

- **Assess Breastfeeding**
  - Ensure correct attachment and positioning of baby
  - Counsel mother to feed 10-12 times in a day and night (in every 2 hours)
  - Counsel to wake the newborn if not fed in last 3 hours by gentle stimulation
  - Counsel to feed fully from one breast before switching to other
- **If newborn is on expressed breast milk, check if newborn is being fed with katori and spoon (advise not to use bottle)**
- **For SNCU discharged:** Check and encourage continuation of KMC as many hours as possible per day; advise to continue prescribed care, medications and continue breast feeding Encourage follow up visits to SNCU as per schedule given in discharge ticket
- **Assess mother's health and nutrition-**
  - Counsel the new mother should eat at least one extra meal every day compared to her diet before pregnancy. Her meals need to include a healthy mix of local foods, such as grains, dals (lentils), fresh fruits and vegetables, and milk, eggs, or meat. Along with this varied diet, she must continue taking the Iron, Folic Acid, and Calcium tablets provided by her local health worker (ASHA or ANM) to ensure she gets all the necessary nutrients.
  - Refer if mother has any serious illness like fever, cough >2 weeks.
  - Counsel mother for timely intake of IFA, Calcium and medicines if any prescribed.
  - In vulnerable households, assess mother's nutritional support and link to available government schemes.
- **Counsel for hand hygiene, timely immunization, development supportive practices and seeking help in case of any of danger signs.**
- **Assess family situation and support:**

  Counsel family members (grandmother, husband) about importance of family support for practicing exclusive breastfeeding.
- **Follow up every week** till child has weight gain on two consecutive visits.
- If the newborn is not gaining weight despite breastfeeding support, the ANM/CHO should reassess breastfeeding, including positioning and attachment, and provide appropriate support. If inadequate weight gain persists or further assessment is required, refer the newborn to the appropriate health facility.

Counselling Points in each visit for 'At Risk' Newborns

- Keep the baby warm and support Kangaroo Mother Care (KMC) for eligible LBW/preterm newborns, as advised.
- Start breastfeeding within 1 hr of birth
- Feed the baby only mother's milk
- Healthy/normal baby can be bathed after 2 days. For 'at risk' do not bathe the baby for the first 48 hours
- Keep the cord dry
- Keep the baby away from sick people
- To keep the baby warm- Keep the baby well clothed and wrapped . In winter, put a cap

and socks and cover the baby with a blanket . In summer also do not make baby sleep directly under the fan without any cloth. **(applicable to normal newborn also)**

During the home-visits, you will fill the details in shaishav app as Annexure which captures information regarding post-natal care of mother and newborn care and helps identify danger signs in both mother and child.

B2

Infant and young child

PART B

B2 Infant and young child

Mother says her 4 days old baby is not taking feeds properly and her breathing is fast . What would you do ?

B.2.1 CONTINUUM OF CARE BEYOND SIX WEEKS :

- Period after 42 days till 3 years of age are equally critical for the child's growth and development as already highlighted in the beginning.
- After 42 days, contact with the health system is often limited to immunization, illness, or malnutrition, so regular home visits are needed to keep a watchful eye on the infant's growth and development .
- There is a possibility that the
  - Mother will stop breast feeding early
  - She may initiate inadequate complementary feeding after 6 months
  - She may not come to the health facility in time for an illness
  - Poor hygienic and sanitary conditions and child-rearing practices might be impacting the growth and development of child.
- First three years of life are crucial; good nutrition during this time reduces infections, illness and deaths, and supports physical and brain development.
- As an ASHA, you already support health and nutrition of children from birth to 5 years through home visits.
- Structured home visits help identify problems early and helps to take timely action.
- Structured home visits should be undertaken as per the SSBSK strategy and the applicable state-approved schedule.

For Young Child (3 months to 36 months)

- Being an ASHA , you would conduct 8 quarterly home visits starting from 3 months till 36 months (3,6,9,12, 18, 24, 30 and 36 months) to ensure continuity of care.
- For healthy children: As an ASHA to complete all tasks as outlined in the Mother and Child Protection (MCP) Card, including growth monitoring, feeding assessment, hygiene

practices, immunization check, and developmental milestone tracking. You would provide age-appropriate counselling on health, nutrition, and early stimulation.

- Identify illness and facilitate timely referral to the appropriate health facility as per the referral protocol.
- For "At-risk" children: As an ASHA should spend additional time with caregivers to reinforce nurturing care practices, counselling them to provide extra attention to the child, practice responsive caregiving, and promote early learning through play and communication. You should also advise on regular follow-up and coordinate with the ANM as required

The SSBSK program targets all children (girls and boys) between 3 months up to 36 months of age. You have to give special attention to the **healthcare and follow-up needs of "At Risk newborns and children"**. Using past training experience, ensure that girl children receive equal care and attention as given to boys. Therefore, counselling of parents/caregivers during home visits to avoid discrimination on account of gender should also receive due priority.

Conduct of SSBSK Visits :

- Make your eligible child list / due list, identify the child who has completed home based newborn visits, to continue the care provided by you to the newborns, the visits have been extended till 3 years
- ASHA diary/register
  - To help you list all young children between 3 months
  - 3 years of age in your area. Among these, you will require to prepare an updated list of children who have registered in Anganwadi Centre (AWC) and are due for immunization

- **Check:**
  - Whether SSBSK visits were completed
  - Birth details (LBW, SNCU/NRC discharge, any illness)
  - Mother and Child Protection card
- **Carry**:
  - SSBSK details in Saishav App*
  - Growth monitoring chart
  - IEC material (breastfeeding, immunization, hygiene)

*SSBSK details will be used to record details of activities. The SSBSK formats will be provided to you by your state for recording details of activities for each child. You will tick mark (√) and write yes/no (as specified) against the activities conducted in two forms , SSBSK formats /

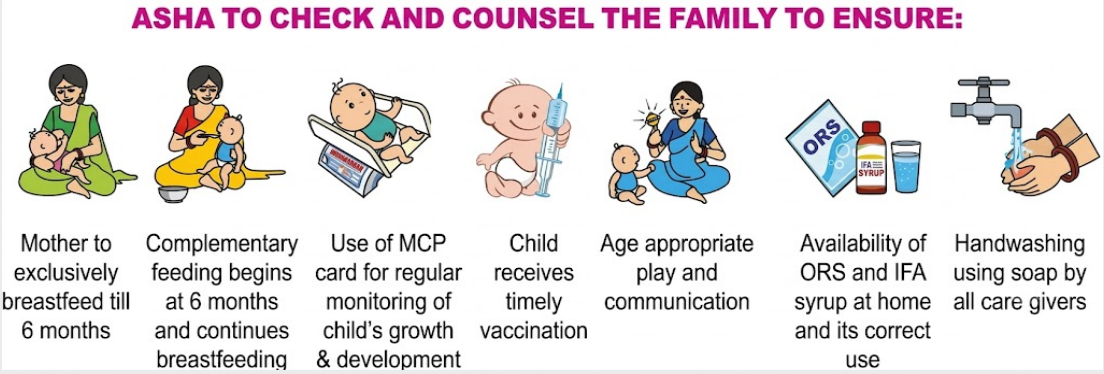
Saishav app and in the MCP card (page-8) of the mother/ caregiver. SSBSK data will be the basis for your payment. The MCP card will be retained by the mother/ caregiver.

As an ASHA, you would start quarterly home visit of child starting from 3 months till 12 months (3, 6, 9,12 months) and extending to at 18, 24, and 36 months to ensure continuity. You will ensure continuity of care by tracking and supporting the "At-risk" children, improve child growth monitoring, nutrition counselling, strengthen disease prevention efforts, and increase family engagement in nurturing care.

Domain specific actions in each visit :

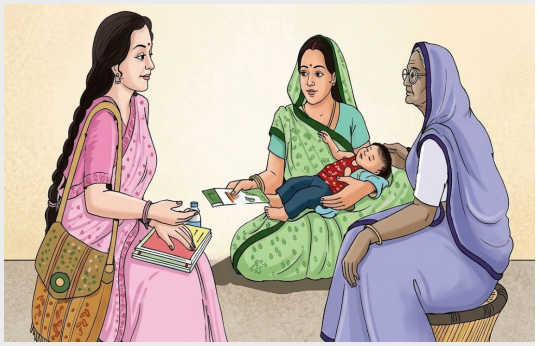
Key Domains	Specific Actions
Nutrition	• Nutrition counselling: Exclusive breastfeeding for six months; • Adequate complementary feeding from six months and continued breast feeding up to two years of age • Ensure age-appropriate IFA supplementation as per the prevailing national/state guidelines • Hygienic food preparation • Promote use of fortified food, local low-cost food and millets
Health	• Ensure age-appropriate immunization as per the National Immunization Schedule. • Growth monitoring till 3 years • Appropriate use of Oral Rehydration Solution (ORS) and Zinc during diarrhoea episodes • Prompt care seeking for 'sick child'
Early Child Development	• Assessment of child's developmental progress -link children with delayed milestones to health facility or AAM • Information regarding positive parenting, age-appropriate play and communication activities by caregivers
WASH	• Appropriate hand washing practices • Safe drinking water • Safe disposal of faeces, use of toilets
Follow up of "At-risk" children	• Identify 'At risk' children: Previously identified and newly identified • Follow up of 'At risk' children and link them to health facility • Specific actions as per the identified condition and advised management
Safety and Security	• Ensure a safe sleeping space , protection from accidental drowning , electric gadgets , falls and poisoning etc.

Build the capacity of family through counseling :



Attitude: You should

- Be humble while talking to the mother, also try to assess mother's mental health.
- Notice all the milestones and warning signs.
- Carry one MCP card for demonstration.
- Check the family support, if the family is not supportive, cousell them.



Trigger Questions

If a child looks healthy and active, can they still be malnourished?

Yes. Most mildly malnourished children look normal; only measurements reveal the problem.

B.2.2 NUTRITION AND COMPLEMENTARY FEEDING :

Let us understand each component in detail :

About 46% of the children below three years in India are underweight. This means that roughly one out of two children weigh less than they should for their age. Under nutrition in early childhood is associated with poor academic performance, reduced work capacity, and poor health and nutrition status through childhood, adolescence and adulthood. Proper nutrition of child is necessary for their growth and development.

Underweight Children
About 3 children out of 10 children under five years of age are underweight (have low weight for their age).

Wasted Children
About 2 children out of 10 children under five years of age are wasted (have low weight for their length/height).

Stunted Children
About 3 children out of 10 children under five years of age are stunted (have low height for their age).

Source: National Family Health Survey (NFHS-6)

What is Malnutrition?

Malnutrition is a general term. It most often refers to undernutrition resulting from inadequate consumption, poor absorption or excessive loss of nutrients but the term also encompasses overnutrition, resulting from excessive intake of specific nutrients.

Types of undernutrition

Underweight: Underweight, or low Weight-For-Age (WFA), identifies children who weigh less than a healthy, well-nourished child of the same age.

Stunting: Low Height-For-Age (HFA) is known as stunting. It is the result of chronic or recurrent undernutrition, usually associated with poor socioeconomic conditions, poor maternal health and nutrition, frequent illness, and/or inappropriate infant and young child feeding and care in early life.

Wasting: Low Weight-For-Height (WFH) is known as wasting. It usually indicates recent and severe weight loss, because a person has not had enough food to eat and/or they have had an infectious disease, such as diarrhoea, which has caused them to lose weight.

Severe Acute Malnutrition (SAM): Severe acute malnutrition is defined by very low Weight-For-Height/Length. Lack of exclusive breast feeding, late introduction of complementary feeds, feeding diluted feeds containing less amount of nutrients, repeated enteric and respiratory tract infections, ignorance, and poverty are some of the factors responsible for SAM

Recognizing Malnutrition:

It is difficult to recognize malnutrition just by looking at a child. Only very severe cases would show obvious signs of weakness or wasting . Most children look normal but their height and weight when measured is found to be less than expected for their age.

Regular weighing and measurement of length/height help to identify growth faltering and undernutrition early. Being an ASHA, You should check the child's growth record in the

MCP card and discuss the growth trend with the mother/caregiver. Children identified as underweight, wasted or having growth faltering should be followed up and referred for timely and suitable management.

Sick children need special attention. However, families of all children especially children below two years should be counselled on feeding the child so as to prevent malnutrition. Regular growth monitoring by weighing the child and measurement of length/ height (with support of AWW) is key to recognize growth faltering and malnutrition.

Skill- Step by Step guide

- Weight of young children aged above 42 days and above is taken at the Anganwadi Centre.
- ASHA should mobilize the mother and child to come to the Anganwadi for monthly weighing.
- Anganwadi Worker (AWW) is responsible for weighing and growth chart plotting.
- ASHA should support AWW during weighing days (VHSND / monthly weighing day).
- ASHA should ensure the weight is recorded correctly in: MCP card and Anganwadi growth register.
- ASHA should check the growth trend (weight gain or no weight gain).
- If weight is not increasing or falling, ASHA should:
    - Inform AWW/ANM.
    - Counsel the family.
    - Refer the child to AAM/PHC if required.

You as ASHA can do following interventions to prevent malnutrition in children

You as an ASHA teach mothers five simple steps during home visits: exclusive breastfeeding, timely complementary feeding, feeding during illness, preventing illness, and accessing services.

A.2.2.a. Exclusive Breastfeeding (0-6 Months)

Give only breast milk—no water or other foods. Watch early hunger signs like restlessness or mouth opening. Benefits include stronger immunity and fewer infections. Continue breastfeeding up to 2 years.

A.2.2.b. Complementary Feeding (From 6 Months)

Start at exactly 6 months when breast milk alone isn't enough. Continue breastfeeding. There are five things to remember about complementary feeding:

Timely, Adequate, Safe, Responsive, Diverse Foods

Timely: Begin at 6 months.

Adequate: Use family foods from all groups cereals (rice, wheat, millets), pulses (dal, chana),

vegetables (leafy greens, coloured vegetables), fruits, milk/curd/paneer, eggs/meat/fish (if eaten by family), oil/ghee, nuts (groundnut if no allergy).

REQUIREMENTS OF COMPLEMENTARY FOODS

1. **Timely** Introduced at completion of six months when requirement for energy and nutrients exceeds that provided by breastmilk alone.
2. **Adequate : When we say adequate -questions which come to our mind ?**

What?	How much?
How many times?	What form?

The answer is also given in the MCP Card . Show it to the mother in her MCP card when you as an ASHA are explaining it to her. You should always carry the MCP card in your kit .

What to give ?

- Combination of pulses (daals) and legumes with cereals and millets should be given. Example- daal with rice or cracked wheat porridge (dalia) with daal, chappati/roti soaked in daal, bajra khichri with daal, etc. Feed should be prepared from locally available pulses and cereals/ millets.
- Oil/ghee/butter, jaggery(gur) roasted crushed and powdered/ mashed groundnut (if the child is not allergic) etc. can be added to the feed for making it rich, tasty and easy to swallow. Do not add spices to the food of the child. Add a suitable amount of oil, ghee or other energy-rich food to make the food more energy-dense.
- Locally available, fresh and seasonal fruits and vegetables should be given to the child. Washed, cooked and mashed fruits and vegetables can be added to the feed.
- Cereals/millets and pulses that are soaked, sprouted, dry roasted and powdered for cooking can be given to the child as they are easily digested.
- Animal products/non-vegetarian foods (meat, liver, fish, poultry, eggs (well-cooked), etc.), wherever culturally acceptable, can be started as early and given as often possible to the child.
- Plan for one to two healthy snacks in between

the main meals.

Snacks are like small meals which are given in between main meals. These must not be a replacement of meals. Mashed fruits like banana, papaya, mango, cheeku and other soft fruits; boiled and mashed potatoes, mashed vegetables, well-cooked eggs, curd, panjeeri, laddoo, halwa, upma, idli, poha with crushed/mashed groundnuts (do not add groundnuts if child is allergic), etc. are

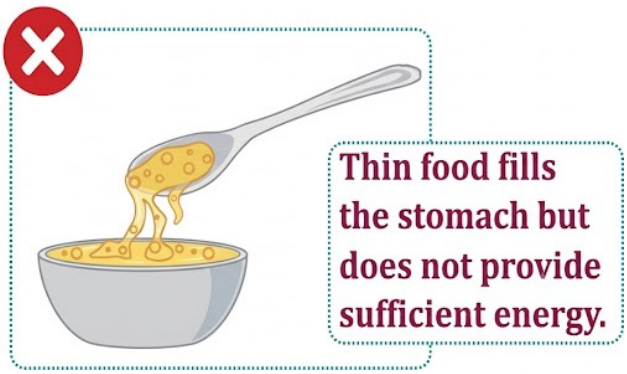
some of the examples of food items to be given as snack to the child.

- Introduce only one food at a time, variety can be increased by adding new foods one by one.
- If the child dislikes a particular food, remove it from the diet for some time and give again at a later stage.

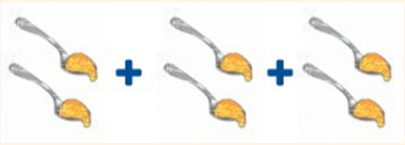
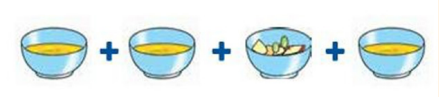
Five important things to remember about Complementary Feeding

Consistency	Quantity	Frequency	Density	Variety
• Depends on age of the child and readiness to chew and swallow. • Initially include soft and mashed foods. • Move gradually to foods with appropriate thick consistency. • Give Daal (and not Daal ka Paani) • Feed prepared should not be too thin and too thick. Test: stays on a spoon when the spoon is tilted	• Increase with the age of the child. • Encourage for better intake • but not force child to eat more. • At one-year child should receive half the mother's nutrition.	• Increase with the age of the child. • Number of feeds will increase gradually with increase in age of the child.	• Add a suitable amount of oil, ghee or other energy-rich food to make the food more energy-dense. Avoid adding unnecessary sugar or jaggery to every feed.	• Add fruits and vegetables -The rule is that the greener it is, or the more red and yellow is the feed, the more is the protective quality. • Meat, egg (well-cooked), poultry, fish, etc. are liked by children and are also very nutritive andprotective

Different consistencies of Complementary Food :



How much and how frequently :

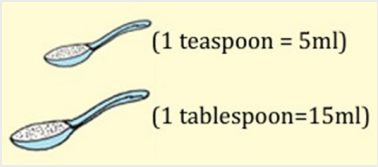
Age	Consistency and amount	Frequency
Breastfeed as often as the child wants and continue breastfeeding if the child is sick.		
At six months	Begin by giving 2 to 3 tablespoons of cooked, soft, mashed (or pureed) food. You can use a little expressed breastmilk or clean water (boiled, treated or filtered) to soften the mashed food. The consistency of the soft mashed foods should be thick enough to remain on the spoon without falling off	2 -3 times a day 
Between 6 to 9 months	2-3 tablespoons to be gradually increased to half (1/2) cup/katori at each meal of mashed food, 2-3 times each day and 1-2 snacks.	2 to 3 meals each day. Offer 1 or 2 additional nutritious snacks each day in between
Between 9 to 12 months	Atleast half (1/2) cup/katori at each meal of finely chopped or mashed food and foods that the baby can pick up with her/ his fingers,	3-4 times each day and 1-2 snacks. (5 times per day if not breastfed) 
12 months onwards	Give at least 3/4 cup serving at a time	Minimum of three meals a day and offer one to two snacks.

Age	Consistency and amount	Frequency
For 2 years and older children, give a variety of family foods to the child, at least 1 full cup/katori (250ml) at each meal, 3-4 meals each day with 1-2 nutritious snacks between meals.		

The quantity mentioned may be difficult for a family to measure correctly. The size of cup/ katori, serving spoon/karchi, teaspoon and tablespoon can vary in size and shape. Thus, it is important for you as an ASHA to explain to the mother and caregiver about the quantity by showing common household utensils that are used in the family for serving food.

Household measurements of commonly used household utensils:

- 1 full cup/katori*= 250 ml (the volume may vary)
- 1 serving spoon/karchi= 100 ml (the volume can vary)
- 1 teaspoon- 5 ml
- 1 tablespoon- 15 ml



With the child's bowl, it can be easy to demonstrate how much is 1/2 (half), 3/4th, and a

full cup/ katori as shown in the figure given below.

3. Properly Fed

- Use responsive feeding. Encourage the child to eat patiently, but do not force the child to eat.
- Children have small stomach therefore should be fed more frequently.
- Feed children from a separate cup/katori/ plate at recommended frequency as it will help mother/caregivers to understand the quantity of food eaten by the child.
- Show interest, smile or play games to encourage children to eat enough food.
- **Continue complementary feeding during illness and increase the amount during the recovery period.**
- **Girls and boys have the same nutrition requirement to grow and develop. So they both should be given the same amount and similar kind of food.**

4. Safe

Complementary foods should be prepared hygienically. Mothers/ caregivers must wash their hands before preparing and before feeding the child. The child's hands should be washed also. Clean utensils should be used to prepare the feed of the child.

Before you can advise on complementary feeding , you have to assess the feeding practices being followed by the mother / family. Eliciting that information also requires skill . How will you get that information?

Assessing Information about Complementary Feeding from the Mother/Caregiver

- Start by asking if the mother/caregiver is breastfeeding the child?

How many times in a day- both day and night?

Is the child breast fed at night? If yes, how many times is the child fed at night.

- **Does the child take any other food or fluids? What foods or fluids?**

How many times per day? Are the foods thick or thin?

What do you use to feed the child?

How large are the servings (cup/katori, teaspoon, tablespoon)? Does the child receive separate serving from the family members? Who feeds the child and how?

What feeding difficulties does mother/caregiver experience, if any?

- **Ask if the child's feeding has changed during the illness?**

If yes, how?

The mother's/caregiver's answers to these questions will give you an idea whether the child is receiving adequate amount of nutrition from breastfeeding and complementary feeding. You should counsel for continuation of breastfeeding during the home visits, support them in maintaining age- appropriate feeding pattern by counselling on what should be avoided and teach right quantities for complementary feeds. It is also important to inform them about feeding during illness and recovery phase and regarding specific nutritional needs of malnourished children.

What should not be given :

- Ready-made or processed food available in the market such as toffees, sweets, chips, chocolates, biscuits, namkeens; drinks such as tea, coffee, cola drinks, cold drinks, fruit juices, sharbats, etc.
- Food which can pose choking hazard such as whole nuts, grapes, raw carrot pieces, etc. should not be given initially.

FEEDING THE CHILD RESPONSIVELY

Mothers/caregivers should recognize the signs of hunger and respond as soon as possible. Responsive feeding means gently encouraging—not forcing—the child to eat.

Counsel the mothers/caregivers to:

1. Be patient in feeding the child and encourage them to eat. Do not force the child to eat.
2. Try different food combinations, tastes and methods to encourage feeding if children refuse many foods.
3. Play games to help the child to eat enough food and to encourage the child to try new foods.
4. Minimize any disturbances - during meals, if the child loses interest easily.

5. Smile and talk to children during feeding, with eye to eye contact as feeding times are periods of learning and affection.

Do not express anger at children who refuse to eat. These actions usually result in children eating less.

Feeding during illness :

Timely initiation of complementary feeding along with responsive feeding are critical quick and complete recovery of sick and malnourished children. The messages given above on complementary feeding are also useful for these children. During this time, the child may not want to eat much, but children need small frequent meals and more fluids, including breastmilk and other liquids to recover more quickly during illness. Children who are breastfeeding, need to be breastfed more often and for longer time. After an illness, children should be given more food and more often than usual for at least 2 weeks to help recover from the weight lost during illness.

One and a half year old child has been discharged from hospital after a severe bout of diarrhea . On your home visit you found that his grandmother is feeding him watery khichdi three to four times a day . She is withholding any milk / oil and vegetables s she believes his stomach is too weak to digest these. How will you convince her about the diet which the child requires ?

Prevent illness through promotion of following :

- Hand wash before feeding/preparing food, after cleaning child stools (to prevent diarrhoea).
- Boil drinking water.
- Ensure timely and complete immunization.
- Keep sick people away from baby
- In malaria endemic areas: Use insecticide-treated bed nets.

Facilitate access to health and allied services

- First day of the illness, if you as an ASHA help the mother to decide on whether it is a minor illness for which home remedy would be adequate, or to be referred to a doctor, such a decision would save lives

- Being an ASHA, you should be frequently contacting ANM and CHO in **Ayushman Arogya Mandir.** Teleconsulation is also available at AAM, which can be utilized for the specialist consultation.
- **Ayushman Shivir** to be held at AAM every month with the aim of catering to all "At Risk" newborns and children for screening , assessment and treatment along with counselling to care-givers. Well- baby clinic is conducted at AAM on immunization days and during VHSND / UHSND for all newborns and children. ASHAs are expected to mobilize the children every month to Ayushman Shivir / Well-baby clinics .
- Anganwadi Centres provide supplementary nutrition to children aged 6 months–6 years, including additional nutrition for malnourished children, and to pregnant women and lactating mothers for the first six months after childbirth.
- Weighing the baby and informing the family of the level of malnutrition is another important Anganwadi service.
- Other services like annaprasan yojana, Pradhan Mantri Matru Vandana Yojana (PMMVY), God Bharai Yojana, meetings being conducted in Anganwadi center.
- Access to contraceptive services is important. If the age of mother is less than 19, or the gap between two children is less than three years, there is a much higher chance of children being malnourished.

Importance of Mother's Nutrition

Pregnancy and lactation are critical phases in a woman's life, marked by significant physical changes, making it essential to prioritize their nutritional needs. Mothers should also take advantage of the nutritional support provided by the Anganwadi Center to maintain their health and well-being.

For the required Calorie Intake: Add extra foods from nutrient-dense foods like

- Whole grains-Wholewheat/Joweri/Bajra/Ragi/Barley/Amarnath,
- Proteins-Daal/Legumes/Dairy Products/Eggs/Meat products,
- Fruits, and vegetables.

Eat Frequently: Eat breakfast , lunch and dinner and two snacks in between.

Hydration: Drink 10–12 glasses of water daily and include hydrating foods like soups and fruits. Mothers can sip water / take fluids after every session of breast feed to avoid dehydration.

Balanced Diet: Focus on proteins, calcium, iron, fats, and omega-3s from sources like fish, dairy, leafy greens, and nuts.

Vitamins & Minerals: Ensure adequate Vitamin D, B vitamins, folate, iron (Take IFA tabs provided by ASHAs), and iodine (via iodized salt).

Avoid/Limit: Reduce tea/coffee intake, refrain from alcohol/smoking/tobacco, and be cautious with potential allergenic or spicy foods.

B.2.3 ROLE OF ASHA IN PROMOTING BREASTFEEDING AND COMPLEMENTARY FEEDING :

Use the MCP card, if available, while counseling about activities related to breastfeeding and complementary feeding, during each home visit from 3 months up to 36 months , you will:

- Encourage the mother/caregiver to exclusively breastfeed the child from birth to 6 months and provide complementary feeding on completion of 6 months of age, to girl and boy children alike.
- Ensure support from family members husband, mother and father in-law, etc. for the mother to provide her sufficient rest and adequate nutrition to breastfeed her child.
- Provide counselling to mother/caregivers on importance of early and exclusive breastfeeding and timely introduction of age-appropriate complementary feeding to the child. Ensure that families having children- low birth weight, malnourished, sick, those discharged from SNCU/NBSU/NRC, etc. are counselled and are following your advice.
- **Undertake joint visits with ASHA Facilitator or ANM/MPW to a household where you are unable to convince the family for exclusive breastfeeding/complementary feeding.**
- Educate the family regarding the importance of regular hand-washing before and after preparing food, before feeding the child and after using the toilet.
- Mobilise the lactating mothers and their children for registration at the nearby Anganwadi centre to receive 'Take Home Ration' (THR) for themselves and their children beyond 6 months of age.
- Emphasize on the importance of Mother's Nutrition and that she must prioritize her nutritional needs
- Refer mothers with problems in breastfeeding and those children who are unable to take breastfeed or complementary feed to ANM / CHO / MO at nearest health facility for appropriate care. Follow-up with them closely to ensure child is provided appropriate care and is growing well.
- As an ASHA, you can mobilise support from VHSNC/MAS, VHNDs/UHNDs, self-help group meetings, mother's group meetings, support groups, etc. for promotion and counselling activities related to breastfeeding and complementary feeding. These groups can also help you in overcoming the harmful traditional practices and beliefs related to young child feeding and nutrition prevalent amongst the community .
- On completion of 6 months of age, counsel mother/caregiver to ensure that all children are being given healthy food in adequate amount through responsive feeding and continued frequent on demand breastfeeding for at least 2 years.

Key Messages to be delivered to Mothers and Family during visits

Hygiene and Infection Prevention

- Maintain strict hand hygiene: Caregivers must wash their own and the child's hands with soap and water before every feeding session.

Responsive Feeding Practices

- Adopt active feeding: Hold the child securely in your lap and assist them directly with feeding.

- Observe hunger and satiety cues: Feed the child according to their natural hunger signals and stop when they show signs of fullness.
- Avoid force-feeding: If a child refuses a meal, do not pressure them. Wait and offer the food again later.
- Introduce new foods patiently: Repeatedly offer new foods and positively reinforce the child's reaction to novel tastes and textures, as acceptance often requires multiple attempts.

Psychosocial and Motor Development

- Encourage self-feeding: Allow the child to hold food and practice using a spoon to develop independent motor skills.
- Foster interactive engagement: Talk to the child and mimic their sounds or gestures during meals to promote communication and cognitive development.
- Create a positive meal environment: Make eating a joyful, play-based learning experience. Completely avoid using digital screens or mobile phones as feeding distractions.
- Promote family meals: Eat together as a family to support the child's behavioral modeling and social-emotional development.

Dietary Safety and Behavioral Guidance

- Model positive eating behaviors: Caregivers should conceal their personal aversions to specific foods to ensure the child learns to accept a diverse diet.
- Separate food from discipline: Never use food as a reward for good behavior or withhold it as a punishment.
- Restrict processed foods and sugary drinks: Strictly avoid ultra-processed snacks (chips, biscuits, candies) and commercial beverages (colas, juices, tea, coffee), particularly those containing chemical preservatives.
- Prevent choking hazards: Withhold hard or round foods (such as whole nuts, whole grapes, and raw carrots) until the child has fully developed the mechanical ability to chew and swallow safely.

Skill – Analysis of adequacy of breast feeding and complementary feeding by you as an ASHA on SSBSK visits .

ASHA should check the child's growth record in the MCP card. Look at weight-for-age and, where available, weight-for-length/height and the direction of the growth curve. Do not decide the child's nutritional status from weight alone. If growth is not progressing well, discuss with the mother/caregiver and refer as required.?

What the child is being fed?

Ask specifically what was fed in the last one day, starting from now and recalling backwards, till the previous day. Things to notice; how many feeds in a day, how much in each feed, whether the child's food included pulses, vegetables, oil.

Ask specifically about protective foods which are not given daily. Ask about feeding during illness.

What is the recent history of child's illness, and whether enough has been done to treat it promptly and to prevent further illness?

Ask whether the child fell ill during past six months (ask specifically about diarrhoea, fever, cold and cough).

Start with most recent illness, and then ask them to recall backwards –" before this when was he/she sick? etc.

What actions did the family take during illness? Which provider did they go to?

What difficulties did the family face in accessing healthcare and how much did it cost? What are the likely inessential services or expenditures which they are getting into?

What is the family's access to the three key services? (ICDS, Health Services and Public Distribution Services)

Is the child taken regularly every month to the Anganwadi Centre (AWC) for weighing? Have they seen the growth curve?

Is the family availing food supplements from the Anganwadi, is it regular, reliable and of variety needed and reasonable quality?

B.2.4 IRON AND FOLIC ACID SUPPLEMENTATION :

Anaemia is a common problem among children in India.

What is Anemia? Anaemia is a condition when there is low haemoglobin level in the body resulting in less ability to carry oxygen to all parts of the body. According to Anaemia Mukta Bharat Operational Guidelines 2026, anaemia in children of age group 6-23 months occurs when the haemoglobin level in the body is less than 10.5 g/dL and in children of age group 24-59 months, anaemia occurs when the haemoglobin level in the body is less than 11 g/dL.

Anaemia in children causes poor learning ability, low concentration, tiredness, poor school performance and poor coordination of language. The child is unable to reach his/her full potential both physically and mentally.

Table : Haemoglobin levels to diagnose anaemia (g/dl)

Age group	Anemia (g/dL)			
	Normal	Mild	Moderate	Severe
6-23 months	≥10.5	9.5-10.4	7.0-9.4	<7
24-59 months	≥11.0	10.0-10.9	7.0-9.9	<7

Causes of Nutritional Anaemia in Children

Babies born on time build up a good supply of iron in their bodies, mostly in their liver—during the last three months of pregnancy. This stored iron is usually enough to keep them healthy for their first 6 months.

Once a baby reaches 6 months old, they grow very fast and use up these iron stores quickly. Because breast milk doesn't have enough iron on its own to keep up with this growth, babies need to start eating iron-rich solid foods right around 6 months, while still continuing to breastfeed.

The common causes of nutritional anaemia are:

1. Low iron stores at birth due to anaemia in mother.

2. Too early introduction of inappropriate complementary food i.e. before completion of 6 months of age (resulting in diminished breast milk intake, insufficient iron intake, and heightened risk of intestinal infections).

3. Late introduction of appropriate (iron-rich) complementary foods

4. Insufficient quantity of iron and iron enhancers in diet (foods rich in Vitamin C) and low availability of dietary iron (especially from vegetarian diet).

5. Iron loss due to parasite load (e.g. malaria, intestinal worms) and repeated infections.

6. Poor environmental sanitation, unsafe drinking water and inadequate personal hygiene leading to frequent illnesses

To overcome this problem, Government has launched Anemia Mukt Bharat campaign recently to promote Iron and Folic Acid (IFA) supplementation for prevention of anaemia in all children 6-59 months of age. The dose and regime of IFA supplementation and deworming under the programme is given below:

Age Group	Dose and regime
Iron Formulation	IFA syrup bottle (50ml) containing 20 mg of elemental iron and 100 mcg of folic acid per ml
Dosage	3 mg of elemental iron/kg/day for 3 months / as advised by treating paediatrician • For 6–12 months (6–10.9 kg): 1 ml IFA syrup Once a day for 3 months • For 1–3 years (11–14.9 kg): 1.5 ml IFA syrup Once a day for 3 months • For children 3–5 years (15–19.9 kg): 2ml IFA syrup Once a day for 3 months

IFA SUPPLEMENT

Source: Anaemia Mukta Bharat Operational Guidelines 2026

DEWORMING

Children and adolescents: To address the problem of transmission of worms from soil, the government has been implementing the National Deworming Day programme. The programme undertakes biannual mass deworming (albendazole tablet) campaign for children and adolescents in the age groups between 1 and 19 years on designated dates – 10th February and 10th August.

Table : Dose and regime for deworming

Age group	Dose and regime	Appropriate Administration
Less than 12 months of age	Not to be given	Not to be given

Age group	Dose and regime	Appropriate Administration
Children 12-24 months of age	Biannual dose of 400 mg albendazole (½ tablet)	Appropriate administration of tablets to children between the ages of 1 and 3 years is important. The tablet should be broken and crushed between two spoons, then safe water added to help administer the medicine.
Children 24-59 months of age	Biannual dose of 400 mg albendazole (1 tablet)	

Source: Anaemia Mukta Bharat Operational Guidelines 2026

Bi-weekly Iron-Folic Acid Supplementation and bi-annual deworming for children aged 6 months to 5 years (Compliance Card)

Mention date of provision of IFA bottle to mother	Bottle 1	Bottle 2	Bottle 3	Bottle 4	Bottle 5
	Bottle 6	Bottle 7	Bottle 8	Bottle 9	Bottle 10

Month-wise Bi-weekly IFA syrup supplementation

Age	Week	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
6-12 month	1 2 3 4 5												
1-2 Year	1 2 3 4 5												
2-3 Year	1 2 3 4 5												
3-4 Year	1 2 3 4 5												
4-5 Year	1 2 3 4 5												

Albendazole (write date)

Age	1-2 Year	2-3 Year	3-4 Year	4-5 Year
Dose - 1				
Dose - 2				

Important things to remember:

1. Provide iron folic acid (IFA) syrup every Wednesday and Saturday
2. Give 1 ml of Iron folic acid syrup using the auto-dispenser
3. Don't give iron folic acid syrup to a child when s/he is sick or severly undernourished
4. Always give iron folic acid syrup to the child after consumption of food
5. One 50-ml iron folic acid syrup bottle lasts for six months and once its finished, contact your ASHA/ANM didi for a new bottle
6. After giving a dose of iron folic acid syrup, mark a ✓ tick in the card
7. In case of any problem after consumption of iron folic acid syrup, contact your ANM immediately

IFA syrup will be provided bi-weekly and you will teach mothers/caregivers to provide the biweekly IFA dose to their children.

- You will be provided 50 ml IFA syrup bottle (with auto-dispenser) from PHC/Sub-centre; 2 bottles/ child/year (in first year of child, one 50 ml bottle will be required).
- You will write the date of giving the IFA syrup bottle to the
- mother/caregiver in the compliance card as given on page 27 in the MCP card.
- The IFA syrup bottles have an auto-dispenser so that only 1 ml of syrup will be dispensed at a time (having the required dosage for children).
- You can provide the 50 ml IFA syrup bottle (with auto-dispenser) to mothers/caregivers during home visits or utilize the platform of VHND/UHND or other dedicated rounds such as Vitamin A round, etc
- Albendazole tablets will be provided to children for biannual deworming, with dose as given in the table above (once in 6 months) during the National Deworming Day (10th February and 10th August every year). Under this strategy, under-five children, out-of school children and adolescents are provided deworming tablet at Anganwadi centres by AWWs, whereas school- going children and adolescents are provided the deworming treatment through school platform.

Role of ASHA in implementation of IFA supplementation and biannual deworming :

- Enumerate and line-list all the eligible children aged 6 to 59 months of age.
- Provide IFA syrup (1 ml) biweekly for the first week during your home visits.
- Demonstrate to the mothers/caregivers to provide IFA syrup through the auto- dispenser bottle.
- Ensure bi-annual deworming as well.

Follow these steps for giving IFA syrup:

a. Child must be held in the mother's/caregiver's lap.

b. Encourage the child to open the mouth.

c. If the child does not open the mouth, press the cheeks gently together for the mouth to open.

d. Shake the IFA syrup bottle well before use. Explain to the mother/caregiver that the entire dose of IFA syrup should be administered into the child's mouth and watch the child swallow the entire dose.

e. Explain to the mother/caregiver that child should be administered IFA syrup only on fixed days on a biweekly basis (preferably Wednesday and Saturday).

f. IFA should be given at least one hour after consumption of food (breastfed/ given semi solid food/solid food).

g. Mark a tick (√) in the compliance card as given on page 27 in the MCP card after giving the dose for the month-wise bi-weekly IFA syrup supplementation.

- Undertake fortnightly home visits from the second week onwards up to the month end (the remaining 6 doses for the month), and encourage the mothers/caregivers to administer IFA syrup to their child themselves in your presence. This would help in confidence

building of the mothers/caregivers in providing IFA syrup to her child.

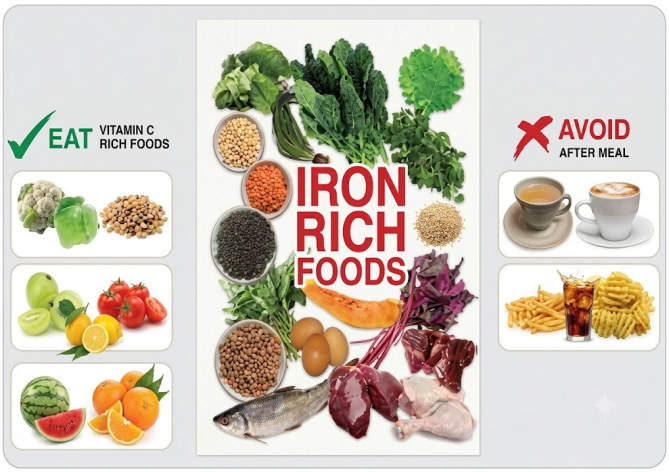
- Explain to the mother/caregiver to record compliance by marking a tick (√) in the compliance card as given on page 27 in the MCP card, in the month-wise bi-weekly IFA syrup supplementation section after giving every dose of iron folic acid syrup. After a month, the mothers/caregivers would acquire the required skills and confidence in providing IFA syrup to their child twice a week and marking the same in the compliance card.
- Regularly motivate the families who refuse to provide IFA syrup and albendazole tablets to their children. Undertake joint visits with ASHA Facilitator or ANM/MPW to difficult households where you are unable to convince the family for biweekly IFA supplementation and biannual deworming for children.
- During the home visits, you as an ASHA will counsel the mothers and caregivers about:
  - » Free availability of IFA syrup and deworming tablets at public health facilities and Anganwadi Centres.
  - » Benefit of IFA syrup for their child, improving iron and folate content of the diets and the importance of sanitation and hygienic practices in order to prevent anemia and worm infestation in the child.
  - » Importance of providing the IFA supplementation and biannual deworming in

children; its positive impact on physical and mental development of the child e.g. improvement in well being, attentiveness in studies etc.

- » Minor side effects associated with IFA administration such as black discolouration of stools.
- » Preservation of IFA bottle – in a cool and dark place, away from reach of children, keeping the lid of the bottle tightly closed each time after administration, etc.
- » Immediately contacting the ANM/MPW in case of any problem after consumption of iron folic acid syrup by the child.
- » Informing them to contact either you or the ANM / MPW for a new IFA syrup bottle if the bottle finishes.

- Monitor that the mother/caregiver has given IFA syrup to the child (by looking at the tick (√) in the MCP card on page 27).
- Encourage the mother/caregivers to include iron-rich and folic acid-rich foods in the diet of the child-dark green leafy vegetables like mustard leaves (sarson saag), drumstick, turnip leaves, fenugreek (methi), bathua, mint (pudina), amaranth (chaulai), spinach (palak), spring onion, colocasia (arbi) leaves, etc. ; ragi, whole wheat flour, pumpkin, raw banana (plantain banana), pulses (daals), legumes (rajmah, lobia, soyabean, black chickpeas (kala chana), jaggery (gur), fresh peas, fresh beans, nuts, dry dates, raisins, sesame (til) seeds, animal foods/ non-vegetarian sources like meat, liver, poultry, egg, fish, etc.

Advice to include foods containing Vitamin C like cauliflower, cabbage, tomato, watermelon, guava, orange, lemon, gooseberry (amla), sweet lime (mosambi), etc. and animal foods- meat, poultry, fish, liver, egg, etc., fermented and sprouted foods (grains and pulses), etc. as these increase the absorption of iron. Iron and folic acid fortified foods can also be included in the diet wherever available.



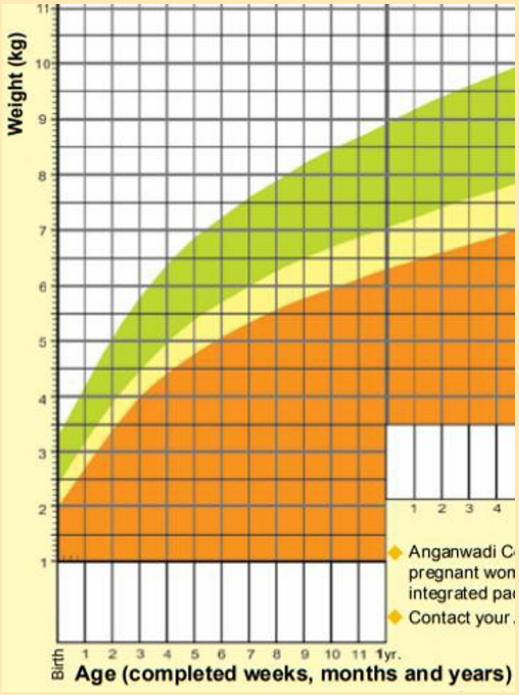
Provide mother / caregiver with the IFA syrup bottle and during your home visits ensure children receive biweekly IFA supplementation. Mobilise the families having children aged 12-59 months of age for biannual deworming with albendazole tablets

B.2.5 GROWTH MONITORING :

- Weight and length/height are the commonly used growth measurements in children.
- Length is recorded for children less than 2 years of age and height for children above 2 years of age.
- Growth monitoring means regularly measuring the child's weight and length/height and recording the measurements on the growth chart to see whether the child is growing well
- Growth monitoring helps in ascertaining if the child is growing adequately or not.

- Recording of child's weight should be done once every month up to age of 3 years and at least once in 3 months, thereafter. Length is to be recorded once in three months from birth to 2 years of age and height once in 6 months (2 years to 5 years of age).
- There are separate growth charts for girls and boys, as they have different weights and lengths/heights beginning at birth and grow to different sizes according to age. These are available in the MCP card.
- The AWW uses the growth chart for monitoring growth for every child, separately available for girls and boys. Every child in the village, should be weighed and her/his weight be plotted on the growth chart according to the age of the child.
- In addition, the length/height of the child will also be recorded in the growth chart given for weight-for-length/height.

Skills- Growth Chart Plotting



1. The left-hand vertical line is the measure of the child's weight

2. The bottom line of the chart shows the child's age in months

3. Find the point on the chart where the line for the child's weight meets the line for the child's age

Decide where the point is in relation to the curves:

4. If the point is below the bottom most (-3SD) curve, the child is severely underweight.

5. If the point is between 2nd and 3rd curve or exactly on the 3rd curve, the child is moderately underweight.

6. If the point is on or above the uppermost curve or between the curve and - 2SD (second curve) or exactly on the 2nd curve, then the child is normal

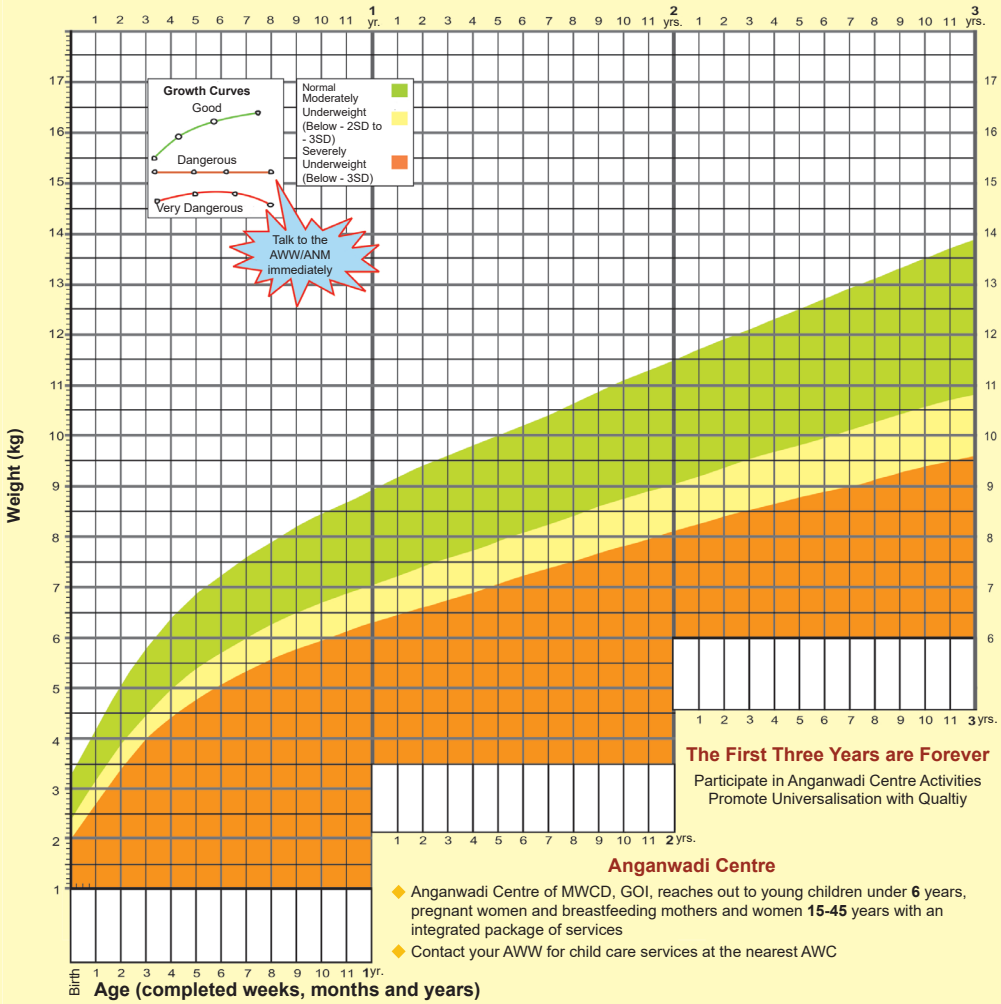
- The AWW will be responsible for recording weight and length/height of the child during VHSNDs/UHSNDs, or the ANM/MPW can also record the weight and length/height of the child in the SC or during outreach sessions.
- As part of your SSBSK visits, you need to ensure that the weight and length/height of the child is recorded by the AWW and details are made available to the mother/ caregiver by the AWW either in MCP card . If the weight and/or length/ height of the child is not recorded, you will mobilise and accompany the mother/caregiver to the nearest Anganwadi Centre (AWC) or AAMSHC for recording the weight and length/height of the child for ensuring growth monitoring.

