सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

REFERENCE MANUAL FOR INTEGRATED RMNCAH+N COUNSELING

Ministry of Health and Family Welfare
Government of India

September 2021

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September 2021

Ministry of Health & Family Welfare
Government of India, Nirman Bhawan, New Delhi-110001

मनसुख मांडविया
MANSUKH MANDAVIYA

सत्यमेव जयते

स्वास्थ्य एवं परिवार कल्याण
व रसायन एवं उर्वरक मंत्री
भारत सरकार
Minister for Health & Family Welfare
and Chemicals & Fertilizers
Government of India

MESSAGE

The Sustainable Development Goal 3 (SDG 3) seeks to ensure healthy lives and promote well-being for all at all ages. Reducing maternal and child mortality and morbidity is crucial for achieving this goal. An integrated approach under the RMNCAH+N lies at the core of the National Health Mission for improving the health of mothers and children. The strategy provides a platform for delivery of services across life-stages thus maintaining the continuum of care.

Thus, this reference manual has been developed to promote integrated RMNCAH+N counselling on various interventions across thematic areas. I hope this will enable counsellors to effectively discharge their responsibilities.

It is a moment of great pride for the Ministry of Health and Family Welfare to come up with this manual to strengthen counselling for RMNCAH+N services in the country. I am hopeful that this will go a long way in promoting better health outcomes for mothers and children of our country.

(Mansukh Mandaviya)

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डॉ. भारती प्रविण पवार
Dr. Bharati Pravin Pawar

सत्यमेव जयते

स्वास्थ्य एवं परिवार कल्याण राज्य मंत्री
भारत सरकार
MINISTER OF STATE FOR
HEALTH & FAMILY WELFARE
GOVERNMENT OF INDIA

सर्वेसन्तु निरामया

स्वच्छ भारत
एक कदम स्वच्छता की ओर

Health is a basic human right and all must have equal access to proper health care. The well-being of mothers, children and adolescents is an important public health goal for India. The integrated Reproductive, Maternal, New-born, Child and Adolescent Health. (RMNCH+A) approach adopted by the Government addresses a wide range of issues that affect the health, wellness, and quality of life of women, children, and families.

This strategy is beginning to bear fruit, and there has been considerable improvement in health indicators of India and a substantial decline in maternal, infant and child mortality. As we celebrate 75 years of independence, the Government strives to reach everybody especially those belonging to underprivileged sections by enabling them to seek and avail services. The Government is working relentlessly to improve the health services, and to remove the imbalances in access to services particularly focusing on women and children.

Counselling is a crucial component of quality service delivery. The counselling process is more like a learning experience wherein the client makes an informed choice to use a service. Our healthcare workers are persevering to improve acceptance and compliance of service usage.

I am very optimistic that service providers at all levels will utilize this manual for providing effective counselling while rendering services. I congratulate the Family Planning Division for developing this manual.

BPw

(Dr. Bharti Pravin Pawar)

"दो गज की दूरी, मास्क है जरूरी"

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SECRETARY

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स्वास्थ्य एवं परिवार कल्याण मंत्रालय
Government of India
Department of Health and Family Welfare
Ministry of Health and Family Welfare

PREAMBLE

Reproductive, Maternal and Child Health in the country has been a key priority for the Government of India for many decades. Over the years, realizing that health in each stage of the life cycle is closely linked to health in the previous stage, an integrated approach towards Reproductive, Maternal, Newborn, Child and Adolescent Health has been adopted. The role of Nutrition at every stage is crucial which determines the outcome of the next stage. This strategy has been pivotal in reducing both maternal and child mortality in the country. With the aim of achieving Sustainable Development Goals, further strengthening of the programme is being done.

Good practices related to Maternal, Newborn and Child Health and Family Planning are adopted and sustained when clients make decisions themselves based on accurate information. Also, the impact of effective counselling and imparting correct updated information influences the perceived quality and uptake of services by the client. The purpose of this Reference Manual is to strengthen counseling services across various components of RMNCAH+N.

This comprehensive Manual is an attempt to develop capacity of all stakeholders including RMNCAH+N programme managers, trainers, and service providers (Medical Officers, Nursing personnel and Midwives, Community Health Officers and Counselors) for improved maternal and child health outcomes.

Place : New Delhi
Date : 04-09-2021

(Rajesh Bhushan)

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PREFACE

The Government of India is committed to strengthen RMNCAH+N service delivery in an integrated manner across all stages of life cycle as per client need. Counseling on the integrated approach requires knowledge on all components and skills to address the service needs of clients availing these services. Effective counseling plays a vital role in dispelling myths and misconceptions, improving compliance and increasing client satisfaction thus ensuring 'Continuum of care'.

Over the years all the programs have evolved, and new strategies have been devised. This led to a felt need to upgrade the existing handbook for RMNCH Counselors and develop a Reference manual for Integrated RMNCAH+N counseling. The manual additionally addresses the distinct needs of youth, helps in busting myths and misconceptions and continuation of RMNCAH+N services in disaster situations including pandemics. Further Nutrition, has been elaborated across all stages of the life cycle.

This reference manual would serve as a ready reference resource for all levels of health care providers, trainers and counselors at District Hospitals, Sub District Hospitals, Community Health Centres, Primary Health Centres, and faculty of Medical Colleges. It has been developed to also serve as a resource for Program Managers to effectively plan and implement the Programme in an integrated manner.

The efforts of the Family Planning Division in developing this manual are appreciated. I hope this reference manual helps in improving the quality of counseling across all components of RMNCAH+N which in turn would help in reducing maternal and child mortality.

(Vandana Gurnani)

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संयुक्त सचिव
Dr. P. Ashok Babu, IAS
Joint Secretary

MESSAGE

The Reproductive, Maternal, Child and Adolescent Health (RMNCAH+N) strategy is at the heart of the National Health Mission (NHM). Counseling plays a crucial role in increasing awareness, generating demand, and facilitating services for various RMNCAH+N components. Effective counseling empowers clients to make timely decisions based on accurate information and enables them to avail good quality maternal, newborn, child, adolescent health and family planning services. All service providers have an important role to play in providing effective counseling thereby improving uptake of services.

This reference manual for integrated RMNCAH+N counseling is a step to equip service providers across all levels including CHOs with necessary skills for counseling. I am confident that this comprehensive manual developed with inputs from all RCH Program Divisions will serve as a reference document on technical and programmatic aspects of counseling under RMNCAH+N.

The efforts of the Family Planning Division in developing this comprehensive manual are highly acknowledged. I hope this manual will go a long way in imparting knowledge, developing counseling skills and eventually scaling up of RMNCAH+N services across the country.

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FOREWORD

The Reference Manual for Integrated RMNCAH+N counselling has been developed to strengthen the skills of RMNCAH+N counselors at all levels of healthcare service providers. This manual will serve as a valuable resource for orientation of counselors and form the basis for counselling on various components of RMNCAH+N.

The scope of the handbook for counsellors has been broadened in line with the integrated approach of RMNCAH+N. Sections have been added on general counselling skills adolescent health and nutrition across all life stages. A separate section on counselling during disaster situations has been introduced in the wake of the current pandemic situation. A dedicated section to dispel common myths and misconceptions on various components of RMNCAH+N has been added. Clarity on program management aspects has been included separately. Key counselling messages have also been added in each section. A new set of annexures and glossary of all technical terms have also been added for greater clarity of concepts.

I am hopeful that the effort that has gone into revising this manual will be worthwhile, and it will enable service providers and counselors to upgrade their knowledge and skills thereby improving client satisfaction and compliance.

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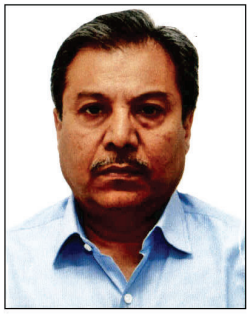


ACKNOWLEDGEMENT

The Reference Manual for Integrated RMNCAH+N Counselling has been developed based on the felt need to upgrade the existing Handbook for RMNCH Counselling 2012, on account of the introduction of a host of new programmes, initiatives and schemes in the RMNCHA+N arena.

This manual has been made possible with the overall guidance of Sh. Rajesh Bhushan, Secretary (H&FW) and constant support of Ms. Vandana Gurnani, Additional Secretary and MD (NHM). I am thankful to Dr. P. Ashok Babu, Joint Secretary (RCH) for his endeavor to augment the efforts for attaining RMNCAH+N goals.

I extend my heartfelt thanks to all RCH Program Divisions in MoHFW namely Maternal Health, Child Health, Immunization, Adolescent Health and Nutrition for providing comprehensive inputs for this manual.

I wish to acknowledge all the experts of Technical Resource Group, especially the core group members comprising Dr. Ravi Anand, Dr. Roli Seth, Dr. Sunita Singal, Dr. Alok Banarjee, Dr. Bimla Upadhayay and Dr. Jyoti Vajpayee for their substantial contribution in developing this manual after extensive review and discussions. My sincere thanks to the State Program Managers who contributed in shaping this manual based on their field experiences.

Appreciation is also due to members of Family Planning Division namely, Dr. Teja Ram, Additional Commissioner, Dr. Divya Valecha, Assistant Commissioner, Dr. Richa Kandpal and Dr. Neha Naik.

I would also like extend my appreciation to Dr. Pragati Singh, Ms. Shikha Bansal and Dr. Sadab Boghani for their untiring efforts in drafting new chapters and support in finalization.

A special appreciation is due to Dr. Nidhi Bhatt who shouldered the enormous responsibility of leading the task of conceptualization, development and finalization of the manual.

I hope this integrated manual empowers all Program Managers, RMNCAH+N service providers and counsellors and serve as a one stop manual for Integrated RMNCAH+N Counselling in the country.

(Dr. S.K Sikdar)

Table of Contents

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Tract Infections
ASHA	Accredited Social Health Activist
BMI	Body Mass Index
CAC	Comprehensive Abortion Care
CHC	Community Health Centre
CHO	Community Health Officer
COC	Combined Oral Contraceptive Pills
DQAC	District Quality Assurance Committee
ECP	Emergency Contraceptive Pills
ECD	Early Childhood Development
FDS	Fixed Day Services
FP	Family Planning
FPIS	Family Planning Indemnity Scheme
FPLMIS	Family Planning Logistics Management Information System
GOI	Government of India
GDM	Gestational Diabetes Mellitus
Hb	Haemoglobin
HBV	Hepatitis B Virus
HBYC	Home Based Care for Young Child
HIV	Human Immunodeficiency Virus
HTSP	Healthy Timing and Spacing of Pregnancy
IEC	Information Education Communication
IFA	Iron Folic Acid
IUCD	Intra Uterine Contraceptive Device
IYCF	Infant and Young Child Feeding
KMC	Kangaroo Mother Care
LAM	Lactational Amenorrhea Method
LARC	Long Acting Reversible Contraceptive
LBW	Low Birth Weight
LHV	Lady Health Visitor
LMP	Last Menstrual Period
MEC	Medical Eligibility Criteria
MO	Medical Officer
MPA	Medroxy Progesterone Acetate
MMA	Medical Methods of Abortion
MTP	Medical Termination of Pregnancy
NCD	Non-Communicable Diseases
NFHS	National Family Health Survey
NFPP	National Family Planning Programme
NGO	Non-Government Organization
NHM	National Health Mission
NSV	No Scalpel Vasectomy
OCP	Oral Contraceptive Pills
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
PAFP	Post Abortion Family Planning
PAIUCD	Post Abortion Intra Uterine Contraceptive Device
PCPNDT	Pre-conception and Pre-Natal Diagnostic Techniques
PPIUCD	Postpartum Intra Uterine Contraceptive Device
PHC	Primary Health Centre
PMS	Premenstrual Symptoms
PNC	Postnatal Care
RCH	Reproductive and Child Health
RH	Reproductive Health
RMNCAH+N	Reproductive, Maternal, Neonatal, Child, Adolescent Health and Nutrition.
RTI	Reproductive Tract Infections
SGBV	Sexual and Gender Based Violence
STI	Sexually Transmitted Infections
SQAC	State Quality Assurance Committee
TFR	Total Fertility Rate
UHC	Universal Health Care
WHO	World Health Organization

SECTION I

Preview of RMNCAH+N

01

Importance of Integrated Approach towards Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition

1.1 Background

Improving maternal and child health and their survival are central to the achievement of SDGs. Following the Government of India's "Call to Action (CTA) Summit" in February, 2013, the Ministry of Health & Family Welfare launched Reproductive, Maternal, Newborn, Child plus Adolescent Health (RMNCH+A) programme/ strategy to ensure effective integration of these health services for reducing maternal and child morbidity and mortality. The RMNCAH+N Strategy, therefore, is at the heart of the flagship National Health Mission.

Due to the importance of nutrition across all life stages, the strategy now includes nutrition as one of its important pillars. RMNCAH+N strategy thus covers Reproductive, Maternal, Newborn, Child and Adolescent Health and the "plus" within it focuses on Nutrition, as well as important linkages between these services and with other components like family planning, adolescent health, HIV, gender, and preconception and prenatal diagnostic techniques. It also focuses on linkages between community-based services and facility-based services and ensures referrals, and counter-referrals between various levels of health care system to create a continuous care pathway.

This integrated approach is important because of the following reasons:

- One stage of life leads to the next stage e.g. childhood leads to adolescence, which then leads to adulthood. Similarly, pregnancy leads to postpartum periods in women and the arrival of a newborn baby. Therefore, to keep people healthy it is important to provide integrated health services across various life stages including the adolescence, pre-pregnancy, pregnancy, childbirth and postnatal period, neonatal period, infancy and childhood and throughout the reproductive age

  During each stage of life, there are some specific healthy behaviours, including nutrition, preventive measures and essential health services that are required to keep the person healthy and enter the next stage in good health
- A healthy outcome at one point in the life course provides a positive determinant for another point in the life course e.g. if pregnant mother is healthy, the newborn baby is likely to be healthy
- Through this approach, health services can be provided to multiple members of a family from a single point of contact e.g. while a couple with an infant is counseled on breastfeeding, immunization and prevention of diseases, contraceptive counseling and services can also be made available to them
- It ensures continuum of care through various life stages as well as focuses on the most vulnerable and underserved sections of the population
- The life course approach also determines equal care and interventions to address both men and women in the community addressing the gender disparity in health seeking behaviour and health education and promotion at all levels

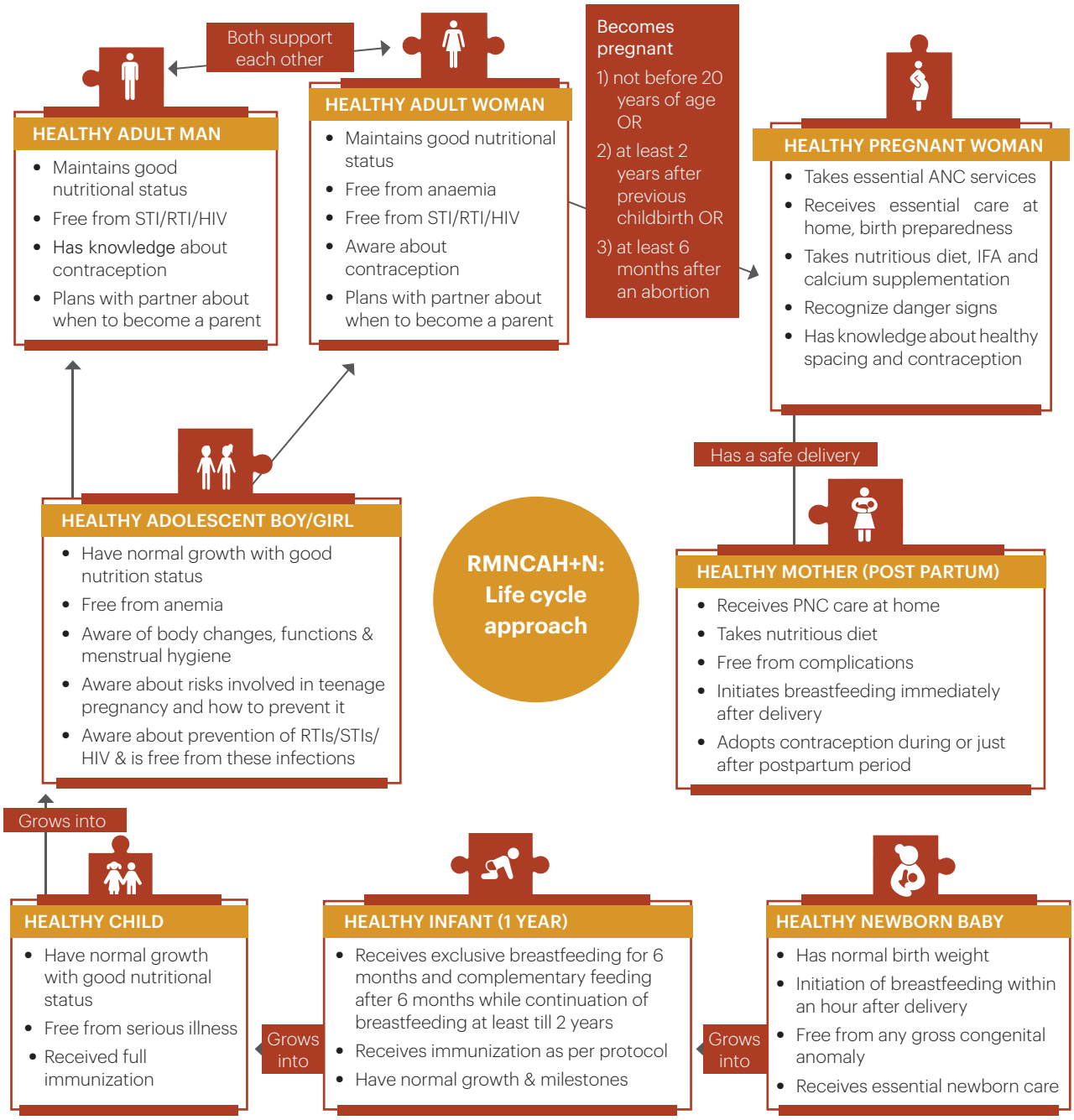


Figure 1: Interlinkages between different life stages

Under RMNCAH+N, reproductive health and nutrition interventions are cross cutting across all life stages. The reproductive health forms the primary pillar of RMNCAH+N and aims at ensuring healthy reproductive practices, encouraging contraceptive use while having an effective integration of the maternal, child, adolescent health and family planning. Increased contraceptive use can reduce the number of maternal deaths by reducing unintended pregnancies, thereby abating the number of times women face the risks associated with pregnancies. With substantial unmet need of contraception – about 22% among married adolescents (15–19 years) – and low condom use by adolescents in general, adolescent girls are at a high risk of contracting sexually transmitted infections, HIV and unintended and unplanned pregnancies. This in turn contributes to maternal morbidity and mortality due to unsafe abortions, high risk pregnancies and infections.

Further evidences also show that the risk of premature delivery and LBW in babies doubles when conception occurs within six months of a previous birth. The use of contraceptives thus has the potential to improve perinatal outcomes and child survival by widening the interval between pregnancies. Especially in areas with poor health infrastructure, family planning is a cost-effective and feasible way to reduce maternal and child deaths as it does not rely on complex technology.

One-third of India's population comprises of adolescents who are the future citizens and workforce of the country. This population has its unique requirements and issues which need to be addressed amicably to ensure they develop into confident and healthy adults. At this stage of life, one struggles with self-identity issues, overall societal belonging and high susceptibility to several preventable and treatable health problems.

Specifically, for access to SRH information and services, adolescents show poor negotiation skills due to prevailing social norms and fear of being recognized. Also, lack of information, non-availability of counseling, judgmental attitude of service providers, and lack of adequate privacy/ confidentiality limits the service uptake. Adolescents being minor may also be discouraged to visit the health facilities alone.

High maternal and child mortality in adolescent mothers and a smaller but significant contribution of adolescents to total fertility brings the focus back on the need to address adolescents as an integral part of the strategy.

The counseling for ensuring maternal and child health starts with the preconception period when the couple is planning for a baby. It aims at improving their health status and reducing individual and environmental factors that contribute to poor maternal and child health outcomes (WHO). A mother's health is a crucial determining factor for child's health and development. The first 1000 days of a child is further important for its well-being and thus it is essential to ensure that immunization, nutrition and a healthy and stimulating environment for psychological and physical development of child are available. Birth weight is an important factor that determines child survival as children with low birth weight (LBW) are more likely to have impaired growth, higher risk of chronic adult diseases and mortality. LBW is also a strong predictor for overall growth in later life as most of these babies have intrauterine growth retardation, and they seldom catch-up with normal size during childhood. In India, 18% babies born each year have LBW (NFHS IV), which is inextricably linked to maternal undernutrition and anaemia among other causes. The mother's condition before pregnancy is a key determinant of its outcome; half of adolescents (boys and girls) have below normal body mass index (BMI) and almost 54% of adolescent girls aged 15–19 years have anaemia (NFHS IV). Teenage mothers are more vulnerable to problems related to pregnancy and childbearing, specifically high risk of preterm births. Therefore, the nutritional status of adolescent girls and young women is inextricably linked to the birth weight of their children and subsequently to child survival.

India is aiming at achieving Universal Health Care (UHC) for which concerted efforts are required to make services available at all levels, including in communities and at the doorstep of beneficiaries. Just as different stages in the life course are interdependent so are the aspects of where and how health care is provided. Household or community education contributes to adoption of healthy practices, thus preventing need of treatments and health complications; quality care provided at the community level helps avoid the need for hospitalization, and sound referral systems at primary care level support early identification of risks and better treatment for acute and complicated conditions. Essential interventions to improve the health of women and children, therefore, need to take place at all levels in the health system. For ensuring Comprehensive Primary Health Care, the Health and Wellness Centers contribute in preventing health complications, providing quality care, early and easy referral for specialized care, thus minimizing the health risks, burden and its outcomes.

The aim is to provide comprehensive holistic services/ information considering the age, sex, health needs and its impact on overall health outcomes of an individual. Towards this objective, a dedicated RMNCAH+N Counselor is placed at the public sector health facilities under the National Health Mission in some of the states. Counseling is the mainstay of any service provision. Service providers at all levels also play a dual role in increasing awareness & generating demand for the various RMNCAH+N services as well as in facilitating/ providing those services. These counselors are expected to ensure that all the women, men, adolescents, children and families coming to the health facilities are given appropriate information about the relevant essential RMNCAH+N services available at the facility, facilitate decision making and adoption of the appropriate health service/ healthy behaviour. The counselors are expected to approach each client and his/ her family holistically, recognizing that the client may have needs that may be inter-related, encompassing a range of reproductive, sexual, maternal, newborn, child and nutrition needs.

The RMNCAH+N Counselors can act as an important link between the health system and client, especially the adolescent clients. Besides promoting healthy lifestyle, preventive measures, follow-up care and referrals, counselors should also support strengthening of outreach services, establish linkages with the community at large and generate demand especially for adolescent friendly health services. With the recent advancements in technology, option of digital counseling/ telephonic counseling is also available and may be used by the persons with limited access to health facilities and those who are comfortable using technology.

Counseling skills are equally important for all health-care providers. Health-care providers are expected to ensure that each client and his/ her family is provided support in terms of relevant information about the available services, facilitate decision making and adopting the relevant health service/ healthy behaviour.

1.2 Scope of the Manual

The Reference manual for Integrated RMNCAH+N Counseling has been formulated with an intent to serve as a one-stop manual for providing programmatic and technical guidance across the RMNCAH+N programme strategies that is useful for RMNCAH+N Counselors as well as other service providers. This manual also lays down the training strategy and curricula to train the counselors for quality service provision in a sensitive manner.

It can also be used for monitoring and ensuring quality counseling services at the public health facilities. It will not only help in enhancing the knowledge and skills of RMNCAH+N Counselors in providing quality counseling but also empower other service providers and programme managers in enhancing service provision in their states and districts, which in turn will help to ensure wider acceptance and continuation of RMNCAH+N services leading to greater client satisfaction and improved RMNCAH+N outcomes.

1.3 Target Audience

This comprehensive handbook is meant to be used throughout the country by all stakeholders, including programme managers at the national, state, district and block levels, trainers, counselors and service providers at all levels (medical doctors, nursing personnel and other paramedical staff).

