

Notes for ASHA Trainers

Part 1
(Includes Content for Rounds 1 and 2 of ASHA training)



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Acknowledgements

The sections on maternal and newborn health in the Notes for the Trainer are excerpted from SEARCH, Gadchiroli's Manual on 'How to Train ASHA in Home-Based Newborn Care'. The training methodology for Integrated Management of Neonatal Childhood Illnesses (IMNCI) package is excerpted from the Training Module for Health Workers, MOHFW, 2003. Thanks are also due to members of the National ASHA Mentoring Group for their inputs.

Introduction to the Trainer Notes

These trainer notes are intended for the use of trainers who are responsible for training ASHA and her facilitators in Modules 6 and 7. The notes are organised in three parts. In this first part, the key functions of ASHA and the skills she is expected to gain are reviewed first, followed by maternal, newborn, nutrition and child health, covering all of Module 6 and Part A of Module 7. Part 2 of the Trainer notes for the ASHA trainer will cover management of the sick newborn and selected infectious diseases. Part 3 will cover general aspects of women's health and other issues.

ASHA and ASHA facilitators will be trained in Modules 6 and 7 over twenty days in four rounds of training. Each training round is expected to last for five days with a gap of eight to twelve weeks between the training rounds to allow the ASHA to practice the skills she has learnt in the training. The ASHA facilitators receive additional training on supportive supervision, mentoring and field support for ASHA. This is covered in a separate Module.

Training of trainers (TOT) for the ASHA takes place as follows: A core of national trainers train state trainers who are affiliated to state level training sites. These state trainers in turn train trainers drawn from the

various blocks of a district who are called the ASHA trainers. They are full time faculty dedicated to ASHA training. The state also identifies about four to five resource persons from the district who are experts in subject matter to support the ASHA trainers when required. Together with the ASHA trainers they constitute the district training team.

TOT of ASHA trainers covers the content of ASHA Modules 6 and 7 as well sessions on participatory training, supportive supervision and evaluation. Round 1 TOT of two weeks is designed to cover principles of participatory training, supervision, the entire content of Module 6 and the nutrition and child health content of Module 7, i.e. Part A. This enables the ASHA trainers to carry out the first two Rounds of the ASHA workshops. The agenda for Round 1 TOT is in Handout 1. Round 2 TOT covers the management of sick newborn and infectious diseases. Round 3 TOT will cover women's health issues and revision of previous topics, including overall evaluation. For ASHA, Round 3 training covers management of the sick newborn and Round 4 covers women's health issues and infectious diseases. Rounds three and four of ASHA training also include time for revision of topics taught in previous

rounds. The agenda for Rounds 1 and 2 of ASHA training is in Handout 2.

Accreditation and certification of trainers and ASHA respectively are also undertaken on completion of these rounds.

The content of the trainer manual is organised in the Table below. Handout 3 contains a note and checklist on how to plan for organisation of an ASHA workshop. Handout 4 contains a note for state trainers on organising the TOT for ASHA trainers.

Organisation of Trainer Manual

| Session No. | Topic | Competencies covered: | Training Modules 6 and 7 Equivalence | Page Nos |
|-------------|--|--|--|----------|
| 1. | INTRODUCTION | Structure of training: Training course content Workshop Schedule (Handout 1) | Not part of Module 6 and 7 | 1-12 |
| 2 | BEING AN ASHA- MEASURABLE OUTCOMES OF ASHA | Linking measurable outcomes to skills, Role Clarity of an ASHA and how to organize her work. | Module 6 Part A, Sections 1-8, Pages 1 to 17 The ASHA film if available would be an important part of this session. | 13-26 |
| 3 | PARTICIPATORY TRAINING | Principles of participatory training Methods of Participatory Training. | Not part of Module 6 and 7. | 27-34 |
| 4 | FACILITATION AND SUPPORTIVE SUPERVISION | Principles of supportive supervision Facilitation skills. Roles of various functionaries who support and complement her work. | Module 6 Part A Section 9, page 18. In addition, specific skills of facilitation for ASHA supervisors will be taught. | 35-56 |
| 5 | CARE OF THE PREGNANT WOMAN | Pregnancy diagnosis – skills in the use of Nischay kit and Determining LMP and EDD. Antenatal care and Birth planning. Management of Anemia, Identifying complications in pregnancy and referral, Interpersonal communication. | ASHA Modules 6, Part B, Sections 1-4, pages 19- 33 | 57-66 |
| 6 | THE BIRTH COMPANION ROLE | Why and what is a birth companion? Essential knowledge for birth companion: What happens during labour and birth? Times of different stages of labour. Readiness for emergencies. Recognising pregnancy outcomes, and providing immediate care at birth. | ASHA Module 6, Part B, Sections 4-5, Pages 34 to 37 | 67-72 |

| Session No. | Topic | Competencies covered: | Training Modules 6 and 7 Equivalence | Page Nos |
|-------------|--|--|--|----------|
| 7 | HOME VISITS FOR THE CARE OF THE NEWBORN AND POST PARTUM MOTHER | When to visit and What to do on a home visit to newborns and the post partum mother | ASHA Module 6 part C: Sections 1 to 3, Pages 41 to 49 and Part B, Section 6: Page 38 | 73-94 |
| 8 | BREASTFEEDING | Initiation of breastfeeding. Support to breastfeeding, Breastfeeding problems and issues, Expressing Breast milk | ASHA Module 6, Section 4: pages 50 to 56, | 95-104 |
| 9 | KEEPING THE NEWBORN WARM | Why keep the newborn warm? How to keep it warm? How to warm a cold baby? How to manage in hot weather? How to manage fever in a newborn? | ASHA Module 6 Section 5: pages 57 to 60. | 105-116 |
| 10 | INFANT AND YOUNG CHILD FEEDING | Why address malnutrition? Adequacy in complementary feeding/IYCF. Skills of counselling. Skills in assessment of malnutrition. Update on immunisation | ASHA Module 7: Part A, Sections 1 to 3 Pages 5 to 19. | 117-126 |
| 11 | ASSESSING THE SICK CHILD | What are the Danger signs? Skills in assessing and classifying ARI, diarrhoea, fever, anemia, malnutrition? Knowing immunisation status and how to ensure complete immunisation. | ASHA Module 7: Part A, Sections 4 and 5, Pages 20 to 23 | 127-130 |
| 12 | CLASSIFYING AND MANAGING DIARRHOEA | Classifying diarrhoea Knowing when and where to refer for diarrhoea. Skills to manage diarrhoea at home. Communicating skills on prevention of diarrhoea. | ASHA Module 7, Part A Section 6, pages 24-28 | 131-132 |
| 13 | ACUTE RESPIRATORY INFECTIONS (ARI) | Signs of ARI. Skills for suspecting pneumonia. Knowing when to refer. Skills in home management for cough and cold. | ASHA Module 7: Part A Section 7, pages 29-31. | 133-136 |
| 14 | FIELD IMMERSION | Working with the ASHA. Understanding her context. Communication with ASHAs | Not part of ASHA Module | 137-140 |
| 15 | EVALUATION OF KNOWLEDGE AND SKILLS OF ASHA | Skills of evaluation and evaluation of ASHA. | Not part of ASHA Module | 141-146 |
| 16 | EVALUATION OF ASHA TRAINERS | How to evaluate trainers and provide feedback | Not part of ASHA Module | 147-149 |

To be Covered in Rounds 2 and 3 of TOT for ASHA Trainers and Rounds 3 and 4 of ASHA training respectively

| | | | |
|---|--|---|--|
| 1 | ASSESSMENT AND MANAGEMENT OF THE HIGH RISK NEWBORN | Skills in diagnosis, management and referral of Low Birth Weight and Pre term Babies, Skills in assessment of asphyxia and sepsis, Skills in management, counseling and referral. | ASHA Module 7, Part C, Sections 1-4, pages 49-55 |
| 2 | WOMEN'S REPRODUCTIVE HEALTH | Skills in counseling for safe abortion, referral, and post abortion care, methods of family planning, contraceptive counseling, spacing and limiting methods, and referral, Understanding RTI/STI/HIV, counseling, referral for testing, treatment and follow up. | ASHA Module 7, Part B, Sections 1-3, pages 35-46 |
| 3 | INFECTIOUS DISEASES | Malaria and Tuberculosis: Knowing Causes, Signs and Symptoms, Role of ASHA in prevention and treatment, | ASHA Module 7, Part D, 59-63 |
| 4 | MAINTENANCE OF RECORDS | What registers to maintain. Why? What not to do. | ASHA Module 6 part A Section 8, Page 17. |

Handout 1

Agenda for Round 1 TOT for ASHA Trainers

Session Detail

Day 1

Introduction, Structure and Agenda
Session: Being an ASHA
Principles of Participatory training
Viewing of the film: ASHA

Day 2

Principles of Supportive Supervision
Facilitation skills, giving and receiving
feedback, interpersonal perceptions
Practice session: Being an ASHA

Day 3

Care of the pregnant woman: Nischay
kit use, LMP/EDD,ANC, Anaemia
counseling, Birth preparedness forms

Day 4

Practice session (classroom): Care of
the pregnant woman
Role of a Birth Companion
Identification of complications,
Immediate care of newborn at birth,
Initiation of breastfeeding, Complete
Delivery Forms 1 and 2

Day 5

Practice sessions by participants in
field: Being a Birth Companion

Day 6

First examination of newborn

- Introducing breastfeeding practices
- Measuring temperature
- Weighing the baby
- Care of eyes, Umbilical cord and skin
- First examination of the Newborn
Forms- Parts 1 and 2

Day 7

Day off

Day 8

Practice sessions by participants:
Making Home Visits to Newborns and
Mothers

Day 9

Thermal Control and rest of
Breastfeeding -Why keep the newborn
warm, How to keep the newborn
warm, How to re-warm the cold baby;
Control of newborn temperature in
hot weather

Day 10

Practice sessions by participants on
Thermal Control and Breastfeeding

Day 11

Infant and Young Child Feeding-
classroom session Followed by field
visit for assessment of malnutrition

Day 12

Assessing, Classifying and Managing
the sick child-Danger signs, Assessing
and classifying ARI, Diarrhea, and
fever,

Day 13

Practice sessions for sick child
management

Day 14

Evaluation and feedback to ASHA
trainers

Handout 2

Agenda for Rounds 1-2 of ASHA Training

ASHA Training Workshop Round 1

Day 1

| | |
|---|-----------|
| Welcome and introduction | One hour |
| Being an ASHA: | |
| Linking Measurable Outcomes to skills | Two hours |
| Role clarity and how to organize her work | Two hours |
| ASHA film and discussion | Two hours |

Day 2

| | |
|--|-----------|
| Care of the Pregnant woman | |
| Using the Nischay Kit | Two hours |
| Components of Antenatal care | Two hours |
| Birth preparedness | Two hours |
| Essential knowledge for birth companion: | Two hours |

Day 3

| | |
|---|------------|
| Essential knowledge for birth companion - continued (Filling in the delivery form) | Two hours |
| Examination of the Newborn and Home visits | |
| • Hand washing: | 30 minutes |
| • How to measure the newborn temperature | One hours |
| • How to weigh the newborn | Two hours |
| • First Examination of the Newborn: Filling the Form Part I (1.5 hours) | |

Day 4

| | |
|--|-----------------|
| First Examination of the Newborn: Filling the Form Part II (1.5 hours) | |
| Briefing for field visit and Field visit | Rest of the day |

Day 5

| | |
|---|------------|
| Care of the eyes, umbilical cord and skin | 30 minutes |
| Supporting and counseling the mother to breastfeed | One hour |
| Thermal control | Two hours |
| Diagnosing and managing hypothermia | Two hours |
| Management of fever in the newborn | One hours |
| Summary of workshop | 30 minutes |
| Planning for work in the community | One hour |
| (Asked to bring completed Birth preparedness, Delivery and First Home visit to the newborn forms for next Round). | |

ASHA Training Workshop Round 2

Day 1

| | |
|--|---------------------|
| Review of field experience | : 1 hour 30 minutes |
| Revision and evaluation of previous workshop sessions: | Rest of the day |
| Management of breastfeeding problems | Two hours |

Day 2

Child health and Nutrition: Classroom and field practice

Day 3

| | |
|--|-----------|
| Common childhood problems and the case management process: | Two hours |
| Assessing and Classifying diarrhea | Two hours |
| Assessing and Classifying fever and ARI | Two hours |

Day 4

| | |
|---|-----------------|
| Assessing and Classifying fever and ARI - continued | Two hours |
| Briefing for field visit and Field visit | Rest of the day |

Day 5

| | |
|--|-----------|
| Reviewing records, (completed birth preparedness, delivery and first home visit to the newborn forms), registers and forms | Two hours |
| Evaluation and Summarising the workshop | Two hours |
| Planning for work in the community | Two hours |

Handout 3

Planning the ASHA Training Workshop: A Note for Trainers

Review by Trainers and Programme Managers to Plan for and Ensure the Following Points:

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

Tips on Organising and Conducting a Successful Training Programme

Making it Residential

- a. The training is residential and all ASHAs should be present for all the sessions of the training
- b. Residential training is always preferred as ASHAs have

opportunity to practice some difficult skills after the formal sessions and have opportunity to discuss with their peers the difficulties. Trainers should also stay at the training site which will generate feeling of safety among the group of ASHAs.

Making it participatory, non hierarchical, and building solidarity

- a. Trainers should eat, sit, sing and play with the ASHAs which gives them the feeling that they are the members of the group.
- b. ASHAs and the trainers should sit in a circle so that the trainers easily become part of the group. As the training involves role plays, group discussions, demonstrations etc. chairs and tables should be avoided.
- c. Trainers should understand the difficulties of the ASHAs and have sympathy for their problems.
- d. Avoid scolding the ASHAs.
- e. Songs and games should be used both as relaxation techniques but also to inculcate a feeling of solidarity and oneness with each other. The ASHA song is a one good beginning, and local songs of inspiration and those celebrating health and women should be used.
- f. Ask the trainees to share the training schedule of each training workshop. It should give

a definite plan for the events in the evenings. For certain events they may ask the ASHAs to share the responsibility. This develops organisation capacity in ASHAs.

- g. Trainers and ASHAs should participate in keeping the training area clean.

Getting the training aids ready

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

time during the session. Trainers should check the material before distribution which will avoid chaos during session.

Field visit preparation

- a. Some sessions require visits to the community: for e.g., filling birth preparedness form, conducting home visits to the newborn, and nutrition counseling. The trainers should arrange the logistics required for this, to enable this to be completed efficiently.
- b. Generally about five ASHA are allocated to one case. This may require the group to split and travel to more than one village. As far as possible nearby villages where good contact with ASHA and community exists, must be selected. It would help to make prior contact the families with pregnant women, newborns and malnourished children so that they are properly informed and consent is obtained, so as to maximise outcomes of the field learning situation. As a supplement the ASHA should be taken to a PHC or CHC to ensure that they do get to practice the skills under supervision.
- c. The trainer should brief ASHA thoroughly before the practice session and provide feedback immediately after the session
- d. Trainers should use the checklists provided to ensure that the skills are taught. There are several distractions during the field visits, and unless the checklists are used, it would not be possible to assess if the skill has been learnt.

Training Evaluation

- a. To be sure the training objectives have been met, the trainer is asked to evaluate the ASHA whether the learning objective has been met. An evaluation box is found at the end of each session indicating how the trainer should check to see if the objectives have been met. Some of the sessions have formal evaluation through case studies or questionnaires. Through questions and answers, the trainers should ask participants to explain the curriculum; if they answer correctly; this will indicate that the objective has been met.
- b. Answer sheets for evaluation should be checked immediately and the scores should be shared with the trainees. The problems should be discussed with the trainees and misconception should be cleared. If this is not done immediately then the trainees proceed further in learning the content and confusion remains in any part of content based on the content of the test. For quite some time after writing the test paper mind of ASHA still lingers in the test and hence it is necessary to share the result when her memory is still fresh. Never delay sharing the result.

- c. The trainers should plan to take out time in the evening to give additional inputs to those who have not performed well in the test.

Other Points to Note

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

Handout 4

Guidelines for State Trainers when Conducting TOT for ASHA Trainers

The state trainers should use the notes to guide the TOT of the ASHA trainers for consistency and familiarity. In addition to training the ASHA trainers the role of the state trainers is also to support and supervise the quality of ASHA training when it takes place in the district or block. Each TOT for the ASHA trainers is conducted by a team of three state trainers.

The agenda and time table for Round 1 of the TOT is in Handout 1 and for the ASHA in Handout 2. The State Trainers need to review this with the ASHA trainers and demonstrate the linkages with the order of Modules 6 and 7.

Several of the training topics include Practice Sessions. In these sessions the state trainers will make sure that the ASHA trainers get enough hands on experience in not only getting familiar with the content of the sessions but are also able to actually conduct the sessions. The ASHA trainers will get feedback from the state trainers and also from the peer group on their performance.

Evaluation of the ASHA trainers is based not only on their content knowledge and skills but also their ability to demonstrate competency in conducting training sessions.

Training Tips for State Trainers

- State Trainers present the ASHA sessions as if the ASHA trainers were actually ASHAs. This “models” the training behaviour for the participants, and allows them to experience the curriculum.
- After each session (depending on time), have the ASHA trainers review the training material for that session..
- Discuss how the training material is structured, the training methods used, the evaluation and the Notes to the trainers. Emphasize that the trainers should review the Notes for the Trainers in each section before the actually conduct the session.
- At the end of day, assign a session to each of the trainees based on the schedule in Handout 1. On the next day, the ASHA trainees will ‘present’ the curriculum back to the group thereby gaining experience with the content of the course and the training methods. ASHA trainers will simultaneously practice in three groups (separate rooms are preferred). All trainers should have the opportunity for presenting a session at least twice. One state trainer is responsible for each group of trainees.

- The training schedule allows for the state trainers to conduct the classroom sessions for 8.5 days, practice and field sessions for about 4 days. One day off is allowed during the two week period and the half day is used as catch up time.
- The state trainers designate some participants as observers for each practice session of the ASHA trainers, who independently assess the session and provide feedback. Guidelines for evaluating ASHA trainers are in Chapter 16 of The Trainer Notes, Part 1

Being an ASHA

Session 2a: Introduction of participants

Aim: To introduce ASHAs in the training workshop to one another.

To make them feel relaxed and get to focus on the workshop.

Methods: Game and interaction.

Materials: One ball.

Duration: 30 minutes

Activities

Step 1: Welcome all participants to the workshop. Acknowledge that they have been working on this task for a number of years, and know each other well. This session will help them relax and know more about each other.

Step 2: Explain the game to the participants.

Step 3: The trainer should throw the ball to a participant, who should catch it. Then the person who caught the ball should tell the group: a) her name, b) the village she works in, and c) whom she thinks is most helpful to her in her work in her family and d) most helpful in the community. These last three questions can be changed

depending on what you would like to focus on and level of familiarity. For example you could ask them to state how long they are working as ASHA, or what they like most in their work etc. But let it not be a programme or work review question, or something that is embarrassing and let it not take more than one minute to answer.

Step 4: The first participant should throw the ball to any other person whom she knows least, and so on. Then she would throw the ball to a third participant who could be anyone in the room, except the first two. Thus the ball would proceed to every participant and everyone would have introduced themselves.

Step 5: Then the trainer would collect the ball and again throw the ball to a participant, who should then catch it and tell the name of the person who threw the ball. If she does so that is good, if not she has to be helped by her neighbour and if still they cannot get the name the participant has to introduce herself again. If they are still unable to get the name, the participant has to reintroduce herself. Now the ball goes around and each person has to name the person from whom they receive the ball. Thus each person has to recollect the names of all those in the room.

Step 6: The game can be allowed to run till everyone's name is familiar or time runs out.

The game can be brought to a close with a thank you by the trainer.

Notes for the Trainer

The trainer could also use some other

game for this introductory activity. Since the ASHAs have all been meeting each other in previous trainings, this game is appropriate for them.

The choice of game and its content depends on the level of familiarity that participants already have. The trainer should keep the session light and relaxed.

Session 2b: Measurable Outcomes and Skills of the ASHA

Aim: By the end of this session the ASHA will know about:

- Expectations from different stakeholders
- Main job description and tasks.
- Measurable outcomes expected of the ASHA

Method: Discussion, Blackboard work

Materials: Blackboard, chart paper, pens.

Duration: Two hours

Activities

Step 1: The trainer asks every ASHA to state what is the work they are doing- in an average week. Also what they would like to do and what expectations the community has from them. The trainer writes these down in three columns till all the work they are doing and their own expectations and peoples expectations of them are listed down neatly in three columns on the black board or on three sheets of chart paper stuck on the wall.

The trainer should prompt them if there is some work that is happening or some work or some outcome that has not been spoken about.

Step 2: The trainer distributes Modules 6 and 7 to each ASHA, and asks them to read Pages 8 and 9, from Section 2 and 3 of Module 6. This is the section on Activities of the

ASHA and Measurable Outcomes. They should read it out loud in turns. The trainer should write what is read out from the book to the charts on the wall. The trainer should point out what has not appeared on the charts- that is those tasks now included, which the ASHA was not doing earlier, emphasize it and write it down on the chart and explain why this has been included. For those tasks which they have listed, but are not included in the Measurable Outcomes as stated in Modules 6 and 7, explain why it is not included in the list of outcomes. The trainer should keep in mind that the suggestion may be a good one and should encourage them to do this work which is not a part of the outcomes, if it is useful and relevant. If it is quite irrelevant, or an impossible task it is crossed out of the chart.

Step 3: Then ask the questions- to do these tasks and get these outcomes- what skills do ASHAs need. Display the list of skills on the board in 6 charts. (Pages 10 and 11, Section 4, Module 6). Ask them whether they have these skills already or not. If yes put a tick next to it and if not - a cross. Explain the difference between learning knowledge and learning skills and also the difference between health education and counseling. The section on Notes for the Trainers provides content and information to discuss this session effectively.

Step 4: Present in detail the reasons behind prioritising these measurable outcomes. See the notes for trainers that follow to be able to enough material for the presentation.

Step 5: Ask them what attitudes and personality traits- as distinct from skills would help them in their work. List these. (Refer Page 12, Section. 5, Module 6).

Step 6: Explain to them in which workshop these skills would be taught to them. They should understand that they will learn the skills over a 20 day training programme. Share the agenda for the four rounds. (Handout)

Notes for the Trainers

ASHAs have been working now for four to five years. They cannot just be told that these are the outcomes expected, or what they ought to be doing. We need to listen to them, respect their views and then explain in context why we are defining these outcomes and expectations.

1. Maternal Health

Step 1: Presentation of health status and introducing measurable outcomes to the ASHA

In India about 67,000 women die each year during pregnancy and delivery. Most of these deaths are a result of causes which can be prevented. Neonatal mortality in India is about 35/1000 live births and accounts for 50% of deaths of all children under five. Three quarters of all neonatal deaths occur during the first week of life, and about 20% die in the first 24 hours. This is also the period when most maternal deaths take place. Maternal and neonatal mortality are

higher among poorer, less educated and marginalised families. Among children less than five years of age, the most important causes of death are diarrhoea, pneumonia, and malaria. Poor nutrition among children may not be a direct cause of death but is an underlying cause.

Every pregnant woman receives health education, is enabled to receive antenatal care and post natal care, and is motivated and facilitated to have a skilled birth attendant available for delivery preferably in a well equipped institution - a 24*7 PHC or an FRU. Those pregnant women who have complications or for some reason may have a greater risk than other women should straight away be recommended to go to a FRU.

For this the ASHA should be aware of which are the services offered in nearby facilities, the cost of such services, how to arrange transport when needed and the skills to counsel a pregnant woman and help her make a birth plan. The home visit to the pregnant woman is also a useful occasion for counseling on family planning services. These services are potentially available for free, but many women who want to delay their next child or limit their family size are currently unable to avail of these services. The ASHA could help close this gap.

Taken together all these activities are most important to reduce maternal mortality- which is one of the most important goals for the family, for the community and for the nation.

This outcome is also easy to monitor by the ASHA trainer when she visits a village. She merely has to ask for the names of pregnant women who are going to deliver a baby or have done so within the month. She then visits two or three such homes and asks whether the pregnant woman has received all these services, and has/had made a birth plan. If these have happened, the contribution of ASHA is evident.

There is some concern in some quarters that if ASHAs are taught too many skills, they would become dais, or that the work of the ANM would be taken over. Is there such a danger? Explain how the ANM's work would also benefit because she would be covering more ante-natal cases, post natal cases and complications. The need for institutional delivery is so that risk is better managed by nurses who are trained to a higher level of skills. ASHA training is not sufficient to make her a good mid-wife and this needs to be explained.

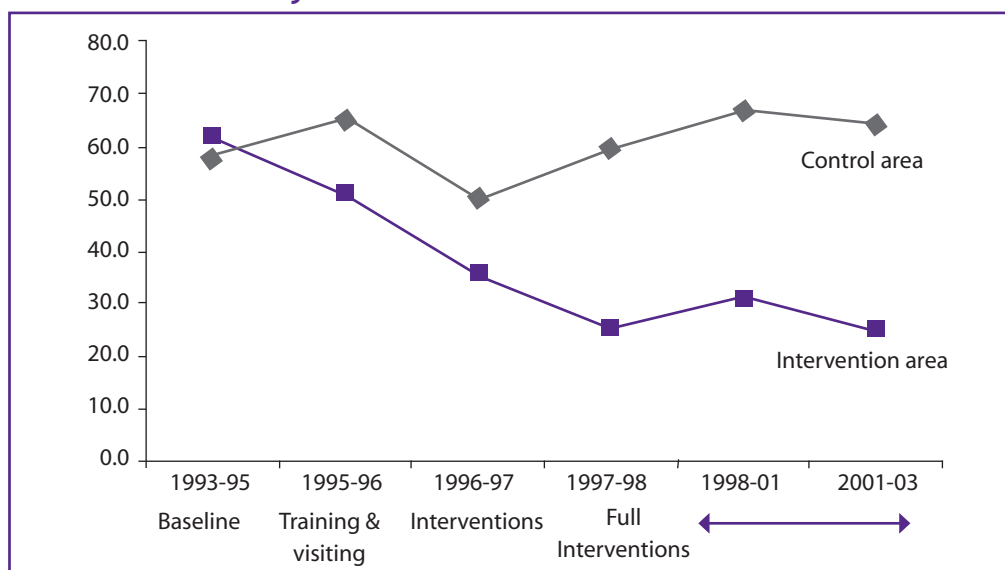
However the ASHA accompanies a mother to the facility and often acts as a birth companion there. To be able to provide good support to the mother it is useful for the ASHA to know about the stages of labour, what is happening in each stage and how much time each stage takes. Birth companions make for a much more comfortable and pleasant birthing experience- but the skills needed to be a birth companion are not sufficient in comparison to the skills of the midwife, who is trained to prevent and manage complications that may take place during labour and delivery.

Newborn and Child Health and Nutrition

1. Saves lives: About one thirds to half of all deaths of children less than five years of age occur in the first month of life and of these a large number occur in the first day of life. There is enough evidence from all over the world that if appropriate newborn care is given from the moment of birth, almost all of these lives can be saved. After nine months of pregnancy, a mother and family are racked by sorrow and guilt if they lose this precious child, and society has to make every effort to prevent it.

2. Importance of newborn care: One way of doing so is to promote institutional delivery- so that a trained nurse or midwife or doctor is available at the moment of birth. However, nation-wide about 40% of births occurring outside institutions. There is enough evidence from all over the world and from India, that a well trained community health volunteer like ASHA can save a significant part of these lives if she were to be available in these critical hours. Even where there is institutional delivery, the mother and child leave for home within one or two days and in the rest of the month, it is upto the ASHA to make the home visit. The graph below highlights the data from Gadchiroli in Maharashtra where Community Health Workers such as ASHA were able to provide home based neonatal care (HBNC), resulting in a reduction in neonatal mortality and also a reduction in maternal illness. The

Neonatal Mortality Rate



major learning from this work was:

- HBNC brings care to the home; all pregnant women and newborns in the community receive care.
- When a newborn is ill, having care at home is often more acceptable to villagers.
- HBNC also includes giving health education to parents and assists them in giving better care to their infants.
- HBNC works in lowering the neonatal and infant mortality rates in poor villages in India, and improving neonatal health.

3. Newborn care is possible and acceptable: Even in the current ASHA programme, even where ASHAs have not been trained for newborn care, most ASHAs are visiting newborns, quite spontaneously. Obviously there is a need and there are cultural factors behind this and one needs to provide ASHAs with the skills to make these visits more useful.

4. How far to go? How much to expect? Sometimes a newborn is born and does not cry or it gives a cry and then stops. The babies are declared dead. If on the other hand there is a skilled nurse or midwife available they could try to resuscitate the baby with a bag and mask and a few of such babies can be saved. This is not to be tried by the ASHA unless she is, despite her best efforts, caught in a situation where she is the most skilled person available at the moment of birth. Also the community should not have too many expectations of the ASHA or even of the institution at such a point, since most such babies do not do well anyway. The importance should be to prevent birth asphyxia.