ANNEXURE 4: Use of growth charts for girls and boys

ANNEXURE -4.1 Growth chart for GIRLS (Weight-for-age - Birth to 3 years)

GIRL: Weight-for-age - Birth to 3 years

(As per WHO Child Growth Standards)



The First Three Years are Forever

Participate in Anganwadi Centre Activities
Promote Universalisation with Qualtiy

Anganwadi Centre

- Anganwadi Centre of MWCD, GOI, reaches out to young children under **6** years, pregnant women and breastfeeding mothers and women **15-45** years with an integrated package of services
- Contact your AWW for child care services at the nearest AWC

Services at Anganwadi Centre

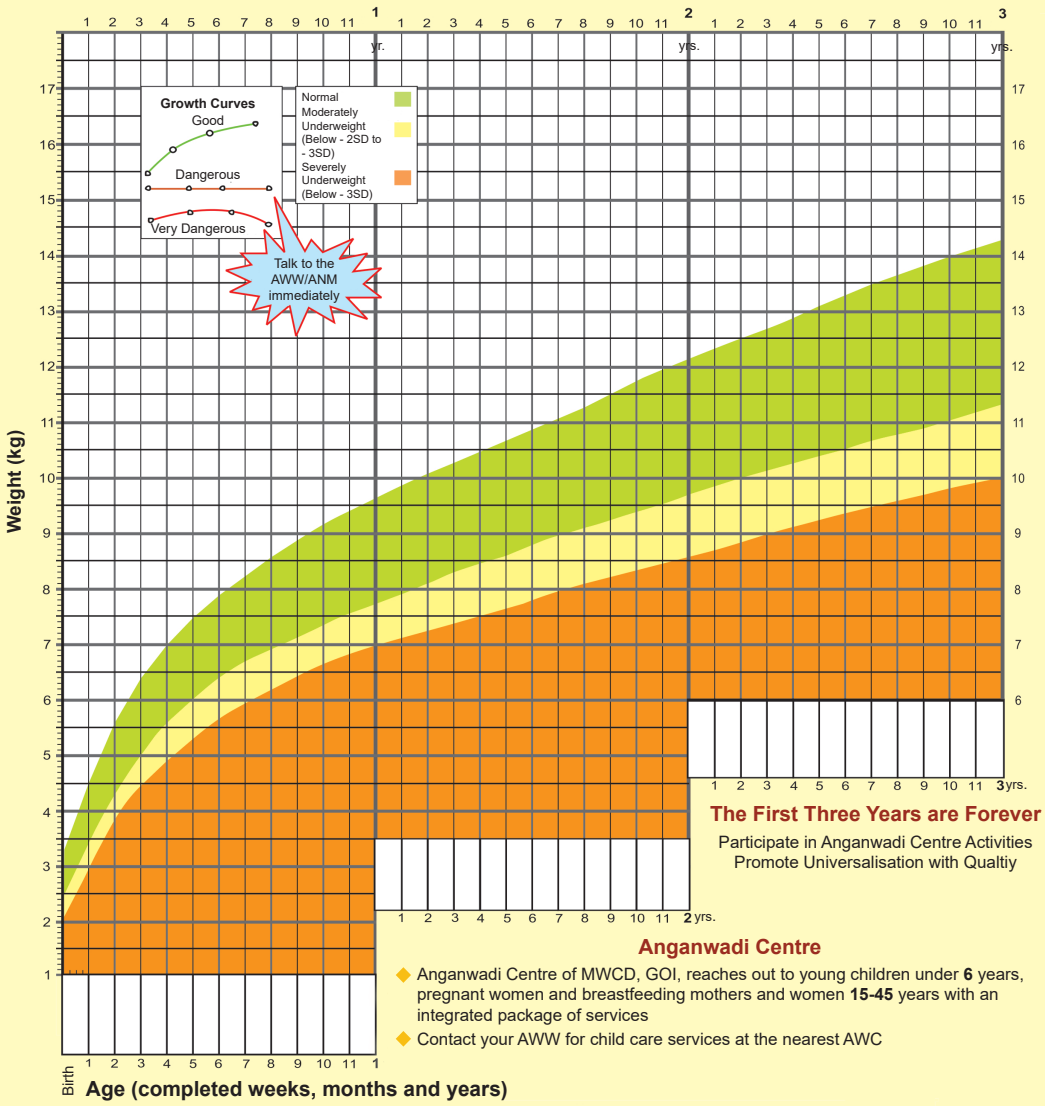
- Supplementary nutritional support, growth monitoring and promotion
- Nutrition and health education
- Immunization
- Health check-up
- Referral services
- Early childhood care and preschool education

Ensure equal care for the girl child

ANNEXURE -4.2 Growth chart for Boys (Weight-for-age - Birth to 3 years)

BOY: Weight-for-age - Birth to 3 years

(As per WHO Child Growth Standards)



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- Contact your AWW for child care services at the nearest AWC

Services at Anganwadi Centre

- Supplementary nutritional support, growth monitoring and promotion
- Nutrition and health education
- Immunization
- Health check-up
- Referral services
- Early childhood care and preschool education

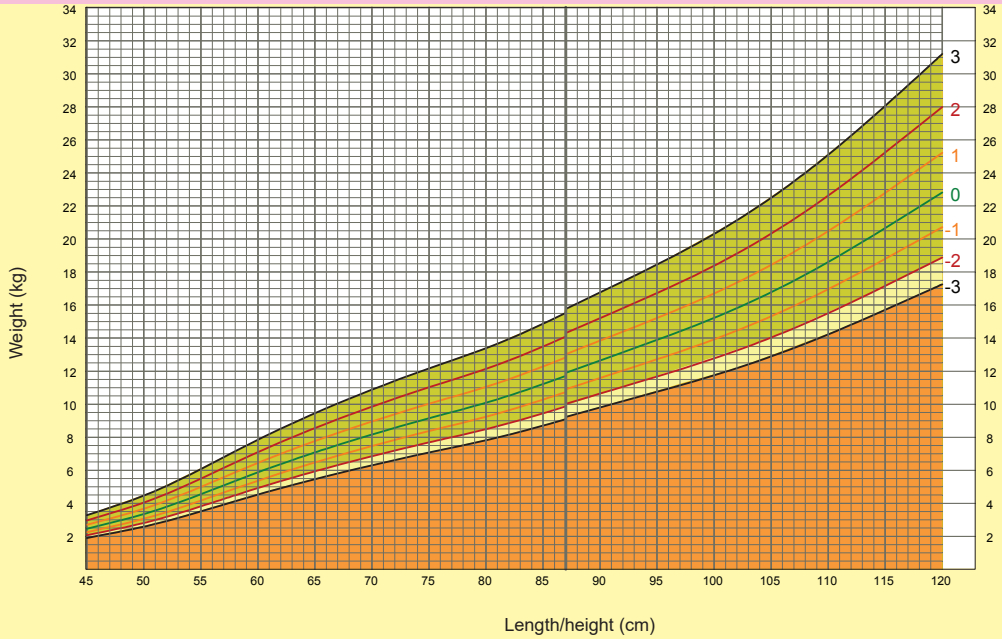
Have your child weighed at the AWC every month

Maximum growth happens in the first two years of life. A healthy child approximately doubles the birth weight at 5th month and is three times the birth weight by the first birthday. By the end of second year, the weight is 4 times the birth weight. We must understand that weight gain is not the only way to assess a child's growth.

ANNEXURE – 4.3 Growth chart for Girls (Weight-for-length/height)

Weight-for-length/height Girls

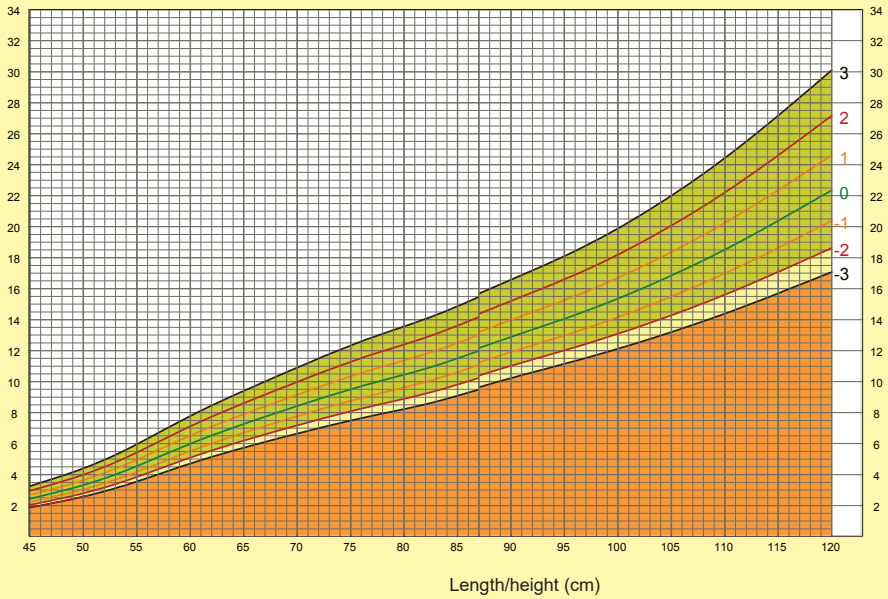
(As per WHO Child Growth Standards)



ANNEXURE – 4.4 Growth chart for BOYS (Weight-for-length/height)

Weight-for-length/height Boy

(As per WHO Child Growth Standards)



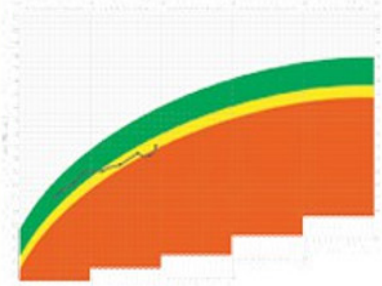
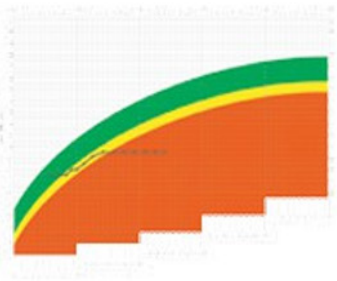
Increase in length or height of the child is also included in the growth pattern of the child. However, changes in child's length are slower than the weight. At the time of birth, the baby's length is around 50 cm. Expected gain in length in the first year after birth is 25 cms and in the second year is 12 cms, contributing to a total increase of 37 cms length/ height in the first two yea rs of life.

WHAT IS GROWTH FALTERING?

Growth faltering is the slowing or stopping of growth. It is a sign that something is wrong with the child and immediate action must be taken to restore growth. Monitoring or measuring growth regularly is important to see whether the child is growing properly.

By joining the weight dots on the growth chart, the curve (called growth curve) on the growth chart can be understood. The direction of the growth curve indicates the progress of the child and is helpful in providing appropriate counselling and initiating necessary actions such as referral etc. for malnourished children.

Table – Interpretation of growth curve

Good - Upward curve	Dangerous- Flat curve	Very Dangerous- Downward curve
The curve is moving upwards. Indicates adequate weight gain for the age of the child. The child is growing well and is healthy. 	The curve is flat, but has not gone down to another colour band. Indicates that the child is not gaining weight and is not growing adequately. This is called stagnation. The child needs extra attention of the mother. Also, the cause needs to be investigated. Talk to AWW/ ANM (MPW) immediately. Such children should be taken to a 24X7 PHC/UPHC or higher facility for a medical consultation. 	The curve is moving down, into another colour band. Indicates loss of weight. Talk to AWW/ANM (MPW) immediately. Child may be severely underweight and she/he needs urgent specialised medical care and immediate referral. 
Praise, and assess feeding to reinforce the good practices of the mother/caregiver.	Review feeding, praise what she is doing well and identify feeding problems, if any and give appropriate feeding advice for bringing about change. Check for any episode of illness. Take corrective action. Follow-up for compliance.	Follow- up after 5 days to ensure compliance.

As an ASHA you know how to check Oedema of both feet, To check for oedema (swelling due to fluid retention), grasp the foot so that it rests in your hand with your thumb on top of the foot. Press your thumb gently for a few seconds on the upper surface of each foot. The child has oedema if a pit (dent) remains in the foot when you lift your thumb. This is one of the ways to detect children with severe malnutrition in the community. Such children will require prompt hospitalisation in a Nutrition Rehabilitation Centre (NRC) in district hospital.

B.2.6 ROLE OF ASHA IN PROMOTING GROWTH MONITORING, PREVENTIVE AND PROMOTIVE COMMUNITY LEVEL CARE

Explain to the family the importance of weighing and measuring length/height regularly

- Discuss the trend of growth of the child with the mother/caregiver during each of the home visits by MCP card or as communicated by the AWW. Provide counselling depending on the direction of the growth curve in the MCP card or by the AWW.
- Prioritize and list children who are underweight, wasted, low birth weight, not gained weight for 2 months, are not growing well or who are 'at risk' of undernutrition due to frequent illnesses like fever, diarrhoea and acute respiratory infection; children with inadequate or insufficient dietary intake, mother with illness or those living in unhygienic conditions, etc., should also be weighed frequently for corrective and timely action.
- Facilitate & ensure early registration of all children soon after birth at the nearest AWC to avail the child care services like supplementary nutritional support, growth monitoring, immunization, early child care, health check-up, referral services, etc.
- Facilitate in ensuring that children from 6 months to 15 months are provided Take Home Ration (THR) at the AWC.
- Counsel the mother/caregiver regarding promotion of exclusive breastfeeding for the first six months of a child's life, age-appropriate complementary feeding practices for all children aged 6–24 months along with breastfeeding, importance of hand-washing, using clean drinking water and its storage, safe sanitation and hygiene practices, age-specific immunization, appropriate play and communication with the child, etc.
- Pay extra attention to malnourished children, sick children, low birth weight children, etc. and refer to the health facility for further management. Follow-up with mother/caregiver to ensure adherence to treatment plan suggested by health facility/ RBSK team.
- Use platforms like VHSNC/MAS, VHND/UHND, camps, mother support groups, self-help groups, community meetings, etc. to disseminate the importance of growth monitoring and finding suitable measures for rehabilitation and management of the malnourished children.
- Explore the option of using untied funds of VHSNC/MAS to meet the special care needs of malnourished children if required.

A nine-month-old girl with a weight of 8 kg and looks pale . She is being breastfed and only this month was started on complementary food. She eats rice and dal from her parents' plate while they are eating, once at about 10.00 am and then about

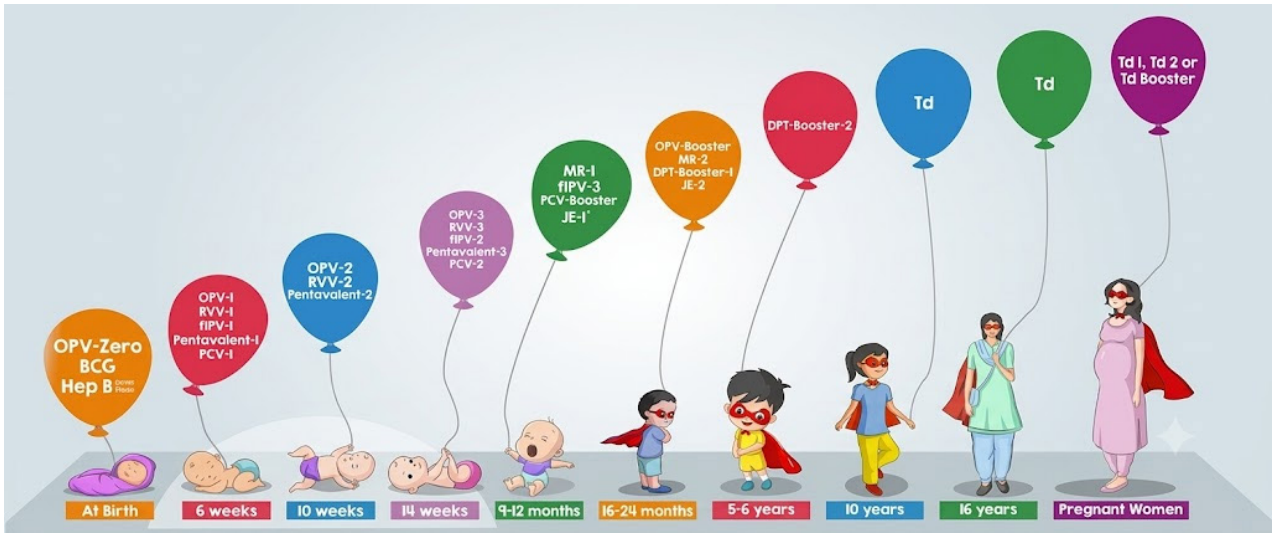
6.00 p.m. She had diarrhea once, one month ago, but no other illness. ASHA gave her ORS and she became alright with it. She does not go to the Anganwadi or get rations from there. Her immunization is on schedule. Can you help her? How will you as an ASHA go about it?

A.2.7 FULL IMMUNIZATION OF CHILDREN :

Immunization

Immunization is one of the safest and most effective methods of preventing diseases. Under the Universal Immunization Programme (UIP), significant achievements have been made in preventing and controlling the Vaccine

Preventable Diseases (VPDs). Immunization helps maintain polio-free status, supports measles-rubella elimination and prevents serious vaccine-preventable diseases. The immunization schedule for newborns, infant and children along with dosage and route & site of administration is below:



The following are the targeted vaccine preventable diseases under Universal Immunization Program:

1. Severe form of childhood Tuberculosis
2. Poliomyelitis
3. Diphtheria
4. Pertussis
5. Tetanus
6. Hepatitis B
7. Diarrhoea due to Rota virus
8. Measles
9. Rubella
10. Japanese Encephalitis
11. Haemophilus Influenzae Type b

related diseases

12. Pneumococcus related diseases

All these diseases can affect children, cause serious illness and sometimes even death . Availability of effective vaccines helps us to protect our children from these diseases .

Vaccines help the body in developing ability to fight infection so that even if the disease germs enter the body later, the child does not fall ill or even if he/she does fall ill the illness is mild and does not lead to disability or death.

Immunization:

- Saves lives
- Prevents disability
- Protects children, mothers, and the community

Vaccines under UIP are **safe, effective, and provided free of cost at government facilities.**

You, as ASHA are the most important pillar of the immunization program because you educate the mother , make her aware of the importance of vaccination , enrol the child for vaccination and then track and ensure that the infant / child gets all the vaccine doses and on time.

With the use of vaccines we have managed to make our country **Polio free**, we have eliminated **Maternal and Neonatal Tetanus** and have managed to reduce and control the other vaccine preventable diseases.

National Immunisation Schedule is given below :

Vaccine and mode of administration	Age of administration	Maximum age*	Message to mother
For newborns and infants			
BCG (Injection)	At birth	Upto one year of age	Protects the baby against severe or serious TB illness
Hepatitis B birth dose (Injection)	At birth	Within 24 hrs after birth	Protects the baby against hepatitis B infection and its serious complications, including chronic liver disease.
b OPV 0 (oral)	At birth	Within the first 15 days of age	Protects the baby against the polio and paralytic disease
b OPV1,2,3 (oral)	At 6, 10, and 14 weeks of age	Till five years of age	

Vaccine and mode of administration	Age of administration	Maximum age*	Message to mother
Rotavirus vaccine 1, 2 and 3 (oral)	At 6, 10, and 14 weeks of age	1 year of age	Protects the child against the repeated diarrhoea caused by Rota virus
f-IPV1, 2	At 6 weeks, 14 weeks	1 year of age	Protects the baby against the polio and paralytic disease
Pneumococcal Conjugate Vaccine (PCV) (2 Primary + 1 booster)	At 6 weeks, 14 weeks for primary doses and 9 to 11 month of age for booster dose	1 year of age	Protects the baby against a serious form of pneumonia
(Injectable)			
Pentavalent 1,2 and 3 (Injectable)	At 6 , 10 , and 14 wks of age	1 year of age	**Protects against five serious diseases – Pertussis, Diptheria, Tetanus , pneumonia / meningitis causes by HiB , Hepatitis B
Measles Rubella Vaccine (MR) Ist dose (Injectable)	9-11 months of age	5 years of age	Protects against measles and rubella
Japanese Encephalitis – 1* (in selected districts) (Injectable)	9-11 months of age	2 years of age	Protects against infection of brain by this virus
Vitamin A (oral)	9 months with MR 1st dose	5 years of age	Is important for health of eyes / a good vision and protects against diseases.
For Children			
BOPV Booster (oral)	16-23 months of age	5 years of age	Same as described above, all doses are required for the vaccine to be fully effective and best possible protection
MR 2nd dose (Injectable)	16-23 months of age	5 years of age	
DPT Booster 1 (Injectable)	16-23 months of age	7 years of age	

Vaccine and mode of administration	Age of administration	Maximum age*	Message to mother
JE vaccine 2nd dose (in selected districts) (Injectable)	16-23 months of age	2 years of age	
Vitamin A (2nd to 9th dose) (oral)	16-23 months of age with MR 2nd dose, subsequent doses at an interval of 6 months, upto 5 years of age	5 years of age	
DPT Booster 2 (Injectable)	5 to 6 years of age	7 years of age	
Td (Injectable)	10 and 16 years of age	16 years of age	At 10 and 16 years Td is given which is available in health facilities and also outreach camps held in schools or community .

*For optimum protection, vaccine should be administered at the prescribed age of vaccination. However maximum age gives the limit upto which age the vaccine can be administered under the UIP.

Definitions you should know :

Full Immunization: Child who has received BCG, 3 doses of bOPV, 3 doses of Pentavalent and 1 dose of MR by first year of age. This is the historical definition used for survey and evaluation purposes and hence has been continued-Full Immunization coverage (FIC).

FIC plus: Child who has received all the vaccines given in the Universal Immunization Programme (UIP) by one year of age.

Complete Immunization: Child who has received all the vaccines given in the Universal Immunization Programme (UIP) by two years of age.

Left-out: Child who has not received any vaccine under UIP (unimmunized).

Drop-out: Child who has received one or more UIP vaccine/s but did not complete the schedule as per the age (partially immunized).

Zero-dose (operational & reporting purpose): Child who has not received first dose of Pentavalent vaccine by one year of age.

Newborns and Children get their vaccines in:

i. Hospital after birth and before they are discharged .

ii. AAM-SHC or AAM-PHC

iii. Outreach immunization session / VHND / UHND.

B.2.8 MICROPLANNING

MICROPLANNING for Routine Immunization:

Routine Immunization (RI) of all eligible children in the community is achieved through an elaborate exercise of microplanning. This detailed planning includes how many times , where and when the immunization sessions would be conducted as well as ensured availability of logistics and vaccines, their transport, meticulous management of cold chain etc. ANM / MO / district and State level personnel are involved. This plan is based on the information collected by you as an ASHA while carrying out your house to house survey . During the survey , information of beneficiaries – eligible children and pregnant women, their number and geographical distribution is collected by you and submitted to your ANM . She then compiles it for her area and proceeds to create her area microplan. This information is collected and submitted in **Head Count Survey forms - SC 3 and Forms SC-4A, SC-4B and SC-4C.**

A household is defined on the basis of “Kitchen“or “Chullah” like if a family has brothers living in one house but has separate chulla, then house holds are counted and marked based on chullas just like in polio microplans.

Know your area:

For an accurate house to house survey for beneficiary head count , you as an ASHA must know your area thoroughly - both the demography and the geography so that no household is missed. You should be aware of the High Risk Areas (HRAs) in your assigned population and the same should be mapped in your area map . Both migratory (Slums with migration; nomads; construction sites, migrants in tea/coffee estates, riverine areas with shifting populations etc) and the non-migratory HRAs (Habitations around brick kilns; fishermen villages, settled slums - notified and non-notified and hard to reach areas should be marked on your map and listed in your list.

Conducting head count survey at village /ward :

The head count survey or house-to-house survey is the most important step of Routine Immunisation (RI) microplanning process. The objective of the headcount survey is to reach the entire population and list out all target beneficiaries (pregnant women, children 0-2 years and children between 2-5 years who have missed the due vaccines/doses of MR, OPV, DPT including boosters). It is conducted by trained ASHA/AWW/Link worker/surveyor.

Preparations for head count survey:

- Your area is clearly demarcated
- You have been trained for the activity
- Necessary logistics like forms, map, chalks etc are available
- You are motivated to visit all the areas and NOT to leave out any beneficiary during the Head Count Survey (HCS)

During the survey

A maximum of 25 to 30 households should be covered per day in rural areas; in urban and densely populated areas the number may be more; fewer houses can be covered in remote and hard to reach areas

All the households in the area are covered in a systematic way. Refer Polio house to house microplan for assistance, if needed

At each house:

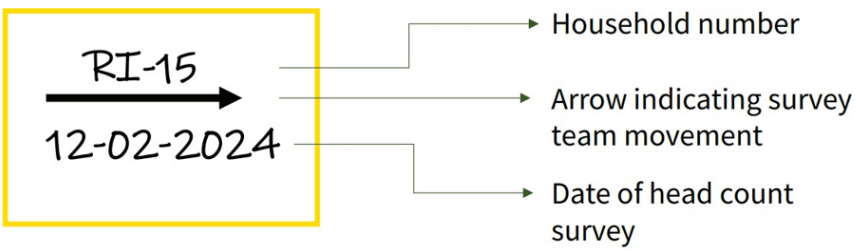
- Greet the family and explain the purpose of visit
- Document the details of first house owner and last house owner for the day
- Information of all households to be entered in house-to-house survey form **(Form SC-3)**
- If the team identifies target beneficiaries, their details with vaccination status (as per MCP/ RI card) is entered in the relevant form **(SC-4A, 4B,4C).**

House to house survey forms used by surveyor:

HEAD COUNT SURVEY FORMS to be filled by ASHA, AWWs, Link worker, other surveyors	SC - 3	Provides total number of households and target beneficiaries' - pregnant women and all children in the age group of 0 to 2 years, 2-5 years (Children who have missed MR 1, MR2, DPT, OPV and JE vaccines) in the area.
	SC - 4A	List of pregnant women - vaccination status and ANC Visits.
	SC - 4B	List of children upto 2 years including new borns with vaccination status.
	SC-4C	List of children between 2-5 years missed for due vaccine doses (Children who have missed MR 1, MR2, DPT, OPV and JE vaccine).

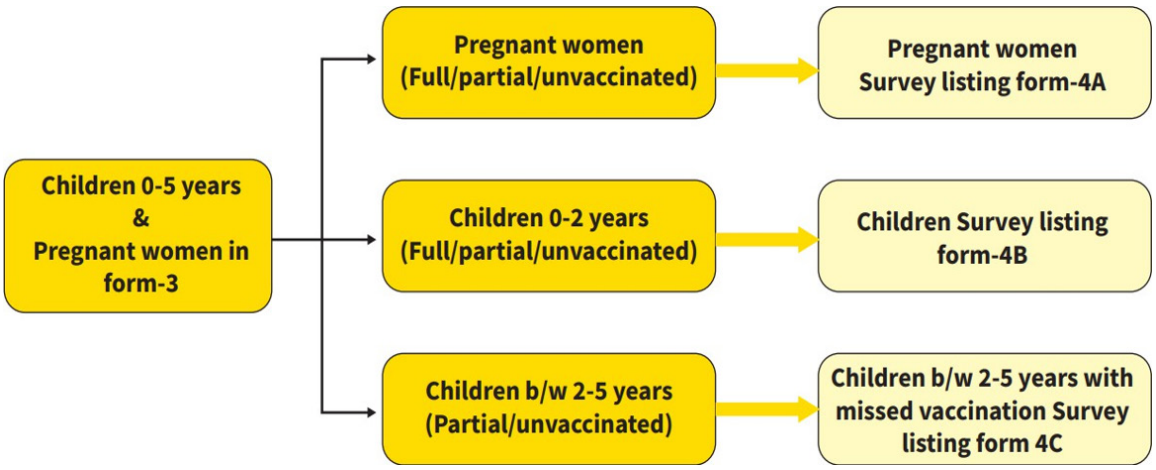
House marking should be done with chalk/geru indicating the serial No of the household and date of survey, as shown below :

This survey should not be done on RI days and may be completed in 7 to 10 days.



House marking during house-to-house survey for RI RI-15 12-02-2024 14-10/04/16 Household number Date of head count survey Arrow indicating survey team movement

Flow Chart of Head count survey documentation in formats



Outputs expected:

- Completion of house-to-house survey in all the areas
- Enlisting all target beneficiaries residing in the area

Role and responsibilities:

Personnel	Activities to be performed	Supervisor
ANM	• Area demarcation for ASHAs/AWWs • Develop a timeline for survey • Facilitate ASHA/AWW/ Link worker/ other surveyor for survey • Supervise and validate head count survey with field visits	MO/LHV/ Health supervisor
ASHA, Link worker, MAS, others	• Conduct survey and fill Forms SC-3, 4A, 4B, 4C • Identify beneficiaries/HRAs/missed areas/ dropouts/left outs	ANM/ASHA facilitator

First house visited today - House No. :_____ Last house visited today - House No. :_____

Name: _____ Address with Name: _____ Address with

	Family Details				Pregnant Woman	Children 0 to 2 years			Children 2 to 5 years	
HH no. (as per chullah)	Name of head of family	Name of Husband (for PW) / Father (for child) / Gaurdian	Contact Number	Total number of family members living in this household? *(Include All adults & children including new borns)*	No. of Pregnant Woman *(if present mention details in form SC-4A)*	No. of children aged less than 1 month *(if present mention details in form SC-4B)*	No. of children aged between 1 month upto 1 year *(if present mention details in form SC-4B)*	No. of children aged between 1 to 2 Years *(if present mention details in form SC-4B)*	No. of children aged between 2 to 5 Years	No. of children 2 to 5 Years MISSED MR-1/ MR-2 dose /DPT/ OPV/ boosters *(if present mention details in form SC-4C)*
A	B	C	D	E	F	G	H	I	J	K

							Td Vaccination			Ante Natal Check Up				For ANM only	
HH no. (as per form SC 3)	Name of the pregnant woman	Year of birth	Age in years	Husband's name	Mobile Number	MCP card number / UWIN ref ID	Expected date of delivery / LMP	Td-1	Td-2	Td-Booster (If 2 doses of Td given within 3 years of the current pregnancy)	1st ANC	2nd ANC	3rd ANC	4th ANC	Td due - Y/N	ANC due - Y/N
A	B	C		D	E	F	G	H			I				J	
								Date/Y/N	Date/Y/N	Date/Y/N	Date	Date	Date	Date		

SOPs for filling Form SC-3:

Each household is to be identified by a number (Column A). **This is the household identification number.**

- The numbering of households is to be continuous until the area is completed
- The assessment of the area may take more than one day but the numbering of the houses will be in serial order for the entire area
- Restart of numbering will be done when a new area is being assessed by the same person
- House marking should be done with chalk/geru indicating the serial No of the household and date of survey
- Interview each household and gather information on the head of household (Column B), name of father/ mother to be included in column C, any contact number in column D and the total number of members in each household (Column E). This must include all newborn children
- Next, enquire if there is any currently pregnant woman in this household. This does not depend on if she is a resident / visitor to the area. Include all pregnant women as each is a beneficiary. If yes, mention number (Column F) and collect information on the pregnant woman and enter in Form 4A
- Similarly for Columns G, H, I, J & K enquire if there is:
  - » Newborn child or child up to 1 month of age, mention the number in Column G
  - » Child/ children between 1 month and 1 year of age, mention the number in Column H
  - » Child/ children between 1 and 2 years of age, mention the number in Column I
  - » Child/ children between 2 and 5 years of age, mention the number in Column J
  - » Missed child/ children between 2 and 5 years of age, mention the number in Column K
  - » If a child/ children is identified in any of these columns, mention the number and enter information on the newborn/infant/child in Form 4B and children who have missed MR-1/ MR-2/ DPT/ OPV/ JE including boosters in SC-4C

SOP for filling RI Form SC-4A: Head Count Survey of Pregnant Women

- Form SC-4A has to be filled when a pregnant woman is identified in Form SC-3 Column F. The number in Column A must be the same as that used to identify the household in Form 3.
- If there is more than one pregnant woman in a house, the same number will have to be entered for each of these pregnant women in separate rows. This number is a unique number that will link the pregnant woman to the house details.
- Columns B, C, D and E are for information which identifies the pregnant woman.
- Column F. Enquire from the woman, if she has been issued a mother and child protection (MCP) card and registered in U-WIN. If she has MCP card or U-WIN reference ID, enter card number or U-WIN number in column F. If she does not have a card, then information should be shared with the ANM of the area to ensure that a card is issued to her. Also, if U-WIN reference ID is not available with the beneficiary, efforts should be made to check for U-WIN registration. If not registered, efforts should be made to register the pregnant

woman in U-WIN.

- Column G. Determine the expected date of delivery (EDD) of the child. This can be sourced from the RI/MCP card if available or from the mother herself. If she is unaware, then determine the EDD as best as possible by assessing her date of last menstrual period (LMP). (Surveyor can consult ANM who can refer to the EDD ready reckoner from RCH register/ training manual).
- The administration of Td vaccine to pregnant women as per the UIP schedule prevents maternal and neonatal tetanus; details of the same are to be entered in the three H Columns.
- Antenatal check-ups help to identify a high-risk pregnancy and reduce chances of any complications. Details of these checks are to be entered in the four I Columns.
- Column J. This is for the ANM to enter if the woman is due for any ANC or Td vaccination. These two columns make it easier for the ANM to extract the information and develop the beneficiary due list for each RI session.
- The dates of administration of Td injections and ANC check-ups should ideally be obtained from the RI/MCP card.

SOP for filling form 4B:

- Column A. The number in Column A must be the same as that used to identify the household in Form 3. If there is more than one child in a house, the same number will have to be entered for each of these children.
- Columns B, C, D, E and F. These columns are used to collect identification information of each child. Attempt to collect the latest mobile number from the parent/household.
- Column G and H - Enquire if the infant/child has been issued an RI/MCP card. If the child has MCP card or U-WIN reference ID, enter card number or U-WIN number in column G. If MCP card not available, information should be shared with the ANM of the area to ensure that a card is issued at the earliest. Also, if U-WIN reference ID is not available with the beneficiary, efforts should be made to check for U-WIN registration. If not registered,efforts should be made to register the child in U-WIN.
- Column H- This records detail of vaccines administered at birth. Dates of administration of BCG, bOPV birth dose and Hepatitis B (within 24 h) are to be mentioned
- Column I- Dates of administration of Penta 1, Rotavirus 1 (where applicable), PCV 1 (where applicable), fIPV 1 and bOPV 1
- Column J- Dates of administration of Penta 2, Rotavirus 2 (where applicable) and bOPV 2
- Column K- Dates of administration of Penta 3, Rotavirus 3 (where applicable), PCV 2 (where applicable), fIPV 2, and bOPV3
- Column L- Enter the dates of administration of vaccines due between the age of 9 – 11 months– MR first dose, Vitamin A, PCV Booster (where applicable), fIPV 3 and JE (where applicable) vaccines
- Column M- Record whether the child is fully immunized – encircle “Yes” or “No”. A child is to be considered as fully immunized plus (FIC plus) if s/he has received all due vaccines up to 1 year of age.
- Column N- Dates of administration of vaccines due for a child between the ages of 1 and 2 years are to be entered in column O. This includes MR 2, DPT-1 booster, bOPV booster dose and JE 2 vaccine (where applicable).

- Column O- Record whether the child is completely immunized– encircle “Yes” or “No”. A child is to be considered as completely immunized if s/he has received all the due vaccines up to 2 years of age.
- RI Form 4C–List of children between 2-5 years missed for MR/DPT/Penta/ OPV doses This form collates the information of list of children between 2-5 years missed for MR/ DPT/ Penta/ OPV doses identified during the house-to-house survey.

SOP for filling form 4C:

- Column A. The number in Column A must be the same as that used to identify the household in Form 3. If there is more than one child in a house, the same number will have to be entered for each of these children.
- Columns B, C, D, E and F. These columns are used to collect identification information of each missed child. Attempt to collect the latest mobile number from the parent/ household.
- Column G - Enquire if the infant/child has been issued an RI/MCP card or have U-WIN reference ID. If the child has MCP card or U-WIN reference ID, enter card number or U-WIN number in column G.
- If MCP card not available, information should be shared with the ANM of the area to ensure that a card is issued at the earliest. Also, if U-WIN reference ID is not available with the beneficiary, efforts should be ensured to check for U-WIN registration. If not registered, efforts should be made to register the child in U-WIN.
- Columns H to Q - These columns are used to collect information on MISSED VACCINE DOSE/ DOSES for MR/ OPV/Penta/ DPT doses. Encircle ‘Y’, if the child has MISSED the vaccine and ‘N’, if the child has RECIEVED the vaccine.
- Columns R to AA - These columns are used to TRACK THE VACCINATION STATUS OF MISSED CHILDREN. The missed children found during head count survey are mobilized to RI session for vaccination of missed dose/s. After vaccination, the date of vaccination of the missed dose/s is/ are to be updated in the columns (R to AA) as per vaccine dose received.

U-WIN

U-WIN is a web based software tool for recording & reporting of each and every vaccination provided under Universal Immunization Programme (UIP). The software also provides real time information on vaccine stock & storage temperature across all cold-chain points in the country. All efforts should be made to identify and register all the beneficiaries on U-WIN.

The software is accessed by health functionaries at different levels and used for creating sessions/updating sessions/entering beneficiaries details/updating their vaccination status/generating vaccination certificates / entering the stocks and tracking their utilization/reporting AEFIs etc .

As an ASHA you have access to the mobilizer module. Once the session has been created in U-WIN, then you will be able to see the detail of the sessions through this module.

- As the mobilizer you can view the list of vaccinated and due beneficiaries in your catchment area
- For the eligible beneficiaries not registered (as per paper-based due-list), you can pre-register the beneficiary or facilitate registration on session site by ANM or guiding beneficiary to register by self-registration on portal
- You can also download e-vaccination certificate for the vaccinated beneficiaries

B.2.9 CONDUCT OF THE IMMUNIZATION SESSION

You as an ASHA are important and active member of the team conducting an immunization session, more so when it is done in an outreach mode and would be participating in following activities.

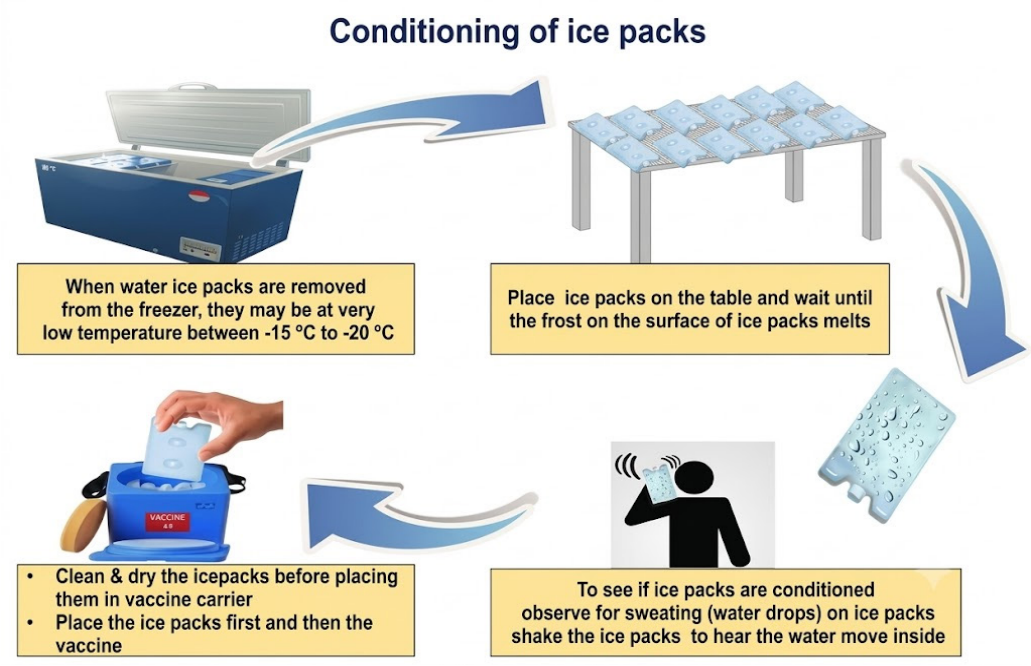
Transporting the vaccines to the vaccination site (Outreach session site): Although the vaccine carrier is packed by the ANM , you might be required to help her in the activity , and you should have basic knowledge of how vaccines are to be packed and transported to the vaccination site.

Vaccine Carrier: You are all familiar with the vaccine carriers. It is an insulated box used for carrying vaccines (16-20 vials) and diluents from PHC/Cold-chain point to session sites and to bring back the open vials (under the open vial policy) from the session sites to the cold-chain point on same day after the session, for storage and subsequent use.

Vaccine carrier (with 4 conditioned icepacks) maintains the inside temperature between +2°C to +8°C for 12 hours, if not opened frequently.

Packing a vaccine carrier:

- Confirm that there are no cracks in the walls of the vaccine carrier
- Take out the required number of icepacks from the deep freezer. Keep them outside for conditioning and wiped them dry before placing into carrier.
- Place four conditioned icepacks into the vaccine carrier along the sides.



The vaccines and diluents to be taken to the session are placed in a Zipper bag by the ANM and zipped .

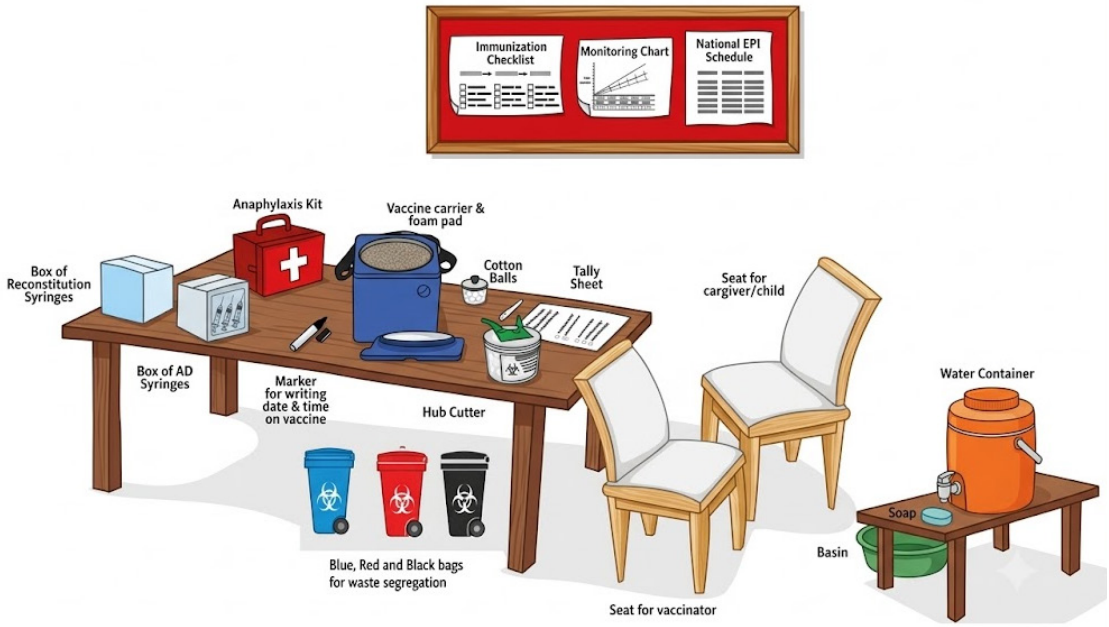
- Put the vaccines with diluents in polythene zipper bag, ensure the zipper bag is zipped properly. Place some packing material between `T' series vaccines (DPT, Td, Pentavalent and Hepatitis B vaccines) and the icepacks to prevent them from touching the icepacks
- The plastic zipper bag is placed in the centre away from the icepacks
- Foam pad is placed on top of the icepacks
- If more than one vaccine carrier is being carried, then the whole range of the vaccines required for the day's use are placed in each carrier so that only one carrier is opened at a time

During the conduct of session , you provide valuable support to the ANM through following activities –

i. Helping in selection of session site .

ii. Preparing the session site on day of immunization session – sourcing of furnitute from local area / neighbours , helping in arrangement of equipment and logistics.

Ideal layout for vaccination site :



iii. Arrangement at the vaccination session site. Vaccine carrier / Hub Cutter /• Immunization cards and records, dry Cotton swabs should be kept on the table. Red and black bags, blue puncture proof container/ hub cutter for disposing immunization waste should be available and kept in place.

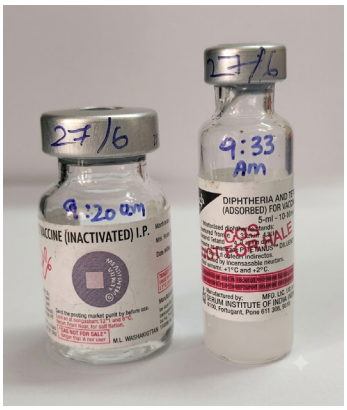
A bowl, water and soap for washing hands clean should be available.

AEFI Kit availability is ensured and kept within easy reach.

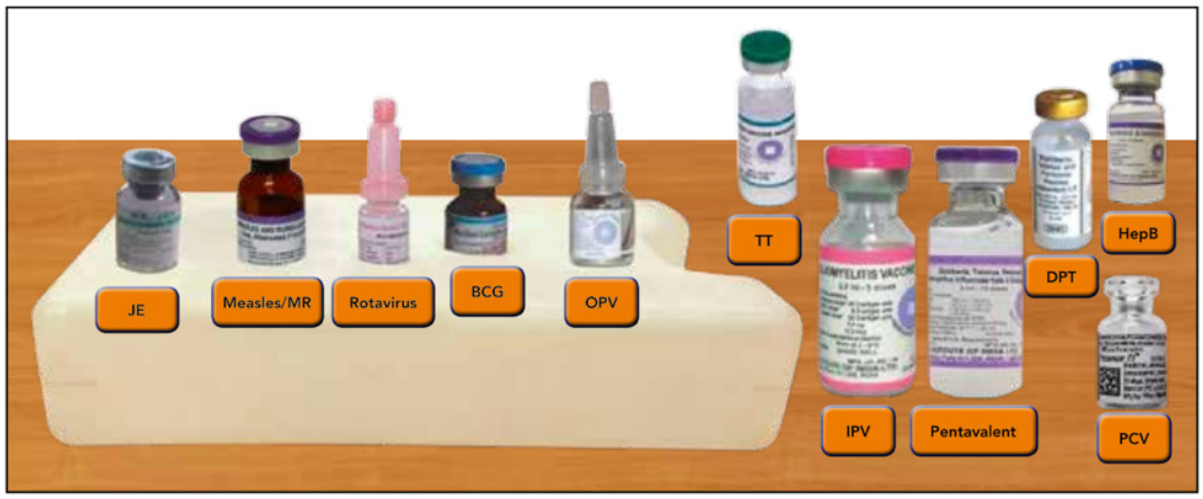
iv. Cold-chain maintenance during the immunization session:

- The vaccinator inspects for and discards vaccine vials with visible contamination or breaches of integrity (e.g. cracks, leaks).

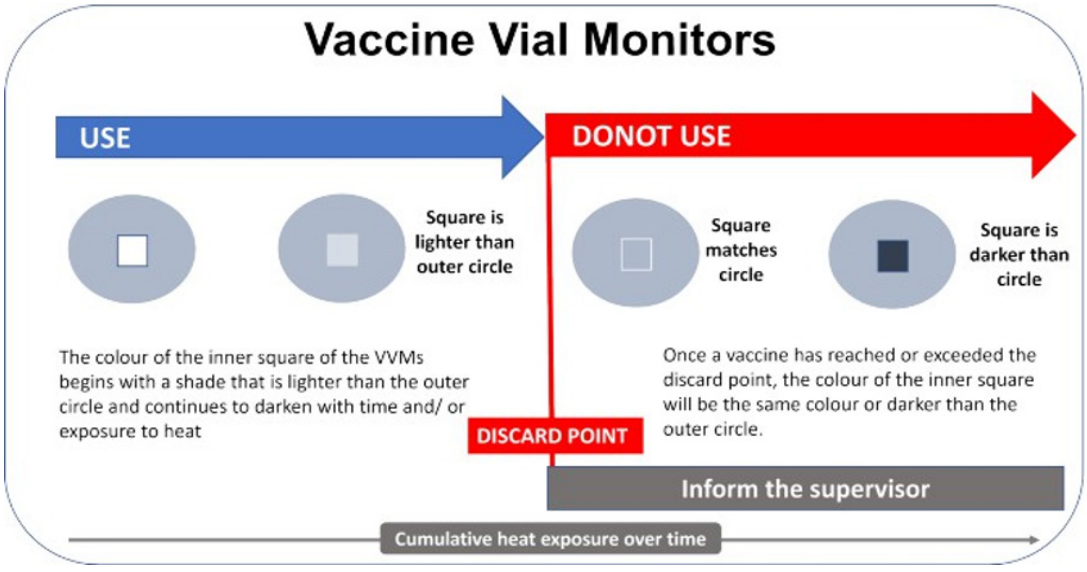
- Vaccinator must mark (in permanent marker) the vaccine vial with date & time of opening on the cap of the vial at first use.
- While moving the vial take care “NOT TO TOUCH THE SEPTUM”
- OPV vial dropper should be recapped with stopper (small cap) after each use and kept on the icepack.
- Do not keep freeze sensitive vaccines like Hepatitis B, Pentavalent, DPT, Td, PCV and JE (Inactivated) vaccines on the ice pack. BCG, OPV, MR, RVV and JE (live attenuated) vaccines on the ice pack as shown in fig below.



Placement of vaccines at the RI session site:

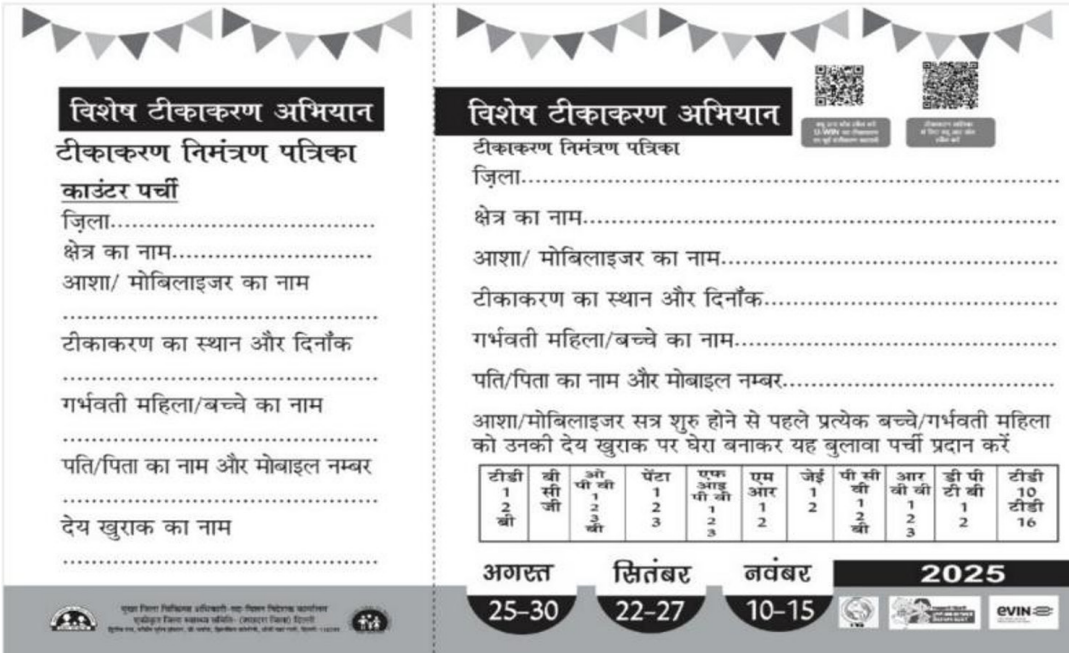


Vaccine Vial Monitor : All vaccine vials have VVM appropriately displayed on them and VVM is checked before using the vaccines.



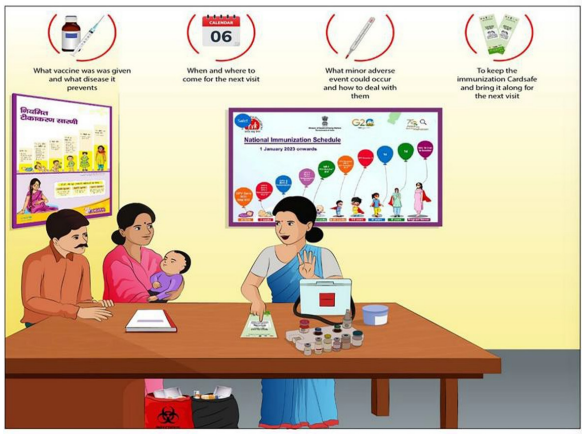
Mobilization of the beneficiaries: This is perhaps the most critical activity for you as an ASHA. All eligible beneficiaries including the pregnant women and children as per the due list needs to be mobilized to the session site .