SECTION II

Counseling Skills

02

Counseling and Effective Interpersonal Communication

2.1 Counseling for RMNCAH+N Services

Counseling is a two-way communication between a health care worker (counselor) and a client, where the counselor builds rapport with the client for the purpose of facilitating decision making by the client regarding adoption of healthy behaviour/s or availing health service/s and reducing health risks. Establishing mutual trust between the client and the provider is central to quality counseling services. The counselor must show respect towards the client, be mindful if clients are not comfortable sharing all information in the first interaction, reassure about confidentiality of the discussion and identify and address client's her/his concerns, doubts, and fears.

2.2 Tasks Involved in Counseling

- Creating appropriate and supportive counseling environment with privacy and noise control etc. that will contribute to effective interpersonal communication
- Helping the clients assess their own needs for a range of health services, providing information and emotional support
- Actively and empathetically listening to clients' problems and work with them to find solutions that fits into their context in order to build trust and confidence
- Providing information appropriate to clients' problems and needs
- Assisting the clients in making voluntary and informed decisions
- Helping the clients in developing the skills that they may need to make the decision
- Understanding from the client if there are any barriers likely to be faced in adoption of healthy behaviour/s or health service/s and helping the clients to overcome them
- Providing suitable referral options and connecting/ liaison with other support services and health workers

2.3 Benefits of Counseling

Effective counseling on RMNCAH+N issues/ services can:

- Lead to increased likelihood of adopting healthy behaviour/s or health service/s
- Dispel client's myths and clear misconceptions
- Promote compliance for consistent and correct adoption of healthy behaviour/s or health service/s, thereby safeguarding the client's health
- Increase client satisfaction
- Increase in demand and utilization of health services

2.4 Principles of Counseling on RMNCAH+N Services

People seeking and availing health services from a health facility/ provider have many rights **(Client's rights)**, such as the right to be treated with respect & without any discrimination, right to privacy & confidentiality, right to get correct information and to voluntarily make an informed choice and right to access quality and continuous services. Client's rights need to be given prime importance while counseling or providing RMNCAH+N health services.

Principles of counseling, which need to be followed by the counselor:

- Consider each client as a unique individual with specific needs and characteristics and accept them without being judgmental
- Never discriminate based on gender, religion, sexual orientation, disability, caste, ethnicity, tribe, language, marital status, occupation, political beliefs etc.
- Have a respectful, empathetic, accepting and caring attitude towards the client
- Ensures client's privacy and confidentiality at all times
- Actively listen to the client and encourage the client to ask questions and express any concerns
- Provide brief, simple and specific information with key messages
- Use simple and culturally appropriate language, by giving simple examples which can be easily understood by the client
- Use audio-visual aids, anatomical models, brochures, samples (whenever possible and relevant) so that the information is easily understood and remembered by the client
- Repeat key information shared by the client, showing and confirming that you have understood correctly what they are saying
- Ensure client's correct understanding of what has been told
- Ensure voluntary and informed decision making by client- never force anyone to adopt any service

Informed choice and informed consent

The concepts of informed choice and informed consent are related but quite different in their intent.

The purpose of *informed choice* is to ensure that all clients choose the best option/s for their health care needs after receiving full information about all available options. Informed choice is a pre-condition for informed consent.

Informed consent means that a client understands the procedure (medical or surgical) and then decides to receive the care. Informed consent can be verbal or written. However, informed consent alone does not constitute informed choice.

2.5 Essentials of Effective Interpersonal Communication

Communication means conveying one's thoughts or any information or message to another person, using words or gestures or both. In one-way communication, one gives messages and the other receives them, without an exchange of ideas. Hence, it is not an effective way of communication for counseling.

During counseling, it is essential to have a two-way communication between the health-care provider and the client so that there is an interaction between them in which both get the chance to express their thoughts and information. Effective interpersonal communication requires both positive verbal communication (words & tone of voice) and positive non-verbal communication (body language).

Table 1: Communication skills for counseling

	Verbal Communication	Non-Verbal Cues
Positive	✿ Clear diction ✿ Positive tone of voice ✿ Use of simple language and culturally appropriate words and phrases ✿ Emphasizing main points ✿ Active listening	✿ Leaning towards the client ✿ Smiling, not showing tension ✿ Maintaining eye-contact ✿ Facial expressions showing interest and concern ✿ Nodding
Negative	✿ Using technical jargons ✿ Monotonous tone ✿ Speaking very softly or very loudly ✿ Speaking fast or very slow ✿ Using judgmental words e.g. "you should not do this" etc. ✿ Repeating a word phrase many times e.g. "I mean to say' "do you understand" etc.	✿ Looking elsewhere ✿ Stern facial expression ✿ Frowning ✿ Impatient look – glancing at the time ✿ Speaking to someone on mobile ✿ Fidgeting ✿ Engrossed in some other task e.g. busy writing in the register

2.5.1 Verbal Communication

Refers to the words used in delivering the information and the tone in which they are delivered. It is largely conscious and is controlled by the individual who is speaking.

2.5.1.1 Effective verbal communication skills for counseling include:

- Using simple language which is easily understood. Counselor should not use technical terms and refrain from using a phrase repeatedly e.g. "I mean", "do you understood", "actually it is" as they cause distraction from the main points
- Giving simple and appropriate examples, which the clients can easily understand
- Using positive and appropriate tone, which is not monotonous or disrespectful
- Speaking at a speed which is neither too fast nor too slow
- Emphasizing the important points
- Giving verbal encouragement to the client to exchange thoughts and feelings, asking questions to clarify their doubts
- Listening Actively: When the client is saying something or answering a question, listen carefully and do not interrupt the person. Maintain positive body language by looking at the person, also give appropriate short response like – "Ok, I see, then what did you do?" so that the client is encouraged to share her or his situation/ feelings freely
- Asking questions effectively- Use close ended questions, which can elicit a short response, for seeking client information like his/her name, age, or number of children. On the other hand, to entirely understand the client's situation, feelings and experiences , it is important to ask open ended questions e.g. "what is your

experience about breastfeeding" or "what is your experience related to use of a specific contraceptive" or "what are your thoughts about having to take injectable contraceptive every 3 months" etc.

After providing the information, do not ask close ended questions like – "have you understood what I told you? because response can be 'yes' or 'no', from which the counselor would not know how much the client has understood. Instead, ask open-ended questions to the client, e.g. "what have you understood from what I just told you?"

- Encouraging questions: While sharing the information, encourage the client to ask questions by saying – "what questions do you have? Please ask me and I will be happy to answer them." Refrain from using sentences like, "I am sure now it must be very clear to you and you must be having no doubts or questions about it"
- Answering questions effectively: Listen carefully to the question. Then answer it in a concise and simple manner. Accurately responding to the queries of the client confirms that they are being heard correctly
- Paraphrasing what the client has said in a simple crisp way to ensure clear understanding of what the client said or meant

2.5.2 Non-Verbal Communication

Refers to actions, gestures and facial expressions which convey feelings. They are largely subconscious and often reveals to the observant the real feelings or messages being conveyed.

2.5.2.1 Effective non-verbal communication (body language) for counseling include:

- Positive body language: e.g. leaning towards the client, smiling, not showing tension or judgement, maintaining eye-contact, facial expressions of interest and concern
- Nodding while listening to the client and not frowning or looking disinterested or in a hurry by looking at the watch
- Observing the client's body language carefully to get an idea if s/he is puzzled, wants to say something, or looks disinterested or hesitant and act accordingly by asking him/ her to share the feelings/ thoughts

2.5.3 Skills of an Effective Counselor

- Good communication skills – both verbal and non-verbal
- Strong and thorough technical knowledge related to the concerned services
- Ability to use audio visual aids and explain technical information in a language that the client understands
- Prepared to answer questions comfortably on subjects including myths, rumors, sexuality, reproductive and personal concerns
- Ability to recognize when to refer the client to a specialist or other health-care provider

2.6 Process of Counseling (GATHER Approach)

2.6.1 Counseling of New Client

G: Greet – This step is to make the client feel welcomed and to create a conducive atmosphere, including audio visual privacy

- Be polite, friendly and respectful: Greet the client, give your full attention, introduce yourself, and offer a seat
- Ask how you can help to fulfill purpose of the visit

- Explain what the client can expect during the visit
- Provide privacy and assure the client that all information discussed will be confidential

A: Ask – This step is to understand client's situation and needs for a service/ healthy behaviour

- Ask for all the information needed to complete the client's records
- Ask about his/ her specific needs for a health service, any health problems, any measures already been taken to solve the problem
- By asking simple questions, assess what the client already knows
- Listen actively to what the client says to understand their situation and current needs
- Identify information gaps that need to be filled or misconceptions that need to be corrected
- Help the clients express their feelings, needs, wants, any doubts, concerns or questions
- Keep questions simple and brief

T: Tell – This step is to provide correct information and guidance about the healthy behaviours and services needed by the client

- Tell the client about healthy behaviours/ services that are needed in the client's current situation e.g. while counseling a pregnant woman, tell her about the importance of taking tetanus injections and iron and folic acid tablets, eating nutritious diet and taking appropriate rest and care at home
- Use counseling job aids effectively while giving relevant and specific information e.g. a pictorial flipbook, brochure and samples. Deliver key messages with simple pictures or samples, while explaining the relevant information. Help the client remain focused and understand the information easily. Encourage the client to ask questions on information being shared
- Tailor information to the client's needs
- Put risks into perspective (e.g.: the risks associated with carrying a pregnancy to term are much higher than risks associated with using a contraceptive method)
- Ask if the client wants to learn more and answer his/ her concerns and questions

H: Help – This step is to help the client in decision making and availing services. Some clients are able to make a quick decision, while others need help in doing so. The counselor should use a consultative approach and try to understand what barriers/ challenges the client is likely to face and suggest ways of overcoming them.

- Help the client understand what the shared information means to him/ her personally (e.g.: what would it take or mean to start a new contraceptive method, to cope with side effects, to discontinue or to switch to another method?/ what would it mean to adopt safe abortion service at the health facility and how to avoid unwanted pregnancies in the future?)
- Help the client to arrive at a decision to adopt the healthy behaviour/ avail services
- Ask if the client wants anything to be made clearer. Reword and repeat information as needed
- Check whether the client has made a clear decision. Specifically ask, "What have you decided to do?" Wait for the client to answer

E: Explain – This step is to explain healthy behaviour and services in details and remove any doubts that the clients may have.

- Dispel myths and remove misconceptions, if any, helping the client to overcome barriers in adopting the healthy behaviours/ availing services

- If the health service cannot be given at once, tell the client how, when, and where the services will be provided
- Ask the client to repeat instructions to make sure that the client understands and remembers them
- If possible, give the client printed material to take home
- Thank the client for coming and invite him/ her to visit if any side effects are noticed

R: Return/ referral – This step is to fix the next visit and ensure appropriate referral, if required

- Schedule return visit by the client for availing/ follow up of services provided
- If required, refer to a service provider/ appropriate place for further services

2.6.2 Counseling of Client during Follow Up Care

- Greet the client and ask for their experience/ compliance regarding the adopted behaviour/ health service
- Also ask if there are any questions or points to be discussed and clarified
- Listen carefully and answer the questions accordingly. Treat all concerns seriously
- If the client is satisfied, encourage to continue with the adopted behaviour/ service as per their ongoing protocol e.g. encourage a pregnant woman to continue taking iron and folic acid tablets regularly and take her next tetanus injection on its due date
- If client is facing difficulty or problems, reassure and counsel accordingly. For e.g.: mother of an infant might report that the child is not taking feeds properly and may need further support/ information regarding infant feeding and overcoming challenges in doing so
- Schedule next visit as per specific service protocol. If a follow-up visit to facility is not required, then provide the names of respective ASHA, Anganwadi worker, ANM or CHO near their home whom they can contact for any help

2.7 Key Aspects of Counseling at Various Life Stages

The basic principles of counseling and communication skills remain the same while counseling across the various life stages. However, it is important to understand that each stage/ age has its own characteristics and sensitivities, which the counselor needs to keep in mind while counseling. For example, adolescents and young people are shy and do not open up fast, so rapport needs to be built; couples are often hesitant and embarrassed to ask for family planning/ contraceptive services and need to be nudged gently to speak up; pregnant mothers may experience emotional changes and need support, young mothers of children tend to get very anxious about their child's health/ well-being and their anxiety needs to be allayed.

2.7.1 Counseling Adolescents

Adolescents often have inhibitions in speaking out or communicating their problems. This increases the responsibility of the counselors to help the adolescents overcome their fears, embarrassment, and curiosity and provide emotional and psychological support to them.

Tips for interacting with adolescents:

- Always start the conversation with non-threatening issues in a friendly and non-judgmental tone and assure confidentiality to build rapport and trust. This helps in creating a safe and conducive environment for the adolescent to speak about his/her issues more openly
- After listening patiently, reassure them of an appropriate solution to their problems

- Provide necessary information/ solutions in a simple and non-alarming way e.g. when adolescents come with signs/ symptoms of STI, do not scare them but tell them about the treatment, discuss the preventive measures and encourage them to make informed decisions on their own. Do not decide for them

Basic principles of adolescent centered counseling

- Respect and accept their norms and concerns
- Avoid any discrimination
- Be non-judgmental and ensure confidentiality of information shared
- Be empathetic
- Listen
- Offer non-directive suggestions
- Provide resources with problem-solving skills

Six essential steps for counseling adolescents

- Connect: with the adolescents
- Reassure: the adolescents
- Stabilize: provide support
- Address their needs and concerns
- Provide support: emotional, physiological, psycho-social
- Facilitate coping with existing situations

2.7.2 Counseling Young People and Adults for Family Planning/ Contraceptives

Contraceptive or family planning (FP) counseling is a sensitive matter to discuss with all age groups. Counselor should adhere to the following key aspects during contraceptive or FP counseling:

- **Voluntarism:** Counselor needs to be conscious of the fact that FP services are voluntary. Unlike other services couples are given information about methods relevant for them and it is the couples' right to choose a method. In other services (e.g. maternity and childcare etc.) clients are explained what needs to be done and are encouraged to follow the directions given
- **Concept of 'two experts in the room':** Counselor should always be mindful that s/he is not the only **'expert'** as the person being counseled is also an 'expert' because:
  - **The client/ person** has thoughts, feelings and opinions about fertility plans, past experiences with FP, relationships, social circumstances and other unexpressed needs
  - **FP counselor** has the knowledge about Healthy Timing and Spacing of Pregnancy (HTSP), FP methods and skills to communicate, build trust, assess needs, tailor information and help the client weigh options and decide with partner
- **Couple counseling:** Acceptance and continuation of the method is higher when couples are counseled together. Couple counseling should be encouraged whenever possible
- **Culturally sensitive:** The counselor should understand and be sensitive to cultural and psychological factors that may affect couple's need and decision for adopting contraceptive method

2.7.3 Counseling Pregnant Women

Pregnant women undergo many physical, mental and emotional changes and pass through various phases (childbirth, lactation etc.). Counselor should keep following aspects in mind while counseling:

- Pregnancy causes a lot of upheaval in the woman's hormones, leading to mood swings or feeling of frustration/ depression/ anxiety. Therefore, the counselor needs to be aware of this and provide reassurance to the pregnant woman

- Involving husband/ family members such as mother-in-law is critical for providing support to the pregnant woman. Besides explaining essential care at home and birth preparedness, it is important to apprise them with possible risks during pregnancy and danger signs, to sensitize them to have a caring attitude towards the woman
- Preferably, counsel the husband, along with the woman, about the importance of postpartum family planning and the contraceptive methods that can be used after childbirth. He or woman's mother/ mother-in-law should also be told about issues like the woman's nutrition, avoidance of heavy work and importance of initiation of breastfeeding within one hour of delivery
- **Group counseling –** In some settings, depending on the infrastructure and health care resource, it may be appropriate to counsel a group of pregnant women, with or without their family members. The group can be counseled on general care during pregnancy such as about essential antenatal checkups, IFA tabs, Td. injection and nutritional advice, birth preparedness, essential care of newborn including importance of breastfeeding, and postpartum family planning

  During group counseling, the counselor should encourage everyone to participate actively and share their knowledge, raise concerns and ask questions. Individual time should be allotted for pregnant women who wish to discuss their health-related issues personally

2.7.4 Counseling for Child Health & Nutrition

Counseling parents on childcare and nutrition plays a pivotal role in determining the maternal and child health outcomes. As per situation, other care givers may also require to be counseled. Counselor should consider following key aspects while counseling:

- Counseling of parents/ other care givers should be initiated early during pregnancy and should be taken forward after childbirth, which should include initiation of breastfeeding within one hour of birth, essential care of newborn and postpartum family planning
- Counseling and supporting the mother in initiation of early breastfeeding and exclusive breastfeeding for first six months is very important so that she understands the benefits of breast milk for the baby and is motivated to breastfeed the baby. Many mothers have doubts about their ability to breastfeed the baby correctly and adequately and need reassurance. Their concerns/ misconceptions also need to be resolved and clarified
- It is important to understand that parents are often anxious about the health and well-being of their child and their anxiety needs to be addressed. For e.g.: a mother who brings her infant for immunization, may be anxious that the shot will hurt her baby or make it sick. At such times, the counselor should reassure the parent and emphasize on the importance of the service

SECTION III

Counseling at Various Stages of Life

03

Counseling Adolescents on Healthy Life Choices and Responsible Decision Making

Adolescence: Adolescence is an age from 10–19 years during which a child develops into an adult, undergoing rapid physical growth, especially of the reproductive organs. Onset of adolescence is puberty.

During this phase of life, adolescents face many challenges and concerns which include: reproductive and sexual health concerns, nutritional problems, other issues like acute and chronic diseases, mental health issues, gender based violence etc.

Thus, it is crucial to provide them counseling on these issues and support them in making informed choices and decisions related to their overall health and in availing the required health services.

3.1 Reproductive and Sexual Health of Adolescents

3.1.1 Growing Up and Changes during Adolescence

Due to sudden spurt in the hormones during adolescence, boys and girls undergo many physical, emotional/ psychological as well as social changes.

Table 2: Summary of changes during adolescence*

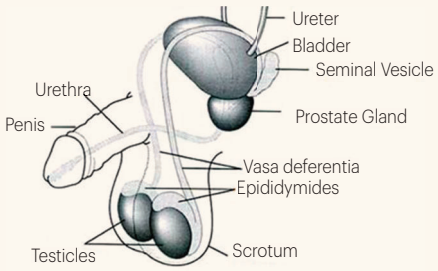
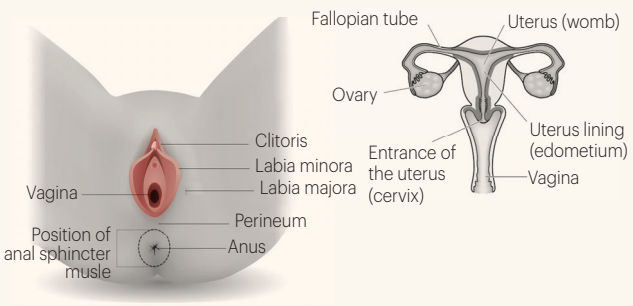
Boys	Girls
Physical Changes	
✿ Beginning of puberty: 9.5 to 14 years old ✿ First pubertal change: enlargement of testicles ✿ Penis enlargement begins approximately one year after the testicles begin enlarging ✿ Appearance of pubic hair: 13.5 years old ✿ Hair under the arms and on face, voice deepening and acne: 15 years old ✿ Nocturnal emissions: 14 years old ✿ Muscle development, chest broadening	✿ Beginning of puberty: 8 to 13 years ✿ First pubertal change: breast development ✿ Pubic hair development shortly after breast development/ hips broadening ✿ Hair under the arms and around genitals: 12 years old ✿ Acne ✿ Onset of menstrual periods: 9 to 16 years old
Emotional Changes	
✿ Attraction with opposite sex, infatuation for someone ✿ Aggression/ shyness ✿ Concern about body changes, identity crisis ✿ Mood changes (swings)	

Boys	Girls
Social Changes	
✿ Searching for identity – influenced by gender, peer group, culture and family expectations ✿ Seeking independence – influenced by his/ her relationships with family and friends ✿ Seeking more responsibility at home ✿ Looking for new experiences which may lead to engaging in risk-taking behaviour ✿ Thinking about 'right' and 'wrong'. Start developing a stronger individual set of values and morals ✿ Developing and exploring a sexual identity. May start having romantic relationships. For some young people, intimate or sexual relationships don't occur until later in life and for some, they may start early. For adolescents whose sexual life starts early, it may be due to social pressures (child marriages) or due to experimentation or forced and non-consensual in exploitative circumstances ✿ Communicating in different ways. The internet, mobile phones and social media can significantly influence communication with peers and learning about the world	

*these changes may vary from person to person

☛ Most adolescent boys and girls get confused due to these sudden changes and find it challenging to cope with them. The counselor needs to reassure them that these changes are normal during adolescence and occur due to the rapid development in the brain and production of hormones to prepare their bodies for adulthood. Their misconceptions/ fears/ myths related to these changes need to be clarified. Since it is a phase of rapid growth, counseling on nutrition should also be carried out

Table 3: Male and female reproductive organs

Type	Male reproductive organs	Female reproductive organs
Male and female Reproductive Organs		 Image Source: RCOG
External organs	Penis, Scrotum	Labia Majora, Labia Minora, Vaginal Opening, Clitoris
Internal organs	Testicles, Epididymis, Vas Deferens, Prostate Gland, Urethra, Seminal Vesicles	Vagina, Cervix, Uterus, Fallopian Tubes, Ovaries

3.1.1.1 Normal Sexual Development and Behaviours in Adolescent Boys

A. **Growth of penis:** Around the age of 13 years, boys experience growth in the penis (first in length and then in width). Size of the penis varies from person to person

B. **Erection of penis:** When there is sudden increase in blood flow to penis due to multiple reasons like sudden excitement, thoughts and fantasies or stimulation (touch) etc., the penis becomes hard, bigger in length and width and in erect position. Erection of penis is a normal phenomenon and can happen irrespective of sexual stimulation

C. **Ejaculation:** Ejaculation is the release of semen from the penis and is a normal occurrence. After ejaculation, the erect penis comes back to its normal size and position

D. **Premature ejaculation:** Premature ejaculation is an involuntary discharge of semen from erect penis occurring sooner than expected. Occasional premature ejaculation is experienced by almost every boy/ man and is normal

E. **Night fall/ wet dreams:** Involuntary ejaculation of semen during the sleep is known as night fall/ wet dreams. This is normal, and one should not be worried about it

F. **Masturbation:** Masturbation is a way of satisfying one's sexual desire by self-stimulation with the use of one's hand or other objects

Adolescents often feel ashamed or guilty of indulging in masturbation and need to be told that it is completely normal to do so, as it is a safe and common way of exploring one's own body. *(Refer to Chapter 8: Busting Myths and Misconceptions with Facts.)*

☛ Counselor should build rapport with adolescent boys so that they can share their concerns and are appropriately counselled/ reassured about them

Common queries of adolescent boys and tips on how to answer them

a) **Is the size of my penis fine/ what is the right size of the penis?**

Answer: The size of penis varies from person to person and one should not be unduly anxious about it. There is no right size for this organ and does not affect reproductive and sexual function.

b) **Why some boys don't have foreskin?**

Answer: Since birth, the penis has a hood of skin, called the foreskin, covering its head i.e. the front end. In some religions and cultures, the foreskin is surgically removed (known as circumcision), exposing the head of the penis. That is why some boys don't have foreskin.

c) **Why do I get erections in the morning?**

Answer: The level of hormone (testosterone) increases in the morning, which may cause an erection, even in the absence of any physical stimulation. This is normal and nothing to be anxious or ashamed about.

d) **Why is the quantity of ejaculation/ semen less or more than other boys?**

Answer: The consistency and amount of semen varies from person to person and from one ejaculation to another. It can also change over time. This is normal.

e) **Why do I have night fall/ wet dreams? It makes me feel very guilty and awkward.**

Answer: This is normal because during adolescence, formation of semen starts which then comes out of penis, especially when one is asleep. There is nothing to feel guilty about it.

3.1.1.2 Normal Sexual Development and Behaviour in Adolescent Girls

A. **Vaginal discharge:** Adolescent girls often begin to have white or transparent mucous like discharge from the vagina, especially before or after menstruation. It is normal to have this discharge. Only if the vaginal discharge is excessive, has an odour, of different color or is accompanied by pain in lower abdomen, the girl requires referral to the doctor for ruling out/ treating possible infection.