5. Breastfeeding promotion: The promotion of timely and exclusive breastfeeding- requires more than preaching, it requires active support- even in most advanced nations. ASHA could make a huge difference here,

for no other single intervention has as much contribution to saving lives as this.

6. Care for the sick child - on the first day providing first contact care: The other major life saver for lives of the young child is prompt and appropriate care- on the very first day - for a child with acute respiratory infection or diarrhoea. In an urban middle class context, if the child becomes ill with diarrhoea or has a persistent cold, the parents could consult the doctor in the evening or even wait to see if the illness progresses, and consult the doctor whenever they think it is serious. But for a mother in a village, where the family has to decide whether to lose the day's wages for husband and wife, and incur the expenditure of a bus to a distant block town to see a doctor, the decision to see the doctor may be to put off until it is too late. On the other hand if an ASHA could help the family decide whether the child can be managed locally with a drug kit or home remedies or should rush immediately- this simple skill could save tens of thousands of lives. Since the ASHA is available at all times within the habitation, she could play this role best. From various field reports, it is clear that even though she is not yet trained in these skills- many families with sick children already are coming to her.

7. Prevention of malnutrition and prevention of illness: We know that from the sixth month of life onwards most infants and young children are at

high risk for diarrhoea and respiratory infection and for slipping into malnutrition. This is also the age when the immunisation schedule should be complete. Yet simple measures like hand-washing or adequacy in complementary feeding, are not followed. Home visits and family counselling can make a huge difference in the prevention of malnutrition, anemia and many common recurrent illness of children. Most of this is based on advice, but there are a few drugs that can treat these conditions and these are provided in the ASHA drug kit for her use

8. Social Mobilisation: One of the key roles that the ASHA plays is that of identifying and understanding the key target groups she has to work with. The way for her to reach these groups is primarily through home visits, and to establish rapport with stakeholders such as PRI representatives, members of the Village Health and Sanitation Committee, and Self Help Groups (SHG). Women and children from vulnerable and marginalised families are often higher risk of illness and death and the ASHA should ensure that every such family in the village is visited often.

Learning specific competencies:

In order for the ASHA to achieve the outcomes in each of these areas, she needs specific competency. A competency may be in the form of Knowledge or Skills which the ASHA training in Modules 6 and 7 is expected to achieve. This training also contributes to building attitudes.

The aim of Modules 1 to 4 was on building the knowledge of ASHA. Module 5 was aimed at building the right attitude, increasing motivation and empowering the ASHA. Modules 6 and 7 focus on the building of skills to achieve the measurable outcomes discussed above. Modules 6 and 7 revise the knowledge taught earlier and to some of the soft skills taught in Module 5- (See Sections 5 and 6: pages 12 to 16 of Module 6).

How does imparting or acquiring a skill differ from imparting or acquiring knowledge?

Learning skills requires more active participation by actually performing and with mentoring and supervision while they are performing that skill.

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

In health communication, a message is communicated. The communication

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

Other skills like taking a temperature, or finding out the EDD or weighing the baby, or calculating grade of malnutrition are specific skills, that can make a big difference to the health of mothers and children. The lists of skills that are being taught are given below. These are to be covered over twenty days- but if they are not achieved the whole sessions are to be repeated again and again till they are achieved. Time is a variable- as long or as short as is needed to achieve this level of skills. But the level of achievement of skills should not be compromised.

Session 2c: Role Clarity and Organising her Work

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

- How to organize her work to achieve outcomes and meet expectations
- What it means in her context to be a service provider, trainer or activist.

Method: Group discussion,

Material: Black board, flip charts,

Duration: Two hours

Activities

Step 1: Discuss in brief whether the ASHA make home visits. Discuss whom should they prioritize for the visit and how much time they need to give to it. (Make them read from Pages 13-14 in Part A, Section 6 of Module 6). Read out the Section on home visits in Notes to Trainers below.

Step 2: Ask whether they visit the village health and nutrition days. Ask what they must do before and on that day. (Make them read from Pages 15-16 in Part A, Section 7 of Module 6)

Step 3: Explain the role of the three registers. (In this session we do not actually teach the registers). (Make them read from Pages 17 in Part A, Section 8 of Module 6)

The trainer must ensure that ASHA are able to relate all the measurable outcomes to these three activities.

Step 4: The trainer reads out the first part of the Section: Role of an ASHA on page 7, Section 1 of Module 6. Now ask the participants what do words like trainer, or link worker or activist or provider or community health volunteer mean? These were explained in Book 5 of ASHA. For those who have been trained in Book 5, ask if they can recollect this and then ask them to state the role of the ASHA.

Step 5: Look at the picture on Page 1, Section 1 of Module 6. The ASHA has three types of roles. What are these roles?

Step 6: The trainer explains the various roles and expectations.

One is the role of an activist who sees health care as a right or entitlement- how can the ASHA help the poor woman get treatment? (Remind them that the last A in the word ASHA stood for “activist” Another is the role of the link worker- how can the ASHA find out and inform the public about on what day the ANM comes. The third is the role of service provider - what advice can the ASHA offer the mother of a child who has with diarrhoea.

Ask the ASHA which of these roles they think is more important? Can the ASHAs give more examples of each type of role?

Allow an open ended discussion, but make sure to emphasize the fact the Measurable Outcomes can be achieved, irrespective of whichever role the ASHA play or which she thinks is most important.

The trainer should not impose any one answer as correct or mark the others as wrong- all three are acceptable - but the emphasis changes with the context.

Evaluation

| Objectives | Assessment Method | Output of the session |
|---|---|--|
| List Measurable outcomes | Individual ASHA writes out key outcomes | Trainer to collect the written responses to this exercise. |
| List the new skills that you would learn in these workshops (Modules 6 and 7) | Groups to write down responses | Trainer collects worksheets |
| Which families to visit- how would you prioritize? | Groups to write down responses | Trainer collects worksheets |

Role Clarity

Given below are more examples of three types of roles that ASHAs may say they are doing. We try to categorize them into three types. As the trainer should note and point out, it is not quite possible to separate these roles. The Trainer could call out each role or write it up on a board and ASHA could call out which of these three categories it belongs and whether they think they could perform this role, (Possible) whether this would make a difference to health outcomes, (effective) and whether they would like to perform it (desirable). ASHA could also say which other tasks they would like included. Trainers must have clarity that this is only to stimulate discussion. It is not mandatory for ASHA to do all these activities. But they could volunteer to do some of these.

Trainer- Link worker Role

- I inform those who are due for immunisation about which day the ANM would be visiting.

- Keep the anti-tuberculosis tablets with me and the patient with TB takes it from me every morning.
- I hire a vehicle and take the pregnant woman with labour pains to the hospital.
- I inform the local ANM or medical officer about any outbreak of disease in my village.
- I help the ANM make a list of all children in the village.

Service Provision

- I stayed with the pregnant woman during the delivery, and she found it very useful.: Birth companion as a service.
- I took a class on how malaria is transmitted in local youth club: health education service.
- I participated in a pulse polio campaign, providing polio drops to children.
- If any child has fever or cough, the family brings the child to me, for some advice and drugs and I decide whether they have to be referred.

- I visit homes with malnourished children to counsel them on feeding practices and prevention of infection.

Activist Role

- There are many dalit hamlets in my area where services were not reaching. I made intensive efforts with all concerned and improved service coverage in these hamlets.
- I went to the hospital with a patient and one staff member asked for Rs. 500 payment. I asked for a receipt to be given to the patient. Even though the staff member got angry with me, I persisted in asking for the receipt.
- No information was taken on my report on disease outbreak, so I informed the collector.
- There is no VHND held in my hamlet and we have to go to the nearby hamlet which is over 5 km away. I led a group of the panchayat to meet the block medical officer and we convinced them to start a VHND in our village.
- I held a village women's meeting to discuss the problem of many fever cases in our village. The women were more interested in discussing the problem of growing alcoholism in the younger men and we discussed that too.
- There was a woman in my area whose husband had left her recently and she was pregnant. When the time came for delivery she had no one else to assist. I stayed at home and looked after her three year old girl, so that

she could go to the institution and have her child birth. I did not even get my incentive- but what to do.... I felt that was the right thing for an ASHA to do.

Notes for the Trainer

When introducing this topic to senior trainers at state and district level, it would be more useful to list these activities in a jumbled up form and ask them to put them into three categories and discuss why they categorised them so. Also ask them to contrast with ANM's and Anganwadi's role in each of these three areas. Discussion could be passionate and sometimes not very well informed of what exactly ASHAs are doing. One can ask them to add possibilities to each of these three categories.

But while transacting it with ASHAs the trainer could ask them to report the activities they are doing. The trainer should have a good background knowledge and prompt them with those that they are actually doing, but they failed to mention. In almost all blocks where ASHAs are active, if we probe closely, many such activities would be happening. The discussion in ASHAs would tend to be matter-of-fact and less controversial and better informed. The difference from the ANM's role would be obvious to them- and one need not spend time on it. The caution is that the trainer should take and not try to impose his or her view of the ASHA's role on the group- but rather see all roles as necessary with the balance between them changing as per the context.

Home Visits and Organising the ASHA's Day

If the ASHA spends only three hours per day for five days per week and that too between 5 PM and 8 PM daily on home visits- how does she prioritize which houses to visit and what frequency. (Assume that an initial visit to all houses have been made and a basic data base is in place).

Here is a possible answer:

- a. Any family with a newborn
- b. Families with pregnant women, especially those in the last month.
- c. Any family with a child in the 6 month to 12 month age, even if the child is normal in weight.
- d. Any family with a malnourished child.

And then if I have time I also visit:

- e. Any family with a child who has diarrhoea, or fever or ARI.
- f. Any family with a child less than 2 years old

- g. Any family with a child less than 5 years old
- h. Any family with an adolescent girl- for anemia management, menstrual hygiene and related issues and other concerns,
- i. Any family where any member has been diagnosed with tuberculosis.
- j. All families in sequence, with visiting about 12 to 15 families per day.

She can also encourage families to visit her in the morning hours or in the evening hours if there is any illness, especially so in a young child and to inform me if any woman has become pregnant or if there is any birth or death. Further to cover the categories in e to j, she should rely more on women's meetings of appropriate groups, rather than visiting each home repeatedly. During a home visit- she will cover one or more issues with them- but on each home visit, the focus is on a different issue.

Annexure 1

Measurable outcomes and essential skills for an ASHA (for background information to trainers- this is an extract from the Operational

Guidelines on Maternal and newborn Health, Ministry of Health and Family Welfare, Government of India) This is only for the trainers reference - not for presentation.

| | Knowledge | Skills |
|-------------------------|--|--|
| General Competencies | <ul style="list-style-type: none"> • Knowledge about qualities that need to be inculcated to successfully work as ASHA • Knowledge about village and its dynamics • Clear understanding of role and responsibilities • <i>Understanding of who are the marginalised and the specific role in ensuring that they are included in health services</i> | <ul style="list-style-type: none"> • Conducting a village level meeting • Communication skills: Especially interpersonal communication and communication to small groups • Skill of maintaining diary, register and drug kit stock card. • Tracking beneficiaries, especially those identified as more vulnerable, and updating MCH/ Immunisation card. |
| Maternal Care | <ul style="list-style-type: none"> • Key components of antenatal care and identification of high risk mothers • Complications in pregnancy that require referral • Detection and management of anaemia • Facility within reach, provider availability, arrangement for transport, escort and payment • Understanding labour processes (helps to understand and plan for safe delivery) • In malaria endemic areas, identify malaria in ANC and refer appropriately • Understanding obstetric emergencies and readiness for emergencies including referral | <ul style="list-style-type: none"> • Diagnosing pregnancy using Nischay kit • Determining the Last Menstrual Period (LMP) and calculating Expected Date of Delivery (EDD) • Tracking pregnant women and ensuring updated Maternal Health Cards for all eligible women • Developing birth preparedness plans for the pregnant woman. • Screening of pregnant woman for problems and danger signs and referral • Imparting a package of health education with key messages for pregnant women • Attend and observe delivery and record various events • Recording pregnancy outcomes as abortion, live births, still birth or newborn death) • Recording the time of birth in Hours, Minutes and Seconds, using digital wrist watch |
| Home Based Newborn Care | <ul style="list-style-type: none"> • Components of essential newborn care • Importance of early and exclusive breastfeeding • Common problem of initiating and maintaining breastfeeding which can be managed at home • Signs of ill health or a risk in a newborn | <ul style="list-style-type: none"> • Provide normal care at birth (dry and wrap the baby, keep baby warm and initiate breastfeeding) • Observation of baby at 30 seconds and 5 minutes for movement of limbs, breathing and crying • Conduct examination of new born for abnormality. • Provide care of eyes and umbilicus • Measure newborn temperature • Weigh newborn and assess if baby is normal or low birth weight • Counsel for exclusive breastfeeding • Ability to identify hypothermia and hyperthermia in newborns • Keep newborns warm |

| | Knowledge | Skills |
|---|--|---|
| Sick Newborn Care | <ul style="list-style-type: none"> ● Knowledge of risks of pre term and low birth weight. ● Knowledge of referral of sick newborns --when and where? | <ul style="list-style-type: none"> ● Identify low birth weight and pre term babies. ● Care for LBW, pre-term babies ● Identify birth asphyxia (for home deliveries) and manage with mucus extractor. <i>In very select situations where despite all efforts no SBA is available</i> also with ambu bag and face mask. ● Manage breastfeeding problems and support breastfeeding of LBW/Pre-term babies ● Identification of signs of sepsis and symptomatic management and referral. ● Diagnose newborn sepsis and manage it with co-trimoxazole |
| Sick Child Care | <ul style="list-style-type: none"> ● Knowledge of diarrhoea and its management at home ● Knowledge of signs of dehydration ● Knowledge of ARI and where to seek appropriate care. | <ul style="list-style-type: none"> ● Ability to prepare and administer ORS ● Ability to identify the sick and dehydrated child needing referral care ● Effective counselling leading to reduction in diarrhoeal episodes ● Ability to distinguish between ordinary coughs and colds and likely ARI- suspect pneumonia. Referral to suitable facility if the latter is suspected. ● First contact care for acute respiratory infection. |
| Nutrition | <ul style="list-style-type: none"> ● Importance of breastfeeding ● Importance of complementary feeding and feeding during an illness | <ul style="list-style-type: none"> ● Counselling and support for timely initiation and exclusive breastfeeding. ● Counselling mothers on adequacy and optimisation in complementary feeding within the limits of available options and access to food and other entitlements ● Being able to assess grade of malnutrition and low birth weight and counsel for mild degrees of malnutrition and refer for severe degrees ● Ability to recognise anaemia and provide care/ referral for this as appropriate. |
| Disease control | <ul style="list-style-type: none"> ● Depends on endemic disease- given below is example of malaria endemic block. ● Knowledge of disease and its control | <ul style="list-style-type: none"> ● Being able to suspect the disease in an individual or as an outbreak ● Blood smear making and use of RDK. ● Planning collective action on control with community. ● Provide presumptive drugs in the appropriate patient as per protocol in use. |
| Social Mobilisation and other soft skills | | <ul style="list-style-type: none"> ● Conducting women's group meetings and VHSC meetings. ● Assisting in making health plans. ● Enabling marginalised and vulnerable sections to access health services. ● Effective health communication skills using different approaches. |

Principles of Participatory Training

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

1. Know how and why adult learning/ training process must differ from teaching children in schools.
2. Describe the principles of participatory training.
3. Explain “experiential training” and its role in ASHA training.
4. Learn the main methods of participatory training that would be used.

Method: Group Discussion

Material: Handout 1, Handout 2

Duration: Two hours

Activities

1. Ask the participants to discuss the differences between ‘traditional education’ (you may suggest they think back about their school days and how they were taught as children), and adult learning. Draw two columns on the blackboard, one headed ‘Traditional education’ and the other ‘Adult learning’. Have them list out the differences based on their discussions.
2. Then ask- what do you think are the constraints to ASHAs learning. Which approach to teaching can help them further? Listen to their

answers. How is it possible to seek participation during sessions? Listen to their answers.

3. Ask if any participants have had experience with participatory training. What was the training, and what were their impressions about this kind of training?
4. Based on their experience, and what they know about ‘Adult Learning’, ask the participants to develop a list of ‘Principles of Participatory Training. Write these on a board. Once these are listed- circulate the answers given below and compare it with their answers.
5. Discuss the differences if any between the way the first round of training, the second to fourth rounds of training and the fifth round of training was conducted. What were the methods used? Which of these you would link with traditional and which with participatory and which parts of it were experiential. (Do not project it as if participatory training was only discovered with this module. Even in earlier trainings many of the components were meant to be participatory, even experiential. Try to encourage citing examples of both what was participatory and what was not).

6. Take three examples of knowledge and skills to train on:
 - a. What happens in labour and child birth.
 - b. Home management of mild diarrhea.
 - c. Making a birth plan.
7. Write down based on participants testimonies- how it was taught earlier (in modules 1 to 4) and what was then the purpose. And describe how the Module 6 and 7 proposes to teach it now - as experiential learning.
8. From this discussion derive the principles of experiential learning as described in the handout 1. This learning has five clear steps:
 - i. **Experiencing:** this is the first step. Each participant has to have a personal experience
 - ii. **Sharing:** Sharing helps reflect on and distance from the experience. Also when members of a group share with each other their individual experiences become a collective experience
 - iii. **Analysing/Processing:** Looking the implications and consequences of the experience. What is the learning?
 - iv. **Generalising:** what is the principles we derive. The general statements- or in other words- in which contexts is the analytic conclusion reached relevant. What are the explanations reached?
 - v. **Applying:** So if as an ASHA I face a similar situation again- the principle that I have arrived at would help me to expect... to happen and in response I should be doing.
9. Explain that the learner does not consciously do each step, but that in the process of learning, each step is gone through. Learning in this way promotes critical thinking and self-reliance. Simply undergoing the experience or feeling some emotions and receiving vague impressions is not sufficient and does not lead to productive learning. The facilitator should take them through these five steps above- for it to be experiential learning. Thus, all practicals are experiential learning - only if there are sessions of sharing, analysis and generalisation after the experience.
10. Trainer explains the Experiential learning cycle using the three examples mentioned earlier.
11. Plan how we can use this method whenever necessary in the field. One could change the examples given above and discuss it.
12. Then ask the participants to list the methods of participatory training they are aware of. Distribute handout 2 and discuss what they have missed out. Note that at senior levels of experienced trainers- almost every group, would as a group, get all the points made out in the handout. So make it clear that one is only revising and reinforcing what they already know.
13. Distribute the modules 6 and 7 and the trainers manual to the group and let them go through with it. They could quietly flip through it, and to themselves reflect on which methods are best used for which chapters.

Experiential Learning

| | Steps | Stages of Labour | Management of Diarrhoea | Birth Planning |
|---|--------------------------------------|---|---|---|
| 1 | Experiencing – | ASHA attends one delivery when baby is delivered quickly but the placenta is not delivered. ASHA asks the family and TBA to put baby to breast. Immediately placenta is delivered. | Each ASHA finds a child with diarrhea in the community and then makes ORS and helps to counsel the mother and feed the child. | Each ASHA visits a family with a pregnant woman and with help, pregnant woman and family make a plan. |
| 2 | Sharing: (Also called Publishing) | ASHAs tell the whole group what each of them saw/did/ experienced | Each ASHA tells her whole group, the child they saw, their experience of making and feeding ORS | Each ASHA tells her whole group, the birth plans they made and the discussions that led to the plan. |
| 3 | Analysis (Also called Processing) | Why did some deliveries take so long? How often were they surprised by the actual time it took. How was it useful to know how much time was available? | Was there anything the ASHA missed? How was it to counsel the mother, what issues did mother raise/what were problems in making and feeding ORS | Was there anything the ASHA missed? How was it to counsel? e.g., What were the different places chosen in different women? In what cases was a medically appropriate choice not the final outcome of the plan? Why? |
| 4 | Generalising | Primis take much longer than subsequent pregnancies. The breaking of the amniotic fluid means that delivery is at hand – but not always. | Useful to have a standard measuring device/vessels. Mothers seem to be convinced easier if..... | For women with complications the best choice is... These factors impeded in women going for the best choice... |
| 5 | Applying | When a woman in labour calls me to accompany her, I am able to make as estimate of whether I have time to reach her to the most appropriate hospitals. I am now able to reassure a woman who is worried about how long her pains are taking as to whether this is usual or not. | When I next attend on a child with diarrhea I would remember to | When I next go to make a birth plan I would remember these points..... |

Handout 1

Differences in the Way Adult Learners have to be Approached - as Compared to Children in Traditional Education Methods.

- 1. Adults have experience.** Adults have considerable experience and based on this some answers and perceptions about many issues. Children would not have the experience. Unless we respect the fact that adults already know a lot, there would be resistance and even hostility to the learning- even a quiet rejection of what is being taught.
- 2. Adults have views:** Adults could have a strong perception of what is right and what is wrong - what is practical and what is not, and what is acceptable and what is not. If the trainer merely gives a lecture, the learner may quietly listen and go his way without getting convinced, since he or she already has another view on it. Not unless there is the space and time for them to express their view and dialogue it, can they be really convinced about it. Children could be more open, passively accepting the teachers views as right or wrong. If there was a senior or charismatic individual even adults could accept, but most often the trainer is one from their own community.
- 3. Experiential learning is superior:** Traditional teaching depends a lot on listening and reading- theoretical. Adult learning requires this, but it also requires to be more experiential- where the learner does and experiences the new skills and knowledge in practice- in the real world. Experiential training is a must for training on skills.
- 4. Critical thinking and equal treatment of learners.** Traditional teaching has the teacher in a position of being more powerful and more knowledgeable- and could even encourage a dependence on external experts whose statements are taken as correct- without critical thinking. Alternative teaching respects that both learners and trainers have areas of knowledge where they know better. Both could help each other learn and both must appraise critically what is learnt.

Principles and Assumptions in Participatory Training

Principles of Participatory Training

1. Participatory training is participant centered
2. Learning through the experience of participants.
3. Respecting the views and experience of participants.
4. Creation of suitable learning environment
5. When participation is valued training becomes a social event; Focus is on building and learning as a group
6. Trainer should be aware of own self and be sensitive to others.

Some major assumptions of this alternative training approach are

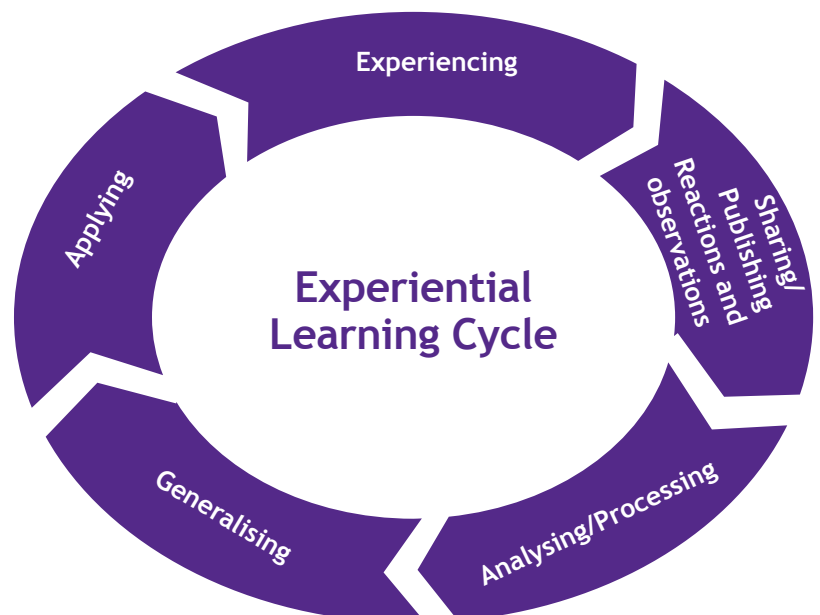
- People cannot be passively developed, they have to be active participants in developing themselves.
- Acquired knowledge does not automatically lead to action or changed behaviour, people first need to be convinced about the importance of change
- Learners themselves are a rich source of information and knowledge about the real world
- The collective is a powerful tool for learning and change
- Training and knowledge, can never be neutral.

Experiential Learning

Experiential learning is - reflecting on the experience, analyzing it - its structure, its dynamics, reacting to it and gaining insights, deriving more broad principles, and based on that going through similar experiences in life with a transformed vision that expresses itself through changed behaviour.

All practical and field based learning must be based on the principles of experiential learning.

Experiential Learning Cycle



Handout 2

Methods of Participatory Learning in Class-room

| | Key points in Method | Pros and Cons- Strengths and weaknesses | When best to use. |
|---------------------|---|---|---|
| 1. Presentation: | <p>Power point presentations, charts, posters or even writing on black board makes it easier to focus and recall.</p> <p>Written text of paper should almost always be circulated and participants given time to read it. (Module text).</p> <p>Needs good presenter and a good preparation.</p> <p>Eye contact with as many participants is possible.</p> <p>Interrupting flow of presentation for a few questions, jokes, visuals helps a lot.</p> | <p>Good for presentation of many facts. In large audiences – not much else can be done.,</p> <p>Could be impressive and inspiring – but difficult to replicate and level of recall of what is said is very poor.</p> | <p>Conveying facts or information. Organised presentation of overviews- where many sub- themes are linked to a single framework., like objectives of the workshop.</p> <p>Large groups.</p> |
| 2. Demonstration | <p>Best for teaching skills: The activity is carried out by facilitator with all participants observing. It could be repeated by each member or by each small group with facilitator observing, using a check list.</p> <p>Use of mannequins and models and appropriate instruments essential for teaching of these specific skills.</p> | <p>Good for teaching skills.</p> <p>Comes near – but is not the same as doing it in real situations.</p> <p>Requires a lot of equipment and preparation.</p> <p>Counselling skills- of one or two mothers in front of a whole group is effective but can be embarrassing to facilitator and to mother with child.</p> | <p>Useful for skill learning.</p> <p>Counselling skills, counting breathing in a child using a mannequin, making ORS solution etc</p> |
| 3. Group Discussion | <p>A topic is given to the group. Different persons are allowed to voice their opinions on it. A good moderator gives everyone time, and allows more time for those who have new insights to offer. Moderator also sums up and draws the generalisations that are emerging.</p> | <p>It could be used to follow or intersperse with a presentation for making the presentation more participatory and interactive.</p> <p>Not everyone gets to speak because the group is large.</p> <p>Needs a skilled moderator.</p> | <p>Issues where there are differing view points- mainly two or three contending view points where a consensus has to be built up. Like on the role of ASHA.</p> |

| | Key points in Method | Pros and Cons- Strengths and weaknesses | When best to use. |
|--|---|---|---|
| 4. Small Group Discussion | <p>The participants are divided into small groups of 4 to 8 persons- usually about 5 to 7 person groups.</p> <p>A set of tasks or questions is set to them which they would discuss in the group. The group may have to read the module pages first. Then each member in the group answers the questions and the consensus answers are written down in a chart paper and stuck up, or noted down and presented to the larger group/plenary.. The moderator of the larger group then facilitates the large group discussion.</p> | <p>The subject matter of the text gets revised thrice- when it is read out, when the questions are answered by each in the group and when they are again presented in the larger plenary. Helps to give more attention to those with low literacy skills and who are slow in learning.</p> <p>Can be conducted even with those with modest presentation skills.</p> <p>Make take much more time, especially where the facilitators are not confident and dynamic.</p> | <p>Becomes the main form in which the modules are covered- when we are not in the experiential/group learning mode. This allows for the text to be read and internalised and prevents transmission loss.</p> |
| 5. Role Plays: | <p>Three steps: Briefing: A situation is given to a selection of participants. Roles of different characters are assigned to each.</p> <p>Play: The situation is then acted out and allowed to develop towards a purpose.</p> <p>Debriefing: the act is stopped and then the participants reflect on what they saw and learnt from the different roles.</p> | <p>Takes time. Needs careful and skilled facilitation to lead to required outcomes. Not useful for skills- but useful to question attitudes. Risk of getting carried away with theatrics some of which could be more powerful with negative messages. Thus the text would be gender sensitive- but the gender insensitive character may act better and more convincingly.</p> | <p>Most useful for exploring attitudes and perceptions, especially where they act as constraints.</p> <p>Used in a limited way in this module 6 and 7. Most role plays are more in the nature of case simulations which must be differentiated from role plays.</p> |
| 6. Case Simulation: a. Oral with handouts/posters etc. b. Video- based | <p>The facilitator plays the role of the pregnant woman or a woman with a young child simulating a real patient/beneficiary. The ASHA asks questions or counsels this beneficiary.</p> <p>Instead of facilitator playing this role orally, a video clipping could show such a child, or a poster or handout could describe such a case. Best is the video –clipping with poster and handout as a back up – but if all else fails a good trainer could herself simulate the case.</p> | <p>Pros- next best to experiential learning for counseling skills – and without the embarrassment and ethical concerns of practicing with a real beneficiary.</p> <p>Video clippings based case simulation best for seeing a wide variety of sick child and newborn situations.</p> <p>Need to organize electronic material carefully.</p> | <p>For Counselling skills.</p> <p>Also for learning to identify sick and severely malnourished children and other danger signs and complication requiring referral.</p> |

Evaluation

| Objectives | Assessment Method | Output of the session |
|---|-----------------------|-----------------------|
| Explain the difference between 'traditional education' and adult education. | Group discussion | - |
| Describe at least 3 principles of participatory training | Questions and answers | - |
| Explain 'experiential learning' and why it is useful for adult learners. | Questions and answers | - |

Principles and Methods of Supportive Supervision

Session 4a: Principles of Supportive Supervision

Aim: At the end of the session the trainer will understand:

- The role of supervisor/facilitator in the ASHA programme.
- How to identify and learn key principles of supportive supervision and how to avoid authoritarian supervision.
- How to introduce the concept of ‘management by measurable outcomes’
- How to understand who are the supervisors and what are the roles of different functionaries.