- For this the families of eligible beneficiaries are informed in advance about date, site and time of the immunization session and their vaccine due and that they should carry their MCP card with them.
- You can use innovative methods like Nimantran patra being handed to the families informing them of the date of the outreach session and inviting them to bring their child who is due for vaccination. These are given before the outreach session day so that families know and can plan to be there in the session.
- You can design your own cards relevant to your local context.
- Escorting the mother/caregiver and child to the session/ health centre for immunization may be required for families living in remote areas or those having sick children, malnourished children, girl child, etc.



Four key messages after vaccination:

- Explain the diseases against which the vaccination protects, use simple terms (in the local language). If there is a poster or chart, use it to help in your explanation.
- Mention possible adverse events and explain how to handle them
- Explain the need for the child/beneficiary to return as per the immunization schedule to be fully protected. Tell when and where to come for next vaccination



- Remind the caregiver to bring the immunization card when they bring the child back for the next vaccination

All infants should be immunized except in these situations:

- Severely sick child, where the caregiver is asked to come on next available session after the child recovers.
- If the infant has had anaphylaxis (a serious allergic reaction) or other severe reaction to a previous dose of the vaccine or a vaccine component.
- Vaccination of a known immunocompromised (HIV/ on steroid/ chemotherapy, etc.) child should be done in consultation with the treating physician.
- High fever (>38.5°C). However , mild illness is not a contraindication and the same can be explained to the caregiver , but even after this , if the caregiver objects to immunization, vaccine should not be given. In this situation the caregiver can be asked to come back when the infant is well.

Vaccinate malnourished children as per schedule as they are more prone for vaccine preventable diseases.

Closing the session:

1. After immunization session is over the vaccine vials (used and unused) are segregated and kept inside in separate properly sealed zipper pouch/bag in the vaccine carrier under the cold-chain and the carrier is picked up by the AVD mechanism and delivered at the designated vaccine/ cold storage point. The site is left clean and tidy.

2. Specifically, after using an outreach site:

- Nothing that might be a health threat to the community should be left behind .
- The table / chairs and other equipment are cleaned and returned to their owners
- Local people who have helped to organize the session must be thanked and reminded of the date of the next session

3. Steps to ensure safe disposal of immunization waste :

- When the ANM uses hub cuter, the cut needles get collected in the puncture-proof container of the hub cutter which prevents needle stick injuries (NSI) associated with recapping and any re-usage of needles.
- The plastic portion of the cut syringes and plastic ampoules/ plastic diluents are segregated and stored into the red bag/container. At outreach session site, red bag bearing the biohazard symbol is used to carry plastic portion of the syringes, used cotton swabs contaminated with blood and used but unbroken vials, discarded medicines, empty Vitamin A bottles.
- Broken Vials/Diluents/Vitamin A bottles are stored in a separate sturdy and puncture proof container or in the same hub cutter, in case its capacity is also able to accommodate broken vials.
- Packaging material, plastic wrappers of the syringe, empty paper/ cardboard boxes and cap of the needle to go into black bag or container as a dry general waste. These are disposed off in the the black bag as general waste.
- From an outreach session the red, black bag, and the hub cutter are transported to designated Cold-chain Point (PHC/UPHC/DH/SDH/RH/CHC) OR Health Care Facility (HCF) for disinfection and disposal by the designated person as per biomedical waste guidelines.

Tracking and ensuring timely and complete vaccination of each child is one of your most important responsibilities .

- After the end of the session, check from your due list who all have not come for vaccination. Add names/ details of children who have come for vaccination but were not there in your beneficiary list. Ideally this number should be zero or minimal.
- Add the children who did not come in the due list for next session and track them .Remind families about next due date and ensure their complete immunization as per schedule.
- Find out reasons for missing the immunization session and address the same - discussed later.

B.2.10 ADVERSE EVENT FOLLOWING IMMUNIZATION (AEFI)

Adverse event following immunization (AEFI) is defined as any untoward medical occurrence which follows immunization, and which does not necessarily have a causal relationship with the usage of the vaccine.

Types of AEFIs: Based specifically on the severity, cause and frequency, vaccine reactions or AEFIs may be broadly grouped as under:

I. AEFIs by severity of the event:

a) Minor reactions (common)

b) Severe vaccine reactions (uncommon)

c) Serious vaccine reactions (rare)

II. Cause-specific AEFIs:

a) Vaccine product-related reactions

b) Vaccine quality defect-related reactions

c) Immunization error-related reactions

d) Immunization-triggered stress response (ITSR)

e) Coincidental events

I. AEFIs by severity of the event: For the purpose of reporting, AEFIs can be minor, severe and serious. Most vaccine reactions are minor and settle on their own. Severe and serious reactions are rare.

Minor vaccine reactions:

Local reaction, fever and systemic symptoms can result as part of the immune response. In addition, some of the vaccine's components (e.g. aluminium adjuvant, stabilizers or preservatives) can lead to reactions.

Local reactions (pain, swelling and/or redness at the injection site) and fever can be expected in one in ten vaccinees . In DPT, or tetanus-adult diphtheria (Td) boosters, this is more frequent where up to 50% can be affected. BCG causes a specific local reaction that starts as a papule (lump) two or more weeks after immunization, which becomes ulcerated and heals after several months, leaving a scar. Measles/MR vaccine causes fever, rash and/or conjunctivitis, and affects 5–15% of recipients.

Serious and severe vaccine reactions:

Severe AEFI: AEFIs that are clinically more severe than minor AEFIs but do not have

characteristics of serious category are reported as severe AEFIs. This category includes cases that are clinically severe, but do not need admission in hospital and/or are treated in OPD/daycare or could not be admitted due to any reason. Examples: seizures, prolonged crying, fall in platelets. These also need to be reported.

Serious AEFI: An AEFI will be considered serious if it results in death, requires hospitalization, results in persistent or significant disability/incapacity or congenital anomaly/birth defect or a cluster (two or more cases) of AEFIs occur in a geographical area or the AEFI evokes community concern.

Cause -specific type of AEFI :

S.No	Cause -specific type of AEFI	Definition
1.	Immunization error-related reaction	An event that is caused by inappropriate vaccine handling, prescribing or administration and thus by its nature is preventable.
2.	Vaccine product-related reaction	Vaccine product-related reaction is an event that is caused or precipitated by a vaccine due to one or more of the inherent properties of the vaccine product.
3.	Vaccine quality defect related reaction	A vaccine quality defect-related reaction is an event caused by a defect in the vaccine that occurred during the manufacturing process.
4.	Immunization triggered stress response (earlier Immunization anxietyrelated reaction)	An event arising from anxiety about the immunization.
5.	Coincidental event	An event that is caused by something other than the vaccine product, immunization error or immunization anxiety.

Coincidental events - this means that the event has occurred after immunization and is not caused due to the vaccine or process of administration. These events have only a temporal association, i.e., event happening after immunization, and are not causally related. Vaccines are normally scheduled early in life when infections and other illnesses are common, or when underlying congenital or neurological conditions are manifested. It is, therefore, possible to encounter many events, including deaths, which may be falsely attributed to vaccine through chance association. Immediate investigation as a response is critical to the community's concern about vaccine safety and to maintain public confidence in immunization.

Managing the AEFIs: Health workers must be vigilant so that AEFIs can be prevented, detected timely and managed.

Preparedness:

- Ensure that recipients wait for 30 minutes at session site after vaccination.
- To reduce chances of occurrence of Immunization stress related responses, minimize overcrowding.

- Ensure privacy during the procedure and keep the beneficiaries engaged during the observation period.
- After vaccination, the vaccine recipient must be informed.

i. About any minor events which may occur such as mild to moderate fever, local pain and swelling at injection site, malaise, etc. can happen and can be relieved with Syrup Paracetamol or tablet Paracetamol (for adults) in the doses as prescribed with a minimum interval of 4-6 hours between two doses .and a maximum of four doses in 24 hours .

ii. Ask the beneficiary to visit the nearest health facility, if minor adverse events persist beyond 2-3 days

iii. In case of adverse event / discomfort / illness, other than minor events, the beneficiary must visit the nearest health facility .

Managing AEFI when it occurs :

When a serious or severe adverse event occurs, the beneficiary is immediately:

- Provided first aid: lay child flat; patency of airway is ensured . If child is unconscious, he / she is placed in semi-prone position.
- Referred to MO (PHC) or nearest AEFI management centre for prompt treatment , accompanied by the ANM / ASHA if needed.
- MO (PHC) at the health centre is informed immediately by the fastest means possible e.g. telephonically.
- AEFI is reported and investigated.

Anaphylaxis and its manifestation:

Anaphylaxis is a very rare but severe and potentially fatal allergic reaction.

The whole body is affected, often within minutes of exposure to the allergen (substance causing the allergic reaction), but sometimes after hours. It occurs because the immune system overreacts to an allergen and causes secretion of chemical substances that cause swelling of blood vessels.

Common allergens include foods such as peanuts, dairy products, eggs, etc. and non-foods suchas wasp or bee sting, medications, vaccines, latex, etc. The symptoms of an anaphylactic reaction include generalized flushing of the skin, nettle rash (hives) anywhere on the body, swelling of throat and mouth, difficulty in swallowing or speaking, alterations in heart rate, severe asthma, abdominal pain, nausea and vomiting, sudden feeling of weakness (drop in blood pressure), collapse and unconsciousness.

Angioedema

Cyanosis

Urticaria

Recognition of anaphylaxis In anaphylaxis, there is sudden onset of symptoms which rapidly worsens. Individual may complain of difficulty in breathing

and/or giddiness/loss of consciousness, hypotension, skin changes such as generalized rashes, swelling of the lips and tongue (angioedema), hives (urticaria) and flushing. The person may have had a severe allergic reaction or anaphylaxis in the past. However, this may be the first time. Sudden onset and rapid progression of ≥ 1 signs and symptoms of any of the two systems (respiratory, cardiovascular and dermatological/ mucosal) should be suspected as a case of anaphylaxis.

Prompt recognition of anaphylaxis , first aid and administration of Inj Adrenaline by the ANM, followed by immediate shifting to the health facilty linked for AEFI management can prove to be life saving .

Treat minor/non-serious AEFIs symptomatically as per Table below:

Some common minor adverse events following immunization are local reactions, pain at injection site and fever. High-grade fever following vaccination may precipitate febrile seizure in susceptible infants.

Minor vaccine reactions	Treatment	When to report
Local reaction (pain, swelling, redness)	• Cold cloth at injection site • Give Paracetamol	• In case of an abscess
Fever > 38.5°C	• Give extra fluids • Give tepid sponging • Give Paracetamol	• When accompanied by other symptoms
Irritability, malaise and systemic symptoms	• Give extra fluids • Give Paracetamol	• When severe or unusual

Use of syrup Paracetamol following vaccinations

The ANM should give age-appropriate dose to all children who have got Pentavalent vaccine or DPT with an instruction to give Paracetamol in case of fever or pain in injection site. The recommended dose of Paracetamol is 10-15mg/kg body weight every 4-6 hours with a maximum dose of four doses in 24 hours. The recommended doses and frequency of administration of Paracetamol syrup (125 mg/5 ml) as per age is as follows:

Age wise dose of Paracetamol syrup (125 mg/5 ml) in infants

Age group*	Dose	How often (in 24 hours)
6 weeks-6 months	2.5 ml	**SOS or 4-6 hourly following vaccination#**
6-24 months	5 ml	
2-4 years	7.5 ml	
4-6 years	10 ml	

*Paracetamol is not recommended in children weighing less than 2 kg.

#Maximum four doses in 24 hours with a gap of atleast four hours between two doses.

Note:

1. Dispense one bottle of 60 ml syrup Paracetamol 125 mg/5 ml after every dose of Pentavalent and DPT.

2. Use the dosage chart to choose volume of single dose of Paracetamol required to be given as per age group.

3. Show the mark on the cap till which the syrup has to be filled to the caregiver and instruct to:

- Administer age-appropriate dose of syrup Paracetamol ONLY WHEN THERE IS FEVER.
- Not administer more than four doses a day
- USE only the cap supplied with the Paracetamol syrup bottle to measure and administer syrup Paracetamol to the child
- Shake the bottle for 10 seconds before use if suspension is supplied in place of syrup.
- Refer the child to a doctor if the fever is >38°C (100.4° Fahrenheit)

In case of AEFI other than minor AEFI , refer the child to CHO / MO . Refer immediately to the nearest linked health facility identified for managing AEFI in case of

- High fever
- Convulsions
- Excessive crying
- Swelling of face or difficulty in breathing
- Baby becomes pale and limp
- Immediately inform the ANM, MO by telephone about the AEFI
- Help the parents access medical care by arranging referral transport.Accompany the parents if so required
- Assist the team in AEFI investigation
- Support ANM / CHO in sustaining confidence of the community in vaccines and vaccination. You must follow up/ inquire about the condition of the child and also inform the CHO / ANM

Responsibilities in AEFI surveillance at community level :

- Report all AEFIs (including the minor ones) to your ANM.
- Regular follow up with beneficiaries to identify AEFIs after the vaccination session, using the beneficiaries' list provided by the ANM.
- Inform the adverse event immediately by telephone to concerned ANM, MO, etc.
- Assist in referral of any suspected cases and assist the team investigating the event.
- Support in building community confidence.

B.2.11 COMMUNICATION:

The goal of health workers is to ensure that all children in Sub Health Centre/ ANM area are fully immunized before their first birthday. From a behavioral perspective, a large percentage of children who are not brought for vaccination or who discontinue vaccination before completion indicates a non-seriousness on the part of parents is a serious problem because it reflects the low priority accorded to immunization which may stem from different reasons.

Possible reasons for low immunization , leftout children and and dropouts

- Lack of awareness of benefits of routine immunization- Families/caregivers are unaware regarding the benefits of Routine Immunization (RI).
- Lack of information- The healthcare providers have not informed the families/ caregivers about what vaccines are due, when they are due and why they are needed.
- Migration : Often families migrate for livelihood and children belonging to these families miss out on vaccination.
- Unreached population- There are usually the vulnerable or marginalised populations who do not know about immunization or face socio-economic barriers to utilize health services.
- Geographic barrier- People living too far away from a health centre or outreach site are unable to travel long distances and face challenges in completing a full immunization schedule for children.
- Resistant population- Families do not believe in immunization services, even though a health centre is within reach, as there is fear of side effects, etc. Fear of AEFI is also a major cause of refusal of vaccines. There is refusal of vaccination due to myths, rumors and misconceptions prevalent in few sections of the society.
- Missed opportunities- Seen in case of children who visit the health centre for some other reason but are not screened for immunization by health workers.
- Gender barrier- Sometimes women are not allowed to attend sessions by their family members. Also, if it is a girl child, family members may not give importance to her vaccination.
- Financial barrier- Sometimes families do not attend immunization sessions because of wage loss, etc.

Effective communication:

Effective communication using all possible channels is required to convince the parents / caregivers about importance of vaccination , allay their fears about side effects and dispel the myths which keep them away from vaccinating their children.

1. Interpersonal communication at the households/ individuallevel is the core communication strategy which informs,clarifies and empowers individuals to make changes in theimmunization behaviours. Establishing trust relationship is imperative between the providers and the communities. It calls for specific skills and values for Inter Personal Communication (IPC) sessions to be effective. IPC sessions provide an opportunity for the caregivers/communities to engage in an open dialogue/ discussion on immunization, importance of immunization, details of age specific vaccinations that are due for the child, where, when the immunization sessions are conducted in the community help them make decisions on vaccinating their children. Frontline workers are expected to engage with communities in IPC sessions, provide useful information in a socio-culturally acceptable manner, use tools to engage with the caregiver and link them to the services.

IPC sessions are conducted during the home visits and during the community meetings to mobilize the caregivers and communities to accept the vaccination.

ANMs/ ASHAs/AWWs are critical link between health services and communities. Front Line Workers (FLWs) need to be trained from time to time to be able to effectively communicate with parents/ caregivers and mobilize them to get their children vaccinated. It is important that their interpersonal communication skills be strengthened. They also need to be equipped with appropriate knowledge about vaccines and their benefits, and how to counter prevailing myths and misconceptions on immunization with facts. A simple IPC approach, **GATHER (Greet, Ask, Tell, Help, Explain and Return)** already explained in part A should be used when interacting with the parents / care givers.

Tips for effective IPC skills for communicating with caregivers - GATHER Approach

Speak clearly

- Use encouraging/helpful non-verbal communication
- Posture – keep your head level
- Spend enough time; do not be in a hurry
- Use responses and gestures to show interest
- Listen carefully and repeat what the mother says

Greet

- Smile. Speak in a pleasant voice and tone
- Maintain eye contact
- Introduce yourself and your organization

Ask

- Ask open-ended questions—What? When? Where? Why? How? Who?
- How many children do you have?
- Why did you not vaccinate your child?
- How did you know about the immunization session?

Tell

- What diseases are prevented by vaccination?
- Where and when will the session be held?
- What minor side-effects can occur after vaccination and how these can be managed?

Help:

Encourage the parents to come for vaccination by telling them about how to manage AEFIs.

Explain:

Use info-kits to explain the importance of immunization and the immunization schedule.

Repeat/Return/Referral:

Use your visit to find out reasons for leftouts and dropouts. Praise and encourage the family for ensuring their child's immunization if all necessary vaccines have been given. Identify family constraints/ reasons for missed immunization and support or counsel to address the same.

Emphasize

- Importance of timely vaccination
- Vaccines are safe and free
- Mild fever or swelling after vaccination is normal
- Immunization should not be stopped due to minor illness

Myth	ASHA's Correct Message
Vaccines cause infertility	Vaccines are safe and tested and do not cause infertility
Too many injections harm child	Multiple vaccines as per the Schedule are safe and are required in order to give maximum protection to the infant / child.

Inform when and where the family can take the child for the next vaccination, for a missed vaccine, or if a vaccine is due soon.

2. IEC materials display: Increasing visibility and awareness of immunization. Display of IEC materials such as poster/ banners/ hoarding/ wall paintings increase the visibility of immunization programme. MOHFW shares the creatives on RI which needs to be printed, distributed and ensure its appropriate use. If needed, customize to the local context (change of language or visual as necessary).

3. Help your CHO / ANM in following activities:

- » Sensitization of and engagement with PRIs/ religious leaders / teachers/ Ration shop dealers/ influencers
- » Community meetings with caregivers . Fathers/ mothers meetings
- » Organization of rallies, announcements through mosques
- » Mid media activities like nukkad natak, cycle prachar, miking, etc.
- » Maximizing the community platforms for convergence
- » Identification of Immunization Champions/Role Models

» Enroll help of VHSNC/MAS members who can play an important role to motivate resistant families for immunization.

Remember:

- Pay special attention to include children from families who are vulnerable or marginalised, sick, LBW and malnourished infants. Joint visits may be undertaken with ASHA Facilitators and ANMs/ MPW to mobilize these children for immunization.
- Initiate community level action to enable positioning of ANM/MPW and AWW in sub-centres/ AWCs in hamlets or urban slums/basti which do have these frontline functionaries.
- Some hamlets or urban slums/ basti have neither MPW or Anganwadi centre/worker taking care of their health needs. This needs to be corrected. As an immediate step, a women representative of the hamlet/slum can be included into the 'village health and sanitation nutrition committee'.

Special immunization drives/campaigns:

You as an ASHA also take part in special immunization drives /campaigns from time to time. These drives are time-bound, mission-mode activities launched to improve coverage, close gaps, or respond to public health priorities. Most use UIP vaccines, but the delivery strategy is intensified.

Some examples of special immunization drives include :

a. Mission Indradhanush for covering missed children and pregnant women

b. Intensified Mission Indradhanush for rapid coverage in low-performing areas

c. Pulse Polio to maintain polio-free status

d. MR Campaigns for measles and rubella elimination

e. Urban Drives to improve coverage in slums/migrant areas

f. JE Campaigns to prevent Japanese Encephalitis outbreaks

g. To Control outbreaks (Measles / Diptheria / Cholera)

Records and Documentation :

As an ASHA you should be familiar with the MCP card and should always carry one as it can serve as a valuable visual aid while explaining to the mother and referencing the national schedule.

Your records pertaining to immunization include :

1. Household register

2. Work Diary which has the line list of all children immunized / in process of being immunized which is updated after every vaccination session .

3. Your survey findings (SC 3, SC 4 – A, B, C)

4. Your beneficiary due lists.

B.2.12 EARLY CHILDHOOD DEVELOPMENT (ECD)

Key Messages for Parents

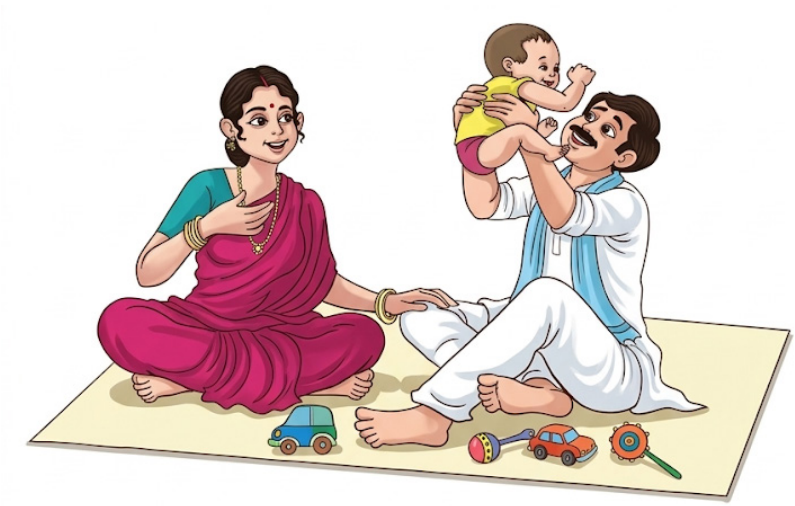
- A child's brain grows the fastest during late pregnancy and the first three years of life. This is the most critical time to support their development.
- Babies begin learning from the moment they are born. Stimulate their senses with touch, talk, and play right from birth to help their brain develop.
- Low birth weight, preterm babies, and those discharged from newborn care units need extra stimulation and care to thrive and grow well.
- Supporting brain growth is just as important as physical growth for child's future health, learning, and well-being.

In this section you will learn:

- What are development milestones?
- What is the use of Early Childhood Development Kit?
- What do you understand by safe environment for the children?

Development

Proper growth and brain development during the early childhood period is closely related to the enabling environment and encouragement of young children provided by parents/ caregivers through-



- Playing
- Communicating-talking and smiling
- Responding appropriately to what the child communicates- for example, hunger, pain and discomfort, interest in something, or affection

Active participation of all family members/caregivers besides the mother like father, mother-in-law, father-in-law, other family members is important for growth and development of the child and also builds a strong, healthy relationship between family members/caregivers and the child. Involvement of family members also provides support to the mother to take adequate rest and provides her time to engage in other activities.

As an ASHA, you can play an important role in encouraging and explaining the family members the importance of Early Childhood Development and role of their appropriate communication with the child in ensuring the child's proper growth and development.

Tracking Develomental Milestones :

Developmental milestones are activities that most children can do by a certain age. It is important for you as an ASHA to learn about the age-specific activities of children and also what parenting tips you can offer to the family members to help the child achieve these milestones.

Low weight babies, malnourished children, sick children, children discharged from SNCU/NBSU/NRC etc. need extra stimulation with play and communication activities, to grow and develop well. Families of such children should be constantly encouraged and motivated to play and communicate with their children.

If the child seems 'slow' or 'unable to respond', families must be encouraged to provide extra care-play and communicate with the child through touch and movement.

What are developmental delays :

Child development is the period of growth (physical, mental and social) that begins at birth and continues through early adulthood.

- Developmental delay is a term used when a child's development is delayed in one or more areas compared to other children.
- Parents and others become aware of delay when the child does not achieve some or all of the milestones at the expected age.
- Other children may present with behavior problems, which may be associated with delayed development.

One of your role as an ASHA under SSBSK is to help the parents/caregivers in providing support for early childhood development during your home visits for young children (3 months up to 3 years). The MCP card (page 12-25) provides details of milestones of children from 2-3 months of age up to 3 years of age, which is divided in three sections. These are "what most babies do", "parenting tips for children" and "warning signs".

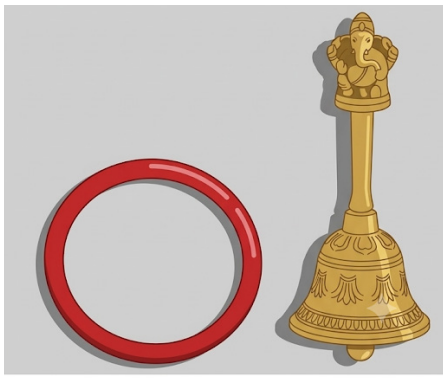
Being an ASHA, you will undertake the following activities during the household visits to support the early childhood development

a. Help the mother/caregivers understand what most babies do at a specific age-This is done by using the MCP card section on 'What most babies do' (page 12-21), to track progress on development milestones of the child. There are certain milestones that have been given for 2-3 months to 3 years of age.

b. Teach the mothers/caregivers to undertake milestone assessment- You will need to teach mothers and caregivers the right method to observe and elicit information for various milestones at a particular age. You can use this tool to teach the mother and caregivers

to conduct an assessment for the milestones achieved by the child at a particular age. The tool provides details of normal milestones/ expected activities that are undertaken by the child at a particular age, what are the ways to observe these milestones and warning signs that require referral. You will need to teach the mother/caregiver, age-specific milestone assessments prior to your scheduled SSBSK visit for the particular age group. For example- To assess the milestone assessment by mother/caregiver at 3 months, you will have to teach them the assessment during your 42nd day of SSBSKvisit or any other in-between contact with the family. Likewise, for assessment at 6 months, you will need to inform mother/caregiver about milestone assessment for this age-group during your 3rd month household visit. Such a pattern will be required for subsequent age groups till 15 months of age of the child.

c. Demonstrate the use of local toys/items to elicit information on milestones-The LTMA mentions using a set of commonly available items for teaching the mothers/caregivers conduct age-specific milestone assessment for the child. These items are easily available, locally in your village/slum area and can be collected while planning your HBNCC visits to demonstrate use of these items to the mothers and caregivers.



d. Inform mothers/caregivers to record observations in the MCP Card- Once the mothers/ caregivers have learnt to conduct the age specific milestone assessment for their child, you will inform them to record their observations for each activity in the child's MCP card on the first day that their child performs these activities. For the child who is able to perform the age specific activity, the parents/caregivers will need to a provide a tick mark (√) against the specific activity in the MCP card. For any activity that the child is unable to perform the parents/ caregivers will leave the box blank ( ) in the MCP card for the activity concerned. You will explain the mothers/caregivers that they should not worry or panic even if the child is unable to perform some of these activities at the specific age mentioned in the MCP card because each child is unique and not all children develop at the same rate. Timings of development milestone could vary from child to child. Some children show an interest or skills in an activity earlier than others or later than others. Some children develop very early, such as learning how to walk or talk much earlier than other children of the same age. Thus, at any circumstance a mother/caregiver is not expected to a put a cross mark (X) in the blank box ( ) provided in the MCP card against these activities.

Do not forget to inform the mother/caregiver that the MCP card will serve as a photo-album for their child. They should preserve it because it is the health record for the child and she/he will find it interesting and will be happy to see her/his developmental journey later in life.

e. Verify the milestone assessment records undertaken by mothers/caregivers- You or the AWW during the home visits, will verify the milestones by examining the child for all the

activities as listed for a particular age of the child. In the MCP card, in 'what most babies do' section, there is a row where you will record your findings after confirming the activities being undertaken by the child. After making the observations, you will provide a tick mark (√) in the box if all the activity milestones for that particular age are being conducted by the child and mark cross (X) on the card, even if one activity is not achieved by the child at that particular age. ***The (X) sign should be put only after you have assessed and ensured that child had cooperated well, is otherwise active but is still unable to perform the particular activity.***

After making the observations for a particular age group, before leaving the household, do not forget to teach the mother/caregiver, the methods to observe and elicit information for milestone assessments for the subsequent age group.

f. While verifying the records if the box provided for the mother/caregiver is left blank- You must confirm whether the mother/caregiver has not marked a tick (√) because she/he has missed recording the particular activity or the child is unable to perform this activity. If any activity for milestone assessment has not been assessed by the mother/caregiver, explain them again the importance of conducting these activities with the child. You should then conduct the assessment for the child and provide a tick mark (√) against that activity if the child is able to do the activity concerned. If not, a cross sign (X) will be included in the box and in your next visit you will follow- up for achievement of that particular milestone which the child was unable to perform.

g. Look for "warning" signs as provided in the MCP card for each age group of the child and refer the child to ANM (MPW) or AWW or healthcare provider immediately in case you notice even a single 'warning' sign.

- Sensitise the parents/caregivers about the "warning" signs- This is given in the MCP card (page 12-21) and also in the learning tool for milestone assessment. On completion of a particular age, inform the families to contact ANM (MPW)/ AWW/health care provider or yourself immediately if the family members see any of "warning" sign for a particular age, for providing support and appropriate treatment at the healthcare facility.

h. Provide parenting tips to support early childhood development in children-As mentioned above, the parenting tips to the family as given in the MCP card (page 12-21), provides information on how to achieve the age-specific milestones. As an ASHA, you are going to help the parent/caregiver to play and communicate with the child appropriately for the age you need to provide the following counselling tips to the parent/ caregiver to support child's development.

- If the parents/caregivers do not play with the child, discuss ways to help child see, hear, feel and move, appropriate for child's age and ask caregiver to do play or communication activity, appropriate for age. Encourage the family members to use non-sharp household objects that are clean and safe for the child for playing, if the household does not have toys for the child to play.
- If the parent/caregiver does not talk to child or talks

harshly to child and child is less than 6 months, ask caregiver to look into child's eye and talk to the child. For older children, give caregiver and child an activity to do together. Help caregiver understand what child is doing and thinking and see if child responds and smiles. Help the caregiver in understanding that talking before the child talks prepares the child for talking, as children copy speech and actions of others around them.

- If the parent/caregiver is unable to make the child smile or child is non-responsive, ask caregiver to make gestures and cooing sounds; copy child's sounds and gestures and see child's responses. Inform them about ways to make the child smile- e.g. make a funny face, gently rub the child's tummy, clap their hands, play games with the child, etc.

- If the parent/caregiver shows anger at the child, help caregiver distract child from unwanted actions by giving alternative toy or activity.
- If the parent/caregiver is not able to comfort child and child does not look at the caregiver for comfort, help caregiver to look into child's eye and gently talk to child and hold child.
- If the parent/caregiver says the child is slow to learn, encourage more activity with the child, check hearing and vision. Refer child with difficulties to the nearest health centre.

Undertaking milestone Assessment to track early childhood development during the home visits with the help of MCP card.

Step 1: Messages to be shared

1. A child's brain grows the fastest during late pregnancy and the first two years of

life and is most sensitive to care and stimulation.

2. Babies begin learning from the moment they are born. Stimulate their senses with touch, talk, and play right from birth to help their brain develop.

3. Early Childhood Development (ECD), is about helping children grow healthy, learn well, and feel safe and loved

4. Low birth weight, preterm babies, and those discharged from newborn care units need extra stimulation and care to thrive and grow well.

5.Supporting brain growth is just as important as physical growth for child's future health, learning, and well-being.

Step 2 - Age appropriate play and communication with the use of ASHA ECD Kit and MCP Card.

As an ASHA, you must remember

- That every child is unique.
- Not all children develop at the same rate.
- Timings of development milestone could vary from child to child. Some children may show an interest in a given activity / skill earlier or later than others. Some children learn how to walk or talk much earlier than other children of the same age.

Age : 2-3 months

Parenting tips

Massage gently, stretch and exercise arms and legs of babies	Encourage babies to lie on tummy for sometime everyday Talk to the babies in your mother tongue daily	Cuddle and play with babies daily. or quickly responding to each cry does not spoil babies	Hang colourful moving objects 30cms (1 foot) away for babies to focus on and follow

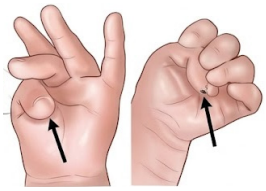
What Babies Do

- Begin to recognize mother's face (faces at 8-12 inches away)
- Pay close attention to and turn head towards the voice of the mother
- Begin to smile at people (Social smile)
- Follow moving objects
- Startle or erupt into cry at loud noises
- Coo, make gurgling sounds when happy or after feeding
- Can hold head up and begin to push up when lying on tummy
- Make smooth movements with arms and legs
- Keep hands relaxed and take swipes at dangling objects

Warning Signs : If the baby is not doing following by 3 months.

No social smile

Does not startle/ wake up/ cry in response to sudden loud sound



Persistently hold thumb inside the palm, with hands kept open or fisted

Does not make any eye contact when being fed, cuddled or spoken to

Head pushed back, with stiff arms and legs

Persistent squinting after 2 months

Advise the parents to avoid use of digital media till the baby is atleast 24 months old

Age : 4-6 months

Parenting tips

Communicate with babies,imitate their sounds and praise them when they imitate yours	Put interesting things on the floor for babies to reach out and explore	Take child outdoors and introduce him/ her to the outside world	Babies suck on their fingers and thumb for comfort. It is not a cause for concern. Do not stop this at an early age

What Babies Do

- Keep head steady when held upright and can sit with support
- Turn head towards direction of sound
- Attempt to reach and grasp an object
- Laugh aloud or make squealing sounds
- Begin to babble “ah, ee, oo” other than when crying
- Like to look at self in a mirror

Warning Signs : If the baby is not doing following by 6 months.

Lacks head control

Cannot sit up even with help

Does not grasp things within reach and Head/eyes do not move to follow/track a moving object

Does not vocalize by making different sounds such as “ah”,”eh”,”oo”

Unable to raise head when on tummy

Age : 7-9 months

Parenting tips

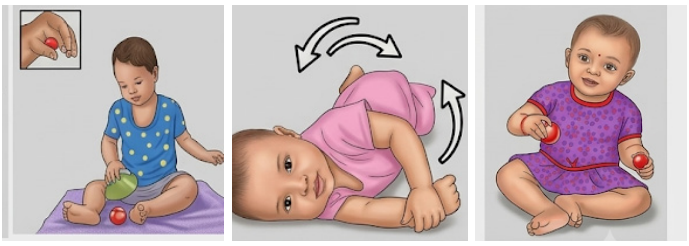
Let children drop, bangand throw things repeatedly. Respond to the noise that children make in a gentle and patient manner

Give children clean, safe household utensils to play and explore

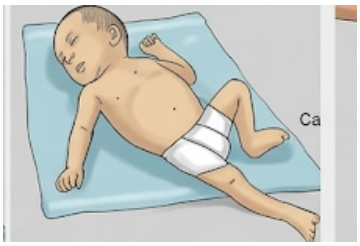
Babies suck on their fingers and thumb for comfort. It is not a cause for concern. Do not stop this at an early age

What Babies Do

- Roll over in both directions
- Grasp a toy by using all fingers
- Turn head to visually follow familiar faces or toys
- Look for toys that have been hidden in front of them
- Respond to name being called

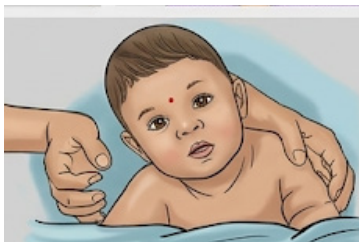


Warning Signs : If the baby is not doing following by 9 months.



Cannot roll over

Needs support to sit



Tilts head always to one side each time when looking at objects

Does not utter papa, ma, mama, baba etc.

Unable to raise head when on tummy

Age : 10-12 months

Parenting tips

Place a toy slightly out of reach to encourage standing and walking while using support

While exploring, babies might hurt others accidently. Show them how to touch gently. Do not shout at them.

Tell your baby stories and read picture books aloud. Show and name things in their environment.

What Babies Do

- Sit without support and reach for toys without falling
- Raise arms to be picked up
- Crawl to get desired toys without bumping into any objects
- Use one or two common words in mother tongue
- Respond to simple requests like “no/come here”

Warning Signs : If the baby is not doing following by 12 months.

Cannot pick small objects with finger and thumb

Does not stretch hands to be picked up

Does not play social games like peek-a – boo (Jhalak / aankh michauli)

Does not search for half hidden toys that the child sees you hide

Does not respond to own name.

Age : 18 months

Parenting tips

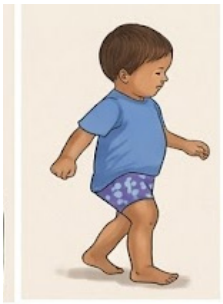
Provide push toy for babies to learn walking

Give some fruits. toys etc to children. Ask them to identify the objects, put them in and take them out of containers.

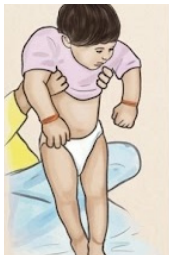
Ask your children simple questions . Encourage them to talk

What Babies Do

- Stand and take several independent steps
- Use a variety of familiar gestures like waving, clapping, etc.
- Put pebbles/ small objects in a container
- Name and identify common objects and their pictures in a book



Warning Signs : If the baby is not doing following by 18 months.



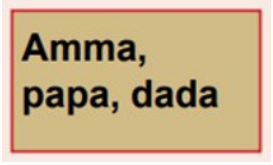
Cannot stand on his / her feet own feet without support

Cannot put small objects in a container

Does not point finger at an object when named

Does not respond to mother's gestures and seems to be in his / her own world

Does not use both hands for everyday activities (shows preference for one hand)



Does not say single words like "mama", or "dada"

Age : By 24 months

Parenting tips

Provide opportunities for children to walk, run and climb in safe environments

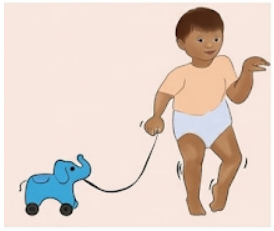
Allow children to imitate you and master their skills. Be patient with them if they make a mess.

- Encourage children to follow a daily routine such as sleeping and waking up at a fixed time
- Read aloud to children, often repeating stories. Provide books and paper, chalk, colours etc for scribbling.

What Babies Do

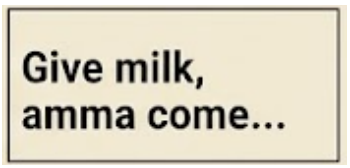
- Walk steadily, even while pulling a toy
- Imitate household chores
- Correctly point out and name one or more body parts in person or in books

Warning Signs : If the baby is not doing following by 24 months.



Does not walk steadily while pulling a toy

Cannot scribble



Does not use two word phrases such as “give milk”

Does not make appropriate response to gestures such as responding to bye-bye/ namaste

Does not point to the body part

Does not seem to understand and follow simple instructions

Emphasize: Adopt a family-centered care approach to child development by involving not just the mother but also the father, siblings, grandparents, and other household members. Their collective support plays a vital role in contributing to the child’s holistic development

Age : By 3 years

Parenting tips

Play outdoor games with your children which require movement and physical activity

Give variety of materials (including blocks, puzzles, rings etc.) to children

Allow children to use their hands and fingers in different ways to improve their skills

What Babies Do

- Drink from a cup without spilling
- Name most familiar things consistently
- Identify colours, shapes, etc. Make a sentence by joining 3 or more words
- Climb up and down the stairs

Warning Signs : If the baby is not doing following by 3 years.

Has trouble climbing up and down the stairs

Cannot eat without help

Does not communicate meaningfully and frequently repeats others' speech.

Does not make appropriate response to gestures such as responding to bye-bye / namaste

Continuous drooling, unclear speech

Does not speak in simple and three word sentences such as "amma give milk"

Recognize: In every visit, age appropriate milestones and warning signs should be noticed and child to be referred for any growth faltering. Parents should also be counselled on these milestones and warning signs

Step 3: Positive Parenting & responsive care giving

As an ASHA, you must explain the importance of positive parenting which involves creating a supportive and loving environment where children can thrive. Also inform parents about responsive care which is to understand and respond to a child's cues, needs, and emotions in a timely and appropriate manner.

Give following messages:

- Try to take out some time to spend quality time with your child every day through play, storytelling, or singing. (Explain to use mother tongue/local language, use pictures while telling stories).
- Have patience while explaining children what is right and wrong, and avoid scolding or hitting your child .
- Praise child's small achievements to build their confidence.
- **Responsive Parenting is:**
  - » When one recognizes when your newborn is hungry, tired, or upset and respond quickly by feeding, comforting, or cuddling them.
  - » Interact with your newborn during daily activities like feeding and bathing by talking, singing.
  - » Encourage your child to express themselves by listening to them and responding to their words or gestures.

Role of ASHA in ECD	Activities for Families
Counsel Parents/Caregivers: • Promote play and interaction, e.g., talking, singing, and physical activities. • Discuss the importance of responding to a • child's needs with affection and attention. • Address harmful practices like neglect or lack of stimulation. **Monitor Development:** • Use tools like the MCP card (red flag signs) to identify growth and development milestones. • Encourage milestone assessments using locally available toys (e.g., rattles, mirrors). **Advocate Gender Equality:** • Ensure equal attention and care for girl children in nutrition, health, and education. **Identify Delays:** • Recognize signs of developmental delay as explained in the MCP Card and refer to health facilities if needed.	**Birth to 6 months:** • Encourage skin-to-skin contact. • Talk and make eye contact during breastfeeding. **6–12 months:** • Play peek-a-boo or provide simple toys. • Introduce safe household objects to explore (e.g., spoons, cups). **1–3 years:** • Encourage walking, talking, and social interaction. • Use songs and stories for language development.

Case Study: Mr.X is a young father of 2 kids aged 3 year and 3 months. He and his wife are managing kids along with land, cattle and his ailing mother. During home visit you as an ASHA notices that 3 months old child is lying next to sick grandmother and no one is interacting. Mr.X is getting ready to leave the house and the 3year old starts crying. He scolds the child and goes away.

Being an ASHA, what do you think is happening?, What needs to be done and How will you go about it?

B.2.13 MENTAL HEALTH DISORDERS IN CHILDREN

Some children may have developmental delays or intellectual disability. Developmental delay means that a child is slower than expected in achieving one or more developmental skills. Intellectual disability involves difficulties in intellectual functioning and adaptive behaviour that begin during the developmental period.

What is Intellectual developmental disability?

It is a disability with difficulty in both intellectual functioning and in day to day behaviour, which covers many everyday social and practical skills. This disability starts before the age of 18. The child may show following features–

Limitation in Intellectual Functioning (Intelligence):

- Difficulty in learning about numbers, time, alphabets, etc.
- Difficulty understanding what is right or wrong and reasoning
- Difficulty in problem solving, and so on.

Limitation in day to day functions/ tasks:

- Difficulty in acquiring skills that are learned and performed by other children in their everyday lives.
- Difficulty in learning language; money, time, and number concepts; and self direction.
- Difficulty in interpersonal skills, social responsibility, self-esteem, social problem solving, and the inability to follow rules/obey laws.
- Difficulty in doing activities of daily living (personal care), occupational skills, healthcare, travel/transportation, schedules/routines, safety, use of money, use of the telephone, taking a bus, riding a bicycle, etc

Possible signs of developmental delay or intellectual disability include:

The child will show following signs–

- Sit up, crawl, or walk later than other children
- Learn to talk later, or have trouble speaking and remembering
- Slow to master things like toilet training, dressing, and feeding himself or herself
- Have difficulty understanding social rules
- Have trouble seeing the results of their actions
- Have trouble solving problems and thinking logically
- Reduced ability to learn or to meet academic demands

- Difficulty in expression
- Irritability when frustrated or upset, fluctuating mood and acting-out behavior
- Children with an intellectual disability show a delay in their understanding of the world and take longer to think and learn new skills. e.g. talking, self-help skills such as dressing and eating independently. The age of acquiring a specific skill depends on the rate of learning.

As an ASHA, you will inform the CHO / ANM if you identify a child with any of the above signs.

What are behavioral disorders among children and adolescents?

There are different kinds of behavioural disorders. As an ASHA, you can identify signs and symptoms which can help in early detection and provide appropriate help by referring the child.

The child may show following signs:

Inattention: • Fails to give close attention to details • Makes careless mistakes in schoolwork, at work, or during other activities • Difficulty in sustaining attention during daily tasks • Often distracted by external stimuli • Forgetfulness in daily activities • Avoiding activities that demand sustained attention • Does not listen when spoken to directly • Unable to organize himself/ herself for daily activities • Loses things frequently	**Hyperactivity:** • Plays with hands and feet while on seat. • Has excessive energy and highly active physically . • Unable to engage and play in leisure activities quietly. • Talks excessively. • Unable to sit in one place.
Impulsivity • Answers before questions are completed. • Interrupts and intrudes in others' activities. • Unable to wait for his/her turn	**Angry and irritable mood** • Often loses temper • Is easily annoyed by others • Is often angry and resentful

Argumentative and defiant behaviour • Often argues with adults or people in authority • Often actively defies or refuses to comply • with adults' requests or rules • Often deliberately annoys people • Often blames others for his or her mistakes or misbehavior	**Vindictiveness** • Is often spiteful or vindictive • Has shown spiteful or vindictive behavior at least twice in the past six months OR • Aggression to people and animals (often bullies, threatens or intimidates others, often initiates physical fights, uses weapon that can cause serious physical harm to others, has been physically cruel to people or animals, steals). • Destruction of property, deceitfulness or theft (breaks into someone else's house, building, or car, lies to obtain goods or favors or to avoid obligations). • Serious violations of rules example: stays out at night despite parental prohibitions, runs away from home or from school.

You will inform the MPW-F/CHO if you identify a child with any of the above signs.

Counsel on Child Safety Measures: Children need a clean, safe and protected physical environment safe from injuries and accidents while they are playing and learning. Thus, it is also important to inform the parents/caregivers during the SSBSK visits, on how to protect children from injuries and accidents.

Advise parents to:

Ensure clean surroundings: Keep playing objects of a child clean and washed. Keep the child in clean surroundings by placing the child on a clean mat or clean carpet (dari) or clean cloth while playing.

Maintain good air quality: Keep the home smoke-free to avoid respiratory issues. Prevent passive smoking. Do not allow smoking in the house . Reduce exposure to indoor air pollution by using clean cooking methods and ensuring proper ventilation.

Prevent Poisoning: Store medicines, cleaning agents, insecticides, fuels, and fertilizers in tightly sealed, clearly labeled containers out of reach of children .

Prevent Drowning: Never leave children unsupervised near water sources such as wells, or ponds or buckets as they can drown in a very small amount of water, even in a tub/bucket. Cover open water storage containers and keep them out of children's reach.

Prevent Injuries: Ensure young children are always supervised, especially near roads or stairs. Install barriers or railings on stairs, windows, and rooftops to prevent falls. Arrange safe sleeping positions to prevent falls. Keep sharp and thin objects like knives, scissors, needles, etc. out of reach of children. Avoid heavy blankets and ensure proper wrapping to protect against suffocation risks.

Prevent burns: Keep children away from fires, cooking stoves, hot liquids and foods, and

exposed electric wires to prevent burn injury. Additional home visits to address the young child is required.

Prevent Choking: Keep small objects like coins, nuts, and buttons out of children's reach as they may put them in their mouths. This can lead to choking.

B.2.14 CARE OF THE SICK CHILD:

Key Messages for Parents

- Early identification of danger signs can save lives.
- Presence of danger signs needs immediate referral to the nearby facility using free referral transport like 102/108 National Ambulance Service.
- Supportive care (feeding, hydration) is essential in transit and during illness.
- Special attention is needed for vulnerable groups (e.g., malnourished, low birth weight).

Initial assessment for danger signs :

Common illnesses in the young child could include fever, diarrhoea and acute respiratory infections. However, before you begin to learn about each specific illness, you as an ASHA need to know about the danger signs in a child.

Ask	Look	Action (Counselling, Referral, Documentation)
Ask about 'danger signs' • Is the child able to drink or feed? • Does the child vomit everything? • Has the child had convulsions? • Loose stools (for how long and if any blood in stools)	**Observe for 'danger sign'** • Lethargy or unconsciousness • Count the breaths in one minute. • Look for chest indrawing. • Fast breathing: (Respiratory rates: » 2-11 months ≥ 50/ min » 12-59 months ≥ 40/min)	**With 'Danger Signs'** • Refer the child to ANM/CHO /MO in case of presence of danger signs **Without 'Danger Signs'** • In case of acute diarrhoea, counsel parents to start ORS and zinc supplementation if no danger signs. Give zinc supplements for 14 days.

Ask	Look	Action (Counselling, Referral, Documentation)
	• Skin pinch goes back slowly. » Sunken eyes » Blood in stool • Fever (axillary temperature more than >=37.5 °C or 99.5 °F) • Stiff neck • Convulsions • Weight for Age/Length (WFA/WFL) <-3 SD score (red color on MCP card) » Oedema of both feet » Severe palmar pallor	• Dosage of zinc tablet: » Give 10 mg (1/2 tab of 20 mg tablet) to infants aged 2-<6 months. » Give 20mg (1 tab of 20 mg tablet) to children 6-59 months. • Counselling for hand washing practices, safe and clean home environment • Educate the mother/family on the identification of danger signs (including diarrhea and pneumonia)

Ensure that you as an ASHA also pay extra attention to girl child, children from vulnerable/ marginalized households, low birth weight children, malnourished children, SNCU/NBSU/ NRC discharged children, etc. as they are weak and are more prone to falling ill due to repeated infections.

Managing Fever :

Being an ASHA, you know that fever is a very common problem in young children. A child of 2 months to 5 years of age has fever if the axillary temperature is 37.5 degree Celsius or above 99.5 degree Fahrenheit. Follow these steps if you come across a child suffering from fever during your home visits.

1. Measure the temperature of the child by placing the thermometer in the armpit of the sick child for 2 minutes.

2. Refer urgently to the nearest health facility if any of the general danger signs mentioned in table above is present or if the fever has been present every day for more than two days. Give one dose of Paracetamol for high fever if the baby is conscious . Advise the mother to continue feeding if the baby is accepting orally and is conscious while traveling to the health facility .

3. In the absence of danger signs give paracetamol for high fever.

4. Advise the mother/caregiver to

- Feed the child during illness.
- Give extra fluids*
  - » Increase breast feeding.
  - » Offer the child extra to drink (home fluids)- rice-pulse based drink, vegetable soup, green coconut water, milk, lemon drink, plain clean water, yoghurt drink, etc. (if child is above 6 months of age).

5. Advise the mother / caregiver about general danger signs.

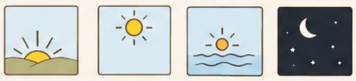
6. Follow up in two days if fever persists. Inform CHO/ ANM for further advice .

Paracetamol dosage and dispensing for fever management:

1. Dosage of Paracetamol for high Fever (38.5 degree Celsius or above/101.3 degree Fahrenheit or above)

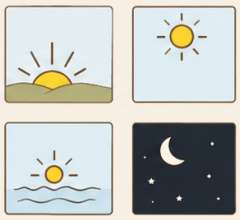
a. Paracetamol tablet

- 1 tablet = 500 mg
- Duration- To be given for 3 days only.
- Frequency- Maximum four times a day at an interval of six hours.