B. **Menstruation:** Menstruation is the cyclic bleeding from the uterus for few days every month. This happens because during adolescence, the girl's reproductive organs start to function and every month, a mature egg is released in her body and the internal lining of the uterus thickens with collection of blood in it. If the egg is not fertilized with male sperm, the egg dies in a day or two and the lining of the uterus is shed and comes out of her body through the vagina as menstrual flow. Since this process occurs every month, it is called menstrual cycle or periods. During adolescence, menstrual cycles may be irregular

and then they become regular after a few years. The duration of the menstrual flow (bleeding) differs from one girl to another. It is generally for 3–5 days, though it could range between 2 to 7 days; This process of menstruation begins in adolescence as menarche and stops around the age of 45–49 years as menopause.

- **Menarche:** Onset of first menstrual period is known as menarche. It usually takes place between 9–16 years of age. Some girls may experience menarche at a much younger age than their mothers and this is normal so it should not cause undue anxiety to the girl or her mother. In case a girl does not start getting periods until the age of 16 years, it is advisable to consult a doctor. When girls are told about menstruation in advance, they are mentally prepared for it and do not get unduly alarmed or scared

☛ Counselor should give the following information to adolescent girls on how to maintain proper **menstrual hygiene** – to prevent infections and ensure their well-being

- It is best to use sanitary pads. If unavailable, soft clean cotton cloth may be used
- Change cloth or pad at least 2 or 3 times a day and wash hands with soap and water after doing so
- Used sanitary or cloth pads should be wrapped in a paper bag and disposed off as per municipal waste management guidelines or by deep burial. They can be incinerated, if incineration facility is available
- If the cotton cloth pad needs to be reused, it should be washed well with soap and water, dried in the sun and stored in a clean paper bag to avoid moisture. Undergarments should be changed daily, washed and dried
- Bath should be taken every day during menstruation and genitals cleaned with plain water, without the use of soap

Common menstrual problems

- ***Irregular periods:*** In the beginning, menstrual cycles could be irregular i.e. shorter (3 weeks) or longer (6 weeks) and then they usually become regular within two to three years of menarche.
- ***Heavy periods:*** A heavy period means when bleeding lasts for eight days or more, the pad gets soaked with blood within an hour or large clots of blood are passed in the menstrual flow. This is common in adolescents because of slight imbalance in hormones. However, if this happens regularly, it may make the girl feel weak and exhausted and a doctor should be consulted immediately.
- ***Painful periods:*** Periods could be accompanied by pain/ cramps in the lower abdomen or back due to spasmodic contractions in the uterus. Usually, pain lasts only for a day or two. Following methods may be recommended for relieving pain: Fill a hot water bottle, wrap it in a towel and place it on the abdomen; Antispasmodic tablets can be taken on doctor's advice. If the pain is unbearable and keeps the girl away from her normal routine activities, a doctor should be consulted.
- ***Premenstrual Syndrome (PMS):*** This refers to a combination of physical and emotional symptoms occurring few days prior to the menstrual bleeding every month. PMS occurs due to the change in the level of hormones at that time of the menstrual cycle and usually subsides once menstrual flow starts. These symptoms include:
  - Temporary weight gain and a feeling of heaviness due to accumulation of water
  - Nausea or diarrhea
  - Headaches and cramps
  - Pain or heaviness in the breasts
  - Easy irritability and mood swings

A doctor should be consulted if PMS is severe

C. **Breast development:** The first puberty change is the development of breast buds when the breast and nipple elevate. The dark area of skin that surrounds the nipple of the breast (the areola) gets larger and the breasts then continue to enlarge. There may be concerns about difference between the size of two breasts and this is normal. Size of the breasts often make girls anxious and they need to be reassured that it is normal for the size to vary from girl to girl.

D. **Masturbation:** Girls and boys both can masturbate to satisfy sexual desire. This is normal and does not require any treatment. *(Refer Chapter: Busting Myths and Misconception with Facts)*

☛ Counselor should discuss and counsel about reproductive changes and explain about menstrual cycle as adolescent girls may have concerns which require only reassurance

Common queries of adolescent girls and tips on how to answer them:

a) **Why do I have bleeding from vagina every month? Does it mean I have a disease?**

Answer: Monthly bleeding is called menstruation or 'periods' and it happens to all grown up girls and women. This is not a disease but a natural phenomenon as it is preparation of their body for reproduction, if opted in future.

b) **Why do I have pain in abdomen and back, or mood alterations like sudden irritation, anger prior to this bleeding every month?**

Answer: It is normal for some girls to experience physical or emotional changes/ symptoms every month prior to the beginning of menstrual period. This happens due to surge in hormones at that time of the menstrual cycle. These are not symptoms of any illness. However, if symptoms are severe, it is advisable to consult a doctor.

c) **My class friends tell me that they have started having periods every month, but I have not started having them yet. Is something wrong with me?**

Answer: Some girls get their periods earlier than the others and almost all will start having them by the age of 16. So, you are also likely to start having periods after some time. If it does not start until the age of 16, it requires consultation with the doctor.

d) **My friends bleed for 4–5 days whereas I have bleeding only for 1–2 days. Why is it so?**

Answer: There is nothing to worry as the number of days of menstrual bleeding varies from girl to girl. Bleeding may occur from 2 day to 7 days and all are normal.

e) **I do not get periods every month but have it earlier or later than that? Is something wrong with me?**

Answer: It is normal for the menstrual cycles to be irregular during the first couple of years after a girl starts getting her periods and then they become regular. There is nothing to be worried about.

f) **What can help to reduce the severity of Pre-Menstrual Symptoms (PMS)?**

Answer: Eat a balanced diet with lots of fresh fruit and vegetables to help food cravings, lower the salt intake, avoid caffeine, use hot water bottle fomentation to relieve abdominal pain, Yoga, meditation and exercise may also help. However, if PMS is severe, seek a doctor's help.

g) **Why do I get pain in my abdomen and back during periods?**

Answer: It is common for girls to have pain in the lower abdomen or lower back during periods. This pain occurs because the uterus contracts to push out the uterine lining and blood. The pain may begin before bleeding starts or just after it starts and usually subsides by itself. Do not get worried about it, relax and use of hot water bottle which may help in relieving pain. If pain is unbearable, consultation with a doctor may be required.

3.2 Sexually Active Adolescents (Need for Contraception and Dual Protection)

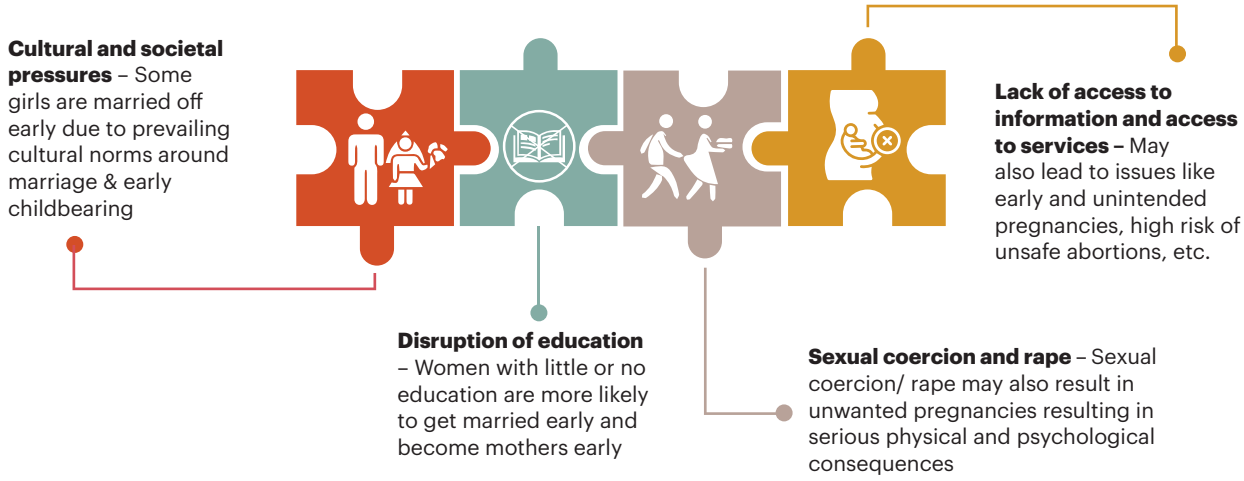
It is important to acknowledge that both married and unmarried adolescents may start having sexual intercourse. The consequences of unsafe sexual activity at this stage can adversely affect their health and future life, thus there is a need to counsel them and provide required information and support so that they can lead a responsible and safe sexual life.

3.2.1 Consequences of Unsafe Sexual Activity in Adolescents

3.2.2 Teenage Pregnancy

Adolescents should be educated about adverse effects and risks of teenage pregnancy on their physical and psychological well-being. Teenage pregnancy can also lead to higher percentage of maternal mortality and morbidity, low birth weight (LBW) babies and increased risk of infant morbidity and mortality.

Factors Leading to Teenage Pregnancy and Early Childbearing



☛ Counselor may need to give **contraceptive choices to the adolescents involved in sexual activity** (whether married or not) so that they can protect themselves from unwanted pregnancies *(Refer Chapter 4 on Counseling of Couples on Contraceptive Choices in Interval and Post Pregnancy Period).* Counseling on contraceptives helps adolescents to exercise sexual and reproductive autonomy and make contraceptive choices and have understanding on POCSO act

- Counsel about contraceptives, while ensuring the adolescents'/ clients' rights to respect, privacy, confidentiality. Most married adolescents may be under considerable pressure to have children, and thus may want to keep contraceptive use a secret. Unmarried adolescents may not seek contraceptive services due to lack of privacy and fear of being judged
- To ensure informed choice, provide all relevant information on contraceptive choices (including benefits and possible side effects); also tell them about emergency contraception. Respond to their concerns, if any, with appropriate information/ answers
- Provide information on where and how contraceptives can be availed and how and from where they can get follow up care/ counseling
- Explain and emphasize on the importance of responsible sexual behaviour. Abstinence or non- penetrative sexual activity needs to be discussed as options. With support, individuals can delay sexual activity until they are adults, and thus be better able to deal with its social, psychological and physical implications
- Encourage adolescent boys to share the responsibility for contraception and STI/ HIV prevention with their female partners
- Explain the importance of getting pregnancy test done at the earliest, when in doubt about pregnancy
- Counsel and discuss about various risks with the pregnant teenagers and address their questions and concerns
- Counsel and educate about pregnancy care (registration with public health system, ANCs, nutrition), early signs of complications, postnatal care, care of the newborn and importance of maintaining healthy birth spacing with use of contraceptives. Refer pregnant adolescent to the ANM and doctor for close follow-up (this may be required for girl, spouse and adult decision maker in the family). Counsel and refer adolescents seeking abortion services appropriately
- Refer the adolescents at risk of STIs/ HIV/ AIDS to Integrated Counseling and Testing Centers, if needed. Counsel on safer sex including use condoms for protection against STIs/ HIV

3.3 Reproductive Tract Infections (RTIs) and Sexually Transmitted Infections (STIs)

RTIs are infections of the genital tract due to poor genital/ menstrual hygiene or lack of standard infection prevention practices during childbirth or abortion. It is important to understand that RTIs can occur in those adolescents/ persons too who have never indulged in sexual intercourse.

STIs are infections transmitted from one person to another predominantly by sexual contact or activity, including vaginal, anal and oral sex. Some STIs can also spread through non-sexual means such as via blood or blood products. Some STIs like Syphilis, Hepatitis B and HIV etc. can also be transmitted from mother to child during pregnancy and childbirth. Some STIs are symptomatic while others are asymptomatic. The signs & symptoms of RTIs and STIs are quite similar, therefore one should not presume that everyone who has any of these symptoms has indulged in sexual activity. It is also important to note that adolescents of any gender can get STIs.

Common signs & symptoms of RTIs/ STIs

- Genital swelling/ ulcers (sores)
- Painful vesicles on genitalia
- Unusual discharge: from penis (boys); from vagina (girls)
- Changes in menstrual flow
- Burning sensation while passing urine
- Swelling in the groin
- Itching in the genital region
- Pain in lower abdomen
- Pain during sexual intercourse

Exposure to STIs during adolescence can have long term consequences like cancer of the cervix or infertility and may severely impact routine activities for education, participation in social activities and individual development. Additionally, stigma and embarrassment associated with STIs can impair psychological development and attitudes towards sexuality later in life.

3.3.1 HIV and AIDS

HIV stands for Human Immunodeficiency Virus and it is the causative agent of HIV infection, which can progress in due of course of time into AIDS i.e. Acquired Immune Deficiency Syndrome. If a person gets HIV infection, his/ her immune system becomes weaker day by day and is unable to produce antibodies to fight against disease producing organisms. As a result, any type of infection can turn life threatening.

Modes of HIV transmission

- Main mode of HIV transmission is anal, vaginal or oral sex. (85% of cases)
- HIV can also be transmitted
  - From an infected mother to her foetus/ child during pregnancy/ delivery/ breastfeeding
  - Through transfusion of infected/ unsafe blood or blood products
  - By sharing of infected syringes, needles amongst drug users, or through infected instruments, needle stick injuries or use of infected razors and blades etc.

☛ Counselor should discuss the **preventive measures for RTIs/ STIs** with adolescents:

- Maintain proper genital and menstrual hygiene
- If sexually active, adopt the following safe sex practices:
  - Using condoms as they provide protection against pregnancy as well as STIs, including HIV/ AIDS
  - Avoiding sex with unknown or multiple partners or an infected partner
  - Avoiding, sex if there is any sign or symptom of RTI/ STI
- If pregnant, Institutional delivery should be opted for/ safe abortion services should be availed.
- Adolescents should also be counselled about the importance of early detection and treatment of RTIs / STIs by recognizing the signs and symptoms and seeking timely medical help

3.4 Nutritional Issues during Adolescence

Nutrition influences growth and development of adolescents in a major way because nutrient needs are the greatest during adolescence. It is believed that up to 45% skeletal growth, 15% to 25% adult height and up to 37% total bone mass accumulation occurs during adolescence.

Good nutritional status prepares their bodies for a healthy life and prevents nutrition-related chronic diseases in adult life. Many adolescents suffer from malnutrition, which means that their nutritional status is not optimal but is either low (undernutrition) or more than required (over nutrition).

Factors causing malnutrition in adolescents are many like poor food choices (eating junk food, snacking throughout day), erratic and unhealthy eating habits (skipping meals), wanting perfect body and shape as their self-worth often depends on it, limited physical activity, associated conditions (e.g. worm infestation; pregnancy).

Undernutrition is more common and can be acute or chronic. **Acute undernutrition** can lead to permanent metabolism issues, kidney and immune system breakdown and even death due to starvation. It is often reflected by loss of weight. **Chronic undernutrition** occurs due to persistent lack of necessary proteins, carbohydrates, fats, vitamins and minerals in the diet over a considerable period which leads to hampered growth and development.

Signs and symptoms (depending on the type of nutritional deficiency)

- Fatigue and low energy level
- Problems with learning/ poor concentration
- Bloated stomach
- Slowed reaction times and trouble paying attention
- Dizziness
- Poor immune function (which can cause the body to have trouble fighting off infections)
- Dry, scaly skin, swollen and bleeding gums
- Decaying teeth
- Underweight and poor growth
- Muscle weakness
- Bones that break easily

3.4.1 Undernutrition

Undernutrition means when one is not getting enough calories or nutrients; it can be due to insufficient intake of nutrients in the diet or a problem in absorption of nutrients. Undernutrition can lead to several medical conditions, such as anaemia, beriberi, pellagra and rickets etc.

3.4.1.1 Nutritional Anaemia

Deficiency of iron in diet leads to decreased amount of haemoglobin in the blood, resulting in less supply of oxygen to different parts of the body; this state is known as anaemia. It may manifest as tiredness, weakness, breathlessness, pale face/ nails/ tongue/ conjunctiva and lack of concentration. Though anaemia can happen in both boys and girls, it is more prevalent among adolescent girls. Anaemia during adolescence can adversely affect the girl's health, education and overall development. It may also affect her health during adulthood. Since anaemic adolescents have lower pre-pregnancy iron stores, they are likely to suffer from anaemia during pregnancy too and have increased risk of maternal morbidity and mortality. Also, they have increased chances of giving birth to children with a low birth weight (below 2,500 grams). Children born to anaemic women are more likely to die before the age of one year or be sick, undernourished and anaemic. Anaemia may be categorized as mild, moderate and severe *(Refer to Annexure 4)*.

3.4.2 Over-Nutrition

Over-nutrition occurs when too many nutrients are ingested. Over-nutrition also has harmful effects on the body. Overweight and obesity during adolescence are mainly due to an imbalance of energy intake from the diet and energy expenditure (through physical activities and bodily functions) and can predispose the person to hypertension, diabetes, heart disease etc. While genetic and environmental factors play a role in determining the body structure, paying attention towards diet and physical activity is equally important.

☛ Counselor should observe adolescent's height and weight or Body Mass Index (BMI) to see if it is in the normal range *(Refer to Annexure 2)*

- Refer to a doctor if the BMI is beyond the normal range and the adolescent appears to be suffering from malnutrition
- Provide every adolescent adequate counseling regarding healthy eating habits and importance of adequate and balanced diet (including legumes, nuts, whole grains, fresh fruits and vegetables) and avoiding junk foods (chips, pizza, cakes, samosa etc. or snacks made of processed items like maida, white sugar, saturated fats) (*Refer to Annexure 3*)

- Explain to them that they need to limit consumption of foods and drinks containing high amount of sugars such as candies and sugar-sweetened beverages, energy and sports drink etc.
- Emphasize on the consumption of iron rich food like green leafy vegetables, (may recommend locally available, cheap options as moringa leaves) whole grains (like ragi), jaggery, nuts etc. Foods rich in vitamin C like mango, guava, orange, lemon etc. should be increased as it enhances absorption of iron
- Provide IFA (blue color) tablets and explain how one tablet should be consumed with water every week
- In case the adolescent is mild to moderately anaemic (Hb: 8gm/dl–11gm/dl) therapeutic IFA supplementation as advised by the health-care provider (ASHA/ ANM/ CHO/ MO) must be initiated. If severely anaemic, the girl needs urgent referral to appropriate facility/ doctor
- Discuss the preventive measures for worm infestation and the bi-annual deworming schedule (400 µg of Albendazole) and encourage them to follow it regularly *(Refer to Annexure 4)*
- Encourage indulging in regular physical activity
- Tell them to contact Anganwadi center for food supplementation (under Anganwadi services)

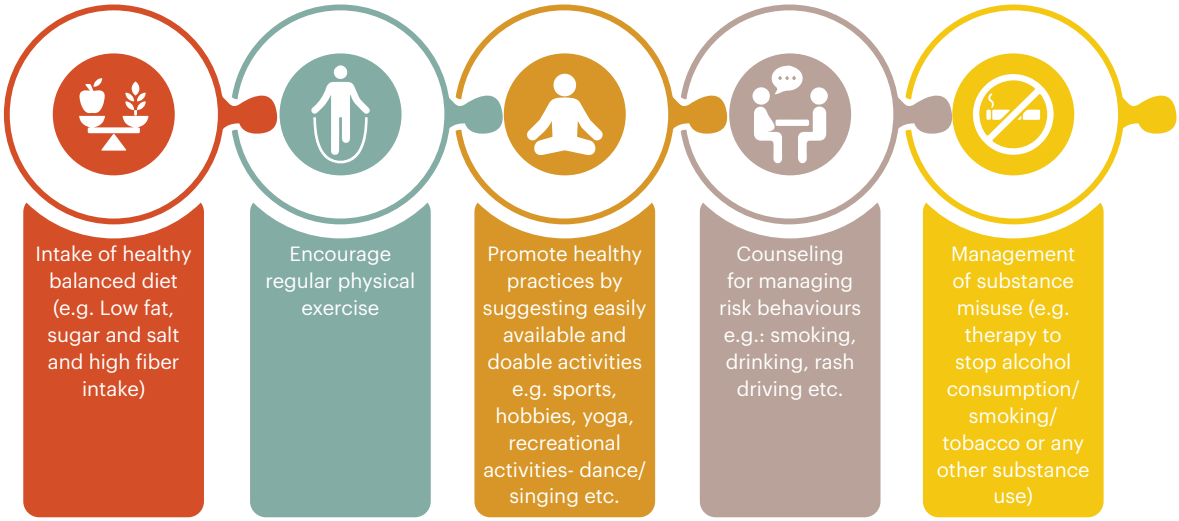
3.5 Other Issues Affecting Adolescent Boys and Girls

3.5.1 Non-Communicable Diseases (NCD) during Adolescence

In past few years, there has been a steady rise in non-communicable diseases (NCDs) like diabetes, cardiovascular disease including hypertension, obesity and cancers even among adolescents. Change in dietary patterns (eating junk food), drug misuse, tobacco chewing, smoking and alcohol consumption, lack of exercise and environmental pollution may increase the risk of these disorders. *(Refer to Annexure 5)*

☛ Counselors should explain the harmful effects of substance abuse and discuss about health promotion, preventive measures and appropriate referrals

Key health promotion interventions



3.5.2 Mental Health Issues and Substance Misuse

Adolescence is a stage of confusion and apprehension which may lead to poor mental health. This can have an adverse social and personal outcome as indicated in Figure 2. Common mental health issues faced by the adolescents are stress, anxiety, depression and substance abuse. Prolonged unaddressed anxiety and depression can lead to suicidal tendency.

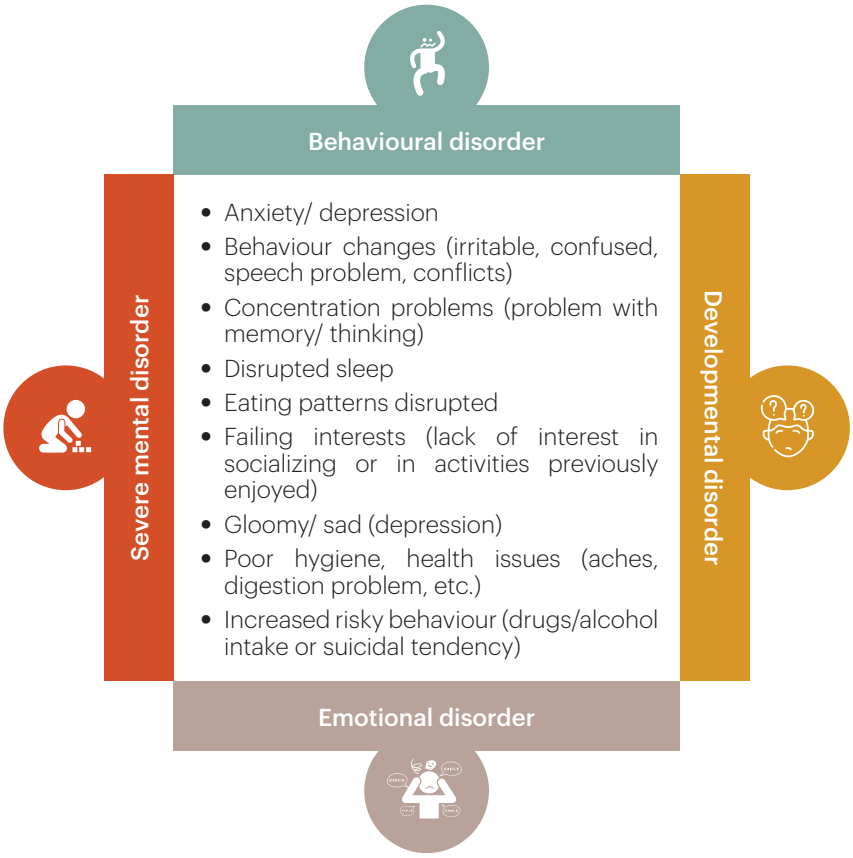


Figure 2: Key mental health issues in adolecents

Although RMNCAH+N Counselors are not specialized to handle these issues, they must be able to identify them and provide appropriate referrals. Some warning signs that may need referral are:

- Persistent irritability/ anger/ social withdrawal and withdrawal from activities that were previously appreciated by the adolescents/ major changes in appetite or sleep (excessive food consumption/ fasting/ binge eating/ sleeping too much or too less or disturbed sleep)
- Disruption in school performance/ actions that harm relationships
- Suicidal tendency
- May resort to substance misuse as coping mechanism and sometime substance misuse could be the cause of mental health issues

☛ Counselors should be assertive (not aggressive) and have a positive attitude

The key to help adolescents is to stay ALERT to their stress:

- **A**cknowledge that adolescents' stress is often different from adult stress
- **L**isten to the adolescents and be aware of how they respond. Sometimes, just listening to them is enough
- **E**ncourage adolescents to express how they feel when stressed
- **R**ecognize that experiences of adolescents may differ from one another
- **T**ime, the parents should understand that there will be times when adolescents will experience things differently than them

Suggest stress management techniques like: relaxation techniques/ regular exercise/ healthy diet/ getting good and enough sleep for addressing mental health issues. The family must also be counseled. Counselor should make appropriate referrals for management of substance misuse (psychologist/ psychiatrist or substance abuse rehabilitation centers etc.).