Method: Role Play and Group Discussion.

Material: Handout 1, Handout 2, Handout 3

Booklet on Supportive Supervision with check lists for the follow up sessions.

Duration: One and half hours in the Round 1 TOT workshop to introduce the topic and make the participants understand the need and nature of supervision. The actual check lists and monitoring approaches will be introduced later.

This would be reinforced during the post training review meetings by six hours of transaction every month for three months - using the separate supportive supervision book and the operational guidelines of the ASHA programme as guide-books.

Activities

(For the first one and half hours of introduction in Round 1 of the TOT workshop).

1. The following scene is given to four or five participants- one plays the role of the block officer who comes and scolds the ASHA for not having brought any sterilisation case or institutional delivery case to hospital. Threatens to drop her from the programme. The others in the play are the ASHA, 2 family members of ASHA, the local panchayat head and some community members. How does this scene unfold? (See Handout 1a for guidance)
2. After debriefing- the same characters repeat the same scene except that now the block officer is displaying “supportive supervision”. How does this differ? (See Handout 1b for guidance)

- Ask participants to describe how the supervisor acted. Listen to their answers and write the main descriptive words on the board or white paper. Distribute the Handout 2 and ask them to compare their observations with the good practices and principles listed in the handout
 - Ask the participants if they noticed any ‘techniques’ used by the supervisor in the role play? Listen to the answers. If any of the following are pointed out, praise the participants. If not, add any points missing:
 - **Good communication skills**, warm greeting, asking about ASHA, listening, kind tone of voice, etc
 - a. **Uses checklist** to ensure all points are covered
 - b. **Praises** ASHAs accomplishments, then sympathetically **identifies** any knowledge, skill or attitude **gap**; **provides on the job training** if necessary; **ends with praise and encouragement** (for motivation)
 - Summarize the characteristics of the ‘supportive supervisor’ (See Handout 1)
 - Ask the trainer who played the worker, to describe how he/she felt when the supervisor was helping her (*glad that some things were done well, respected, treated with kindness, wanting to do better next time*)
 - Emphasize that an important purpose of the supervisor’s monthly visit is to help people discover their strengths and weaknesses, to rectify any weaknesses so that performance is improved. When everyone is working at top performance the goal of reducing neonatal deaths is closer to reality.
 - Ask participants if they know what ‘motivation’ means. Listen to their answers. Ask for examples of when they have been motivated to do something. **Motivation** means wanting to do something. When someone is motivated, they try harder to succeed. **Praise and encouragement** are tools the supervisor should use to motivate ASHAs.
 - Ask participants in what other way ASHAs can be motivated? Listen to their answers. Praise the participant who says that ‘ASHAs are motivated when people in their communities are helped by their work’, or ‘when people in the community start treating her with more respect’ etc. If no one says anything, the trainer should say these things. Ask if participants think this is true and why?
3. Now ask a supervisor known for being a good supportive supervisor to come and brief the team on how he organises and does his supervision. Look at Handout 2. Ask the supervisor to state how much he is able to follow these steps- and if not why is he not able to follow these steps.
 4. Why do we need measurable outcomes for managing the programme? The reasons are listed in the handout. Go through

them. Tell them we would discuss indicators and exact monitoring process during the first post training review programme. Also we would discuss training evaluation in the last session of this workshop. For now it would be adequate to understand these principles.

5. Discuss who all play supportive roles: A short list of those who play such roles could include the following:

Within the Village

- a. Self Help groups.
- b. Women's health committees
- c. Village health and sanitation committees.
- d. Anganwadi Worker
- e. The gram panchayat

From Outside the Village- Health Department

- a. The ANM
- b. The PHC medical officer
- c. The ASHA facilitator
- d. The ASHA trainers/block coordinators.
- e. NGOs assigned for support.

6. Distribute the handout (Hand out-3) and ask?
 - a. Which tasks done by ASHA which is not done by ANM or AWW but which helps the ANM and AWW to achieve their tasks. Thus it is a facilitation of the ANMs/AWWs work
 - b. Which tasks are done by ASHA **and** one of the following: ANM and AWW: is this an overlap/ reinforcement or wasteful duplication?
 - c. Which of these tasks are done by ASHA and not by either ANM and AWW: and what is the purpose?
 - d. Which do you think are tasks that ANMs and AWWs should not get ASHAs to do, but this is happening. Do you think that the actual amount of work ANMs and AWWs do has increased, or decreased or remained the same after ASHAs have come.
 - e. In what ways do each of these potential support structures within and outside the village support ASHA- how could they be made to support?

Handout 1a

Model Role Play Script (Authoritarian Style)

Script Below is to Indicate the Sort of Dialogue that Can Happen. Do Not have to Follow this Script- Let it Proceed Spontaneously

ASHA: Hello (to supervisor).

Supervisor: Hello. I came to check on your work. How many cases have you sent for institutional delivery. I believe there are still home deliveries happening in your area.

ASHA: I tried - but they would not go. You see there are many problems. Mainly with the transport.

Supervisor: Don't give excuses. You must be able to deliver, other wise we have to look for some other ASHA. Even no cases of sterilisation or IUD you have brought.

ASHA: I did bring- but the day they were willing to come, that day the doctor did not come, and when the doctor came next time, I did not know.

Supervisor: You shouldn't be so careless. You should have found out. I'm surprised everyone else is able to do it and you are not. Did you visit the newborn at least.

ASHA: (embarrassed). I'm sorry. I will try harder. I did visit the newborn.

Supervisor: Where is the record of it? Why is not entered into your register? How can we pay you if you do not enter it. Did the baby get colostrum.

ASHA: (happily) Yes, it did, First they were unwilling, but I persuaded them.

Supervisor: But what is the use? You have not recorded it. How do I believe you?

END OF ROLE PLAY

Guideline to Dialogue (to use as Reference in Discussion after the Role Play)

ASHA: Hello (to supervisor).

Supervisor: Hello. I came to check on your work. How many cases have you sent for institutional delivery. I believe there are still home deliveries happening in your area.

(Poor greeting and communication skills; did not make the ASHA relaxed. Starts with a complaint)

ASHA: I tried - but they would not go. You see there are many problems. Mainly with the transport.

Supervisor: Don't give excuses. You must be able to deliver, other wise

we have to look to some other ASHA. Even no cases of sterilisation or IUD you have brought.

(Makes ASHA feel bad about her performance. Does not even try to find out what the problems were- much less help her. Scolds her rudely and goes on to the next fault finding).

ASHA: I did bring- but the day they were willing to come, that day the doctor did not come, and when the doctor came next time, I did not know.

Supervisor: You shouldn't be so careless. You should have found out. I'm surprised everyone else is able to do it and you are not. Did you visit the newborn at least.

(Again makes ASHA feel bad about her performance. Does not own systems roles and faults in responding- tries to shift blame to her. Scolds her rudely and goes on to compare with others.)

ASHA: (embarrassed). I'm sorry. I will try harder. I did visit the newborn.

Supervisor: Where is the record of it? Why is not entered into your register? How can we pay you if you do not enter it? Did the baby get colostrum?

(Shows no concern about the newborn- only about the register. It is clear that this supervisor is only interested in his targets and could not care very much for people and their problems- which is different from the mind set of the usual ASHA. Of course with such supervision, even the best ASHA would get into the wrong attitudes.)

ASHA: (happily) Yes, it did, First they were unwilling, but I persuaded them.

Supervisor: But what is the use? You have not recorded it. How do I believe you?

(Again supervisor does not show any interest in the actual work done. This visit is an unmitigated disaster. Better no supervision than such supervision).

END OF ROLE PLAY

Handout 1b

Model Role Play Script (Supportive Style)

This is Helpful for Facilitator, as the Person Playing the Supervisor's Role must be Briefed Accordingly. Not Too Much Spontaneity in This Role Play for We Do Want to Depict the Supportive Role- Much Better.

ASHA: Hello (to supervisor).

Supervisor: Hello Preeti. I'm very happy to see you today. How are you?

ASHA: Hello, I'm fine.

Supervisor: How have you been finding your work as a ASHA? Have you had any problems?

ASHA: No problems although I find I that I have not been able to get many persons to come to the institutions. I don't know why and feel bad because the other ASHAs are able to do so.

Supervisor: Don't worry, in the beginning it is difficult. I'm sure that with practice you'll make an excellent ASHA! But tell me what happened in the last baby that was born.

ASHA: Well I tried, but only one person has a vehicle in our village and he was reluctant to let it out that

night, though he had agreed before. I find he is not very happy with giving it to families outside his own hamlet and part of the village. Also some of these families cannot pay at once.

Supervisor: Hmm. Don't worry about this. I see this problem in so many places. I will go and talk to the panchayat chief on your behalf and if even that does not work, I will talk in the nearby town on the road and if you give them a mobile call they would send a vehicle down. Why don't you try to get the SHG to give an advance at this time- if the money you have with you is not sufficient. But tell me about the baby how is it doing. Is there any problem.

ASHA: (happily) No the baby and mother are fine. The baby is coming fine. Would you come and visit them, they would be happy and it would help me, next time I visit them to get the woman to go for an IUD. I have not yet talked to them.

Supervisor: Of course. I am so happy to see you happy with this work. Is there any problem you face with the promoting contraception.

ASHA: OH it is difficult to talk about it, but I am trying. The more difficult problem is that I never know when the doctor is coming and the camp is going to take place.

Supervisor: Oh, is that so. That is our fault. Give me your mobile number. Next time he is coming i will ring you up and let you know. Are you recording all of this work in your register. Let me have a look.

ASHA: Oh I keep forgetting (showing the register which is incomplete).

Supervisor: This is good. You have written down quite a bit. But if you were to maintain it more regularly, in the beginning it is more work- but later it helps you carry out your work easier and when you look at it you feel proud of it. It also helps if there is a problem in payment. You know what you have done for the family is such good work- but do make the bit extra effort to record it. It would help you in the long run. See you can make out which mothers or children need

what service. It would be difficult to keep all of it in your mind.

ASHA: I will try- but do come to the family.

Supervisor: Of course, Preeti, not only to that family- but also to one or two of these families who are not yet convinced about going to the facility for delivery. Let me see what their reasons are- and perhaps I can help you- though I dare say you are doing a very good job. You just must persist without getting frustrated. Change takes some time. Now tell me about other children who are sick now and let us visit some of them together, so that we can go over some of the main points you learnt in training once more.

END OF ROLE PLAY

Handout 2

Why is Supervision Necessary?

- To ensure that the team achieves the objectives
- To provide opportunity for ASHAs to get answers to their questions
- To support ASHAs in problem solving
- To provide guidance and education to improve performance

Principles of Supportive Supervision

- Supervision is a continuous process
- Treat all people especially workers you are supervising with respect
- Visit the worker at regular intervals
- Inform the ASHA of the date of the visit
- Don't rush the visits
- Use a checklist (or ASHA progress book) to guide the work- this makes sure that all aspects are covered.
- Monthly visits are an excellent opportunity for in service training if needed
- Visits homes with ASHAs, talk to mothers
- From time to time, visit village leaders to see what they think of the programme
- Review records and forms.

Characteristics of a Supportive Supervisor

- Is kind and greets the ASHA warmly,
- *Praises what is done well, there is always something to praise. This bolsters the worker's self-esteem and trust in you as the supervisor.*
- *Explains what can be improved clearly without making the worker feel badly about herself, asks what the worker thinks would help the situation, Use good communication skills*
- If there is a weakness, identify the cause (insufficient training, insufficient resources (drugs etc), not understanding the task, ASHA discouraged by lack of progress or lack of encouragement, ASHA worried by personal problems).
- Give feedback (suggestions for improvement) with kindness. The supervisor must provide feedback in such a way that workers respond positively and try to improve their performance.
- Using the 'sandwich approach', praises accomplishments, gives constructive suggestion to improve work, and ends with praise and encouragement (for motivation).

Management Using Measurable Outcomes:

- If there are clear outcomes/objectives, ASHA knows better

what is expected of them and can try to reach these outcomes.

- If there are clear outcomes/objectives, the supervisor can
 - i. Reward and encourage good work.
 - ii. If objective hasn't been completed properly, the supervisor can identify what the problem is and try to correct it. This may mean:
 - a. Identifying and addressing gaps in a workers knowledge or skill, they can help them on the spot, or arrange for additional training
 - b. Identifying a social problem (between the ASHA and the community, or ASHA, and ANM/AWW/TBA etc) and try and resolve this through discussion, individually or in a group of those concerned or where needed bring the influence

of the government to overcome the problem.

- c. If problem is there with lack of supplies, try and ensure sufficient supplies
- If there are clear objectives/outcomes community also knows what is expected of ASHA and would not have unreasonable expectations of her and would be able to cooperate with her, where needed. Also the work or gaps in performance of other functionaries would not be attributed to her.

Supervisor/Facilitator Visits therefore begin with trying to identify and assess the situation in outcomes. Some of the measurable objectives are called process objectives and some are called programme objectives.

These are given in detail in the Facilitator's handbook.

Handout 3

Support Structures and Partners of the ASHA.

Role and Integration with ANM

The role of the ANM is primarily service delivery. She is responsible for managing the functions of the sub center and providing services for maternal and child health, some components of primary care, and recording and reporting. In addition the ANM is expected to run the services component of the Village Health and Nutrition Day (VHND). The VHND has a component of service delivery and a component of communication. Services for antenatal care, postnatal care, family planning, immunisation, and care for selected ailments, including RTI/STI services are provided. In addition, women, adolescent girls and children from the village are mobilised for orientation and health education on health related issues such as importance of nutritious food, personal hygiene, care during pregnancy, importance of antenatal check up and institutional delivery, home remedies for minor ailment, the importance of immunisation and early care seeking for illnesses.

ANM is the first level of worker in the health system that the ASHA is in contact with. The ANM will:

- Hold weekly/fortnightly meeting with ASHA and discuss the activities undertaken during the week/fortnight. She will enable

the ASHA in resolving issues and problems faced while working.

- Be a resource person for the training of ASHA.
- Let the ASHA know the timing and date of the VHND, and ascertain that the list of pregnant women, postpartum women, newborn children, women eligible for family planning services and children who require immunisation matches that of the ASHA.
- Guide the ASHA in motivating pregnant women for coming to sub centre for antenatal check ups, including completing the course of IFA and ensuring two doses of TT.
- Share with ASHA the list of eligible couples in need of family planning and enable her to motivate such couples for family planning.
- Visit, at least once, every post partum mother and newborn to support ASHA.
- Supervise and ensure the technical quality of care provided by the ASHA.
- Will work in ASHA to ensuring that women and children from marginalised communities receive the care and support they are entitled to.
- Visit every neonatal sepsis case being treated by ASHA and support her.
- Assist ASHA in organising referral of pregnant women, sick neonates and children.

- Act as the liaison between ASHA and the PHC.
- Support ASHA in the motivation and counselling of a non-cooperative mother or family.
- Replenish the Drug kit of the ASHA
- ASHA will refer cases of malnutrition to the AWW and enable referral or other support, such as feeding counselling, availability of supplementary nutrition, and home visits.

Role and Integration with Anganwadi Worker

At the community level, the Anganwadi Worker (AWW) is in charge of the AWC, which serves as the locus for VHND and other health education activities including for nutrition and health. The AWW will work closely with the ASHA in performing following activities:

- The ASHA and AWWs will support the ANM in organising the VHND.
- The AWW will support the ASHA on conducting IEC activities on the VHND through display of posters, role plays, folk dances and other activities needed to sensitize the beneficiaries on health related issues.
- AWW will support ASHA in updating the list of eligible couples and also the children less than one year of age in the village with the help of ASHA.
- AWW will enlist the support of the ASHA in mobilising pregnant and lactating women and children for nutrition supplementation.
- AWW will work with ASHA in ensuring growth monitoring and feeding counselling for all children under five.
- AWW will enlist ASHA support in ensuring that children from marginalised families avail the services of the ICDS.

ASHA Facilitator: Her functions will be

- 1) To assist the ASHA trainers in conducting the four Rounds of ASHA training workshops,
- 2) Visiting ASHAs in their villages, at least once in 15 days.
- 3) To ensure that ASHA acquires and practices the skills and attitude as expected in the training.
- 4) To accompany ASHA in her home visits to pregnant women as well as post partum mothers, neonates and sick children. Help her do her work correctly and effectively. She will function as the on site field trainer.
- 5) To check ASHAs records for completeness, correctness as well to detect and solve problems.
- 6) Personally visit every pregnant woman at least once, every post partum mother-newborn at least twice. Visit the high risk neonates or neonates with sepsis more often. Also visit children treated for pneumonia, dysentery, diarrhoea or severe malnutrition. Visit children and mothers from families that are marginalised, impoverished and who live in small hamlets with no workers. Ensure the quality of care given to these, and also convince mother/family to comply with advice given by ASHA.

- 7) Use feedback from families who received services from the ASHA to encourage the ASHA and correct any mistakes.
- 8) To provide the ASHA with emotional and social support, and help solve her problems.
- 9) To meet community leaders and key persons (such as TBA, AWW, SHG group leaders, PRI representatives etc) to inform them, get feedback and solicit support.
- 10) Support ASHA in organising and providing community health education
- 11) Attend monthly PHC meeting at the block organisation.
- 12) Coordinate with ICDS supervisor and ANM by meeting them at least once in 15 days.
- 13) Assist ASHA in referral of very

sick neonate or child, and also in case of any emergency help she needs.

Functions of the PHC MO

- 1) To support ASHAs, ASHA facilitator, and ANMs in discharging their roles for maternal, newborn, child care and nutrition.
- 2) To encourage ASHAs, appreciate those who are working well, identify problems with those who are not functional, and solve the problems, if any, in the monthly meeting.
- 3) To help ASHA and the family in seeking referral at the appropriate level.
- 4) To adhere to reinforce the technical guidelines and orders given to ASHA in the training

Session 4b: Skills of the Facilitator

Aim: By the end of the session the trainer/facilitator will understand:

1. Active Listening and good inter-personal communication: including summarisation and paraphrasing.
2. How to develop the skill of giving - and receiving feedback - so that their advice is well received and acts as encouragement.
3. How to identify gaps in performance and analyse the causes for the same.
4. Skills of Social Mobilisation.
5. Insight: To develop an insight into their own beliefs and behaviours and assist them in making links between this and their personal growth needed to play a leadership role. To understand the content of the terms: facilitation, supervision and leadership and why the goal of personal growth is leadership.

Methods: Group Discussion and group exercises, and field learning (experiential).

Materials Handouts 1 and 2.

Duration: Two hours as introduction in class room and two to three hours in a field practical linked to other skills. However it would be mainly imparted during the first few monthly review meetings of the facilitators and supervisors using the facilitator's manual.

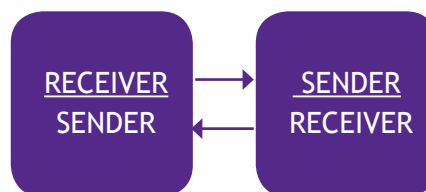
Activities

Step 1: Tell the participants that other than good knowledge of the content of the programme, a supervisor needs several other skills. Three skills that will be taught are:

1. Interpersonal Communication Skills
2. Giving feedback
3. Having an insight/understanding of oneself and how others perceive you.

Step 2: Explain the skill of communication:

- a. Ask the participants if they can explain what 'communication' is. Listen to their answers. Work their responses into the following definition: *Communication is the process of sending and receiving information among people.*
- b. Explain that if drawn, the process may look like this: (draw the following diagram on the board)



- c. Explain that although the definition of communication is simple, in actuality it is one of the most complex things that people do. We may think we are sending a clear message, but the person who receives it may hear it differently from the way it was intended. Sometimes we are

distracted and do not ‘hear’ or listen very carefully. Sometimes a person may have a different way of looking or understanding things (a different perspective). Differences in education and social and economic class can be the reason for some of this difference in perspective.

- d. Ask participants if they can give some examples of when there was a problem in communication. Listen to a few examples.
- e. Explain that a trainer/supervisor needs to be able to communicate well, to make sure that the people they are talking to really understand what they mean to say. There are some ‘tools’ that can be taught to ensure greater understanding. These skills are known as facilitation or communication skills. Later, you will teach some of these skills to the ASHA because it is very important that the ASHA knows how to talk to the community, to give clear advice on how to care for babies etc, and how to ascertain if the family members understand what to do.
- f. We shall now teach five skills related to better communication: these are the skills of (i) paraphrasing, (ii) summarisation, (iii) active listening and (iv) use of encouragers or prompters. Please read through Handout 1. Then conduct these demonstrations and finally break into group work.

Step 3: The trainer demonstrates (i) paraphrasing, (ii) summarisation,

(iii) active listening and (iv) use of encouragers or prompters. (See Trainer notes)

Step 4: If there is time then these three skills (paraphrasing, open ended questions, and summarising) can be done within the small groups, with every participant having a chance to practice these skills.

Step 5: The trainer will now distribute Handout 2. Let the participants read about why feedback is needed, key points to keep in mind while receiving or giving feedback. The groups will now consider the three role play situations given in Handout 2. Each group would then present the role plays to the plenary. If there are enough facilitators present the role plays could be presented within the groups itself and not in the plenary.

Step 6: If time permits the trainer can go on to helping the participants to develop an insight about themselves or about how others perceive them. There is an interesting exercise by which this can be done, called the Johari Window exercise. This is included in the Trainer’s notes. The trainer would also need to distribute Handout 3 for the groups to carry out this exercise amongst themselves.

Step 7: Conclude the session after informing them that we have not had the time to cover two important areas, namely the skills of performance/gap assessment and social mobilisation and community mobilisation skills. These will be covered in later sessions.

Notes for the Trainer

Demonstration of Communication Skills: (40 minutes)

The participants can be divided into five groups- but they are all sitting together in the same hall- in groups. The seating arrangement in five circles would help.

Paraphrasing

- Invite two volunteers on stage one from each group: let one person do the supervisor role and the other be a community member. The supervisor is asking the person what the health problems are in the village, and the supervisor is trying to explain the benefits of counseling for adequate complementary feeding.
- However, there is a ‘paraphrasing rule’’: *Before one responds to the other person, he or she must first paraphrase what the person said to their satisfaction.*
- Allow this to go on for a couple of minutes then relax the ‘rule and have the pairs continue for another few minutes.
- Ask another group what their reaction to the exercise was. What did paraphrasing do to the communication process? What happened when the rule was relaxed? What have you found useful about paraphrasing?

Active Listening

During the above demonstration, each listens actively to the other. Their body language should also reach out

and show that they are concerned and listening. Good eye contact, and appropriate head movements, and prompts demonstrate active learning. Prompting or the use of conversation encouragers is also an important part of active listening.

Point this out and explain how active listening encourages the person being counseled to talk more freely.

Closed and Open Questions Game

- Have volunteers call out open ended questions and close ended questions. One person calls out the question and another states whether it is open ended or close ended. Continue until a number of persons have had at least one chance at formulating an open-ended question and close ended question.
- If people are having trouble, the trainer should review the basic points again.

Summarisation

- Ask for a volunteer from each group to present a topic in two or three minutes.
- Like the considerations that go into a birth plan in a family, or the causes of malnutrition in a specific child or the importance of home based newborn care.
- Then another volunteer from another group should summarise this into a three or four lines. Let four of five such summarisations be demonstrated. What makes for a good summary.

Facilitation Skill 2: Feedback

- A. Let each small group now consider Handout A on feed back. Let them read why is feed back needed. What are things to keep in mind while receiving or giving feedbacks
- B. Each group may consider the case studies in handout B and each person in the group may prepare to present these. Then one by one each group would present one of the case studies to the plenary. **If there are facilitators/trainers available these case studies could be presented in each small group itself and not brought to a plenary**

Facilitation Skills 3: Developing Insight

- Discuss with participants the Johari Window exercise. Ask if anyone has any idea about it. Ask them- what happens if they open any window? More of the outside world is visible.
- State that the Johari window divides the knowledge about self in four parts - known to me, unknown to me, known to others and unknown to others. Whatever about my personality is known to me and known to others is open. That which is known to me but unknown to others is hidden. The part unknown to me but known to others is blind. The portion unknown to me and unknown to others is unknown.

| | Known to me | Unknown to me |
|-------------------|-------------|---------------|
| Known to others | Open | BLIND |
| Unknown to others | Hidden | Unknown |

- The aim is to increase the open area and that is called opening window.
- Review the window briefly. Explain that:
 - ◆ Once we receive feedback we can analyze it, look inside (introspect), discuss the feedback with others, and try to understand this new information about oneself.
 - ◆ The more we know about ourselves, the more the window opens and the part of me which is known to me as well as known to others increases. This automatically reduces the blind, hidden and unknown self.
- ◆ After accepting feedback and knowing more about oneself the Johari window will look like the following:
- Explain that a person open to receiving feedback creates an opportunity to know more about ones capacities and behaviour. Self development depends more on how much a person wants to know about her and change her.
- To think about this more divide into small groups and work out the exercise as given in handout 3.

| | Known to me | Unknown to me |
|-------------------|-------------|---------------|
| Known to others | Open | BLIND |
| Unknown to others | Hidden | Unknown |

Handout 1

Exercises to Teach Select Communication Skills

Paraphrasing

- One of the skills used to ensure that communication is really taking place is to use **Paraphrasing**. Paraphrasing is “*capturing the meaning of a statement and saying it back to the other person in your own words*”. In other words paraphrasing is like catching a ball and throwing it back—except the ball you throw back is your own and perhaps a bit different from the original ball. Nonetheless it is still a ball.
- Demonstrate the process of paraphrasing by asking a volunteer in the group to discuss a subject of your choosing, for example “How is the work going in your region?” As you talk with the participant, make a conscious effort to paraphrase at appropriate times using different phrases such as the following:

“You were saying ... (Then say in your own words what has been said)

“In other words

“I gather that

“If I understood correctly what you were saying

“You mean”

- After the short discussion, ask the participants to identify the phrases you used to introduce the

paraphrasing. Write them on the board or white paper. Ask them for examples of other phrases they can use. Write these on the board.

- Ask the participants what paraphrasing does. Listen to their answers.

Possible answers:

- it shows that you are listening
- *it allows you to explain what you heard the other person say so if you did not understand correctly the other person can explain further*

Asking Questions

- Explain that asking questions is a critical skill for the trainer and supervisor. Questions can be asked in two ways: as closed questions and as open-ended questions. (See content box for explanation and examples)
- Group Exercise: Write down the following sentences on a board or white paper. Ask the participants to explain if it is an open or closed question and why. Have them change closed questions into open-ended questions

Are you feeling tired right now?
(Closed; This can be changed to an open question by asking: Can you tell me how you are feeling right now?)

Closed Questions generally result in a yes/no or other one word answers. They should be used only when you want precise, short answers, for example when you are filling in a form (for example: Are you married? What is your age?). Otherwise closed questions inhibit discussion; people don't feel free to express themselves.

Example:

Supervisor: Do you think that recommendation will work?

Participant: No

Open-ended Questions seeks more information and requires the person to answer in longer sentences. How? What? Why? - are words used in open-ended questions. Open ended questions are helpful in learning more about what a person thinks and in fostering participation. Open-ended questions should be used as much as possible.

Example:

Supervisor: Tell me what you like about that recommendation.

Participant: I think it is a good strategy because it involves families in decision making.

What can you tell me about your community? (*Open-ended question, requiring a description*)

What do you usually feed the child? (Open ended)

What did you feed the child this morning? (Closed question)

How much rotis did the child have today? (Closed question)

Why do you think your child is underweight? (Open ended)

Summarisation

- Ask the participants if they can explain what 'summarising' is. Build on their answers so the definition is something like:

Summarising is recalling and stating in a few words the essence or the most important points in a conversation

- Explain that the purpose of summarising is to:
 - ◆ Pull important ideas, facts or data together
 - ◆ Establish a basis for further discussion or make a transition
 - ◆ Review progress
 - ◆ Check for clarity; check for agreement
- Explain that summarising requires you to listen carefully, in order to organize and present information systematically. Summarised information ensures that everyone taking part in the discussion (or meeting, or encounter) is clear about what

happened in the just-completed portion of the discussion.