Paracetamol		
Age and weight of the child	**Dose of Tablet**	**Frequency**
2 months up to 3 years (4 - 14 kg)	¼ tablet (One-fourth)	Maximum 4 times a day
3 years up to 5 years (14 - 19 kg)	½ tablet (Half)	Maximum 4 times a day 

b. Paracetamol syrup

- 5ml (1 tsp) syrup=125 mg/5ml (Each 1ml contains 25mg of paracetamol)
- Per kg dose of paracetamol=10-15 mg/kg/dose
- Duration: To be given for 3 days only
- Frequency: Maximum four times a day at an interval of six hours

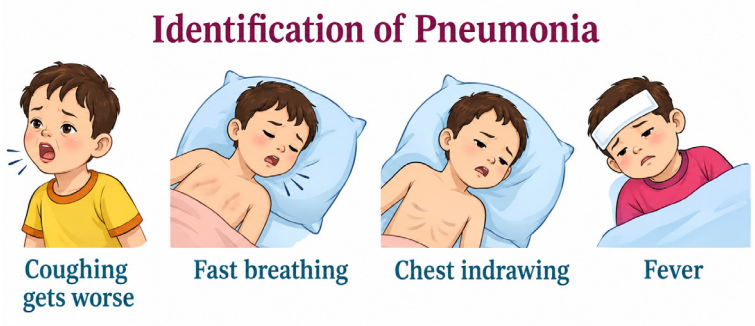
Age	Dose of Syrup		Frequency
	In ml	In teaspoon (5ml)	Max 4 times a day 
Newborn <3 kg	1ml	¼ tsp (One fourth)	
<1 year (>3kg-8kg)	2.5ml	½ tsp (Half)	
1-3 years (>8-14 kgs)	5 ml	1 tsp (One)	
>3 years (>14 kgs)	7.5 ml	1 ½ tsp (One and a half)	

In Malaria endemic areas follow the local instructions given to you (Carrying out Malaria-RDT provided to you and if positive , making a smear , administering first dose of anti-malarial and giving one dose of paracetamol for high fever (Temperature 38.5 degree Celsius or 101.3 degree Fahrenheit or above) and informing the CHO/ANM . Advise caregivers on use of insecticide-treated nets (ITNs).

Managing Acute Respiratory Infection: (ARI)

You as an ASHA may also come across children with cough and cold and/or difficulty in breathing during your household visits. These children are said to be suffering from Acute Respiratory Infection (ARI).

Pneumonia, one of the most **common ARI in children,** is caused by certain germs, such as bacteria or viruses and affects the lungs. It can spread in a number of ways. They may also spread via air-borne droplets from a cough or sneeze.



If the child's age is	The child has fast breathing if you count
Less than 2 months	60 breaths per minute or more
2 months to 12 months/ 1 year	50 breaths per minute or more
1 year to 5 years	40 breaths per minute or more

Note: The child who is exactly 12 months old (1 year) has fast breathing if you count 40 breaths per minute or more

Management of Pneumonia

Signs/ Symptoms	Status	Action to be taken
Presence of any general danger sign • Not able to drink or breastfeed • Persistent vomiting • Convulsions/fits, • Lethargic or unconscious • Chest indrawing	Severe Pneumonia Or very severe disease	Give first dose of Cotrimoxazole. (If you have been provided this medicine in your kit and instructed to use it). Inform CHO/ ANM Refer Urgently to hospital
If only fast breathing in absence of any of the above signs	Pneumonia	Inform CHO/ANM Give Cotrimoxazole for 5 days (in consultation with CHO / ANM) Follow-up in 2 days. If improving, advise home care** and tablets to continue. If no improvement, refer to a hospital.

Signs/ Symptoms	Status	Action to be taken
No signs of pneumonia or very severe disease	No pneumonia: Cough or cold	Advise home care for cough or cold**. If coughing for more than 3 days, refer for further assessment to a hospital.

Home care for cough or cold**

Advise the mother/caregiver to-

- Feed the child during illness.
- Give increased fluids: Increase breast feeding. Offer the child extra to drink (home fluids) like- rice-pulse based drink, vegetable soup, green coconut water, milk, lemon drink, plain clean water, yoghurt drink, etc. (if child is above 6 months of age).
- Soothe the throat, with a safe remedy for infant of 6 months or more. Honey, tulsi, ginger, herbal teas and other safe local home remedies.
- If the child's nose is blocked and interferes with feeding, clear the nose.
- Avoid cough syrups and antibiotics.

Watch for the following signs and advise to go to the health facility if they occur:

- Child becomes sicker
- Not able to drink or breastfeed
- Difficult in breathing / Fast breathing
- Develops a fever, chest indrawing

How can pneumonia be prevented?

- Vaccinations: Immunizations include the pneumococcal vaccine, Measles vaccine, and Hib vaccine.
- Good hygiene: Regular handwashing and avoiding exposure to sick individuals.
- Proper nutrition: Strengthens the immune system.
- Avoiding smoke exposure: Protect children from cigarette smoke and air pollution.

Managing Diarrhea :

You as an ASHA are aware that diarrhoea is the leading cause of death in children. You are also aware that a child is said to be suffering from diarrhoea if he/she is passing stool more than three times a day, which is usually watery. The normally frequent or semi-solid stools of a breastfed baby is not diarrhoea.

You need to follow these steps if you come

across a child suffering from diarrhoea during your home visits:

- Identify the nature of diarrhoea.
- Ask the mother about the duration of diarrhoea; If the diarrhoea is of 14 days or more, the child has persistent diarrhoea and needs to be referred to hospital.
- Refer if the child is passing blood in stools .
- Assess for the classification of dehydration and administer appropriate treatment as per the table below.
- Counsel mother/caregiver on prevention and treatment of diarrhoea using the MCP card during your home visits.

Classification for appropriate management for different types of dehydration in children

Signs/ Symptoms	Status	Action to be taken
Two of the following signs: • Lethargic or unconscious • Sunken eyes • Not able to drink or drinking poorly. • Skin pinch goes back very slowly	Severe dehydration	Refer URGENTLY to hospital with mother/caregiver giving frequent sips of ORS/fluids on the way
Two of the following signs: • Restless and irritable • Sunken eyes • Drinks eagerly, thirsty • Skin pinch goes back slowly	Some dehydration	Refer to a health facility to treat 'Some dehydration' with ORS Follow-up in 2 days (Plan B)
Not enough signs to classify as some or severe dehydration. Passing urine normally. Accepting feeds	No dehydration	Give fluids (home-available fluids/ breast milk / ORS) and food to treat diarrhoea at home Follow-up in 2 days if not improving. (Plan A)
Blood in the stool	Dysentery	Refer for further management.

Management of Diarrhoea: The diarrhoea can be managed by giving Oral Rehydration Solution (ORS) and Zinc

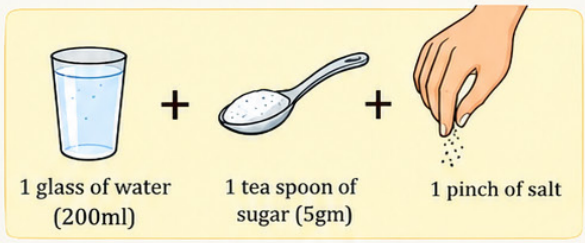
1. Preparation of ORS using ORS packet

Teach the mother/caregiver how to prepare ORS

1. Wash your hands thoroughly with soap and water.
2. Pour all the ORS powder from a packet into a clean container.
3. Measure one litre of clean drinking water and pour it into the container in which you poured ORS. (If you have ORS packets for 1/2 liter of water then take 1/2 liter water.)
4. Stir until all the powder in the container has been mixed with water and none remain at the bottom of the container.
5. Taste ORS solution before giving it to the child. It should taste like tears - neither too sweet nor to salty. If it tastes too sweet or too salty then throw away the solution and prepare ORS solution again.
6. Any ORS solution which is left over after 24 hours should be thrown away.

2. Homemade ORS solution:

1. Wash hands properly using soap and water.
2. To prepare one glass of ORS, take 1 glass (200 ml) of clean water, add a pinch of salt and one teaspoon of sugar. (See in the diagram given how a pinch of salt is taken with three fingers and how a teaspoon of sugar is measured).
3. Stir the mixture until the sugar and salt dissolve.
4. A juice of half a lime can be squeezed in. Taste the ORS solution before giving it to the child. It should taste like tears - neither too sweet nor to salty. If it tastes too sweet or too salty then throw away the solution and prepare ORS solution again.
5. After washing hands again with soap and water, the mother should administer ORS solution to the child.
6. Any ORS solution which is left over after 24 hours should be thrown away.



Initiate and suggest plan A to mothers and care-givers if the child has diarrhea but no dehydration:

TREATMENT FOR DIARHOEA WITH NO DEHYDRATION AT HOME (PLAN A)

1 GIVE EXTRA FLUID

If patient is less than 6 months age	If patient is more than 6 months age
Breastfeeding frequently and for longer + ORS	**Give home fluids + ORS** Yoghurt drink, milk, lemon drink, nce or pulses- based drink, vegetable soup, green coconut water or plain clean water. If child is breastfeeding then continue it.

Teach care-giver how to prepare and give ORS solution. Give 2 packets of ORS to use at home.

SHOW CARE-GIVER HOW MUCH ORS TO GIVE IN ADDITION TO THE USUAL FLUID INTAKE

Upto 2 months	2 months upto 2 years	2 to 10 years	> 10 years
5 tea spoons after each loose stool	1/4 glass to 1/2 glass (50 – 100 ml) after each loose stool.	1/2 cup to 1 cup (100 – 200 ml) after each loose stool	As much as wanted upto 2 liter a day

Tell the care-giver to:

- Give frequent small sips from a cup.
- If the patient vomits, wait 10 minutes. Then continue, but more slowly.
- Continue giving extra fluid until the diarrhoea stops.

2 GIVE ZINC SUPPLEMENTS FOR 14 DAYS

Age	Dose
2 – 6 months	10 mg (half tablet) in breast milk in spoon
6 months – 5 years	20 mg (one tablet) in clean water in spoon

Teach the care-giver how to prepare Zinc supplements. Give one dose of Zinc in front of the care-giver

3 ADVICE CONTINUE FEEDING, HAND WASHING AND TOILET USE

4 INFORM WHEN TO RETURN

- Child becomes sicker • Not able to drink or breastfeed • Drinking poorly • Blood in stool • Develops a fever

5 IF A CHILD HAS SEVERE ACUTE MALNUTRITION REFER FOR APPROPRIATE CARE AS PER STATE POLICY

Remember

- Ask the mother/caregiver to give one teaspoon of the solution to the child. This should be repeated every 1-2 minutes (an older child who can drink it in sips should be given one sip every 1-2 minutes).
- In case of a diarrhoeal or vomit episode during ORS administration, clean the child and mother/caregiver and the area should be thoroughly cleaned.
- After washing hands again with soap and water, the mother/ caregiver should administer ORS more slowly than before. Breastfeeding babies should be continued to be breastfed between ORS administration.

Zinc Supplements for a Child having Diarrhoea:

- Zinc helps in overall growth and development and supports in proper functioning of the immune system.
- Body loses Zinc during diarrhoea, and it needs to be replenished.
- ORS and Zinc have proven to be successful in the prevention and management of diarrhoea and dehydration.
- Zinc is only given to children of 2 months up to 5 years of age for 14 days.
- The mother/caregiver will need to be taught (explained below) the right way to administer zinc tablets at home for a child suffering from diarrhoea (with no dehydration).

Teaching mother/caregiver regarding administration of zinc tablets at home for a child suffering from diarrhoea (with no dehydration)

One zinc tablet in the blister pack contains 20 mg of zinc (zinc tablets will be provided to you as an ASHAs):

1. If zinc is to be administered to **children 2 – 6 months age**

- Half- tablet (i.e. 10 mg). is to be given. Discard the remaining half tablet.
- Take a clean teaspoon.
- Request the mother to express milk from her breast into the spoon and then add ½tablet.

2. If Zinc is to be administered to **children 6 months to 5 years age**, the dose is full tablet (20mg).

- Take a clean teaspoon, place one tablet in the spoon.

- Pour potable water carefully on the tablet taking care that the water does not reach the brim of the spoon.
- Shake the spoon slowly till the tablet dissolves completely. Do not use fingertip or any material to dissolve the tablet.
- Tell the mother/caregiver to hold the child comfortably and ask her to feed the solution to the child.
- If there is any powder remaining in the spoon, let the child lick or add little more breast milk or water to dissolve it and then ask the mother/caregiver to give it again.

3. Counsel the mother/caregiver to administer zinc once a day for a total of 14 days to children of all ages (2 months - 5 years of age as mentioned above).

IN DIARRHOEA DO NOT :

- Starve the child. Continue to offer them small, frequent breastfeeding/milk/ home-cooked hygienic food.
- Do not give antibiotics/ any other drug on your own except ORS,
- Do not use sugar/glucose solutions, fruit juices, or carbonated drinks for rehydration.

B.2.15 ADVISING THE FAMILIES ON SAFE WASH PRACTICES

Drinking water

Promoting Water, Sanitation and Hygiene Practices during Household Visits

- Store drinking water and food items in clean utensils on raised platform, in a covered container.
- Ensure drinking water is clean. Drinking water can be made safe by boiling (especially in case of repeated infections), adding chlorine tablets, using water filter (if possible) and keeping it covered.
- Drinking water to be drawn by ladle/ utensil with a handle designated just for drawing out water. Families can also use water pots which have attached taps, wherever available.

Sanitation

- Encourage households to build their own toilet.
- Promote use of toilets in the house by all household members, including children.
- Promote use of community toilets where household toilets are not present.

- Encourage families not to practice open defaecation.
- Practice safe disposal of faeces. Keep human and animal faeces away from water sources.
- Household waste should be regularly thrown or dumped only in the dustbins or places designated for garbage collection.
- Inform family members that ward members of municipal corporation (parshad)/gram panchayat members should be contacted on issues related to garbage collection in their areas.

Hygiene

- Ensure that the child's surroundings are hygienic.
- Encourage personal hygiene of all family members including children- daily bathing, daily changing of clothes and daily brushing of teeth.
- Washing food items before cooking and washing fruits and vegetables before cutting.

Hand Washing

Promote hand washing frequently with soap and clean water for all family members, including children. Wash both hands of children, frequently. Tell family members to wash their hands whenever they do the following:

Most Critical-

- Before eating food or feeding children
- After using the toilet
- After cleaning children- child has passed urine or stool
- After quick and safe disposal of child's faeces.

Essential-

- When hands are dirty
- Before preparing and serving food
- Before picking up a child
- Before attending to a child or sick person
- After preparing and eating food
- After coughing or sneezing, or being in contact with someone who is ill
- After wiping or blowing nose
- After being in contact with animals, animal feed and animal waste
- After outdoor activities
- After touching garbage waste

Your role as an ASHA in ensuring safe wash practices

- Teach the steps of hand washing to the mother and care-givers and educate the families on when and why to regularly wash hands correctly.
- Create awareness in the community about the importance of following safe WASH practices.
- Work closely with platforms like VHSNC/MAS, gram panchayat members, self-help groups, urban local bodies, religious organizations, AWWs, ANMs/ MPW, non-governmental organizations (NGOs), representatives from department of drinking water and sanitation, municipal corporations, community members, etc. to construct toilets at household and community level, safe disposal of faeces, improving water supply and sanitation facilities in the community, ensuring availability of dustbins and timely collection of waste disposal to control the spread of diseases.
- **You must practice the steps of hand-washing during each visit. Also, ensure that families are counselled on hand- washing and hand-washing is practised by them to prevent the spread of illness within the household.**

B3
Adolescent Health

PART B

B.3 Adolescent Health

After completing this Section, As an ASHA, you will be able to:

1. Understand adolescence and be able to explain normal physical, emotional, and social changes to adolescents and their families.

2. Identify common health problems in adolescents such as anemia, poor nutrition, menstrual problems, stress, and behavioral issues.

3. Counsel adolescent girls confidently on menstruation, menstrual hygiene, nutrition, and anemia.

4. Counsel adolescents on healthy lifestyle to protect themselves from non-communicable diseases (NCDs), harmful effects of substance abuse.

5. Create awareness on sexual and reproductive health, including RTI/STI, HIV, contraception, safe abortion services, and dangers of early marriage and teenage pregnancy.

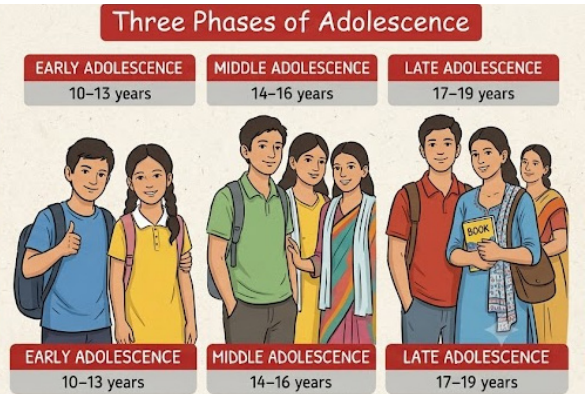
6. Identify risks related to injuries and road traffic accidents (RTA) and counsel adolescents on their prevention and safety.

7. Recognize adolescents needing help and link them to the required health services through timely referral and follow-up.

B.3.1 WHAT IS ADOLESCENCE?

Part of life of an individual between 10-19 years of age is known as adolescence. An individual in this age period is called an adolescent.

What is special about adolescence ?



This phase is characterised by acceleration of physical, psychological and behavioural changes which bring about the transformation from childhood to adulthood. More than one fifth of the population in your area is comprised of adolescents.

Adolescence is divided into three phases: early, middle, and late adolescence, referring to ages 10 to 13 years, 14 to 16 years, and 17 to 19 years respectively.

Why is adolescence important ?

Think and reflect

How many adolescents are there in your area? Why is it important for you to know the adolescents in your area?

- The physical, emotional, and psycholaogical changes that occur during adolescence make children in this age group particularly vulnerable.
- Rapid bodily changes, evolving body image, emerging identity, curiosity, and a desire to experiment often expose adolescents to risk-taking behaviours.
- At the same time, they face strong peer pressure and expectations from family and society, which they may find difficult to handle without guidance.
- Behaviours and habits formed during this period strongly influence health and behaviour in adult life. It is estimated that nearly 60% of premature adult deaths are linked to behaviours adopted during adolescence, such as unhealthy eating habits, use of tobacco and alcohol, lack of physical activity, high-risk sexual behaviour, early marriage, and teenage pregnancy etc.
- Easy access to social media, and unrealistic expectations from self and family can add to emotional distress.

Therefore, adolescents form a critically important group among your beneficiaries and require focused attention. Increasing awareness about healthy behaviours, counselling against harmful practices, supporting adolescents in coping with stress, and helping them build self-esteem, confidence, and decision-making skills during this stage contribute to the development of healthy, confident, and responsible adults.

Think and reflect

What are the most common adolescent health problems faced by adolescents in your area? Do they come to you with their problems?

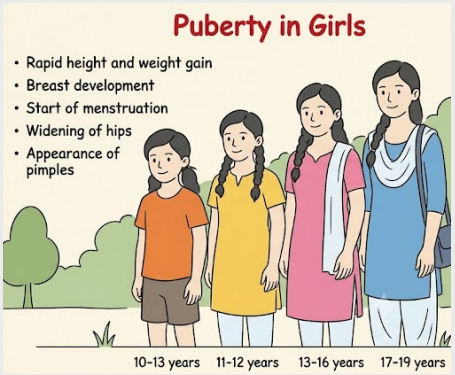
Think and reflect

What is mensturation and what is the usual age of onset of mensturation?

B.3.2 WHAT ARE THE CHANGES DURING ADOLESCENCE?

Puberty is the time in life when body changes from that of a child to an adult. These changes occur under the influence of chemicals in our body called hormones.

Changes occurring in the body may be physical, functional, emotional and social



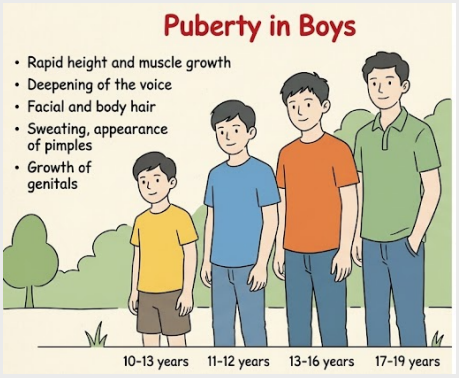
Physical changes in girls: These changes usually begin between 9 and 13 years of age, though the timing may vary from one individual to another. These are :

- Gain in height and weight.
- Breasts. The shape and size of the breasts may differ between individuals and may develop at different rates, which is normal.

- There is growth of hair in the underarm and pubic region.
- The hips gradually become broader, and body fat increases around the hips, thighs, and breasts, giving the body a more feminine shape.
- Sweat and oil glands become more active, which may lead to body odour, oily skin, and pimples or acne.
- The most important change is the onset of menstruation (menarche), which usually occurs between 9 and 15 years of age.

Lack of awareness that these are expected physical changes and a part of normal development , can be a cause of concern and embarrassment .You can provide the correct information , reassure and help her in adapting confidently to these changes.

Physical changes in boys: These changes usually begin between 10 and 14 years of age, though the timing may vary for each individual.



- A rapid increase in height and weight.
- The shoulders broaden, muscles develop, and the body gradually becomes stronger.
- The testes and penis increase in size.
- Boys may also experience nocturnal emissions (wet dreams), which are normal and indicate the start of sperm production.
- There is growth of hair in the underarms, pubic region, face (moustache and beard), chest .
- The voice begins to change and may crack initially before
- Increased activity of sweat and oil glands can lead to body odour, oily skin, and acne.

These physical changes are normal and part of healthy development. However, boys may feel confused or embarrassed if they are not prepared for them. Proper information, reassurance, and emotional support helps boys adjust confidently to these changes.

Emotional Changes: Include shyness, rapid mood changes, lack of confidence, attention seeking behaviour, sexual attraction . During this period unhealthy habits like smoking and drinking or experimenting with drugs and unsafe sex may also set in.

- Desire to establish own identity and independent thinking often makes them question rules, traditions, and authority.
- Peer relationships become very important during this stage. Adolescents may feel pressure to fit in or be accepted, which can sometimes lead to risky decisions.

- Adolescents may also experience self-doubt, low confidence, or fear of failure, particularly due to academic pressure or expectations from family and society.

While some emotional ups and downs are normal, persistent sadness, withdrawal, anger, or risky behaviour are warning signs that need attention. You can provide supportive communication, guidance, reassurance, and also help the parents and the community to provide a safe environment to help adolescents manage.

Social changes

- Adolescents begin to form their own identity and place in society.
- Peer opinions may sometimes influence behaviour more strongly than family advice.
- While family remains important, adolescents
- may prefer spending more time with friends
- and may want greater privacy. Differences of opinion with parents or elders are common during this phase and are usually a part of normal development.
- Adolescents also become more aware of social roles, gender expectations, and societal norms. They may compare themselves with others and feel pressure to meet social standards related to appearance, behaviour, or academic performance. Increased exposure to social media and digital platforms can further influence their self-image, relationships, and aspirations.
- As adolescents grow, they begin to develop values, beliefs , form close friendships, or romantic feelings. You can be their trusted adult and guide them. You also have an important role in making the parents aware about these changes and how their patient and supportive behaviour can help adolescents navigate these social changes safely and develop healthy relationships.

B.3.3 MENSTRUATION AND PROBLEMS RELATED TO MENSTRUATION

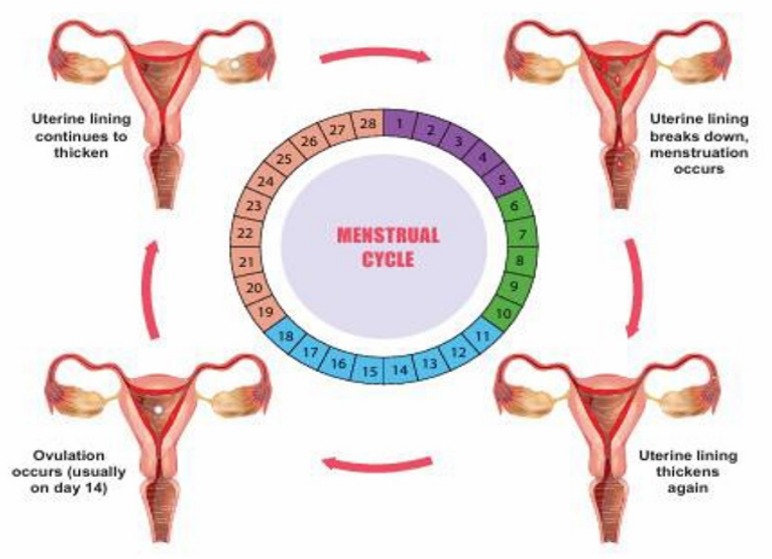
At the onset of puberty, when the girl gets her first period is known as Menarche. Menarche may take place between 9-16 years of age. During this period, most girls observe bleeding for the first time from the vagina. This bleeding becomes a periodic occurrence in a girl's life with the cycle of bleeding observed in a gap of 28-40 days.

Why does menstruation occur?

In a girls' body at puberty, every month, or about once in 21-40 days, one of the eggs from the ovary, travels through pipes called fallopian tube. This is called ovulation. As the egg travels in the fallopian tube, a soft spongy lining gets formed within the uterus. This lining is mostly made of tiny blood vessels. In case an egg and sperm meet to form an embryo, or a baby, that begins to grow in the uterus this lining provides the nutrition for the baby. If the egg is not fertilised by a sperm, the lining of the uterus begins to break. The unfertilised egg along with broken uterine lining is released as blood and flows out of the vagina. This bleeding is the menstrual period. This whole cycle is called menstruation.

Menstrual Cycle: A menstrual cycle lasts from the first day of one period to the first day of

the next. The typical cycle of an adult female is 28 days, although some may have as short as 22 days and as long as 45 days. Periods usually last about 3-7 days, which can vary too. During a period the amount of menstrual bleeding varies from one girl to another. Very heavy bleeding - for example, soaking through a pad every hour for several hours, bleeding for more than 7 days, or bleeding that interferes with daily activities needs medical assessment.



Think and reflect

What are the common menstruation related problems faced by the girls? What advice do you as an ASHA offer them?

Problems during menstruation

Common problems that girls might experience during menstruation are :

- **Irregular Periods:** For the first few years of menstruation, cycles may be irregular and but usually they become regular within two to three years after menarche. They may vary from 3 weeks to 6 weeks. They should get their haemoglobin checked and consume iron rich foods / IFA as advised.
- **Heavy periods:** The periods may be heavy , when the pad gets saturated within a short time, or last longer than seven days or there may be passage of blood clots .
- **Iron rich** foods should be consumed and IFA supplementation is advised . Haemoglobin should be checked and if she is anemic , IFA should be taken in the therapeutic dosage. The flow should normally stabilise in year or two.
- Child should be referred to AAM-SHC / AAM PHC for further evaluation and management.
- **Painful period:** Some girls may experience nausea, headaches, diarrhoea and severe cramps during menstrual period. Usually, this lasts only for a day or two.

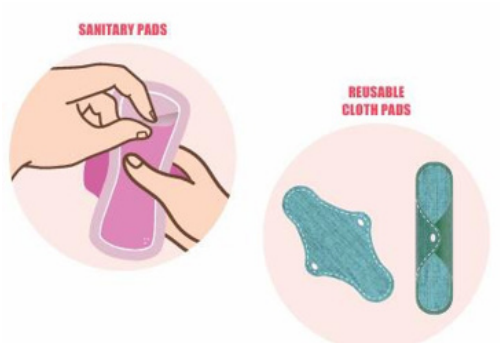
For relief from these symptoms, a girl should try the following methods:

- Use a hot water bottle, wrap it in a towel and place it on the abdomen,
- Local remedies such as drinking hot ginger tea

Premenstrual Syndrome (PMS)

- This refers to a combination of physical and emotional symptoms experienced by women and girls during the menstrual cycle, usually five to seven days before the period starts and disappear when the bleeding begins.
- These symptoms include- temporary weight gain, feeling of heaviness in the body particularly breast, headaches, cramps, pain and mental irritability.
- It is important for you as an ASHA to help the girls understand that menstruation is a part of every woman's life and there should be no shame or embarrassment around this. It is not to be seen as an obstacle to daily activities. There is no impurity or pollution associated with menstruation. Practices such as seclusion or staying away from school or the kitchen must be strongly discouraged. Mothers should be involved in counselling and guided to support girls.
- **Diet:** Girls loose blood every month therefore it is very important for them to consume a balanced and iron-rich diet such as green leafy vegetables , pulses , jaggery, beetroot to replace this loss.
- **Cleanliness:** Germs can grow in the blood on the external genitals so it is important to maintain general hygiene.

Menstrual Hygiene, Use and Disposal of Sanitary Napkins



Commonly women use a cloth which is folded and placed within the underwear, or kept beneath the private parts by means of a string tied around the waist. This cloth is washed and reused . A sanitary napkin is a pad worn within the underwear during menstruation to absorb the flow of blood . Disposable sanitary napkins are more convenient and easier to use than washing and reusing the cloth pad . The blood is absorbed better and there is a feeling of dryness.

With more frequent change , it prevents infection and allows more mobility. The girl is more comfortable and able to take part in school activities as usual .You should organise monthly meetings on a fixed day with adolescent girls to provide health education on issues of menstruation and hygiene, provide and promote the use of sanitary napkins and other important adolescent health related information . The venues of VHND and VHSNC can also be used for this purpose.

You should explain to adolescent girls to:

- Change the used napkin once it feels wet. Wet napkin can cause irritation on the inside

of the thighs and lead to itching and infection.

- Wash the body and private parts daily and during menstruation, the outer genitals should be washed from time-to-time to remove any blood that is left. Wash her hands every time she changes the napkin.
- If the underwear is soiled, it must be changed. Otherwise bacteria may grow and can cause infection.
- Use a clean cloth pad if sanitary napkins are not available. Cloth should be changed three to four times a day in case of heavy periods and should be washed with hot water and soap, dried under the sun and stored in a clean dry place.
- To keep track of her menstrual cycle so that she is prepared for the time when the bleeding starts.
- As periods can be irregular in the early years, as she is a school going girl or plans to be out of home for a long time she should carry a sanitary napkin with her for changing.
- In areas where waste disposal mechanisms are in place, it can be wrapped in a used newspaper and thrown in the community dust-bins. Where there is no such mechanism, then the sanitary napkins should be disposed either by deep pit burial any other approved mechanism.

Important :

- The blood lost during menstruation is normal blood and is not contaminated or dirty blood.
- Practises like restricting their entry into kitchen, temple, participation in family functions etc should be strongly discouraged.
- Mothers should be encouraged to talk openly with their daughters about menstruation and related issues.

Menstrual Hygiene Scheme (MHS)

A Government of India initiative aimed at promoting safe and hygienic menstrual practices among adolescent girls aged 10-19 years.

Objectives of the Scheme

- Awareness on menstrual hygiene and health is increased among adolescent girls.
- Girls are empowered to manage menstruation with dignity and confidence.
- Access to high-quality sanitary napkins at a subsidised cost is ensured.
- Environment-friendly disposal of used sanitary napkins is promoted.

Key Interventions under MHS

- Health education and outreach activities are conducted in communities and schools to promote correct menstrual hygiene practices.
- Sanitary napkins are made available through ASHA at a subsidised rate of Rs. 6 for a pack of six napkins.
- Monthly group meetings are organised for adolescent girls at Anganwadi Centres or Panchayat Bhavan to discuss menstruaion, hygiene, nutrition. and related adolescent health issues.
- Household visits are carried out to reach girls who are unable to attend group meetings.

Your Role in the Community as an ASHA

- Use a tracking register to identify and track adolescent girls in your catchment area.
- Conduct and document monthly meetings on menstrual hygiene.
- Distribute or sell sanitary napkins and maintain stock and accounts.
- Conduct home visits to ensure coverage of all eligible girls.
- Submit monthly reports to the CHO/ANM

Supply and Management:

Sanitary napkins are supplied from PHC to AAM SHC, and from there distributed to ASHAs. An initial imprest fund is given to you as an ASHA to purchase napkins, which is replenished through sales. Funds collected are routed back through AAM SHC and PHC to the District Health Society under a separate MHS account.

Monitoring and Supervision:

- Distribution, counselling activities, and record-keeping are monitored at village and sub-centre level.

- Registers and accounts maintained by you as an ASHA are reviewed and co-signed by a female member of the VHSNC.
- CHO/ANM and PHC staff conduct periodic reviews and field visits to ensure quality implementation.

ASHA tracking Register for Adolescent girls-month-wise reporting

Name of ASHA	Number of adolescent girls	Month 1		Month 2	
		No of packs of napkins sold	No of AGs attending meeting	No of packs of napkins sold	No of AGs attending meeting

ASHA Monthly Reporting Format

1	Name of ASHA	
2	Name of Village	
3	No of napkin packs at the month beginning	
4	No of napkin packs at the month end	
5	Transportation cost (if any)	
6	Storage cost (if any)	

Case Study: Menstrual Hygiene Management

Ms. S is a 13-year-old adolescent girl who started her menstrual cycle about 6 months ago. Since there are no toilets in her school, she does not go to school during her menstrual periods. Ms. R, an ASHA in the village found out about this. On further inquiry she learnt that there are many other girls in the village who do not attend school during their periods due to absence of toilet in the school. Ms. R first shared this information with the Anganwadi worker and then called for a meeting of the adolescent girls in the village to discuss the matter. She

offered them sanitary napkins and tried to convince them to attend school during their periods. The girls urged that they would need a place to change the pads during school hours. The girls suggested to Ms. R that she should speak to the school teachers and headmaster on this subject. This put Ms. R and the Anganwadi workers in a tough spot as their task was to distribute sanitary napkins only. Now what should they do?

Question 1. Why were the adolescent girls refusing to go to school during the periods despite having access to sanitary pads?

Answer: Due to the absence of fully functional toilets and dustbins adolescent girls were not ready to attend school during their periods. Not just a fully functional and clean toilet, but also one that has running water and a dustbin with proper disposal mechanism (cover) for the sanitary napkins is essential for managing periods. The absence of this makes it difficult for adolescents to attend school and many a times they even end up dropping out of school at this age, due to these issues.

Question 2. Do you think that the ASHA and Anganwadi worker could have intervened in this situation? If yes, then how?

Answer: When Ms. R and the Anganwadi worker found out that the girls had stopped attending school during their periods due to absence of toilets, they could have approached the school authorities, headmaster and principal with this problem so that the necessary arrangements for the toilets could be made. If this does not yield a positive response, then Ms. R and the Anganwadi worker can raise the issue with the Panchayat representatives in the VHSNC meeting.

B.3.4 SPECIFIC CONCERNS OF ADOLESCENT BOYS

Boys may also experience anxiety related to adolescent changes. Some of these include:

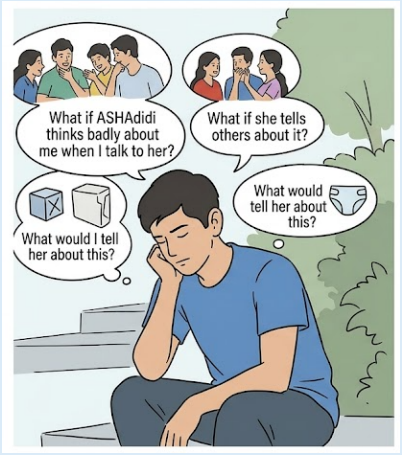
Erection of Penis- In response to thoughts, fantasies, temperature, touch or sexual stimulation, the penis fills with blood and becomes hard and erect. In young adolescents, erections may take place even in absence of sexual thoughts or stimulation and this is a natural phenomenon and not a defect or disease.

Ejaculation - The release of semen from the penis is called ejaculation. This may occur at night and is commonly called a 'wet dream'. It is a natural and normal phenomenon-and not a defect.

You as an ASHA must allay any fear / anxiety being felt by the adolescent. Educating the mother / parents about this can also help in addressing these issues being faced by adolescents.

Case Study

Mr. V is a 14-year-old boy living in Bhagpur village. Since the last few days Vivek has been experiencing pressure around his penis and when he wakes up in the morning, he finds that his underwear is wet. This makes Mr. V feel embarrassed and he wants to talk about this with someone but not sure who. He is worried that he may be suffering from some illness. Listening to the conversations amongst his peers in school, he feels even more concerned about this. He once heard the ASHA in his village discussing sexual health with some young girls. He is wondering if he



should speak to her about his 'condition' but feels hesitant about this. There are many questions in his mind which also affect his confidence, for e.g., "What if ASHA didi thinks badly about me when I talk to her? What if she tells others about it?

Question 1. Do you think it is difficult for adolescent boys to obtain information about sexual and reproductive health? What could be the negative implications of this?

Answer: It is natural for adolescents to be concerned about the bodily changes that they experience because there are few safe spaces for them to talk about these openly. The main source of information on sexual and reproductive health for boys are their peers or the internet. However, this information is half- baked and inaccurate, and this makes it even more concerned. It could even impact their health and emotional state negatively.

Question 2. Do you think Mr. V's hesitation is justified? What could be the reasons behind it?

Answer: Since most of the ASHA, ANMs/MPW-F and staff of the Primary Health Centre are also members of the community, it is natural for adolescent boys to feel anxious about approaching them. Also, sexual and reproductive health is a taboo topic in society and it is considered 'bad' or 'dirty' or 'unnecessary' for adolescent boys to talk about it. Since young people who try to access information about sexual-reproductive issues are often looked down upon they hesitate to talk to ASHA on the subject.

If any adolescent boy approaches you as an ASHA to seek information about their bodily changes or sexual and reproductive health, then the following need to be kept in mind:

- If you have some hesitation on the subject, it's best to deal with it first. It is your responsibility to equip yourself with accurate and full information on sexual and reproductive health issues. We must not let our own personal dilemmas interfere or influence our work.
- Reassure them about confidentiality and keep the discussion private.
- If the person approaching you is hesitant, inform them that having questions related to bodily changes is absolutely normal.

Boys need to be made aware of the genital hygiene. It is important to tell them that the genitals need to be washed daily as secretions accumulate under the foreskin of the penis and can cause infection if not cleaned regularly. They should wear dry, cotton undergarments which are changes every day. These should be washed and dried in the sun. Although you may not be consulted by boys directly, the information could be communicated to mothers of adolescent boys who seek your help for these concerns.

B.3.5 ANEMIA IN ADOLESCENTS

1. Anemia: Anemia is a condition in which the number of red blood cells (RBCs), or their oxygen-carrying capacity, is insufficient to meet the body's requirements. These requirements vary by age, sex, altitude, smoking habits and during pregnancy.

Nutritional anaemia is commonest form of anemia in adolescence and may be due to deficiency of Iron, Folic Acid or Vitamin B 12 in their diet.

Hemoglobin levels to diagnose Anemia (g/dl) (as per Anemia Mukt Bharat Abhiyaan Guidelines 2026)

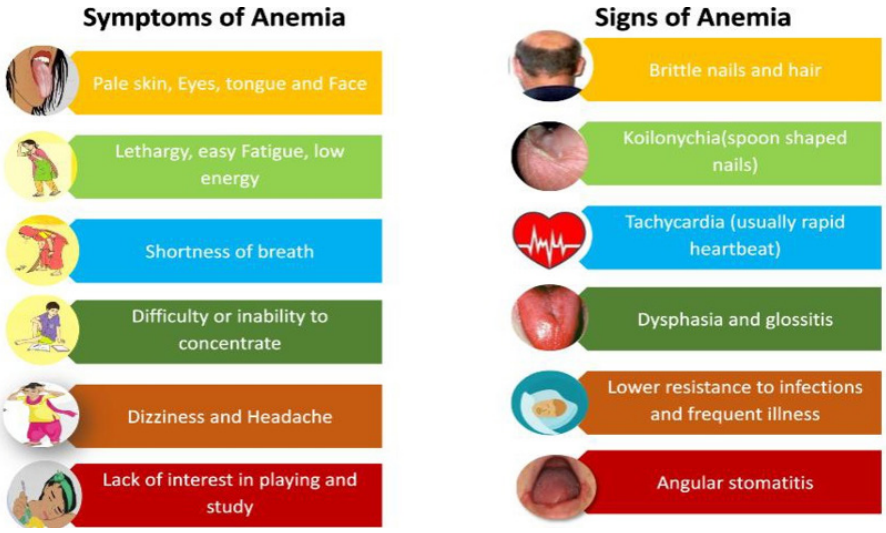
Age group	Anemia Levels			
	Normal	**Mild**	**Moderate**	**Severe**
Children 5 -11 years	11.5 or higher	11-11.4	8-10.9	<8
Adolescents 12-14 years	12 or higher	11-11.9	8-10.9	<8
Non- pregnant women (15 years and above)	12 or higher	11-11.9	8-10.9	<8
Men (15 years and above)	13 or higher	11.0-12.9	8-10.9	<8

Think and reflect
Why are adolescent girls more prone to anaemia?

During adolescence, the rapidly growing body needs extra iron for increased production of blood. When this extra requirement of iron is not met through proper diet and nutrition it leads to nutritional anaemia. It is more common in girls because of loss of blood through menstrual bleeding. Anaemia has a negative impact on overall growth, wellbeing and performance in school.

Causes of nutritional anemia:

- Inadequate intake of iron rich foods
- Poor absorption of iron from the ingested food
- Loss of iron from body
- Worm infestation



Think and reflect
Name some of the iron rich foods .

What dietary advice would you give to the parents of adolescents?

Prevention & Control of anaemia: Iron rich diet

Intake of adequate and balanced nutrition with adequate amount of iron and other required nutrients prevents nutritional anaemia.

Sources of dietary iron: Iron is found in plant foods like whole grains, nuts, seeds,legumes, beetroot and leafy greens. Jaggery is a good source of iron . Iron is also present in meat. As an ASHA you must educate and encourage parents to include these foods in the diet of their children routinely.

Think and reflect
What food habits of adolescents increase the risk of anaemia?

Think and reflect
What difficulties do you face in ensuring regular IFA intake?

Prevention of anemia: Prophylactic IFA Supplementation

Weekly Iron and Folic acid Supplementation Programme:

This is implemented to prevent nutritional anemia in adolescents by distributing free IFA tablet on a fixed day of the week to:

- School going adolescent girls and boys of classes 6th to 12th in government/ government aided/municipal schools.
- Out of school adolescent girls (10 to 19 years).

In schools, trained teachers administer these tablets to the children and out of school girls are administered IFA in anganwadis. Twice a year, deworming tablet (Albendazole Tablet) is also given to these children.

As an ASHA you must ensure that the school going kids and their parents are aware of the scheme and avail the benefit of the same. Similarly you must have a list of the out of school adolescent girls and ensure that they take their IFA supplement from anganwadis.

For worm infestation

Age Group	Dosage (Albendazole 400mg tablet)	Administration
10-19 years	One tablet	Adolscents can chew the tablet and if required should consume some water. Clean drinking-water should be available at the school/ AWC on the deworming day.

Non-nutritional anemia can be due to chronic blood loss in conditions such as heavy menstruation and/or hemorrhoids. Non-nutritional anemia can also be due to inherited defects in formation of red blood cells such as sickle cell disease and thalassemia . In areas endemic for malaria, it is an important cause contributing to anemia .

Over nutrition (Overweight and Obesity):

Overweight and obesity are mainly due to an imbalance between energy intake and energy expenditure (through physical activities and bodily functions). Obesity leads to high blood cholesterol, high blood pressure, heart disease, diabetes, and certain types of cancer. Genetic and environmental factors also play a role but paying attention to diet and physical activity can significantly decrease the risk of developing non communicable diseases later in life. This has been dealt with in a separate section on NCDs.

B.3.6 MENTAL HEALTH AND BEHAVIOURAL CHANGES:

There are behavioural changes as the child goes through adolescence. You may notice some adolescents becoming aggressive while others may become shy and less confident of themselves. Some others may display attention seeking behaviour. These are a result of their ongoing emotional development, a search for their identity and independence which may sometimes lead them to defy their traditions and authority.

Difficulty in forming interpersonal relationships, violent or delinquent behaviour, dropping out of school, use of alcohol, tobacco or other illicit substances may indicate underlying mental health issues. Various changes going on during adolescence make them more vulnerable to these issues. Humiliation, rejection, violence and feeling of being worthless can increase the risk of developing mental health problems.

These changes should be dealt with empathy and patience. Any emerging negative behaviours should be recognized and managed timely or they may lead to serious consequences such as alcohol/drug abuse, juvenile delinquency etc. Family environment and peer influence are the two most important factors in shaping the behaviour of the adolescent.

Think and reflect
How can parents and you as an ASHA help in early identification and referral of mental health problems?

Following may provide some clue to mental health issues being faced by the adolescent :

- His own statements about what he/she thinks and feels or does.
- Observing how he/she sounds or looks (takes care of self) and behaves with others.
- Observations of his/her siblings, teachers and peers
- Declining academic performance
- Social withdrawal or reduced participation in school, work or social activities
- Past history of high risk behaviour / substance abuse

Sometimes mental health issues may have accompanying physical symptoms/signs like sleep problems, anxiety, palpitations, trembling, sweating and generalized aches and pains. There may be loss of appetite and weight loss.

Think and reflect

Why do some adolescents start using tobacco, alcohol, or drugs?

	Symptoms
Substance use disorder	While some adolescents might use the substance occasionally – but do not lose control over the amount they use. However, even such use can cause brain and muscle incoordination, leading to accidents / injuries . Others can become dependent which increases the risk of various health and social problems. • Symptoms identifying dependence: • Strong desire to use substance (craving) • Unable to reduce the amount used. • Withdrawal symptoms appear when they don't use or use less than usual amount (e.g. hands shaking, feeling irritable, not able to sleep) • Needing more and more quantities of the substance to get the desired effect. • Neglecting responsibilities and spending more time using the substance or with related activities • Continuing to use although aware of the negative effects.

Think and reflect

What behaviour changes make you as an ASHA feel that an adolescent is having mental health issues?

Adolescents can face following mental health conditions.

- Depression disorder
- Anxiety disorder
- Panic attacks
- Behavioural disorder
- Substance use disorder

Un-addressed mental health issues can lead to lot of distress at personal as well as family level. These interfere with the adolescent's ability to study, work or become independent. Their behaviour invites discrimination and abuse. They are isolated and miss out on opportunities in life.

Some mood fluctuations, transient depressive feelings, and anxiety are common in adolescents but in presence of non supportive family and social environment, these problems may become serious and sometimes may lead to suicidal thoughts or even attempted suicide. High risk taking behaviour may lead to unsafe sex and substance abuse.

Remember

A supportive and loving family which encourages self expression can protect their adolescent and help him/her in overcoming any internal or extraneous negative pressures.

Similarly a safe and caring school environment leads to mentally and emotionally healthy young men and women.

A non-discriminatory, tolerant and sensitive community moulds and promotes well balanced, mentally healthy adults.

Your role as ASHA:

- During your regular interactions with the families keep enquiring about their adolescents.
- Be approachable to the adolescents and let them know they can come to you if they need any health related information / help.
- Be alert to mental health issues and watch out for any such problems / behaviour patterns in adolescents in your area.
- Provide the correct , required information to the adolescents and their parents. Counsel the parents to watch out for and recognise the signs of emotional stress in their children.
- You can provide valuable support by counselling the parents about these changes and importance of rapport building with their adolescents and providing parental supportive supervision.
- Make parents aware about the Adolescent Friendly Health Services available in your area and the availability of counsellors to help adolescents in such situations.

- Refer any adolescent suspected to have mental health issues to the nearest adolescent friendly health clinic for detailed assessment , counselling and any treatment if so required.
- Facilitate their access to these facilities / services
- Follow up during home visits
- Help in creating a safe and conducive environment for our adolescents to grow into mentally and physically healthy adults.

B.3.7 REACHING OUT TO ADOLESCENTS:

Think and reflect

Why is it important for you as an ASHA to be non-judgemental while counselling adolescents?

Think and reflect

What kind of words or behaviour can break an adolescent's trust? How can you as an ASHA build a friendly relationship with adolescents?

To gain the trust of the adolescents and to identify the factors that influence their decision-making process, you may need to understand and acquire effective communication and counselling skills which are tailor made to address the unique adolescent wellbeing issues. This will enable you to identify early signs of adolescent health issues and risk-taking behaviour and eventually help you in intervening effectively to promote their mental and physical wellbeing.

Use GATHER approach for discussion

G

Greet the adolescent

- Put them at ease. Show respect and trust
- Emphasize the confidentiality of the discussion

A

Ask - how can I help you

- Encourage them to speak about their anxieties , worries and needs in their own words . Ask helpful questions .
- Determine their access to support and help in the family and community .
- What steps have already been taken to deal with the issue
- Actively listen and show that you are paying attention
- Show respect to what they are saying and do not pass judgement

T

Tell them the relevant information they need

- Provide accurate and specific information in reply to their questions .
- Give information on what they can do to remain healthy and well . Explain any background information they need to understand the particular health issue.

- Keep the language simple, repeat important points and ask questions to check if they have understood.

H

Help them to make decisions

- Explore various alternative.
- Raise issues which they may not have thought of, being careful not to let your own views, values and prejudices influence the advice you give.
- Ensure that it is their own decision and not imposed by you.
- Help them make a plan of action.

E

Explain to clear any misunderstanding / misconceptions / myths

- Ask questions to check their understanding on important issues
- Ask them to repeat what they have understood in their own words

R

Refer / Return for follow-up

- Refer to the AAM-PHC / Adolescent friendly health clinic in CHC / Hospital

Depression / Anxiety / Panic attacks / Substance abuse are dealt with in the Mental health section.

Concepts of sexuality are laid during this phase.

They start developing romantic feelings and exploring relationships. Therefore having correct and complete information about sexual and reproductive health is important for them. This can be provided to them with the help of ANM / counsellors available in the CHC / hospital .

Failure to provide this information can lead to:

- Reproductive tract infections
- Sexually transmitted infections
- Teenage pregnancy
- Unsafe abortions

B.3.8 RTIS (REPRODUCTIVE TRACT INFECTIONS) AND STIS (SEXUALLY TRANSMITTED INFECTIONS)

Adolescents may be at risk of STIs, including HIV, particularly when they have unprotected sex or other risk factors. Accurate information, condoms, HIV/STI testing and treatment help prevent STIs.

Reproductive Tract Infections (RTIs) RTIs are infections of the reproductive organs. In girls, these infections can affect the reproductive organs and reproductive tract. If not treated on time, this can lead to infertility. Other causes of RTIs include poor hygiene, unsafe delivery, unsafe abortions etc.

Sexually Transmitted Infections (STIs) STIs are mainly spread through sexual contact from one person to another. Some STIs can also spread through infected blood through sharing of needles or transfusion of infected blood . Some of these infections can also pass on from an infected mother to her baby during pregnancy or childbirth and cause harm to the baby.

STIs cause serious physical illness and mental stress in the infected person.