3.5.3 Violence

The violence against adolescents, whether sexual, physical, emotional or gender-based may be perpetrated by family or other caregivers/ peers/ romantic partners/ strangers. This often has lifelong consequences on survivor's physical, mental health and social functioning. Also, due to their aggressive behaviour, adolescents can also cause injury to others. It must be remembered that **all adolescents, irrespective of their gender may inflict or be subjected to violence.** If the counselor is informed or can observe that an adolescent is subjected to violence, the case needs to be handled very carefully and informed to a doctor at the health facility. If a counselor is informed or observes that an adolescent is subjected to violence, the instance should be informed to a doctor and can also be reported at Child Helpline (1098) (for children for children upto 18 years)/ police.

☛ Counselor should:

- Tell the adolescents about their rights
- Counsel parents on creating a conducive and non-threatening environment
- Encourage the adolescents to respect other people's choices and human rights
- Explain to them that any incidence of violence must be reported
- Be sure to inform the adolescent about formal channels for lodging a complaint, if needed
- Be sure to redirect to a medical health facility, if required
- Encourage them to channelize energy on constructive things like exercising, meditation
- Follow up with adolescents, if needed

Assessing adolescent health issues *(Refer to Annexure 6)*

HEADS Assessment: It is a structured assessment that helps the counselor to start discussion with non-threatening issues.

- **H:** Home
- **E:** Education/ Employment/ Eating (Diet)
- **A:** Activity
- **D:** Drugs
- **S:** Sexuality; Safety; Suicide/ Depression

04

Counseling Couples on Contraceptive Choices in Interval and Post Pregnancy Period

Couples have the right, as well as the responsibility, to plan their families i.e. deciding whether to have children, when to have children and taking appropriate steps to achieve the goal of a desired family size. Many couples do not use a contraceptive even though they need protection against unintended pregnancies. This leads to unmet need for family planning.

Many women/ couples of reproductive age group who come to a health facility for a health service do not think contraceptive services are important for them while some couples are shy and hesitant to talk about their need for contraception. Hence, it becomes important for the counselor to start the discussion by simply asking them their plans regarding having a child in future and then taking the discussion forward by explaining advantages of HTSP and giving contraceptive options to choose from.

Couples should also be made aware of the bad consequences related to maternal & child health if births are: too early/ too late (teenage and higher age group), too frequent (inadequately spaced births) and too many (high order births).

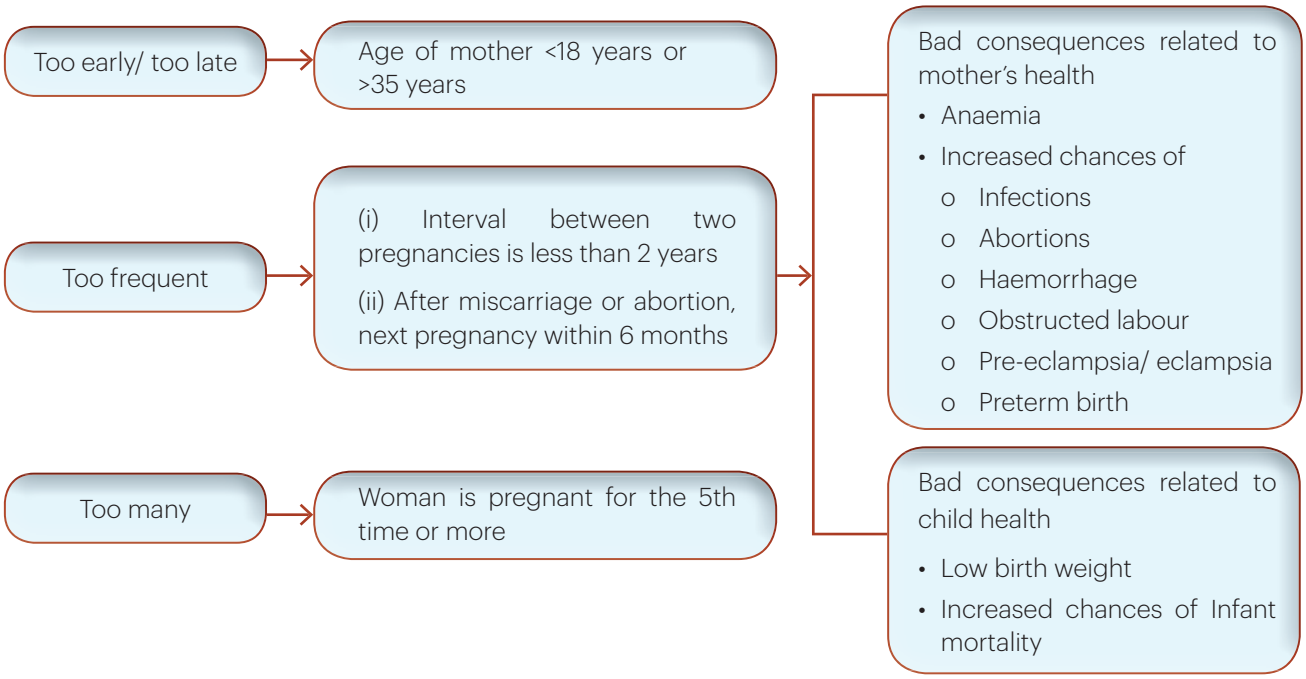


Figure 3: Maternal and child health issues due to too early/ too late/ too frequent and too many births

Healthy Timing and Spacing of Pregnancy (HTSP)

HTSP is an approach of achieving healthier pregnancies and their outcomes.

Three key messages about HTSP:

1) First pregnancy should be planned only after the age of 20 years, in order to avoid bad consequences of teenage pregnancies
2) After a live birth, next pregnancy should be planned only after 2 years or later to keep adequate interval between two births (ideal spacing between two births is 3–5 years)
3) After a miscarriage or abortion, next pregnancy should be planned only after 6 months or later to avoid chances of an abortion again

Use of contraceptives helps in maintaining HTSP, because pregnancy can occur as early as:

- 6 months postpartum, if woman is exclusively breastfeeding her child
- 6 weeks postpartum, if woman is not exclusively breastfeeding her child
- 4 weeks postpartum, if woman is not breastfeeding at all
- 4 weeks of second trimester abortion
- 10 days of first trimester abortion

Pregnancy can occur even before resumption of menses after childbirth/ abortion.

☛ Counselor should provide the following messages to explain the benefits of adequate birth spacing and importance of using contraceptives:

- Adequate birth spacing can lead to health benefits for the mother and baby (reduction in maternal complications and chances of LBW/ preterm births)
- Spacing between births allows the mother to bond with her baby and Early Childhood Development
- Limiting the number of children in a family means more resources for each child and more time for the parents to dedicate to each child
- Use of a contraceptive protects against unwanted/ untimed pregnancy, hence the couple can enjoy life without worrying about it
- Correct and consistent use of condoms prevent STIs including HIV/ AIDS
- Delaying pregnancy during teenage helps the girls attain physical maturity, study further and complete their education. Once they become adults, the chances of having a complication free pregnancy and giving birth to a healthy baby increase
- Older women (over 35 years) can prevent unwanted pregnancies that are often risky for their health and can lead to complications for both mothers and infants

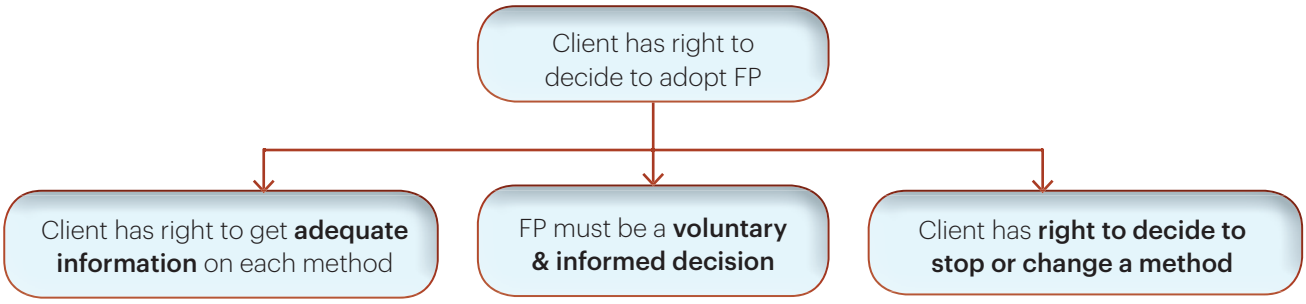


Figure 4: Client's rights & voluntary decision for family planning

4.1 Opportunities to Initiate FP Counseling and whom to Counsel

There are many opportunities for initiating discussion and providing family planning counseling to persons of reproductive age who come for availing various services from health facilities:

- Newly married couples coming for any health service and for pre-conceptional counseling
- Pregnant women coming for antenatal care
- Women who have recently delivered/ undergone abortion
- Women seeking post-partum or post-abortion care
- Couple seeking emergency contraception
- Women/ couples coming for child immunization
- People of reproductive age who come to the health facility with any other issue

The counselor/ service providers should try not to miss any of these opportunities and thus help in fulfilling their unmet need for FP.

4.2 Stages of Family Planning Counseling

Counseling for family planning is done at three stages. *(Following the GATHER Approach discussed in the Chapter on Counseling Skills)*

Initial/ general counseling (prior to making a decision on FP method) – to understand client's reproductive needs, provide general information (key FP messages) on various contraceptive options relevant for their situation/ need, and help them choose and adopt a method. *(Refer to Annexure 7)*

Method specific counseling (prior to or immediately following adoption of a method)– to provide detailed information about the chosen method including method use, effectiveness, possible side effects & their management, protection against RTI/ STI etc. *(Refer to Chapter 8 on Busting myths for how to dispel myths related to each method)*

Follow up counseling (during return visit) – to find out client's experience with method and provide support for its continued use, as well as address the concerns if any.

4.3 Counseling New and Continued (Returning) FP Clients

Clients and their situations differ; therefore, best counseling is tailored to the individual needs of the client. Some women/ couples may come with a method in mind, while others may not have any method in mind. Hence, initial counseling needs to progress accordingly. Similarly, some clients will return with no problem and may require minimal follow up counseling, while other clients returning with problems or concerns may require a lot of reassurance and elaborate follow up counseling.

☛ Counselor should provide FP counseling to clients as per the following table:

New Clients – With No Method in Mind	New Clients – With a Method in Mind
✿ Discuss client's situation, plans, and what is important to the client ✿ Help the client consider methods that are relevant to their need. If required, help the client reach a decision about which method to use ✿ Support the client's choice, give key instructions on its correct use, discuss how to cope with any side effects ✿ Tell that method switching is possible and allowed ✿ Schedule a return visit	✿ Check that the client's understanding of the method is accurate ✿ Support the client's choice, if the client is medically eligible for the method, otherwise help in choosing another method ✿ Discuss how to use the chosen method correctly ✿ Tell the client about possible side effects and how to cope with them ✿ Schedule a return visit
Returning clients – with no problems or concerns	**Returning clients – experiencing problems or have concerns**
✿ Ask about how the client is doing with the method. Answer all questions of the client ✿ Provide more supplies or conduct routine follow up ✿ Encourage the client to continue using the method until pregnancy is desired. ✿ Schedule a return visit	✿ Explore and understand the problem ✿ Help the client resolve the problem: whether its side effects, difficulty in using the method, an uncooperative partner or any other problem ✿ Refer to a doctor for treatment of side effects. ✿ If needed, help the client switch to another method ✿ Schedule a return visit

4.4 Overview of Contraceptives (Under National Family Planning Programme)

To understand contraception (how the methods protect from pregnancy), it is necessary to know how conception (pregnancy) occurs.

Process of conception: During sexual intercourse, the male partner ejaculates semen inside the female partner's vagina and the sperm in the semen enter the uterine cavity through its 'mouth' or opening situated high up in the vagina. The sperm then travel towards the fallopian tubes. If the woman has recently ovulated and there is an egg (ovum) in one of the tubes, it can be fertilized with a sperm. In 3–4 days, the fertilized egg travels into the uterus and gets implanted into the inner lining of the uterus. Here it grows for next nine months into a baby. *(Refer to Annexure 1)*

A range of contraceptives – for spacing and limiting children, are available under the National Family Planning Programme (NFPP) *(Refer to Annexure 7)*. There are different types of contraceptive methods.

- ✿ Some are to be used by men, while others to be used by women
- ✿ Some are reversible i.e. pregnancy can occur when their use is discontinued, while some are irreversible i.e. pregnancy cannot occur once method is adopted

- Some contain hormones while others are non-hormonal
- Some of the methods are to be used at the time of sexual act while others are to be used regularly
- Some can be used by the client/ couple without any consultation while others are taken after consultation of trained health service provider
- Some may affect quantity of breast milk e.g. COC (Mala-N) while others don't affect it
- Some provide protection from STIs/ HIV, while all other methods do not provide this protection

Remember: No contraceptive method is 100 percent effective and this needs to be clearly explained during counseling.

Table 4: Types of contraceptives and for different needs/ reproductive intent

Why is Contraception Needed?	Contraceptive Options
For delaying the first child	✿ Condoms ✿ Oral contraceptive pills (Mala N, Chhaya) ✿ Intra Uterine Contraceptive Devices (IUCD 380A & 375) ✿ Injectable contraceptive MPA (Antara Programme) ✿ Emergency contraceptive pills (Ezy Pill, not to be used routinely)
For healthy spacing between two pregnancies	✿ Condoms ✿ Oral contraceptive pills – (Chhaya, Mala N) Mala-N pills – not to be given until the breastfed baby is 6 months old ✿ Intra Uterine Contraceptive Devices (IUCD 380A & 375) ✿ Injectable contraceptive MPA (Antara Programme)
For limiting family size*	✿ Male Sterilization (Conventional/ Non Scalpel Vasectomy) ✿ Female Steriliazation (Minilap tubectomy/ Laproscopic tubal occlusion) ✿ Long acting reversible methods – ■ Intra Uterine Contraceptive Device (IUCD 380A & 375) ■ Injectable contraceptive MPA (Antara Programme) *Oral pills & condoms can also be used to limit the family size; however, the client should be counseled about the importance of correct & consistent use of the method as incorrect or inconsistent use may lead to failure.

4.5 Details of Family Planning Options under NFPP

The summary of different types of contraceptives are placed at Annexure 7.

4.5.1 Male Condoms (Nirodh)

Condom is a simple and effective method for men, which must be used correctly and consistently during every act of sex. Condom is made of latex and is to be worn on the erect penis before sex. It is a barrier method of contraception that physically prevents sperm from uniting with the egg as it does not allow ejaculated semen to be deposited in the vagina. Condoms have additional benefit as they also provide protection against RTIs/ STIs and HIV.

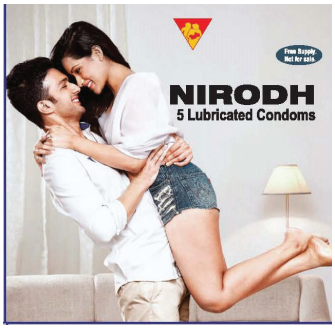


Figure 5: Male condom under NFPP

☛ **Counselor should explain basic steps of using a male condom and demonstrate wearing of condom on penile model**

- Use a new condom for each act of sex (do not use a torn or damaged condom. Check for the expiry date before using a condom)
- Before any physical contact with partner, place the condom on the tip of erect penis with rolled side out
- Unroll the condom all the way to the base of erect penis and then have sex
- Immediately after ejaculation, hold the rim of the condom in place & withdraw from the penis while it is still erect
- Dispose off the used condom safely, by wrapping it in a piece of paper and throwing it in a bin
- In case there is any mistake in use of condom or it slips off/ breaks during intercourse, pregnancy can occur. In such case the female partner needs to take an ECP, as soon as possible after intercourse, within next 72 hours

Condoms can also be used with other contraceptives for dual protection or as a backup method.

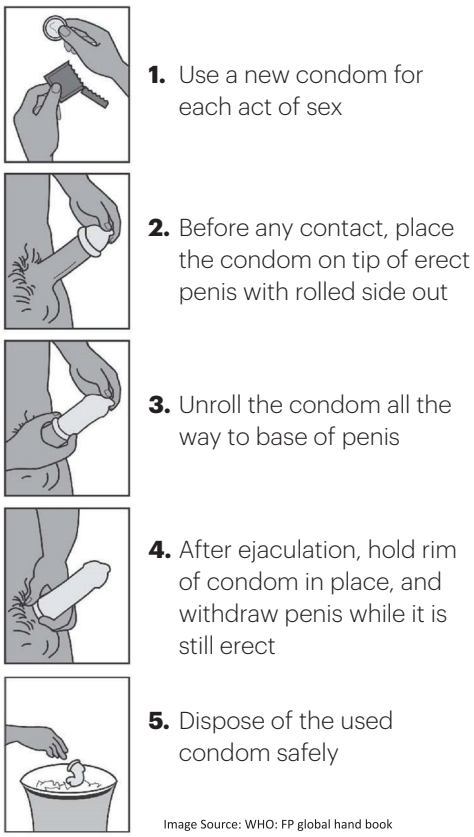


Figure 6: Steps for using male condom

4.5.2 Oral Contraceptive Pills

Oral contraceptive pills are of two types: hormonal or non-hormonal.

- Hormonal pills (Combined Oral Contraceptive and Progestin only pills) must be taken daily
- Non-hormonal pill (Centchroman), is a weekly pill (taken twice a week in first 3 months and once a week thereafter).

Note: All new clients should be screened by a trained health provider (Doctor/ Nurse/ CHO/ ANM) before starting any type of oral contraceptive pills.

Combined Oral Contraceptive Pills (COC) (Mala N): (28 pills per packet – 21 hormonal pills (white) and 7 non-hormonal pills (red)).

Figure 7: COC under NFPP

One pill is to be taken every day, even if there is no intercourse. For greatest effectiveness, linking pill intake to a daily activity such as after dinner may help the woman remember and reduce some side effects. Missing the pills increases the risk of unwanted pregnancy. After a packet of 28 pills is over, the next packet should be started from next day itself, irrespective of monthly bleeding. If the woman vomits within 2 hours of taking a pill, another pill from the pack should be taken as soon as possible and rest of the pills should be continued as scheduled. Few women may experience bleeding changes like unexpected and irregular or no bleeding. Some may experience nausea, headache or heaviness in breast. All these are temporary and subside in due course of time.

Ask the woman to consult the provider immediately, in case of following danger signs (ACHES):

- **A:** Abdominal/ pelvic pain
- **C:** Chest pain, cough or difficulty in breathing

- **H:** Headache, which is severe or migranous, vertigo or numbness in any limb
- **E:** Eye symptoms – blurring of vision, seeing double or not able to see
- **S:** Severe pain in calves or thighs

COC pills reduce milk production and should not be used by breastfeeding women, unless their child is at least 6 months old.

Centchroman non-hormonal pill (Chhaya): (8 pills per packet)

Centchroman is commonly known as weekly pill as for the first three months it is taken biweekly and from 4th month onwards, once weekly. It can be initiated anytime during the menstrual cycle if it is reasonably certain that the woman is not pregnant.

Figure 8: Centchroman under NFPP

However, the following timing of initiation can be opted by the women to start the package after proper screening by health-care provider:

- on first day of period
- on the day of abortion itself
- within 4 weeks after childbirth, whether breastfeeding or not

To start with, take one pill at the correct time (mentioned above) and take another pill three days later (2 pills in a week). Then the schedule of these 2 pills per week to be followed for three months. From fourth month onwards, only one pill per week to be taken (the first pill day to be repeated every week) This weekly regime to be continued, regardless of menstrual cycle, till protection from pregnancy is needed

Table 5: Schedule of Centchroman

First Day of Pill	First 3 Months (twice in a week)	After 3 Months (once in a week)
Sunday	Sunday and Wednesday	Sunday
Monday	Monday and Thursday	Monday
Tuesday	Tuesday and Friday	Tuesday
Wednesday	Wednesday and Saturday	Wednesday
Thursday	Thursday and Sunday	Thursday
Friday	Friday and Monday	Friday
Saturday	Saturday and Tuesday	Saturday

With Centchroman, periods may not come on time every month and get delayed, bleeding may also get lighter. These changes are not harmful. However, if periods are delayed by more than 15 days, pregnancy needs to be ruled out.

Progesterone Only Pills (POP): (28 pills per packet)

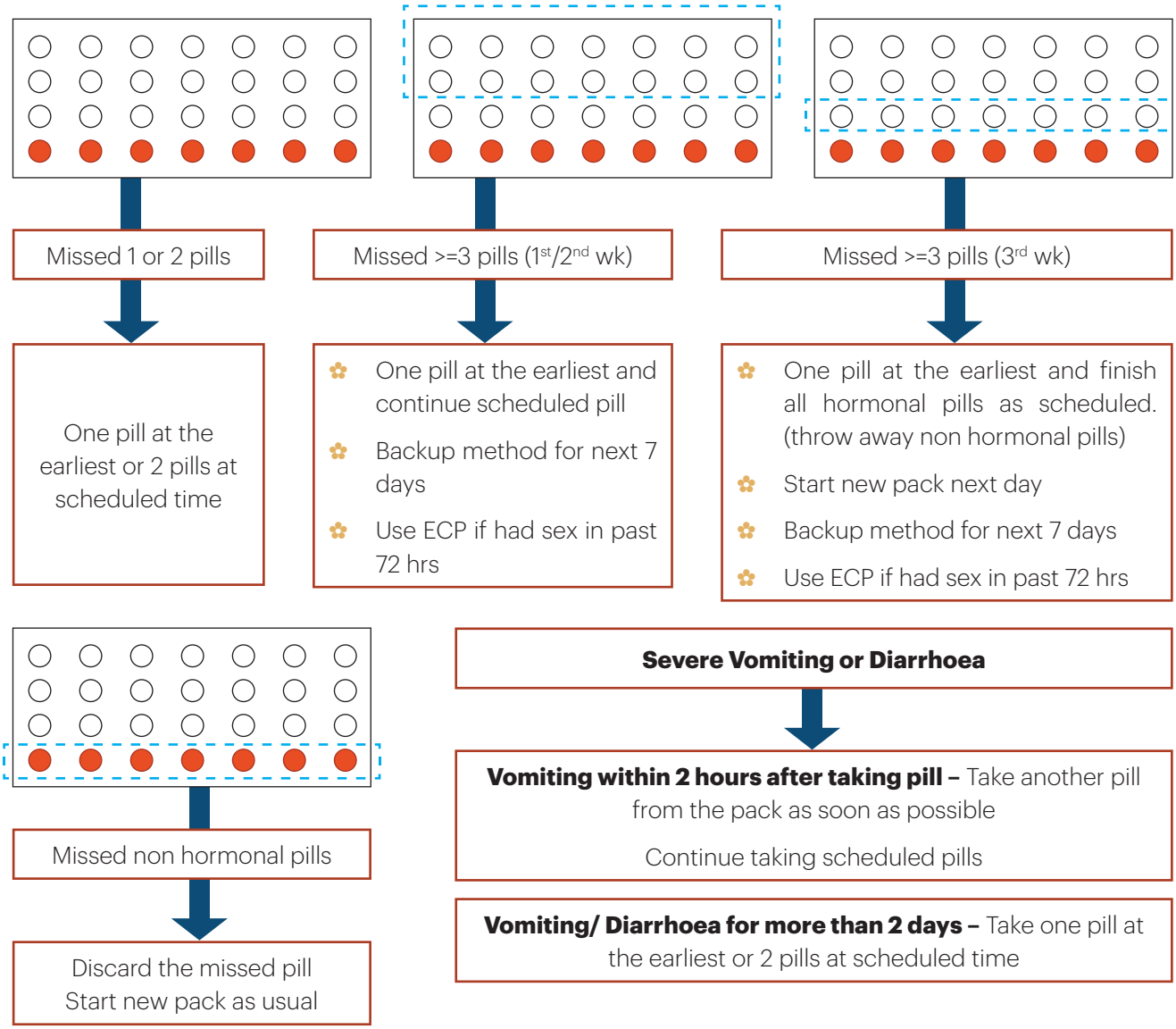
Unlike COC, all pills in POP packs are of same color and are active pills containing progesterone hormone. One pill should be taken every day and at the same time. Once a pack is consumed, a new pack must be started on the next day itself at the same time. Delay of more than 3 hours in starting the new pack or taking the daily pill increases chances of failure/ risk of pregnancy. POPs do not affect milk production and can be safely used by breastfeeding women. In fact, contraceptive effect of breastfeeding adds to POPs' effectivity. POPs can also be used by non-breastfeeding woman though their effectivity reduces marginally.