- Give an example of summarisation. Ask a participant to explain how she feels being trained as a trainer. Listen carefully to what she is saying. After a few minutes, summarize by using phrases such as:

‘Let me see if I understood what you said.

First you explained that....
Then you said that.....

- Explain that summarisation is very important to a trainer, to ensure that participants remember what has been said or to emphasize key points. Some additional starter phrases are:

If I understand you, you feel this way about the situation...

I think we agree on this—what you are saying is that....

There seem to be some key ideas expressed here.....

Active Listening - Encouragers or prompters:

- Explain that there are a number of other facilitation skills, some are non-verbal and some are verbal. These ‘encouragers’ let the other person know that you are listening to them and that you are concerned, you value what they say and prompt them into talking more on some area of interest.
- Write the following on the board:
 - ◆ Good eye contact
 - ◆ Nodding one’s head
 - ◆ Picking up the last word or two of someone else’s sentence
 - ◆ Repeating a sentence, or part of a sentence
 - ◆ Asking someone “say more about that’
 - ◆ Stating ‘That’s good, anyone else has something to add’
 - ◆ Maintaining eye contact and open body position
 - ◆ Saying uh huh

Handout 2

Giving and Receiving Feedback

I. Guidelines for Giving Feedback

1. Feedback should be constructive; do not give irresponsible and destructive feedback which may scare off the other person
2. If the other person is not ready to accept feedback, then do not give it.
3. Feedback is most useful if given immediately after the event.
4. Be specific in feedback. Avoid general statements, but if used, support general statements with specific examples.
5. Use descriptive rather than judgemental language.
6. Focus on behaviour that the 'receiver' (i.e. ASHA) can do something about.
7. Do not judge actions of the other person. - You were wrong in shouting at me.
8. Do not describe other person's feelings, or intentions. - You wanted to hurt me.
9. Be direct, clear and to the point but not abrupt or rude.
10. Take into account the needs of the receiver as well as your own.
11. Plan how to give feedback (think about the best way to give feedback; don't rush right in)
12. Giving feedback:
 - ♦ use the "sandwich" approach: give positive reinforcement, provide constructive criticism, then end with positive reinforcement/compliments on work
 - ♦ be positive and give encouragement for improvement

II. Guidelines for Receiving Feedback

1. Solicit feedback in clear and specific areas (i.e. could you tell me how I could improve this session?)
2. Make a point to understand the feedback; paraphrase major points; ask clarifying questions. Avoid making explanations of "why I did that" unless asked.

Summarisation

Summarising is recalling and stating in a few words the essence or the most important points in a conversation

A real value of summarising is that it gives you the opportunity to check for agreement. If people do not agree, it is better for you to know about it at that time, then to find out later when a task is not completed or a deadline is missed.

3. Show appreciation for the effort it took for the other person to give you feedback.
4. Remember that feedback is one person's perceptions of another's actions, not universal truth.

Role Play Situations

1. Neeta, a Supervisor visits ASHA Veena one morning. While observing a home visit, Neeta sees that Veena is not being friendly with the mother and at one point Veena says to the mother 'didn't I tell you before? If you don't put more clothes on the baby it will get sick and die!'"

Show how Neeta should give feedback to Veena

2. Preeti is an excellent ASHA, very eager and smart. One day, her

Supervisor Geeta, thought Preeti made a mistake when weighing an infant; Preeti read the scale at 2.3 kg, but Geeta thought it was 2.1 kg. Since this was the 28th day, the reading was important (if the baby was less than 2.3 it would have to be visited for another month).

What should Geeta do and how should she give feedback to Preeti?

3. Lakshmi is ASHA visited by her Supervisor Meena. While reviewing the medicine box, Meena sees that the box is not properly closed, and that the gentian violet bottle was not properly closed and leaked all over the other tablets.

Demonstrate how Meena should give feedback to Lakshmi.

Handout 3

Interpersonal Perceptions - Questionnaire

(This Exercise can be very useful after the Input on Johari Window, and Principles of Feedback.)

| A | B | C | Are you someone who - |
|---|---|---|--|
| | | | 1. Listens carefully to others |
| | | | 2. Takes an active role in a group |
| | | | 3. Often interrupts others |
| | | | 4. Is work oriented |
| | | | 5. Tries to make others feel at ease |
| | | | 6. Waits for others to greet first |
| | | | 7. Prefers to work by yourself |
| | | | 8. Tells jokes/has a good sense of humour |
| | | | 9. Is a difficult person to manage |
| | | | 10. Always has something to say |
| | | | 11. Blames others especially when under pressure. |
| | | | 12. Is satisfied with yourself and your level of achievement. |
| | | | 13. Volunteers to help others |
| | | | 14. Makes friends easily |
| | | | 15. Has difficulty in saying no |
| | | | 16. Points out mistakes of others |
| | | | 17. Has the respect of those junior to you/working under you and treats them with respect. |
| | | | 18. Accepts criticism gracefully |
| | | | 19. Does things on the spur of the moment |
| | | | 20. Does not reveal himself/herself to others |
| | | | 21. Has an urge to serve the people. |
| | | | 22. Has every reason to be very worried about ones personal future |
| | | | 23. Person who has lot of friends |
| | | | 24. Can't keep a secret |
| | | | 25. Manages difficult situations |
| | | | 26. Lacks control of emotions |
| | | | 27. Is serious |
| | | | 28. Is willing to consider and accept other's suggestions |
| | | | 29. Support others |
| | | | 30. Finds it difficult to relax |

Should be used in a small group of persons known to each other. Each participant in the small group fills column A and then folds it and clips it so that the answer is not visible. Then asks a friend who knows you well to fill column B and then fold

and clips the answer and then asks another acquaintance, not necessarily a friend to fill up column C. Then two groups of three sit together and discuss the perceptions of one self as compared to how others have judged.

Care of the Pregnant Woman

Session 5a: Confirming Pregnancy and Diagnosing LMP and EDD

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

- Diagnose pregnancy using the Nischay kit
- Determine Last Menstrual Period (LMP) and Expected Date of Delivery (EDD)

Methods: Discussion, demonstration and practice exercises.

Materials: Nischay Kit (one per five participants/one for every participant), Sample of urine from Antenatal clinic, Evaluation worksheet on LMP and EDD: one per participant

Duration: Two hours

Activities

Step 1: The trainer explains that one of the tasks of ASHA is to know at a particular time who in her village is pregnant and who is likely to get pregnant (newly weds, couples with one child where the child is past two years of age). The way the ASHA will need to reach out to these women is through home visits, in particular visiting houses where a marriage has taken place recently, or visiting

families who have migrated into the village from outside. She should also ask families to inform her if an eligible woman gets pregnant, and emphasize early diagnosis.

Step 2: Discussion on importance of early diagnosis: Ask group to list the various ways in which women confirm pregnancy. List the methods on a chart as they call out.

Step 3: Demonstrating the use of the Nischay kit: For this part of the session a sample of urine from a pregnant woman should be made available. This can be brought from the ANC clinic in the nearby health facility, or from a pregnant woman in the community. It is important for the group to see a positive and negative pregnancy test. The trainer must emphasize the importance of maintaining confidentiality. The ASHA should read from Pages 21-22 of Part B, Section 1, of Module 6. Annexure 2 of Module 6 describes how to conduct the Nischay test.

Determining LMP and EDD

Once pregnancy is confirmed ASHA should be able to tell the woman what the EDD is Trainers should explain what LMP and EDD are. The trainer then demonstrates the circle aid to find out the EDD.

The trainer then gives each ASHA the worksheet below, and asks them to fill in the EDD, working individually.

The trainer then calls out the correct answers and has the ASHA score themselves.

Note: The trainer should clarify that if a woman has not had her period since her previous delivery, and she is pregnant again, the ASHA will not be able to determine the LMP or EDD.

Notes for the Trainer

ASHA may have been using Nischay kits already. If all ASHA are experienced in using the kit, the time for demonstration should be cut short- with the trainer conducting the demonstration.

The evaluation worksheet on LMP and EDD should be handed out to the participants at the end of this session. The correct responses are provided for the trainer.

Answer sheet for LMP EDD exercise

| LMP | EDD |
|------------------|-------------------|
| 11 July 2003 | 17 April 2004 |
| 1 December 2003 | 7 September 2004 |
| 27 October 2004 | 3 August 2005 |
| 1 July 2004 | 7 April 2005 |
| 7 November 2004 | 14 August 2005 |
| 14 June 2004 | 21 March 2005 |
| 30 November 2004 | 6 September 2005 |
| 23 March 2004 | 28 December 2004 |
| 2 February 2004 | 9 November 2004 |
| 26 January 2004 | 2 November 2004 |
| 15 August 2003 | 22 May 2004 |
| 20 January 2004 | 27 October 2004 |
| 4 May 2003 | 8 February 2004 |
| 3 April 2004 | 8 January 2005 |
| 29 February 2004 | 7 December 2004 |
| 1 January 2005 | 8 October 2005 |
| 30 April 2005 | 4 February 2006 |
| 31 March 2004 | 5 January 2005 |
| 4 September 2004 | 11 June 2005 |
| 15 December 2005 | 21 September 2006 |

Worksheet: Determining EDD

| LMP | EDD |
|------------------|-----|
| 11 July 2003 | |
| 1 December 2003 | |
| 27 October 2004 | |
| 1 July 2004 | |
| 7 November 2004 | |
| 14 June 2004 | |
| 30 November 2004 | |
| 23 March 2004 | |
| 2 February 2004 | |
| 26 January 2004 | |
| 15 August 2003 | |
| 20 January 2004 | |
| 4 May 2003 | |
| 3 April 2004 | |
| 29 February 2004 | |
| 1 January 2005 | |
| 30 April 2005 | |
| 31 March 2004 | |
| 4 September 2004 | |
| 15 December 2005 | |

Session 5b: Antenatal Care

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

- Understand the key components of Antenatal care
- Understand the importance of regular and complete Antenatal care check ups
- Understand key tasks for her to undertake to promote ANC
- Correctly state what high risk signs are and what complications can occur in pregnancy
- diagnose anemia and counsel pregnant women with anemia
- become familiar with the ANC section of the Mother and Child Protection Card.

Methods: Discussion, Role Play

Material: Mother and Child Protection Card: ANC part, Worksheet for anemia management

Duration: One hour and thirty minutes

Activities

Step 1: The trainer asks the participants what the schedule and components of ANC are, and list them on the blackboard. Then the ASHA are asked to read aloud, taking turns, Pages: 23 of Part B of Module 6,. They

are asked to identify any missing/ erroneous information is corrected. Trainer and group discuss where ANC is generally provided.

The trainer then asks the ASHA what are the likely high risk signs and complications that occur during pregnancy. ASHA are asked to read the section on pages 24-25 of Module 6

Step 3: The ASHA are then asked to read pages 28 and 29 in Module 6 - the section on Anemia. The trainer will tell the ASHA that the Haemoglobin (Hb) level of the pregnant women would be confirmed by the ANM. This information should be communicated to the ASHA or the ASHA should ensure that she knows the Hb level of the pregnant women. Then the trainer should distribute the worksheet (below) and ask ASHAs to fill in the advice for pregnant women in the three categories: normal, moderate, and severe.

Step 4: All ASHAs are given a copy of the Mother and Child Protection Card and asked to review the ANC section. The trainer lists each item and asks clarificatory questions to assess if ASHA are able to complete these.

Step 5: If communication cards are available, the ASHA can discuss how they will transact different situations with each of these cards.

Worksheet: Advising pregnant women based on Haemoglobin (Hb) levels

| Hb Level | Advice to be given |
|-----------|--------------------|
| 11.5 g/dl | |
| 7.5 g/dl | |
| 10 g/dl | |
| 6.0 g/dl | |
| 9.0 g/dl | |
| 4 g/dl | |
| 13 g/dl | |

Session 5c: Birth Preparedness for a safe delivery

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

- Be clear about how to plan for a safe delivery, and be able to match levels of health facilities with required level of care.
- Understand the terms: abortion, still birth and newborn death
- Become competent in completing the birth preparedness form

Methods: Demonstration, Role play, Practice session

Material: Birth Preparedness form: one per participant

Duration: Three hours

Activities

This session includes classroom discussion, and a field visit

Step 1: The trainer introduces the concept of birth preparedness, i.e.. As a method of planning in advance by the family for a safe and comfortable delivery,

Step 2: The trainer uses the content box in the Notes for the Trainer section to teach ASHA how to assess previous pregnancy outcome. Then the worksheet (given below) is used to score each individual participant. This exercise is important for ASHA to distinguish between abortions, still births, live births and newborn deaths.

Worksheet to determine pregnancy outcome

After each story, put an 'X' on the timeline showing when the baby died and write whether it was an abortion, stillbirth, or neonatal death.

Step 3: The trainer then asks the participants to read the section from Module 6, Part B, pages 30-33 on complications during pregnancy. Emphasize that they need to be clear on how to recognize each sign and action to be taken. The pictures in the module or posters and cards can be used. Call out each complication to ask how many in the group have even seen each of these? Ask which needed immediate referral and those that are to be referred but not on an emergency basis. What did they do then? Discuss what they would do now?

Step 4: The trainer hands out the birth preparedness form to the participants and explains each item in the form.

Step 5: The trainer asks each participant to read Pages 26-27 of Module 6 on birth preparedness.

Step 6: The trainer then divides the group into four. In each one participant is nominated as the ASHA, one as the pregnant woman and the remaining as family members. The groups are designated the following situations:

- Where pregnant woman has no complications?
- Where pregnant woman has had a complication (she had a

Caesarean section in the previous pregnancy)?

- Where pregnant woman has no complications and family reluctant to go to a PHC which is far away.
- Where there are no complications, but the pregnant woman is a single woman and wants the delivery to take place at home?

This is to be conducted as a role play and a birth preparedness form filled by each group. The trainer should ensure that the ASHA identify facilities by specific names rather

than just stating a category/level of facility, such as PHC, CHC or district hospital. This is also to be conducted when the ASHAs are taken for a field practice exercise in combination with filling in the Delivery Form.

Step 7: Planning for Safe Delivery: Revision exercise: The trainer then asks the group to list key areas that should be covered in planning for a safe delivery, based on what they have just learnt. Hint: starting from identifying pregnant women in the community, (The trainer uses the box on page 25, Part B, ASHA Module 6)

Evaluation

| Objective | Assessment Method | Output |
|---|-----------------------|--|
| Assessing skills in calculating LMP and EDD | Individual Worksheets | Trainers to collect worksheets, score and provide feedback |
| Assessing skills in counseling for anaemia, defining pregnancy and birth outcomes | Individual Worksheets | Trainers to collect worksheets, score and provide feedback |
| Able to fill in all parts of the Birth Preparedness forms | Individual forms | Trainers to collect forms and provide feedback |

Case

1. After 9 months of pregnancy, Meera delivered a baby girl who died after two weeks.

| Pregnancy starts | 6 months | 15 days Birth | 28 days |
|------------------|----------|---------------|---------|
| * | * | * | * |

2. Jeena got pregnant in June and lost the pregnancy in August.

| Pregnancy starts | 6 months | 15 days Birth | 28 days |
|------------------|----------|---------------|---------|
| * | * | * | * |

3. Geeta was pregnant for 7 months when she started labour pains. The baby was born but didn't breathe, cry or move its limbs.

| Pregnancy starts | 6 months | 15 days Birth | 28 days |
|------------------|----------|---------------|---------|
| * | * | * | * |

4. Neeta got pregnant but started bleeding at 6 months and lost the baby.

| Pregnancy starts | 6 months | 15 days Birth | 28 days |
|------------------|----------|---------------|---------|
| * | * | * | * |

Notes for the Trainer

Content Box to define pregnancy outcomes:

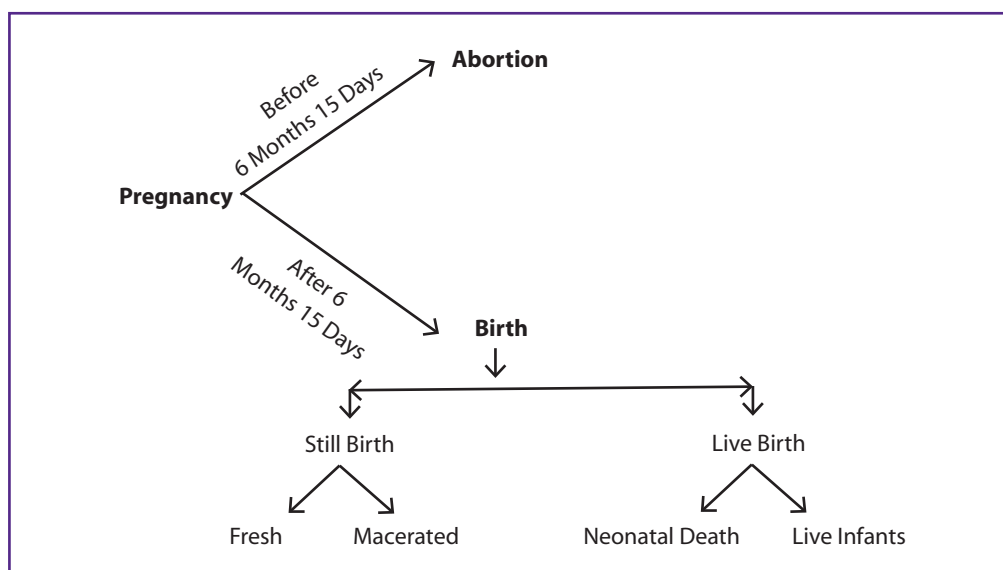
Gestation: Duration of pregnancy

Live Birth: Baby (born after more than 6 months and 15 days of gestation) shows any one of the signs of life¹ at birth (even if briefly): breathing, crying, or movement of limbs.

Abortion: If the foetus dies before 6 months and 15 days of gestation. An abortion can occur naturally (miscarriage) or it can be performed by a medical person (Medical Termination of Pregnancy; MTP). Sometimes unqualified people also perform abortions, which is dangerous.

Stillbirth: Baby (more than 6 months and 15 days gestation) is born without any sign of life¹ i.e., breathing, crying or movement of limbs; and hence, is dead at birth.

1. **Fresh Stillbirth:** Baby looks normal but is not alive. A fresh stillbirth means the baby died inside the mother's womb only recently.
2. **Macerated Stillbirth:** Baby does not look normal; skin is falling off and is decaying. In a macerated still birth, the baby was dead inside the mother's womb for some time.
 - ◆ **Neonatal Death:** If a baby (with a gestation more than 6 months and 15 days) who was born alive dies between birth and 28 days of life. Even if the baby only breathes once and then dies, it is still considered a neonatal death.
 - ◆ **Pregnancy occurs without resuming monthly bleeding (Inde):** A women becomes pregnant before she resumes her monthly bleeding after her last delivery.



Answers to Exercises to Determine Abortion, Stillbirth, and Neonatal Death

After each story, put an 'X' on the timeline showing when the baby died and write whether it was an abortion, stillbirth, or neonatal death.

Case

Neonatal death

1. After 9 months of pregnancy, Meera delivered a baby girl who died after two weeks.

| Pregnancy starts | 6 months | 15 days Birth | 28 days |
|------------------|----------|---------------|---------|
| * | * | * | X |

Abortion

2. Jeena got pregnant in June and lost the pregnancy in August.

| Pregnancy starts | 6 months | 15 days Birth | 28 days |
|------------------|----------|---------------|---------|
| * | X | * | * |

Stillbirth

3. Geeta was pregnant for 7 months when she started labour pains. The baby was born but didn't breathe, cry or move its limbs.

| Pregnancy starts | 6 months | 15 days Birth | 28 days |
|------------------|----------|---------------|---------|
| * | * | X | * |

Abortion

4. Neeta got pregnant but started bleeding at 6 months and lost the baby.

| Pregnancy starts | 6 months | 15 days Birth | 28 days |
|------------------|----------|---------------|---------|
| * | * | * | * |

The Role of the ASHA as a Birth Companion

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

- Understand her role as a birth companion
- Understand the processes of labour and delivery
- Identify emergencies that can occur during labour and delivery
- Be able to recognize and classify the various pregnancy outcomes
- Be able to identify complications and danger signs in the newborn.
- Learn how to provide immediate care of the newborn

Methods: Classroom discussion, using a case study, visit to a labour ward in the nearest health facility (optional).

Material: Photocopy of illustrations on pages 35, 36, 37 of ASHA-module 6 copies of Delivery forms, copies of case studies, (Handouts 1 and 2), Digital watch.

Duration: Five hours in two parts.

Activities

For Part 1

Step 1: The trainer explains that the ASHA is asked to escort the woman for delivery in the institution. Wherever possible it is also desirable that the

ASHA stays with the woman for the first day if not for the 48 hours. This role is called The Birth Companion Role. In some cases where the woman chooses to have the delivery at home, the ASHA may need to be present at the birth to assist the Skilled Birth Attendant. This is also a Birth Companion role. In both instances the ASHA should understand the processes of delivery, even though she should not conduct the actual delivery. She should also ensure that the woman gets the best possible care, and is treated well by the doctors, nurses and ANMs in the health facility.

Step 2: The trainer then asks the participants how many of them have observed a delivery taking place. They are asked to describe the various steps of labour. Then the trainer uses the Module 6: pages 34-37, and conducts a guided reading session using the illustrations.

Step 3: If possible, the ASHA are taken to a labour ward but care must be taken that only one or two ASHA are at any one labour table. The labour room should not be crowded up by all the participants. The privacy and dignity of the women who are having a delivery must be maintained and the ASHA should be allowed to observe only after her permission is obtained. If this does not take place

during the training, the ASHA are asked to observe a delivery while they are working and can be asked to report their experiences and findings in the next workshop round.

Step 4: The trainer needs to emphasize that certain complications occur during labour and delivery and need prompt attention and may require referral to a higher level hospital. Ask participants what they are: Answers should include: Excessive bleeding at any time, fits, long labour, and retained placenta.

Step 5: Discuss how what they have learnt can help. It can help taking a decision on the time available to reach a facility. It is useful knowledge to reassure the pregnant woman and her family about features of delivery that are normal, such as breaking of the waters,

It is useful for the ASHA herself to remain confident and provide the necessary support when the woman may be frightened or nervous.

If there is time and the discussion based on experiences has not been very active, or if they are new ASHA the Stories with Questions (in Section on Notes for the Trainer below) can be used.

Step 6: The trainer then distributes the delivery form, and asks the ASHAs to read out each line. Each ASHA is then given Handout 1. The trainer should ask one ASHA to read the case aloud, and each ASHA is independently asked to fill out the Delivery form (Parts 1-8).

Step 7: The trainer then reviews the responses and gives feedback to the participants.

Part 2: Activities

Step 8: The trainer then asks the ASHA to list the possible complications of the newborn immediately after birth. Responses can include: baby's hand or foot or shoulder comes first, rather than the head, baby does not breathe at birth, or has a weak cry.

Step 9: The trainer asks the participants to read pages 43-45 of Module 6. This describes the actions to be taken for the newborn immediately after delivery, (The schedule of home visits for the newborn is taught later). The trainer emphasizes that these actions are important for the survival and health of the newborn. In an institutional delivery the ANM, nurse and doctor are present to take care of the newborn, but even here in crowded situations, or where the staff are doing something else, the ASHA may need to do this, and therefore she needs to practice the skills of drying the baby, wrapping, and helping the mother to start breastfeeding immediately.

Step 10: The trainer explains the decision tree on page 45 of Module 6, and emphasize the importance of recognising and differentiating between a live birth and a still birth.

Step 11: The trainer then hands out copies of Handout 2, and asks the ASHA to complete the rest of the Delivery form.

Handout 1

Case Study to Enable ASHA to fill in the Delivery Form (Parts 1-8)

Shanthi is 20 years old and is pregnant with her second child.

She first started feeling labour pains early in the morning today, just at dawn. Today is September 11, 2010. You knew that her due date was September 14, so you were expecting this to happen. You had already helped her to make a birth preparedness form and the family had decided to go to Nagar PHC, where there is a doctor available night and day. The husband came

to get you at six am. You went with Shanthi and her husband to the Nagar PHC. It took you half an hour to reach. Just as you got to the labour ward the contractions got stronger and the water came out. The water was clear. The labour pains grew stronger and at 11:00 am the baby's head could be seen at the opening of Shanthi's vagina. The head came out first and then the rest of the baby. A baby girl was delivered at 11:30: 45. You dried the baby, wrapped her and put her to the mother's breast.

Handout 2

Case Study to Enable ASHA to fill in the Delivery Form (Parts 9-13)

Malini is a 20 year old, pregnant for the first time. You were called to her house yesterday evening at about 7:00 PM since she had begun having pains. You went with her to the Community Health Center. This had already been decided by her family. The bag of waters broke at about 01:00 hours. The colour was clear. The baby was born at 03:30:22 hours. The ANM was attending to

Malini. You observed the baby at 30 seconds. The baby had a weak cry. You then observed the baby at five minutes, 03:35:52 hours. The baby had a strong cry, the breathing was good and the baby was moving its limbs. You made sure that the baby was wiped dry, wrapped, and encouraged Malini to feed immediately. The placenta was delivered at 03:50 hours.

Evaluation

| Objective | Assessment Method | Output |
|---|-------------------|--|
| Able to correctly fill in all parts of the Delivery forms | Individual forms | Trainers to collect forms and provide feedback |

Notes for the Trainer

This session is long and needs to be conducted in two parts. It involves reading the Module, two case studies and filling in the Delivery form (parts 1-13). This form is in Annexure 4 of Module 6. The trainers should ensure that they provide feedback on the completed forms to each individual participant.

Story of Neetha

Neetha lived with her husband in a remote village. Her husband was poor farmer and they did not have much money or land. Neetha had one baby daughter. She did not want more children as it was hard managing even the one she already had. Yet, she became pregnant again. Neetha received one ANC where one injection and a few tablets were given to her. No other examination was done. She was also often exhausted, breathless and pale. One morning Neetha woke up and started having labour pains. She sent word for the ANM, but before the ANM could come, the waters broke and the husband rushed to call the local dai, who came and delivered a little girl. The baby was given gur-water, because the mother was considered too weak to feed the baby. After the delivery, Neetha started bleeding. When Neetha became cold, and continued to bleed, the TBA said

she could not do anything more to help and said that they should go to the hospital. It took about three hours for the family to find money and transport to take Neetha to hospital. By the time they reached the hospital, Neetha was unconscious, and soon afterwards, she died.

Story of Geetha

Geetha lived with her husband in a remote village. Geetha was pregnant. She was member of a self-help group. She had a little money and her husband owned a small plot of land. She used to meet didi (ANM/ASHA) and learnt about family planning from her. Geetha and her husband planned to have two children. Soon, Geetha became pregnant with her second baby. She went for regular ANC. During the ASHA's home visit, Geetha learnt about danger signs that could occur during pregnancy or delivery, or after delivery (postpartum or postnatal period) and how to plan to move to the hospital quickly. In the ANC the ASHA requested the ANM to get Geetha's blood checked for anaemia, since the ASHA was worried that Geetha had the signs of anemia. The ANM advised Geetha to take two tablets of IFA every day. The ASHA made a point of including Geetha's husband and mother-in-law in the discussion with Geetha on taking the IFA regularly, on the right foods to eat,

knowing possible danger signs and the need to get to the hospital quickly, should they occur. One day Geetha woke up with labour pains. Since she and the ASHA had already made a birth plan, Geetha's husband knew which jeep owner had to be called. The ASHA also accompanied Geetha to the PHC that they had selected. A healthy baby girl was delivered. But after the delivery, Geetha bleeding seemed to increase. The ANM and doctor were busy attending to other patients, but the ASHA recognised at once that this was a complication. She immediately called the doctor and put the baby to the breast. Geetha and her baby spent the night in the hospital under observation.

Story -telling and discussion

1. Tell the story of Neetha. Trainers must prepare before the session by reading the story, then tell the story to participants (try not to read it from the paper). After telling the story, the trainer ask the following questions. After telling the story asks the following questions:
 - ◆ Why did Neetha die? Ask for the cause of death as well as the social and economic factors. Listen to the answers and list them on the flip chart (immediate cause: she was bleeding excessively (Post Partum Haemorrhage), then got cold (a sign of shock, when the body is shutting down because of loss of blood. Shock is a sign that death will come soon if emergency medical care is not received

immediately). Social and economic factors: Neither the TBA nor Neetha recognised the risk, because there was no planning during pregnancy for emergencies, the family was not prepared and took too long to find money and transport etc.).