Symptoms of RTI and STIs:

- Pain in lower abdomen
- Burning sensation while passing urine
- Itching in the genital region
- Abnormal discharge from vagina (girls) or penis (boys)
- Pain during sexual intercourse
- Ulcers / vesicles / nodules in genital region
- Swelling in groin region

In case of suspected RTI / STI the adolescent must be advised not to indulge in any further sexual activity and referred to the AAM -SHC / PHC for necessary evaluation and treatment. If the STI is confirmed , the partner / sexual contacts must be evaluated and treated for STI .

Human Immunodeficiency Virus (HIV)/Acquired Immuno-Deficiency Syndrome (AIDS) in Adolescents:

STIs, especially those causing genital sores or ulcers, increase the chance of HIV transmission between sexual partners. Preventing and treating STIs is therefore very important to control the spread of HIV. You must have heard about AIDS . It is caused by Human Immunodeficiency virus. This can spread from an infected individual

- Through sexual contact including unprotected anal, vaginal, or oral sex.
- From an infected mother to her child (Mother to Child Transmission: MTCT) during pregnancy, delivery, or breastfeeding.
- Sharing of infected syringes and needles contaminated with infected blood and other body fluids.
- Transfusion of infected/unsafe blood or blood products.

HIV/AIDS transmission can be prevented by raising awareness about :

- Safe sex
- Danger of using unsterile needles
- Dangers of sharing needles by Injectable Drug Users (IDUs)
- Needle exchange programme
- Dangers of unsafe blood transfusion
- Existence of and services provided at the nearest ICTC (Integrated Counselling and Testing Centres)

- As an ASHA, you should educate adolescents about safe sexual behaviour, correct and regular use of condoms, early identification of symptoms of RTIs/STIs, and the importance of timely treatment.
- As an ASHA, you should promote confidentiality, reduce stigma, and link adolescents to friendly and safe health services.

B.3.9 TEENAGE PREGNANCY:

Pregnancy at a young age is dangerous for both the mother and the baby. Adolescent girls have a higher chance of problems such as anemia , high blood pressure, early delivery , difficult delivery, restricted growth of baby and infections. There are higher chances of the babies being premature , underweight and getting sick . Pregnancy and child birth related complications are an important cause of death in 15 to 19 years age group. It falls in the category of high risk pregnancies .

Teenage Pregnancy:

It may also be added that teenage pregnancy is one of the high-risk categories under Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA).

Early marriage puts adolescent girls at high risk of early pregnancy. Soon after marriage, girls are often expected to have a child, even when their bodies are not fully ready. Early marriage usually leads to disruption of education, reducing her chances of future economic independence and social status .

Early pregnancy also affects the mental and social wellbeing of the girl. Many girls feel scared, stressed, or sad because of early responsibilities and lack of support.

Pregnancy outside marriage is another serious issue. It may happen due to rape, force, or sexual abuse. Such pregnancies carry strong social stigma. The adolescent girl may face blame, isolation, and violence, and is at high risk of physical harm and long-lasting mental trauma.

Factors contributing to teenage pregnancy:

- Customs and traditions that lead to early marriage
- Lack of education and information about reproductive sexual health
- Lack of access to effective contraception
- Peer pressure to engage in sexual activity/substance abuse
- Exposure to abuse, violence, and family strife at home

As an ASHA, you should talk to families and adolescents about the harms of early marriage and early pregnancy, encourage girls to continue education, identify girls at risk, provide counselling, and link them to health services and support them.

Unsafe Abortion

Adolescent pregnancy often leads to unsafe abortion, especially when the girl is unmarried. Fear of family, society, and stigma makes many girls hide their pregnancy and seek unsafe methods to end it. Unsafe abortion can be very dangerous and can even cause death.

Reasons for unsafe abortion among adolescents:

Delay in seeking abortion: Many adolescents do not realise early that they are pregnant or try to hide the pregnancy, hoping the problem will go away and delay approaching health facility.

Fear of health facilities: Judgmental behaviour and unkind attitude of some health providers also make adolescents afraid to approach health centres, causing further delay.

Going to untrained / unskilled providers: Many adolescents, especially unmarried girls or those with unwanted pregnancy, go to untrained and unsafe providers to keep the matter

secret from family or in-laws. Younger girls are more likely to undergo unsafe abortions done in unhygienic conditions by unskilled persons.

Lack of awareness about legal and safe abortion: Most adolescents are not aware that safe abortion services are available legally at registered health facilities.

Use of dangerous methods: Untrained birth attendants, quacks or sometimes even mothers may advise use of harmful methods like inserting sticks or roots into the vagina, or ingesting certain potions or medications for inducing abortion. These methods can cause severe bleeding, infection, and even death.

Problems after abortion: Even after a spontaneous abortion, adolescents can develop serious problems if the abortion is incomplete, infection occurs, or unhygienic practices are followed.

For methods of Contraception please refer to Family Planning Chapter

As an ASHA, you should spread awareness that abortion is legal and safe services are available at health facilities. You should ensure confidentiality, encourage early care-seeking, discourage unsafe methods, and support adolescents in accessing safe abortion and post-abortion care without fear or stigma.

Case Study

Ms. D is a 19-year-old woman who lives in a small town with her parents. She takes tuitions for little children. She has a boyfriend and once had unprotected sex with her friend, after which she got pregnant. She was 3 months pregnant and unable to share about the pregnancy with anyone. She visited a female doctor at Primary Health Centre located 3 kms from her home, with her boyfriend to inquire about having an abortion, because the centre closer to her home had many people who knew her. She applied sindoor (red vermillion applied in the hair-parting used by married women) but when the doctor asked her how long she had been married, she was not able to give a clear answer. This made the doctor suspicious, and she asked Ms. D to return again with her mother-in-law.

An ASHA who had heard this conversation that Ms. D had with the doctor told Ms. D that she could support her getting an abortion and that no one would find out about the same. She told Ms. D that she would introduce her to a private nurse who could give her some abortion pills for Rs 5000/- Ms. D had no clue what to do.

Question 1. The doctor refused to give Ms. D an abortion. Was this the right thing to do?

Answer: The doctor had figured that Ms. D was unmarried and that she was sexually active. She refused to extend medical support for abortion to Ms. D because in our society pre-marital sex is considered to be taboo. The doctor should not have done this because 19-year-old Ms. D had the right to decide if she wanted to terminate the pregnancy. According to the Medical Termination of Pregnancy Act 1971, any unmarried woman who is not physically and mentally ready to continue with her pregnancy can approach a certified medical practitioner for the termination of her pregnancy. Considering that Ms. D was above 18 years of age, this did not require the consent of her family members.

Question 2. Did the ASHA give Ms. D the correct advice?

Answer: The ASHA did not give Ms. D any advice related to medical termination of pregnancy. It was completely wrong of her to direct Ms. D to a private nurse for abortion. She was perhaps attempting to take advantage of Ms. D's helplessness. Only a certified medical practitioner can advise on the procedure for pregnancy abortion.

Further, since Ms. D was 3 months pregnant, abortion pills would not have been effective in her case. What the ASHA did was illegal and could have put Ms. D's life in danger.

Question 3. What kind of support should the ASHA have extended to Ms. D?

Answer: The ASHA should have discussed with the doctor to help Ms. D and provide the correct information and refer to the hospital for abortion. If the doctor did not agree, she should have told Ms. D about another hospital where safe and legal abortion is provided. Also, she should have provided Ms. D with information about contraception methods and safe sex.

Here we discuss the critical practices that will enable you to have a dialogue with youth and also assess their own attitudes, in order to build a positive relationship with them. These are essential for any health worker to be able to create a friendly and open relationship with the youth.

Maintaining Privacy: Protecting the privacy of youth, especially those who approach to you for advice and information about their problems, especially on issues such as contraception is very critical. It is important to ensure that counselling sessions or sharing of information is done with privacy in the absence of other people. It's common for people to be curious when they see a young person talking to you. In such a scenario you should be ready to respond tactically so that the curiosity is also responded to and privacy of the person involved is maintained.

For instance: If a young married woman has approached you for an emergency contraceptive pill at the Anganwadi centre and there are other older women of the village present there, how will you talk to her.

(Here X indicates 'inappropriate practices' and ✓indicates 'appropriate practices')

X Ask in front of the others why she has come and what help she needs. And send her back without a one- on- one private sharing.

✓ Start a casual conversation with her in front of the rest and then look for an opportune moment to talk to her in private or set up another time and date to meet her personally. If any elder women ask about the topic of conversation, you could think of something else to say, like "she had come to ask about fever or stomach upset or vaccinations etc".

Once the older women have left, You could then speak to the young woman.

Accepting the autonomy of young people: It is important to treat youth as adults, who can take their own decisions in life. Do not let your own personal or moral beliefs influence your behaviour towards them. Do not advise them, instead be a listener and provide full relevant information so that they can make their decision.

For instance: If a 19-year-old young woman has approached you for information related to abortion, which of the following responses from you show or indicate openness:

X While having fun with your friend you should have thought of the outcome. Now be ready to face the consequences. Just think of what your parents will go through when find out about this.

✓ Do not worry. You have done the right thing by approaching me. The decision to have an abortion is entirely yours. I will take you to the health centre and will ensure that this remains between us if you wish so.

Sensitive and Respectful behaviour: Apart from respecting the freedom of youth, it is important to treat them with dignity. Address them by their name, do not threaten or intimidate them instead listen to them in a non-judgmental way. This is the duty of a health worker.

For instance: If a young woman talks to you about her irregular menstrual cycle, then what would be the appropriate sensitive and respectful response?

X You are so thin and weak, you don't eat properly and so you are facing these problems. If you don't take care of your health, then your menstrual cycle will remain irregular.

✓ This is common when girls are growing up. There is no need to worry. First, could you tell me a bit about your diet? Do you eat three proper meals a day?

Non-critical attitude: A non-critical attitude makes you more approachable for young people. If you have a non-judgemental attitude about pre-marital sex, abortion, sexual orientation etc. and are able to behave in a non-discriminatory manner, then young people will be encouraged to share their thoughts without hesitation.

For instance: If an unmarried young girl speaks about her pregnancy, how would you respond to her?

X Oh, what have you done? Boys will be boys, but you are a girl and should have known better. You should've thought about the honour of your parents! If anyone finds out, you will not be able to face people!

✓ There is no need to be fearful. I'm here with you. Could you share if this was a consensual relationship or if you were forced or pressurised in any way? Even if you have made this choice, you can tell me openly.

There is nothing wrong about it. You can speak to me without any hesitation, these are your options now. I will help you.

Accepting the sexual rights and sexuality of young people: young people have the complete right to make decisions about their own bodies and also to choose their sexuality. If they choose to exercise this right, which might be against societal norms, their choices should not be questioned. You should not question their choices citing their young age as a reason. You have to accept their choices and provide them the service and support they need as per their requirements with dignity and respect.

For instance: If young unmarried men or women ask for condoms, how would you talk to them?

X You are not yet married and too young, what will you do with a condom? This is only for married people.

✓ You can take this pack of condoms. Do remember that your sexual relationship must be consensual.

Providing clear, correct and complete information: Sexual and reproductive health are sensitive issues around which there are several pre-existing notions and myths in the society. You can play an important role in dismantling these myths and preconceived notions. It is thus critical that you are equipped with full and clear information about their subject matter, and it is only that they can provide the same to the youth.

For instance: If a young woman does not want to continue with her unintended pregnancy but is concerned that if she carries out an abortion, she will never be able to get pregnant again. What will be your response in such a situation?

X You will deter her from having an abortion and tell her that it will hamper her ability to conceive again since she wants to have a child.

✓ You will inform her that if a safe procedure of abortion is provided by a trained medical practitioner, then chances of there being complications and of affecting her future fertility were very remote . With this information she will be able to make her own decision. You extend support to help her by providing her access to a safe and trained medical practitioner at a health centre.

Taking Consent: Since young people are adults, before sharing any information about them with anyone else, taking their consent is a must, be it a medical practitioner or a family member. Before seeking consent provide detailed background information as to why sharing the matter is important.

For instance: If a woman would like to go in for an HIV test. You feel that you need to discuss the matter with a medical practitioner before providing support for the test service. How will you discuss the matter?

X Good you have brought this matter to me. I will discuss your case with the doctor so that the tests may be carried out.

✓ Good that you have brought this matter to me. Testing will require a visit to the hospital. Before we do that, may I share the details of your case with the doctor? In case any other tests need to be done I will find out the details. I will not be sharing your name with the doctor – you can share it as per your level of comfort.

Non-Communicable diseases (NCDs):

Across the country in the past two decades, people have experienced a dramatic change in the pattern of diseases. There is a declining trend in infectious (communicable) diseases and a steady rise in the so-called lifestyle diseases or non-communicable diseases – Diabetes , hypertension, stroke, heart attack etc.

Unhealthy diet and lifestyle are two major factors responsible for increased susceptibility to these diseases. Drug abuse, smoking, increased tobacco and alcohol consumption, as well as lack of exercise are known to increase the risk of developing these diseases in later part of life.

There is greater rate of obesity due to sedentary lifestyle, more time on computers/phones and increased intake of high energy, sugar rich and fried foods.

You have to:

- Identify adolescents with unhealthy food habits and lack of physical activity
- Counsel adolescents and families on healthy diet and regular exercise
- Motivate adolescents to avoid tobacco, alcohol, and substance use
- Encourage outdoor games and reduced screen time
- Refer adolescents with obesity or suspected NCDs to AAM

B.3.10 NATIONAL PROGRAMS FOR ADOLESCENTS

Rashtriya Kishor Swasthya Karyakram (RKSK)

To address the health and overall development needs of adolescents, the Government of India is implementing Rashtriya Kishor Swasthya Karyakram (RKSK). It focuses on prevention, health promotion, counselling, and life skills, and reaches adolescents in their communities, schools, and families, instead of waiting for them at health facilities.

Program aims at:

- Improving the sexual and reproductive health in adolescents ,
- Improving their nutrition and reducing anemia
- Enhance mental health and prevent substance abuse
- Inculcate healthy life style and dietary habits for prevention of NCDs
- Reduce violence and injuries

You have learned about all these in the preceding pages and your role in achieving these.

Target Population under RKSK covers all adolescent girls and boys in both rural and urban areas whether they are in school or out of school including the married adolescents.

Special attention is given to the vulnerable and marginalised adolescents, such as:

- Adolescents living in urban slums and tribal areas

RKSK
Rashtriya Kishor
Swasthya Karyakram
राष्ट्रीय किशोर स्वास्थ्य कार्यक्रम

- Migrant and working adolescents
- Adolescents with mental or physical disabilities
- Street children
- Adolescents living in care homes and juvenile homes

Under the program certain services are provided in the centre , some services are provided in the community and the others are provided in school.

Facility based approach	Community based approach	School based approach
• Adolescent Friendly Health Clinics (AFHCs) providing clinical and counselling services • Adolescent Health Resource Centre at District Hospital	• Weekly Iron Folic Acid Supplementation (WIFS) • National Deworming Day (NDD) • Provision of sanitary napkins (MHS) • Peer Education Programme (PE) • Quarterly Adolescent Health Days (AHD) • Adolescent Friendly Clubs (AFCs)	• Strengthening of school health activities (School Health Programme) • Screening of adolescents for 4 Ds (RBSK) • National Deworming Day (NDD) • Provision of sanitary napkins (MHS) • Peer Education Programme (PE)

As an ASHA, you should know about your nearest AFHC and adolescent health resource centre. You play a key role in identifying adolescents, creating awareness about adolescent health issues, encouraging healthy behaviours, providing counselling, and linking adolescents, especially those from vulnerable groups, to appropriate RKSK services.

You are expected to play a key role in community based activities under the program

Adolescent Friendly Health Clinics (AFHCs)

Adolescent Friendly Health Clinics (AFHCs) provide safe, confidential, and supportive health services for adolescents. These clinics are meant to help adolescents talk freely about their health problems without fear, shame, or judgement.

AFHCs are set up at PHC, CHC, Sub-District Hospital (SDH), District Hospital (DH), and Medical Colleges. At these higher health facilities, services are available daily, and a trained counsellor is present on all working days at CHC level and above.

Sub-centres identified as Ayushman Arogya Mandir can act as walk-in clinics for adolescents. At sub-centres, services are provided by the CHO or ANM. At the PHC, adolescent-friendly services are provided once a week by a trained Medical Officer and ANM.

Services Provided at AFHCs

Adolescents can receive the following services at AFHCs or be referred within the same health facility if needed:

- Measurement of BMI (Body Mass Index)
- Hemoglobin testing to detect anemia
- RTI/STI diagnosis and treatment
- Antenatal care (ANC) for pregnant adolescents
- Treatment of menstrual problems
- Management of iron deficiency anemia
- HIV testing and counselling

- Screening, counselling and appropriate management/referral for relevant NCD risk factors and conditions.
- Care for injuries due to accidents or violence
- Counselling Services at AFHCs
- Counsellors provide guidance and support on:
  - » Nutrition and healthy eating
  - » Puberty-related changes
  - » Counselling on relationships, sexual and reproductive health, contraception, consent and healthy decision-making
  - » Sexual health problems
  - » Contraception and family planning
  - » Safe and legal abortion
  - » RTI/STI and HIV prevention
  - » Substance abuse (tobacco, alcohol, drugs)
  - » Learning difficulties
  - » Stress, depression, suicidal thoughts
  - » Violence and sexual abuse
  - » Other mental health issues
  - » Healthy lifestyle habits

Role of ASHA: As an ASHA when you come across an adolescent needing any of the above mentioned services, you are to refer the adolescent to the nearest AFHC. You should inform adolescents and their families about AFHC services, motivate adolescents to visit these clinics, ensure privacy and confidentiality, reduce fear and stigma, and support referrals and follow-up care when needed.

Peer Education Programme (PEP)

Under Rashtriya Kishor Swasthya Karyakram (RKSK), adolescents in the community are reached through the Peer Education (PE) Programme. Trained peer educators, known as Saathiya, help adolescents learn from people of their own age group in a friendly and comfortable way.

Through regular peer education sessions, adolescents receive correct information on all six RKSK themes. This approach is especially useful for reaching out-of-school adolescents, along with those who attend school.

Key Features of the Peer Education Programme

- Four peer educators are selected in each village/ASHA habitation (about 1,000 population) – two boys and two girls.
- Selection of Saathiya is facilitated by ASHA, in consultation with the Village Health, Sanitation and Nutrition Committee (VHSNC).

- Each Saathiya forms a group of 15–20 adolescents (boys or girls separately) from the community.
- Saathiya conducts weekly sessions of 1–2 hours using the Peer Education (PE) kits. Sessions are participatory and encourage open discussion.
- Saathiya maintains a diary, noting details of each session and the number of participants.
- Saathiya helps adolescents understand health issues and informs them about adolescent-friendly health services, so they can use these services when needed.
- Saathiya helps organise quarterly Adolescent Health Days (AHDs) and participates in Adolescent Friendly Club (AFC) meetings. They inform adolescents about the date, place, and benefits of attending AHDs and motivate them to participate.

Peer education helps adolescents learn, share, and support each other.

As an ASHA you act as the village-level Saathiya coordinator

- Help in identification of peer educators.
- Create awareness about PE program amongst the community, and provide support in formation of adolescent groups .
- Help the Peer educators in reaching out to the adolescents in your area.
- Help peer educator in organizing awareness activities and support him / her by being there to answer the queries / provide services along with ANM / AWW.

Your guidance and support are crucial to make the Peer Education Programme effective and sustainable at the village level. If needed, CHO/MPW supports and moderates monthly AFC sessions at the Sub- Health Centre.

Adolescent Friendly Club Meetings

Adolescent Friendly Club (AFC) meetings are also organized once a month at AAM-SHC level under the overall guidance of CHO. These typically cover 5 villages/5000 population composed of 15-20 Saathiya each. During meetings, Saathiya from different villages meet and clarify issues which they have encountered during their weekly sessions with the help of CHO/ANM. The community level implementation process of peer education program given below

Adolescent Health Days (AHDs)

Adolescent Health Day (AHD) is a quarterly community-level activity under Rashtriya Kishor Swasthya Karyakram (RKSK). Its purpose is to strengthen preventive and promotive health care for adolescents and to increase awareness among adolescents, parents, families, and other community members about adolescent health needs and problems.

Key Features of Adolescent Health Days

- AHDs are organised once every three months at the village level.

- They are held at Anganwadi Centres (AWCs) or any other public place that is easy for adolescents and community members to reach.
- A budget of Rs.2,500 is provided for organising each quarterly AHD.
- An incentive of Rs.200 per ASHA is given for mobilising adolescents, parents, and other stakeholders to attend AHD.
- On the scheduled day, Peer Educators (Saathiya), ASHAs, AWWs, and other frontline workers mobilise adolescents, parents, and community members to gather at the AWC or a decided community space.

Activities during AHD

- To attract adolescents and spread messages on health, health check-ups and interactive activities are organised.
- These may include skits, street plays, puppet shows, games, quizzes, and discussions on adolescent health topics.
- Presence of CHO and ANM during AHD is desired to provide services and educate the community.
- Adolescents and parents get a chance to interact directly with health staff, receive basic services, and clarify doubts.

Identification of Adolescents for Referral

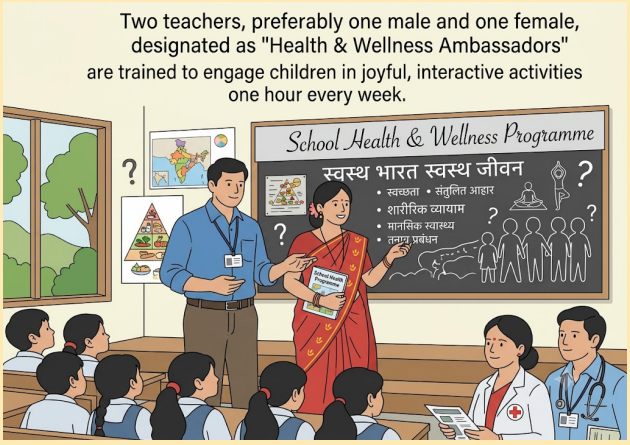
If health screening is done during AHD, by CHO/ANM, adolescents should be identified and referred to AFHCs or higher health facilities for further care in case of:

- Very low or high BMI
- Moderate or severe anaemia
- Pregnant adolescents
- Symptoms of RTI/STI
- Mental health problems such as stress, depression, or suicidal thoughts
- Adolescents facing violence, including gender-based violence
- Adolescents with non-communicable diseases (NCDs)

As an ASHA you play a key role in planning AHDs, mobilising adolescents and families, supporting activities on the day, identifying adolescents who need referral, and ensuring follow-up after referral.

School Health & Wellness Programme:

Schools play a critical role in helping students establish lifelong healthy behaviours. Recognizing the importance of this, school-based health promotion activities have been incorporated as a part of the Health and Wellness component of the Ayushman Bharat Programme.



School Health & Wellness Programme is being implemented in government and government aided schools in districts. Two teachers, preferably one male and one female, in every school, designated as "Health and Wellness Ambassadors" shall be trained to transact with school children, health promotion and disease prevention information on 11 thematic areas in the form of interesting joyful interactive activities for one hour every week.

- As an Asha, your role is, Routine meeting with the school Health and Wellness Ambassadors to discuss the activities and facilitating them whenever needed.
- Orienting the Ambassadors on the available services as a part of various National Health Programs from time to time.

Accompanying CHOs and ANMs to mobilize adolescents

Referral Mechanism for Adolescent

Program being close to the community, you as an ASHA can play a pivotal role in identification of health and behavioral issues that put adolescents at risk of negative health outcomes. You should also be aware of when and how to refer adolescents to higher health facilities and/or social service providers, as and when necessary.

List of referral conditions under adolescent health services:

S. No.	Condition	Referral
1.	Moderate to Severe Anaemia	HWC-PHC/UPHC
2.	Growth Abnormalities/disabilities	SDH/DH
3.	Case of drug/substance abuse	De addiction centre (DH/SDH)
4.	PMS/Menorrhagia	PHC/UPHC-HWC
5.	Mental Health Issues	A-HRC (District)
6.	Management of RTI/STI	HWC-SHC/UPHC/PHC
7.	Early or late appearance of secondary sexual character	SDH/DH
8.	Unsafe abortion	CEmONC facility/SDH/DH
9.	Risk factors (BP, BMI, Random blood sugar, family history of NCD etc.)	PHC/UPHC-HWC
10.	Management of physical violence and sexual abuse	CHC/SDH/DH

Follow-Up

One of the key components of Comprehensive Primary Health Care is the assurance of the mechanism of 'Continuum of Care'. To maintain the trust of adolescents and to provide quality services, continuity of services should be one of the primary focuses.

Community/Household: You would undertake home visits to ensure that the adolescent is taking actions for risk-factor modification, provide counselling and support and issue reminders for follow up appointments at AAM and for collection of medications if needed. The CHO should also visit and counsel parents and the community whenever the need is perceived. The service providers should also spread awareness among the adolescents and community regarding Adolescent Friendly Health Services under the RKSK programme, psychological support services, health clinics and the school-based programmes under RBSK.

AAM: In AAM, dispensation of medicines, repeat investigations/diagnostics as required, identification of complications and facilitating referrals to a higher-level facility/teleconsultation with a specialist as required needs to be undertaken with proper maintenance of records. Adolescents should be referred to AFC for counselling if the need is sensed.

B.3.11 ADOLESCENT IMMUNIZATION

Under Universal Immunization Program (UIP), adolescents aged 10 years and 16 years are to be vaccinated with Tetanus and adult Diphtheria (Td) vaccine as per national immunization schedule. Different strategies are being followed in the states to optimise adolescent immunization with Td10 and Td16 vaccination:

- Convergence with Rashtriya Bal Swasthya Karyakram (RBSK) programme to improve Td10 and Td16 coverage mainly at schools.
- Using VHSNDs and UHSNDs to provide Td10 and Td16 vaccination for out of school children.
- Organize Td immunization week(s) to improve Td10 and Td16 coverage.
- School-going adolescents of class 5 and class 10 can be vaccinated using platforms like School Health program (SHP) as well as by carrying out Td adolescent immunization week once every year where all out of school adolescents can be vaccinated.

As an ASHA you play a key role in ensuring adolescent immunization by identifying and listing eligible adolescents, including both school-going and out-of-school children.

Awareness and counselling are provided to adolescents and parents to address fears and myths related to vaccination and to explain its benefits. Mobilisation and coordination are done with ANM, CHO, and schools to ensure attendance at immunization sessions. Follow-up and record updating are ensured so that no eligible adolescent is missed or left out.

B4
Maternal Health

PART B

B.4 Maternal Health

In this section we will discuss the following topics:

1. Pre-conception stage
2. Antenatal Care
3. Care during delivery and immediately after delivery (Post-natal and Newborn care is discussed in Newborn section)
4. Family planning
5. Reproductive Tract Infection and Sexually transmitted Infections (RTI & STI)
6. Comprehensive abortion care
7. National health programs for Maternal and Newborn health

Introduction: Your Role as an ASHA in Maternal and Newborn Health:

As an ASHA, you play an important role in ensuring the health and survival of pregnant women and newborns in your community. From the time a couple starts planning a family till the baby is born and breastfeeding is established, you are the person they trust, turn to, and listen to. Your actions during this period can prevent illness, complications, and deaths.

This section will help you understand maternal and newborn health in a simple and practical way. It will strengthen your knowledge, sharpen your skills, and build the right attitude so that you can confidently support women and families during pregnancy , childbirth and after delivery care of mother and newborn.

By the end of this section, you should be able to identify and list all pregnant women in your area, counsel couples before pregnancy, help in early confirmation and registration of pregnancy, ensure regular antenatal check-ups, recognise high-risk pregnancies and danger signs and facilitate access to the required care, support families in birth planning, ensuring safe institutional deliveries, post-natal care and adoption of a suitable family planning method.

B.4.1. PLANNING TO CONCEIVE: THE PRE-CONCEPTION STAGE

The journey to a healthy pregnancy starts even before conception. As an ASHA, you should talk to families about the right age for marriage and the right time for the first pregnancy.

The legal minimum age for marriage in India is 18 years for women and 21 years for men. However, pregnancy below 21 years of age, especially teenage pregnancy, is associated with many risks. Young mothers are more likely to suffer from anaemia, pre-term labour, and complications during delivery. Babies born to very young mothers are more likely to have low birth weight and higher chances of neonatal illness and death. Early marriage also interrupts education and chances of gainful employment , increases the risk of domestic violence and mental health issues.

You should help your community understand that delaying the first pregnancy till at least 21 years of age gives the woman time to grow physically and emotionally, complete her education, and enter pregnancy in a healthier state.

Counselling Newly Married Couples: Whenever a newly married couple comes to live in your area, you should make it a point to visit their home. Begin by congratulating the elders and the couple. Build trust before starting counselling.

Remember, the same message does not work for everyone. Your advice must depend on the age of the woman, the financial condition of the family, and whether the couple is eager to have a baby immediately. For example, for a 19 years old girl, your advice will focus on delaying pregnancy and improving nutrition. If she is 24 years old and wishes to conceive, your advice will be different.

If available, ask your ANM didi to show you the Nayi Pehal Kit and carry it with you during such visits to support your counselling.

Advise all women of reproductive age group who are not pregnant about once a week IFA supplementation and iron rich diet.

Any pale looking woman should be advised to get her Hb test done and if found anemic should be treated as advised by CHO / MO.

Think and reflect

Mrs. P got married one year ago. She and her husband have decided to start their family. What advice will you give her now ?

Once she conceives, when should she go for her first checkup ?

Advice once the couple decides to start a family:

- When a couple decides to conceive, you should advise the woman to stop using any contraceptive method.
- All women of reproductive age should be advised to take folic acid for two to three months before conception and continue it during the first 12 weeks of pregnancy. This significantly reduces the risk of neural tube defects in the baby. The recommended daily dose is 400 micrograms taken orally.
- You should counsel her to eat a healthy and nutritious diet, which is described in

following section. She should avoid alcohol and tobacco completely and should not take any medicine without a doctor's advice. She must inform the doctor that she is trying to conceive.

- You should also explain the importance of using iodised salt regularly, as low iodine levels during pregnancy can cause mental and physical retardation in the baby.

Most importantly, you should tell her that if her period is missed, she should immediately contact you or visit the nearest AAM for confirmation of pregnancy using a urine pregnancy test.

Confirming the Pregnancy

- Pregnancy should be confirmed as soon as possible after the first missed period.
- As an ASHA, you can conduct a urine pregnancy test using kits such as the Nischay kit.
- This is a simple and reliable method to detect pregnancy in the first trimester and can be done immediately after a missed period.
- A positive test means the woman is pregnant.
- A negative test means she is not pregnant.
- If the test is negative and the woman does not wish to conceive, you should counsel her about the available family planning methods.
- The result of the pregnancy test must always be kept confidential.

How to Conduct a Pregnancy Detection Test

You should remove the pregnancy test cassette from the kit and place it on a flat surface. Using the dropper, collect a morning urine sample and put two to three drops into the well marked 'S'. Wait for five minutes before reading the result.

If two parallel red bands appear, the test is positive. All pregnant women must then be registered by the ANM to receive antenatal services.

If one red band appears in the result window, the test is negative. Encourage the woman to adopt family planning methods if she does not want pregnancy.

Early Registration for Antenatal Care:

As soon as pregnancy is confirmed, the woman should be registered for antenatal care at the nearest AAM-SHC. Early registration is extremely important.

Many communities believe that pregnancy should not be disclosed to outsiders until three or four months. This myth is one of the main reasons for late registration. You must use the first interaction to gently counter this belief. Explain to the woman and her family that the foundation of a healthy baby is laid during the first three months. Important tests are done at this stage, folic acid is started, and early problems can be detected.

Reassure her that her privacy will be maintained by you and the ANM didi at the AAM.

Estimating Pregnant Women in Your Area

To ensure that no pregnant woman is missed, you must estimate how many pregnancies are expected in your area each year. This is based on the birth rate. To estimate pregnancies, a correction factor of 10% is added to account for abortions and stillbirths. This means that under one ASHA, around 28 to 29 pregnancies are expected in a year. (Based on the birth rate)

This calculation helps you check whether all expected pregnancies are being registered on time.

How many newborns in your area?

Birth rate= 25.5/1000 population Population under each ASHA= 1000

Therefore, expected number of live births= (25.5x1000)/1000= 25.5 births annually under each ASHA.

Hence number of newborns per month= 25.5/12= 2 – 3/month.

How many pregnant women are in your area?

Birth rate of Bihar= 25.5/1000 population (SRS May 2022)

Population under each ASHA = 1000 Therefore, expected number of live births= (25.5x1000)/1000 = 25.5 births

Correction factor= 10% of 25.5 (i.e. [10/100] x25.5)= 2.55

Therefore, total number of expected Pregnancies in a year under one ASHA = 25.5+ 2.55 = 28.05=29 pregnancies per year / 2-3 pregnancies per month

At any given time, an ASHA looking after 1000 population will have approximately 16-24 pregnant / delivered post-natal women in her care in a rural area. Around one fourth of these may be high risk.

B.4.2 ANTENATAL CARE: WHAT IT MEANS AND WHY IT MATTERS

Antenatal care is the systematic supervision of a woman during pregnancy to monitor growth of the baby and the health of the mother. Proper antenatal care helps detect problems like anaemia, high blood pressure, and poor foetal growth early. It allows timely referral, helps in preparing a birth plan, and improves outcomes for both mother and baby. As a member of the primary healthcare team, you are responsible for ensuring that every pregnant woman in your area has access to complete antenatal care.

Calculating the Expected Date of Delivery (EDD)

Once pregnancy is confirmed, you should ask the woman the first day of her last menstrual period. This date is used to calculate the expected date of delivery. The formula is simple: add nine months and seven days to the first day of the last menstrual period.

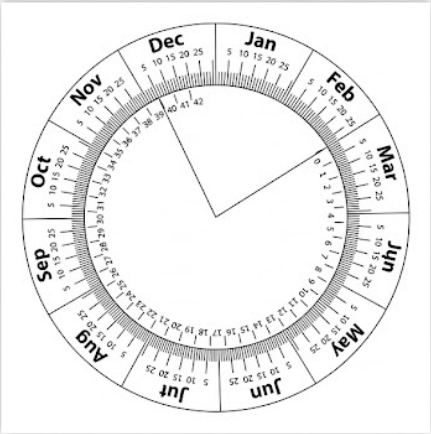
For example, if the first day of the last menstrual period was 20 December 2021, adding nine months brings you to 20 September 2022. Adding seven more days gives an expected delivery date of 27 September 2022. Remember that this is an approximate date, and delivery may happen up to 15 days before or after this date.

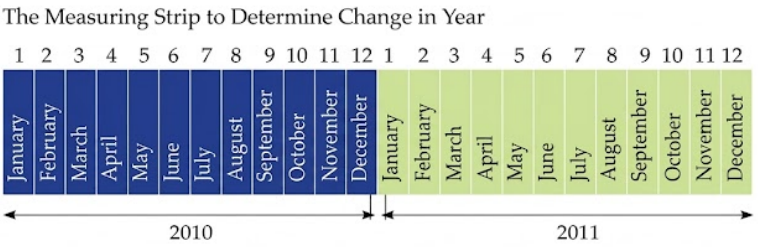
If the first date of LMP is: 20th December 2021

Nine months later is: 20th September 2022

Adding seven days is: 27th September 2022

Therefore, the expected date of delivery is 27th September 2022





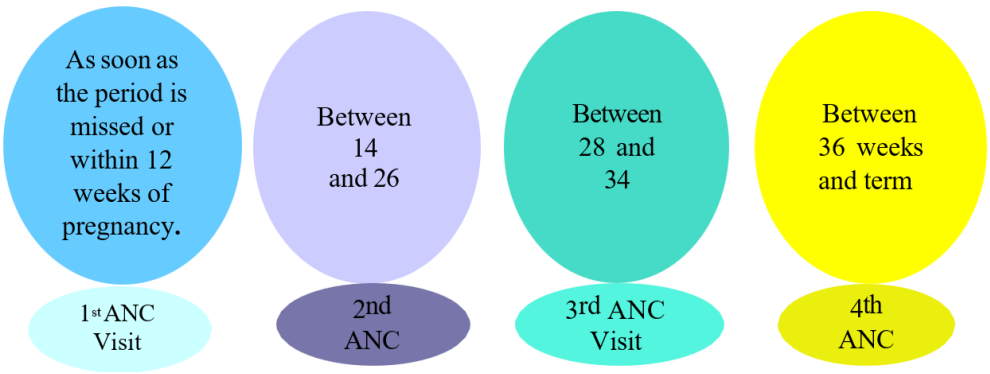
This is pregnancy wheel which helps you to determine the last menstrual period (LMP) and expected date of delivery (EDD)

Activity

If the first day of the last menstrual period is 15 August 2025, calculate the expected date of delivery.

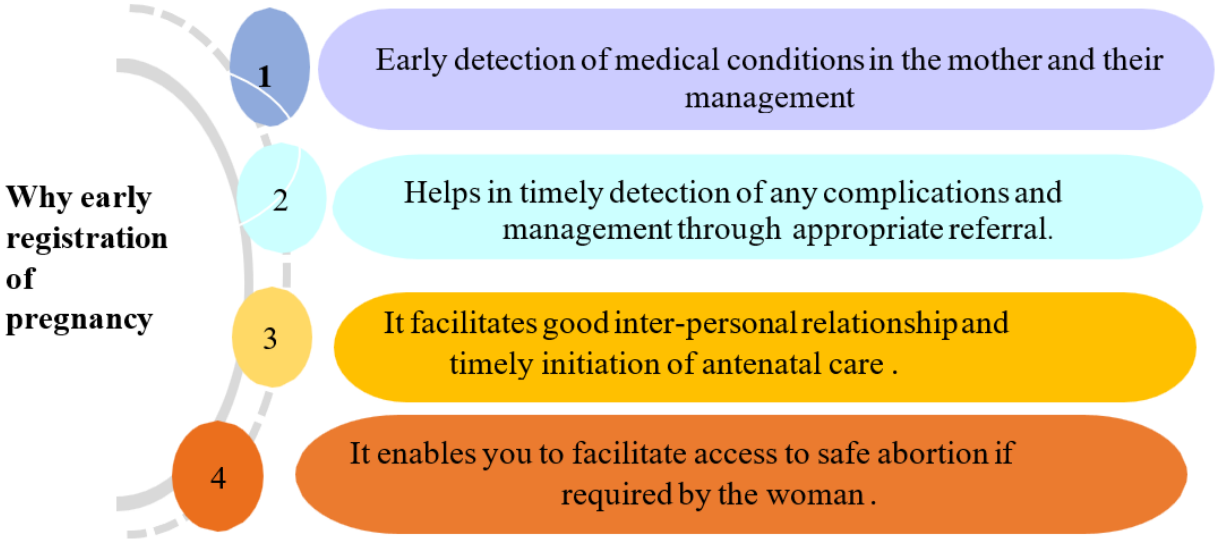
Schedule of Antenatal visits :

The first antenatal visit should happen as soon as pregnancy is suspected / confirmed, well within 12 weeks. The second visit should be between 14 and 26 weeks. The third visit should be between 28 and 34 weeks, and the fourth visit should be between 36 weeks and term.



Schedule of Antenatal check-up

The first antenatal visit should happen as soon as pregnancy is suspected / confirmed, well within 12 weeks. The second visit should be between 14 and 26 weeks. The third visit should be between 28 and 34 weeks, and the fourth visit should be between 36 weeks and term.



Early registration is important because it allows early detection of medical conditions, timely management of complications, access to safe abortion services if required. It helps in building a trusting relationship between you and the woman and it allows timely initiation of antenatal care and proper birth planning.

As an ASHA, you must refer all pregnant women to ANM for early registration. You should keep track of all pregnant women in your area. In case a woman who is registered with you does not return for her antenatal check-up, she must be followed up at her home and counselled to go for her due antenatal check-up.

A minimum of four antenatal check-ups are essential for pregnant women. It is advisable for the pregnant woman registered at AAM-SHC to visit the Medical Officer at the AAM-PHC for an antenatal check-up during the period of 28–34 weeks (third visit). You should also mobilize the pregnant mother on 9th of every month for antenatal check-up by doctors at PHC/CHC/DH under **Pradhan Mantri Surakshit Matritva Abhiyaan (PMSMA)**.

Services During the First Antenatal Visit

When a woman comes for her first antenatal visit, usually in the first trimester. As an ASHA, you must ensure that she reaches the ANM in time and that all required services are availed.

- During this visit, the pregnancy is formally registered and the MCP card is filled. A detailed medical and obstetric history is taken, including previous pregnancies, abortions, surgeries, and any existing illnesses.
- The woman's weight and blood pressure are measured, and a general physical examination is done. Blood and urine investigations are conducted to check haemoglobin

levels, blood group, blood sugar, and infections.

- Based on this assessment, the ANM identifies whether the pregnancy is low risk or high risk. Folic acid tablets are started, and the injection Td is given as required.
- The woman is counselled on diet, rest, hygiene, and danger signs. Her details are also registered in the Kilkari app, and the date for the next visit is clearly explained to her.

You must follow up to ensure that all investigations are done on time and that the reports are reviewed by the ANM or Medical Officer so that corrective action can be taken early if needed. During your follow up home visit, you should reinforce the counselling on diet, rest and hygiene and see if she is taking her Folic acid tablets. You should enquire if she is receiving and listening to the Kilkaari messages.

Injection Td

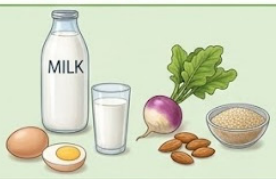
- Tetanus Diptheria (Td) injection protects both the mother and the baby from tetanus and Diptheria both of which are life-threatening diseases .
- The first dose is given as early as possible, preferably at the time of ANC registration.
- The second dose is given one month after the first dose and at least one month before the expected date of delivery.
- If she has already received two doses during a previous pregnancy within the last three years, only one booster dose is needed in the current pregnancy.
- You should inform her that mild pain, swelling, or redness at the injection site for one or two days is normal and not a cause for worry.
- If due to some reason, the woman receives the first dose after 38 weeks of pregnancy, the second dose may be given after delivery with a gap of four weeks.

Tab Folic Acid is started.

Counselling on Diet during pregnancy

During pregnancy, a woman is not eating just for herself but also for her growing baby. You should explain to her that she needs to eat more food and eat nutritious food.

- She should eat one extra meal every day.
- Milk and milk products such as curd, buttermilk, and paneer are important sources of calcium and protein.
- Fresh seasonal fruits and vegetables provide vitamins and iron. Green leafy vegetables, pulses, black gram, beetroot, and jaggery are especially good for preventing anaemia.
- Cereals, whole grains, and pulses provide energy and protein. Pulses are important sources of protein for vegetarian women. Non-vegetarian foods such as eggs, meat, chicken, and fish are excellent sources of protein, iron, and vitamins.
- As far as possible, she should eat freshly cooked home food.
- You should encourage the family to use locally available seasonal foods grown in and around the area.

Iron		**Green leafy vegetables, whole grains, cereals, dry fruits, nuts, meat, jaggary.**
Calcium		Milk, milk products, sesame seeds, almonds, soya milk, turnip, egg.
Vitamin		Orange and dark green vegetables, citrus fruits, apple, tomato, amla, vegetables, meat, fish, eggs, sunlight, milk and milk products, soya products.
Proteins		Paneer, milk and other milk products, combined grains, pulses, seeds, nuts, egg, meat, poultry, soya beans.
Fats		Butter, ghee, oils, nuts.

Counselling Tip:

- Ask the woman gently about what she eats, how much she eats, and how many times she eats in a day. Some women, especially from poor households, may hesitate to speak openly. Be respectful, sensitive, and tactful.
- Consider the family's financial condition, the husband's employment, and whether the woman herself is working and has enough time to eat properly.
- If needed, link her to the nearest Anganwadi for supplementary nutrition.
- Also listen carefully to traditional food practices during pregnancy. Do not dismiss them immediately. Understand first, then guide the family appropriately.

Vomiting During Pregnancy

- Many women experience nausea and vomiting during the first trimester. You should reassure them that this is common and usually improves as pregnancy advances.
- Advise her to eat frequent small meals and choose foods she prefers.
- In the morning, she should start with dry foods like biscuit or a rusk instead of liquids.
- If vomiting is excessive or continues into the second trimester, you must refer her to the AAM for further assessment.

Counselling on Hygiene During Pregnancy

- Good personal hygiene protects the woman from infections and prevents their transmission to the baby.
- You should advise her to wash her hands with soap and water before meals and after using the toilet. You can demonstrate to her the correct hand washing technique.
- She should keep her nails short, brush her teeth regularly, clean her breasts daily and keep the genital area clean and dry.
- She should avoid tight clothes.

Counselling on Rest During Pregnancy

- Adequate rest is essential for the physical and mental well-being of both the mother and the baby.
- Advise her to sleep for at least eight hours at night and rest for two hours during the day.

Think and reflect

Can you think of high risk conditions that may be identified during the first antenatal visit?

B.4.3 HIGH RISK PREGNANCIES

There are certain high-risk factors which can be identified at the first visit itself. This further emphasizes the importance of early registration. Women having these are at a higher risk of complications during this pregnancy and are therefore categorized as highrisk pregnancies needing special attention. These high risk factors are:

S.No	High risk factors identified at the first visit itself :
1	Woman below 19 years of age and above 40 years.
2	Woman who is very short (less than 145 cm).
3	Underweight woman (less than 45 kg).
4	Anemic woman.
5	Woman with RTI/STI.
6	Woman having Tuberculosis/Hepatitis B.
7	Woman having Diabetes/Hypertension/Hypothyroidism.
8	Woman with Rh negative blood group.

S.No	High risk factors identified at the first visit itself :
9	Woman with history of previous caesarian delivery/other abdominal surgery.
10	A woman with history of repeated abortions.
11	A woman with history of previous difficult child birth/still birth.
12	Woman with chronic disease/epilepsy.
13	Mother who already has more than 3 children.

If the woman is identified with a high risk condition, she should be followed up with 3 additional visits under PMSMA.

These women need closer follow-up, more frequent visits, repeat investigations, and sometimes referral to higher centres. Being an ASHA, you must maintain a list of all high-risk women in your area and coordinate closely with the ANM, CHO, and Medical Officer to ensure timely care. Your continuous support and monitoring can make the difference between a safe and unsafe outcome.

Apart from the existing high risk factors, there are conditions which can occur anytime during the pregnancy in an otherwise normal pregnancy or a known high risk pregnancy. These are recognized by certain signs and symptoms called danger signs.

Danger Signs During Early Pregnancy

During the first visit, the woman must be counselled to immediately seek care if she has vaginal bleeding, abdominal pain, high fever, convulsions, or any other severe symptom. If she contacts you with such complaints, simply telling her to go to the health centre is not enough. You must actively ensure that she reaches the facility and receives care without delay.

Services during the Second Antenatal Visit (14–26 Weeks)

- During the second antenatal visit, the MCP (Mother and Child Protection) card is updated and the woman is asked about any problems or danger signs.
- She is examined to assess her wellbeing and her weight and blood pressure are measured.
- She is examined for signs such as pallor indicating anaemia, yellowish eyes suggesting jaundice, abnormal pulse or breathing rate, swelling of face or hands, high blood pressure, abnormal weight gain, pain or burning during urination, fever with chills, and reduced or absent fetal movements. Any such finding requires referral to a higher facility.
- Abdominal examination is done to assess the growth of the baby.
- Blood haemoglobin and urine tests are repeated.
- Normally, a woman should gain 9–11 kg during her pregnancy. Ideally after the 1st trimester, a pregnant woman gains around 2 kg every month. Excessive weight gain (more than 3 kg in a month) should raise suspicion of high blood pressure, Diabetes, Twin pregnancy. Refer immediately to CHO/MO if weight gain is more or less than this.

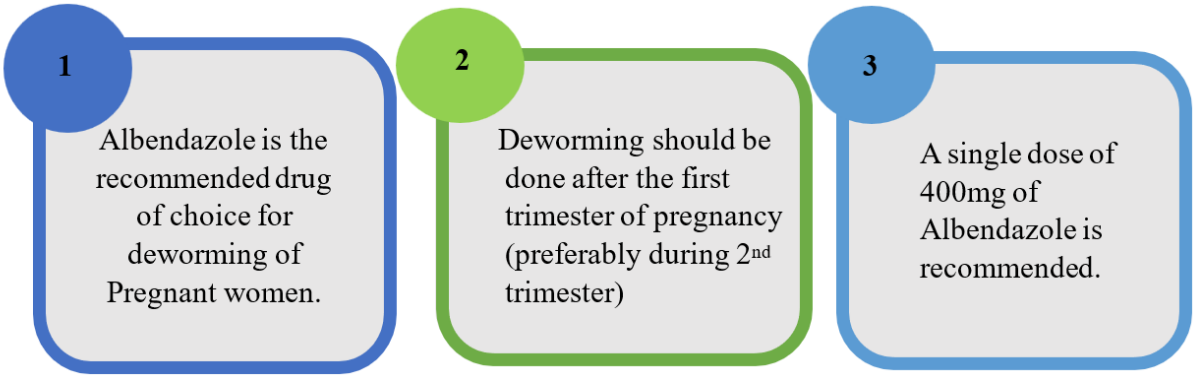
Ultrasonography (USG) at 18-22 weeks: PMSMA recommends atleast one USG scan at 18-22 weeks for all pregnant women . This provides important information about foetal well being , position of placenta and helps in ruling out gross congenital anomalies

IFA Iron Folic Acid) supplementation is started. She is counseled for taking one IFA tablet daily . Dealt with in detail in section on anemia .

Calcium supplementation :

- Pregnant woman is counselled to consume two calcium tablets every day (1 after breakfast and 1 after lunch)
- Consuming calcium tablets during pregnancy helps in bone growth, decreases the
- chances of complications associated with hypertension.
- She is counselled not to take calcium tablets with IFA tablets.

Deworming is undertaken during second trimester of pregnancy Soil Transmitted Helminthes (STH) infections are common worldwide, contributing to high burden of malnutrition, anaemia and morbidity. Albendazole tablet is administered during antenatal visit



Injection Td: The second dose of Injection Td is administered if due.

She is counselled again on diet, rest, hygiene, and danger signs, and the next visit date is explained.

Monitoring Baby's Movements

You should ask the woman if she has started feeling baby's movements . These are usually perceived by the mother between 18 and 20 weeks. Normally the pregnant woman begins to feel the fetal movement as any discrete kick, flutter, swish, or roll . A healthy baby usually has regular movements and the mother can feel them . With time she recognizes the pattern and understands her baby's normal movement pattern. If she notices that movements are reduced or absent she must report immediately.

Monitoring movements becomes especially important after 24–28 weeks and in the third trimester.

A pregnant women, especially in high risk conditions is advised to maintain daily foetal movement record.

How to maintain a daily foetal movement record:

- She should pay attention to baby's movements daily, particularly after meals and when resting.
- Ask her to lie down on the left side in a calm setting and concentrate on movements . This helps her in understanding her baby's normal pattern — the baby may move less during sleep cycles but has regular activity periods.
- Usually 3 or more movements in 1 hour at designated times after meals or 10 movements in 12 hours when focusing on counting the movements (DFMR - Daily Foetal Movement Chart) is reassuring.