Note: POPs are not available under the NFPP.

☛ Counselor will need to explain to the clients of COCs, POPs and Centchroman on what should be done for **missed pills, i.e.** if they fail to take few pills

During initial counseling, the women who choose pills are told that missing pills can lead to pregnancy. However, at times they are likely to miss pills and will require the following instructions.

- **Missed COCs:**



- **Missed Centchroman pills:** If pill is missed by less than 7 days, take the pill as scheduled and use back up method till her next periods. If pill missed by more than 7 days, the woman needs to start taking it all over again like a new user (twice a week for 3 months and then once a week).
- **Missed POPs:** If 3 hours late in taking the pill, take the pill as soon as possible. Then continue taking the remaining pills each day, even if that means taking 2 pills on the same day. Use condom for next 2 days.

If a pill client comes with the complaint of missing periods/ other signs and symptoms of pregnancy, she should be checked for pregnancy. If pregnant, she should be reassured that the baby growing in her womb will not be harmed by the pill, therefore, she can safely continue with the pregnancy if she wishes to.

4.6.3 Intra Uterine Contraceptive Device (IUCD)

The intra-uterine contraceptive device, popularly known as IUCD, is a small, flexible plastic frame containing coiled copper, having two nylon strings at its lower end. It can be easily inserted in the uterus by a trained service provider. Once inserted, the threads of IUCD lie high up in the vagina. When the woman wants to get IUCD removed, it can be easily removed by the service provider, with the help of these strings.

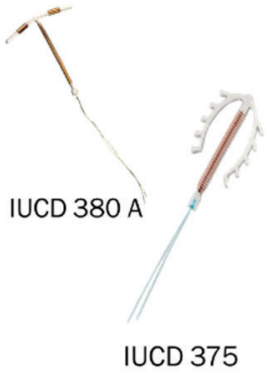


Figure 9: IUCDs under NFPP

Under the NFPP two types of IUCDs are available- **IUCD 380 A** – effective for 10 years; **IUCD 375** – effective for 5 years.

IUCDs are also classified into 3 types, based on the timing of insertion:

- **Interval IUCD:** IUCD inserted anytime during menstrual cycle/ after six weeks postpartum/ after 12 days of abortion. IUCDs are not inserted between 48 hours & 6 weeks postpartum
- **Postpartum IUCD (PPIUCD):** IUCD inserted concurrently with caesarean delivery or within 48 hours after vaginal delivery
- **Post Abortion IUCD (PAIUCD):** IUCD inserted within 12 days of completion of abortion (surgical abortion). In case of medical abortion, the completion of abortion is ascertained on 12th day after the intake of second pill or 15th day after intake of first pill

Advantages of PPIUCD/ PAIUCD

- Client is motivated to prevent next pregnancy immediately after delivery or abortion
- Extra visits can be avoided as it can be inserted after normal or caesarean delivery or completion of abortion
- It assures the woman that she is not pregnant
- Initial bleeding & cramps due to insertion are masked with the bleeding after delivery/ abortion
- Follow up visits may be clubbed with child's immunization after delivery or follow up visits for abortion

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Schedule of abortion pill	1st pill		2nd pill												Ensuring the abortion is complete; (PAIUCD insertion)

☛ Counselor should provide following key messages during pre and post insertion counseling:

- **Pre-insertion IUCD counseling**
  - **Effectiveness:** IUCD is one of the safest and most effective long acting reversible contraceptive methods. It becomes effective as soon as it is inserted and provides contraceptive protection for up to 10 years (IUCD 380A)/ up to 5 years (IUCD 375).
  - **Advantages:** IUCD insertion is a minor, one-time procedure which involves pelvic examination for screening. It relieves the woman from remembering to use a method on a regular basis. IUCD does not affect sexual activity or sexual pleasure. It can be removed whenever the woman wants to become pregnant. The return to fertility is immediate after removal of IUCD.

- **Side effects:** Periods are regular, though menstrual bleeding may increase and there may be pain/ cramps in the abdomen. These side effects usually subside within first few months of use. Client should be explained this and referred for symptomatic treatment, if required.
- **How IUCD is inserted and removed:** Explain in a simple language understood by the client (avoid using technical terms) on how the insertion and removal of IUCD is carried out. This will allay her anxiety and fear related to this aspect.
- **Prevention from STI including HIV:** Explain the risk factors to the client and basics of safe sex behaviour – (Abstinence/ being mutually faithful & condom use). IUCD does not provide protection against HIV or other STIs. Therefore, clients who are at risk should also use condoms for protection.

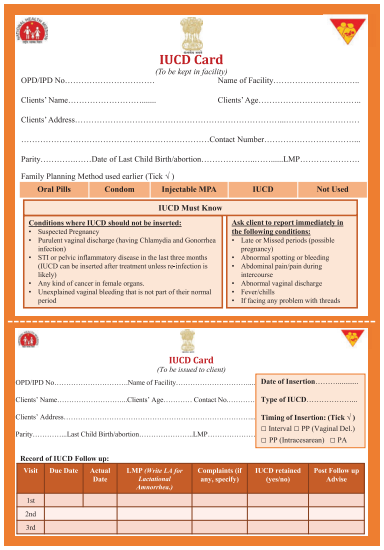

IUCD Card
(To be kept in facility)
OPD/IPD No.....
Name of Facility.....
Clients' Name.....
Clients' Age.....
Clients' Address.....
Contact Number.....
Parity.....Date of Last Child Birth/abortion.....LMP.....
Family Planning Method used earlier (Tick √)
Oral Pills | Condom | Injectable MPA | IUCD | Not Used
IUCD Must Know
Conditions where IUCD should not be inserted:
• Suspected Pregnancy
• Purulent vaginal discharge (having Chlamydia and Gonorrhea infection)
• STI or pelvic inflammatory disease in the last three months (IUCD can be inserted after treatment unless re-infection is likely)
• Any kind of cancer in female organs.
• Unexplained vaginal bleeding that is not part of their normal period
Ask client to report immediately in the following conditions:
• Late or Missed periods (possible pregnancy)
• Abnormal spotting or bleeding
• Abdominal pain/pain during intercourse
• Abnormal vaginal discharge
• Fever/chills
• If facing any problem with threads
IUCD Card
(To be issued to client)
OPD/IPD No.....Name of Facility.....
Clients' Name.....Clients' Age.....Contact No.....
Clients' Address.....
Parity.....Last Child Birth/abortion.....LMP.....
Date of Insertion.....
Type of IUCD.....
Timing of Insertion: (Tick √)
☐ Interval ☐ PP (Vaginal Del.)
☐ PP (Intracesarean) ☐ PA
Record of IUCD Follow up:
Visit | Due Date | Actual Date | LMP (Write L.A for Lactational Amenorrhea.) | Complaints (if any, specify) | IUCD retained (yes/no) | Post Follow up Advise
1st
2nd
3rd

Figure 10: IUCD card

✿ Post Insertion Counseling

- Reinforce the key messages related to IUCD and inform the woman regarding importance and schedule of follow-up visits.
- Ensure that a filled IUCD card providing all relevant instructions has been given to beneficiary.
- Return for follow up: Emphasize upon the necessity for follow-up visits and that the client should return after 6 weeks or first menstruation, whichever is earlier for a follow up examination. Emphasize that client should return any time if she has any concerns or experiences any warning signs or if the IUCD is expelled.
- **Warning signs** that indicate the need to return to the facility (PAINS)
  - **P:** Periods related problems or pregnancy symptoms
  - **A:** Abdominal pain or pain during intercourse
  - **I:** Infections or unusual vaginal discharge
  - **N:** Not feeling well, fever, chills
  - **S:** String problems (strings are felt by the partner during vaginal intercourse)

✿ Counseling during other conditions:

- **Post IUCD removal:**

  Although most women will not experience problems after IUCD removal, all women should remain at the facility for 15 to 30 minutes.

  - Ask the woman how she is feeling? – if she says she is feeling absolutely normal and does not require/ want another contraceptive, she can go home
  - If she has nausea/ lower abdominal pain/ cramping/ dizziness or fainting (rare symptom, provide reassurance and let her remain on the examination table and keep observing her condition, until she feels better
  - If the woman wants another contraceptive method, it should be provided immediately after the removal procedure

- **IUCD failure (pregnancy with IUCD in place)**

  IUCD is a very effective method. However, in rare cases, failure can occur. This fact should be told to women during initial counseling about the method and kept in mind every time she comes for a checkup.

  - When a client comes with missed periods/ other signs and symptoms of pregnancy, she should be checked for pregnancy.
  - If pregnant, she should be reassured that the baby growing in her womb will not be harmed by IUCD so she can continue with the pregnancy, if she wishes to.

4.6.4 Injectable Contraceptive Medroxy Progesterone Acetate (MPA) under Antara Programme

Injectable contraceptive Medroxy Progesterone Acetate (MPA) is a three-monthly contraceptive for women. It is a safe, highly effective, convenient contraceptive and can be taken maintaining confidentiality. Depending upon the route of administration, MPA is of 2 types:

Figure 11: MPA under NFPP

- Intramuscular (IM) MPA injected in the muscle
- Subcutaneous (SC) MPA injected under the skin.

Both types have same characteristics of MPA. Only difference is in way of administering the injection.

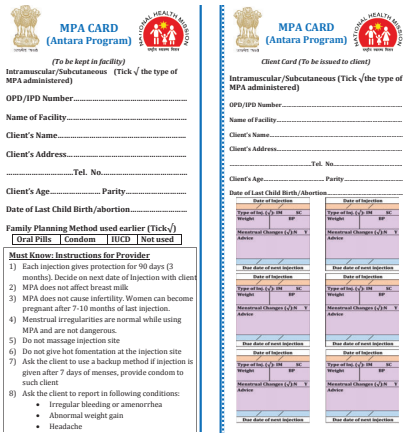
☛ Counselor should provide following key messages during pre and post injection counseling

- **Pre-injection counseling**
  - It is a three-monthly injection i.e. needs to be repeated every three months
  - It is best to take next injection on schedule, though it can be taken within two weeks before or four weeks after scheduled date
  - It is a safe and effective method
  - It does not affect breast milk, hence can be used safely by breast feeding mothers at 6 weeks
  - It causes menstrual changes like irregular/ prolonged bleeding and amenorrhea which are harmless and occur due to the effect of the method
  - Other minor temporary effects may include change in weight, mood swings, headache and decrease in bone mass
  - It is a reversible method, but it takes 7–10 months from date of last injection for the fertility to return (average 4–6 months after 3 months effectivity of last injection is over)
  - When the woman wants to conceive, she should discuss it with her provider and discontinue taking the method well in advance
  - It does not protect from STIs/ HIV (Condoms must be used for STI/ RTI protection)

- **Counseling on menstrual changes**

  During counseling, special emphasis is needed for explaining the reason of menstrual changes and other side effects that might occur. This understanding helps the women to opt for the method without getting worried about the side effects and to cope with them when they occur. Many women tend to worry about amenorrhea as they do not know why menstruation occurs, and many think it is the dirty blood that comes out of the body. Women need to be told that absence of periods occurs because that is the way the method works and is not harmful. Reassure that periods resume after discontinuing MPA

- First explain the **process of menstruation**, using simple language and examples *(Refer Chapter 3)* Then explain **why menstrual changes occur:** With MPA, the monthly preparation for pregnancy in woman's body does not occur. There is no release of ovum or thickening of inner lining of uterus. The menstrual cycle gradually comes to a stop after irregular bleeding for some time. When the woman stops using MPA, body starts preparing for conception again and menstrual cycle is resumed. Women can be explained that if they do not want to become pregnant, there is no significance of menstruation


MPA CARD
(Antara Program)

(To be kept in facility)

Intramuscular/Subcutaneous (Tick √ the type of MPA administered)

OPD/IPD Number.....

Name of Facility.....

Client's Name.....

Client's Address.....

.....Tel. No.....

Client's Age..... Parity.....

Date of Last Child Birth/abortion.....

Family Planning Method used earlier (Tick√)

Oral Pills	Condom	IUCD	Not used

Must Know: Instructions for Provider

1) Each injection gives protection for 90 days (3 months). Decide on next date of Injection with client
2) MPA does not affect breast milk
3) MPA does not cause infertility. Women can become pregnant after 7-10 months of last injection.
4) Menstrual irregularities are normal while using MPA and are not dangerous.
5) Do not massage injection site
6) Do not give hot fomentation at the injection site
7) Ask the client to use a backup method if injection is given after 7 days of menses, provide condom to such client
8) Ask the client to report in following conditions:
   - Irregular bleeding or amenorrhea
   - Abnormal weight gain
   - Headache

MPA CARD
(Antara Program)

Client Card (To be issued to client)

Intramuscular/Subcutaneous (Tick √the type of MPA administered)

OPD/IPD Number.....

Name of Facility.....

Client's Name.....

Client's Address.....

.....Tel. No.....

Client's Age..... Parity.....

Date of Last Child Birth/Abortion.....

Figure 12: MPA card

✿ Post-injection counseling

Right after MPA injection is given to a woman, it is important to advise her:

- Not to massage or apply hot fomentation to the injection site as it may hasten the absorption of MPA, due to which its effect may go away before 3 months
- That menstrual changes are common with the method so she should not get unduly alarmed if they occur
- Tell her she can return any time, especially if she has concerns or problems
- That the injection needs to be repeated every 3 months so she should try to come for the next dose on the date mentioned on the MPA client card. Tell her that if she is unable to come on the specified date due to any reason, she should still come for the injection, as it can be given a few days earlier or later

  (Although all clients are told about the scheduled date for next injection and it is written on MPA card, still some women may come early or later than the date)

- **If the client comes for next injection on scheduled date**
  - Support her in getting the injection
  - Tell her the scheduled date for next injection and encourage her to continue coming on time after every 3 months
- **If the client comes for the next injection within the grace period (which is upto 2 weeks earlier and 4 weeks later from the scheduled date)**
  - Support her in getting the injection
  - Tell her the scheduled date for next injection which will now be calculated 3 months from the date of taking the injection
  - Counsel her on the importance of coming on time for next injection, as per the date given on the MPA card
- **If MPA client comes for the next injection after the grace period of 4 weeks is over (more than 4 months have passed since she took her last injection)**
  - Take her to the provider to rule out pregnancy
  - If not pregnant, MPA injection can be given – she will be now be recorded as a "new client". She will also have to use a back-up method (e.g. condom) for next 7 days
  - Counsel and ask reason for coming late, because if returning within 4 months is a problem for the client, discuss other contraceptive methods

- **Counseling of clients coming with concerns**
  - There are no serious side effects of MPA. Menstrual changes in the form of irregular bleeding, prolonged bleeding or amenorrhea are common and can easily by managed by reassurance and medicines
  - Assess menstrual changes through simple questions and counsel accordingly (is it irregular/ prolonged/ heavy bleeding) – this usually resolves concerns of the women
  - Send her to the provider/ refer to a higher center to manage bleeding changes
  - If the client does not want to continue MPA, but does not want to get pregnant, counsel her about other methods which she can use & help her choose an option
- **Counseling of MPA client coming with pregnancy (failure case)**
  - MPA is a very effective method. However, in few cases, failure can occur. This fact should be told to women during initial counseling about the method and kept in mind every time she comes for a follow up
  - When a client comes with signs and symptoms of pregnancy and says she is not having monthly periods since few months, she should be checked for pregnancy

  If pregnant, she should be reassured that the baby in her womb will not be harmed by MPA injection so she can continue with the pregnancy, if she wishes to.

4.6.5 Sterilization

Sterilization is a permanent method and should be adopted only if the couple has decided that their family is complete and does not want any more children in future. Between the husband and wife, either one can opt for sterilization.

There are two types of sterilization:

- **Female sterilization:** It is a one-time surgical procedure where tubes carrying the eggs from ovary to uterus are blocked. It can be done through a Minilap Tubectomy/ Laparoscopic Tubal occlusion method.
- **Male sterilization:** It is a one-time surgical procedure where two vasa (tubes carrying sperm to urethra) is blocked. It can be done by either conventional or NSV method.

The counselor should know that for availing sterilization services in public health facilities, the client must meet the following criteria:

- Client should be ever married
- Age should be 22 years or above for female clients and between 22–60 years for male clients
- The couple should have at least one child, whose age is above one year, unless the sterilization is medically indicated
- Client or his/ her spouse/ partner must not have undergone sterilization in the past (not applicable in cases of failure of previous sterilization)
- Client must be in a sound state of mind, to understand the full implications of sterilization
- A mentally ill clients must be certified by a psychiatrist and a statement should be given by the legal guardian/ spouse regarding the soundness of the client's state of mind

☛ Counselor should provide following key messages during pre and post procedural counseling. It is important to know that client was offered all FP choices and has given informed consent for the sterilization

- **Pre-procedural counseling**
  - It is a permanent procedure for preventing future pregnancies and does not affect sexual pleasure, ability or performance, nor does it affect client's strength or ability to perform normal day to day functions
  - Informed written consent is mandatory for sterilization (*Refer to Annexure 8*)
  - The consent of the partner is not required. However, the partner should be encouraged to come for counseling
  - It is a one-time procedure and the client is not required to remember to use a contraceptive every time, no regular contraceptive supply is needed, and no repeat clinic visits required after initial follow-up visit on 7th day
  - It is a surgical procedure that has a possibility of complications, including failure, requiring further management
  - Sterilization does not protect against RTIs/ STIs including HIV/ AIDS
  - A reversal of sterilization is possible, but the reversal involves major surgery the success of which cannot be guaranteed
  - In the unlikely event of any complication/ failure/ death, there is a redressal mechanism available in the form of an indemnity coverage
  - Client should also be told about the sterilization compensation scheme *(Refer to Annexure 16)*

Note: The consent of the partner is not required for sterilization. However, the partner should be encouraged to come for counseling.

- The client's signature or his/her thumb impression on an informed consent form is the legal authorization for the sterilization procedure to be performed
- Consent for sterilization should not be obtained when physical or emotional factors may compromise a client's ability to make a carefully considered decision about sterilization
- A client who is unfit for sterilization should be counseled and offered another method of contraception

- **Post-procedural counseling:** The client should be explained about the post-operative instruction card (Refer to Annexure 9) and explained following key points
  - Follow-up is required:
    - After 48 hours (first contact is established)
    - On the 7th day for stitch removal (female sterilization/ conventional vasectomy)
    - **Female sterilization**: After one month or first menstrual period, whichever is earlier

      Male sterilization: After 3 months, for semen examination to ascertain that semen has become free of sperms. In case sperms are still present in semen sample, come for repeat semen examination every month till 6 months

- Report immediately at the nearest health facility in case of an emergency – if there is excessive pain, fainting, fever, bleeding or pus discharge from the incision, or if the client has not passed urine, not passed flatus and experiences bloating of the abdomen

- Medication should be taken, as prescribed
- Return home and adequate rest to be taken
  - **Female sterilization:** Resume only light work after 48 hours and gradually return to full activity in two weeks following surgery
  - **Male sterilization:** Scrotal support or snug undergarment for 48 hours; Resume normal work after 48 hours and return to full activity, including cycling, after one week following surgery
- Resume normal diet as soon as possible
- Keep the incision area clean and dry. Do not disturb or open the dressing
- Bathe after 24 hours of surgery. If the dressing becomes wet, it should be changed so that the incision area is kept dry until the stitches are removed
- Resumption of Sexual intercourse:
  - **Female sterilization:**
    - After interval sterilization (Minilap and Laparoscopic), the client may have intercourse one week after surgery or whenever she feels comfortable thereafter
    - After postpartum sterilization (after caesarean or normal delivery) client may have intercourse 2 weeks after sterilization or whenever she feels comfortable
  - **Male sterilization:** The client may have intercourse whenever he is comfortable after the surgery but should use condom for next 3 months or if his wife is using a contraceptive, she needs to continue using it for the next 3 months i.e. until success of the male sterilization is established
- Encourage every male and female sterilization client to collect their sterilization certificate and explain its importance and when it will be issued: *(Refer to Annexure 10)*
  - **Female sterilization certificate:** is issued by medical officer in-charge of facility where procedure was conducted one month after the procedure or after the first menstrual period, whichever is earlier. If the client does not resume her periods even after one month of surgery, pregnancy is ruled out before issuing sterilization certificates
  - **Male sterilization certificate:** is issued by the medical officer of the facility where client underwent sterilization after three months of the procedure, on confirming that the client's semen examination shows no sperm, because this means male sterilization has become successful. If the sperms are still present after 3 months, certificate issuance can be delayed till 6 months of the procedure. After 6 months, if semen still has sperms, the certificate is not issued and the procedure is considered as unsuccessful
- **Importance of sterilization certificate:** In case of failure (Pregnancy) after issuance of sterilization certificate, certificate acts as a valid proof to claim indemnity coverage for the failure as per Family Planning Indemnity Scheme, GoI (Refer to Annexure 16)

Counseling of sterilization failure (client/ partner coming with pregnancy)

Sterilization is an irreversible method and is almost 100 percent effective. However, in rare cases, failure can occur. This fact should be told to women and men during initial counseling about the method. As mentioned above, for initial three months after male sterilization, the couple must use another method e.g. condom or pills, injectable contraceptive or IUCD. The chances of failure increase if contraceptive is not used during first 3 months of male sterilization

- When a client/ client's partner comes with signs and symptoms of pregnancy and says she is not having monthly periods since few months, she should be checked for pregnancy
- Semen analysis to be done in case her male partner was sterilized

Sterilization compensation and Indemnity compensation are different

Every client who has undergone sterilization operation in public or private accredited facility is eligible to get compensation as per compensation scheme applicable in the state. **For payment of sterilization compensation, discharge slip/ card is considered as a valid proof of undergoing sterilization**.