- ◆ Ask if any woman in their villages had this kind of problem? Listen to the stories and analyze them as was done with the previous example.
2. Trainer now tells another story, the story of Geetha. As with the previous story, trainer should prepare beforehand by becoming familiar with the story so they can tell it as a story and not simply read it

Ask

1. How did the ASHA help Geetha's family plan for the delivery? Listen to the answers and write on the flip chart. (The ASHA motivated her for ANC, identified anaemia, and alerted the ANM, helped Geetha and her family to plan the birth so was happy about it, Geetha prepared for emergency by saving money, was able to rush to the hospital in time, ASHA and Geetha recognised the bleeding as a danger sign, Geetha also is a member of the self-help group and has self -confidence, and a belief in being able to control her life).
2. Display both the lists from the stories of Neetha and Geetha. Ask the trainers what made difference? Why did Neetha die and how was it that Geetha

could be saved? Encourage the participants to discuss the differences between the stories. List main points on the flip chart (Main differences: recognition of danger signs, emergency readiness including saved funds for transport, family understanding need for referral, general differences, Geetha a member of self-help group, more

self-confidence, and wanting to take control of her life, etc.) Trainer should save these lists for use in the next session.

3. Has any woman in your village been saved due to timely help? Listen to the answers and analyse any stories.
4. Ask them what is necessary to save the life of pregnant women and child?

Home Visits for Care of the Newborn and Post Partum Mother

Session 7a: (Optional): Introductory Session

Aim

- To enable to share experiences to bring out the celebrations associated with the birth of a baby.
- To help them question attitudes related to son-preference.

Methods: Discussion, Singing

Materials: Nil

Duration: 45 minutes

Activities

Step 1: If possible, the trainers should get cassettes or CDs of traditional songs on celebrating birth of a child and play them during the activity. Initiate a discussion with participants on the ceremonies associated with the birth of a baby.

Step 2: Key questions: How is the birth of a baby celebrated in your community?, Are there any common customs followed throughout the State ? What are they?, In what way do family members participate? Is there any special ceremony for naming the baby? Are there any special gifts given to welcome the baby? Does the sex of a baby make a difference to the celebrations? Do you think the

preference for a son still exists in most families? Are there families you know where the birth of a baby girl was a cause for celebrations?

Step 3: The trainers should encourage participants to share their experiences, to bring out the diverse cultural practices and rituals related to baby's birth. Also the trainer should use the opportunity to get participants to share their own attitudes as well as the attitudes prevalent in the community towards issue of gender.

Step 4: At the end of the discussion, the trainer explains that most communities also have special songs that are sung to a newborn. Call for volunteers to sing such songs. (If the trainer has brought along a CD of traditional songs, you could play it before getting participants to sing.)

Step 5: After three or four songs have been sung, ask the group whether they would like to create a song to welcome a baby girl into this world. Encourage them to create such a song by modifying existing songs and/or adapting popular tunes. They could do this in the evenings and present it the next morning.

Step 6: This session is useful as a lighter way to start the sessions on newborn health - but it is not mandatory.

Session 7b: ASHA's Roles in Post Partum and Newborn Care

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

- Understand her role in newborn health and post partum care
- Understanding the schedule of visits needed
- Identify complications of the post partum period
- List the advice to be provided to the post partum mother

Methods: Discussion, Reading

Materials: NIL

Duration: Two hours

Activities

Step 1: The trainer initiates a discussion with the group on an ASHA's role in caring for the newborn and mother post-delivery. Key questions for discussion include: What are the different things that an ASHA should do to ensure the health of a new mother? What role does an ASHA play in caring for the newborn? What kind of support should an ASHA provide to help a new mother care for her baby? Do you think an ASHA's work can make a difference to the health of a new mother and her baby? -Do you think the level of skills proposed is adequate- or should it be more or less? Is there any risk that the ASHA would get blamed if things go wrong? Or is the problem that she would feel responsible, but the skills provided to her are inadequate. How does her role supplement roles of ANM, AWW etc.

Step 2: Encourage participants to come up with as many responses as possible. Conclude the activity by

telling participants that the quality of care given to a newborn and the mother can make a huge difference, and that an ASHA has a crucial role to play in such care-giving.

Step 3: Now tell participants that this session focuses on the activities that need to be done by ASHA so as to provide the right care at the right time, thus enabling them to ensure the health of mothers and newborns. The activities that the ASHA has to perform could be enumerated as follows:

- Observing and assisting during the immediate newborn period in case she is present at the time of delivery.
- Recording the time of birth and the birth outcome.
- Observing the baby during the first hour,
- Observing the baby during the first two days and during the first month to take care of the newborn,
- Support and help the mother to breastfeed,
- Support to the mother to keep the baby warm.
- Manage fever locally even while referral is organised.
- Identifying the pre-term and low birth weight baby and providing appropriate support as needed.
- Identify signs indicating a sick newborn for ensuring early referral or care where needed.

Explain that some of these skills have already been taught to the ASHA and the rest will be covered as the training progresses.

Step 4: The trainer then asks the ASHAs to read Page 38-40, Section 6, Part B of Module 6. The ASHA are then asked to list out the number of visits to be made for the newborn and those for the postpartum mother.

Session 7c: Key Skills for the ASHA to Learn While Making Home Visits for the Newborn

Aim: At the end of this session the ASHA will learn:

- Key task to be undertaken during the first hour
- First examination of the newborn
- The skills and importance of handwashing
- Skills required to measure temperature of the newborn
- Skill to use hand held scale to weigh newborns, correct to the nearest 50 gms (Or as per the scale in use).
- Skills to see whether the breathing of the child is normal and to identify if the newborn that has in-drawing of chest.

The trainer should ask the ASHA to read pages 46-49 before beginning the session.

Learning the Skill of Hand-Washing

Methods: Demonstration, Discussion and Practice.

Material: Photocopies of Annexure 7: Hand Washing check list, Soap and a bowl of water, bucket and mug.

Duration: 30 minutes

Activities

Step 1: This activity must also be conducted on-site, but in the classroom it is conducted as a

demonstration. Call for a volunteer. Give her a copy of the checklist and ask her to read it aloud.

Step 2: As she reads out each step, demonstrate exactly what is to be done. Then get the group to share their thoughts on what they have just observed- using the following questions: Ask them to state when to wash hands ? Write it on black board under the heading - When?

- Anytime before touching a new borne or young baby for example during your home visit.
- After using the toilet or cleaning; up after the baby's toilet.
- Before preparing food. Before feeding the child.

Step 3: The trainer asks what are the other cleanliness habits that ASHAs must observe: The box in the Notes for the Trainer identifies these. The trainer should read these aloud and discuss with the group.

Step 4: Then the group can proceed in pairs to the wash basins or a row of taps and one ASHA practices it once under observation, while another uses the check list to monitor her. If there is no tub with water and no assistance, pour water into the bowl. Clean hands in it and then lift up to drying position.

Notes for the Trainer

Handwashing

- Newborn babies are particularly prone to infections, as their immunity is low.
- It is therefore necessary to take special care before touching or

carrying a newborn. And in order to ensure that one's hands are absolutely clean, it is important to wash one's hands the right way. Germs that cause disease are invisible to the eye. A hand may appear clean, and may even have been washed recently, but that is not enough to remove germs.

- Therefore, apart from doing it right herself, an ASHA should also make the family members aware of the need to wash their hands properly before holding the baby. She should clearly communicate to them the need to wash hands with soap, especially after cleaning the baby, changing nappies, or using the toilet themselves.

ASHA Cleanliness Habit

When you are leaving your home for visiting the newborn, make yourself clean and tidy.

Does not visit newborn if you are ill (Cough, cold, fever, diarrhoea, or skin infection).

Cover your mouth if you have to cough or sneeze Cold germs are carried by droplets from our nose and mouth (When we sneeze or cough) and they travel in the air or are passed through our hand.

Always wash hands after using the toilet before preparing food, and before touching a newborn or young baby.

Wash hand more frequently if you have a mild cough or cold, especially after blowing the nose.

Do not touch the ground, floor or dirty objects after washing hands.

Skill 1: Hand Washing

Learning the Skill of Measuring the Temperature of the Newborn

Method: Presentation, Demonstration,

Materials: Digital Fahrenheit/Centigrade thermometers, Skills Checklist-Measuring Temperature: Annexure 8 in Module 6, Mannequin/Doll

Duration: 1 hour

Activities

Step 1: The trainer explains why it is necessary to measure the temperature. Just touching the baby is too unreliable a method to assess the temperature. Explain that a baby's temperature should be taken soon after birth to see whether it is normal or whether the baby is cold. A cold baby needs to be re-warmed at once. Learning to measure temperature is also a useful skill in order to determine whether a baby has fever.

Step 2: The trainer asks the ASHAs if they are familiar with the two different temperature scales: Fahrenheit and Centigrade. Listen to their answers. Which one are they familiar with? Tell them that in this curriculum, they will be using the Fahrenheit scale. Discuss.

1. Explain the Fahrenheit scale: 32 F (0 C) = ice (freezing), 212 F (100 C) boiling water, 98.6 F (37 C)=

human body (newborns)

2. Draw the thermometer scale on the blackboard from 96 F (35.6 C) - 104 F (40 C) with 9 marks between each number to denote 1/10 of a degree. (See content box)
3. Explain the range of thermometer, usually 91 F (32.08 C) - 105 F (40.6 C)
4. Ask if anyone can tell at what temperature a person has fever?

Step 3: The trainer distributes the thermometer. 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, which is placed in the armpit (axilla and NOT in the mouth or rectum) and also the display.

Step 4: The Trainer asks ASHAs to refer to the Skills Checklist: Measuring Temperature, Annexure 8 module 1

Step 5: The trainer reads each of the checklist steps out loud, and ensures that the trainees are following along in their copy.

Mention that the battery in the thermometer should last three years. If they see this in the display window on the top of the thermometer it means that the battery is dead and needs to be replaced. They should inform the supervisor. If you use another type of thermometer, show the ASHAs how to check if the battery is dead. Explain each step in the check list and answer questions, if any.

Step 6: The trainer asks for a volunteer. It is preferable if a baby or younger child is available for a demonstration. The temperature is taken with the ASHAs reading the step out loud as each step is performed. Have trainees follow the checklist along with you. In summers, the thermometer taken the atmospheric temperature and may show 99 C + temperature in the afternoons when pink button is pressed. To see the three lines in the display window, place the tip in cold water. In winter the thermometer may fail to record any temperature then it may be necessary to rub the tip gently.

Step 7: The trainer then divides the group in pairs. Have trainees take each other's temperature, using the checklist as a guide. Have trainees change partners and continue practicing. Have trainee later take temperature on babies or young

children in the community. Have each trainee record temperature at least on five individuals and let the peers record the correctness of steps in annexure 8. Move around to each pair/small group checking & assisting whenever needed. Let the practice continue till all steps are performed correctly by all the ASHAs.

Step 8: In the end, trainer evaluates the skill by recording all steps as they are performed by each ASHA on the worksheet and is scored by giving 1 point for each correct step. Trainer saves these checklists as output of the session.

Step 9: Conclude the activity by saying that if a newborn baby's temperature falls below 97 degree F (36.1 degree F), then the baby is cold and needs to be warmed; if it falls below 95 F (35°C), then the baby is too cold and needs immediate attention.

Notes for the Trainer

Fahrenheit Scale

96.....98.....98.....99.....100.....101.....102....
.....103.....104.....

- Each dot represents 1/10th of a degree.
- 97.0 F (36.1 C) to 98.6 F (37.0 C) is considered 'normal'.
- Temperature above 99.0 F (37.2 C) (newborns/children) and 100 F (37.08 C) in adults is considered 'fever' for the purpose of treatment.
- The digital thermometer will display the temperature in the window e.g., 98.2 or 101.8 etc.

Skill checklist: Measuring Temperature

Take the thermometer out of its storage case, hold at board end and clean the shining tip of the thermometer with a cotton ball soaked in spirit.

Press the pink button once to turn the thermometer on. YOU WILL SEE “188.8’ flash in the centre of the display window. For 3 seconds, the thermometer will show the last temperature taken and then three dashes like this--- and a flashing ‘F’ in then upper right corner.

Place thermometer upward and place the shining tip in centre of the armpit. Please arm against it. Do not change the position.

You will hear the beep sound every 4 seconds while the thermometer is measuring the temperature. It usually takes 4 minutes for the thermometer to reach the body temperature. When you hear 3 short beeps, look at the display. If “F” is flashing and numbers are changing, leave the thermometer in place. When “F” stop flashing and the numbers stop changing, remove the thermometer.

Read the number in the display window.

On the form, record the temperature reading.

Turn the thermometer off by pushing the pink button once. Clean the shining tip of the thermometer with a cotton ball soaked in spirit (alcohol).

Place thermometer back in its storage case

Skill 2: Weighing the Newborn

Learning the Skills to Weigh the Newborn

Materials: Weighing scales, Copy of the Skill Checklist in Annexure 9, Mannequin OR a hot water bottle that can hold two litres of water. This often comes with a cover and is useful where a mannequin is not available. It could be weighed a bit more with small stones in the cover One could alter weight of “baby” by pressing out water. Alternatively a doll or even small stones can be used.

Activities

Step 1: The Trainer discusses the importance of birth weight and subsequent weight gain during the neonatal period. A growing baby is a healthy baby. Lower birth weight babies are more at risk.

Step 2: The trainer shows the weighing scale to the trainees and points out its different parts: top bar, adjustment knob, and gradation, hook sling, and explains the range of the scale (Starts at 0 gm and weighs up to 5 kg, with 50 gm gradations) Draw the scale on the blackboard or white paper/flip chart paper. The scale is also colour -coded; up to 2 kg is red (to indicate very low birth weight and high risk), 2 kg -2.5 kg is yellow (to indicate less risk, but still LBW) and above 2.5 kg is green (to indicate a good birth weight).

Step 3: The trainer distributes the scales to each ASHA and lets them name and identify the parts and examine the scale. Ask if any one has any questions, and answer them accordingly.

Step 4: The trainer asks ASHAs to refer to the Skill Checklist in Annexure 9: Weighing the Baby, given to all trainees., and asks them to read each step out loud while she/he demonstrates how to use the scale;. Use a hot water bottle or a doll, suitably weighted as the baby. Later if possible one could demonstrate with a baby also. Have trainees follow along using their checklist as a guide. Check if there are any questions.

Step 5: The trainer divides the trainees into pairs. Have each ASHA practice weighing dolls (or books or stones) while the partner follows along with the Checklist and records on the Worksheet skills Checklist: Weighing the Baby. Keep moving constantly in the room and assist wherever needed. Only after the ASHAs have weighed the doll (or other suitable weight) accurately at least five times, they should be asked to weigh a baby in the community - and that too not to weigh a baby more than once. (If one is available and family consents).

Step 6: Explain that babies need to be weighed soon after birth, definitely within two days. This is important because babies whose birth weight is low need special care.

Evaluation

| Objective | Assessment Method | Output |
|---|--|--|
| Explain the importance of weighing the baby for monitoring health | Question/Answers | _____ |
| Can use a hand- held scale to weigh newborns to the nearest 50 grams. | Each trainee demonstrates how to weigh a baby correctly. | Record the performance of ASHAs on the Worksheet 2 and score. The sheet are saved as output of the session |

Skills Checklist: Weighing The Baby

1. Place the sling on scale hook.
2. Hold scale by bar off the floor, keeping the adjustment knob at eye level.
3. Turn the screw until its top fully covers the red and “0” is visible.
4. Remove sling from 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,

Conclude this part of the activity by explaining that the weighing scale also indicates the kind of care the baby needs. If the weight is in the green zone (2.5 kg or more), then she is of normal weight and needs normal care; if the baby is in the yellow zone

(weighing less than 2.5 kg but more than 1.8 kg), then she needs extra care but can be managed at home; if the baby is in the red zone (weighing 1.8 kg or less), then she needs to be referred to the health centre for special care.

Skill 3: Evaluate Newborn's Breathing

Learning the Skill to Evaluate the Newborn's Breathing

Materials

- Video clipping showing ARI- with chest in-drawing
- Worksheet

Methods: Video case study

Duration: 30 minutes

Instructions to trainers/activities

Presentation

- The trainer explains why it is necessary to assess the breathing of the newborn. There are two aspects to assess- the rate of breathing and any sign of chest in-drawing or other abnormal pattern of breathing. Chest in-drawing is a sign of respiratory distress.
- The trainer shows the ARI video film if available, to show that chest in-drawing is respiratory distress and explain what the method of identifying this is.
- The trainer explains **Chest in-drawing:** Look at the infant's chest as it breathes in. The baby has chest in-drawing if the lower chest wall goes in when the baby breathes in. (Show the drawing) chest in-drawing occurs when the effort to breathe in is much greater than normal. Slight in-drawing of skin below the ribs is not chest in-drawing. The whole of lower chest should move in.
- The trainer runs the video film for a while and show the ASHAs the clippings of a few more babies- labelled it as case 1, case 2 case 3. Case 4, and case 5. Pause the film after each clipping. Give time to ASHAs to write yes/no on the worksheet. Yes if there is chest in-drawing. No if there is not.
- After all cases are screened, ask ASHAs to exchange their Worksheet Review the answers one by one. Each ASHA checked whether the identification of chest in-drawing mention in the worksheet is right or wrong. Give two points each for a correct answer. Collect all the worksheet as output of the session. If there are any doubts screen the film again and clarify them.

Evaluation of the session (during class time: additional 5 minutes if needed)

| Objective | Assessment method | Output |
|---------------------------|--|---|
| Identify chest in drawing | Identify chest in drawing in 5 babies in the screened film | Worksheet of all ASHA Checked and scored by the peers |

Worksheet: Identifying Chest Indrawing

| Sr.No | | Chest indrawing present |
|-------|--------|-------------------------|
| 1 | Baby 1 | Yes/No |
| 2 | Baby 2 | Yes/No |
| 3 | Baby 3 | Yes/No |
| 4 | Baby 4 | Yes/No |
| 5 | Baby 5 | Yes/No |

Session 7 d: First Examination of the Newborn: Form Part I

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

- Determine if the baby is pre term.
- Complete the First Examination of Newborn Form
- Complete the Home visit of Newborn Form

Materials

- Annexure 5 & 6
- Handout 1 and 2
- Ensure availability of adequate copies of Worksheet 1, Worksheet 2.

Time Required: 1 hour 30 minutes

Training Methods

Step 1: The trainer explains that this is only a rehearsal before they repeat this entire process in a home situation or in a facility with a newborn. A few case- studies are given in the handout. Using this as cases, take the trainees through the form in annexure 5, asking them to fill the following questions:

- First question. They need to write the date of birth of the baby.
- Question. 2. Here they need to write pre term cut -off date. In practice they would take this information from the delivery form. Here they derive it from the date of LMP that is given in the case study. If the date of birth is either the pre term cut -off date or before the pre term cut-off date, then the baby is pre term. Then circle 'Yes'. If baby is not pre term, circle 'No'.

- In the next question (3) they need to write, in the spaces provided, the date of the exam, when it was conducted - early morning/morning/afternoon/evening/night, and time of the exam in hours. The date of the first examination of baby may be different from the date of birth either if the mother delivers in hospital or returns to the village after a day or two, or when she does not deliver in the village & returns only afterwards. You would notice how this information differs in each of the case studies.
- Go through questions 4-7. (See content box)

Step 2: The trainer asks the ASHA what is the first feed usually given to babies in their community. If the answer is not breast milk, ask why other liquid or food is given. Discuss the answers. Ask if they had breast fed their own children. Discuss their experiences.

Step 3: The trainer reminds ASHAs that in these first months of training, they will only observe and examine the baby. Later in the training, they will be required to take a more active role in teaching & helping mothers to feed and take care of their newborns.

Step 4: The trainer then has the ASHAs exchange the filled Forms. Each ASHA checks the Form of another ASHA based on the discussion and review of answers. Each ASHA scores one point for each correct answer. Problems if any, should be clarified.

Step 5: The trainer asks the trainees to look at the form in annexure 6. Go through each item in this section (questions 1-7). See Handout 2. The trainer asks if any trainee has experience of having observed oozing eyes, a cleft lip, a baby with a limp arm or leg, etc. Discuss what to look for and how to mark the appropriate answer.

Step 6: This same process should be repeated in the community. Let each participant fill at least one form with a mother and baby who delivered in an institution, and if possible another with a mother and baby delivered at home- within the last one month. If for reasons of logistics or lack of contacts they are unable to meet so many newborns in the community they could do the first form in the health care facility as well.

Evaluation of the session

| Objective | Assessment Method | Output |
|--|---|--|
| Determine if baby is pre term | Question and Answers | Part I,II of the First examination of Newborn: Form Filled by each ASHA and corrected and scored by peers. |
| Determining mother's complaints | Question and Answers | |
| Complete part I of the First Examination of Newborn: Form (questions 1 to 7) | Each trainee to fill in the First Examination of the newborn: Form-part I correctly, based on the case presentation | |

Handout 1

Case Studies

1. Anjana gave birth to a baby girl born on April 20th at 8:10 PM at home. Her LMP was 20 July. This baby's EDD was 26 April and pre term cut-off date was 3 April.
 - a. The ASHA performed the first examination of the baby at 9:15 PM.
 - b. Anjana had no complaints. She had no fits. Her BP was normal. There was no excess bleeding.
 - c. The baby was put to the breast right away at 8:30, and nothing else was given to the baby.
 - d. The baby suckled strongly.
 - e. The weight of the baby is 3.0 kg.
 - f. The temperature recorded showed normal.
 - g. The umbilical cord was tied and not bleeding.
 - h. Its eyes are clear.
2. Shanti gave birth to a baby girl on February 1, 2010 at 1.00 PM in the afternoon at home.
 - ◆ Her last menstrual period could not be ascertained because she got pregnant while breastfeeding her little boy.
 - ◆ You are doing the first exam on February 1 at 2 p.m.
 - ◆ Shanti did not lose consciousness or have fits, and her bleeding, she says, is normal.
 - ◆ The baby was put to the breast at 1.20 PM
 - ◆ No other fluids were given.
 - ◆ The baby was feeding well, without any problem.
 - ◆ The baby's temperature was 98° F (36.7° C)
 - ◆ Her eyes were clear
 - ◆ Her nipples were slightly swollen
 - ◆ The umbilical cord was tied correctly and is not bleeding
 - ◆ She weighs 2 kg 900 Gms.
3. Banu gave birth to a baby boy on 15th August; 2010. Baby was born in the CHC. There had been some complications at delivery but did not require surgery or blood transfusion.
 - ◆ Her LMP was 7th November 2009.
 - ◆ You are doing the first examination on 21st August.
 - ◆ The baby is breastfeeding - some sugar water has also been given.
 - ◆ Baby's temperature is 99° F
 - ◆ Eyes are clear. Umbilical cord stump looks normal.
 - ◆ Weight is 2 kg.
4. Sukhee gave birth to a baby boy on 5th September, 2010. Baby was born in the health sub-center and ASHA visited her there within an hour of the birth.
 - ◆ Her LMP was 15th August 2009
 - ◆ The birth weight is 1.8 kg.
 - ◆ The baby is suckling - but weak.

- ◆ Baby's temperature is 97°F.
 - ◆ Baby's eyes are clear.
 - ◆ Umbilical stump is normal.
5. Anusuya gave birth to a baby girl on March 8th, 2010 at 10.00 PM in a private clinic. Baby and mother returned home next morning and ASHA met them at 7.00 am.
- a. The mother's EDD was March 1st 2010.
 - b. The birth weight was 3.5 kg.
 - c. The baby is not yet put to the breast and mother says that there is no milk; hence cow's milk with sugar has been given.
 - d. The baby's temperature is 98.8°F
 - e. Doubtful swelling and watery ooze from the eye is there.

Note: Conditions that are not mentioned in the case should be considered to be normal while filling the form.

Handout 2

Question: First feed: Write down the first thing the baby has to drink/lick. This may be breast milk but some people give jaggery water, honey, cow's milk, etc

Question: Time of First breastfeed: write down the time of the first breastfeed. This may be the same as the first feed above.

Question: How did the baby take the breastfeed: circle the appropriate option depending on the following?

If the baby's mouth is open wide, the lower lip is turned outwards, it is taking slow deep sucks with some pauses, and you can see or hear it swallowing, the baby is feeding well (forcefully).

Observe if the baby is feeding weakly, can not breast feed & has to be fed with a spoon; or can neither breastfeed nor is able to take milk given by a spoon, encircle the appropriate Option.

Question: Does the mother have breastfeeding problem See if mother is able to breast feed the baby on first day after delivery, if mother has any problem write the nature of the problem. Eg. Inverted nipples, problem of attachment, problem of position etc. If any such problem is observed help the mother to overcome it. Assist mother in

proper attachment and positioning. If mother has inverted nipple which did not protrude after delivery help the mother to massage and bring out nipple.

Guidance to fill form: First Examination of the Baby

1. Body temperature of baby: Record the baby's temperature in the space provided. (If necessary review the session 'How to measure the newborn temperature')
2. Eyes: normal, swelling or pus oozing out: Look at the baby's eyes. Oozing means if something is coming out of the eyes: water will be clear; pus 'will not be clear, but white or yellowish. Circle the appropriate finding.
3. Is umbilical cord bleeding: There should be no oozing of blood? Circle 'yes' if cord is bleeding. If no then circle 'No; If cord is bleeding ASHA should get it tied by a skilled birth attendant. If such is not available then try for at least a trained dai. If even this is not available then the ASHA should herself tie the cord again.
4. Weight: write down weight to nearest 50 grams, or as per the accuracy level of the weighing scale in use(If necessary review the session 'How to weigh newborns;') also circle the colour

seen on scale; red, yellow or green.

5. Record: observe and record if the limbs of the baby are limp, feeding is less or has stopped, and whether the cry is weak or has stopped

Note: If ASHA is conducting this examination on the 1st day, she should fill this information based on her observations. IF she is conducting the first examination on any other day, she should fill this information after checking with the mother.

Routine newborn care: wrap the baby in a piece of clean and dry cloth, keep the baby warm, do not give bath, keep the baby close to mother and initiate breastfeeding. Write on the form whether these actions were performed

1. Anything unusual, new or different: here you can record anything you find unusual if it is a cleft lip or curved limbs, circle the option if you observe anything else, describe it in the space provided.

Subsequent Visits

Is the baby crying incessantly or passing urine less than 6 times a day: Ask the mother about the cry of her bay. If the baby is crying incessantly or if it is passing urine less than 6 times a day, ask mother to feed the baby more frequently, once every two hours.

Are the eyes swollen or filled with pus: Note any swelling or discharge from eyes. Pus appears thick, ‘the muco purulent ‘ discharge is thinner (see the photograph). If ‘yes’ ask mother to apply tetracycline ointment into baby’s eyes twice a day for 5 days. You will learn how to apply tetracycline later in this workshop.

Weight: Weigh the baby on day 3rd, 7th, 14th, 21st, 28th and record the weight in the space provided.

Temperature (axillary): Measure temperature and write it down. Remember what is normal temperature for newborn. (Session - ‘How to measure the newborn temperature’).

Skin: Pus filled pustules?: If baby has pus filled pustules on the skin treat with gentian violet and observe for signs of sepsis.

Cracks or redness in skin fold: rash on skin on any part of the body is usually harmless. The skin cracking or redness between skin fold (thigh/. Axilla/buttocks) can be prevented by keeping baby clean and dry and using talcum powder. If it persists treat with G.V. paint.

Yellowness in eyes or skin(Jaundice): Show the photograph of normal baby and baby with jaundice. If the baby has jaundice the skin appears yellow. If jaundice is present on 1st day or beyond 14th day then it is abnormal jaundice. Refer baby to hospital.

Signs of sepsis: When the baby gets serious infection in its blood, chest, or brain it is called sepsis. This is a serious illness and can cause death. Hence, it is important to carefully observe every baby for any signs suggestive of sepsis. An early recognition of sepsis can save baby's life. You can learn to recognise sepsis by observing and recording following signs in every newborn. You will record these findings on the Home Visits Form- Signs of Sepsis.

If a particular sign is present on the day of visit mark a (✓) in the column and if it is not present mark a (X). (The column of day 1 should be copied from the First Examination of the New born: Form Part II question 5)

1. **All limbs limp:** See how the limbs of the baby are. See the photograph for reference. If on a day of visit all the limbs are limp mark a (✓) in the column.
2. **Feeding less/stopped:** Ask mother about the feeding of baby and observe. If it is less or has stopped mark (✓) in the column. If the baby has less number of feeds than usual then it is considered less. If baby does not take any feed for more than 8 hours then it is called 'stopped feeding'.
3. **Cry weak/stopped:** See how is the cry. If baby is sleeping, flick the sole and observe the cry. On flicking sole baby wakes up and cries. If baby does not cry or cries weakly even on flicking the sole then mark (✓) in the column.

4. **Distended abdomen or mother says baby vomits often:**

Abdomen: A normal abdomen (or tummy) is soft to the touch, a bloated abdomen is excessively bulging and is tight (see photograph)

Baby vomits: Normally babies throw up some milk. If baby vomits (not just a spit-but most or all of the feed) after each feed for the last three (3) feeds then it is called vomiting. There are two options (distended abdomen or baby vomits) given in point 4 in the form. Even if one of them is present, mark (✓) in the column.