Decreased/absent foetal movements is an emergency and she must report immediately to the nearest health facility.

Some important high risk pregnancies :

Anaemia: A Major Threat to Mothers and Babies

- Anaemia is an extremely common condition among women , especially pregnant women. It occurs when haemoglobin levels in the blood are low, reducing oxygen supply to the body.
- A haemoglobin level below 11 g/dl during first and third trimester and below 10.5 g/dl during second trimester of pregnancy indicates anaemia.
- Anaemia increases the risk of infections, pre-eclampsia, bleeding , low birth weight, prematurity, fetal distress, and even maternal and neonatal death. Severe anaemia can lead to heart failure.
- A woman with anaemia looks pale, feels tired, complains of breathlessness on exertion . In severe anemia , she may feel breathless even on doing routine work and might have swelling on the face and body.
- The most common causes are poor dietary intake of iron, folate and vitamin B12, repeated infections, worm infestation, blood loss, and hereditary blood disorders.
- The level of hemoglobin can be tested by a simple blood test, which is undertaken by the ANM in AAM-HSC or the lab technician at the PHC -AAM . Hemoglobin is measured in all four antenatal visits . In case of an anemic woman, it is measured every month till it becomes normal.
- Danger to the pregnant women and the baby increases as the anaemia becomes more severe.

Adult Pregnant Women	Anemia Mukta Bharat Abhiyan 2026			
	Normal	**Mild**	**Moderate**	**Severe**
First and Third Trimester	11.0 g/dl or higher	10.0-10.9 g/dl	7.0-9.9 g/dl	<7.0 g/dl
Second Trimester	10.5 g/dl or higher	9.5-10.4 g/dl	7.0-9.4 g/dl	<7.0 g/dl

Preventing and Managing Anaemia

A. Consumption of healthy balanced diet rich in iron

Counselling for diet in pregnancy is an important activity . Give special emphasis to iron rich foods and how to consume them. These include as green leafy vegetables, beetroot, whole pulses, millets like ragi, jaggery, meat and liver, etc as well as fruits rich in Vitamin C – mango, guava, orange and sweet lime etc.

IFA Supplementation: Diet alone is often not enough to meet iron needs during pregnancy. Therefore, all pregnant women must take one iron-folic acid Tablet daily starting from the second trimester for at least 180 days during pregnancy and another 180 days after delivery.

Management as per Anaemia Mukta Bharat Abhiyan Guidelines 2026:

Mild to Moderate Anemia:

IFA tablet - 2 tablets daily for 1 month after Hb testing

- If there is improvement, but target Hb not reached; the treatment is continued with 2 tablets daily for 1 months
- If there is improvement, and target Hb reached; switch to prophylaxis dose (once daily)
- If no improvement, refer the Pregnant women to higher facility - FRU/DH for further investigation and management of anemia

Severe Anemia:

- Refer the Pregnant women to higher facility - FRU/DH for further investigation and management of anemia (IV iron /Blood transfusion). Follow up as per advice of treating specialist/gynaecologist.

Iron tablets should not be taken with tea, coffee, milk, or calcium tablets.

Mild side effects like nausea or constipation can be managed with simple advice.

- Nausea, occasional vomiting, mild diarrhoea - can be reduced by taking the tablet after meals.
- Constipation - can be reduced by drinking more water and eating fruits.
- Black coloured stools - reassure the woman that Black stools are normal and not worry her.

Severe anaemia may require injectable iron or blood transfusion at a hospital. The husband and other family members must be sensitized to the dangers of anemia and the importance of IFA supplementation and iron rich diet for preventing / treating anemia to get their help in ensuring compliance with regular intake of iron.

Think and reflect

Ms. B a 25-year-old pregnant woman, arrived at the district hospital in labour with haemoglobin of 8 g/dl. After delivery, she developed severe bleeding and died.

As an ASHA, how could you have helped prevent this death?

Your role as an ASHA in preventing anemia and management of anemic woman:

- You must ensure early registration, (early diagnosis gives us more time to correct anemia)
- At all times you must know which women are anaemic as they need your special attention .
- Ensure regular intake of IFA Tablets .(Two IFA tablets in anemic women and one IFA tablet in non-anemic women) .
- Counsel and help her in managing side effects if any.
- Make more frequent initial visits to ensure that she has started taking IFA regularly .
- Ensure uninterrupted supply of IFA / Calcium tablets,
- Follow up for monthly haemoglobin testing in an anemic woman till her Hb becomes normal.
- Flag less or no improvement to the ANM / CHO
- Accompany women for injectable iron or blood transfusion when required.
- Ultimate aim is to bring her hemoglobin to normal as soon as possible well in time before delivery.

Attitude:

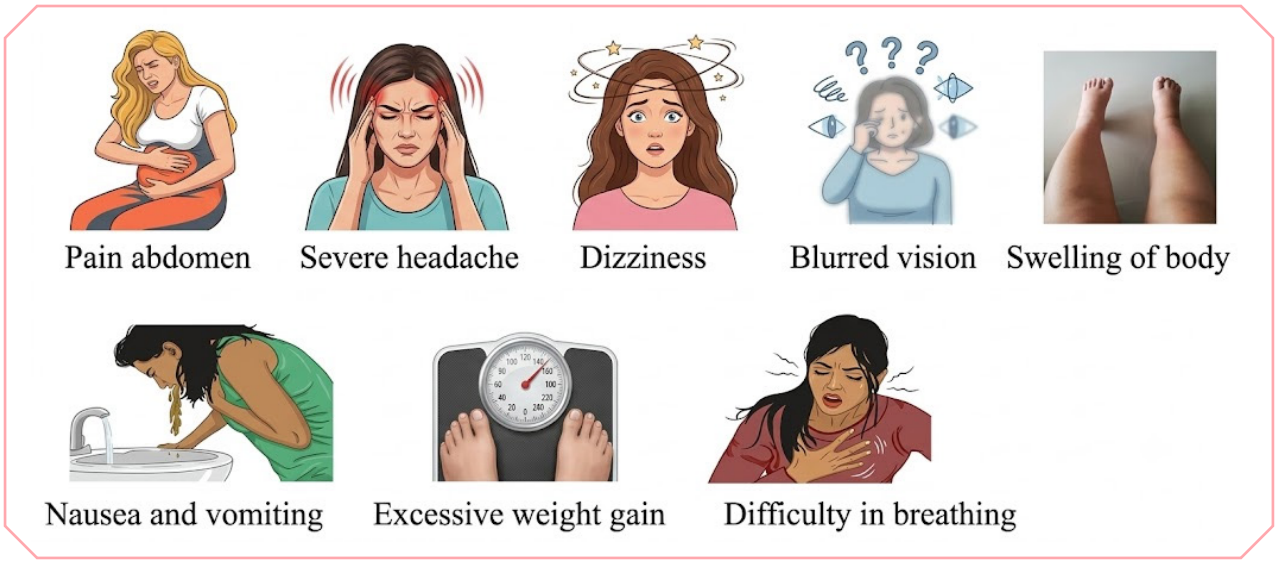
Anaemia is a major cause of maternal death. You as an ASHA are the strongest link in preventing it. Your persistence, follow-up, and compassion can save lives, especially among the most vulnerable families. Also remember that the family which is already isolated due to distance / socioeconomic reasons or due to their resistance to use healthcare is the most vulnerable one and needs your special attention.

Raised Blood Pressure during pregnancy (Pregnancy induced hypertension) is an important high risk factor you might come across. Blood pressure becomes high (more than 140 / 90 mm of Hg) around or after 20 weeks of pregnancy and If there is leakage of protein (albumin) in urine, it is called Pre-ecclampsia. A woman with PIH / Pre-ecclampsia must be included in your high risk list for extra care.

Complications of PIH / Pre-ecclampsia: In the pregnant woman, if untreated, the condition affects all organs and in extreme cases, a woman may have fits and may even die. There is decreased foetal growth and premature delivery.

You must ensure that such pregnant women make ANC visits as frequently as advised by the doctor, with regular BP checkup and that they take their medications, get the necessary blood investigations and USG if so required. She should rest in left lateral position and keep a watch on foetal movements. There must a birth plan in place and the facility chosen for delivery must be capable of dealing with high risk pregnancy and premature babies. Pregnant woman and her family must be aware of the danger signs and that they must immediately report to the already identified health facility in case of development of a danger sign.

Danger signs in Pre-ecclampsia



Complications and these danger signs can appear in post natal period also , and must be kept in mind when making postnatal visits. After delivery the BP becomes normal in a few weeks.

Gestational Diabetes :

It is a condition when blood sugar rises during pregnancy in a pregnant woman who was previously normal. Oral Glucose tolerance test (OGTT) is done on first antenatal visit and subsequently at 28 weeks . A value above 140 mg/ dl indicates abnormal glucose tolerance. Complications of GDM include – abortion, infections of the reproductive tract, increased fluid in uterus and premature delivery, a big baby and difficult delivery, increased chances of Caesarian, post partum hemorrhage.

For OGTT, the woman need not be empty stomach. You must ensure that this pregnancy with an abnormal OGTT is entered in you high risk list for extra care.

You must ensure ANC in linked higher center, the required extra visits, the investigations for maternal and foetal well being and adherence to the prescribed diet and medications. If antidiabetic medicine or injection is started, the woman must take regular diet and not skip a meal to avoid any abnormal drop in blood sugar. She should be counseled about how to recognize symptoms of low blood sugar and what to do if this happens (covered in section on emergencies). She should rest in left lateral position and keep a watch on foetal movements. Delivery should always happen in a hospital equipped to deal with high risk pregnancies. Post delivery contraception should be advised.

Pregnancy with previous caesarian:

With increase in Caesarian deliveries , you will now find many women with history of previous caesarian . Such women should be diligently treated for any anemia and IFA supplementation should be ensured. Previous CS pregnancy is high risk as the uterus is scarred and there is a fear of scar giving way in late pregnancy or during labour. Depending upon the reason for CS, pregnant woman may be given a chance to deliver normally . But remember the delivery must be in a hospital where she can be closely watched for any complication and prompt CS if so required. There are increased chances of a repeat CS being required in such cases.

These women may require blood during surgery so a donor must be kept available before hand . Pain in lower abdomen / tenderness / or onset of labour is an indication for immediate

reporting to the hospital identified for delivery . Birth plan should be in place and the center identified for delivery must be equipped to carry out CS and take care of baby in case of premature / difficult delivery.

She should be counseled on adoption of contraceptive method as per advise of the doctor.

Pregnancy with Rh negative mother :

If a woman with Rh negative blood group conceives, the father's blood group is tested. If father's blood group is positive, then certain precautions are required and woman might require some extra blood tests for checking baby's well being. She might also require certain injections depending upon the blood reports. You will have to followup and ensure extra visits and investigations as advised by the doctor.

Think and reflect

Can you think of any high risk factors which are identified in second visit?

High risk factors identified during second visit :

1. Abnormally located placenta
2. Multiple pregnancy (Twins / triplets)

Danger signs during pregnancy

Counselling for Danger Signs on second visit : As an ASHA you should understand what are the danger signs during pregnancy and be prepared for immediate referral. Family members shall also be educated on how to recognize these danger signs. These include :

1. High grade fever
2. Burning sensation and pain while passing urine
3. Bleeding from vagina
4. Foul smelling discharge from vagina
5. Severe pain abdomen / continuous pain abdomen
6. Severe headache / blurring of vision
7. Swelling over face / hands / body
8. Breathlessness
9. Convulsions
10. High Blood Pressure
11. Labor pains before the due date
12. Breaking of water much before due date and without any pain.
13. Decreased foetal movements

Family Support: Care and support by husband and mother-in-law gives assurance and confidence to the pregnant woman in going through the pregnancy and childbearing. As you are a part of the community, advice family members of the pregnant women on the following points:

- Family behaviour and attitude should be pleasant and encouraging.
- Family should ensure provision of healthy diet and timely visits to health facility.
- Ensure that there is no delay in contacting health facility in case of a danger sign or when the labour starts .
- Adequate finance and transport should be arranged beforehand.
- A blood donor should be identified for unforeseen emergency.

Services to be provided during third Antenatal Visit (28 to 34 weeks):

- During the third antenatal visit , the MCP (Mother and Child Protection) card is updated and the woman is asked about any problems or danger signs.
- She is examined to assess her wellbeing and her weight and blood pressure are measured.
- She is examined for any abnormalities / danger signs .
- Abdominal examination is done to assess the growth and well-being of the baby.
- Blood haemoglobin and urine tests are repeated. OGTT is repeated at 28 weeks.
- IFA (Iron Folic Acid) and Calcium supplementation is continued .
- Breast examination is done to identify possible breastfeeding difficulties.
- Birth preparedness planning is initiated, including identifying the place of delivery, transport, finances, blood donor, and family support.
- Counselling for Diet , adequate rest , hygiene , danger signs , early initiation of breast feeding , post delivery family planning is done .

Breast examination :

Breast examination is done in third trimester. Flat or inverted nipples can lead to poor latching and difficulties in breast feeding . Early detection and regular nipple exercises by the pregnant woman

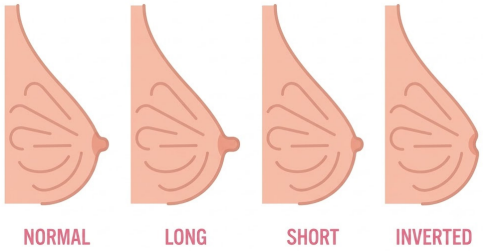
to pull out the retracted nipples prevent subsequent difficulties in breast feeding.

Counselling for family planning:

mmediately after birth woman is most receptive to adoption of a family planning method. You

should start counselling her from third trimester giving her time to choose from the available options so that she can accept post partum CuT insertion or Post partum sterilization (if her family is complete) while she is still in hospital (This is explained in more detail in Family Planning section)/

B.4.4 BIRTH PREPAREDNESS FOR SAFE DELIVERY :



Birth preparedness means planning in advance so that the woman reaches the right facility at the right time without delay. You and the ANM help the family prepare a clear birth plan covering transport, money, blood donor, birth companion, baby clothes, and post-delivery support.

Components of birth preparedness

1 Identify health facility for delivery depending upon whether a low risk normal delivery is expected

2 **Supplies needed for mother and baby:**

You should advise her about items such as clean, dry & warm clothes for drying & wrapping the baby, sanitary pads, clean clothes for herself etc..

3 **Identify people who can support:**

The family needs to discuss in advance about: A companion of mother's choice to support her during birth. Someone to take care of the family in mother's absence.

4 **Financial plan for delivery:**

Need to have some money available for transport / contingency although public healthcare facilities provide free services / drugs / logistics / diet etc.

5 **Blood donor**

Ensure that the family has identified an appropriate blood donor and that person will be available in case of emergency.

6 **Transport**

Arrangement for transporting the pregnant woman should be worked out. If ambulance is not available private vehicle will need to be arranged, so have a backup plan in place. Call on 108 for ambulance.

Birth plan preparation is guided by the whether the pregnancy is a high risk pregnancy , the available health facilities in the vicinity , the family's willingness to avail the services .

It includes the details like:

- Any risk factors:
- Nearest SBA: Phone number :
- Nearest 24X7 PHC: Distance: Time: Cost

- Nearest Sub-Centre with a Skilled Birth Attendant
- Nearest CHC with facilities to manage complications: Distance: Time: Cost
- Distance to District Hospital:
- How much is transport going to cost?
- Is the vehicle fixed: Owner: Phone No.:
- Will extra money be required for the transport / treatment / contingency ? How to organise it?
- Who will take care of the children when mother goes to the facility?
- Who will accompany her to the facility?
- Where will they stay?
- How will they finance their stay?
- Have they organized clothes and blankets for the baby?
- Blood donor has been identified in case of emergency.

Services in Fourth Antenatal Visit (36 weeks onwards)

The fourth visit should ideally be at the health facility identified for birth .

- During the fourth antenatal visit , the MCP (Mother and Child Protection) card is updated .
- The woman is asked about any problems or danger signs.
- She is examined to assess her wellbeing and her weight and blood pressure are measured.
- She is examined for any abnormalities/danger signs.
- Abdominal examination is done to assess the growth and well-being of the baby and the presentation of the foetus is checked.
- Adequacy of the birth passage for a normal delivery is assessed.
- Haemoglobin and urine tests are repeated.
- IFA (Iron Folic Acid) and Calcium supplementation is continued.
- Breast examination is done to identify / see progress in correction of flat or inverted nipples to decrease chances of difficulties in breastfeeding.
- Birth plan is rechecked and revised with family
- Counselling for Diet, adequate rest, hygiene, danger signs, early initiation of breast feeding, post delivery family planning is done.

Services to be provided during different ANC Visits:

As ASHA you must know what are services are to be provided at each visit and where they are available so that you can facilitate and ensure that the pregnant woman accesses these.

First ANC Visit (from confirmation of pregnancy to within 12 wks)	Second ANC Visit (14 -26 wks)	Third ANC Visit (28-36 wks)	Fourth ANC Visit (after 36 wks)
Registration of pregnancy			
Filling of MCP Card	Updation of MCP Card	Updation of MCP Card	Updation of MCP Card
Detailed history taking / medical / Obstetric	History for expected events / new high risk factor / danger signs	History for expected events / new high risk factor / danger signs	History for expected events / new high risk factor / danger signs
Examination of the woman including weight and BP	Examination of the woman including weight and BP	Examination of the woman including weight and BP	Examination of the woman including weight and BP
			Pelvic assessment
Blood and urine investigations Hb / CBC Blood Group Blood Sugar/ OGTT HIV, HbsAg, VDRL Urine Alb / Sug . TSH*	Hb and Urine	Hb and Urine and repeat OGTT	Hb and Urine
	USG at 18-22 wks		
Provision of Folic acid tablets	Provision of Iron and Folic acid Tablets (IFA) and Calcium Tabs	Provision of Iron and Folic acid Tablets (IFA) and Calcium Tabs	Provision of Iron and Folic acid Tablets (IFA) and Calcium Tabs
	Deworming Tablet		
Inj Td (First dose or Booster dose)	Inj. Td (Second dose)		
Counselling for Diet, adequate rest, hygiene etc.	Counselling for Diet, adequate rest, hygiene,danger signs etc.	Counselling for Diet, adequate rest, hygiene,danger signs, Breast feeding and Family Planning etc.	Counselling for Diet, adequate rest, hygiene,danger signs, Breast feeding and Family Planning etc.
		Birth Plan	Birth Plan
		finalization	finalization

First ANC Visit (from confirmation of pregnancy to within 12 wks)	Second ANC Visit (14 -26 wks)	Third ANC Visit (28-36 wks)	Fourth ANC Visit (after 36 wks)
Registration in Kilkaari App	Enquire about use of Kilkaari	Enquire about use of Kilkaari	Enquire about use of Kilkaari
Tell the date for next visit.	Tell the date for next visit.	Tell the date for next visit.	

*TSH not mandated for all women

A.4.5 YOUR ROLE AS AN ASHA IN FACILITATING ANTENATAL CARE:

- **List all pregnant women:** Ensure that you always have a complete updated list of pregnant women in your assigned population. Make special efforts to cover the women in the poorest families and those in the sections which tend to get left out, e.g. women from SC/ST communities, women headed households , those living in hamlets far from the main village or slums, or in hamlets that fall between villages, newly migrated women.
- **Early registration:** Help the pregnant women in getting registered as early as possible once the pregnancy is suspected / confirmed and having her first ANC checkup well in time.**Ensuring full ANC:** You should educate women about the importance of the four ANC visits. Remind them when next ANC is due and/or escort them to health facility/ VHSND if they need such support. Ensure that all components of ANC are delivered, and the Maternal and Child Protection Card is updated.
- **Counselling for ante-natal care:** Counsel the pregnant women and family on:
  - » **Importance of a balanced and nutritious diet:** The diet of the pregnant woman should contain a mix of cereals, pulses (including beans and nuts), vegetables, milk, eggs, meat and fish. If possible, the mother should be encouraged to add oils, jaggery and fruits to the diet. You should explain to the mother and family that no food is forbidden during pregnancy.
  - » **Importance of adequate rest and harmful effects of heavy manual labour:** Pregnant women should not carry out heavy manual labour, like working on construction sites, brick kilns, etc and take adequate rest for better growth of the baby.
  - » **Danger signs during pregnancy:** You must make the pregnant woman and her family aware of the danger signs and impress upon them that if she has any of the danger signs , she must be taken to the identified health facility.
  - » **Supplementary Ration from Anganwadi Centre (AWC):** Ensure that all pregnant women receive this benefit from their nearest anganwadi centre.
  - » **Extra care for pregnant adolescent girls:** They are more likely to be under-nourished and are therefore more prone to problems during pregnancy / delivery.They need extra help for complete ANC and safe delivery at a health facility.
  - » **Safe institutional delivery:** You must promote safe institutional delivery for all pregnant women in the community and facilitate this by timely preparation of the birth plan with the family in consultation with the ANM.

Your role as an ASHA role in Birth preparedness:

- Calculate EDD and communicate to the pregnant women
- Inform the pregnant women and her family regarding birth plan during her third ANC visit and finalize on the follow up visit.
- Know which health facilities have the required services in vicinity and establish linkages with health providers there.
- At least once before the delivery take the pregnant women to the health facility identified for delivery and introduce her to the providers.
- Know what transport is available-whether funded by state or private means, that is easily accessible and affordable and how to call on it when need arises.
- Advise the family to keep a small amount of money for any contingent need .
- Ensure that the pregnant woman / family knows what all records need to be carried to the health facility.
- You must at all times have a list of your high risk women . Keep a close watch on these women. Facilitate the extra follow up visits , investigations and adherence to treatment.
- Ensure that the birth plan is in place and the family is fully prepared to act quickly when required. Accompany them to the higher center if so required.

High Risk Pregnancies (As per PMSMA Guidelines)

1	Teenage Pregnancy	13	Severe anemia
2	Early Primi	14	Pregnancy Induced Hypertension
3	Elderly Primi	15	Gestational Diabetes Mellitus
4	H/O Still Birth	16	Hypothyroidism
5	Bad Obstetric History	17	Previous LSCS
6	HIV	18	Cephalo-pelvic Disproportion
7	Syphilis	19	Congenital Malformation
8	Tuberculosis	20	Negative Blood Group
9	Malaria	21	Twins/Multiple pregnancy
10	High Fever	22	Grand Multipara
11	Hepatitis B	23	Short Stature
12	RTI/STI	24	Abnormal fetal heart rate

Attitude: Be patient and empathetic . Do not be judgemental . Be extra vigilant for the high risk women in your care . Be accessible at all times to the pregnant woman and their family. They are relying on you and trust you.

B.4.6 CARE DURING DELIVERY

Promotion and facilitation of institutional delivery

- Institutional delivery is promoted for all pregnant women because complications during childbirth can occur suddenly, even when the pregnancy has been normal.
- Serious problems such as heavy bleeding after delivery, convulsions, or difficulty in breathing in the newborn may develop without warning and can be life-threatening if timely care is not available.
- Health facilities are equipped with trained doctors and nurses, essential medicines, equipment, blood transfusion services, and newborn care facilities to manage these emergencies immediately.
- In addition, close monitoring of the mother and newborn during the first 48 hours after delivery, which is the most critical period, is possible only in a health facility.
- To make delivery services in public hospitals accessible to all, delivery services, medicines, diet, transport, and stay are all provided free of cost.

As an ASHA:

- You should counsel the pregnant woman and her family about the importance of institutional delivery.
- Make sure that a birth plan is prepared, in consultation with the ANM and CHO/ Medical Officer, well before the expected date of delivery.
- You should help arrange transport and ensure that the woman reaches the health facility in time when labour begins.
- Although it is not compulsory, if needed , you may stay with the woman at the health facility, to support her and coordinate with the staff. While you are there, you should observe the do's and don'ts, learn about the care given during and immediately after delivery, and understand how the mother and baby are monitored in the first few hours. This experience will help you during your work in the community.

Care Immediately after delivery :

Baby:

- Baby is separated from mother by cutting and tying the umbilical cord using a clean blade and a clean tie.
- Immediately after birth, the first concern is breathing. The baby should cry or breathe within a few seconds. If the baby is not breathing or crying, immediate help is required.

- The next concern is keeping the baby warm. The baby should be dried immediately, placed skin-to-skin on the mother's chest, and covered properly. Getting cold can be dangerous for a newborn, especially in the first hours of life.
- The third concern is early feeding and bonding. Breastfeeding should be started within one hour of birth. Early breastfeeding provides colostrum, helps protect the baby from infections, and strengthens bonding between the mother and the baby.
- The fourth concern is prevention of infection. The umbilical cord should be cut with a sterile instrument and kept clean and dry. No substances should be applied to the cord.
- Clean handling of the baby is essential.
- Once the baby has been settled with mother , one should be alert for any danger signs such as difficulty in breathing, poor feeding, lethargy, or bluish discoloration.

Mother:

- After delivery, the mother's pulse, blood pressure, uterine tone, and vaginal bleeding is checked to ensure she is well .
- Outer birth passage is seen for any tears and cleaned. Episiotomy (a cut given at the mouth of the uterus to ease delivery) is stitched .
- Mother is encouraged to pass urine.
- She should be kept warm and comfortable, given oral fluids and light food once stable, and encouraged to rest. Early initiation of breastfeeding, within one hour, should be supported, as this helps uterine contraction and promotes bonding.
- The mother should be reassured, informed about what to expect in the next few hours, and observed closely for bleeding and her pulse and BP is monitored regularly so that any abnormal signs are detected early.
- Perineal care provided at regular intervals to ensure cleanliness and prevent infection.
- The mother is also observed for severe headache, visual disturbances, breathlessness, or convulsions, which may indicate serious underlying conditions . Continuous monitoring in the first few hours after delivery is essential so that any danger signs are identified early and managed.
- Utmost cleanliness is observed during delivery to prevent infection of mother or baby.
- After 48 hours of stay, if both mother and baby are healthy and there are no complications, they are discharged from the health facility.
- In case of excessive bleeding, fits, hypertensive complications, breathlessness, severe infection mother is managed at the facility or promptly shifted to higher center if required.

As an ASHA:

- Ensure that the woman stays in the facility for atleast 48 hours after delivery . Counsel her about the advantages of the same.
- Facilitate care of the small children at home if any.
- If you are staying with mother in the health facility as birth companion, you should ensure that the mother and the baby are seen by doctor and nurse at least twice a day and whenever required if there are problems.

Points to pay attention if you are present at the time of delivery / or are assisting in a home delivery by SBA in an emergency

- It is not necessary to shave the area or give an enema to the mother at the time of delivery.
- All the deliveries do not require episiotomies (cut at the perineal site).
- During delivery, applying pressure on the abdomen to push the baby out is harmful and should not be done.
- Similarly injections given to hasten the process of delivery are harmful and may even lead to stillbirth.
- The injection given after the delivery of baby to control the bleeding should only be given by ANM / CHO or doctor.
- Absolute cleanliness is observed during the delivery / cord cutting and handling of the baby.

Post natal care is covered in the newborn section.

B.4.7 NATIONAL HEALTH PROGRAMS FOR MATERNAL AND NEWBORN HEALTH

Surakshit Matritva Aashwasan (SUMAN):

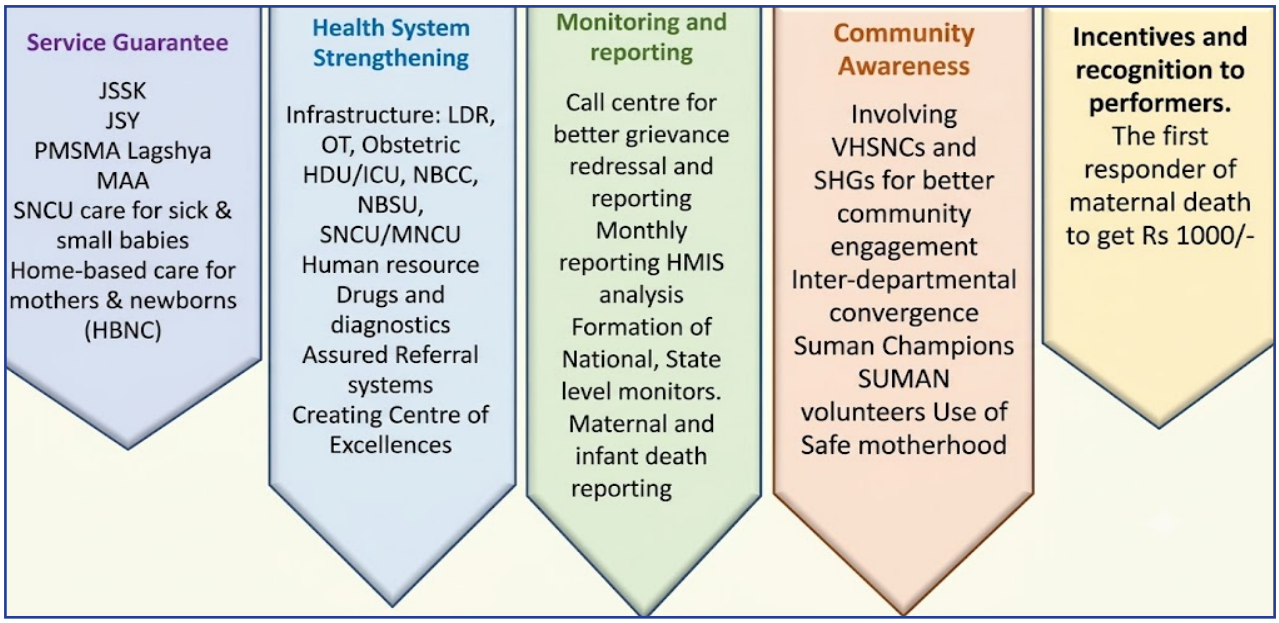
Ministry of Health & Family Welfare, Government of India has launched a new initiative namely- "SUMAN-Surakshit Matritva Aashwasan" with an aim to provide assured, dignified, respectful, and quality healthcare at no cost and with zero tolerance for denial of services for every woman and newborn visiting the public health facility in order to end all preventable maternal and newborn deaths and morbidities and provide a positive birthing experience.

Labour Room and Delivery:

In a place where the AAM-SHC is a delivery point, the CHO will do the normal delivery of the pregnant woman only after getting SBA training. All the identified high- risk pregnant women shall be referred to a higher centre. CHO will ensure that the labour room is equipped as per the maternal health guidelines and all the logistics and drugs needed in the labour room are present.

Under the SUMAN initiative, all Pregnant Women & Newborns visiting public health facilities are entitled to a set of free services given below:

- Free Antenatal, Delivery, and Post Natal Care.
- Free management of sick neonates and infants.
- Required secondary and tertiary care services for the High-Risk Pregnant Women.
- Quality assured care compliant with prescribed standards at all levels of care.



Janani Suraksha Yojana (JSY):

To promote institutional deliveries, incentives of Rs. 1400/cases are being given to pregnant women for deliveries in public health facilities.

Benefits for Pregnant Mothers:

- Low performing states- Rural- Rs.1400/- & Urban- Rs.1000/-
- High performing states (SC, ST, BPL)- Rural- Rs.700/- & Urban- Rs.600/-
- Home Delivery by SBA- Rs.500/- is given to meet incidental expenses of delivery regardless of age of pregnant women at number of children.

Janani Shishu Surksha Karykaram:

The entitlements include free drugs, consumables, free diet during the stay, free diagnostics, and free blood transfusion if required. This initiative also provides free transport from home to institution, between facilities in case of a referral, and drop back home. The scheme was expanded to cover complications during ante-natal and post-natal periods and also sick infants up to 1 year of age.

Pradhan Mantri Surkshit Matritva Abhiyaan (PMSMA):

Under PMSMA, all pregnant women are provided a fixed day, free of cost and quality assured antenatal check up by a Specialist/Medical Officer on the 9th day of every month.As part of the campaign, a minimum package of antenatal care services (including investigations and drugs) is being provided to the beneficiaries on the 9th day of every month. The Abhiyan also involves the Private sector's health care providers as volunteers to provide specialist care in Government facilities.

Extended PMSMA for Tracking of High-Risk Pregnant women:

Under the Extended PMSMA all the high- risk pregnant women are tracked and followed up for healthy outcome. The salient features of the program are:

- The ASHA mobilizes all the pregnant women in her village to attend the nearest PMSMA clinic and undergo high risk screening by a doctor/ obstetrician.
- All high-risk pregnancies detected in PMSMA clinics are treated, counselled and a line-

listing is maintained by the facility and the respective ANM & ASHA.

- Once a PW is categorized as a HRP, it is the responsibility of the respective ASHA/ANM to ensure 3 additional ANC visits for that HRP to the doctor / Obstetrician. eg. For each of these follow up ANC visits with the doctor/Obstetrician, ASHA shall accompany the high-risk pregnant woman to the clinic.
- It is mandatory that all identified high risk pregnancies must be linked with nearest First Referral Units (FRU) for ensuring a safe delivery after completion of pregnancy and prompt management of complications, if any. Free transport for referral to the FRU at the time of delivery is to be ensured by the ASHA under JSSK.
- Case-based incentives to ASHA: Rs.100/- per HRP for mobilizing her to PMSMA clinic for a maximum of 3 additional follow-up ANC visit and Rs.500/- per HRP on achieving a healthy outcome for both mother and baby at 45th day post-delivery after due verification by ANM and MO.

Mothers Absolute Affection (MAA) program:

MAA is a nationwide programme of the Ministry of Health and Family Welfare in an attempt to bring undiluted focus on promotion of breastfeeding and provision of counselling services for supporting breastfeeding through health systems. The program has been named 'MAA' to signify the support a lactating mother requires from family members and at health facilities to breastfeed successfully. The aim of the initiative is to revitalize efforts towards promotion, protection and support of breastfeeding practices through health systems to achieve higher breastfeeding rates.

Pradhan Mantri Matru Vandana Yojana (PMMVY):

PMMVY aims to provide compensation for wage loss in terms of cash incentives so that women can take adequate rest before and after delivery of first child. Cash incentive is provided in 3 instalments-

- 1st Instalment of Rs.1000 given to beneficiaries after early registration of pregnancy at the Anganwadi Centre/approved Health facility.
- 2nd Instalment of Rs.2000 given to beneficiaries when at least one ANC received (can be claimed after 6 months pregnancy)
- 3rd Instalment of Rs.2000 given to beneficiaries after registration of childbirth, Child has received first cycle of BCG, OPV, DPT and Hepatitis-B.
- The eligible beneficiaries would receive the incentive given under the JSY for Institutional delivery and the incentive received under JSY would be accounted towards maternity benefits so that on an average a woman gets Rs.6000/.

Poshan Abhiyaan:

Poshan Abhiyaan is also known as the National Nutrition Mission (NNM) was launched in 2018 by the Government of India with the aim of tackling the malnutrition problem prevalent in India. Mission Poshan 2.0 is India's flagship program to improve nutritional outcomes for children, adolescents, pregnant women and lactating mothers by leveraging technology, a targeted approach and convergence.

Maternal Death Surveillance and Response (MDSR):

A process has been setup through which each maternal death is reported . Effort is made at both the facility and community level to identify not just the medical causes, but also some

of the socio-economic, cultural determinants, as well as the gaps in the system, which could have contributed to the maternal death . This is with the objective of taking corrective action at appropriate levels , improving the quality of obstetric care and bringing it within reach for everyone. Rs 200 is given to 2 members of deceased family for travel support during review of maternal deaths which take place in presence of the district collector.

Reporting of maternal deaths:

ASHA gets an incentive for reporting death of a woman in the reproductive age (Women in 15-49 years age group) within 24 hours of occurrence of death to medical officer as per the guideline.

B.4.8 COMPREHENSIVE ABORTION CARE (CAC)

Addressing Unsafe Abortions

Unsafe abortions are a major cause of maternal deaths in India. Most abortion-related deaths and complications are preventable if women access services from trained providers at approved facilities. Although abortion is legal in India, many women still seek unsafe services due to lack of awareness, stigma, and social barriers.

Early access to safe abortion services and post-abortion contraception can prevent most complications and repeat unintended pregnancies.

Law Related to Abortion - MTP Act

The Medical Termination of Pregnancy (MTP) Act was enacted in 1971 and amended in 2021.

- Abortion is legal up to 20 weeks under specific conditions
- 20-24 weeks abortion is permitted for special categories of women
- Abortion is allowed at any time for major foetal abnormalities with Medical Board approval
- Sex selection is illegal and not a valid reason for abortion

Indications for Abortion up to 20 Weeks

- Save the life of the pregnant woman
- Continuation of pregnancy can cause grave injury to her physical or mental health
- Substantial risk that the child, if born, would be seriously handicapped due to physical or mental abnormalities
- Pregnancy is caused by rape
- Pregnancy is caused due to the failure of contraception used by any woman or her partner to prevent pregnancy

Indications for Abortion (20-24 Weeks)

- Survivors of sexual assault or rape or incest
- Minors
- Change of marital status during the ongoing pregnancy (widowhood and divorce)
- Women with physical disabilities [as per Disabilities Act, 2016 (49 of 2016)]
- Mentally ill women including women with intellectual disability
- Foetal malformation that has substantial risk of being incompatible with life or if the

child is born it may suffer from such physical or mental abnormalities to be seriously handicapped

- Women with pregnancy in humanitarian settings or disaster or emergency situations as may be declared by the Government.

Consent for Abortion

- Only the woman's consent is required if she is above 18 years
- Consent of guardian is required if the woman is below 18 years or mentally ill
- Husband's or family's consent is not required

Who Can Provide Abortion Services

- Only trained Registered Medical Practitioners
- MBBS doctors must be trained in Comprehensive Abortion Care / Medical Methods of Abortion

Where Abortion Services Are Available

Government facilities at different levels as well as approved private health facilities can provide abortion services, as per their eligibility.

Your role as an ASHA in Comprehensive Abortion Care

- ASHAs play a key role in providing information, referral, support, and follow-up. Key Responsibilities
- Educate women and families about legal and safe abortion services
- Discourage unsafe abortions and untrained providers
- Inform women about nearby approved health facilities
- Refer and accompany women for abortion services and follow-up visits
- Identify danger signs and complications and ensure timely referral
- Provide empathetic, non-judgmental, stigma-free support especially for adolescents and young girls/ women wanting information related to contraception and abortion services
- Support post-abortion contraception counselling and uptake
- Maintain records as per guidelines

Post-Abortion Counselling - Key Messages

- Early abortion is safer than in the later pregnancy period
- Inform the woman about the available and safe methods (Surgical/ Medical Methods) for the termination of pregnancy
- Some bleeding and pain is normal after abortion
- Avoid sexual intercourse until bleeding stops
- Normal diet and routine can be resumed soon

Danger signs requiring immediate care:

- Heavy or prolonged bleeding
- Fever or foul-smelling discharge
- Severe abdominal pain
- Dizziness or fainting
- No periods even after 6 weeks

Post-Abortion Contraception

- Fertility can return as early as 10 days after abortion
- Contraception should be started immediately or soon after
- As an ASHA, you should:
  - » Explain available methods
  - » Address myths and misconceptions
  - » Provide methods (if allowed) or refer to facility

Essential Points for ASHA

- Maintain privacy and confidentiality
- Be empathetic and non-judgmental, especially with adolescents
- Encourage early care-seeking
- Promote contraception to prevent repeat unintended pregnancies . It is described in following section.
- In cases of sexual assault, immediate referral to higher facility is critical

Case study

A 22-year-old unmarried woman from your village. She comes to you quietly and tells you that she has missed her periods for two months. She is very scared and says she knows a local person who can “remove the pregnancy” using medicines at home. She is worried that her family or neighbours should not come to know about this and asks for your advice.

Questions for Discussion:

1. What information will you give her regarding abortion?
2. What will you advise her to do?
3. How will you support her while ensuring privacy, confidentiality, and safe care?

B.4.9 FAMILY PLANNING

You will learn the following in this section:

1. Understand the Healthy Timing & Spacing of Pregnancy (HTSP) and its benefits.

2. To know about various contraceptive methods to maintain healthy timing and spacing of pregnancy.

3. Identify the eligible couple and provide correct and comprehensive counselling

4. Promote male and family participation and shared responsibility

5. Know about schemes under the National Family Planning Program

What is Family Planning?

As ASHA you have a unique opportunity and a responsibility in empowering the couples in your area for planning their families by providing them with correct information and facilitating their access to available methods of contraception.

This knowledge helps the couples in having a child when they want to and number of children as per their desired family size.

Different couples have different needs:

- Some couples want to delay the first child.
- Some want enough gap between two children.
- Some want to stop having children once their family is complete.

Contraceptives help to prevent unwanted pregnancies and preventable deaths occurring due to 'too soon/ too frequent / too many births, thus impacting maternal, newborn, and child health outcomes.

Pregnancy	Description	Consequences to mother's health
Too early/ Too late	Age of mother < 18 years or >35 years	• Anemia • Increased chances of Infections • Abortions • Hemorrhage • Obstructed labour • Pre-eclampsia/ eclampsia • Pre Term Birth
Too frequent	(i) Interval between two pregnancies is less than 2 years (ii) After miscarriage or abortion, next pregnancy within 6 months	
Too many	Women is pregnant for the 5th time or more	

As an ASHA you have the responsibility of identifying eligible couples, informing them about all relevant contraceptives available in the national family planning program, addressing myths, helping them to adopt a method of their choice as per their reproductive intent and desired family size, and supporting access to the services, while respecting the couple's choice and confidentiality.

As an ASHA you should also encourage the involvement of husband/family member during counselling on contraceptives before a woman adopts the method of her choice.

Using any family planning method for preventing pregnancies can lead to the following benefits for the health of the mother and children in the family.

Advantages of Healthy Timing and Spacing of Pregnancy (HTSP)

- Mothers and babies are healthier when unintended pregnancies, are avoided.
- Smaller family means availability of more money for expenditure per family member on health, nutrition, and education, especially for children.
- Parents have more time for their family and their work.
- Adolescents below the age of 18 years are still in the growing phase and not ready physically or mentally for pregnancy.
- Some contraceptives, i.e. condoms (both male and female), while preventing unwanted pregnancies also help in protecting against infections of the genital tract, including HIV/ AIDS.
- Some methods help in making the periods regular.

Use of contraceptive method empowers the woman to regulate her fertility and thus allowing her total autonomy over her body.

As an ASHA you must know about Healthy Timing and Spacing of Pregnancy (HTSP):

A woman considering using a family planning method before trying to become pregnant should:

- Wait until the age of 20 years before she conceives for the first time.
- Wait at least 24 months after childbirth to become pregnant again (the recommended birth interval between two births is minimum 36 months).
- Wait at least 6 months after miscarriage or abortion to conceive again.

Use of contraceptives helps in maintaining HTSP, because pregnancy can occur as early as:

- 6 months postpartum, if woman is exclusively breastfeeding her child
- 6 weeks postpartyum, if woman is not exclusively breastfeeding her child
- 4 weeks postpartyum, if woman is not breastfeeding at all.
- 10 days of first trimester abortion
- 4 weeks of second trimester abortion

Pregnancy can occur even before resumption of menses after childbirth/ abortion.

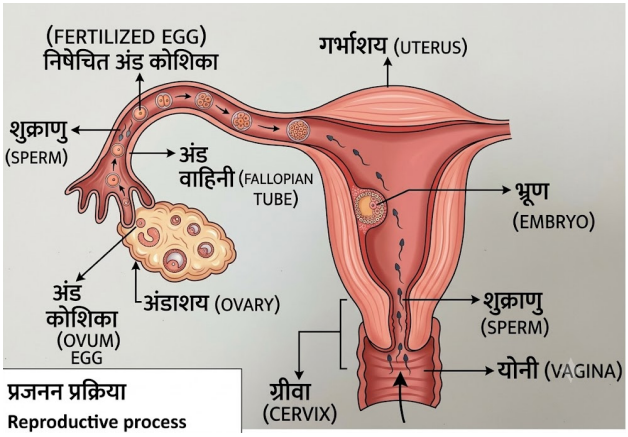
Different Methods of Family Planning:

Family planning methods are broadly categorized into spacing methods and limiting methods, allowing couples to choose a method according to their age, health status and reproductive intentions. The beneficiaries for family planning services are women/couples of reproductive age group (15-49 years). The contraceptive basket of choice under National Family Planning program includes following methods:

Spacing Methods	Permanent Methods
• Intra-Uterine Contraceptive Device - IUCD 380A, IUCD 375 • Injectable Contraceptive MPA (under Antara Program) • Subdermal Contraceptive Implant (Single Rod) • Combined Oral Contraceptive Pills (Mala N) • Centchroman Pills (Chhaya) • Condoms (Nirodh)	• Female Sterilization (Laparoscopic/ Minilap Sterilization) • Male Sterilization (Conventional / Non Scalpel Vasectomy)

Note: All available methods are provided free of cost through public health facilities and ASHAs.

Process of reproduction



The male sperm and the female ovum contain all the necessary information required for the beginning of a new life.

Almost every month, the ovary develops one ovum and releases it into the fallopian tube. During sexual intercourse, the man's semen, which contains sperm, enters the woman's vagina. The sperm travel through the vagina, cervix, and uterus to reach the fallopian tube. One sperm enters the ovum and fertilizes it. The fertilized ovum develops into an embryo, and after it gets implanted in the uterus, pregnancy begins.

Family planning methods interfere with this reproductive process and prevent pregnancy. Condoms prevent semen from entering the vagina. Hormonal methods such as Mala-N, Antara, and implants affect the development of the ovum in the ovary, due to which a mature ovum does not reach the fallopian tube. Hormonal methods also thicken the cervical mucus, making it difficult for sperm to move and travel. In addition, these methods affect the inner lining of the uterus, where implantation of the embryo occurs, and make it unfavorable for implantation.

The presence of an IUCD in the uterus also makes the uterine lining unfavorable for implantation of the embryo and, thereby reducing the movement of sperm.

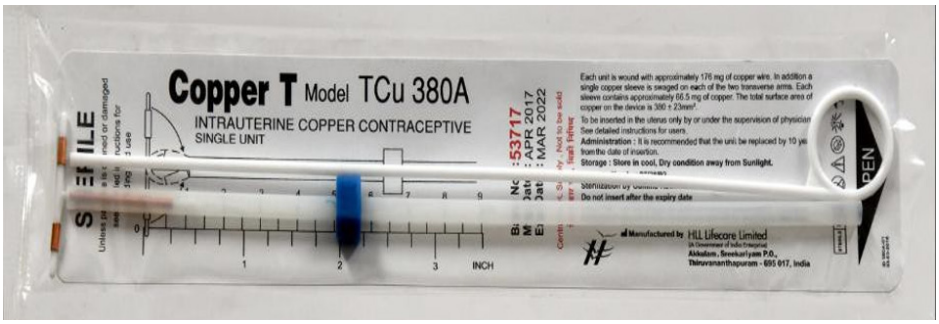
Female or male sterilization (tubectomy/vasectomy) prevents the availability of ovum or sperm altogether, and thus pregnancy does not occur.

B.4.10 SPACING METHODS

With this background we can discuss different methods of contraception in some detail.

I. Intra-Uterine Contraceptive Devices (IUCDs)

This is a method of contraception wherein a small soft device made of plastic and copper is inserted inthe womb of the woman. Commonly used device is “T” shaped with thin copper wire wound around the limbs of the T.



The most common IUCD is Copper-T. This is a small T-shaped intra-uterine device (IUCD).

There are two types of IUCD:

a. IUCD 380 A- protection for 10 years

b. IUCD 375- protection for 5 years.

How does Copper-T work?

Copper-T works mainly by preventing sperms and egg from meeting. IUCD decrease sperm motility thus preventing sperm from reaching the fallopian tubes and fertilizing the egg It also prevents implantation if fertilization occurs. Copper IUCD can also be used as an emergency contraceptive method if inserted within five daysof unprotected intercourse.

Advantages of IUCDs

Advantages of IUCD	Clarifying Misconceptions
• Highly effective long acting reversible contraceptive method. • No hassle of remembering to use contraceptive before each sexual contact. • Immediately effective on insertion/ immediate return of fertility on removal. • Free from side effects of hormonal methods. • Can be used as emergency contraception if inserted within 5 days of unprotected sex. • Can be used where hormonal contraceptives contraindicated	• Does NOT cause Infertility. • Does NOT cause Cancer. • Does NOT travel from uterus to other parts of the body. It is placed in a muscular thick walled uterus . • Does NOT increase risk of infection. • Does NOT cause discomfort during sex. • Does NOT lead to frequent abortions.

Limitations :

Requirement of a provider trained in IUCD insertion and a health centre setup for insertion of an IUCD.

Other effects:

The woman may have some light bleeding during the first week after getting an IUCD. Some women also have longer, heavier and more painful monthly bleeding, but this usually stops after the first three months.

Warning signs:

After Copper T insertion, the woman should visit the health facility immediately if she experiences:

- Severe lower abdominal pain
- Abnormal or heavy bleeding
- Foul-smelling vaginal discharge
- High fever
- Pain during sexual intercourse
- Delayed or missed period

These symptoms require prompt medical attention.

Who can use / who cannot use the method:

IUCD can be inserted in most of the women except certain cases like current PID, pus like discharge from cervix , unexplained bleeding from vagina . Screening by a trained provider to rule out cases of pelvic infections is important before IUCD insertion

When should it be inserted:

Interval IUCD- Interval IUCD - can be inserted at any time during the menstrual cycle when it is reasonably certain that the woman is not pregnant.

Postpartum IUCD (PPIUCD) - Immediately after OR within 48 hours of vaginal delivery/ concurrent with C Section

Post-Abortion IUCD - within 12 days of completion of abortion (surgical abortion). In case of medical abortion, the completion of abortion is ascertained on 12th day after the intake of second pill or 15th day after intake of first pill.

Follow-up: After insertion of the Copper T, a follow-up visit should be made after six weeks or after the first menstrual period, whichever is earlier.

Key points to remember:

- After obtaining verbal consent from the woman, the Copper T is inserted at the health facility by a trained health-care provider following proper cleanliness and all necessary precautions.
- The IUCD is placed inside the uterus.

- IUCD is effective for five/ten years
- IUCD must be inserted by a trained provider (CHO, MPW-F, Staff Nurse, LHV, ANM, or a Doctor) after doing a pelvic examination to rule out any medical condition in which IUCD should not be inserted.
- IUCD can be inserted at most of the government health facilities like AAM- SC, AAM- PHC and above where a trained provider is available.
- If the period stops at any point of time after insertion of IUCD, the woman should consult the doctor at any government health facility.
- Women can get IUCD removed anytime on demand and can become pregnant anytime.

Common side-effects: The woman may have some light bleeding during the first week after getting an IUCD. Some women also have longer, heavier and more painful monthly bleeding, but this usually stops after the first three months.

Follow-up: After insertion of the Copper T, a follow-up visit should be made after six weeks or after the first menstrual period, whichever is earlier.

Case Study: IUCD for Family Planning

A 26-year-old woman living in a village. She has two children, the youngest being 8 months old. Her family wants her to have another child soon, but she feels she needs time to recover and wants to focus on her children's health. She visits the Ayushman Arogya Mandir during a Village Health and Nutrition Day.