Indemnity coverage is given to the client in the event of failure (pregnancy after sterilization certificate is issued). For payment of indemnity compensation, sterilization certificate is considered a valid proof

4.6 Timing of Initiation of Contraceptive Methods

Based on the timings of adopting a method at different phases of reproductive life of the women,

it can be classified into:

- **Interval:** When a method is chosen during any time of reproductive cycle provided a client is not pregnant based upon eligibility criteria
- **Postpartum:** When a method is opted after delivery based on eligibility criteria;

  There are various opportunities to counsel clients to encourage use of contraceptive in postpartum period:

  - ***During antenatal visits:*** It is best to begin counseling regarding importance of HTSP and available postpartum family planning choices when pregnant women come for the antenatal visits. This gives them ample time to think and decide which method to use after childbirth
  - ***At the time of admission/ early labour/ during elective caesarean/ immediately after delivery:*** Every opportunity needs to be tapped to counsel pregnant women for postpartum family planning

A woman should NOT be counseled for the first time during active labour as she may not be able to make an informed choice due to stress of labour

- **Post abortion:** When a method is adopted after an abortion, based on the eligibility criteria

  Provide information and counsel the women that after abortion, there are chances of pregnancy very soon as ovulation can return within 2 weeks of abortion. If a woman is seeking an abortion following a contraceptive failure, discuss whether the method was used incorrectly and how to use it correctly, or whether it may be appropriate for her to change to a different method
- There are various opportunities to counsel woman/ couple to encourage use of contraceptives in post-abortion period:
  - *On confirmation of pregnancy,* if the woman wants termination of pregnancy: provide information about safe abortion services and simultaneously counsel for adoption of various relevant post-abortion family planning methods
  - *Before initiating the abortion procedure* at the health facility give her information about post abortion family planning

- *After completion of abortion* for the woman who could not be counseled prior to abortion, (for example in case of woman with incomplete abortion requiring emergency management) counsel her on post abortion contraception after completion of abortion procedure and once she is comfortable

Table 6: Summary of initiation of FP methods at different phases of reproductive life

FP Method	Postpartum	Post-abortion	Interval
Intra Uterine Contraceptive Devices (IUCD 380A & 375)	Within 48 hours of vaginal delivery or concurrently with C-section	Immediately or within 12 days after completion of first or second trimester abortion	Anytime during the menstrual cycle or any time it is reasonably certain that woman is not pregnant OR after 6 weeks of delivery OR 12 days after abortion
Injectable contraceptive MPA (Antara Programme)	**Breastfeeding:** at 6 weeks after delivery. **Non-Breastfeeding:** earlier than 6 weeks	On same day or within 7 days of an abortion	Within 7 days of start of monthly bleeding or any time it is reasonably certain that woman is not pregnant
Combined Oral Pills-Mala N	**Breastfeeding:** after 6 months **Non-Breastfeeding:** any time on days 21–28 after giving birth	Immediately or within 7 days of an abortion	Within 5 days of start of monthly bleeding or any time it is reasonably certain that woman is not pregnant
Progesterone only Pills	**Breastfeeding/Non-Breastfeeding:** Earlier than 6 weeks	Immediately, or within 7 days of miscarriage or abortion	Within 5 days of start of monthly bleeding or any time it is reasonably certain that woman is not pregnant
Weekly oral pill–Chhaya	**Breastfeeding/Non-Breastfeeding:** Any time after delivery	Immediately, or within 7 days of miscarriage or abortion	First day of monthly bleeding
Emergency Contraceptive Pills (Ezy Pill)*	Within 72 hours of an unprotected intercourse	Within 72 hours of an unprotected intercourse	Within 72 hours of an unprotected intercourse
Female sterilization	Within 7 days of delivery	Surgical abortion: Concurrently or within 7 days of abortion Medical abortion: done after next menstrual cycle	Any time it is reasonably certain that woman is not pregnant OR after 6 weeks of delivery OR after 7 days of abortion
Male sterilization	Anytime as it has no relation with female partner's physiological situation		
Condoms	Anytime, when both the partners are ready and comfortable to use		
Conventional family planning method- **LAM (Lactation Amenorrhea Method)****	LAM – an effective method if all 3 conditions are met, which are: ✿ Woman is exclusively breastfeeding her child ✿ Monthly periods have not returned after childbirth ✿ Child is less than 6 months old.	Not applicable	Not applicable

*ECP – not to be used as a regular contraceptive
**LAM – is not under NFPP

4.7 Emergency Contraception

Sexually active person/ couple may sometimes face an 'emergency' situation because of unprotected sex, and they may need protection from unwanted pregnancy e.g.:

- Incorrect use/ slippage/ broken condom
- Missed pills
- Expulsion of IUCD
- MPA client comes more than 4 weeks late for her next injection
- Not using a contraceptive and had sex
- Coerced sex

Figure 13: ECP under NFPP

In the National Programme, Emergency Contraceptive Pill (ECP) is available by the name of **Ezy Pill** and it contains progestin hormone (Levonorgestrel 1.5 mg)

Remember: ECP is not a regular contraceptive and should only be taken in emergency. Client should be counseled to use a regular method.

☛ Counselor should counsel the client requiring emergency contraceptive pills on following messages:

- ECP can help to prevent pregnancy in emergency situations, if taken within 3 days (72 hours) of unprotected sex. **The sooner it is taken, the better it is.**
- ECP does not disrupt an existing pregnancy, therefore, **it is not an abortifacient**
- It is **not a regular family planning method** and is meant to be used only as an emergency measure
- ECPs provide an opportunity for women to start using regular contraceptive method – women who are sexually active on a regular basis, need to be counseled about using a regular contraceptive method after taking the emergency contraception. Most contraceptive methods can be started on the same day of ECP use
- Some women may experience side effects like nausea, vomiting, abdominal pain, slight bleeding or change in time of monthly bleeding as next menstrual bleeding may be earlier or later than expected
- It is required **to be taken whenever an emergency arises** because the EC pill may work only after one episode of unprotected sex, and it cannot protect woman from future pregnancy, if unprotected sex occurs again. If unprotected sex occurs after ECP is taken there won't be any contraceptive protection and client will again have to take emergency contraception
- **ECPs do not provide protection against RTI/ STIs including HIV**
- **After taking EC Pill, woman should be advised to consult a health provider if**
  - she does not get periods even after one week of its expected date (suspected pregnancy)
  - the next menses is unusually light (pregnancy) or is accompanied by severe pain in the lower abdomen (suspected ectopic pregnancy)

4.8 Involving Men as Equal Partners in Family Planning

Reproduction and related decisions are joint responsibility of both the partners. Hence, men also need to participate in discussions on the importance of contraception, birth spacing and spousal communication, information about various contraceptive methods and understand their role in family planning. This can be done at outreach by involving men in discussions, and when they accompany their wives or partners to the health facility. Hence, women should be encouraged to bring their partners to take part in family planning counseling sessions so that they can jointly understand the methods and decide the method to use. Several studies have shown that family planning method use is more successful when partners choose and agree upon a method together.

This gives an opportunity to discuss their role in protecting their health and the health of their wives and children. Men have special counseling needs and should receive special attention from providers to motivate them to make responsible choices regarding reproductive health practices.

4.8.1 Men's Special Counseling Needs for Adopting FP Method

- Men need to be encouraged to use family planning method themselves (condoms or vasectomy)
- Men often have serious misconceptions and concerns that family planning methods will negatively impact their sexual pleasure and/ or performance
- Some men may not know how to use condoms correctly. Therefore, counselors/ providers should always explain correct use of condoms/ demonstrate it, using a model, whenever possible (Refer section 4.6.1)

4.9 Counseling of Client/ Couple with Special Needs

In addition to regular clients visiting the health facilities, there are some clients who may require extra support and counseling on contraceptives. Examples of clients with special needs are:

4.9.1 **Adolescent girls,** either married or unmarried, may have poor negotiation/ decision making power in matters related to sex/ reproduction. The importance of dual protection from STIs/ HIV, as well as from pregnancy needs to be emphasized to them. They may also need special assistance in obtaining the contraceptives that suits them the best and should be counseled in a non-judgemental manner.

4.9.2 **Women with HIV infection** must be counseled on the necessity of dual protection for which they need to use condoms regularly along with any other contraceptive of their choice.

4.9.3 **Women in violent relationships** may not be able to discuss family planning with their partners or get their support for adoption of a contraceptive as their partners are unlikely to adopt a method themselves or let the women do so. These women may need extra support to explore the contraceptives that will serve their purpose and protect them from unwanted pregnancies.

4.9.4 **Differently abled women** may have special requirements in terms of methods suitable for their situation and disability. To counsel these clients, it is equally important to consider their preferences and the nature of their disability. For example, barrier methods may be difficult for some people with a physical disability; the disability may not allow IUCD insertion but Injectable contraceptive MPA or oral pills could be suggested; women with an intellectual disability may have trouble remembering to take a pill each day or dealing with changes in monthly bleeding, in such cases woman's family should be involved in counseling.

4.9.5 **Couples facing infertility** (who want but are not able to have a child): While most couples need counseling on how to avert unwanted pregnancies by using contraceptives, some are likely to come with the problem that they are not able to have a child. They may either report that they have never conceived (primary sterility/ infertility) though they are leading sexual life together, without using any contraceptive, or report that in the past they have had an abortion or gave birth to a child, but are not able to conceive again (secondary sterility/ infertility).

- There can be different factors or conditions which can reduce fertility, such as:
  - Infectious diseases (STIs, including HIV and other RTIs), mumps that develop after puberty in men)
  - Anatomical, endocrine, genetic or immune system problems
  - Ageing
  - Medical procedures that can bring infection into woman's upper reproductive tract

☛ Counseling of clients with infertility:

- Counsel both partners together, if possible, as both are equally responsible for reproduction and anyone of them may require treatment
- Tell both that they need to go to a health facility for checkups and some examinations. Based on their reports, the doctor will decide on future course of action
- Listen to couple's concerns and issues actively and empathetically
- Explain that there can be various reasons for infertility
- Understand the pattern of menstrual cycle of the woman and if they are regular, explain the couple about the fertile days (when chances of ovulation are maximum) and importance of sexual contact during these days for them
- Inform about STI (including HIV) preventions, and encouraging clients to consult a doctor in case of suspected STI or exposure to the same

05

Counseling on Essential Maternal and Newborn Care

Becoming a mother is a natural process and often a satisfying experience for a woman and her family. The process of motherhood involves pregnancy, childbirth and postpartum period (period of 42 days following childbirth). Pregnancy and childbirth are normal physiological events during which women experience a lot of physical, psychological and social changes and are likely to have anxiety and inquisitiveness about taking proper care of themselves and their children. While most pregnancies result in healthy outcome i.e. healthy mother and healthy newborn, complications may develop during few pregnancies leading to severe illness or death in mothers and infants. Therefore, it is important to prevent/ identify early and manage the complications effectively.

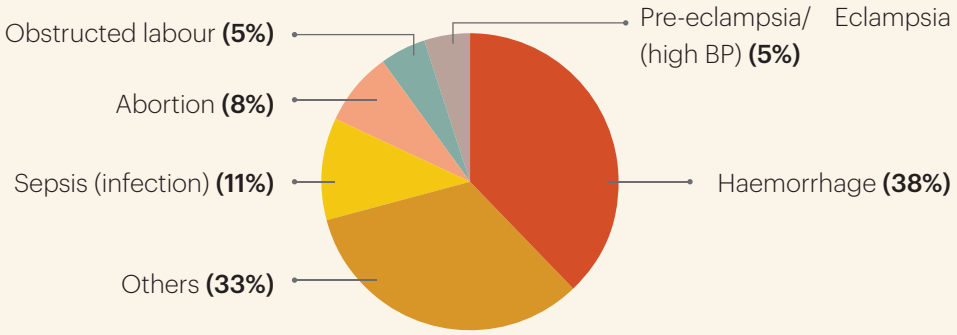
Causes of maternal and infant deaths

1. **Maternal death causes:**

   Maternal deaths result either from direct causes or indirect causes.

   The direct causes account for 67% and indirect causes (due to associated conditions like HIV, heart disease, diabetes, malaria, TB etc.) accounts for 33% of the maternal deaths.

Causes of maternal mortality (SRS 2001–03)



2. **Infant/ newborn deaths** can be due to preterm delivery, low birth weight, asphyxia or infection. Preterm delivery and low birth weight are directly related to maternal causes.

The vulnerabilities for these deaths further increase due to **three delays**:

1) *Delay in decision to seek care* – can be a result of low socio-economic status, poor understanding of complications/risk factors
2) *Delay in reaching care* – can be due to transportation related issues
3) *Delay in receiving adequate health care* – can be due to poor quality of health services, poor referral system

Every mother and her child should be kept safe from these complications throughout the process of motherhood. Therefore, the counselor must support pregnant women in availing essential antenatal, delivery, postnatal and newborn care in order to remain healthy and free from complications.

The counselor is likely to come across pregnant women with following diverse situations and needs:

- Married pregnant women of any age group with their first pregnancy
- Unmarried pregnant women wanting to continue or terminate pregnancy
- Married/ unmarried women with the history of abortion, still birth or death of earlier children
- Multiparous women (woman who have given birth more than once)
- Women with special needs – HIV positive, women with disabilities, pre-existing medical or pregnancy related complications, facing domestic violence or from low a socio-economic background

☛ Counseling messages/ important information for women who decide to continue the pregnancy

- **Essential services and general care during pregnancy and postnatal period including personal hygiene and nutrition**
  - The pregnancy is divided into three trimesters – *(Refer to Annexure 11)*

First trimester	Up to 12 weeks	This is the most crucial phase for baby's development. Women may have various symptoms like nausea, fatigue, breast tenderness and frequent urination. Most miscarriages and birth defects occur during this period.
Second trimester	13–26 weeks	During this phase the unpleasant effects of early pregnancy disappear. However, women may experience back pain, abdominal pain, leg cramps, constipation and heart burn. Between 16–20 weeks, baby's first movement may be felt.
Third trimester	27–40 weeks	Few women may experience shortness of breath, hemorrhoids, urinary incontinence and sleeping problems. The symptoms are largely due to increase in the size of uterus.

- The counselor needs to:
  - Explain the main points related to each trimester of pregnancy
  - Explain the importance of early and regular antenatal visits for availing essential services. For e.g.: Td injection and IFA tablets
  - Explain the general care to be taken at home, including adequate nutrition, birth preparedness, advantages of natural birthing and importance of institutional delivery
  - Emphasize on the importance of HTSP, give information on relevant contraceptive choices which can be adopted after delivery
  - Counsel on care of the mother and baby during postnatal period esp. importance of breastfeeding
  - Educate on how to recognize the danger signs, emergency readiness and referrals

5.1 Care during Pregnancy

A counselor should support the pregnant women in taking better care of themselves and cover the following aspects during counseling:

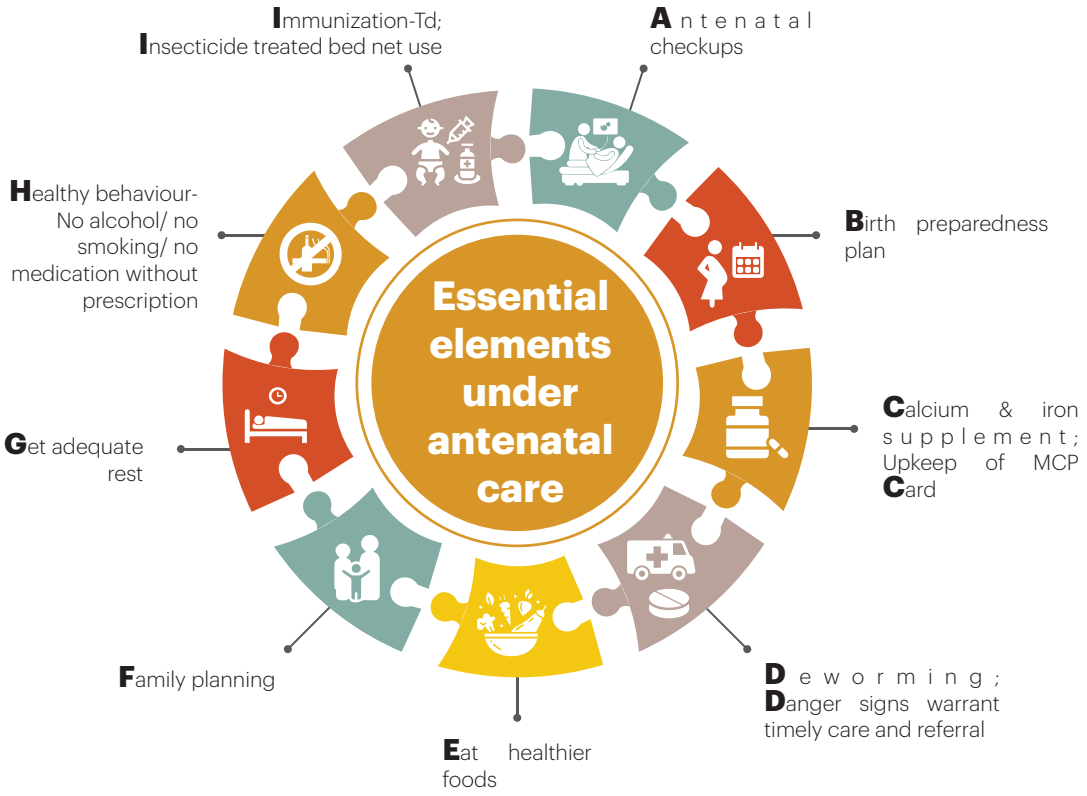


Figure 14: Essential elements under antenatal care

5.1.1 Antenatal Checkups

Antenatal checkups refer to the systemic checkup of pregnant woman to ascertain the well-being of the mother and the foetus.

Importance of antenatal checkups:

- Regular checkups help in ascertaining the health of the pregnant mother and the unborn child and identify and manage any complication or ailment in time
- Woman gets essential care during pregnancy for her/ her foetus's well-being. E.g.: Routine lab investigations, IFA tablets, Td injection and counseling on nutrition and postpartum family planning.
- Woman and her family members learn about the signs of labour and possible danger signs of complications during pregnancy
- Woman gets information on how she and her family can prepare a birth plan, including dealing with complications, if they arise
- Woman gets information about various GoI schemes like JSY, JSSK, PMSMA and SUMAN and how to avail them (*Refer to Annexure 16*)

5.1.1.1 Service delivery points for ANC services:

The ANC services can be availed at

- Village level – at the Anganwadi center, during the monthly VHSND
- At health facility – Sub-Centre, PHC, Health & Wellness Centre, CHC, SDH, DH, and Medical college hospitals

Counselor should inform the beneficiary that under **"Pradhan Mantri Surakshit Matritva Abhiyan" (PMSMA)** high quality ANC services are provided on fixed day every month in public health facility. PMSMA visit is in addition to the routine ANC at the health facility. *(Refer to Annexure 16)*

5.1.1.2 Timings and frequency of ANC visits:

A minimum four ANC visits are necessary for every pregnant woman. High risk pregnancies require more than 4 visits, as per doctor's recommendations.

Table 7: Essential visits during antenatal period

ANC Visit	Timings	Remarks
1st ANC visit	Within 12 weeks (preferably as soon as the period is missed/ pregnancy is suspected)	✿ 1st ANC visit within 12 weeks ensures **early registration of pregnancy and identification of any high-risk conditions**, facilitating in proper planning and adequate care to mother and baby ✿ Early registration may be done by ANM/CHO at VHSND/ SC/ HWC or other provider at health facility. At the time of registration MCP card is given ✿ During the first visit, EDD (Expected date of Delivery) is calculated ✿ EDD = LMP+9 months+7 days
2nd ANC visit	14–26 weeks (4–6 months). Preferably before 20 weeks with one USG to rule out fetal malformations	
3rd ANC visit	28–36 weeks (7–8 months)	It is advised that pregnant women must visit the doctor at the nearest health facility for 3rd ANC, even if there is no complication.
4th ANC visit	Between 36 weeks and term of pregnancy.	**Warning signs of labour to be explained:** ✿ Painful contractions occur at regular interval ✿ Interval between contractions gradually shortens ✿ Intensity gradually increases ✿ Discomfort in back and abdomen ✿ Presence of bloody mucoid discharge or watery discharge

☛ Counselor should know that early detection of pregnancy is also possible through use of Nishchay kits (pregnancy testing kits) that are available free of cost in Sub centers and with ASHA. This test can be performed soon after a missed period and is simple to perform

Figure 15: PTK under NFPP

Use of Nishchay Kit: Collect urine in a container (preferably 1st morning sample). Put 3 drops of urine into sample well (present on detection card) with the help of a dropper. Read the results within 5 minutes. (*Refer to Annexure 11*)

Table 8: Key elements of antenatal visits

ANC Visits	1st Visit	2nd Visit	3rd Visit	4th Visit	Remarks
History Taking					
Done by Doctor/ Nurse	√	-	-	-	**History is taken for** ✿ Date of LMP ✿ Order of pregnancy, birth interval ✿ Symptoms during present pregnancy ✿ History of previous pregnancies, systemic illnesses, drug intake or allergies/ use of habit-forming substance ✿ Screen for TB (ask about cough or fever> 2weeks, inadequate weight gain/ loss in last 3 months, night sweats or Extrapulmonary symptoms like localized swellings/ lumps in the body) ✿ History of COVID-19 vaccination ✿ Family history of systemic illnesses
Physical Examination During each visit the health-care provider assesses – Weight, pulse, respiration, BP, pallor, oedema, breast and abdominal examination. **Counselor may also refer to MCP card for client specific counseling**					
Weight	√	√	√	√	✿ Normally, a woman gains 9–11 kg during her pregnancy. Ideally after the first trimester, a pregnant woman gains around 2 kg/ month ✿ Weight gain <2 kg/month may result in IUGR/LBW ✿ Weight gain >3 kg/month may indicate eclampsia, twin pregnancy or diabetes Refer the woman for doctor's consultation
Respiratory rate	√	√	√	√	If woman complains of breathlessness, Respiratory rate of >30/min with anaemia, she should be immediately referred to doctor
Pallor (for presence of anaemia)	√	√	√	√	For anaemic mothers, nutritional counseling along with IFA supplementation is important
Oedema (swelling)	√	√	√	√	Pregnant women may have swelling which appears in evening and disappears in morning. This may be a normal manifestation of pregnancy. If a woman has swelling on face, hands, abdomen, vulva she should be referred to a doctor
Abdominal examination	√	√	√	√	Abdominal examination is done to assess fetal condition. **Fetal movements –** are a reliable sign of fetal well-being. Fetal movements, also called 'quickening', can be felt by the women at around 18–22 weeks of pregnancy. Woman may feel 2–3 movements within an hour of taking meals. Decreased movements may be an indication of fetal distress. Women in whom the fetal movements are decreased need to be referred
Breast examination	-	-	√	√	Examination of the breasts to be conducted for diagnosis and management of difficult breast conditions – flat nipples, inverted nipples, sore nipples, cracked nipples, engorgement of breast, mastitis, etc. for appropriate and timely management of any problems

ANC Visits	1st Visit	2nd Visit	3rd Visit	4th Visit	Remarks
Laboratory and Other Investigations- Haemoglobin (for anaemia), Urine test (for sugar and proteins), Blood Group, Blood Sugar, HBsAg (Hepatitis), VDRL (for STDs), Syphilis testing, HIV screening, Rapid Malaria testing					
Haemoglobin	√	√	√	√	For assessing anaemia
Urine test	√	√	√	√	For sugar and protein
Blood Group including Rh factor	√	-	-	-	For Rh compatibility
Blood Sugar	√	-	√	-	For detecting diabetes
HbsAg	√	-	-	-	For detecting hepatitis
VDRL,Syphilis test	√	-	-	-	For detecting STDs
HIV screening	√	-	-	-	For detecting HIV
Rapid Malaria test	√	-	-	-	For detecting malaria
Anomaly scan	-	√	-	-	Anomaly scan is done at 18–20 weeks
Supplementation					
Folic Acid	√	With IFA			400 mcg supplementation
IFA	×	√	√	√	
Calcium	×	√	√	√	
Immunization (Td) – The first dose of Td is administered as soon as possible, preferably when the woman registers for ANC The second dose is to be given one month after the first injection If the woman is immunized with two doses during previous pregnancy within past three years, then one dose is administered as early as possible in this pregnancy					
Deworming	×	√	√	√	Given in areas with high prevalence of helminthic infection as per health provider's consultation
Counseling on: ✿ Trimester wise changes *(Refer to Annexure 11)* ✿ Planning and preparing for birth (birth preparedness) ✿ Recognizing and preparing for danger signs (complication readiness) – Women should be counseled on danger signs and it should be emphasized that if any complications occur, she should seek medical help urgently. Guide her beforehand on the availability of assured referral linkages (for e.g.: 108 services) and the place where she can seek care ✿ Diet and rest ✿ Infant-feeding ✿ Sex during pregnancy ✿ Domestic violence ✿ Contraception					

☛ Counselor should provide counseling on supplementations i.e. IFA tablets, Calcium tablets, Immunization, Deworming and management of common ailments during pregnancy:

✿ **Iron and folic acid (IFA) supplementation:**

- Explain that it is essential to take one IFA tablet daily for at least 180 days during the pregnancy (i.e. from 4th month to 9th month) to protect against anaemia and 180 days after the delivery (during lactation period) to protect herself and the child from anaemia *(Refer to Annexure 4)*
- If the pregnant woman is anaemic (mild to moderate; Hb: 7–10g/dl) tell her to take two IFA tablets daily, one tablet after one hour of each meal (for at least 180 days i.e. at least 360 tablets). Same doses need to be continued after delivery, if anaemia persists. Severely anaemic women must be immediately referred irrespective of period of gestation *(Refer to Annexure 4)*
- Advise her to take plenty of fruits and vegetables and increase intake of vitamin C rich food such as mango, guava, orange, lemon as these enhance the absorption of iron
- Explain about the changes that can be noticed after IFA consumption such as dark stools, nausea, gastritis etc. Inform her that it is a sign that the tablet is being digested in the body and it will reduce over-time
- Advise not to take IFA along with tea, coffee, milk, or with the calcium tablet, as it reduces iron absorption
- Ask the woman to drink more water and add roughage (plenty of green leafy vegetables) to her diet in case of constipation
- Dispel the myths and misconceptions related to IFA and convince the woman about the importance of taking it. (Refer Chapter: Busting Myths and Misconception with Facts)
- Explain that taking tablets regularly will make the woman feel better in general and less tired than before. However, despite feeling better, she should not stop taking the tablets and must complete the course, as advised by health-care provider
- Ask her to return/ consult the health provider if she has problems in taking IFA tablets but not to stop taking them on her own.