5. **Mother says baby is cold to touch or the baby's temperature is more than 99°F (37.2°C):**
Ask the mother if baby's body is cold to touch. If mother feels that baby's body is colder then mark (✓). Similarly, on measuring baby's temperature if it is more than 99.0°F(37.2°C) then mark (✓) in the column. Presence of any one of these two situation (mother says baby is cold to touch or baby has fever) then mark a (✓).
6. **Chest indrawing:** Open the shirt and observe the chest ; mark an ✓if chest indrawing is present. Chest indrawing is when the lower part of the baby's chest is sucked in deeply when the baby breathes in. Show the photograph and the video. Sometimes when the normal baby breathes in forcefully, the skin between the ribs in sucked in: this is NOT chest indrawing.

7. **Pus on umbilicus:** Note if any pus is formed on the umbilicus. At this stage, observe and examine baby carefully and fill the form correctly. Practice till you learn management of sick babies, later on in the training.

Examination of Mother

Temperature: Measure and record: Measure temperature of mother and write it down. ASHA has already learnt to treat fever with paracetamol, If mother has fever upto 102°F (38.9°C), send her to the hospital.

Foul smelling discharge and fever more than 100°F (37.8°C): Ask mother if she has dirty, smelly discharge on pad. This might be due to infection. If mother says 'yes' and she has fever more than 100 (37.8°C) send her to hospital.

Is the mother speaking abnormally or having fits?:

See if the mother is speaking abnormally. See if she has fits or if the family members report that she has fits. Circle the appropriate answer on the form and refer mother to hospital.

Mother has no milk since delivery or if mother perceives breast milk to be less:

Check whether mother has no milk since delivery or she feels that she has less milk and circle appropriate answer.

Cracked nipples, painful and/or engorged breasts:

See if mother has cracked nipple, painful or engorged breast. Encircle appropriate answer. In the next workshop ASHA will learn about breastfeeding and thereafter she can help mother in managing breastfeeding problems.

Session 7e: Care of the eyes, Umbilical Cord and Skin

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

- Demonstrate through simulation, how to put tetracycline ointment into the eyes of newborns.
- Apply gentian violet (G.V. paint) to the stump of the newborn's umbilical cord if there is pus on umbilicus.
- Explain how to prevent and care for cracks or redness in the skinfold (thigh/axilla/buttock).

Materials: Tetracycline eye ointment (3-4 tubes for practice). Each ASHA should have one for field use, Gentian violet paint (1⁺ strength), Cotton, Doll or baby, Reading Material 1: Skill Checklist of applying Eye Ointment

Methods: Presentation and demonstration

Duration: 1 hour

Eye care Activities

1. Explain that to prevent infection in the baby's eyes (which could if during pregnancy the mother had some vaginal infection, even without symptoms). ASHAs will be treating newborns with Tetracycline eye ointment at the first examination after birth (1 hour). Usually once is enough. If the baby's eyes are swollen or oozing with pus, tetracycline needs to be applied two times a day for 5 days. Give the tube to the mother and ask her to apply tetracycline in both the eyes of the baby.

2. In most situations ASHA would not have any eye ointment or drops with her. In which case she has to ask the mother for the baby to be taken to the hospital.
3. Ask ASHAs to refer to Handout 1: Eye Care- skill checklist Applying eye ointment. Review the steps with ASHAs.
4. Inform ASHAs that when tetracycline is applied in the eyes of the baby, they must document this on the First Examination of the Newborn Form as well as on the Home visit Form.
5. Demonstrate how to apply tetracycline on a doll using the checklist. **Practice: applying antibiotic ointment**

Activities

6. Divide trainees into groups of two.
7. Distribute the tetracycline ointment tube to each group.
8. Have one trainee practice the steps, while the other reads out each step.
9. Circulate in the room and assist. Clarify any doubts
10. Trainers should observe the skill of ASHAs in applying eye ointment with the help of checklist and record correctness of the steps.
11. Check if there are any questions and clarify doubts.

Umbilical cord care Activities

1. Ask trainees to review how the umbilical cord should be cut to prevent infection. Listen to the answers.
2. Ask the trainees if anything is applied on the umbilical cord

at the time of delivery. Listen to their answers. If the answers indicate the use of dung or ash, explain that these things are very dangerous and should never be used.

3. Ask how to care for the cord. Listen to their answers. (The cord should be kept clean and dry. It is not necessary to cover the cord.)
4. Remember, the most important thing is to keep the cord stump clean and dry. Nothing else should be put on the cord stump. Explain that if there appears pus on the umbilicus, A baby with pus on the umbilicus should be taken for referral. However if the health facility is far away, and the parents are unwilling to go, Gentian violet (G.V.Paint) on the cord can be applied in the morning and evening.. Clean the cord stump with a clean swab. A small amount of G.V. Paint can be put on the cord with clean gauze or swab soaked in gentian violet. Allow it to dry, because if wet, it will stain clothes. It is best not to cover the cord;

let just the baby’s loose shirt cover it.

5. Ask the trainees if they have ever seen a baby with a skin rash in the groin or thighs, generally called skin rash.
6. Ask them to explain what it looks like. (Response should include: redness or cracking of the skin in the creases of the thighs, buttocks, armpits.)
7. Ask the trainees if they know how this can be prevented. Listen to the answers and note them on the board. (Answer may include: keep the baby clean and dry; if the baby urinates, clean with water and dry with a clean cloth).
8. Ask the trainees if they know how a rash should be treated. Listen to the answers; praise correct answers, and make sure all trainees know the treatment. *(Keep the skin and dry; if the weather is not too cold, expose rash to the air for some minutes during the day, If it does not improve, use G.V. paint (gentian violet); apply twice day until there is improvement.)*

Evaluation (during session and summary)

| Objective | Assessment method | Output |
|--|---|--|
| Demonstrate through simulation how to apply tetracycline ointment in a newborn’s eyes. | Simulation with doll. Each trainee correctly demonstrates how to put tetracycline ointment in the newborn’s eyes. | Observation of the trainers with the help of checklist while ASHAs performed the skill |
| Explain how to put gentian violet paint on the umbilical cord, if there is pus on umbilicus | Questions and answers | -- |
| Explain how to prevent and care for cracks or redness in the skinfold (thigh/axilla/buttock) | Questions and answers | |

Handout 1

Skill Checklist of Applying Eye Ointment: How to put Antibiotic Ointment in the Baby's Eyes

1. Gently pull the baby's lower eyelid down
 2. Squeeze a thin line of ointment moving from the inside corner to the outside of the eye.
 3. Do not touch the baby's eye with the tip of the tube. (The tube will be used for other babies and it shouldn't get contaminated)
- Put the eye ointment in both eyes at the time of the first examination of baby. (1 hour)
- Usually once is enough. If the eyes are swollen or filled with pus then put the ointment two times a day for 5 days.

Breast Feeding

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

1. Identify the major parts of the breast.
2. Explain in simple terms how the baby suckling at the breast affects milk production.
3. Explain the most likely problem if a woman says she doesn't have enough milk.
4. Demonstrate how the ASHA should discuss early initiation of breastfeeding with a mother and her family
5. Demonstrate how the ASHA should help a mother breastfeed for the first time.
6. Demonstrate how to effectively counsel mothers on breastfeeding:

Materials: Poster drawing of unlabeled picture of breast, Handout 1-labeled picture.

Methods: Presentation, Role play, and small group discussion:

Duration: Two hours

Activities

Step 1: Divide the participants into small groups. Draw the breast and its structure. (Handout 1- Labeled diagram of the breast).

The poster should not be labeled. Explain the parts of the breast. Have the trainees call out and label the nipple, areola, milk reservoir (also called sinus), milk duct, gland tissue, and supporting tissue.

Step 2: Ask the groups why is breastfeeding important- and why should a mother breastfeed exclusively for six months. List out the reasons on the black board and add in any that they miss.

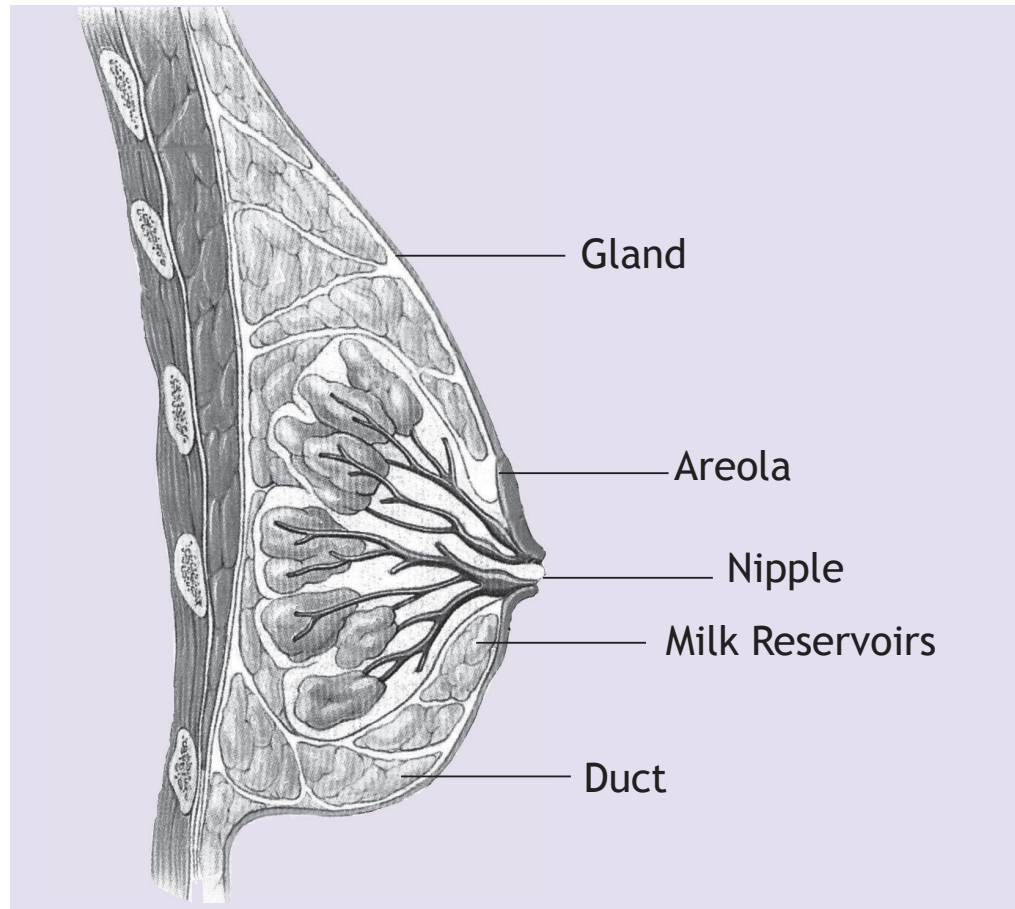
Step 3: Ask ASHAs- what is the most common reason for mother not having enough milk- emphasize that it is the effort and stimulus of suckling that is most important. See Notes for Trainers below for some more points.

Step 4: Ask the groups to read pages 50 to 52 from Module 6.

Step 5: Then ask ASHAs to consider what they would do in a home visit. They could ask about breastfeeding and praise the mother for the baby and her taking care of it. Then they could observe the baby being breastfeed, speaking words of encouragement. Look at page 52 for what to observe and the tips for counseling.

Handout 1

Labeled Diagram of Breast



Step 6: What should be the frequency of breast-feeding, and what is the correct position? Look at the answers to this given in page 50-51.

Step 7: Now the trainer conducts a role play to demonstrate correct counseling technique for breastfeeding. Here the main message is to help with the mother with the position of breastfeeding and confidence that she is getting it right. The notes for the trainer also has several tips on counseling the mother. The role play demonstration should be used to bring out.

1. How to ask open ended questions
2. How to praise and build confidence
3. How to respond to some of the most frequently asked questions and minor worries and problems of breastfeeding. See the tips below.
4. Let each small group practice it, with ASHAs taking turns in role playing counseling the mother.

Step 8: Ask ASHAs what could be the explanation if a mother says she doesn't have enough milk. Listen to the answers. (*Correct answer: The baby is probably not suckling enough at the breast. The more the baby suckles the more milk is produced. Possibly, the mother is not interested in feeding the baby. Another possibility is that the baby may not be compressing the areola to get the milk out, but may be only sucking the nipple which will not be effective in getting milk out.*)..

Activities

1. Divide the group into small groups of three ASHAs in each. Each group practices at least three of the role play topics below, taking turns playing an ASHA, a mother, a mother-in law or a SBA:
 - ◆ Antenatal visit: explaining early initiation to the mother and the mother-in-law
 - ◆ At delivery: early initiation; focus on positioning
 - ◆ At delivery: early initiation, discussion with the mother-in-law who wants to give jaggery water to the baby
 - ◆ Day 2: mother having sore nipples
 - ◆ Day 2: mother letting baby sleep all day
 - ◆ Day 3: mother giving extra water to the baby
4. Circulate in the room; observe how the ASHAs behave with the "mothers" and the kind of advice they give. If needed, clarify any doubts.

Notes for the Trainers

The structure and functioning of the Breast.

The breast is made up of supporting tissue, gland tissue and fat.

Gland tissue (also called alveoli) makes the milk.

Milk ducts carry the milk to the sinuses for storage.

Milk reservoirs (or lactiferous sinuses) are wider than milk ducts and collect the milk. Milk leaves the sinuses and enters the **nipple** through 10-20 fine ducts.

Nipple is the tip of the breast where the milk comes out.

Areola is the darkened skin area around the nipple. The milk reservoirs are under the areola (in a circle around the nipple).

Supporting tissue or breast tissue ‘supports’ the gland tissue, the ducts and the sinuses.

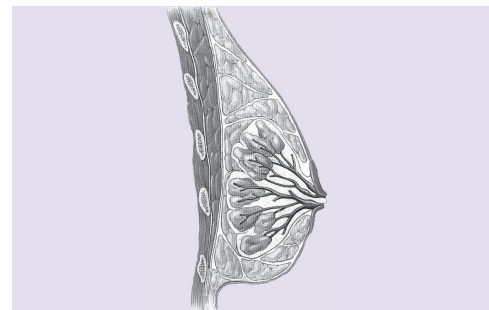
How milk is produced

- Toward the end of pregnancy, the body is getting ready to feed the newborn. The breasts get bigger so that milk can be produced. Milk is produced when the gland tissue in the breast is stimulated. Before delivery, a signal is sent from the mother’s brain to ‘make milk’. In response to this stimulus, the first milk, called **colostrum**, is made and becomes present at the time of birth.
- When the baby suckles at the breast, the mother’s brain gives a stimulus to the breasts to produce the usual breast milk. The baby’s suckling controls the

amount of milk produced so if the baby suckles more, more milk is produced. The baby’s suckling also makes the uterus contract. (Which is why some women feel a tightening in abdomen when they breastfeed) This helps limit blood loss from uterus after delivery.

- How a mother feels while feeding her baby, can affect milk flow. If the mother is not giving time for feeding the baby or is tense and less milk is available for baby. When the milk is in the reservoirs, the baby compresses the areola with its upper mouth (palate) and tongue, squeezing the milk reservoirs and causing the milk to flow out of the nipple into the baby’s mouth. When the baby suckles, a message is sent to make more milk for the next feed.
- The baby gets the milk out by compressing the areola; not by sucking on the nipple alone which will only make the nipples sore.

Inside of Breast (without labels)



Counseling Tips

| Judgmental- closed questions. | Non- Judgmental- open questions. |
|---|--|
| Is she suckling well? | How is she suckling? |
| Is he urinating regularly- over six times per day | How frequently is he passing urine? |
| Do you have any problems breastfeeding? Does he cry too much at night | How is the breastfeeding going for you? How does he behave at night? |

Introduce the characters and scene to the trainees. The ASHA helps a mother, Parveen, to breastfeed her baby girl a few minutes after delivery.

ASHA: Parveen, what a good job you have done. I am drying the baby and will place her against your skin, in your arms. *(Places the baby near the breast.)*

Parveen: She looks just like her father. Look at her eyes. Oh, her tongue is moving toward my nipple.

ASHA: That is a sign that the baby wants to feed; she is hungry after her hard work.

Parveen: Are you sure it is all right to feed so soon?

ASHA: Yes. Remember our talks while you were pregnant? The first milk is very important for the baby. She needs the energy which the first milk has, and the substances it contains that will fight infection. And look how much she wants to eat! Let me help you on your side so you can be comfortable. *(ASHA helps turn mother on side, places baby near breast.)*

Parveen, touch the baby's lip with your nipple. See how she opens her mouth? That shows she really wants some milk. When she does it next time, aim the nipple and areola toward her bottom lip. Make sure she gets a lot of the areola in her mouth.

Parveen: Like this?

ASHA: Yes, that's perfect. I can see she is suckling well. Very good; you are doing so well! Can you feel anything?

Parveen: Yes, I feel a cramp in my womb.

ASHA: Yes, that is another benefit of starting to breastfeed early because the hormone that makes the milk flow contracts the womb and helps to prevent too much bleeding. Do you remember what I explained about how often to feed?

Parveen: Yes, you asked me to feed whenever the baby wants to.

ASHA: Yes, that usually means every 2-3 hours in the first weeks. Remember to switch breasts when one breast is empty. If the baby is sleeping for more than 4 hours, wake her up for a feed. That way your milk supply will stay full.

Look at the baby; she is sleeping blissfully now!
(reflecting or empathising)

Mother's Word: My baby was crying a lot last night **ASHA answer:** Your baby kept you up last night?
(The ASHA's answer lets the mother know she is listening to her and cares for her. Sometimes health workers ask a lot of questions instead of emphasising... such as 'How many

times did he wake up?' This question is not that helpful and the mother may begin talking lesser and lesser.)

Mother's word: My baby feeds a lot, my sister thinks he needs a bottle you feel about this?

ASHA answer: What do you feel about this?

(This leaves the way for the mother to say how she feels. You can praise her and say how well she is doing, she should be proud about how the baby loves her milk. You should not force a mother to do something, but only

give her the best possible advice and support.)

Mother's word: I think the baby needs extra water. **ASHA answer:** Why do you think that?

(Listen to the mother; base your response on what she says. If she says it is very warm, explain that her breast milk has enough liquids required by the baby. Assure her that if she is feeding the baby often, and the baby urinates at least six times, is also growing well, he is getting enough fluids even in the warm season. And does not need water.)

Session 8b: Managing Breastfeeding Problems

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

1. Explain what symptoms indicate breast feeding problems
2. Describe how to observe the mother breastfeeding and detect problems
3. Explain how to help a mother with cracked or sore nipples, not enough milk, or engorged and painful breasts
4. Explain what are the signs that the baby is not getting sufficient milk

Methods: Presentation, Demonstration

Material: Blackboard, chalk, Handout: Breastfeeding Problem management form

Duration: Two hours

Activities

Step 1: The trainer asks the participants what symptoms suggest breastfeeding problems. List them on the blackboard. See if they have left

out anything and includes these in the list.

Step 2: Ask participants to read pages 53-55, Section 4, Part C of Module 6. (Expression of breast milk is dealt with in a later section).

Step 3: The trainer asks the participants to list what are the signs that the baby is not getting enough milk.

Step 4: The trainer makes three columns on the blackboard and writes Sore Nipples, Not enough Milk, and Engorged breasts in each and asks participants to (i) list causes of each, (ii) management and (iii) counseling for each..

Step 5: The trainer uses Handout 1, which contains a breastfeeding problem management form to each participant. The story for the trainer to use and the correct responses are in the Notes for trainers section below.,

Step 6: The trainer then discusses the Breastfeeding Observation Tips (Box on page 51, Section 4, Part C of Module 6).

Evaluation

| Objectives | Assessment Method | Output of the session |
|---|------------------------|---|
| Describe symptoms suggestive of breastfeeding problems | Questions and answers | Blackboard listing of responses |
| List the signs that show a baby is not getting enough milk | Each ASHA makes a list | Trainer collects lists and provides individual feedback |
| Explain how to help a mother with sore or cracked nipples, insufficient milk, or engorged and painful breasts | Questions and answers | Blackboard listing of responses |
| Assess completed breast feeding problem management forms | Questions and answers | Trainer collects forms and provides individual feedback |

Handout 1

Breastfeeding Problem: Management Form

(Tick mark if symptom is present)

| Symptoms on the day of diagnosis and on subsequent days of management | 1 st day | | 2 nd day | | 3 rd day | | 4 th day | | 5 th day | | 6 th day | | 7 th day | |
|--|---------------------|---|---------------------|---|---------------------|---|---------------------|---|---------------------|---|---------------------|---|---------------------|-------|
| | M | E | M | E | M | E | M | E | M | E | M | E | M | E |
| 1) Baby not suckling well since first day | | | | | | | | | | | | | | |
| 2) Mother has no milk since delivery | | | | | | | | | | | | | | |
| 3) Baby continuously crying or passing urine less than 6 times in 24 hours | | | | | | | | | | | | | | |
| 4) Baby's suckling is weak or has stopped | | | | | | | | | | | | | | |
| 5) Cracked nipples, engorged and painful breasts | | | | | | | | | | | | | | |
| Weight of the baby | | | | | | | | | | | | | | |
| Weight gain from 1 st to 7 th day of treatment | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | Grams |

M- Morning

E- Evening

Notes for Trainer

Story for Step 5: Baby Sita is three days old. She was born in the hospital, and returned home on the second day. When you visit her house for the newborn visit, her mother tells you that she is not feeding well and actually has not done so since birth. During the night she sleeps for seven hours without feeding and during the day she cries a lot, and is not suckling well. The mother's breasts are full and painful. Ask the ASHA to mark these on the form. What is the diagnosis? What is the treatment?

- Answer: The ASHA should Mark number 1 (not suckling well) and number 5. (Painful breasts)
 - Diagnosis: Poor attachment, not emptying breasts, infrequent feeds
 - Treatment: Will observe breastfeed, assist with attachment, and positioning if needed, advise the mother to feed the baby frequently, even if the baby has to be woken up, apply towel dipped in warm water on the breasts frequently to reduce the engorgement.
 - Weigh the baby on first day of treatment and 7th day of treatment. If after completion of 7 days, the breast feeding problem persists, or if the baby's weight gain is less than 100 grams in 7 days then refer to hospital
-

Session 8c: Helping Mother to Express Breastmilk

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

- Assist mother who is having difficulty in breastfeeding even after proper positioning, to express breastmilk and feed the child, with a cup and spoon.

Methods: Discussion

Material: Blackboard, chalk

Duration: One hour

Evaluation

| Objectives | Assessment Method | Output of the session |
|---|---------------------------------|--|
| List the main steps in expressing breastmilk by hand. | Each ASHA to write individually | Trainer to collect individual sheets, check and provide individual feedback. |

Notes for the Trainer

Although a demonstration is an effective way of teaching this session, it is difficult to do as the privacy of the mother has to be respected. Explain to the group that in the course of

Activities

Step 1: The trainer asks the ASHAs (i) when the mother needs to manually express breast milk, (ii) how the milk is expressed (iii) what is done with the milk, and (iv) if the baby is fed with the milk, how this is done. These are listed on the board as the responses to each are called out.

Step 2: The trainer asks ASHAs to read pages 54 -55, Section 4, Part C of Module 6 on how to express breastmilk. Each ASHA reads the piece individually.

their work, they will encounter these situations and should try and help the mother to express breastmilk as they have studied in this session. They can use this experience and discuss in subsequent training sessions on the sick newborn in rounds 3.

Keeping the Newborn Warm

Session 9a: Why Keep the Newborn Warm

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

1. Explain why it is important to keep the newborn warm
2. Explain what are the risks to the newborn if it becomes too cold
3. Explain to the mother how to keep the baby warm
4. Know how to measure the newborn's temperature (this skill has already been taught)
5. Identify normal, temperature and what is low or high.

Methods: Discussion

Material: Blackboard, chalk, Handout 1, doll/mannequin, dry towel.

Duration: Two hours and thirty minutes

Activities

Step 1: The trainer asks the ASHAs to describe in their communities how newborns are taken care of immediately after birth? Whose role is it to take care of the baby while the mother is being attended to? Write the responses on the blackboard.

Step 2: The trainer then asks the ASHAs to read pages 57 -58, Section

4, Part C of Module 6. This is done through loud reading, with several ASHA getting a turn.

Step 3: The trainer then refers to the blackboard to see how existing practices compare with the content in the Module and asks ASHA to point out what is correct and what is not.

Step 4: The Trainer divides the group into three and gives the case situations in Handout 1.

Step 5: The groups then review the case situations and write their responses

Step 6: The trainer then has each group read out the responses to the case situations and has groups compare responses, discuss and correct those that are incorrect. (The correct responses and important facts about the newborn's temperature are in the section on Notes for the Trainer below).

Step 7: The trainer then asks the ASHAs to list one by one, (going in a circle) one way of keeping a newborn warm.

Step 8: The trainer then demonstrates how to wrap the newborn baby, using the doll and dry towels. The ASHA take it in turns to show how the baby is wrapped.

Step 9: The trainer asks the ASHAs what are customary bathing practices for newborns in the community. Then the trainer asks the group to read the points on bathing the baby on page 58 aloud and concludes the session by emphasising that for Low birth weight babies the seven day rule is a must.

Evaluation

| Objectives | Assessment Method | Output of the session |
|--|---------------------------|---|
| Explain why it is important to keep the newborn warm | Questions and answers | |
| List the risk to the baby if the baby becomes too cold | Case situation work sheet | Trainer to collect worksheets completed through group work, and discuss |
| Explain how to check if the baby becomes too cold | Case situation work sheet | Trainer to collect worksheets completed through group work, and discuss |
| Explain how to keep the newborn warm | Questions and answers | |

Handout 1

Keeping the Newborn Warm After Delivery

Case 1: Shakila gave birth to a baby boy. He was left wet until the placenta came out. He didn't breastfeed until about 4 hours after delivery. At that time, his temperature was 94.4°F (34.7°C).

1. What is a newborn's normal temperature?

2. Was the baby's temperature normal or hypothermic?

3. What could be the causes (try to identify 3 causes):

a. _____

b. _____

c. _____

Case 2: Murali was born in January. He weighed 1.8 kg. He was handed over to his mother soon after delivery. She put him next to her skin, covered him and started breastfeeding. His temperature was 98.2°F (36.8°C).

1. What can you say about Murali's temperature?

2. Would you say Murali was more at risk of becoming hypothermic? Yes or no? Why?

3. What did the mother do that helps prevent hypothermia?

Case 3: Basanti gave birth to a girl in a room at the back of her house. The room was cold and it was winter. The baby was dried and wrapped and put on a small mattress. Basanti fell asleep. Later the mother-in-law brought the baby to breastfeed. The baby felt cold. Her temperature was 94.1°F (34.5°C).

1. How can you tell if a baby is hypothermic?

2. What signs did this baby have?

3. What can you say about the baby's temperature?

4. What could be the causes? (Name at least three)

Notes for the Trainer

Answers to Case Situations (Handout 1: Keeping the Newborn Warm after Delivery)

Case 1: Shakila gave birth to a baby boy. He was left wet until the placenta came out.. He didn't breastfeed until about 4 hours after delivery. At that time, his temperature was 94.4°F (34.7°C).

1. What is a newborn's normal temperature? *97.0°F - 98.6°F (36.1°C - 37.0°C)*
2. Was the baby's temperature normal or hypothermic? *Hypothermic*
3. What could be the causes (try to identify three causes):
 - a. *Left wet until placenta came out... perhaps 20 minutes*
 - b. *Left uncovered until placenta came out*
 - c. *Delayed breastfeeding*

Case 2: Murali was born in January. He weighed 1.8 kg. He was handed over to his mother soon after delivery. She put him next to her skin, covered him and started breastfeeding. His temperature was 98.2°F (36.8°C).

1. What can you say about Murali's temperature? *Within normal range*
2. Would you say Murali was more at risk of becoming hypothermic? Yes or no? *Yes*

Why? Because he has low birth weight.

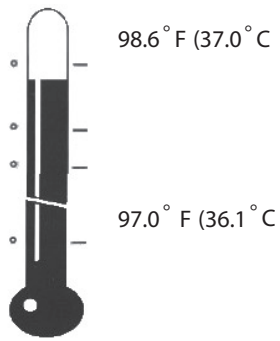
3. What did the mother do that helped prevent hypothermia?
 - 1) *mother took him soon after delivery*
 - 2) *placed him next to her body*
 - 3) *started breastfeeding early*

Case 3: Basanti gave birth to a girl in a room at the back of her house. The room was cold and it was winter. The baby was dried and wrapped and put on a small mattress. Basanti fell asleep. Later the mother-in-law brought the baby to breastfeed. The baby felt cold. Her temperature was 94.1°F (34.5°C).