During counselling, ASHA explains different spacing methods of family planning. She is worried because she has heard that IUCD causes infertility and moves inside the body. She also fears that insertion will be very painful.

ASHA reassures her and arranges counselling with the CHO/Medical Officer, who explains that IUCD is a safe, long-acting, reversible method that can prevent pregnancy for up to 10 years and fertility returns after removal. After counselling, She agrees and gets an IUCD inserted at the health facility.

During follow-up, She experiences mild pain and spotting for a few days. ASHA visits her, explains that these are common and temporary side effects, and encourages her to continue. After one month, She feels comfortable and is satisfied with the method.

Discussion / Questions for Brainstorming:

1. Why was IUCD a suitable family planning method for her?
2. What myths about IUCD did she have? How should ASHA address such myths?
3. What role did ASHA play in helping her adopt IUCD?
4. What common side effects can occur after IUCD insertion?
5. When should ASHA advise referral to CHO/Medical Officer after IUCD insertion?
6. How can ASHA involve the husband and family in IUCD counselling?
7. What key messages should ASHA give during IUCD follow-up visits?

II. Injectable Medroxy Progestrone Acetate (MPA) (Antara)

You as an ASHA must be aware that new family planning methods have been introduced over last few years which are gaining popularity due to ease of use and effectiveness. One such method is use of hormonal 3 monthly Injectable contraceptive under the Antara Program.

This injection prevents pregnancy by

i. Stopping the release of the egg.

ii. Making the uterus unsuitable for pregnancy.

A single injection provides protection for 3 months with a single dose. They are repeated after every three months.

Advantages of Injectable hormonal contraceptive :

Advantages of Injectable MPA	Clarifying Misconceptions/ Myths
• Private and confidential method. • There is no interference with sexual intercourse. • Can be adopted as postpartum in a breastfeeding mother - at 6 weeks of delivery and in non-breastfeeding mother at 4 weeks after delivery. It can be given immediately or within 7 days as post-abortion contraception. • It does not affect quantity or quality of milk. • Decreases menstrual cramps and menorrhagia (heavy bleeding) • Prevents / improves anaemia. • Protects against endometrial & ovarian cancer. • Protects against ectopic pregnancy	• Does NOT cause infertility. • Does NOT cause weakening of bones. • Does NOT lead to abortions or birth defects. • Does NOT cause cancers (breast/ cervix/ endometrium).

Effects of Injectable MPA (non-harmful and reversible)
• Menstrual Irregularities: Light/ Heavy/ No bleeding. • Delay in return of fertility (7-10 months from last dose of injection). • Slight weight gain. • Mood swings. • Headache.

Antara should not be used if the woman has unexplained bleeding, breast cancer, severe liver disease, or stroke/severe diabetes.

When to start Antara

1. Interval (woman not pregnant and not recently delivered)
- The first injection should be given within 7 days from the start of menstruation.

2. Post-partum (after delivery)
- If the woman is not breastfeeding, Antara injection can be started any time within 4 weeks after delivery. After 4 weeks, ensure that the woman is not pregnant before giving the injection.
- If breastfeeding: start after 6 weeks (42 days) postpartum , ensure that the woman is not pregnant before giving the injection.

3. Post-abortion (after miscarriage or abortion)
- Injection can be given within 7 days after abortion or miscarriage.

Injectable contraceptive Antara comes in 2 forms:
- Intramuscular Antara-Single dose vial with disposable syringe and needle (govt supply)
- Subcutaneous Antara-Prefilled auto disable syringe Both are effective for 3 months.

Intramuscular Antara is given by trained provider in arms, buttocks or thighs whereas Subcutaneous Antara can be given in abdomen, thigh & arm as per client's preference. Except for the quantity of hormone & how it is administered , Antara IM & SC are similar in all aspects , i.e how it works, effectiveness, menstrual changes & return of fertility .

Switching from IM to SC or vice versa: it is safe to switch back and forth between IM and SC after three months with the same level of contraceptive protection but switching should not be a routine practice

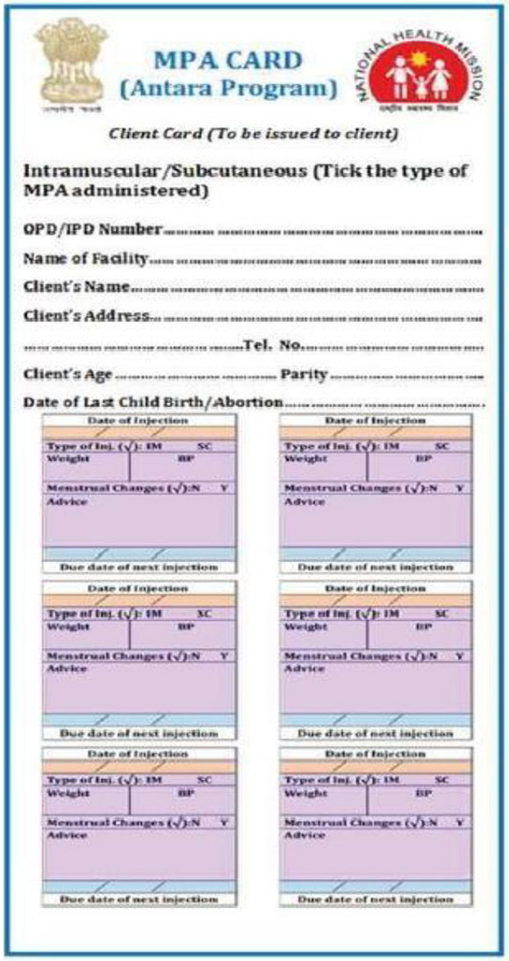
Dosage and administration : 1st dose of Antara is given only by a trained MBBS or above doctor and subsequent doses may be given by trained health provider (MBBS or AYUSH Doctor/ CHO / SN) in the health facility.

Subsequent doses: Woman must visit the health facility on scheduled date (3 months from earlier dose). It is best to come on the scheduled date, though there is a flexibility of (2 weeks earlier or 4 weeks later) than the exact date.

Post Injection instructions :
- Instruct client not to massage or apply hot fomentation to the injection site because the drug needs to stay there for a long time and release very slowly for the next three months.
- Instruct client to come after 90 days for a repeat injection and give her the scheduled date.
- Assure the client for consultation anytime if she has any concern or problem or might be pregnant.
- Hand over the MPA Client Card to her after explaining its content to her.

Follow-up: As an ASHA your role would be to ensure that women who have taken the first dose receive further doses every 3 months.

MPA Card: Once a woman receives the injection, she is given MPA card. The card should have information about the details of the woman, it includes date of current dose and next dose. As an ASHA, you should inform and encourage the woman to carry this card to the facility every time. The counterfoil of this card is maintained at the health facility where the first dose of injectable MPA is given.



MPA CARD
(Antara Program)

Client Card (To be issued to client)

Intramuscular/Subcutaneous (Tick the type of MPA administered)

OPD/IPD Number.....

Name of Facility.....

Client's Name.....

Client's Address.....

.....**Tel. No**.....

Client's Age..... **Parity**.....

Date of Last Child Birth/Abortion.....

Date of Injection	Date of Injection
Type of Inj. (√): IM SC	Type of Inj. (√): IM SC
Weight BP	Weight BP
Menstrual Changes (√):N Y	Menstrual Changes (√):N Y
Advice	Advice
Due date of next injection	Due date of next injection
Date of Injection	**Date of Injection**
Type of Inj. (√): IM SC	Type of Inj. (√): IM SC
Weight BP	Weight BP
Menstrual Changes (√):N Y	Menstrual Changes (√):N Y
Advice	Advice
Due date of next injection	Due date of next injection
Date of Injection	**Date of Injection**
Type of Inj. (√): IM SC	Type of Inj. (√): IM SC
Weight BP	Weight BP
Menstrual Changes (√):N Y	Menstrual Changes (√):N Y
Advice	Advice
Due date of next injection	Due date of next injection

Instructions for clients

- Once taken it is effective for 3 months
- Return on scheduled date as decided with the provider

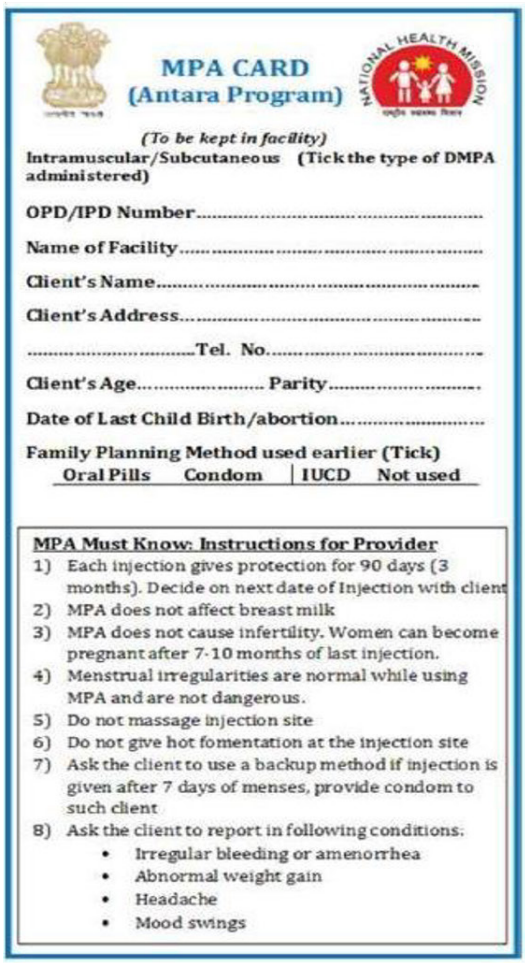
After Injection Do not massage injection site

Do not give hot fomentation at the injection site

- MPA does not affect breast milk
- MPA does not affect future pregnancy however some women may take 7-10 months to conceive after injection
- There are some menstrual changes which are not harmful
- Use backup method (like condom) if injection is taken after 7 days of menses

Contact health provider in following conditions:

- Irregular bleeding or amenorrhea
- Abnormal weight gain
- Headache
- Mood swings



MPA CARD
(Antara Program)

(To be kept in facility)

Intramuscular/Subcutaneous (Tick the type of DMPA administered)

OPD/IPD Number.....

Name of Facility.....

Client's Name.....

Client's Address.....

.....**Tel. No**.....

Client's Age..... **Parity**.....

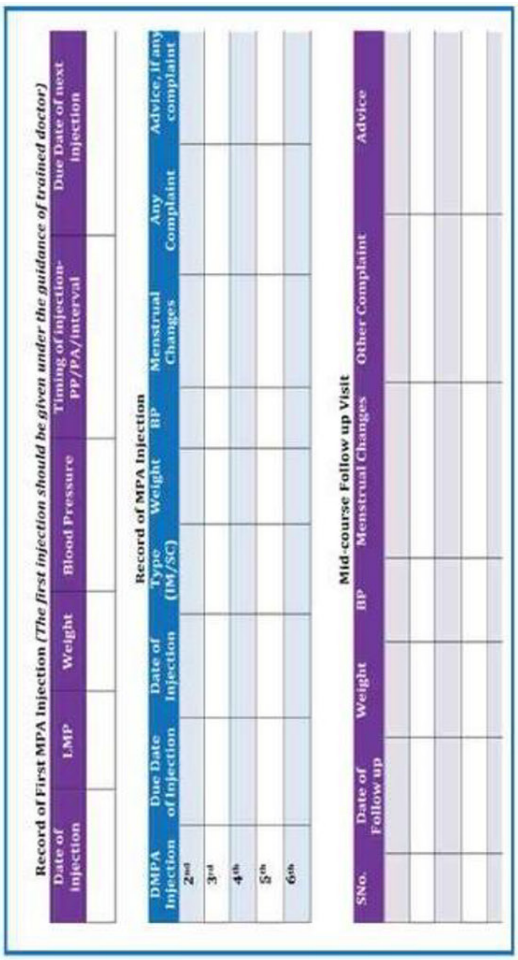
Date of Last Child Birth/abortion.....

Family Planning Method used earlier (Tick)

Oral Pills | Condom | IUCD | Not used

MPA Must Know: Instructions for Provider

1) Each injection gives protection for 90 days (3 months). Decide on next date of Injection with client
2) MPA does not affect breast milk
3) MPA does not cause infertility. Women can become pregnant after 7-10 months of last injection.
4) Menstrual irregularities are normal while using MPA and are not dangerous.
5) Do not massage injection site
6) Do not give hot fomentation at the injection site
7) Ask the client to use a backup method if injection is given after 7 days of menses, provide condom to such client
8) Ask the client to report in following conditions:
   - Irregular bleeding or amenorrhea
   - Abnormal weight gain
   - Headache
   - Mood swings



Record of First MPA Injection *(The first injection should be given under the guidance of trained doctor)*

Date of injection	LMP	Weight	Blood Pressure	Timing of injection- PP/PA/interval	Due Date of next injection

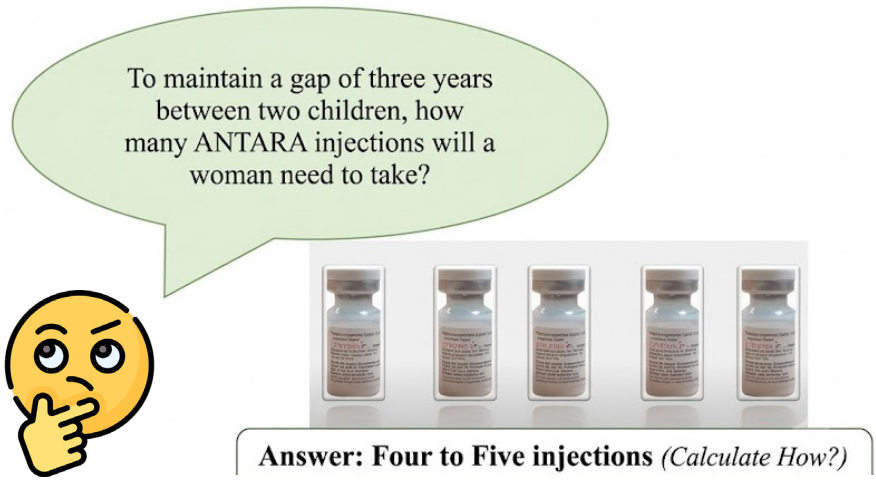
Record of MPA Injection

DMPA Injection	Due Date of Injection	Date of Injection	Type (IM/SC)	Weight	BP	Menstrual Changes	Any Complaint	Advice, if any complaint
2nd								
3rd								
4th								
5th								
6th								

Mid-course Follow up Visit

SNo.	Date of Follow up	Weight	BP	Menstrual Changes	Other Complaint	Advice

With the use of **Antara Injection,** some women may experience reduced menstrual bleeding or sometimes complete absence of menstruation. This is not a cause for concern. The blood that flows during menstruation is clean blood. When pregnancy is not desired, there is no need for preparation for pregnancy and monthly blood loss. Not having this bleeding is not harmful to health; in fact, it can be beneficial and prevents anemia. This Reduced or absent menstruation does not cause weakness of the bones or the eyes. When a woman stops taking the injections, menstruation usually returns within a few months.



Key Points to remember

- Very safe & effective method for women
- Injection has to be taken at every 3 months on schedulesd date
- If the woman does not take the injection on time, she can take it upto 4 weeks late or 2 early from the schedules date
- Woman should not rub/massage the injection site after taking the injection as it may decrease the effectiveness of the method
- It takes 7-10 months for fertility to return after stopping the injections

III. Subdermal Contraceptive Implant

A Contraceptive Implant is a small flexible rod about the size of a matchstick, placed under the skin of the upper arm of the woman, using a pre-loaded sterile disposable applicator. It is a long acting, reversible hormonal contraceptive method effective for 3 years after insertion. It is inserted by a trained provider (MBBS and Above) at the designated health facilities.

The implant placed under the skin slowly releases hormones which prevent pregnancy by:

i. Stopping the release of the egg

ii. Blocking sperm from entering the uterus

iii. Making the uterus unsuitable for pregnancy.

Advantages of Contraceptive Implants

- Highly safe and effective long-acting reversible contraceptive method.
- There is an early return of fertility following removal.
- Can be used by nearly all women, including those who are breastfeeding.
- Can be taken safely immediately after delivery and abortion.
- Helps protect against risks of pregnancy, including ectopic pregnancy.
- Helps protect against symptomatic pelvic inflammatory disease.
- May help protect against iron deficiency anaemia, by reducing menstrual flow as amenorrhoea sets in.
- Does not require any action from the user after insertion.
- Does not interfere with sexual activity or pleasure.
- A walk-in procedure and once inserted, effective for 3 years, hence better compliance.

Effects of Contraceptive Implant (non-harmful and reversible):

Some women may complain of changes in monthly bleeding pattern: Irregular/ prolonged/ heavy bleeding often followed by no bleeding

Can occasionally be associated with headaches, mood changes, breast tenderness etc.

When to place the sub-dermal implant:

1. Interval (woman not pregnant and not recently delivered)

- The implant may be inserted within 7 days from the start of menstruation .

2. Post-partum (after delivery)

- If the woman is not breastfeeding, Implant may be inserted any time within 4 weeks after delivery. After 4 weeks, ensure that the woman is not pregnant before inserting the implant.
- If breastfeeding: Insert the implant after 6 weeks (42 days) postpartum , ensure that the woman is not pregnant.

3. Post-abortion (after miscarriage or abortion)

- Implant can be inserted within 7 days after abortion or miscarriage.

Implant **should not be** used if the woman unexplained vaginal bleeding, has breast cancer or severe liver disease.

Site of implant: Implant is inserted just under the skin, on the inner side of the non-dominant upper arm.

Post Insertion Instructions or messages:

- Insertion site should be kept dry and clean for at least 2 days, to prevent chances of infection. After 2 days, the outer bandage may be removed.
- Puncture site usually heals in 3-5 days. The inner dressing can, thus, be removed after 5 days.
- Can resume routine work immediately; only caution is to avoid repeated touching of the insertion site or applying unusual pressure and, carrying heavy loads for 5 days.
- Some swelling or bruising may be experienced for a few days at the insertion
- site which is normal.
- Return to the health facility anytime in case of any side effects / problems or if she wants the implant to be removed.

Follow up:

- Contraceptive implant users do not require a routine return visit until it is time to replace the implant i.e., after 3 years of insertion. However, visits at 6 weeks and 3 months after insertion are encouraged to review her menstrual pattern, and address concerns, if any.
- Ask client to return to the health facility if she experiences any of the following:
  - » Menstrual changes affecting her daily routine work
  - » Pain, swelling, pus, or redness at the insertion site that becomes worse, or she sees the rod coming out
- Ensure that every client who has got implant inserted has received Implant card.
- Explain her details in the Implant card like do's and don'ts along with other necessary information like date of Insertion, due date of removal, site of insertion, expected menstrual changes etc. Explain that it is important to retain card if she wants to get implant removed at the designated facility.

Post Removal Instructions or messages:

- Keep the area around the removal site dry and clean for at least 2 days. The incision could become infected if the area gets wet while the client is bathing.
- Remove the outer bandage after 2 days and inner dressing until the incision heals (about 5 days).
- There may be bruising, swelling, or tenderness at the removal site for a few days. This is normal.
- Routine work can be done immediately. Avoid repeated touching or applying unusual pressure to the site, including carrying heavy loads.
- After healing, the area can be touched and washed with normal pressure.
- Ask her reproductive intentions and if she wants contraceptive protection, implant needs to be reinserted or another method may be offered.

Points to Remember

- Very Effective method for women, protects from unwanted pregnancy for 3 years
- Safe and suitable for nearly all women of reproductive age,including breastfeeding
- Inserted in upper arm under the skin by a trained provider
- Woman can do all routine work after Implant insertion
- Follow up is important at 6 weeks & 3 months after insertion Implant can be removed easily by a trained provider once the duration is over or as per client's demand
- Return of fertility is early after removal

IV. Oral Contraceptive Pills (OCPs) :

There are two types of oral contraceptive pills - Hormonal and Non-hormonal

Hormonal	Non-Hormonal
• Combined Oral Contraceptives (COCs • Emergency Contraceptive Pill (ECP)	• Centchroman (Ormeloxifene)

They are available at Ayushman Arogya Mandir.

a. Combined Oral Contraceptive Pills (COCs) (Mala N)

Mala N is a hormonal oral contraceptive pill. It contains hormones which prevent egg from maturing and / or getting released into the fallopian tubes.

Oral contraceptive pills are available in a 28-day cycle pack, of which the first 21 pills contain hormones and the remaining 7 pills contain iron supplements. One pill must be taken every day, and after completing the 21 hormone pills, the 7 iron pills should be taken. Since anaemia is common among women, these iron tablets are also beneficial. Oral contraceptive pills do not interfere with sexual activity and, unlike condoms, they are a woman-controlled method of contraception. MALA-N (combined oral contraceptive pills) are supplied by the CHO at the SHC-AAM.

Advantages of COC
• Decrease in menstrual flow and cramps. • Regulate menstrual cycle. • Decrease ovarian cysts.

Advantages of COC
• Decrease benign breast lumps. • Protect against ovarian and endometrial cancer. • Prevents ectopic pregnancy. • Immediate return of fertility on discontinuation.

Effects of COC (Non-harmful and reversible)
• Bleeding pattern may change (irregular / scanty / no bleeding / spotting) • Nausea / vomiting / headache. • Weight changes / breast tenderness / Acne. • Side effects like nausea, mild headache, breast tenderness, spotting, or irregular periods are not serious and usually reduce within 3 months.

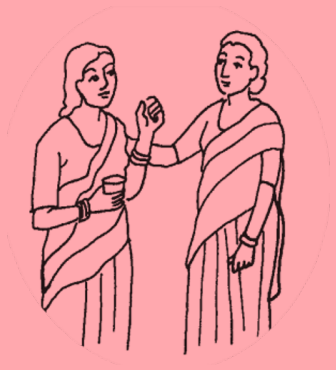
When to start COCs:

- **Interval** (normal menstrual cycle: Start within the first 5 days of the menstrual cycle (preferably on Day 1 of menstruation).
- **Post-partum** (after delivery):
  - » Non-breastfeeding: start after 3 weeks (21 days) postpartum
  - » Breastfeeding: start after 6 months postpartum
- **Post-abortion/miscarriage:** Can be started immediately or within 7 days after abortion.

There are certain conditions in which a woman is not advised COCs . That is why it is essential that the woman is screened by CHO / MO at AAM before the pill can be started.

Women who cannot use COCs

- Breastfeeding women < 6 months of pregnancy
- Non breast feeding women <3 weeks postpartum
- Women who smoke 15 cigarettes/day and are more than or equal to 35 years old.
- Women with the following conditions:
  - » Deep vein thrombosis
  - » Heart disease, bleeding disorders
  - » Liver disease
  - » Recurrent migraine headaches
  - » Unexplained abnormal vaginal bleeding
  - » Breast cancer
  - » Currently taking anticonvulsants for epilepsy
- With advice of clinician, in case of following conditions:
  - » Women with hypertension (BP 140/90)
  - » Diabetes, (advanced or long standing), with vascular problems, or central nervous system, kidney, or visual diseases



How to start the pills?	
S.No	**Description**
1	Assist the woman in getting examined by the CHO/Medical Officer at AAM who will decide and start oral contraceptive pills.
2	She can start the pill within the 5 days of the start of menstrual bleeding.
3	She must take one pill every day at the same time until the pack is finished.
4	Start a new pack immediately after finishing the previous pack.
5	Oral Pills is a very effective method, if the woman takes it regularly without missing it.
6	These pills do not cause abortion.

How to manage missed pills	
Missed 1 or 2 pills	• Take one hormonal pill as soon as possible / two pills at scheduled time.
Missed 3 or more pills in 1st/2nd week	• Take one hormonal pill as soon as possible and continue scheduled pill. • Use back up method (condom) for next 7 days.
Missed 3 or more pills in 3rd week	• Take one hormonal pill as soon as possible and finish all hormonal pills as scheduled. • Throw away the non-hormonal pills. • Start new pack next day. • Use back up method (condom) for next seven days .
Missed any non-hormonal pills (Iron pills)	• Discard the missed non-hormonal pill(s) • Continue taking COCs. Start new pack as usual.

Your role as an ASHA:

- Give her correct information.
- Facilitate her examination at the AAM for assessment of her suitability for starting COCs
- Ensure her regular follow
- Provide her monthly supply

Points to Remember (Combined Oral Pills)

- One pill has to be taken daily even if there is no sexual intercourse on a particular day
- Woman can become pregnant soon after stopping the pills
- It reduces the quantity of breast milk, hence to be started after 6 months if the woman is breast feeding
- Woman should keep extra supply of pill packets so that there is no gap between two pill packets
- Use of pills can regularize the menstrual cycle & also decrease blood flow & abdominal cramps during periods

b. Non-hormonal pills: Centchroman pills or 'Chhaya'

These are non-hormonal, non-steroidal, weekly pills which are suitable for nearly all women including those who are unmarried and have no children.

At the AAMs and other public health facilities, Chhaya pills are available free of cost.

Chhaya prevents pregnancy by delaying the movement of the egg and making the uterus unsuitable for pregnancy.

Advantages of Centchroman
• No hormonal effects. • No interference with sexual intercourse/ pleasure. • Can be adopted as postpartum (6 weeks) or postabortion contraception (within 7 days of completion of abortion). • There is no affect on quantity and quality of milk. • Immediate return of fertility on discontinuation. • Prevents/ improves anaemia.

Effects of Centchroman (non-harmful and reversible)
• Periods may get delayed / Prolonged Periods. • Bleeding may become scanty. • However if periods are delayed by more than 15 days , pregnancy needs to be ruled out.

When to start Chhaya

Interval (normal menstrual cycle): Start on Day 1 of the menstrual cycle (first day of menstruation).

Post-partum (after delivery): Chhaya can be started in breastfeeding women, including before 6 weeks after delivery in breastfeeding women as it does not affect quantity and quality of milk. Chhaya can be started in non-breastfeeding women postpartum. If not breastfeeding it may be started after 4 weeks postpartum.

Post-abortion/miscarriage: Can be started immediately or within 7 days after abortion.

How to start Chhaya: It is available as 8 tablets per strip. To start, the first pill is to be taken on the first day of period (as indicated by the first day of menstrual bleeding), next pill three days after. Therefore, one pill is taken twice a week for first three months; Starting from fourth month, the pill is to be taken once a week on the first pill day and should be continued on the weekly schedule.

How to start the pills?		
If the 1st day ofpill is	**For First 3 months, pill to be taken twice on**	**After 3 months**
Sunday	Sunday and Wednesday	Sunday
Monday	Monday and Thursday	Monday
Tuesday	Tuesday and Friday	Tuesday
Wednesday	Wednesday and Saturday	Wednesday
Thursday	Thursday and Sunday	Thursday
Friday	Friday and Monday	Friday
Saturday	Saturday and Tuesday	Saturday

Managing the missed pill :

- Take the pill as soon as possible after it is missed.
- If pill is missed by 1 or 2 days but lesser than 7 days, normal schedule should continue to take her pill as usual and she must use aback-up method (e.g. Condoms) till next period.
- If pill is missed by more than 7 days, discard the pill, use condom till next cycle and start the pack as a new beneficiary.

Chhaya should not be used in woman with ovarian disease, unexplained bleeding from vagina, liver disease.

Key Points to Remember (CHHAYA) :

- Pills have to be taken correctly as per the schedule even if there is no sexual intercourse on a particular day.
- Woman can become pregnant soon after stopping the pills.

- It does not affect the quantity of breast milk, hence can be started immediately after delivery.
- Woman should keep extra supply of pill packets so that there is no gap between two pill packets.

V. Emergency Contraceptive Pill (ECP)

These pills are also called as Morning-after pills" or post coital contraceptives and are meant for emergency purposes only. These are available under the name 'Ezy pill' in public health facilities. ECPs may be taken if no birth control method was used or if the condom tore or following forceful sex like rape / incest to avoid unwanted pregnancy.

It acts by preventing release of egg.

How to Use ECP?

Pill is taken immediately afterunprotected / accidental intercourse or as soon as possible within next 3 days (72 hours).

- ECPs are safe for everyone including those who cannot use combined hormonal contraceptive methods.
- ECPs do not disrupt an existing pregnancy and provide an opportunity for women to start using a regular contraceptive method.
- ECPs help to prevent pregnancy when taken up to 3 days (72 hours) after unprotected sex. The sooner they are taken, the more is the efficacy.

VI. Condoms (Nirodh)

The Male Condom (Nirodh) is a barrier method of contraception.

- It covers the penis and acts as a barrier preventing semen from entering the vagina. As the sperm is not able to enter and meet the egg , there is no pregnancy . Also protects from infections.

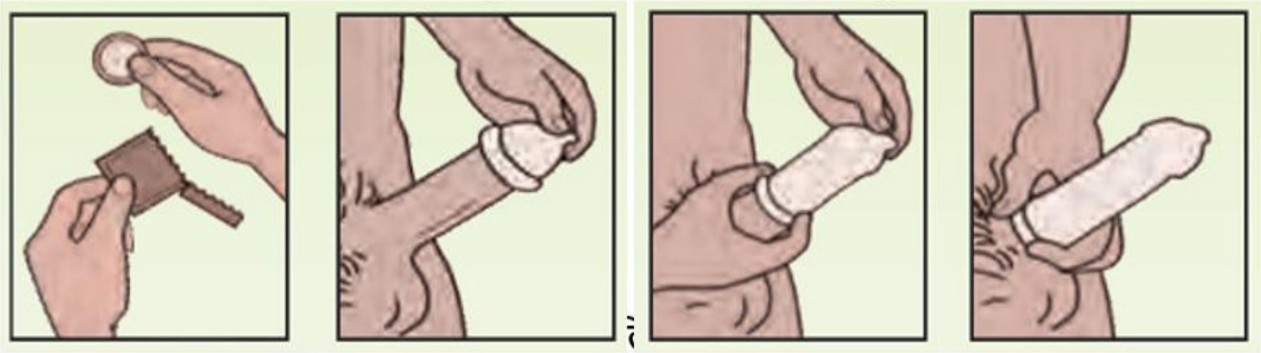
Advantages of condom:

- It is the only contraceptive method that protects against both unwanted pregnancies and sexually transmitted infections including HIV/AIDS.
- If used correctly and consistently, it is an effective method of contraception.
- It shows the commitment of male partner in family planning
- It does not have any side effects.
- It is easily available and is easy to use.
- There is no need for follow up.

Limitations :

- A new condom is to be used each time during sex.
- Correct and consistent condoms use is essential to prevent unwanted pregnancies
- A new condom is to be used every time , therefore availability has to ensured.
- There is a fear of slipping or tearing of the condom during the act.
- Participation and intent of the male partner is a must for successful use of condom.

Correct and consistent condoms use is essential to prevent unwanted pregnancies and therefore the beneficiary being counseled must be explained its use properly.



Explain to the beneficiary - How to use the condom:

- Open the packet carefully, if the packet is torn or cut in any place , do not use that condom .
- Condom is placed inside the packet rolled as a ring .Lift it as the ring and place the condom on the erect penis as shown in the diagram.
- Pinch the tip of the condom and unroll the condom toeards root of penis so that it covers the penis.
- After the act, hold the rim of the condom carefully while withdrawing the penis from the vagina to avoid any spilling of the semen.

Condom Disposal:

- After use, tie a knot at the open end of condom to keep the content intact and place it in a waste paper/bag before disposing it off in a dustbin. It must NOT to be flushed in the toilet.

Key Points to Remember (Condoms) :

- Advise families to use condom as a family planning method. Also explain that condoms prevent sexually transmitted infections.
- As an ASHA, you are provided with condoms in your ASHA kit, for distribution to women who need them. Women are shy to buy them from the market.
- You can show the woman or if possible -the couple , the correct use of condom. Use a flip chart, IEC etc.

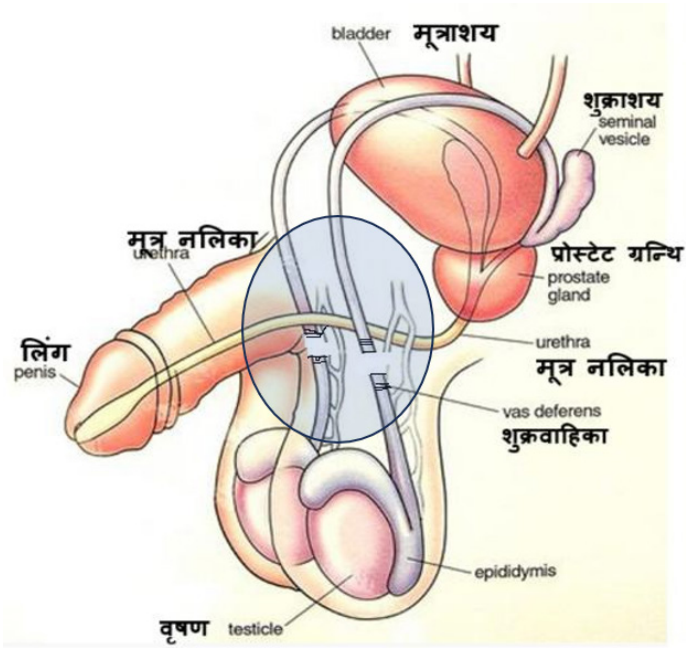
- A fresh condom is to be used every time the intercourse takes place . A condom that has been used before is more likely to break.
- Condoms are to be kept in a cool, dry place away from sunlight. Condoms that are from old or torn package are more likely to break.
- Educate that if condom can bursts or is torn during use, emergency contraceptive pills should be used.
- Some myths and doubts about condoms need to be answered. Address myths like - Condoms reduces pleasure of sex and that a condom user is an “easy” person.

The female condom is now available in cities, so that even women can use a condom. That is helpful when men are unwilling to put on condoms and empowers women in risky sex situations. However, it is not available in public health facilities.

B.4.11. LIMITING/PERMANENT METHODS:

I. Sterilization (male sterilization):

This is a very small operation for permanently preventing childbirth. Vasectomy requires less time and does not cause much trouble for men. No hospital stay is required. There are two methods for vasectomy:



a. Conventional vasectomy:

The procedure takes a few minutes, and the person can go home inan hour. An experienced doctor uses a scalpel to make a small slit in the scrotum and finds the tube that carries sperm on each side. The tube is tied and cut to stop the sperm from reaching the semen sac. One stitch is required.

b. No-scalpel vasectomy:

The no-scalpel method uses only a needle puncture to complete the process. No stitch is required. So, no need to come back for stitch removal. This method has become popular. There are trained surgeons available in hospital .There are fewer side effects of NSV as compared to conventional vasectomy. This is a safe and easy method and requires only 10- 15 minutes.

Advantages of Male Sterilization:

- **Highly effective and permanent:** Male sterilization has a high success rate and is a permanent contraceptive solution, eliminating the need for continuous ongoing effort or repeated expenses for temporary methods.

- **Minimally invasive procedure:** The recommended No-Scalpel Vasectomy (NSV) technique is a simple, quick, and stitchless outpatient procedure that involves minimal discomfort, less bleeding, and a lower risk of complications (like infection or hematoma) compared to conventional methods.
- **Fast recovery:** Most men can resume normal activities within a few days after the procedure.
- **No Impact on sexual function:** The procedure does not affect a man's sex drive, hormone levels (testosterone), ability to have erections, or the experience of ejaculation and orgasm. Seminal fluid is still produced; only sperm transport is blocked.
- **Reduces burden on partner:** It allows men to play an equal role in family planning, easing the physical and psychological burden of contraception that often falls disproportionately on women.

Post Sterilization Counselling & Follow Up - Male Sterilization
• Adequate rest to be taken at home. • Medication should be taken, as prescribed • Bathe after 24 hours following the surgery. If the dressing becomes wet, it should be changed. • Keep the incision area clean and dry. • Scrotal support or snug undergarment for 48 hours; Resume normal work after 48 hours and return to full activity, including cycling, after one week following surgery. • Resume normal diet. • In an emergency, as and when required go to the nearest health facility. • **Danger signs:** Report to the doctor if there is excessive pain, fainting, fever, bleeding or pus discharge from the incision, or if the client has not passed urine, not passed flatus and experiences bloating of the abdomen. • Ensure follow-up after 3 months, for semen examination for sperm count. • Vasectomy does not interfere with sexual pleasure, ability, or performance. The client may have intercourse whenever he is comfortable after the surgery but must ensure the use of condom for next 3 months if his wife/partner is not using any method of contraception.

Sometimes pregnancy may occur after vasectomy – Why ?

After vasectomy three months are needed to make the semen sperm-free. A condom has to be used during this period. This point is often ignored by men and conception can take place. Condom has to be used for three months after vasectomy to prevent chances of pregnancy.

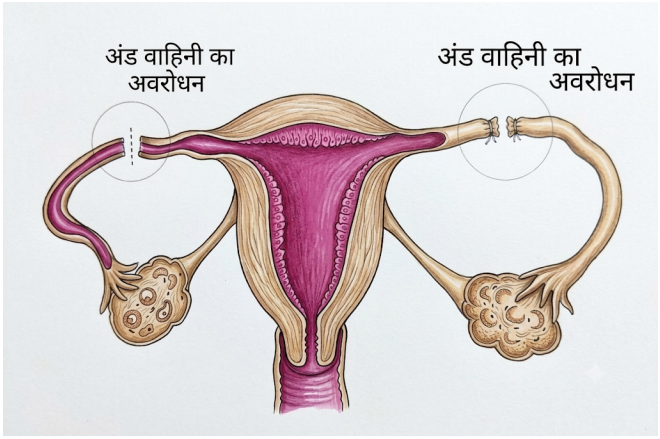
II. Tubectomy (female sterilization)

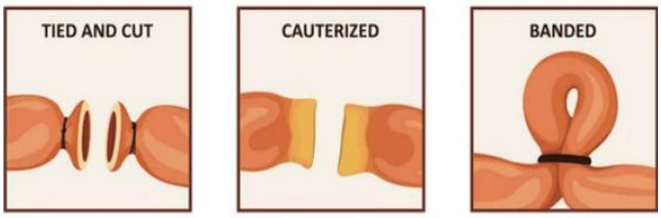
Tubectomy is a permanent method of contraception adopted when a couple has completed their family. In this procedure, both tubes carrying egg to the uterus are tied and cut to prevent pregnancy. It can be performed either through a mini-lap surgery or a laparoscopic (doorbeen) procedure. By blocking the tubes on both sides, the meeting of the ovum (egg) and sperm is prevented. Tubectomy is a safe, effective, and widely used sterilization method in India.

Two methods of tubectomy:

a. Mini laparotomy is the conventional method: This involves opening the abdomen through a small incision and operating by hand. Local anaesthesia is given by injection. The mini-lap method needs hospitalization for two days. It is useful for post-childbirth tubectomy, when the womb is still high in the abdomen and the tubes are easy to reach .

b. Laparoscopic tubectomy: This involves inserting a laparoscope into the abdomen and applying tight plastic rings on the tubes. Laparoscopy can only be performed when the uterus (womb) returns to its normal size and position (at least six weeks after childbirth). Although tubectomy performed by an experienced surgeon is usually successful, laparoscopic sterilization may sometimes fail.





Post Sterilization Counselling & Follow Up- Female Sterilization

- After discharge, adequate rest to be taken at home.
- Medication should be taken, as prescribed
- Resume normal diet as soon as possible.
- Keep the incision area clean and dry.
- Bathe after 24 hours following the surgery. If the dressing becomes wet, it should be changed.
- In an emergency, as and when required go to the nearest health facility.
- **Warning signs:** If after surgery , there is pain abdomen , weakness and /or giddiness, bloating of abdomen , discharge / bleeding from stitchline , immediately report to nearest health facility .
- Resume only light work after 48 hours and gradually return to full activity in two weeks following surgery.

Post Sterilization Counselling & Follow Up- Female Sterilization
• After interval sterilization (Minilap and Laparoscopic), the client may have intercourse one week after surgery or whenever she feels comfortable thereafter. • After post-partum sterilization (after caesarean or normal delivery) client may have intercourse 2 weeks after sterilization or whenever she feels comfortable. • Ensure follow-up after one month or first menstrual period, whichever is earlier.

Complications are rare in the case of tubectomy; sometimes there may be internal bleeding, infections, and possible tubal (ectopic) pregnancy later if a tube happens to open / reconnect.

In cases of major complications attributable to sterilization, failure and unlikely event of death, you must help her / husband in accessing compensation available as per Family Planning Indemnity scheme (FPIS). ANM / CHO will provide more information for this.

Who can adopt sterilization in government health facilities?

- Client should be ever-married.
- Age should be between 22-49 years (for females) and 22-60 years (males).
- Should have at least one child who is above one year of age (unless medically indicated).
- Client and their spouse / partner should not have undergone successful sterilization in the past.
- Medical eligibility (to be ascertained by the healthcare provider).

Important Point to Remember:

Sterilization, Injections and pills do not protect against STIs and Human Immuno-deficiency Virus (HIV). So, for protection from STIs and HIV, a condom should be used during every sexual intercourse, if the woman is at risk of contracting them.

Post Partum FP & it's Importance:

Postpartum Family Planning (PPFP) means initiating the use of a family planning method immediately after childbirth or within 1 year after delivery . Counseling for the same should be started in the last trimester of pregnancy itself to prepare the woman for adoption of most suitable method of her choice following delivery.She is most receptive to the counseling during this period and immediately after delivery.

PPFP is important because:

- No repeat visit to the Health facility is required if woman adopts a method like sterilization / PPIUCD.
- Prevents closely spaced pregnancies (less than 2 years gap).
- Reduces maternal risks like anemia, PPH, and poor recovery.

- Reduces newborn risks like low birth weight, prematurity, and neonatal death.
- Helps the mother regain strength and care for the newborn properly.
- Prevents unintended pregnancy during the breastfeeding period

Post-Abortion FP& it's Importance

Post-abortion Family Planning (PAFP) means starting a contraceptive method immediately after abortion .It is important because:

- Ovulation can occur any time after 10 days of abortion.
- Pregnancy can happen before the next menstrual period.
- Timely adoption of a suitable method prevents repeat unintended pregnancy.
- It reduces risks associated with repeated abortions and protects mother's physical and emotional health.
- It supports healthy birth spacing (minimum 3 years between births).

Role of Family and Men in Family Planning

Family planning is a shared responsibility of both women and men, with active support from the family. The involvement of men and family members plays a crucial role in the successful adoption and continuation of family planning methods.

Role of Men:

Men should actively participate in family planning decisions by discussing and choosing suitable methods along with their partners. They can support spacing and limiting births by using male methods such as condoms or opting for male sterilization (vasectomy). Men should encourage their wives to seek timely care, attend AAMs, and follow medical advice. Emotional support and correct information from men help reduce fear, myths, and misconceptions related to family planning methods.

Role of Family:

Family members, especially elders, influence reproductive decisions. Their support is essential in promoting healthy birth spacing, institutional health services, and continued use of contraceptive methods. Families should support women in managing minor side effects, attending follow-up visits, and maintaining regular use of chosen methods.

How do you access the family planning services?

Village Level: ASHAs and VHNDs					
IEC for Family Planning	Counselling on Choice of Method	Re-supply of Oral Contraceptives Pills	Dispense Condoms & Emergency Pills (ECPs)	Referral for IUCD & Sterilisation	Follow-up for contraceptive acceptors

Sub-Centre						
IEC for Family Planning	Counselling on Choice of Method	Check-ups for new clients interested in Oral Pills & IUCDs	Provision of IUDs, Oral Pills, ECPs & Condoms	Investigation of family planning problems	Referral for sterilisation	Support, training and resupply of CBDs

PHC and Higher Health Centres					
IEC for Family Planning	Method Counselling	Check-ups for new clients interested in sterilisation services	Provision of sterilisation services, IUDs Oral Pills, ECPs & Condoms	Investigation of family planning problems	Support, training and resupply of Sub-centres and CBDs

B.4.12 YOUR ROLE AS AN ASHA:

ASHA plays a key role in ensuring that individuals and couples are aware of family planning options and are able to choose and use methods safely and voluntarily.

As the ASHA of your area, you are responsible for:

1. Eligible Couple Survey in your area:

- Line listing all eligible couples in your area. The survey should be updated atleast twice a year and as an when required. You should know the newly weds, recently delivered unprotected, couples in active reproductive period having urgent spacing needs along with those who have completed their families.
- These unprotected couples should be of high priority for you with home visits, counseling and facilitation for adoption of the chosen method.
- Date of last home visit to the particular couple should be clearly recorded in your diary/survey record.

- On an average , there are 170 eligible couples in a populationof 1000.

2. Awareness Generation

- Educate women, men, and couples about all family planning methods (spacing and limiting)
- Explain benefits of spacing and limiting births for mother and child health
- Promote delay of first pregnancy and adequate spacing between children
- Advise women on proper hygiene and cleanliness.
- Educate women on natural family planning methods.
- Talk about benefits of family planning to couples and individuals, boys and girls at different occasions. These issues can also be discussed in the meetings of self-help groups, adolescent groups. Include information about prevention of RTIs/HIV/AIDS also. Dispel any rumours or misconceptions about contraceptives in villages.

3. Counselling :

- Provide one-to-one and couple counselling
- Explain advantages, limitations, side effects, and duration of each method
- Encourage male participation in family planning

4. Addressing Myths and Misconceptions

- Clear common myths related to IUCD, pills, condoms, injectables, implants, and sterilization with the help of ANM/ CHO/ MO if required.
- Reassure beneficiaries about safety and effectiveness of methods
- Address fears related to infertility, weakness, and sexual performance

5. Involving the men as equal partners in Family Planning

- On your home visits, involve the husband during your counselling explaining that number and spacing is a joint decision and thus family planning is responsibility of both husband and woman.
- Involve him during home visits and counselling.
- Promote male methods by giving complete and correct information and encourage use of Male Condom .
- Encourage use of No Scalpel Vasectomy by dispelling myths and fears regarding vasectomy and facilitating access to services .
- Use the community platforms like VHSNC / MAS and enlist support of MO / CHO to promote male participation by removing fears / prevalent myths surrounding vasectomy .

6. Service Facilitation

- Distribute condoms, oral contraceptive pills, and emergency contraceptive pills
- Motivate and refer eligible couples for IUCD, injectable, implant, and sterilization services

- Accompany the woman to the nearest health centre for the required method IUCD insertion/Antara/implant Sterilization/Screening for COCs etc
- Help the CHO to contact women wanting to have a Copper-T insertion.
- Support and mobilize beneficiaries during fixed day services and camps

7. Follow-up and Continuity of Care

- Ensure regular follow-up of pills, injectables, IUCDs, and implants
- Identify and refer cases with side effects or complications

8. Record Keeping and Reporting

- Maintain records of eligible couples and contraceptive users
- Update eligible couple register and report services provided

9. Community Mobilization

- Organize and participate in VHNDs, community meetings, and home visits
- Engage husbands, mothers-in-law, (Saas-Bahu Sammelan) and community leaders
- Promote government family planning schemes and incentives

Case Study: Which contraceptive is right for me?

Mrs. P is a 23-year-old woman who is married and lives in the city with her husband and his family. She has a one- year-old daughter. Mrs. P does not want to have her next child for the next 5 years. She spoke about this to her husband and he is also in agreement for the same. She went to her ASHA to seek help and information about familyplanning methods. ASHA gave her information about Copper-T, an IUCD, and called Mrs. P over to the Primary Health Centre to get the IUCD insertion. Mrs. P was not keen to get the IUCD inserted and asked instead for some contraceptive pills or injection that she could use. The ASHA said that the IUCD was the best option for Mrs. P and that she shouldn't give it so much thought.

Question 1. Do you think Mrs. P was given the right advice by her ASHA?

Question 2. If someone comes to us seeking advice on contraceptive methods, what should we do?

Answer:

- Give complete and accurate information about all available contraceptive methods.
- Clear out any misconceptions about existing contraceptive methods.
- Do not insist on the use of any one type of method.
- Inform about the centres where different contraceptive methods would be available to them. If a method of client's choice is not available at the public health facility, inform them about other facilities.

Family Planning Logistics Management System

FP-LMIS Application (Family Planning Logistics Management Information System)

The FP-LMIS is used to manage the supply chain of family planning commodities and ensure uninterrupted availability at community and facility levels.

Key Functions:

- Tracks stock of family planning commodities
- Reports demand and consumption
- Prevents stock-outs at sub-centres and villages

ASHA's Role

- Update distribution of contraceptives
- Ensure availability at village level
- Support informed family planning choices

Access - Mobile SMS-based FP-LMIS and Accessible only to authorized users involved in the supply chain.Standardized Commodity Codes instead of full names are used for SMS while indenting, issuing, or updating stock) to facilitate use of old keyboard phones.

FP-LMIS MOBILE APP

The FP-LMIS App is protected by user ID and Password. Only an authorized user user client it to operate the supply chain process for the assigned store.

Downloading FP-LMIS App

The FP-LMIS andried App is available under **Google Play Store**. Download the FP-LMIS App. After downloading the App, the FP-LMIS App icon (as shown) would be displayed in your mobile.

FPLMIS

Login Screen

This screen allows the user to login in in the FP-LMIS mobile App.

Step 1: Enter the user name.

Step 2: Enter the password

Step 3: Click on **"Login"**.

In case of unsuccessful login, message would appear **"Invalid username/password"**.

To clear the username and password fields, click on **"Clear"**.

Main Maon Screen

After successful login, the main screen would appear. Following six menus would appear.

i. **Current Stock:** To enquire the current physical stock position available at mere.
ii. **Indent:** To raise indent.
ii. **Issue:** To issue appeat an indent.
iv. **Acknowledge:** To receive and acknowledge the FP commodities.
v. **Issue to Client:** To issue FP commodities to the client.
vi. **Stock Update:** To update the current physical stock after issuance to the clients (If issue to client not used for issuence of FP commodities to the client)

To logout, click on **"Logout"**.

Indent Raise

To raise indent, follow the steps below.
Step 1: Click on **"Indent"** menu.
Step 2: Select **"Ge"**.
Step 3: Enter required quantity in the **Quantity** column.

Step 4:
Indent re message would appear for confirmation, click on **"OK"**.
Result:
Indent raised successfully with Indent No. would appear.

Issue to Client

FP-LMIS Mobile App allows the user to issue the items to the stemu according to their demand or choice. To issue item/s to client, follow the steps below.
Step 1: Click on **"Issue to Client"** menu. A new page with some empty fields would appear for entering client details. However, these fields are choice. Manary. user may fill the required informations or may left blank.

Step 1: Click on **"Select Commodity"**. Select the commodity from the list.

Step 3: Select the commodity from the list.

Step 4: Click on **"Select Batch"**.

Step 5: Enter quantity againts the batch and click **"OK"**.

Step 6: Click on **"Issue"**. Select commodity from the list.

Result: Item issued successfully with the issue no. would appear.

Stock Update

A popus Mobile App allows the user to update their physical stock current available with the store (if the user not issoed the FP commodities of the menu. through **"Iesue to Client"** stock. To update the physical stock, follow the steps below.
Step 1: Click on **"Stock Update"** menu.
Step 2: Click on **"Select Commodity"**. Select the commodity from the list.

Step 3: Click on **"Selest Batch"**. Enter the sslect quantity against the batch and then then **"OK"**.