Note: In India, anaemia among women is very common. The chances of a mother having delivery before term, or even dying due to PPH are higher among mothers with severe anaemia. **All pregnant women should take iron and folic acid tablets, even if they are not anaemic, to have good store of iron in the body**. Low level of haemoglobin (Hb below 11g/dl) (tested during the antenatal check-up) means anaemia.

Calcium supplementation

- Explain to the pregnant women that calcium tablets would make her bones strong and is essential for the development of bones in the baby. It also helps in reducing the risk of pre-eclampsia and high blood pressure
    - One tablet twice a day (total 1 gm calcium daily) from second trimester (14 weeks) onwards throughout pregnancy for 6 months (360 tablets) and continued for 6 months after delivery (360 tablets)
    - One calcium tablet should be taken with the morning/ afternoon meal and the second tablet with the evening/ night meal. It is not advisable to take both calcium tablets together as > 800 mg calcium interferes with iron absorption
    - Calcium tablets should not be taken empty stomach since it may cause gastritis

Iron Folic Acid tablets and calcium tablets should not be taken together at the same time. There should be a gap of at least 2 hours between IFA and calcium for better absorption of both.

- **De-worming:** All pregnant women need to take deworming tablets to prevent worm infestation and in turn anaemia. Single dose i.e.one Albendazole tablet (400 mg) to be taken after 1st trimester (after 12 weeks)
- **Management of common ailments during pregnancy:**

Nausea and vomiting

- Drink plenty of fluids and maintain hydration
- Eat small frequent meals
- Have non greasy meals with little odor
- Ginger or chamomile tea can help reduce morning sickness
- If excessive, vitamin B6 supplements can be tried

Heartburn

- Eat small, frequent meals
- Avoid spicy, greasy foods
- Elevate head of bed when lying down
- Avoid lying down immediately after taking a meal

Constipation

- Eat fresh fruits and vegetables
- Drink 8–10 glasses of water
- Eat foods with high fibre (e.g.: wheat bran)

Pedal edema

- Rest with legs elevated
- Lie in the left lateral position
- Avoid sitting or standing for long periods

Leg cramps

- Ensure intake of daily magnesium/ calcium supplements.

5.1.2 Danger Signs in Pregnancy

Most women go through a pregnancy without any serious problems. However, there are a few complications which can endanger the life of the woman and/ or her baby. Counselor should ensure that the woman and her family members understand the common danger signs of these complications and when to ask for help and where to seek support.

If any of the following danger signs occur, the woman should be taken immediately to the hospital:

Figure 16: Danger signs in pregnancy

Different complications are managed at different level of facilities. It is also important for the beneficiary to know from where to seek medical help in case of any complication. This can reduce the transit time and can directly impact the delays in seeking care as well as delays in transport.

Table 9: Danger signs during pregnancy and level of facilities for referral *

Visit FRU	Visit 24-Hour PHC
✿ Vaginal bleeding in advanced pregnancy ✿ Labor pains or leaking before 9 months of pregnancy ✿ Leaking for more than 12 hours without labor pains ✿ Labor pains more than 12 hours ✿ Decreased or no fetal movements ✿ Swelling all over body, palpitations, shortness of breath ✿ High blood pressure detected in ANC ✿ Fits or convulsions ✿ Foul smelling leaking with or without fever ✿ Continuous abdominal pain ✿ Headache & blurred vision	✿ Vaginal bleeding in early pregnancy ✿ Leaking per vaginum before on set of labor ✿ Burning micturition ✿ High grade fever or any medical illness ✿ Excessive nausea and vomiting ✿ High blood pressure detected in ANC ✿ Fainting and/or pain in abdomen

* The referral sites may vary from state to state. Under certain situations and circumstances, if possible, teleconsultation may be done for seeking preliminary advice

5.1.3 Birth Preparedness Plan

As indicated above, childbirth is a normal physiological process. However, some women and newborn babies may have complications that require emergency/ urgent medical services at a higher-level facility. In many cases, it is not possible to identify in advance which women or babies will have the complications. Therefore, every pregnant woman and her family should have a birth preparedness and complication readiness plan made in advance.

Birth preparedness plans assist women, their partners and families to be adequately prepared for childbirth. This plan helps in:

- Developing an understanding on how to respond if complications or unexpected adverse events occur with the woman and/ or the baby at any time during pregnancy, childbirth or the early postnatal period
- Ensuring skilled delivery care and augmenting the men's participation in maternity care

☛ Counselor may support in preparation of birth preparedness plan and identification of the potential solutions to the concerns that may arise

5.1.3.1 Components of birth preparedness plan:

Micro-birth planning and birth preparedness plan is an integral part of GoI's maternal health interventions. At the community level, ASHAs and ANMs/ CHOs facilitate this planning. The final birth plan is made during the last antenatal visit.

Mentioned below are the key components covered under birth preparedness plan:

5 Is of micro-birth planning

- Inform about the essential antenatal and intra natal care components, signs of labour and danger signs
- Inform expected date of delivery
- Itemize the essentials that will be required at the time of delivery (e.g.: money, towel, cloths, transportation etc.)
- Identify the place of delivery
- Identify the referral facility

A. Skilled attendant care

Care by a skilled attendant (a person who can handle common obstetric and neonatal emergencies, recognize when the situation reaches a point beyond her/ his capability and refer the woman or the newborn to a First Referral Unit/ appropriate facility without delay) helps in averting the maternal morbidities and mortalities.

☛ One of the important tasks of the counselors is to guide and support the woman in birth preparedness and developing her own birth plan. This can be achieved by:

- Educate woman in recognizing the signs of labour:
  - Sticky or bloody discharge/ frank watery leakage from the vagina
  - Abdominal pain which increases in intensity with passage of time
- Provide information on key components of antenatal care (Td, IFA & calcium supplementation, ANC visits), EDD, when to seek care if danger signs (Refer to section 5.2.2.4.b) appear during pregnancy, birth and the postnatal period (for both the woman and her baby)
- Re-emphasize the importance of identifying the safe place for birth and referral facilities (taking account of personal and local circumstances)
- **Inform about the place of delivery:** It is best to have the delivery in a health centre/ hospital where trained providers are available and should a complication occur, they know how to manage it and refer

appropriately in a timely manner. (The family should identify the appropriate and preferred health facility for the delivery well in advance as this helps in saving time by going to the right facility when woman goes into labour)

- Encourage family members in making a collective decision for ensuring safe delivery
- Ensure and encourage the women and family members to be in a frequent contact with the ASHA/ ANM/ CHO for their area, while keeping their contact details readily available
- **Other important preparation for institutional delivery or an emergency:**
  - Keep the pregnant woman's documents (MCP card) in an easily assessible place at home and remember to carry them to the hospital
  - Keep clean cotton clothes for the mother and baby, baby sheet/ towel, toiletries like toothbrush, toothpaste, comb, cup/ glass etc. ready in a bag
  - Decide who will accompany the woman to the hospital for delivery or in any emergency. It is good to have a female companion who is of good health and can provide necessary support
  - Support person identified for care of the home and children
  - Identify possible blood donors in case of hemorrhage/ another emergency


MINISTRY OF HEALTH AND FAMILY WELFARE
MINISTRY OF WOMEN AND CHILD DEVELOPMENT
MOTHER AND CHILD PROTECTION CARD
paste photo of child here
Is the pregnancy high risk?
FAMILY IDENTIFICATION
PREGNANCY RECORD
BIRTH RECORD
INSTITUTIONAL IDENTIFICATION

Figure 17: MCP card

B. Transportation:

Timely transportation facility can impact 2nd delay (delay in transport) and thus reduce the maternal and newborn mortality. Counselor can educate the women and her family on the available transport options (e.g. 108, Janani express, etc.) through the national and state government programmes. The counselor should support in identification of all available transport options with their contact details.

C. Funds/ Expenses:

Pregnancy and childbirth may have financial implications for the women/ her family. A counselor must, therefore, encourage the pregnant women to go for institutional delivery at government health facilities to avoid any out of pocket expenditure. GoI has launched various schemes like JSY and JSSK where most of the cost incurred in pregnancy/ childbirth is covered. JSSK is a flagship scheme of Government of India to cover all the expenses related to pregnancy, delivery and postnatal care at government health institutions from pregnancy up to 1 year after childbirth. The counselor should educate about the details of existing government schemes (Refer to Annexure 16) and the costs covered in the schemes. (Incentives, pre-conditions-like having a bank account etc.). However, counselor should also encourage the family to keep some fund aside or plan for it in advance, for delivery/ any emergency.

GoI has launched SUMAN – "Surakshit Matritva Aashwasan" with an aim to provide assured, dignified, respectful and quality health care at no cost and zero tolerance for denial of services for every woman and newborn visiting the public health facility in order to end all preventable maternal and newborn deaths and morbidities and provide a positive birthing experience. The expected outcome of this new initiative is **'Zero Preventable Maternal and Newborn Deaths and high quality of maternity care delivered with dignity and respect'.**

5.1.4 General Care during Pregnancy (At Home)

Adequate rest, nutrition and healthy behaviour is vital for maintaining healthy pregnancy and its outcomes. At every trimester of antenatal period, message related to these general aspects need to be emphasized.

☛ Counselor should explain that **adequate rest** is important for physical and mental relaxation of the pregnant woman. Following messages should be given:

- Have 8 hours sleep at night and at least 2 hours rest during the day
- Lie on the left side as it increases the blood supply to foetus
- Avoid hard work such as lifting heavy weight
- In malaria endemic areas, the pregnant women should sleep under LLIN (Long lasting insecticidal nets) (As per state specific guidelines including other preventive steps for prevalent community acquired infections and contagious diseases: COVID 19, Measles, Chicken pox, Influenza, Dengue and Zika)

☛ Counselor should explain that **adequate nutrition** is important for women's health and development of foetus. Inform the pregnant women that healthy food choices will prepare her for a healthy pregnancy and will help her deliver a healthy baby. Following messages should be given

- Eat one extra meal a day during pregnancy-eat frequently and in small portions and drink plenty of water/ fluids
- The diet must include: *(Refer to Annexure 3)*
  - **Seasonal fruits and vegetables;** Starchy vegetables like potato, beet, carrot and other vegetables, like brinjal, tomato, beans etc. Green leafy vegetables, ragi, jaggery are rich source of iron and folic acid and prevent anaemia. Anaemia may negatively impact child's mental development. Green leafy vegetables, legumes, nuts, jaggery and liver are good sources of folic acid and should be consumed especially 3 months before conception, and during the first 3 months of pregnancy to protect the baby from birth defects (involving brain and spinal cord). The daily requirement of folic acid is 400 mcg
  - **Cereals** (e.g. rice, wheat, ragi, bajra, jowar); processed foods/ refined flour (maida) should be avoided
  - **Protein** – Fish, full boiled eggs, and cooked meat are non-vegetarian options while pulses can be consumed by vegetarians
  - **Milk and milk products** – At least 2 glasses of milk, or curd or 60 gm paneer/ day
  - **Fat** – Try to get your fat intake from vegetable sources like mustard oil, rice bran oil etc. Use a mixture of mustard oil and rice bran oil or mustard oil and groundnut oil, to ensure adequate quantities of Omega 3 and Omega 6 fatty acids in your diet. You can also consume flax seeds (Alsi) to get enough Omega 3 fatty acids in your diet
  - **Water** – Drink at least 10–12 glasses of water every day
- Avoid taking tea, coffee or aerated drinks before or after two hours of having a meal
- Consume iodized salt as iodine helps in boosting baby's brain. The salt should be added in later stages of cooking or after cooking because during cooking 7–70% of iodine may be lost. Maximum loss is during pressure cooking and boiling and less in deep frying
- **The diet should be modified as per the underlying condition**. For e.g.: in GDM sugar intake and foods that increase blood sugar (potato, fried food, red meat) should be restricted. Pregnant woman with GDM should not skip or delay meals

- **Breastfeeding counseling:** Counseling on importance of colostrum feeding, role of early initiation of breastfeeding and exclusive breastfeeding must be done during antenatal period. Practices of giving pre-lacteal feeds must be discouraged due to its harmful effects on both mother and newborns

☛ Counselor should explain the **importance of following hygienic practices** and healthy behaviours in ensuring health of pregnant mother

- Maintain oral hygiene during the antenatal period by proper brushing of teeth
- Bathing daily to reduce the chances of getting an infection (washing breasts and genital area by washing with clean water and gentle soap)
- Washing and combing hair regularly
- Wearing clean clothes which are loose and comfortable
- Wearing low heeled shoes or slippers that support the feet well
- Not taking any medicine unless prescribed at the hospital/ health center
- Avoiding alcohol and tobacco (chewing/ smoking)
- Practising safe sex, including use a condom correctly in every sex act to prevent STIs or HIV/AIDS, if she or her partner is at risk of infection

Key messages for pregnant women

- Avoid maternal stress
- Avoid working near furnace or fire in the first trimester
- Avoid carrying cellphone on your body or placing it on or near your abdomen. Use cellphone in speaker setting
- Use the concept of flavor bridge–eat green vegetables and a variety of foods so that baby develops the flavor and attachment to that food
- Interact with foetus in the 3rd trimester by talking to him/her
- To avoid infection, wash hands, soak vegetables, fruits etc in warm saline water to remove pesticides, eat freshly cooked
- Maintain oral hygiene by proper brushing of the teeth
- Choose a birth companion to accompany you during childbirth

5.1.5 Family Planning Counseling

Pregnancy is an opportune time to counsel mother about early adoption of contraceptive after delivery.

☛ Counselor should not miss the opportunity of **contraceptive counseling** during pregnancy and following key aspects should be kept into consideration while counseling *(Refer Chapter: Counseling Couples on Contraceptive Choices in Interval and Post Pregnancy Period)*

- Explain the importance of healthy timing and spacing of pregnancies
  Explain that return of fertility may be earlier than resumption of menses (within 4 weeks) and pregnancy can occur even while breastfeeding
- Discuss the advantage of adopting a contraceptive right after delivery:
  - Most of the changes due to contraceptives are masked with bleeding and pain occurring after delivery and does not cause anxiety

- Follow up for contraceptive may be clubbed with visits for postnatal checkup and child immunization schedule. Give information on all methods that can be used by postpartum women, with focus on those contraceptive options which can be started soon after delivery – PPIUCD, Centchroman, condoms, sterilization
- Also give information about emergency contraceptive pill but encourage to adopt a regular family planning method
- Provide specific counseling on the method client is interested to adopt and note it down on her MCP card

5.2 Care during Labor and Childbirth

Government of India is laying emphasis on promoting institutional deliveries through various programme initiatives like JSY, JSSK. (*Refer to Annexure 16*). It also encourages hospital stay after normal and caesarean deliveries and promotes the presence of **birth companion** with the pregnant woman during and immediately after delivery. Evidence suggest that good emotional support during labour tends to shorten the labour duration and lessen the need for medical intervention.

Counselor should explain the benefits of birth companion to the pregnant woman and help her in identifying the birth companion in the ANC period. Once the birth companion is identified, counselor should counsel birth companion about her/ his roles and responsibilities during and immediately after the delivery.

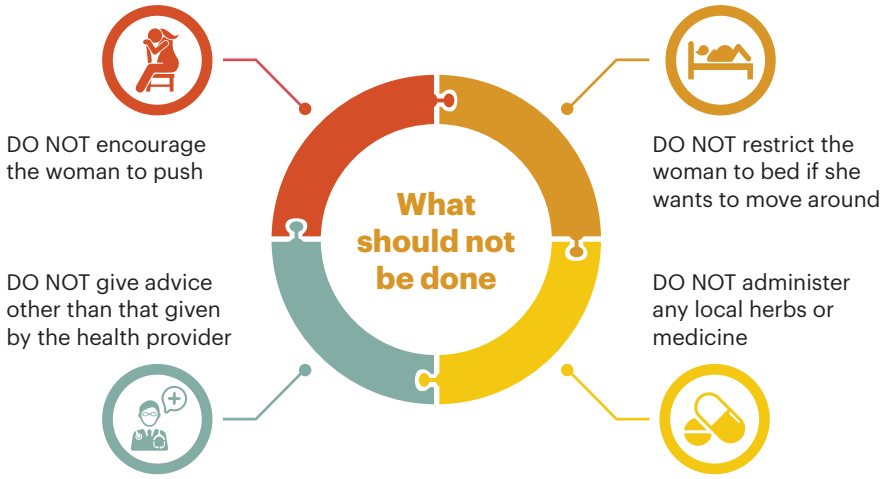
5.2.1 Birth Companion

A Birth companion should be a person who is willing to accompany the pregnant woman to the health facility and to stay with her throughout labour/ childbirth. She should be able to provide emotional support to the pregnant woman, without interfering in the service provider's work. She can be her mother, mother-in-law, or a friend/ relative. Preferably, the birth companion should be the one who has had a delivery herself and can help in taking essential care of mother and her newborn, including the identification of danger signs. She should not be suffering from any communicable diseases. In facilities where privacy protocols are followed in the labour room, the husband of the pregnant woman can be allowed as a birth companion. The provision of birth companion during birth creates a stress-free environment and promotes cognitive development of the baby.

Role of birth companion:

The counselor should explain the role of the birth companion.

It is also important to tell the birth companion what they **SHOULD NOT DO**:



Role of birth companion

Emotional support

Makes the woman feel strong, safe, secure and confident. (Birth companion should praise and reassure woman about the condition to help her feel in control)

Prevent and safeguard the woman against potential mistreatment by the staff

Raise an alarm

Identifies danger signs and call for help for timely treatment

- **Bleeding**
- **Swollen face and hands**
- **Water breaks** but labor does not start within 18 hrs or more
- **Fever, fits**
- **Colour of water** – green or brown
- **Prolonged labour** – woman bearing down for >12 hrs. (8 hrs for multipara) with baby not coming out
- **Retained placenta**

Assist service provider

Helps the pregnant woman to breathe and relax by

- Rubbing her back
- Providing sips of water as allowed
- Wiping her forehead with a wet cloth
- Doing other supportive actions as directed/ allowed by the provider

Support in essential practices

Early initiation of breast feeding by the woman

Promoting the skin to skin practices to keep the baby warm

Positions to make labour shorter and easier: Physical movements like walking during labour will help an expecting mother to cope with strong and painful contractions and at the same time gently moving the baby through the birth canal. Research supports that walking, moving around, and changing positions may shorten labour, and are effective forms of pain relief and assures the newborns safety. The woman should select the position in which she is comfortable which could be sitting, squatting, reclining or lying on the side.

5.3 Care during Postnatal Period

Woman and newborn require utmost care and support in the postpartum period (up to 6 weeks after delivery) as most of the complications and deaths occur in this period. Counseling for care of mother and newborn during this period focusses on:

ASHAs conduct home visits in postpartum period on 3rd, 7th, 14th, 21st, 28th and 42nd day under HBNC (Refer to Annexure 16)

☛ Counselor may conduct individual or group counseling in postnatal ward and emphasize on the specific points to be considered for care of the mother and newborn and benefits of postnatal visits

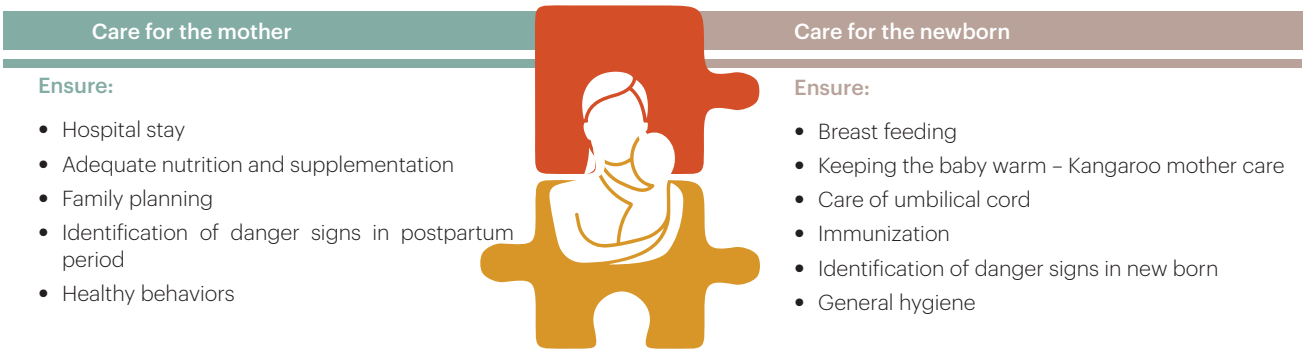


Figure 18: Care during postnatal period

5.3.1 Counseling for Care of Mother after Childbirth

- **Hospital stay:**
  - Explain the importance of hospital stay after delivery to the woman and family members
  - Advice hospital stay for at least 72 hours in case of normal delivery at the facility and 7 days in case of C-section
- **Adequate nutrition and supplementation:**
  - Counsel the women to eat adequate amounts of healthy and nutritious foods *(Refer to Annexure 3)*
  - Educate her to drink plenty of clean and safe water
  - Reiterate on the importance of taking IFA and calcium supplementation even after delivery:
    - One tablet of IFA tablet to be continued for 180 days after delivery – not to be taken along with tea, coffee, milk
    - If anaemic (Hb 9–11 g/dl), she needs to take 2 tablets of IFA every day for 180 days. *(Refer to Annexure 4)*
    - One tablet of calcium to be taken twice a day (total 1 gm calcium daily) for 6 months after delivery (total 360 tablets)– to be taken in between meals and not immediately after a meal
    - Maintain a gap of at least 2 hours between IFA and calcium tablets for better absorption of both
- **C. Post natal family planning:**
  - Re-emphasize that she can become pregnant as early as:
    - 6 months postpartum, if exclusively breastfeeding
    - 6 weeks postpartum, if not exclusively breastfeeding
    - 4 weeks postpartum, if she is not breastfeeding
  - Re-emphasize the importance of HTSP (Refer Chapter: Counseling Couples on Contraceptive Choices in Interval and Post Pregnancy Period)
  - Explain family planning methods that can be adopted after delivery (Refer Chapter: Counseling Couples on Contraceptive Choices in Interval and Post Pregnancy Period)
  - Help her to decide the method which best meets her and her partner's needs
  - In case the woman does not want to adopt a method immediately after childbirth/ before discharge from the hospital, tell her that she can opt for injectable contraceptive MPA (Antara Programme) or IUCD after six weeks

- Encourage exclusive breastfeeding for newborn's health. Also, explain that it will act as a natural contraceptive and will delay the return of fertility

✿ **Danger signs in mother during postpartum period:**

Counsel the woman and family members to call for help (during stay in hospital) or come back to the facility (after being discharged) in case of any of the following signs and symptoms:

- Excessive vaginal bleeding
- Fits/convulsions
- Fast or difficult breathing
- Fever with pain surrounding the c-section surgical site; reopening of the surgical wound; pus discharge in or coming from the wound
- Severe headache with blurred vision

Ask woman and family to come back to hospital or health center immediately, day or night, DO NOT wait)

- Swollen, red or tender breasts or nipples
- Problem in passing urine
- High fever
- Severe abdominal or perineal pain
- Foul smelling vaginal discharge

Ask woman and family to come back to the hospital/ health center as soon as possible

✿ **General care during postnatal period:**

Advise women to:

- Use clean sanitary pads and change them every 4 to 6 hours
- Maintain hygiene, especially of the perineal area and not insert anything into the vagina
- Take adequate rest and avoiding hard-physical work
- Avoid sexual intercourse until the wound in the perineum heals. It is best to avoid it during first six weeks after delivery or until bleeding/ lochia stops
- Avoid any medications (unless prescribed at the hospital/ health centre), alcohol, smoking and tobacco intake
- Sleep under bed net in malaria endemic areas

5.3.2 Counseling for Care of the Newborn

✿ **Breastfeeding:**

Important counseling messages:

- **Encourage early initiation of breastfeeding –** Breastfeeding should be started within 1 hour of delivery. Baby should be put to the mother's breast even before placenta is delivered. It is useful for both the baby as well as the mother
- Encourage breast crawl and initiate breastfeeding. Every newborn, when placed on mother's abdomen soon after birth, can find its mother's breast on its own and take breastfeed. This is called "Breast Crawl", which is helpful for the baby (as early initiation of breastfeeding is successfully established for baby's nutrition) and for the mother (as it helps in uterine contraction for faster expulsion of placenta, reduce maternal blood loss and prevents anaemia)
- Explain that the first milk, also called the **'colostrum'** must not be discarded but fed to the baby as it contains high concentration of protective immunoglobulins which prevent baby from contacting infections

- Educate to wash hands with soap and water every time before breastfeeding the child
- Advise NOT to give pre-lacteal fluids such as sugar water/ honey/ ghutti etc. to the newborn as these are harmful for the baby (may lead to infection, interfere with the success of breastfeeding and the baby will not get the advantages of colostrum feeding)
- Advise the mother to seek support if she faces any problem in breastfeeding from health-care providers (ASHA/ ANM/ CHO/ MO)
- Do specific counseling and management of a HIV positive mother. Provide information on where to seek further advice and support for breastfeeding
- Counsel separately for – Infant feeding for working mothers, mothers who cannot produce adequate quantity of milk, mothers on medication or with specific illnesses

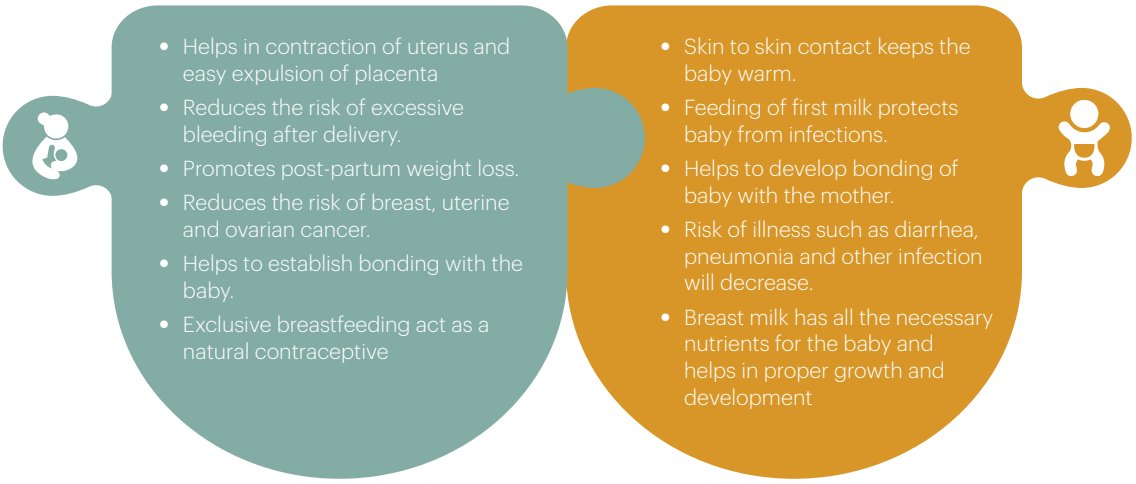


Figure 19: Benefits of breastfeeding

- Support mother in starting and maintaining breastfeeding – Baby should be held in correct position and needs to be put correctly to the breast to get it maximum benefit of breastfeeding.