1. How can you tell if a baby is hypothermic?
By taking the baby's temperature, & feeling her feet and body
2. What signs did this baby have?
Low temperature at 94.1°F (34.5°C), baby was cold.
3. What can you say about the baby's temperature?
Temp. of 94.1°F (34.5°C) means that the baby was hypothermic.
4. What could be the causes? (Name at least three)
Cold room, winter season, did not breastfeed early, not kept close to mother

Facts about newborn temperature

Normal newborn (axillary) temperature: 97.0° - 98.6°F (36.1° - 37.0°C)



Baby at risk of Hypothermia (getting cold)
95.0° F (35.0° C), and below; Hypothermia

**Newborn getting cold: 95.0° - 97.0°
F (35.0° - 36.1° C)**

**Newborn too cold (Hypothermia):
less than 95° F* (35.0° C)***

Range of Normal Temperature:
Temperature is measured in baby's
armpit (axilla)

Session 9b: How to Rewarm Cold Babies and Control Newborn Temperature in Hot Weather

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

- Explain to the mother how to rewarm cold babies
- Explain to the mother how to control newborn temperature in hot weather

Methods: Discussion, demonstration, case situation analysis using Handout 1 and story telling.

Material: Doll, Warm bag, Handout 1

Duration: Two hours

Activities

Step 1: Ask the participants to read page 59, Section 5, Part C, Module 6 on how to keep the newborn warm.

Step 2: explain and discuss each step. Explain that the ASHA will be provided as part of their supplies, a warm bag for the baby who is getting cold, but

until then they should ensure skin to skin contact and covering with a warm cloth.

Step 3: Demonstrate using a doll and warm bag as well as warm cloth.

Step 4: Distribute Handout 1 to each ASHA and allow them about twenty minutes to complete the case analysis and write their responses.

Step 5: The trainer then collects the worksheets, scores them and provides individual feedback. The correct responses are in the Notes for the Trainer section below

Step 6: Ask the participants to read Page 60, Section 5, Part C, Module 6

Step 7: The trainer then explains the difference between a baby that has fever and one which has just been dressed too warmly especially in very hot weather by telling the story of Ramshila in the Notes for the Trainer section

Step 8: The trainer emphasizes to the ASHA that when the temperature of the newborn is above 99 degrees F then the child needs to be referred.

Evaluation

| Objectives | Assessment Method | Output of the session |
|---|---------------------------------|--|
| Case analysis of situation in Handout 1 | Each ASHA to write individually | Trainer to collect individual sheets, check and provide individual feedback. |

Handout 1

Prevention and Management of hypothermia in the newborn

Daramba gave birth to a baby girl in December. The TBA delivered the baby and put her to the side while she waited for the placenta to come out.

After 20 minutes, the placenta came out. The TBA wiped the baby and wrapped it in a cloth. The mother-in-law took the baby to show to the relatives.

When she came back an hour later, the baby was put on the bed and she fell asleep. When the baby woke up, she was pale and her feet and body were cold. Her temperature was 94° F (34.4° C). The mother offered the baby her breast but she didn't suckle well. The next day the baby was very weak and they had to call the doctor. The doctor said the baby had pneumonia.

1. Would you say the baby is cold? Yes/No

Why? What signs does she have?

a. _____

b. _____

c. _____

2. Name four things that could be a cause of the baby's low temperature:

a. _____

b. _____

c. _____

d. _____

3. What could have been done to prevent the problem? (Give at least six answers.)

a. _____

b. _____

c. _____

d. _____

e. _____

f. _____

4. What is a normal temperature range for newborns?

5. What can happen to a baby that gets too cold? (Give at least two answers.)

a. _____

b. _____

6. Write down at least four steps in re-warming the baby:

a. _____

b. _____

c. _____

d. _____

Name of the ASHA: _____

Date: _____

Name of the trainer: _____

Block: _____

Total score: _____

Notes to the Trainer

These notes contain the responses to the Questions in Handout 1. They also contain important facts on how to rewarm the hypothermic baby which

the trainer should emphasize to the ASHA. The final section is the story of Ramshila which the trainer uses to train ASHA in distinguishing between an overdressed child and one that has fever.

Answers to Case Study Assessment I
100 points

Daramba gave birth to a baby girl in December. The TBA delivered the baby and put her to the side while she waited for the placenta to come out.

After 20 minutes, the placenta came out. The TBA wiped the baby and wrapped it in a cloth. The mother-in-law took the baby to show to the relatives.

When she came back an hour later, the baby was put on the bed and she fell asleep. When the baby woke up, she was pale and her feet and body were cold. Her temperature was 94°F (34.4°C). The mother offered the baby her breast but she didn't suckle well. The next day the baby was very weak and they had to call the doctor. The baby had pneumonia.

1. Would you say the baby is cold? Yes/No 3 points total 15 points
Why? What signs does she have? (4 points each = 12 points)
 - a. cold feet
 - b. cold body
 - c. temp 94.0 F (34.40 C)
2. Name four things that could be a cause of the baby's low temperature: 5 points each: 20 points
 - a. born in winter - hence the room was colder
 - b. not dried immediately
 - c. not wrapped for some minutes
 - d. not breastfeed early
 - e. not put close to mother
3. What could have been done to prevent the problem? Give at

least six answers. 5 points each: 30 points

- a. warm room
 - b. immediate drying
 - c. skin-to-skin contact with mother and kept covered; or wrapped with dry cloth and placed close to mother
 - d. hat on head
 - e. early initiation of breastfeeding
 - f. quickly re-warmed when mother felt its feet were cold
 - g. frequent feeding
4. What is a normal temperature range for newborns? 5 points
97.0 -98.6°F (36.1 - 37.0°C)
 5. What can happen to a baby that gets too cold? 2 answers; 5 points each: 10 points
 - a. not able to suckle well
 - b. greater risk of infection
 - c. greater risk of death
 6. Write down at least four steps in re-warming the baby: 5 points each: 20 points
 - a. increase room temperature
 - b. remove any wet or cold blankets and clothes
 - c. hold the baby with its skin next to its mother's skin (skin-to-skin contact) and place a warmed cloth (ensure it is not too warm, so as to avoid burns) on its back or chest. As this cloth cools, replace it with another one until the baby is warmer.
 - d. put clothes on, put in warm bag, puts its hat on, and make it lie in skin-to-skin contact with its mother

Key Content Information

How to re-warm a baby getting cold <97°F (36.1°C) or too cold <95°F (35.0°C)

- Increase the room temperature.
- Remove any wet or cold blankets and clothes.
- Hold the baby with its skin next to its mother's skin (skin-to-skin contact) and place a warmed cloth (not too hot to avoid burns) on his back or chest. As this cloth cools down, replace it with another warmed one, and repeat until the baby is warmer. Continue until the baby's temperature reaches the normal range.
- Put on its clothes & its hat, put it in warm bag, and make it lie close to its mother.
- Monitor the baby's temperature twice on that day, and the next two days so as to ensure the baby is kept warm.
- Continue to breastfeed the baby to provide calories, and fluids to prevent a drop in the blood glucose level - a common problem in hypothermic babies.

If a baby is too cold (<95°F (<35.0°C)), follow the above advice, and

- place skin-to-skin, and once the baby is a little warmer, then clothe baby and place in a bed prewarmed with either a hot stone or hot water bottle (remove these articles before putting baby on the bed).

Story of Ramshila

Ramshila gave birth to a baby at the end of April, when the weather had turned very warm. When the ASHA came to visit during her pregnancy, she had showed Ramshila some pictures to explain how important it is to wrap a newborn baby and keep him warm, because otherwise he can get cold quickly, and this could lead to other illnesses. Ramshila loved her baby and wanted to be a good mother. She didn't want her baby to get sick, so she kept him wrapped in blankets, and put on a hat, even though it was very warm in the house. Ramshila herself felt warm and tired, but she was only trying to follow the ASHA's instructions. The baby slept a lot and hardly woke up even to take his feed. Two days later, when the ASHA came to visit Ramshila, she entered the house and found it very warm inside. She touched the baby and thought he felt warm. She took his temperature; it was 100°F (37.8°C). Then she thought to herself: 'Why did Ramshila keep him wrapped up & with a hat on his head in such warm weather? Was he so warm simply because he was over-dressed, or did he have fever?

1. At this point, ask the participants what they could do in this situation? Listen to the answers, and praise correct responses (based on the following):
In the case of high body temperature of a baby during summers, if this is due to the

baby being overdressed or does it really have fever verify in the following manner:

- ◆ *unwrap the baby and take off its hat*
- ◆ *ventilate the room to cool the baby*
- ◆ *ask the mother to start breastfeeding*
- ◆ *if there is a source of extra heat (like a fire) in the room, put it out*
- ◆ *wait for 30 minutes and take the temperature once again*

If the baby's temperature returns to normal, explain to the mother that in very warm weather, the baby does not have to be kept covered with additional cloth or kept wrapped.

Appreciate Ramshila for following your instructions, but explain that in very warm weather, the baby

should be covered only with a loose, light cotton cloth. She can understand that if she herself feels too warm and uncomfortable, the baby must surely be hot and uncomfortable too!

If the temperature is still above normal after the above measures have been taken, treat the baby for fever.

3. *Ask the participants why Ramshila kept her baby so wrapped up in such warm weather? Listen to their answers and encourage discussion. (Answer: Ramshila was following the ASHA's instructions - which is good. But ASHAs must explain to mothers that in very warm weather, when they themselves feel warm, they should keep their babies covered with only light cotton clothing. This will prevent them from overheating.)*

Infant and Young Child Feeding

Session 10a: Counselling for Malnutrition.

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

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

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

Materials: Trainee check lists, Trainer check sheets,

Duration: Two Hours

Notes for the Trainers

- Please note that this session plan assumes that breastfeeding and counselling and support for the promotion of breastfeeding has already been intensively covered).
- The trainers should have

experience of training in counselling in a community situation.

- The facilitators check sheets and check lists are not to be followed mechanically.
- Considerable flexibility and understanding on the facilitators part is needed to conduct this session in the class room.
- It is much easier to conduct in the community with real situations. However without a class room session preceding- too much time is lost on the field to explain the basic steps.

Activities

Step 1: Short Presentation of 15 minutes. Use a power point if available or else posters. Explain the importance of addressing child malnutrition and the major social as well as proximate causes of child malnutrition. The quality of the presentation should be measured by the ability of the group to later answer the five questions given below.

Step 2: Let the trainees break into five groups each and read out Pages 7 to 10, Module 7. Fifteen minutes to read this is adequate.

Step 3: After reading these pages each group should answer the following five questions which should be written up on a chart paper. Then call each group to present the answer to one of the five questions- and the others to correct it if they have left out anything. If there is time, all five groups should answer all five questions. Though the answers to these five questions were given in the presentation and in the text, there could be different emphasis and views that come forth. The facilitator should be able to judge and take in the positive suggestions and correct false or wrong positions.

The Five Questions are

1. “Poor families require money for purchasing food. Educating them on improved nutrition is not going to solve the problem of malnutrition.” How would your group respond to this comment.
2. How does malnutrition affect the child? Is the ASHA's time spent on counselling for child nutrition well spent? How does her contribution complement or differ from that of the Anganwadi worker and the ANM on this task.
3. If malnutrition is as high as 46% of all children - why are we not so aware of this problem. Should we focus on all children or should we address some of these children more rigorously?
4. What are the most important messages related to feeding practices of the young child?
5. What are the main messages related to prevention of illness

and access to services? Which are the services that are meant to reach the malnourished child and where there should be a special effort to facilitate access?

6. When must a malnourished child be referred for medical advice? Where must she be referred? What is severe acute malnutrition?

This whole activity may take anywhere for about 30 to 45 minutes- should not let this discussion proceed for very long.

Step 4: Now introduce the need for counselling and why counselling is a special skill. Take them through Pages 10 to 13, Module 7. Have the ASHA read this section aloud, taking turns.

Step 5: Role play on counselling and management of mother with a malnourished child. Please note this is not a drama - and trainer and participants should not get carried away with the theatrics. Some role plays are meant to bring out the relationships and perceptions of different people. This is not such a role play. In this role play, the trainer plays the role of the mother with a malnourished child, and a trainee to play the role of the ASHA. The purpose of this role play is on teaching the trainees which questions to ask and how it is to be asked, and enable them get the opportunity to use the skills learnt thus far. The trainees are given information on the child's age and grade of malnutrition, and a rough idea of the family's socio-economic status (which the ASHA can assess

through observation without asking questions). Prompt the trainee if any question is left out till all the areas are covered.

Then ask the trainee to present a brief analysis of what the causes of malnutrition are in that child. See box on page 11 for two examples of such a presentation. The whole exercise takes about 60 minutes and it is done about three or four times with one of the trainees volunteering to be the ASHA each time.

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

- a. *On feeding:*
 - i. What did the child receive to eat? in the last 24 hours.
 - ii. Was there an effort to assess the exact quantity of each food that the child was given.
 - iii. What special/protective foods does the child get in the last week ? especially was the amount of proteins, the amount of fats and oils and greens that the child got assessed?
 - iv. Was frequency of feeding assessed?
 - v. Was feeding during recent illnesses assessed?
 - vi. What were the constraints explored in each of the above- did the mother have the knowledge of the correct feeding issues.
 - vii. Is there expenditure on tonics, health foods, vitamin tablets, etc.

- b. *On illness*
 - i. Was the history of recent illnesses and their frequency assessed? Was diarrhoea, ARI and measles specifically asked for?
 - ii. What treatment was given? By whom? What were the expenditures?
- c. *On access to services*
 - i. Is the child immunised on schedule?
 - ii. Has the child received vitamin A? Deworming tablets/ Paediatric iron tablets?
 - iii. Is the child getting rations from the anganwadi? Attending anganwadi?
- d. *On family and economic context?*
- e. *Is mother able to give time on feeding, on child care? Who takes care of the child for much of the day?*
- f. *Could they afford protective foods like egg, meat, milk, fruit etc?*
- g. *What is the order of this child? What is the spacing with earlier child?*
- h. *Is the mother using any spacing methods/limiting methods?*

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

Session 10 b: The Measurement of Malnutrition

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

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

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

Materials: Malnutrition/Growth charts, Pictures of malnourished children Salter weighing machine (can weigh children upto 25 kg)

Duration: One and half hours.

Activities

- a. Present identification of malnutrition from page 14 and 15 of Module 7. Show a few pictures of malnourished children- both slide projection and posters which shows the visible signs of wasting.
- b. Emphasise that an underweight child need not have any of the above signs. Teach about weighing the child using the Salter weighing machine. This is available at the Anganwadi Center. Emphasise that

it this is NOT part of the ASHAs work responsibility to measure the weight of the child regularly, but that she needs to know where the weighing machine is available. And there may be times where a child needs to be weighed by her.

- c. Give the weights and age of a number of 10 children in a worksheet. Each group has to fill up the grade of malnutrition.
- d. Mention the difference between the old scale and the new reference scale that is used in this module.
- e. Ask how the weight of the child and the severity of being underweight is to be conveyed to the family. What would be the words used? Work out what is culturally appropriate but at the same time conveys adequately the seriousness of being underweight.

Notes for the Trainers

You need to know that the chart shown is called WHO standards - and has been recently introduced. On the field health and ICDS staff may still be using the earlier standards which classified malnutrition in grade I, II, III and IV. Broadly what is marked as below the red line corresponds to level II and that which is below the last line corresponds to severe malnutrition.

Work sheet of Severity of Malnutrition Calculation Drill

| | Age of Child | Sex of the Child | Weight of Child | Grade of Malnutrition. |
|----|------------------|------------------|-----------------|------------------------|
| 1 | 2 months | M | 7 kg | |
| 2 | 6 months | F | 8 kg | |
| 3 | 9 months | M | 8 kg | |
| 4 | 11 months | F | 6 kg | |
| 5 | 14 months | M | 7 kg | |
| 6 | 22 months | F | 9 kg | |
| 7 | 22 months | M | 9 kg | |
| 8 | 2 and half years | F | 13 kg | |
| 9 | 2 years 7 months | M | 13 kg | |
| 10 | 12 months | F | 7 kg | |
| 11 | 12 months | M | 7 kg | |

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

Session 10c: Counselling and Behaviour Change for Malnutrition

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

- Learn how to counsel the mother and the family on infant and young child feeding.
- Become skilled in community mobilisation for VHND, immunisation and child health.

Methods: Role Play and Group discussion:.

Material: Five case studies printed out in work sheets.

Duration 3: hours in the class room and field practice session

Activities

Circulate the worksheet with the five case studies and ask each group to counsel a family in this situation. Work it out as a role play with the facilitator playing the role of the family again. This should be done with each group presenting one case. Take about one hour to complete this.

Use the check list given after Session 4- field practice session to check whether all aspects have been covered.

Then ask - what more is needed other than such interpersonal communication or counselling

to make for a change in feeding practices? In particular what should be the community level action and how should we use the village health and nutrition day?

Ask ASHAs to read out Pages 18-19, Module 7 role of ASHA in immunisation. Discuss- in practice what happens in your village. What should happen? Each group can present their views.

The first six activities given in the list relate to what most would understand as the facilitation of services. But the five activities given under g. would be understood by most as the role of ASHA as activist. Compare and contrast the skills and support needed for these roles.

Notes for the Trainers

This is best done in the community with families of malnourished children. However to reduce the learning time in the field situation- this should be introduced in the class room before the group leaves for the field.

Case-Studies of Malnutrition

Banu was a nine month old girl with moderate malnutrition. She is being breastfeed and only this month was started on complementary foods. She eats rice and dal from her parents' plate while they are eating, once at about 10.00 am and then at about six PM. No other complementary food is given. She had diarrhoea once, one

month ago, but no other illness. You gave her ORS and she became alright with it. She does not go to the anganwadi or get rations from there. Her immunisation is on schedule. How would you counsel this family

Rafay is an 18 month old boy who is severely underweight. He has no odema, but there is some wasting. He cannot go to the hospital because his mother cannot leave her younger child and she also has to go to work as she is the only earning member. Rafay is not being breastfeed, but gets to eat roti, dal and vegetables. He eats about half a roti or one roti thrice a day. But his mother complains that he does not eat a lot and has very poor appetite. He has frequent episodes of respiratory infection but no other illness. His immunisation schedule is complete. How would you counsel this family?

Akila is a 3 month old girl. The girl is of low birth weight. Now the weight is 4 kg. She gets breast-feeds but since the days her hot she is being given water to drink also. There is no illness now, though in the second month there had been fever treated with antibiotics. No services from the anganwadi are accessed. One dose

of DPT and one dose of BCG and one dose of polio has been given. How would you counsel this family?

Krishna is a 12 month girl weighing 7 kg. This girl has stopped receiving breastfeeds and is on complementary feeds. The parents complain that though they try to feed him adequately, the child refuses feeds. The family's knowledge about complementary feeds is adequate. Immunisation is complete. The child has recurrent diarrhoea and is pale. It is a poor family and the earlier child is three years old. The mother goes out to work daily leaving the two children with the aging grandmother. What advice would you give this family?

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

Session 10 d: Field Practice Session on Counselling for Malnutrition

Aim: To teach the skills of counselling on infant and young child feeding to the mother and their family.

Methods: Counselling in the community

Materials: Identification of families and one facilitator for every five trainees.

Duration: About three hours in the community

Activities

1. Let each participant visit 5 households each. One of them should be a newborn family, another a family with a child in 6 months to one year age where the child is normal and the others should be families with malnourished children.
2. Each participant should talk to the family under observation by the facilitator and then should counsel again under observation. Ideally each participant should talk to five families and all of them are marked in the check sheet. The weight of the child is told to the participant, but the age has to be found out. In practice, if counselling even one family per participant is achieved it would be a good start. The rest can be done on the follow up on the job visit by the supervisor.
3. Discussion hints for the facilitator could be drawn from the check list given. All these points are to be covered while preparing the trainees for counselling.

Notes for the Trainers

For community level practice one has to take the help of Anganwadi workers and identify about five families for each group of five trainees to see. It helps to have one trainer or facilitator for every group of five trainees during the field work

Check-List: Participants/Trainee did the following

| | Name of the participant: | Yes | Partially | No |
|----|---|-----|-----------|----|
| 1 | Introduced herself and the purpose of the visit | | | |
| 2 | Was able to estimate the age of the child adequately | | | |
| 3. | Was able to ask about breastfeeding adequately- especially about exclusive breastfeeding if child is in first six months. | | | |
| 4 | Was able to ask about amount, variety and frequency of complementary food adequately | | | |
| 5 | Was there feeding in illness | | | |
| 6 | Was history of illness taken | | | |
| 7 | Was family situation assessed | | | |
| 8 | Was access to services determined | | | |
| 9 | Did the participant demonstrate active listening. | | | |
| 10 | Did the participant follow the flow while asking questions- or was it like reading off a list? Was an active conversation established | | | |
| 11 | Did counselling start with praise and reinforcement of good practices | | | |
| 12 | Did participant resist the temptation to immediately respond negatively to any wrong answer – or make negative or derogatory remarks | | | |
| 13 | Did participant resist giving gratuitous advice – like be clean, eat healthy food, take proper care of children etc. | | | |
| 14 | Did participant place her advice as suggestions and discuss with the mother/family whether they could adopt these suggestions- instead of merely prescribing advice | | | |
| 15 | Did participant counsel on prevention of disease | | | |
| 16 | Was counselling done on access to services | | | |
| 17 | Were there any indications for medical referral for this child? If so was referral advice given? | | | |
| 17 | Was the family thanked and follow up visit indicated before the session closed. | | | |

Assessment of a Sick Child

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

- Understand why these skills are important.
- Learn the skill of assessment of a sick child for identification of danger signs

Methods: Group discussion, Case simulation/video simulation, Field practice.

Materials: Video clippings, Handouts.

Duration: 2 hours

Activities

Step 1: Present why ASHAs need these skills. See the Notes for the Trainer, for content of this presentation. Keep the presentation brief.

Step 2: Ask the participants in small groups to read Module 7 pages: 20 to 24.

Step 3: If you have video clippings showing different sick children as a teaching exercise you could show these and ask them to call out what are the danger signs that they see. The video clipping show the four danger signs and how to look for a stiff neck. If you do not have video organised, you would have to use the case studies given as part of the

training notes. Please note that these notes are no substitute for having the video clipping- but in case there are technical problems- something is better than nothing. Also one should try and get the participants to see some sick children both in the hospital and in the community.

Step 4: List out the questions that ASHA must ask every sick child they see and what all they must examine in any sick child. The list should read like this

What to ASK

- A. First ask for the danger signs:
 - a. Is the child able to drink fluids or breastfeed: How much water is it drinking? Is it able to drink water and swallow it normally? If breastfeeding- is the child able to suckle at the breast? If you are not sure about the answer What has the child eaten today? Is it the normal amount?
 - i. If one is not sure of the answer, give the child some water or put it to the mothers breast and see how it drinks/suckles.
 - ii. If there is difficulty suckling or drinking make sure it is not due to a blocked nose, clear it and try again. If it

- still fails then this danger sign is present.
- b. Does the child have vomiting? This must be such that no food, or water or drugs are retained.
 - c. Did it have fits?
 - d. Then LOOK and ASK: Is the child active as usual? Also form an opinion by examining/interacting with the child. What is the main complaint of the child? For how long has the child been having this problem?
- B. Does the child have cough - if the answer is yes, tell them that we would learn to categorise it in the next session.
 - C. Does the child have diarrhoea- if the answer is yes, tell them that we would learn to categorise it and manage it in the next session.
 - D. Does the child have fever-
 - a. For how long?
 - b. If it is there for more than 7 days, ask if it was present on every day.
 - c. Then LOOK and FEEL On examination- did the child have a stiff neck?
 - E. Ask and LOOK to see if the child has malnutrition. And if so, of what severity. We have discussed earlier what to do in a child with malnutrition.
 - F. Ask and LOOK to see if the child has anemia. And if so, of what severity.

The groups could write out the answer to the question - “what are the *questions to ask the mother* and

the *things to look for in a child* when a sick child comes for your advice”. The group could write up the answers on a chart paper and stick it on the wall. It would act as a session output for evaluation as well.

Step 5: Ask ASHAs how many sick children they saw in the last one month. How many have they seen with these danger signs- in the last one month and in the last one year. What are the main danger signs, and causes? What do they see and what do they do? Which is the usual clinic/hospital where children with danger signs are taken for treatment and what are the problems in accessing these facilities? One could also discuss with respect to the case studies- what would have been the choice if the nearest PHC was functional for seeing and admitting sick children and as it is today- when only the block or district hospital is able to see children with danger signs. But the point should be clear- with a danger sign there is no option- one has to get the child to a qualified doctor or a trained nurse in a government health facility- however difficult it is. And all ASHAs should know which is the suitable choice of facility in their area.

Notes for the Trainer

Importance of ASHA having skills related to sick children: presentation hints:

It would be good if every sick child could see a doctor who provides the appropriate care. However in most situations in India, this is not possible today.

Imagine a situation in an urban middle class setting. My child has developed fever for the last one day. I could wait and see or I could rush. I decide to come back from office and then in the evening take the child to a doctor. The good doctor, sees my child, and states there is nothing to worry and prescribes tablet paracetamol. I ask, the child looks very sick, should I not give antibiotics or some injections. The good doctor reassures me that this looks like a viral fever and will settle down on its own and if it does not within four days, to come again. If any danger sign develops I could come then at once.

Imagine the situation in a rural poor household. My child has developed fever for the last one day. If I have to see a doctor, both I and my wife cannot go to work tomorrow and would lose our wages, other than annoying my employer who may decide to hire someone else. Then I would have to find Rs 75 for up and down bus tickets for all three of us or Rs 45 for both me and the child to go to the block PHC and come back. When I go there, the experience is that I am sure to be prescribed a tablet for fever, and an anti-biotic and a tonic or two- and it would not cost less than Rs 200 to buy it all. In all about Rs. 270 rupees of expenses plus about Rs.. 200 in wage loss. And I would have to come back and if a danger sign happens rush again. If I go to a local unqualified doctor, it would cost me about Rs.. 50. I go there and decide to go to the PHC only if the child gets serious- and may delay till it is too late.

If there was an ASHA to turn to, the ASHA would be able to make a difference between waiting longer, treating locally with home remedies and correctly and rushing to the doctor every time there is a diarrhoea, a cough or cold or a fever. At any given time, about 5 to 10% of children have these symptoms and only one in ten of them would require referral to a doctor. Thus there is a huge savings in terms of money that the ASHAs work helps them in.

In terms of lives too, this simple intervention may save more lives than any other single intervention. For one thirds to half of all child deaths below the age of 5 are due to either diarrhoea or acute respiratory infection or due to malaria. What we are going to learn in this session and the next two, would help poor families to:

- a) Prevent recurrent episodes of these three common complaints
- b) Provide prompt care for these three common complaints such that they do not progress to becoming life threatening- this is especially true with ORS for diarrhoea and prompt treatment for malaria and co-trimoxazole for ARI
- c) Identify those who have symptoms of serious illness requiring medical attention early and persuade them to seek medical care at the appropriate facility.

Each of these three actions that the ASHA could provide would save many

lives in the community. In the nation as a whole- the 7 lakh ASHAs we have could save lakhs of young lives.

Case-Studies to Discuss

1. Asha Latha is a 2 year old girl who has been having cold on and off. This has led in turn to her losing weight and a poor appetite. Now she again has mild cough but with some fever. No other features. She responds well and is not lethargic and she eats less, but she is eating.

The family has consulted the local RMP, but also want the ASHAs opinion. Is there a danger sign? What could be the ASHA's advice.

2. Kusum is a three year old girl having cough off and on. Now she has developed high fever and she is not responding well to being called. Her speech is slow and sometimes not focussed and she is lying in bed, not making an effort to get up. The family has consulted the local RMP, but the ASHA is now paying a visit.

Is there a danger sign? What could be the ASHA's advice.

3. Dinesh is a 9 month old boy who has developed diarrhoea. He is passing urine well and the skin is normal and no signs of dehydration or blood in stools. What would be the ASHA's advice.

On the third day of diarrhoea the boy develops vomiting and is unable to keep down even the

ORS fluid. After this has lasted four hours they consult the ASHA. What would be the advice?

4. Gutoo is a five year old boy who had fever. On the second day he got convulsions, but his fever was less. There was no cough, or diarrhoea. What would be the ASHAs advice. Is this a danger sign?
5. Yasmin is a three month girl who developed a mild fever with cough, but has then stopped breastfeeding from the fourth day. She is since then lying quietly, occasionally crying and not playing at all. Is this a danger sign? What would be the ASHAs advice.
6. Peter is a four year old boy who has developed fever and from the third day is in addition very irritable and restless. There is no cough or diarrhoea. He is not eating and on examination his neck seems stiff. What were the dangers signs present. What would be the ASHAs advice.

Note when actually discussing with ASHAs let them name which specific facility they would refer to for each - not just a level of care or category of facility. Like let them say, the PHC in Balod and not any BPHC. How would these case studies have been different if they were staying in an urban area and from a middle class family that could afford and choose the care they needed?