Repeat Step 2 and Step 3 hil completion of all commodities.

Step 4: Click on **"Update Stock"**.

Result: Stock updated successfully would appear.

B.4.13 SCHEMES UNDER NATIONAL FAMILY PLANNING PROGRAM

1. Home delivery of contraceptives by ASHA

Under this scheme, ASHA delivers the contraceptives at the doorstep of the clients as per the need. The contraceptives include condoms (Nirodh), centchroman pills (Chhaya), COCs (Mala-N) and emergency pills (Ezy Pill). The salient features of the scheme are as follows:

- ASHAs would make a list of all the eligible couples of village and preferred method of contraceptive of each couple. This data of users should be updated regularly and shared with Sub center and PHC.
- ASHA shall replenish her contraceptive stock every month from the sub center/ PHC/ block (as per the existing system established by the state). Monthly meetings could be one of the opportunities to receive contraceptive stocks every month.

2. Pregnancy Testing Kit (Nishchay Kit)

Under this scheme, ASHA would regularly collect Nishchay kit from the sub center and provide it to women for the detection of pregnancy. Salient features of the scheme are as follows:

- ASHA should inform the women about the availability of Nishchay Kit with them. ASHA should counsel women regarding the advantages of early detection of pregnancy.
- ASHA should provide the Nishchay kit to client for early detection of pregnancy and tell her how to use the Kit. She should also tell the client how to read the pregnancy test results. ASHA may help and conduct the test for clients who are not able to understand how to read the results on their own.
- ASHA should refer the client, as per client's need and pregnancy test results.

3. Family Planning- ASHA Incentive:

Family Planning - ASHA Incentive		
1	Ensuring delaying of 2 years after marriage (ESB-1)	Rs. 500/-per case
2	Ensuring spacing of 3 years after birth of 1st child (ESB-2)	Rs. 500/-per case
3	Ensuring a couple to opt for permanent/ limiting method after 2 children (ESB-3)	Rs. 1000/-per case
4	Counselling, motivating and follow up of the cases for Tubectomy	High focus states (Odisha, Uttarakhand, Haryana, Gujarat)- Rs.200/per Case
		Mission Parivar Vikas (Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Chhattisgarh, Jharkhand, Arunachal Pradesh, Manipur, Mizoram, Meghalaya, Nagaland and Tripura) – Rs.300/per Case.

Family Planning - ASHA Incentive		
		Other High focus states (Sikkim, Ladakh, J&K, Himachal Pradesh) - Rs. 150/- per Case
		Non-High Focus States- Rs. 150/- per Case
5	Counselling, motivating and follow up of the cases for Vasectomy/ NSV	High focus states (Odisha, Uttarakhand, Haryana, Gujarat) - Rs.300/Case
		Mission Parivar Vikas (Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Chhattisgarh, Jharkhand, Arunachal Pradesh, Manipur, Mizoram, Meghalaya, Nagaland and Tripura) - Rs.400/Case.
		Other High focus states (Sikkim, Ladakh, J&K, Himachal Pradesh) - Rs. 200/Case
		Non-High Focus States - Rs. 200/Case
6	Female Postpartum sterilization	High focus states (Odisha, Uttarakhand, Haryana, Gujarat) - Rs.300/Case
		Mission Parivar Vikas (Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Chhattisgarh, Jharkhand, Arunachal Pradesh, Manipur, Mizoram, Meghalaya, Nagaland and Tripura) - Rs.400/Case
7	Injectable Contraceptive MPA (Antara Program) - Incentive to ASHA	Rs 100/ per dose (for each dose)
8	Escorting or facilitating beneficiary to the health facility for the PPIUCD insertion	Rs. 150/per case
9	Escorting or facilitating beneficiary to the health facility for the PAIUCD insertion	Rs. 150/per case
Mission Parivar Vikas- MPV Extended in all districts of the seven high focus states (UP, Bihar, Jharkhand, MP, Chhattisgarh, Rajasthan and Assam) as well as six North- Eastern states of the country.		

Family Planning - ASHA Incentive		
10	Injectable Contraceptive,MPA (Antara Program) - Incentive to ASHA	Rs 100/ per dose (up to 3rd doses) Rs. 200 only for Fourth Dose
11	Escorting or facilitating beneficiary to the health facility for the PPIUCD insertion	Rs. 300/per case
12	Escorting or facilitating beneficiary to the health facility for the PAIUCD insertion	Rs. 300/per case
13	Mission Parivar Vikas Campaigns Block level activities- ASHA to be oriented on eligible couple survey for estimation of beneficiaries and will be expected to conduct eligible couple survey- maximum four rounds	Rs. 150/per ASHA/ per round
14	Nayi Pahel Kit (NPK)- an FP kit for newlyweds- a FP kit would be given to the newlywed couple by ASHA	Rs. 200/ASHA/NPK distribution
15	Saas Bahu Sammelan-mobilize Saas Bahu for the Sammelan- maximum four rounds	Rs. 200/ Sammelan

B5
Caring for the Elderly

PART B

B.5 Caring for the Elderly

At the end of this section, you would know about:

i. Providing opportunity for dignified aging to your elderly with community and health system support.

ii. Challenges of aging and how you can help your elderly in coping with them.

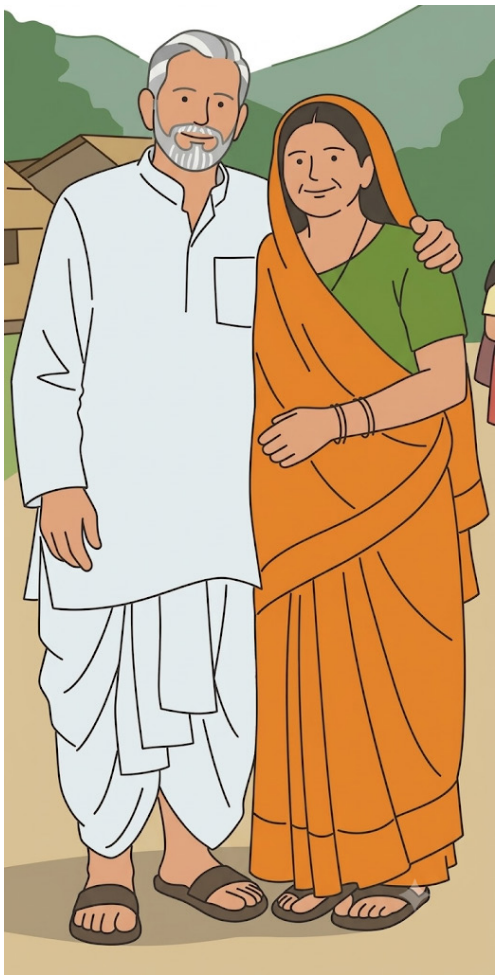
iii. Line listing and identifying the more vulnerable and the most vulnerable of your elderly population.

iv. Helping the caregivers and linking the vulnerable elderly requiring care to the AAM-SHC teams.

B.5.1 ELDERS ARE SPECIAL

As an ASHA, you are an important member of the Ayushman Arogya Mandir team and the closest link to the community. You play a crucial role in identifying elderly individuals who need care and in facilitating their access to appropriate health services. You also serve as a key resource in promoting healthy ageing, ensuring adequate nutrition, and providing psychosocial support to elderly persons and their families.

This section is devoted to help you in understanding the needs of the elderly population in your area and assisting them to attain healthy aging. It also includes common health conditions affecting the elderly and the appropriate actions to be taken in different situations. You are also expected to help the caregivers in the family in taking care of their elderly.



Principles of Care for the Elderly

Supporting Health, Independence, and Dignity for Every Elderly Person

- Healthy & Active Aging
- Equity & Non-Discrimination

- Prevention & Early Detection
- Family & Community Support
- Continuity of Care
- Safety & Protection
- Respect & Dignity
- Person-Centred Care
- Equity & Non-Discrimination
- Coordination & Referral
- Comprehensive Care
- Accessibility of Services

Aging is not a disease: Aging is not a disease, nor is it a condition to be regretted. It is a natural and inevitable part of life that reflects survival, experience, and growth. As people age, their needs may change, but this does not mean they are unwell or less valuable. On the contrary, older persons carry knowledge, wisdom, and social contributions that enrich families and communities. Caring for the elderly is not only about managing illness, but also about ensuring their dignity, independence , comfort, emotional well-being, and quality of life.

Being elderly makes them special
• Elderly persons have rich life experience and wisdom gained over many years. • They often serve as advisors, and decision-makers within families and communities. • They now have more time for rest, reflection, social interaction, and community participation. • Their strong emotional bonding with grandchildren and family members provides emotional stability to households. • Their knowledge of local traditions, culture, and values strengthens community identity.

How many elderly are there in your area?

On an average there are about 80 to 120 elderly in population of 1000. While doing the household survey in your area, you capture the age of the individuals and so you already have the list of the senior citizens (more than 60 years of age) in your area.

If an elderly person does not remember their exact age, it can be estimated by asking about indirect indicators such as:

- The age of their eldest child or grandchild
- Major historical or political events that occurred during their youth or early adulthood

How do you assess the risk in elderly?

As an ASHA , you have to fill the Community Based Assessment Checklist (CBAC) for the entire population of your area including the elderly. The section B3 is specific to elderly.

B3: Elderly-specific (60 years and above) - CBAC	Y/N
Do you feel unsteady while standing or walking?	
Do you forget names of your near ones or your own home address?	
Do you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet?	
Frequent Falls	
Do you feel you require assistive devices like hearing aid, spectacles, walking stick, wheel chair etc.	
Are you suffering from any physical disability that restricts your movement?	

This enables you to identify elderly individuals who require Comprehensive Geriatric Assessment under CPHC if the response to any question in Part B3 of the CBAC is “Yes” and you are to refer them to the CHO / ANM for further assessment. Responses should be obtained directly from the elderly person if they are oriented; otherwise, information should be collected from the primary caregiver.

The Operational Guidelines for Elderly Care at Health and Wellness Centres recommend a mobility-based classification of elderly into three categories:

1. Mobile elderly

2. Restricted mobile elderly (requiring personal assistance or assistive devices for mobility)

3. Bed-bound or home-bound elderly (requiring assistance in any form), including those needing palliative or end-of-life care.

Assessment of high-risk elderly is primarily based on their level of mobility. Services are prioritized in the following order: bed-bound elderly, restricted mobile elderly, and mobile elderly.

Functionality and independence level of an elderly individual is main indicator of his / her health and well-being rather than mere age in number of years.

B.5.2 HEALTH PROMOTION AND COUNSELLING FOR ELDERLY CARE

As an ASHA, you have the opportunity to sensitize your community about the health needs of elderly, to promote healthy lifestyle, recognize signs and symptoms of common health problems affecting the elderly and facilitate referral to AAM-SHC / PHC when required and follow up.

You will also need to create awareness amongst the care givers during home visits and in VHSNC/ MAS meetings regarding promotive, preventive and rehabilitative care of the elderly. This will include the required environmental modifications, lifestyle changes - nutritional interventions and physical activities which favour healthy ageing.

One of the important tasks during your visit to a household with elderly will be to counsel the elder on health promotion, self care and any specific issue related to their illness.

Good counselling approaches are build upon a foundation of respect, empathy, and support.

In case of elderly, remember that they are much older and experienced than you and have lot of wisdom. A high degree of sensitivity, awareness, and acceptance from your side is required for giving care and counselling to elderly. Counselling the elderly should also address issues of anxiety and stress, related to the losses in their life, and particularly the sense of losing control over one's life.

DO's While Counselling the Elderly

- Do treat every elderly person with respect and dignity, irrespective of their health condition, economic status, or family support.
- Do listen patiently to the elderly person's complaints, concerns, and fears; give them adequate time to speak. they might have lost some of their ability to hear or see. Raise your voice accordingly but don't shout at them.
- They might not accept your suggestions immediately. Pursue them slowly for seeking care. Try to pursue the family members and caregivers as well.
- Do pay attention to mental health issues, loneliness, neglect, or abuse, and inform the ANM or Medical Officer when required.
- Respect their autonomy. Ask them whether they need assistance. They might not like to be assumed as weak individuals.
- Be gentle with them while helping them around.

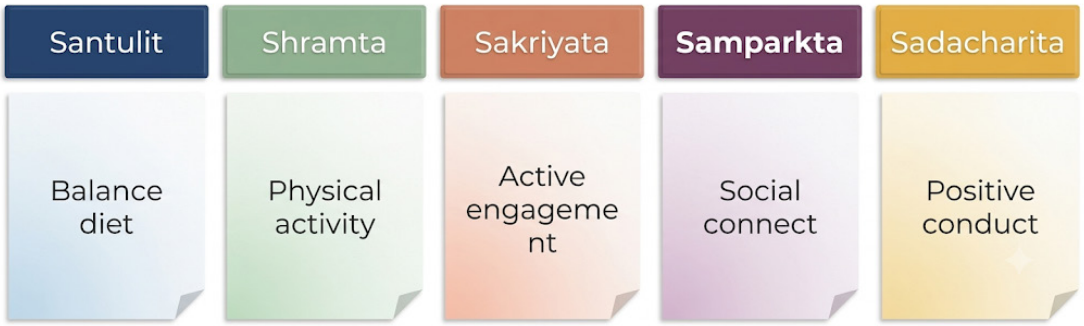
DON'Ts While Counselling the Elderly

- Do not consider health problems in old age as "normal" and ignore them. Early care can prevent complications.
- Do not speak harshly, rush conversations, or dismiss complaints as unnecessary or exaggerated.
- Do not breach confidentiality or discuss the elderly person's health issues casually in the community.
- Do not force decisions regarding treatment; instead, explain options and encourage informed choices.
- Do not overlook mental health symptoms such as sadness, withdrawal, forgetfulness, or disturbed sleep.
- Do not delay referral when serious symptoms or sudden deterioration is noticed.
- Do not assume family members are always providing adequate care. Assess and support where gaps exist.
- Do not discriminate on the basis of gender, caste, disability, or economic dependence.

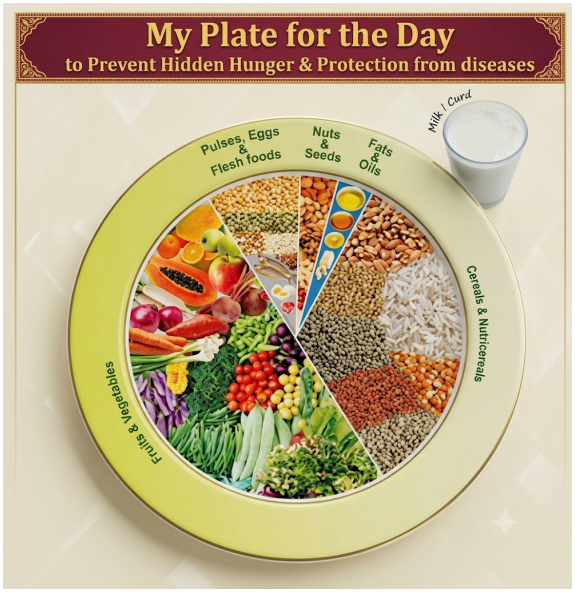
Promotion and facilitating adoption of a healthy life style and self care is required for all age groups . It is equally important for our elderly population to be able to lead a healthy, active, and fulfilling life.

B.5.3 HEALTHY LIFE STYLE

The **five "S" principles** summarize the core components of a healthy life style for attainment of physical, mental and social well being. These are



Santulit Ahaar (Balanced diet) emphasizes consuming a balanced diet that includes



i. Chapatti, rice, dal, vegetables, fruits, milk, curd, salad, and adequate water. It provides nutrition required for maintenance of body and prevents diet related problems like constipation. Eggs and meat may be consumed in moderation.

ii. The diet should have moderate amount of salt and sugar. Adding extra salt / consumption of highly salted or sugary foods should be avoided.

iii. Diet should be low in fats (preferably use unsaturated vegetable fats, avoid animal red meat fat),

iv. Consume plenty of fruits and vegetables These provide the required dietary fibre and prevent constipation . They are also rich in micronutrients and vitamins for strong bones and good immunity against infections.

v. Over-nutrition is as bad as under-nutrition and should be avoided.

vi. Sufficient amount of liquids to be taken (6–8 glasses of water daily).

vii. Food should be hygienically cooked, stored and servedFreshly cooked foods are preferred.

Shramta (Physical activity) highlights the importance of regular physical work and exercise for maintaining physical and mental health.

i. Physical activity is essential for physical and mental health and helps in prevention/control of diseases like obesity, diabetes, heart disease, osteoporosis , falls, and some cancers.

ii. It improves sleep and quality of life. Physical activities may be occupational, household, or transport-related work.

iii. Recommended exercises include aerobic activities like brisk walking for 30–45 minutes for at least 4-5 days every week, along with weight-bearing exercises such as stair climbing, chair sit-ups.

iv. Simple extension and rotation exercises keep joints healthy.

Case study

Mr. R, 68 years old has recently been diagnosed as Type 2 diabetic.

MO at the AAM-PHC has started him on medication.The ASHA worker, Ms. S , visits Mr. R's home as part of routine follow-up of elderly persons with non-communicable diseases (NCDs).

Mr. R appear anxious and confused. He believes diabetes is a "very dangerous disease" and fears that he will soon become bedridden or blind.

He has not started taking medicines regularly, as he is worried about lifelong dependency on tablets. He has also drastically reduced his food intake, feeling that "eating causes sugar."

Do you think his fears are well founded ?

If you were in Ms. S's place how would you have counselled Mr. R.

Sakriyata (Active engagement) refers to staying mentally and physically active beyond formal traditional exercises. This includes hobbies and pastimes such as gardening, reading, indoor games like carrom, solving puzzles, learning new skills, and using computers. Such activities keep the brain active, enhance cognitive function, and contribute to emotional wellbeing.

Samparkta (Social connectedness) stresses the value of social interaction through maintaining relationships with friends and relatives, participating in community groups, club memberships, and attending social functions. Regular social engagement reduces loneliness, improves mental health, and enhances overall quality of life.

Sadacharita (Positive conduct and attitude) focuses on ethical living, positive thinking, and practices that promote inner peace. Yoga, pranayama, meditation, prayers, spiritual activities, and listening to devotional or inspirational content help in mental relaxation and emotional stability. Accepting ageing gracefully and maintaining a positive outlook enables the elderly to live with dignity and improves their overall wellbeing.

B.5.4 SELF-CARE FOR THE ELDERLY

Self-care is one of the best health promotion strategies which means practicing care by the individual himself / herself .

Your Role as an ASHA: Your key role is to educate, motivate, and enable the elderly and their families to practice and maintain self-care routines for better health and independence.

Personal Hygiene - Personal cleanliness prevents infections and upholds an individual's dignity and self-esteem.

Key Hygiene Practices Include:

- Brushing teeth regularly
- Bathing and changing clothes
- Frequent handwashing
- Combing hair
- Caring for nails and feet

Skin care

Problems/conditions which affect skin	Practices in skin care
Intrinsic Vulnerabilities: • Decreased skin sensation • Reduced food and water intake • Skin irritation from allergies, dryness, or medications • Contamination from sweat, urine, or faecal matter due to incontinence • Contact with wound discharge • External devices like casts, braces, bandages, or dressings	Proper skin cleansing during bathing is essential for maintaining hygiene and preventing complications. • For Mobile Elderly: Pay special attention to thoroughly cleaning the armpits (axilla) and groin area. • For Those with Wounds: Take care to keep the dressing clean and dry during the bath. Avoid direct water contact with the wound site.

Care of Dry and Itchy Skin in Elderly (Winter Season)	
Do's	**Don'ts**
• Use lukewarm water for bathing • Apply oil or moisturizer daily immediately after bathing • Use mild soap • Wear soft, loose cotton clothes • Use cotton inner layer under woollens • Keep skin covered in cold weather • Cover hands, legs, and feet • Maintain adequate fluid intake	• Do not use hot water for bathing • Do not bathe frequently without need • Do not scrub skin with rough cloth or loofah • Do not use strong, scented, or antiseptic soaps • Do not scratch the skin • Do not apply steroid or antibiotic creams without doctor's advice • Do not apply talcum powder on dry skin

Refer to AAM-SHC / PHC/ UPHC if :

- Severe itching disturbing sleep
- Cracks, bleeding, or open wounds
- Redness, swelling, pus, or pain
- Persistent itching without visible dryness
- Elderly person with diabetes, kidney, or liver disease and severe itching

Care of Hair :

Care of hair	Conditions requiring special hair care
a. Washing hair with soap/shampoo (once in two to three days in summer and once in week in winters) b. Oiling and massaging the scalp c. Use wide tooth combs will decrease hair breakage. d. The comb should be cleaned. e. Comb should not be shared by other people.	• Dandruff- soap/ anti dandruff shampoo should be used. • Hair loss – weak, breaks easily and thinning, regular oiling, washing and tying them loosely. • Pediculosis or lice – bedding, clothes, hair comb, brush should also be clean. In case of lice in hair, anti-lice shampoo, oil should be used

Oral Care - Key Practice:

Brush teeth twice daily.

Brushing Steps:

1. Place a pea-sized amount of toothpaste on the brush at a 45-degree angle to gums.
2. Gently brush outer surfaces with short back-and-forth strokes.
3. Brush inner surfaces
4. Place the brush and tilt on the inside surface of the front teeth and move up in strokes
5. Brush chewing surfaces of all teeth.

Use a plastic tongue cleaner or brush to clean the tongue from behind to the front in 4-5 stroke

If he / she is using a denture , then tell them about the denture hygiene and maintenance

Denture maintenance:

- Denture should be cleaned regularly.
- One can use clean water, soap and toothbrush to clean the denture.
- It should be cleaned gently and take care that it does not fall and break.
- Denture should be removed in the night and kept in clean water overnight
- Dentures should be kept away from children's reach

Care of Hands, Feet & Nails to prevent infection, injury and odor.

Method of foot care is shown below

1. Wash feet daily.

2. Dry between the toes.

3. Creams or lotions can be applied to soften the fee to prevent dryness.

4. Wash and dry thoroughly, especially between toes and fingers.

5. Wear moisture resistant socks.

6. Never walk barefoot.

7. Wear shoes that fit well. Check feet for sores, cuts, corns, blisters and redness.

8. Trim nails regularly and keep them clean.

9. Check daily for cuts, redness, or swelling, particularly if the elderly has diabetes or reduced sensation.

These practices help maintain hygiene, prevent complications and support the overall well-being of the elderly.

Hand washing

The most important step in caring the hands

is by handwashing. Hand washing can prevent several infectious diseases.

Steps of hand washing:

STEP 1: Wet hands and wrists. Apply soap. STEP 2: Place right palm over the left or left over the right, interlace the fingers.

STEP 3: Interlock back fingers to opposite fingers

STEP 4: Hold right thumb by left palm, rub

in a rotational manner. Repeat the procedure for left thumb with right palm

STEP 5: Rub tops of fingers and thumb of right hand in left palm and vice versa

STEP 6: Interlock the fingers and rub between the fingers

STEP 7: Wash hand up-to the wrist using palm of the other hand

Care of eyes, ears and nose

A common problem of the eyes is secretions that dry on the lashes as crusts These crusts are softened by placing a cotton ball over lids for some time, then wipe the loosened secretions from inner to outer angle of the eye .

You must emphasize that no drops should be put in the eyes unless prescribed by the doctor .

Care of eye after cataract surgery must be explained to the person as well as the care givers

Care of nose

The secretions can collect inside the nose, dry into crusts and block the nose. These crusted secretions can be softened and removed gently during bath with the help of wet cloth. Make sure that the nails are trimmed.

Think and reflect

72 year old Mrs. R was becoming hard of hearing. Mrs. S, her daughter-in-law was not getting time to take her to the AAM-SHC. Also, Mrs. R kept insisting it was just wax. So when when they heard the local ear cleaner was passing down the street, Mrs. S rushed out and called him in. He took out his instruments and started cleaning her ear. Towards the end she felt a sharp stab of pain. He reassured her that it will go away after sometime. Towards the evening her pain had increased. By next morning the pain was still there and there was some blood stained discharge also from her ear. Mrs. S called ASHA didi. What do you think had happened? What would you do / advise if you were her ASHA.

- If there is sudden change in bowel habit it should be reported to the health care provider.
- Constipation is a common problem in elderly but it can be avoided by taking high roughage and fibre diet, drinking adequate amount of water and physical exercise.

Sleep hygiene:

- A sound sleep implies an undisturbed sleep for 6-8 hours.
- Sound sleep is useful for good health.
- It reduces the chances of high blood pressure, high blood sugar, dementia, depression etc.
- A sound sleep can be ensured by several measures such as:
- Keeping a gap of at least 1-2 hours between dinner and bedtime
- Avoiding radio and television at bedtime
- Avoiding daytime naps
- Adequate daily exercise
- A calm atmosphere and soft light in the room
- By observing food discipline/ avoiding Coffee, tea, close to bedtime.

B.5.5 SAFETY MEASURES IN ELDERLY:

A. Poly pharmacy: Elderly might be on multiple drugs at any given time which might have side effects, drug interactions and effect on multiple organs. Cumulative action of drugs may cause harm. Regular follow-up , correct understanding of drugs and dosages, prompt reporting of any untoward , new symptom must be reported immediately.

B. Protect from pollution: They should protect themselves against extremes of weather. Areas with high levels of pollution , smoke and dust should be avoided to the extent possible.

C. Avoid driving: They should not drive in cases of low vision, slow reflexes or after taking medications that cause drowsiness.

D. Easy access to emergency call system such as police helpline no. (100), fire (101), Ambulance (108), women helpline number (1091).

E. Use of assistive devices: Judicious use of assistance devices like cane, walker etc.

F. They should be advised to get up from the bed slowly, first rolling on the side and then sitting up followed by standing up slowly. Sudden standing may lower blood pressure and the person can feel dizzy and fall.

G. Accidents and falls should be prevented by taking care of following:

- Adequate lighting in the house
- Guards or side rails should be present at bed, window, stairways and bathroom
- Floors should be non slippery
- Bathroom floors should be kept dry
- Coloring of house should be helpful in defining doors, stairs etc.
- Furniture should be comfortable and sturdy to allow weight
- Noise should be controlled
- Proper cleanliness should be maintained
- Electric appliances should be shock proof
- No wires from extension cords on the floor
- Home should be free from pests
- Drugs, pesticides, insecticides etc. should be kept in isolation.
- Use of call bells.

B.5.6 CHALLENGES OF OLD AGE:

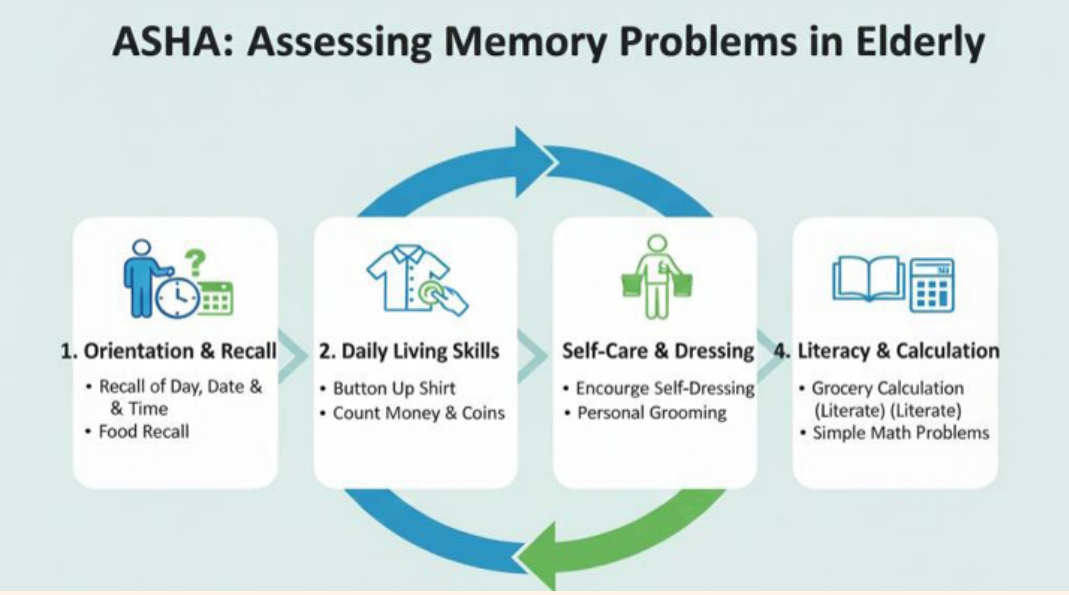
Aging is also accompanied by certain changes and accompanying challenges. The family, the community and the health system can together facilitate and help the elderly to navigate these challenges with dignity.

<table>
<tr><th>Challenge</th><th>How you can help as an ASHA</th></tr>
<tr><td colspan="2">Financial concerns (Impacting their self reliance, Self esteem and independence)</td></tr>
<tr><td>Economic insecurity due to loss of regular income or inadequate pensions.</td><td rowspan="3">• Making them aware and facilitating their access to Government schemes and entitlements like pension / Ayushmaan Card
• Access to public health facilities and free services, drugs and diagnostics</td></tr>
<tr><td>Dependence on others for transport, finances, or personal care may increase.</td></tr>
<tr><td>Difficulty in accessing health services due to distance, mobility issues, or lack of awareness.</td></tr>
<tr><td colspan="2">Psychological, Social, emotional and concerns</td></tr>
<tr><td>Loneliness and social isolation, especially after retirement, widowhood, or migration of children.</td><td rowspan="3">• Sensitize family for inclusion in all family activities.
• Facilitate Peer Support: Form and encourage elderly support groups for social interaction and peer-led wellness activities.
• Engage During Home Visits: Talk with the elderly about their feelings and recent well-being to identify concerns.</td></tr>
<tr><td>Fear of being a burden on family and society, affecting self-esteem and well-being.</td></tr>
<tr><td>Mental health concerns such as anxiety, depression</td></tr>
</table>

Challenge	How you can help as an ASHA
Mood swings	
Decline in memory over the years (Age related memory loss/ forgetfulness to dementia)	

Activities to assess memory problems in elderly:

- Recall of day, date and time
- Food recall
- Practise button up shirt, calculation of money and coins in purse
- Encourage elderly to dress up self
- If literate, they may also be engaged in grocery calculation



Screen & Refer:

Complete the PHQ-2 assessment (Part D of individual assessment). If the score is more than 3, immediately inform the CHO for further evaluation.

Notify the CHO if observed:

- Social withdrawal or loss of interest in food / pleasurable things
- Feelings of hopelessness or worthlessness.
- Neglect of personal care (grooming / bathing / clothing
- Increased confusion, agitation, or anger outbursts.
- Lack of sleep / excessive sleep .
- Confusion
- Frequent incidents of irritation and agitation leading to anger outburst.

Challenge	How you can help as an ASHA
Physical health	
Gradual decline in muscle strength and joint mobility affects.	You should ensure that the diet is healthy and adequate **Notify CHO** if any of the following signs and symptoms are observed or as informed by the first care giver: • Joint Pain • Difficulty in walking/squatting • Swelling in joints • Neck pain • Back ache Facilitate visit to the HWC if she / he is mobile.
Oral Health Problems in the Elderly Poor oral health significantly impacts overall well-being, nutrition, and quality of life. **Primary Causes:** 1. Inadequate Hygiene: Reliance on traditional, often insufficient, cleaning methods. 2. Diseases in other parts of the body can increase oral disease risk. 3. Treatment Side Effects: Medications or treatments can cause dry mouth and altered taste/smell. **Consequences:** 4. Impaired nutrition and general health. 5. Reduced self-esteem, wellbeing, and quality of life.	Counsel regarding correct way of brushing teeth . Correct way to wear / remove and store the denture when not being used Notify the CHO if any of the following signs are observed or reported: • Dry mouth • Tooth pain or infection • Discoloration of teeth • Swelling, infection, or bleeding of the gums • Inability to open the mouth Facilitate access to the dental clinic in nearby CHC / hospital if so required

Challenge	How you can help as an ASHA
Decline in vision Difficulty in seeing the nearby objects / reading / threading a needle is common Cataract, if not treated can lead to significant decline in vision making them prone to accidents, estricting their mobility and making their life difficult. Blindness due to Cataract is correctable. No elderly should have to suffer from it.	• Complete the assessment for reduced vision using the CBAC. • Help in getting eye checkup at AAM-PHC and getting spectacles for correction of this problem. Motivate and facilitate the elderly, along with family members, to visit the nearest AAMHealth and Wellness Centre for referral to linked hospital for Cataract surgery which is available free of cost in Government hospitals. **Details given in section on eye.**

Spectacle maintenance - Advise :

- Should not touch the glass / lens directly to prevent smudging.
- Should keep the spectacles by their side.
- Lenses/ glasses of the Spectacle should be cleaned by a soft, clean cloth.
- Spectacles should be always kept in a box when not in use.

Mrs. S has bilateral cataract and is having difficulty in performing her day to day activities and self care. Walking down to some distance from her home to relieve herself is a torture and she had fallen once .

As her ASHA can you help her? Bina got her operated for Cataract from the linked hospital, she got a toilet behind her house.

Challenge	How you can help as an ASHA
Gradual Decline in hearing: • Difficulty in hearing clearly and often ask others to speak louder. • This causes frustration and irritation for both the elderly person and those around them. • Affects communication and leads to social isolation and loss of independence. • Associated with anxiety and depression. • Family members may not recognize this problem early and may mistakenly perceive the elderly person as being “slow” or inattentive	• Complete the assessment for difficulty in hearing, using CBAC. • Reassure elderly individuals and their families that some degree of hearing loss is common with ageing. • Motivate and facilitate the elderly, along with family members, to visit the nearest Health and Wellness Centre for screening and appropriate management. • Help access to getting free Hearing Aid if such initiative is there by the government and help in its correct use

Challenge	How you can help as an ASHA
• High Blood Pressure can silently continue to damage heart / brain / kidney and can lead to heart attack or stroke. • Normal cut off for hypertension among the elderly 140/90 mm of Hg. • Refer to the NCD section for diagnosis of hypertension.	• Advise for regular check up of BP as advised at the AB-HWC • Motivate elderly in compliance to treatment plan for drugs • Advise for regular physical activity ASHA should notify CHO if she observes or is informed by the first care giver: » Complaints of headache » Attacks of sweating, headache and palpitations » Breathlessness » Bleeding from nose
Diabetes also silently damages the eyes / heart / brain / kidney and can lead to heart attack or stroke.	1. Ensure followup and regular check-up at the AB-HWC. 2. Facilitate lifestyle modifications and compliance to treatment plan for drugs as advised by the medical doctor. 3. Ensure that the patient and their family members receive education on diabetes management. Be alert to new signs and symptoms - they may be due to side-effects of the medicines being taken. Teach them to prevent , recognize and manage drop in blood sugar levels. 4. Conduct regular visits to households which are vulnerable and marginalised, treatment defaulters or those who experience complications and bring these cases to the notice of the MPW (F/M), CHO and the Medical Officer.
Genitourinary problems: In men Prostate enlargement may lead to • Frequent and urgent need to urinate, • Difficulty in starting urination, • Weak urine stream, • Dribbling of urine • Inability to completely empty the bladder. • Women may have less control and dribbling of urine due to weak muscles. • This may cause significant distress to them.	• These individuals must be referred to the Medical Officer for evaluation and management . • You can teach the women about perineal exercises to prevent / improve incontinence due to weak pelvic floor muscles .

Pelvic floor muscle exercises

Urine leakage is common in old age but it is not untreatable. Simple daily exercises can strengthen muscles and improve bladder control.

1. Sit or lie down comfortably.
2. Tighten the perineal muscles (as if stopping urine).
3. Hold for 3–5 seconds.
4. Relax completely for 3–5 seconds.
5. Repeat 10 times.

Frequency: 3 times a day (morning, afternoon, night)

You can feel the improvement in few weeks and good control by six weeks.

Challenge	How you can help as an ASHA
Increased risk of Falls and fractures due to multiple factors like • Difficulties with vision • Balance and mobility issues • Weak bones • Medications like sedatives etc • Acute illness • Lower limb muscle weakness • Slippery flooring • Dim lighting & Obstacles • Unsafe kitchen • Poor stairway design, • Uneven streets and footpaths • Improper use of assistive devices • Inappropriate footwear • Falls may cause fractures which are very dangerous in this age as healing is delayed , make the person immobile and prone to multiple health problems	1. Advise family members for support to the elderly while carrying out routine activities 2. Mobilise the elderly and family members to the nearby AAM for appropriate care. 3. The family should also be facilitated for getting assistive devices through the health and wellness centre. 4. Assess the risk of falls by ruling out environmental and individual-level factors and asking the elderly to stand up and walk to a nearby wall. 5. Complete B3 (according to the latest version of CBAC) section of the individual assessment. 6. Record keeping of provision of assistive devices to the beneficiary. 7. If there is any recent fall that has caused a wound or a bruise, you should notify the CHO. You should also help the MPW(F) in nursing of the wound if any. 8. Follow up for the fall injury, working of assistive devices and compliance with them.

Mr. S had a mild stroke last month with paralysis of his left arm and leg. He is shaken after that and lies despondent in his bed day and night .

Though he is recovering he makes very little effort when his wife tries to feed him or change his clothes or in cleaning him. She is tired and does not know how to cope. Can you help them ?

ASHA flagged this to the AAM team. As a team they worked to nurse him back to health. His son living in the city also came . CHO / ANM made frequent visits reinforcing the physiotherapy and exercises. His wife was trained to help him do these and to prepare nutritious meal in the form he could consume easily.

ASHA ensured compliance with his medications.

Maintenance of Assistive devices (sticks, walker etc.) : Advise :

- They should keep the sticks or walker within easy reach .
- These devices should be kept away from water to avoid rusting / rot.
- They should be cleaned regularly and strength ascertained by them / care givers.

Forgetfulness in Old Age (Normal Ageing)

As people grow older, mild forgetfulness is common and usually not a disease.

Common features:

- Forgetting names or where things are kept
- Taking more time to remember
- Forgetting recent conversations but remembering later
- Able to manage daily activities independently

This type of forgetfulness does not interfere with daily life.

Dementia Usually only elderly people (over 60 years) are affected by dementia. Both men and women can get dementia. A severely alcohol dependent person may get dementia at an earlier age. Dementia may vary from mild to severe depending upon the severity of symptoms and signs.

Symptoms of dementia

- Loss of Memory: The person may forget things more than usual, in more severe cases the person may even stop recognizing their closest relatives.
- Loss of orientation: the person may stop relating to the time of the day. He / she may get lost even in familiar surroundings and not be able to find their way back home.
- Change in behaviour: May become suspicious, irritable or fearful. May commit senseless actions (e.g. putting food under the bed) The speech may become disturbed.
- Loss of daily living skills: Is not able to manage money , cooking and taking medications.
- In more severe cases the person looses his/her ability to care for him/herself and needs help for dressing, feeding , bathing and toileting and in final stages the person may be

completely bedridden and in need of constant care.

Causes of dementia

- Normal aging processes (mild cases)
- Insufficient blood circulation in the brain (due to smaller strokes in the brain)
- Alzheimer's disease (destruction of brain tissue)
- AIDS may also cause dementia

How to suspect Dementia in an elderly individual?

In the CBAC form, you ask four specific questions to the elderly (those 60 years and above). Yes to any one of the following two questions should make you alert to the possibility of Dementia:

- Do you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet?
- Do you forget names of your near ones or your own home address?

How to help a person with dementia?

- If the person exhibits any of the symptoms of dementia, refer him/her to the nearest health facility with Medical Officer.
- Some symptoms of dementia can be treated with medicines.
- You can provide first aid to the individual. ~ Mental Health First Aid for a person with dementia will focus on encouraging appropriate professional help for certain symptoms and giving information and practical tips to the family .
- Disturbed behaviours and sleeping problems can be treated with medicines, refer to a mental health specialist or medical doctor
- A person with dementia will usually not be in danger of committing suicide, but the person may cause harm to himself due to his helplessness (e.g. running away from home)
- A person with mild dementia may have symptoms of a common mental disorder.

How to help family living with a person with dementia

The family having elderly person with Dementia may also need your support in caring for him/her. They also need someone to talk to and assure them.

As ASHA you may be able to help them through providing psychosocial support. What can you help family members?

- Educate them about dementia, disturbed behaviours and aggressive behaviours.
- Assure them that they will be able to handle this.
- Family members should understand that person with dementia needs to be cared with patience and compassion.
- It is common for the person to forget that they have eaten or taken a bath.

B.5.7 KEY MESSAGES FOR THE ELDERLY CARE:

Key messages for community regarding elderly care:

- Elderly individuals have different health needs. They need to be looked after with care.
- After a certain age they face loss of sensory functions - sight and hearing. One needs to keep it in mind while interacting with them.
- Everyone in the community should be responsible for their elderly. As a community we should support and help them around if they need any help.
- If anyone in community comes across any destitute or single elderly, they should enquire about them, their health and whether they require any support. They should also notify their area ASHA/MPW about them.
- Elderly abuse could be happening in the community but may stay hidden. If anyone suspects elderly abuse happening with any individual, they should take initiative to prevent it and also immediately report it to you as their ASHA or to the CHO / ANM in their health and wellness centre.

Key messages for families with elderly individuals:

- Be patient with them! Family members should understand that elderly need to be cared with patience and compassion.
- Elderly may also feel isolated because of reduced hearing and vision. Family members must make all efforts to make them feel included in the family functions.
- They should speak to you as their ASHA if they need any support in helping or taking care of their elderly . You will be able to help them and also connect them to the health and wellness centre.
- They would not be skilled at nursing needs of the elderly (in case of bed bound or restricted elderly). If there is any nursing task like wound care/ catheterization/ changing diapers, they must contact you and you will connect them to MPW F/M at the AAM to their household. The team will also train them in these tasks.
- The family members should accompany them to the AAM for check-ups.
- In case their elderly is restricted, or bed bound, they should notify their ASHA about health concerns. She will connect the AAM-SHC team for home visits.

B.5.8 SERVICE DELIVERY FRAMEWORK FOR ELDERLY CARE

Elderly individuals require comprehensive, continuous, and compassionate care. The Primary Health Care Team is responsible for delivering elderly care services across the continuum- from the community level to Ayushman Arogya Mandir - Sub Health Centre (AAM-SHC) and Ayushman Arogya Mandir - Primary Health Centre (AAM-PHC).

Community Level	AAM-SHC	Referral Centre Level
As and Multi-Purpose Workers (Male/Female)	**The Community Health Officer (CHO) will:**	**At higher health facilities: Medical Officers and specialists**
• Identifying and listing elderly individuals in the community • Conducting risk assessments for common geriatric conditions • Providing counselling and psychosocial support to the elderly • Supporting caregivers and facilitating the formation of elderly and caregiver support groups • Identifying medical conditions requiring attention and referring cases to the CHO • Ensuring follow-up care and continuity of services	• Manage common geriatric ailments at the facility level • Refer elderly patients with complications to higher health facilities as required • Facilitate access to supportive and assistive devices (e.g., walking aids) from higher centres to improve mobility and independence • Provide counselling and guidance to elderly individuals and their caregivers	• Will provide diagnosis and treatment of complex geriatric conditions • Surgical care • Rehabilitation services • Specialized counselling will be ensured as per need

B.5.9 KEY TASKS OF ASHAS FOR CARE OF THE ELDERLY:

Key Tasks of ASHAs for Elderly Care (Community Level)

1. Identification and Listing of Elderly

- Line-list all elderly persons in the village
- Categorize them as bed-bound, restricted, or mobile
- Identify destitute, poor, and single elderly who need special care
- Use this information to plan your visits for assessments / regular follow-up home visits and ensure linkage with the primary health care team
- Encourage mobile elderly and caregivers to visit Ayushman Arogya Mandir (AAM)
- Inform and mobilize elderly for screening services and health camps

2. Awareness Generation

- Create awareness on healthy ageing using platforms like VHSNC and MAS
- Educate families on Preventing falls and injuries, Malnutrition among the elderly, Creating geriatric-friendly home environments
- Sensitize caregivers to identify common geriatric problems and provide home-based care
- Inform the community about the National Programme for Health Care of the Elderly (NPHCE) and available services

ASHA will also:

Support the PHC team in organizing health education camps on hygiene, nutrition, and caregiver guidance.

Provide individual and family counselling during home visits, especially for bed-bound elderly.

3. Mobilization of Elderly Support Groups – "Sanjeevini"

- Facilitate formation of Elderly Support Groups and Caregiver Support Groups
- Start with 2–3 members and explain the purpose of the group
- Promote social inclusion, emotional support, and shared caregiving practices
- Ensure regular meetings and encourage gradual participation of more members

Key tasks of ASHAs for elderly care: In continuum of care

1. Household visits: During your home visits for filling CBAC form, you will be able to identify the households where elderly individuals are residing. With the support from MPW(F/M), you can undertake counselling of the elderly and their family members on healthy lifestyle, improved care seeking and increasing supportive environment in families and community.

2. Risk assessment: Completion of Community based assessment checklist (CBAC) is required forall the elderly. This is the same one that is carried out for the screening of NCDs. The section B3 is specific to the elderly which needs to be filled. You should keep in mind that if a person says "yes" for a question, it does not necessarily mean that they have the disease. Similarly, if a person says "no" for a question, it does not mean that they do not have the disease. You need to build rapport and engage in conversation with the elderly individuals in order to obtain the necessary history for any health condition.

3. Notification to the CHO: You should notify to the CHO according to the instructions in the individual assessment form, for increased risk, or if any disease, health condition, malnutrition or case of abuse is suspected. MPW (F/M) will support you for such notifications.

4. Home based follow up visits: Follow up for those who have been referred to the CHO ordischarged from higher facilitiesis an important step to ensure continuum of care. In case patient presents with any complain during follow up, you must refer the patient to the nearby health and wellness centre. If the patient is bed bound/ restricted the CHO needs to be notified for home visit.

5. Compliance to treatment: For any elderly individual on medication, you must note whetherthere is compliance for the medication and treatment.

6. Assistive devices: In case any elderly individual is prescribed or using any assistive devices ordentures or spectacles, you should ask if they are being used regularly. If there are not being used regularly, you should ask for the reasons of non-usage to the elderly and the caregiver. You should counsel such individuals about importance of regular use. In case the patient still does not continue the use of devices, you will notify the MPW (F/M) and CHO for further assistance.

You should inform the caregivers about regular cleaning of spectacles, dentures and maintaining the devices in good state:

Key points regarding maintenance:

a. Denture maintenance

b. Spectacle maintenance:

c. Assistive devices (sticks, walker etc.)

Assisting MPW (F/M) for the nursing tasks: In case any elderly individual requires nursing care like changing dressing or wound care etc., you may support the caregiver for the same. You will also assist MPW(F) if they carry out any nursing task. You are not required to carry it out on your own.

Community Based Assessment Checklist (CBAC) (to be relaced with new)

General Information			
Name of ASHA:		**Village/Ward:**	
Name of MPW/ANM:		Sub Centre:	
		PHC/UPHC:	
Personal Details			
Name:		Any Identifier (Aadhar Card/ any other UID – Voter ID etc.):	
Age:		State Health Insurance Schemes: Yes/No If yes, specify:	
Sex:		Telephone No. (self/family member/other - specify details):	
Address:			
Does this person have any of the following? Visible defect/known disability/Bedridden/ require support for Activities of Daily Living		If yes, Please specify	
Part A: Risk Assessment			
Question	**Range**	**Circle Any**	**Write Score**
1. What is your age? (in complete years)	0 – 29 years	0	
	30 – 39 years	1	
	40 – 49 years	2	
	50 – 59 years	3	
	> 60 years	4	
2. Do you smoke or consume smokeless products such as gutka or khaini?	Never	0	
	Used to consume in the past/ Sometimes now	1	
	Daily	2	
3. Do you consume alcohol daily	No	0	
	Yes	1	

General Information			
4. Measurement of waist (in cm)	Female		
	Male		
5. Do you undertake any physical activities for minimum of 150 minutes in a week? (Daily minimum 30 minutes per day - Five days a week)	At least 150 minutes in a week	0	
	Less than 150 minutes in a week	1	
6. Do you have a family history (any one of your parents or siblings) of high blood pressure, diabetes and heart disease?	Yes	2	
	No	0	
Total Score			
Every individual needs to be screened irrespective of their scores. A score above 4 indicates that theperson may be at higher risk of NCDs and needs to be prioritized for attending the weekly screening day			

Part B: Early Detection: Ask if Patient has any of these Symptoms			
B1: Women and Men	Y/N		Y/N
Shortness of breath (difficulty in breathing)		History of fits	
Coughing more than 2 weeks*		Difficulty in opening mouth	
Blood in sputum*		Any ulcers in mouth that has not healed in two weeks	
Fever for > 2 weeks*		Any growth in mouth that has not healed in two weeks	
Loss of weight*		Any white or red patch in mouth that has not healed in two weeks	

Part B: Early Detection: Ask if Patient has any of these Symptoms			
Night Sweats*		Pain while chewing	
Are you currently taking anti-TB drugs**		Any change in the tone of your voice	
Anyone in family currently suffering from TB**		Any hypopigmented patch(es) or discolored lesion(s) with loss of sensation	
History of TB *		Any thickened skin	
Recurrent ulceration on palm or sole		Any nodules on skin	
Recurrent tingling on palm(s) or sole(s)		Recurrent numbness on palm(s) or sole(s)	
Cloudy or blurred vision		Clawing of fingers in hands and/ or feet	
Difficulty in reading		Tingling and numbness in hands and/or feet	
Pain in eyes lasting for more than a week		Inability to close eyelid	
Redness in eyes lasting for more than a week		Difficulty in holding objects with hands/ fingers	
Difficulty in hearing		Weakness in feet that causes difficulty in walking	
B2: Women only	**Y/N**		**Y/N**
Lump in the breast		Bleeding after menopause	
Blood stained discharge from the nipple		Bleeding after intercourse	
Change in shape and size of breast		Foul smelling vaginal discharge	
Bleeding between periods			
B3: Elderly Specific (60 years and above)	**Y/N**		**Y/N**
Feeling unsteady while standing or walking		Needing help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet	

Part B: Early Detection: Ask if Patient has any of these Symptoms			
Suffering from any physical disability that restricts movement		Forgetting names of your near ones or your own home address	
In case of individual answers Yes to any one of the above-mentioned symptoms, refer the patient immediately to the nearest facility where a Medical Officer is available			
*If the response is Yes – action suggested: Sputum sample collection and transport to nearest TB testing center			
** If the answer is yes, tracing of all family members to be done by ANM/MPW			

Part C: Risk factors for COPD
Circle all that Apply
Type of Fuel used for cooking – Firewood/Crop Residue/Cow dung cake/Coal/ Kerosene/LPG
Occupational exposure – Crop residue burning/burning of garbage – leaves/working in industries with smoke, gas and dust exposure such as brick kilns and glass factories etc.

Part D: PHQ 2					
Over the last 2 weeks, how often have you been bothered by the following problems?		Not at all	Several days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things?	0	+1	+2	+3
2.	Feeling down, depressed or hopeless?	0	+1	+2	+3
Total Score					
Anyone with total score greater than 3 should be referred to CHO/ MO (PHC/UPHC)					

National Health Systems Resource Centre (NHSRC)
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