The Categorisation and Management of Diarrhoea

Aim: At the end of the session the ASHA will learn how to:

- Counsel a family where a child has recurrent diarrhoea.
- Categorise diarrhoea.
- Decide between home based care and need for referral in a child with diarrhoea.
- Provide treatment for children.

Methods: Presentation and Group discussion, Case simulation/video simulation, Field practice.

Materials: Video clippings

Duration: 3 hours

Activities

Step 1: There are families with children having recurrent diarrhoea. Because of this, they are also losing weight. Though preventive measures against diarrhoea are relevant to every family there is an urgency about preventing this recurrent diarrhoea in such families. Ask the ASHAs to call out what would be the preventive measures that the family and community could take. Make sure the importance of handwashing is stressed. Also discuss the safe disposal of feces and how to ensure safe drinking water. The link between

fecal contamination of drinking water and diarrhoea should be emphasised- as the only cause of this problem.

Step 2: Explain that when a child has diarrhoea there are a few questions to ask and a few signs to look for. These are given in pages 29 and 30 of Module 7. Let them in small groups read this.

Step 3: The signs of dehydration can be further taught, by showing the video clip and asking participants to write down whether the child is dehydrated or not.

Step 4: Based on the response to the questions and the signs of dehydration the child could be categorised into one of four groups- Diarrhoea with Severe dehydration, Diarrhoea with some dehydration, Diarrhoea with no dehydration and Dysentery. This is given in Page 30 in the table in step 3. Make sure that this is understood by the participants.

Step 5: Read out a few case studies/ or show a few video clippings and ask them to categorise the child. This is for practice.

Step 6: Treatment Plans: First discuss which categories need to be referred

to hospital- at once. Then discuss what you would do in the other categories. This is given in pages 27 and 28- and should be read out in the small groups and discussed.

Step 7: Discuss their current experience of managing diarrhoea. Do mothers/families heed their advice regarding ORS. Do they help the family make the first solution and initiate ORS. They should. What are the problems they encounter. Do they get enough ORS packets.

Step 8: Discuss how to make ORS solution- and let each small group make such a solution using the packet and using sugar and salt and taste it. It is important to get them to make it. Emphasise that it is always preferable to make the ORS using the packet supplied because one is sure of the right proportions- but if that is not available, they should not hesitate to use home-made substitutes. List all possible home based substitutes. This is given in Page 27 Module 7 paragraph I.

Notes for Trainers

Case Studies for categorisation of diarrhoea exercise: For each child let each group work out the categorisation and then later tell the plan of treatment.

- a. Kumkum aged 6 years has diarrhoea for last 15 days. Her stools are semi-solid and she passed stools four to five times a days. There are no signs of dehydration and there is no blood in the stools.
 - b. Pappi aged one has diarrhoea for three days. The stools are very watery and passing frequently. The child has passed much urine twice in last six hours, but of dark yellow colour. The child is irritable and the skin when pinched up goes back slowly. Mouth is dry. Child is very thirsty and drinks water eagerly.
 - c. Chintu aged three years has diarrhoea for one day. The stools are watery and passing frequently. Child has passed almost no urine in last six hours. It does not show any interest in drinking water and when forced drinks poorly. The skin gets pinched up and goes back slowly. There is no blood in stools.
 - d. Rekha aged six months is having diarrhoea for last three days. Stools are watery and there is no blood. Child is otherwise normal, passing urine frequently and breastfeeding well.
 - e. Ramesh aged 5 years is having diarrhoea for last two days, and there is blood in the stools. There are no signs of dehydration.
-

Management of Acute Respiratory Infections: The Categorisation and Management of Cough and Fever

Aim: At the end of the session the ASHA will learn how to:

- Categorise cough and fever.
- Decide between home based care and need for referral in a child with cough or fever.
- Provide home based care for children with mild coughs and colds where appropriate.

Methods: Group discussion, Case simulation/video simulation, Field practice.

Materials: Video clippings,

Duration: 3 hours: plus one hour for evaluation.

Activities

Step 1: First let us learn about coughs and colds. Other than the danger signs we learnt in an earlier session there are a number of questions to be asked and a number of signs to be looked for. Learn about these

Questions to ASK: From when/is there difficulty in breathing/is there also fever

Things to LOOK for: is there chest indrawing? And what is the breath rate

Step 2: Chest indrawing has been taught earlier. But this could be repeated now.

Step 3: Teach the ASHAs to measure the breathing rate. This should be done by observing normal babies at the community or in a nursing home-without touching the baby. They could do it with older children also if such children are available as volunteers. The skills are related to reading time in the watch and counting upto 50 without difficulty.

Step 4: Drill them on remembering the correct normal and abnormal rate at different ages. You could go around a circle asking each and every ASHA to state normal or abnormal as you call out from the list given in the trainers notes below. Or you could distribute these notes as a worksheet and ask ASHAs to fill them up and correct it as part of group work.

Step 5: Ask the ASHAs to state what would be the advice in the following situations:

A child who has had a cough for more than 30 days.

A child who has cough who also has any one of the danger signs.

A child who has cough with fast breathing and chest indrawing.

A child who has cough with fast breathing with or without fever.

A child who has cough with neither fast breathing nor chest indrawing.

The ASHA should read this from pages 30-31.

Step 6: Go to page 46 Annexure 6 of Module 7. Discuss and drill how to decide on dose for co-trimoxazole. There are four aspects of a dose. What is the tablet strength? What is the number of tablets to be given a time? What is the number of times in a day this has to be given? And what is the number of days it has to be given. Make sure they know this and also know this for each age group. You could actually distribute some tablets there and make them wrap the correct dose in a piece of paper. Emphasise the cautions and side effects carefully. Also take care that the dose is told according to the strength of the tablet available and supplied to ASHA.

Step 7: Now discuss what is the advice to be given for the child who has to receive home remedy for cough and cold. This is given in Page 31- but one could also discuss what practices are being followed in the community and recommend those which do not have any harmful effects. Do not encourage any practice where oil is put into nose or ears. That is harmful. Most of these conditions are self limiting and needless expenditure could be avoided. Include advice on feeding during an illness and the importance of it.

Step 8. Discuss the situation where a child comes with fever and there is neither cough, nor diarrhoea. What must we ask? How long the fever is for and whether it comes and goes every day or whether it is there continuously. Also whether it is high fever or low grade fever most of the time.

Step 9: Discuss why it is useful to check with a thermometer and not go only by impressions or touching with the hand. Revise how to take a temperature with a thermometer.

Step 10: Show how to look for a stiff neck. Usually this comes with a danger sign- but sometimes may develop before the danger signs develop. A stiff neck - even if doubtfully present is a reason for immediate referral. (if this was done in session 11A, it need not be repeated).

Step 11: Discuss how to manage fever and how much paracetamol to give. (see annexure 6 page 81) Demonstrate tepid water sponging. Note that we are not advising for ASHA to give paracetamol to any children below 2 months of age. That only a doctor can decide.

Step 12: In a high malarial area chloroquine or equivalent drug is to be given. This could be taught at this stage from someone from the department- if it is urgently needed in this area- or we could wait for the next round of training when this would be covered in some detail.

Evaluation

- This is to revise and drill every trainee on what has been taught over the last 8 hours and three sessions.
- Show a few video clips. In the worksheet- each participants writes the name of the child and then what is their observation as regards danger signs, category of illness and treatment plan or advice. Also what advice to *prevent* recurrent episodes. In case video clips are not available or cannot be shown- the relevant case studies given in the session on evaluation could be used.
- At least two cases from each of the four situations- fever, diarrhoea, coughs and danger signs - should be given to them in this evaluation. The worksheets written by each participant should be collected and marked.
- This entire evaluation would be repeated in the field with real situations later on.

Notes for the Trainers

Assessing Breathing

| Situation: | Normal or abnormal |
|---|---|
| A baby of 4 weeks with 70 breaths per minutes | Normal |
| A baby of 7 weeks with 55 breaths per minutes | Abnormal- from 12 months anything above 40 is abnormal. |
| An infant of 12 weeks with 55 breaths per minutes | Abnormal. – from 2 months to 12 months upto 50 is normal. |
| A child of 11 months with 50 breaths per minutes | Normal. – from 2 months to 12 months upto 50 is normal. |
| A child of 12 months with 50 breaths per minutes | Normal - upto 8 weeks age above 60 is abnormal |
| A child of 15 months with 50 breaths per minutes | Abnormal- from 12 months anything above 40 is abnormal. |
| A child of 18 months with 35 breaths per minute | Abnormal- upto 8 weeks age above 60 is abnormal |

Worksheet: Decide dose of Co-trimoxazole

| Situation: | Even while referral is also insisted on where treatment has to begin: How much co-trim and how much paracetamol to give- |
|--|--|
| A child of 15 months classified as having pneumonia and fever | |
| A baby of 3 months old classified as having pneumonia and fever | |
| A 10 month old child with only cough and mild fever, but no pneumonia. | |
| A baby of 1 and half months classified as having pneumonia | |
| A child of 3 years, classified as having pneumonia. | |
| A baby of less than 3 kg weight having pneumonia. | |

Field Practice and Field Immersion

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

- Understand the reasons, scope and types of field visits.
- Learn how to organise field visits sessions.
- Learn how to maximise learning outcomes for field visits.
- Build the skills needed for on the job facilitation and training.

Methods: Group discussion

Activities

Step 1: Discuss the main reasons for field practice

Notes for the Trainers

Field visits are essential to build skills through a process of practicing the skills learnt in a context that is similar to where the ASHAs would have to live and work.

Field immersion is a specific form of field work where the participants are expected to spend their entire day with the ASHAs, even living in the village and going with them on their house visits and to visit newborns, VHNDs etc. This, the participants have to do for over 4 days- so that they get to see all the work that the ASHA does. Its main gain, is that it shapes the attitudes of the participants and

lets them understand and empathize with the ASHA. This would make them much better trainers.

Step 2: discuss how learning occurs in field visits.

Learning in field visits could occur because the participants are able to see ASHAs who are experienced and practicing all the skills in the way they ought to be. This is the demonstration effect. For this we need to build up best practice sites in the states. Currently only Gadchiroli would be able to play this role- and that too only for home based newborn care. But we need to build up best practice sites in each state where ASHAs are confidently and effectively practicing all these six skills. The plan is to develop a few blocks in each state as best practice sites.

Learning in field visits could also occur because the participants are able to carry out the tasks that ASHAs are expected to undertake so that they themselves gain experience in the skills they are to teach. Of these the skills of counselling are the most difficult to learn and they need considerable field practice under supervision. Participants are also able to provide on the job training for ASHAs working in these areas and that too helps build the skills of on the job

training. However since these ASHAs may not have gone through the classroom sessions such teaching would be limited. Another way to practice this skill is for participants to be in small groups and while one does the home visit, the others take on the role of their supervisor- a form of peer supervision.

Step 3: Discuss how to prepare for the latter type of field visits and field immersion.

- a. Select a few villages that are not too far away. Within one hour of the training site. Better to choose large villages. In each village plan to drop a group of 5 persons- along with the trainer- 6 persons. It could be a 4+1 group also if that is more convenient for arranging transport. Thus for a batch of 25, one needs to select 5 or 6 villages.
- b. Arrange for transport of the participants to the village and to bring them back.
- c. In each village, inform a contact person and the ASHA when the batch of participants would be coming and how long they would be there. Ask the ASHAs to identify the following on the day of the visit. It would be useful to ask the ANM and AWW to help and even for a trainer to visit the village and help with listing the following families.
 1. Families with a newborn
 2. Families with a pregnant woman in the last trimester.
 3. Families with a pregnant woman in the first trimester.

4. Families with a child in the 1 to 5 month age group who is normal or malnourished.
 5. Families with a child of about 9 months to 18 months old who is malnourished.
 6. Families where there is a child with diarrhoea, or a child with recurrent diarrhoea who may not currently have diarrhoea.
 7. Families where a child has fever or cough and cold.
- d. If further the ASHA could get the consent of the family for a visit from the participants/ASHAs for the purpose of learning- that would be better. If not, at the time of visit consent should be taken. And there would be a loss of time if consent is not given.

Step 4: Discuss the organisation of the field visit on the day of the visit.

- a. Hold a briefing session at the training site itself. Tell them what is expected of them during the field visits. Distribute the worksheets and check lists.
- b. During the visit the ratio of trainers/facilitators to trainees is important. Ideally, it is one is to five. But if that is not available, one would have to ask senior persons from within the team to play the role, or just peer supervision exchanging roles. This is not ideal- but it may be the best one can achieve till the number of trainers/facilitators builds up. In a training institution there would be part time trainers who could be called in to play this role.

- c. In the field visit each participant should interact with and counsel one of each of the above family types- at least. The first four would be in the first round of ASHA workshops and all the families after the second ASHA workshop. For trainers it would be all 7 family types after the first ten day workshop.
 - d. De-briefing: After they return collect the worksheets and allow time for discussion as to the cases they saw and to the issues they want clarification on.
- Step 5: Discuss how this would be useful for providing on the job support and supervision and whether currently there is anyone playing this role.*

Evaluation and On-the-Job Training for ASHA

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

- How to assess the learning levels of ASHA at the end of the training workshops.
- How to assess the learning levels of ASHA in the field situation and integrate such field evaluation with on the job training that closes the skill gaps.

Methods: Group discussion and practice

Materials: Question papers, Check lists.

Activities

Step 1: Briefly discuss the importance of evaluation and certification of ASHAs. It is to give the ASHAs confidence and to ensure that the ASHAs are proficient in asset of skills. It also helps to assess the quality of training, so that subsequent rounds of training can be improved and remedial supplementary training can be provided to those who have not yet reached the requisite level of proficiency.

Step 2: Explain the basic principles of evaluation.

- a. Training is a process that builds/ imparts specific competencies-

knowledge and skills to the trainee. Evaluation helps us ensure that these competencies have been built.

- b. Thus training evaluation must be competency based and also check whether the ASHA are able to apply these skills to their specific contexts.
- c. This evaluation must be done in steps- one is at the end of the workshop. This evaluates the immediate outcome of the training workshop.
- d. The subsequent evaluation is three months later and six months later and then quarterly or six monthly on the field. This assesses the retention of skills and their utilisation in the field situation. It would also assess on the job training and support.
- e. At the end of the evaluation process, feedback must be provided to the ASHA who are evaluated and a report must be provided to the programme managers. The feedback to the ASHA should be supportive and help her improve and should not discourage her.

Step 3: Let us learn how a supervisor/ trainer would conduct an on the job evaluation three months after the training programme. This would

also be an assessment of ASHA performance. Once we learn this, we could work backward to construct the training outcome evaluation at the end of the workshop.

- a. When the trainer visits the ASHA they would ask/do the following:
 - a. Who were the last three newborns in your area? Did you visit them? What were the health problems encountered if any? What was the advice you gave? Did they heed this advice? (Score this after confirmation - awareness of this is itself noteworthy).
 - b. Now visit the family with the newborn who relatively had the most problems- it could be the next scheduled visit or an extra visit. The trainer in conversation with the family would be able to check on what the ASHA told him. Then he could ask the ASHA to proceed to examine and counsel the newborn *and post partum mother* using a check list score the ASHA's performance under supervision. If there are competency gaps- then and there teach her to do it right.
 - c. Then ask which are the three pregnant women whose EDD is coming up next? Was a birth plan made? Is ANC completed? (Score this after confirmation- awareness of this is itself noteworthy).
 - d. Now visit the family of one of these women- who apparently is having the most problems.

Confirm what the ASHA advised? ASHA could now counsel the pregnant woman again. Use a check list to see if all steps are correctly carried out. If there are competency gaps- then and there teach her to do it right.

- e. Now ask whether the ASHA knows how many children below one there are in her village and how many of these are malnourished. Also their current grade of malnutrition. Even if she has a broad sense of the numbers it would do.
- f. Then ask the ASHA to take you to a woman with a child which is in the first six months of breastfeeding. Has the ASHA been visiting her? Let the ASHA counsel her under supervision. The ASHA should cover spacing, weaning and prevention of infection other than exclusive breastfeeding. Use a simple check list to score her performance on this.
- g. Then ask the ASHA to take you to a family with a child between 9 months and 2 years which is malnourished. How many times has ASHA visited this house? What does the ASHA state about why the child is malnourished- before the visit starts?
- h. Then ask the ASHA to counsel this family for the management of malnutrition and anemia in this child. Use the check lists to check how well she is doing.

- i. Then find out whether there is a child with diarrhoea, a child with cough or a child with fever and visit the house and request the ASHA to counsel this family under supervision. Use the check lists to see how well she is doing.
- j. Finally find out whether there have been any village level meetings. What has been the content of these meetings. How could it be improved.
- k. Find out what problems she has in mobilising for VHND and in promoting institutional delivery.

This entire exercise could take two to three hours. Or rather one could do as much of this as possible in two hours- beyond which it would be difficult to

retain the interest and time of the ASHA or the facilitator.

Step 4: If this is what the ASHA should be doing- we could now evaluate the training workshop similarly using case studies. One could generate a full question bank organised into sets of 20 questions each. From this bank a set of 20 questions are to be used for the end of the workshop evaluation. About 5 marks for each question. One sample question set of 20 questions is given below. This could be given as a written test to be done by each ASHA individually. Help those with lower literacy skills to understand and complete their replies. One set of questions could be first worked out in small groups before ASHAs are asked to write this individually.

Sample End of the Session Evaluation Paper (for first two rounds of training)

(Best administered individually and orally- though where ASHAs are fluently literate- and 8th or even 10th class pass- a written examination is acceptable). Trainers can develop other similar situations and list the correct responses from Module 6 and 7

| | The situation | What to look for in the answer |
|----|--|--|
| 1. | Ante-natal period: Sushma is in the seventh month of her first pregnancy when she is able to attend the VHND and gets registered. She has received one TT this visit and been given 100 tablets of IFA. She has moderate anemia- 9g/dl and BP is normal. Her weight is 45 kg. There is a sub-center 2 km away, a 24*7 PHC 20 km away and the district hospital which is an FRU is 30 km away. What would you advise and what is the birth plan you would make. | <ul style="list-style-type: none"> a. The second TT can/must be given. b. She needs 200 tablets of IFA. c. The choice should be for the 24*7 PHC and there would be time after labour starts. d. Other advice on diet rest etc need to be given. |
| 2. | Sharifa is in the ninth month of pregnancy. This is her second pregnancy. Last pregnancy she had a C-section. This pregnancy is normal. The sub-center is 2 km away, the 24*7 PHC is 20 km away and the FRU in the district hospital is 30 km away. It is difficult to get transport at night time. Her antenatal care is complete and except for haemoglobin of 10g/dl she is normal. | <ul style="list-style-type: none"> a. Choice of FRU for delivery b. Management of mild anemia- 200 tabs of IFA c. Explore possibility of moving to district HQ even before pain starts |
| 3. | As ASHA you are called to Amina's house when labour pain starts. This is her second pregnancy and by the time you reach over two hours elapses and the bag of waters has burst. Labour seems to be progressing well. To get transport and begin shifting would take an hour and another half hour to reach the PHC. The sub-center ANM could be called home. You have her mobile number. | <ul style="list-style-type: none"> a. The choice between SBA home delivery and risky transfer to the PHC. b. The birth companion roles in a home delivery-preparations. |
| 4 | A baby is born normally. In the first hour what are the things for the birth companion to help the mother with. Demonstrate on a doll/ mannequin how to dry the baby, weigh it, keep it warm and initiate breastfeeding. How would you counsel the mother on it. | <p>List of things to do as part of first visit to the newborn.</p> <p>Skills of a) how to take temperature, and b) how to weigh the baby, c) how to dry it and clothe it and d) how to initiate breastfeeding</p> |
| 5 | A baby is born normally at an institution and you are there as the birth companion. The baby is weighed. Demonstrate weighing. The weight is 2 kg. The temperature is taken and it is 96 degrees F; The room has a draught and the family wants to go home just six hours after delivery. What is the advice you would give. | Skills of (a) telling the family the risks of hypothermia, (b) advising the mother and family to keeping the baby warm, and (c) counselling them on breastfeeding, and (d) Being able to list what needs to be done at the home |
| 6 | You visit a mother who has just delivered a baby 7 days ago. The baby is feeding well- about 6 or seven feeds in the day. Its umbilical cord is normal and dried up. Since it is a hot season, they are also giving some small amount of boiled water with sugar added. The mother has some fever and her discharge is foul smelling. What is your advise? | Skills of (a) identifying post partum sepsis, (b) prompt referral to PHC, (c) motivate and counsel the mother to breastfeed exclusively and not give any other feeds, explain the dangers of fluids other than breastmilk. |
| 7 | Visiting the newborn and mother on the 28 th day, you see that both are normal except for the baby showing some redness of skin in the folds and crying frequently. Mother is not sure that she has adequate milk and has been supplementing with some cows milk as well. What is your advice? | Skills for counselling (a) reassure her that the redness is harmless and the baby must be kept dry at all times. (b) motivate and counsel the mother to breastfeed exclusively and not give any other feeds, explain the dangers of fluids other than breastmilk, highlight the risk of allergies and other problems with giving cow's milk. |

| | The situation | What to look for in the answer |
|----|---|--|
| 8. | You are visiting a mother with a two month old baby boy, just before they are going back to the husband's house after delivery. Baby is weighing 4 kg and crying often. The mother complains of painful breastfeeding and cracked nipples. What would you advise? | 9a) Observe the attachment or position, (b) if not correct teach the mother the correct positioning, (c) build her confidence and motivate her to continue breast feeding (d) teach her how to express the milk and relieve the engorgement. (e) apply breastmilk on the nipples to lubricate them and allow to air dry. |
| 9 | You visit a mother who has a five month old baby. The baby is of normal weight, but it is a poor household where malnutrition is likely to set in later. The elder child now two years old has malnutrition. How would you advise the mother. (The elder child's malnutrition need not be covered here) | (a) motivate the mother to continue breastfeeding, (b) Dialogue with mother and family on what are foods the family regularly eats (c) give the seven messages for complementary feeding, (d) enrol in Anganwadi centre), (e) ensure attendance at VHND for immunisation, 9f) advice on prompt care seeking for fever, cough or diarrhoea. |
| 10 | A one year old child weighs 8 kg. The mother states that she is still breastfeeding as well as gives her a cup of rice with daal water about twice a day. Child has had diarrhoea twice this month. There is no diarrhoea now. This is the mothers' only child. The child's appetite is poor and not gaining weight. Is the child malnourished? How would you advise the mother? | The child is malnourished. The following steps have to be taken: (a) ensure enrolment in AWC and assess status of malnutrition, (c) Dialogue with the mother on what the baby is being fed, (d) counsel mother on proper feeding, prevention of diarrhoea (e) close follow up to watch for improvements, f) escort to VHND for immunisation, anaemia assessment. |
| 11 | Nine month old Child has developed diarrhoea since the previous day. Passes watery stools over ten times per day and the eyes are sunken and skin pinched up takes time to return to normal. Child is however passing urine- though of dark colour. Weight of the child is normal. What would be the advice? | 9a) teach the mother how to make ORS, b) give her ORS packets, C) advise her on giving at least 3 cups of ORS in a four hour period, d) advise her to give extra fluids, (Home available fluids) |
| 12 | A two year old child develops diarrhoea and there is blood in the stools. There is no dehydration You advise referral, but the mother is unable to go as her husband is away and other children are at home. What tablets and what dose would you start on. After how many days would you decide your treatment is not working as the symptoms have increased. | (a) Co-trimoxazole tablets 3 tabs twice a day, (b) follow up in two days, (c) and try to refer her again- if necessary taking the child with you |
| 13 | A one year old girl has fever, cough, chest in-drawing and breath rate at 50 per minutes. They are unable to go to hospital today but would be able to go the next day. What advice would you give. | (a) Co-trimoxazole tablets 2 tabs twice a day, b) advise on keeping the child in a warm place, giving food as normal, cleaning the nose or putting drops of boiled water in which salt has been added. |
| 14 | A one year old girl develops fever and cough and on the third day develops lethargy and stops feeding. There is no chest in-drawing but breath rate is 50 per minute. What would be the advice. | Immediate Referral to a PHC or CHC |
| 15 | A three year old girl has a temperature of 101 degrees F, for the last one week. You advice her to go to the hospital, but they say they went yesterday and were just given a tablets which looks like paracetamol as the doctor was not there. This is a district known for malaria. Fever has been continuous but today there was chills and shivering also. What would you advice. | a) Take blood smear/RDK b) Give paracetamol c) Give chloroquine |

| | The situation | What to look for in the answer |
|----|---|--|
| 16 | A six month old boy has fever of two days duration and no cough or diarrhoea. Fever is mild. There are no danger signs, and child is breastfeeding and playing well. What would be the advice. | Give one quarter tablet of paracetamol four times a day. Measure temperature twice a day Observe for change in symptoms |
| 18 | When to refer in diarrhoea | a. Persistent diarrhoea- 14 days b. Dysentery- at once plus if not responding over two days of cotrim c. Some dehydration- not improving. d. Severe dehydration |
| 19 | Lakshmi works in the fields. This is harvest time and she is able to find only an hour each evening for her ASHA work this month. She has about 100 families or about 600 population to look after. Which families would she prioritise for her home visit. | a. Newborn child b. Pregnant woman in the last month- one visit. c. The others should be asked to come and meet her if there is any illness in the child and they need her advice. |
| 20 | You are planning to go to the VHND- but last minute some work has come up. You decide to remind those who have to go there to go with the help of the helper of the anganwadi. Who are the families who have to be so reminded. | Families who live in the poorest and most distant households, children of migrant labourers, handicapped children, children who are mentally challenged, dalit families, |

Evaluation of ASHA Trainers

This session guides the state trainers on evaluating the ASHA trainers. Evaluation of the ASHA trainers is based not only on their content knowledge and skills but also their ability to demonstrate competency in conducting training sessions. This evaluation is the basis for ascertaining the eligibility of ASHA trainers to continue as trainers.

Step 1: Several of the sessions for the ASHA trainers require Practice Sessions. In these sessions the state trainers will make sure that the ASHA trainers get enough hands on experience in not only getting familiar with the content of the sessions but are also able to actually conduct the sessions. The ASHA trainers will get feedback from the state trainers and also from the peer group on their performance.

Step 2: The state trainers designate 3-4 participants as observers for each practice session of the ASHA trainers, who independently assess the session and provide feedback. All ASHA trainers should get an opportunity to function as observers during practice sessions.

Step 3: State Trainers and observers use the Training evaluation Checklist (Handout 1) to observe the practice session using the.

Step 4: State trainers save all the filled checklists as the out put of the session and these are kept at the state training site.

Step 5: The observers' checklists are used to provide feedback to the participants. This exercise allows the observers to work with the state trainers to learn the skills of evaluation. After each practice session by an ASHA trainer, the state Trainer asks for feedback from the peer group.

Step 6: The state Trainer then gives feedback to the ASHA trainers based on their performance as noted in the Training Evaluation Checklist. Trainer also summarizes the feedback of peer group.

Step 7: The state trainers should calculate the score of each participant on the practice session.

Based on the marking system, those ASHA trainers who score over 60% are certified as being able to function independently as ASHA trainers.

Those scoring above 55% but below 60% are designated as Co-trainers. This implies that while they cannot conduct sessions independently they can support training sessions for ASHA and conduct sessions under

the guidance of the more skilled trainers. State Trainers should make a special effort to supervise those training sessions in which co-trainers take sessions. After Round 1 of one ASHA training the state trainers re-evaluate their performance. If they

score over 60% they are then certified as being able to conduct independent sessions.

For those ASHA trainers who score less than 55%, they would require to undergo re training.

Evaluation of the ASHA Trainers

Name of the ASHA Trainer: _____

Name of the Organisation _____

Date of Evaluation _____

Name of Evaluator _____

List of Items on which practice sessions should be evaluated - Total Marks 100

| Sr. No. | Items for Evaluation | Marks |
|---------|--|-------|
| 1 | Content <ul style="list-style-type: none"> • Clarity of content • Sequencing of content • Flow of the session • Correctness of communicated content | |
| 2 | Presentation <ul style="list-style-type: none"> • Confidence • Board work/charts/transparencies • Participation from group • Tone of voice & body language • Time utilisation | |
| 3 | Problem solving <ul style="list-style-type: none"> • Handling of situation sympathetic/authoritative • Presence of mind • Satisfaction of the trainees • Correctness of the response | |
| 4 | Summary and evaluation <ul style="list-style-type: none"> • Whether session was summarised • Method of summarising monologue/dialogue • Whether questions were asked for evaluation • Whether objectives of the session were achieved | |
| 5 | Use of training method <ul style="list-style-type: none"> • Use of the training method | |
| | Total of above 5 columns | |

Each item in the above list has 20 marks. Within the item distribution of marks is equal.

Write additional points if any in the space provided below: _____

Signature of Evaluator _____