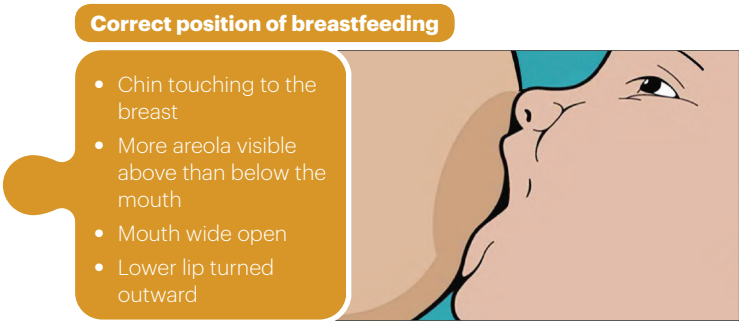


Figure 20: Positioning for breastfeeding

- Explain the correct position for holding the baby:
  - While holding the baby, the mother should also support the baby's bottom, and not just the head or shoulders
  - Mother should hold her baby close to her body
  - The baby's face should be towards the breast, with nose opposite the nipple

- **Explain the benefits of exclusive breastfeeding** (up to 6 months after birth) – Feed only breast milk to the baby and no other food or drink, not even water till 6 months (with the exception of oral rehydration solution, drops or syrups consisting of vitamins, minerals, other supplements or medicines, when advised by the health-care provider). Breast milk provides all the water a baby needs, even during the summer months
- Encourage her to breastfeed as often as the baby wants and for as long as the baby wants
- Educate her to breastfeed the baby during day and night (at least 8–10 times in 24 hours). Feeding more often helps in production of more milk. The more the baby sucks, more milk is produced. In case of LBW babies (<2.5 kgs), breastfeeding should be more frequent. In case LBW newborn is not able to suck, expressed mother's milk should be frequently provided using a katori (bowl) and spoon. Mother should be taught the technique of expressing breast milk and its usage *(Refer to Annexure 13)*

Figure 21: Breastfeeding positions

- Tell her to keep the baby against shoulder for burping every time after breastfeeding
- Discourage the use of feeding bottles
- Advise to consult a health-care provider/ lactation management counselor/ IYCF trained person, for breastfeeding problems- if the baby is not feeding well or if the mother has complained of 'not enough breast milk', sore nipples or painful breasts. Encourage the family members to support lactating woman in management of common breastfeeding problems

Keeping the newborn baby warm:

It is crucial to keep the newborn baby warm, in order to maintain the body temperature, which tends to become low (hypothermia) very soon and can endanger the baby's life.

Counselor must give the following important counseling messages to mother/ family:

- Ensure skin to skin contact of the baby with an adult person, preferably the mother, as it helps in keeping the baby warm
- Breastfeed the baby
- Keep the room warm
- Delay bathing the baby for two days and in case of LBW babies, for up to 7 days. Meanwhile, the baby can be kept clean by wiping with a warm wet cloth and should be dried immediately
- Keep the baby wrapped in several layers of clothing/ woolen clothing depending upon the season. In cold weather, head should be covered with cap and feet with socks to prevent the fall in body temperature
- If baby has low birth weight, educate the parents and family on Kangaroo Mother Care

Kangaroo Mother Care (KMC)

KMC is the simplest method for care of the low birth weight babies (<2.5kgs) that includes prolonged skin to skin contact with the mother or substitute caregiver and exclusive and frequent breastfeeding. It can be done with clothing that is acceptable, convenient and suitable to the mother and family like front open light dress, sari-blouse or gown etc.

Benefits of KMC:

- Reduces the risk of hypothermia
- Promotes lactation and weight gain
- Reduces infection and hospital stay
- Promotes better bonding between mother and newborn

Positioning for KMC:

POSITION OF MOTHER DURING KMC

- Mother should adopt a semi-reclining position while sleeping with the help of 3–4 pillows or can use semi reclining chair
- Mother can also walk, stand, sit or engage in different activities provided with good support to the baby

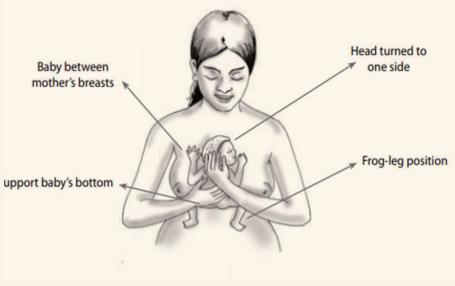


Figure 22: Positioning for KMC

POSITION OF BABY DURING KMC

- Infant should be placed between mother's breast in an upright position
- Head should be turned to one side and in a slightly extended position
- Infant's abdomen should be at the level of mother's epigastrium
- Support the baby from the bottom with a sling/ binder

Figure 23: Various support methods for KMC

- **Care of umbilical cord:**
  - Advise not to apply anything on the stump and keep it dry and clean.
  - Educate that the cord falls off by itself in 5–7 days.
- **Immunization:**
  - Help the woman in getting the birth dose of vaccines (BCG, 0 dose of Polio (OPV), 0 dose of hepatitis B) before leaving the health facility.
  - Explain about the vaccination schedule (6 weeks, 10 weeks, 14 weeks, 9–12 months, 18 months and five year), importance and place of vaccination.
- **Danger signs in a newborn:**

  Counsel the woman and family members to call for help (during stay in hospital) or report back immediately after being discharged (during stay at home) in case the newborn has any of following signs and symptoms:
  - Does not suck or sucks poorly at the breast
  - Vomits the feed

- Unable to cry or has difficulty in breathing
- Fast breathing (60 breaths per minute or more)
- Severe chest in-drawing
- Feels hot to touch (axillary temperature of 37.5 degrees celsius or above), or cold to touch (axillary temperature of less than 35.5 degree celsius)
- Convulsions (abnormal movements)
- Baby's body does not move at all unless stimulated
- Excessively drowsy or cries continuously
- Boils on body or umbilical redness or pus/ blood oozing out of umbilicus
- Pustules/ rashes on the body or discharge from eye
- Bloated abdomen and difficulty in passing stools
- Yellow staining of palms and soles
- Visible birth defect/s

✿ **General hygiene:**

- Advise to limit the number of visitors and people who handle the baby
- Educate that the people who are sick with cold, cough, fever, skin infection, diarrhoea etc. should not hold the baby or come in close contact with the baby. Educate the family members to wash hands with soap and water every time after changing the nappies/ diapers

Key messages for day of birth to be communicated to the mother

- ✿ A birth companion should accompany for delivery
- ✿ Delivery must be in a place where privacy is assured
- ✿ Do not ask for quick or painless delivery as this would lead to induction and augmentation of labour
- ✿ The newborn will be kept with mother all the time, without any separation (zero separation)
- ✿ Baby will be kept immediately on mother's breast to ensure skin to skin contact
- ✿ The first hour of delivery will be spent in holding (skin to skin), stroking and looking at the baby by mother as she is alert and responsive during this time and will soon go off to sleep. Delayed cord clamping (not earlier than 1 minute after birth) is recommended for improved maternal and infant health and nutrition outcomes
- ✿ Initial thick yellow coloured milk, called colostrum, should be given to the baby within the first hour. Educate that newborn requires only about 1 tsp of milk per feed initially to satisfy his/ her hunger, since stomach is only about the size of a grape. Baby will wet only one diaper the first day and pass 1–2 black or dark green stools. Try to give 8–12 feeds in the first 24 hours
- ✿ In the first week, the child's stomach size increases to that of a walnut. The quantity of milk produced will increase proportionately to 4–5 tsp (20 ml) full per feed. By 10th day the quantity becomes 9 tsp (45 ml) full. By the 10th Day the child starts wetting 6 diapers a day
- ✿ Newborn will sleep about 16 hours a day divided into 3–4 hours naps, evenly spaced between feedings
- ✿ Educate that any rashes or birthmarks on baby's skin will fade away quickly without treatment

5.4 Comprehensive Abortion Care

Abortion refers to the termination/ ending of pregnancy, either spontaneously or after inducing. Induced abortions are legal in India under certain conditions as per the MTP act, 1971. Abortions were legalized to increase the access of women to safe abortion services and to protect the service providers from any litigation associated with abortions. Despite this, lack of awareness in the community and stigma associated with abortions expose the women to unsafe abortions (availing services of the unqualified providers/ quacks for abortion at places not fit for providing services).

Role of the counselor, thus, becomes very critical in providing the correct information about safe abortion services, clarifying doubts and misinformation and allaying anxieties. The woman should be told about the legality and different methods available for abortion. Regardless of the age/ marital status/ social and economic condition, every woman should be provided with non-judgmental and unbiased counseling, in the language that she understands, on all the aspects of abortion care, so that she can take an informed decision.

Women may require elective/ induced abortion for different reasons:

- Pregnancy due to contraceptive failure
- Cannot continue pregnancy due to medical reasons etc.
- Due to economic or social reasons
- Pregnancy due to rape, incest, sexual violence
- The unborn child has abnormalities

In all situations, counsel the woman that abortion can be done either with medicine (medical method of abortion) or by a surgical procedure (surgical method of abortion). Provide adequate information about the procedures, support in accessing services and address existing myths and misconceptions around abortions *(Refer Chapter: Busting Myths and Misconception with Facts)*. Counselor should support the woman's decision of terminating the pregnancy, provide general information about safe abortion services, as well as post abortion care and contraception.

In case of a spontaneous abortion, appropriate counseling should be done with empathy as it may cause emotional upheaval in the woman.

Important note: Counselor should inform the women and family members that abortion is legally not allowed on grounds of sex determination because prenatal sex determination is a criminal offence and any individual found guilty of disclosing or seeking information about the sex of the foetus may be punished by court under the PC & PNDT act.

Women opting for induced abortion need pre and post-procedure counseling. The women who have had a spontaneous abortion also need counseling on post abortion care and HTSP.

Note:

- Abortion is legal if it is being done by a registered medical practitioner at an approved place
- Only the consent of the woman is required for abortion. In case of a minor girl, consent of the guardian is required
- Name and other particulars of pregnant woman should not be disclosed to anybody except to the person authorized by law
- As per the MTP (Amendment) act 2021
  - Both married and unmarried women can opt for abortion upto 20 weeks with the opinion of 1 registered medical practitioner in case of contraceptive failure
  - Upper gestational limit of abortion has been enhanced for special category of women upto 24 weeks with the opinion of 2 registered medical practitioner
  - If the unborn child has major abnormalities, pregnancy can be terminated anytime during the entire course of pregnancy with approval from the Permanent Medical Board. Abortion can be done by either medical method (by taking tablets) or surgical method (Manual Vacuum Aspiration/ Electric Vacuum Aspiration). A registered medical practitioner assesses eligibility of a woman for abortion and helps her in selecting the method of abortion

- **Pre-procedure counseling:**
  - Explain the consent form for abortion to the woman and get it signed by her
  - Tell her about the various methods of abortion and once she chooses a method, explain its details – as given below

Medical Method of Abortion (MMA):

- Reiterate the schedule for MMA drugs – Woman is required to take the medicine on the 1st and 3rd day as per the advice of registered medical practitioner
- Emphasize the importance of MMA card and ask her to record her symptoms in the MMA card
- Explain about the **number of facility visits** required for medical abortion: Woman is required to visit the registered hospital for abortion on 1st day for assessment and intake of 1st tablet; on 3rd day (2nd tablet administration) and on the 15th day (for follow up visit). 3rd day tablet may be given to the woman for home administration at the discretion of the service provider, if she has access to 24 hours emergency services
- Tell her about the signs and symptoms that are common with MMA:
  - Bleeding is part of MMA and it is usually heavier than what happens during regular menstruation. This, however, decreases over time. In case of excessive bleeding (i.e. soaking 2 or more thick pads per hour for two consecutive hours), the woman should contact the health care facility/ provider
  - Abdominal pain like menstrual cramps may happen, especially one to three hours after taking 2nd tablet. This usually lasts up to four to six hours. In case of continuous pain, which is not relieved with the pain killer, the woman should contact the health-care facility
  - Other symptoms – nausea, vomiting, and diarrhoea

- Explain about the possibility of surgical evacuation in case of:
  - Failure of complete expulsion of pregnancy tissue
  - Excessive bleeding
  - Continuation of pregnancy as foetus may have congenital malformation
- **Provide information about the service availability** (information of health facility where she can reach quickly in case of an emergency)

Surgical method of abortion

- Explain her that the procedure is safe and takes 10 to 15 minutes
- Inform her that the products of conception will be evacuated by vacuum suctioning. For pain management, local anesthesia and/ or pain killer may be given by the registered medical practitioner
- Tell her that she can leave the facility when she feels fit, as per the advice of the doctor

- **Counsel on contraceptive choices available after abortion** and encourage the woman to adopt contraceptive method after abortion – (Refer Chapter: Counseling Couples on Contraceptive Choices in Interval and Post Pregnancy Period)

- Post-procedure counseling:

Counselor should emphasize on following points in post-abortion period:

- Advise to take adequate rest for a few days, especially if she feels tired
- Tell her to change pads every 4 to 6 hours. Wash cloth or dispose off pads safely
- Ask her to ensure perineal hygiene – Wash perineum. Tell her not to rinse the vagina (vaginal douching) or place anything inside the vagina
- Advise her to avoid intercourse till bleeding stops or condoms should be used. After uncomplicated abortion, woman may have intercourse as soon as she desires, or she feels comfortable
- Explain her that the next period would return within 4–6 weeks after abortion. She should come for a check-up if she does not get her periods in next six weeks
- Tell her to consume iron rich food and take iron supplementation
- Explain that after an abortion she needs to wait for at least 6 months before trying to conceive again (even if abortion was spontaneous)
- Encourage her to use a contraceptive method, if she has not accepted any method during pre-procedural counseling. Explain her that her fertility may return as early as 7–10 days after first trimester abortion and within 4 weeks of the second trimester abortion and there is possibility of conception almost immediately, if no contraceptive is used (Refer to Chapter: Counseling married couples on contraceptive choices in interval and post pregnancy period)
- Explain her to come for a **follow up visit**:
  - After MMA, the client should visit the health facility on 15th day for follow up.
  - Explain her to return to the health facility as advised or in case of any problems/ concerns/ danger signs.
  - **Danger signs following an abortion**: If the woman has any of these signs, she needs to visit the health facility immediately:
    - Increased bleeding

- Continued bleeding for more than 2 weeks
- Fever, feeling ill
- Dizziness or fainting
- Abdominal pain, not relieved with pain killer
- Nausea or vomiting or if other pregnancy symptoms continue
- Foul-smelling vaginal discharge

It is also important to inform her partner/ family about key aspects of abortion (as indicated above) and referral sites (with availability of referral slips) while ensuring proper recording/ documentation for the same.

Supporting women facing violence

- Find out if the woman is getting adequate and necessary support in terms of diet, rest or other support from the family
- Ensure confidentiality and discuss such instances individually
- Avoid asking direct questions to the woman and guide her to deal with the situation as well as extend psycho-social support

06

Counseling for Child Health

Childhood is the period between birth and adolescence, out of which the first year is infancy and the child is referred to as an infant. The first 4 weeks of infancy is the neonatal period and the child is referred to as a neonate or a newborn. Healthy infancy and childhood make the foundation for healthy and productive adult life. Children can lead a disease-free and healthy life when they get proper nutrition, receive timely immunization, and early care and treatment for common childhood illnesses. The most common causes of infant and childhood illness (e.g.: acute respiratory infections (pneumonia), diarrhoea, malaria, measles, and undernutrition), which often lead to death, are preventable.

It is crucial to keep children safe from diseases so that they remain healthy, with normal physical and mental growth and development. The poor health of the child during initial years often leads to delay/ retardation of the growth of brain and body mass (Annexure 2) and delay the milestones of the child.

Therefore, preventive and promotive measures should be started from infancy and childhood. The parents, particularly the mother, as well as other members of the family should be made aware about the importance of taking promotive and preventive measures as early as possible.

Counselors have important role in

- Generating awareness & providing key messages to parents/ care givers:

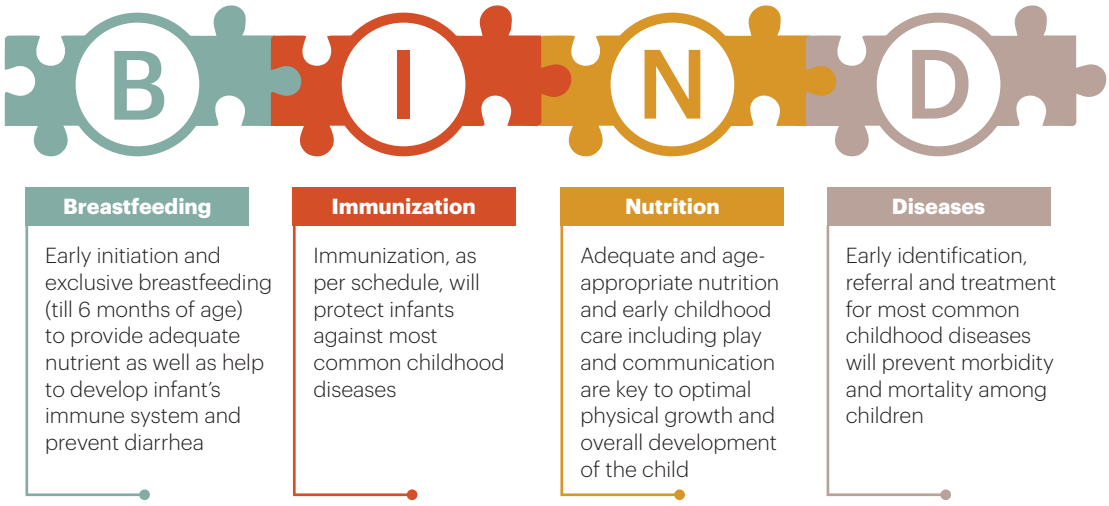


Figure 24: Key counseling aspects in childcare

- Providing information about various services and supporting in availing these services (immunization, management of common health problems, supplementary nutrition, etc.)

6.1 Breastfeeding

As discussed in the previous chapter, (Refer Section 5.3.2), breastfeeding is vital for health, growth and development of babies and has benefits for the mother too. The infant should be exclusively breastfed for the first 6 months after birth. The counselor should promote optimal feeding practices for infant and young child by counseling the mother and other family members about the benefits of breastfeeding and explaining how giving top feeds (formula milk, animal milk etc.) may harm the baby in following ways:

- Baby takes less amount of breast milk
- May cause diarrhoea due to risk of contamination during preparation of feed through feeding bottles/ utensils/ water. It may also cause malnourishment, if feed is too dilute
- Baby does not get enough iron from cow's, goat's and buffalo's milk and may thus develop anaemia.
- Baby may have difficulty digesting animal milk and formula milk
- If the breastfeeding is to be temporarily discontinued due to an inadvertent situation, re-lactation should be tried as soon as possible and detailed counseling to be provided in such cases

6.2 Immunization

Immunization is the process of giving a vaccine to a person to protect them against disease(s). Under Universal Immunization Programme (UIP) of Government of India, vaccines are given to the children against some life threatening and debilitating diseases. The programme aims that no child is left out and parents of every child are supported for getting their children immunized as per the schedule. (Refer Annexure 14). Every child needs to be fully immunized.

The counselor should provide **counseling on child immunization** to the following people coming to the facility:

- Pregnant women and their family member/s
- Women delivering at the health facilities
- Women coming for postpartum visits
- Women availing any services and having children younger than 5 years old
- Parent/s bringing a child for any health service i.e. a sick child

Counselor should explain and emphasize that immunization will boost child's immunity/ body's fighting power against the following life-threatening infections:

- BCG prevents tuberculosis
- OPV/IPV prevents polio
- Pentavalent vaccine prevents diphtheria, tetanus, whooping cough, hepatitis B and haemophilus influenza type B disease
- DPT prevents diphtheria, whooping cough and tetanus
- Rotavirus prevents diarrhoea
- MR prevents measles and rubella (viral infection)
- JE prevents Japanese encephalitis (infection of brain) – only in endemic areas
- Vitamin A given as a supplementation for preventing vitamin A deficiency (vit. A deficiency can cause night blindness or even vision loss in severe form of vit. A deficiency)
- PCV prevents pneumonia

- Inform about the dose and schedule under the National Immunization Programme; (Refer to Annexure 1)
  - **At birth:** BCG (within one year), Hepatitis B (within 24 hours), OPV-0 (within 15 days)
  - **6 weeks:** OPV, Pentavalent, Rotavirus, PCV, Fractional IPV
  - **10 weeks:** OPV, Pentavalent, Rotavirus
  - **14 weeks:** OPV, Pentavalent, Rotavirus, PCV, Fractional IPV
  - **9–12 months:** MR-1st dose (measles can be given till 5 years of age), vitamin A 1st dose, PCV booster, JE-1st dose (only for endemic districts)

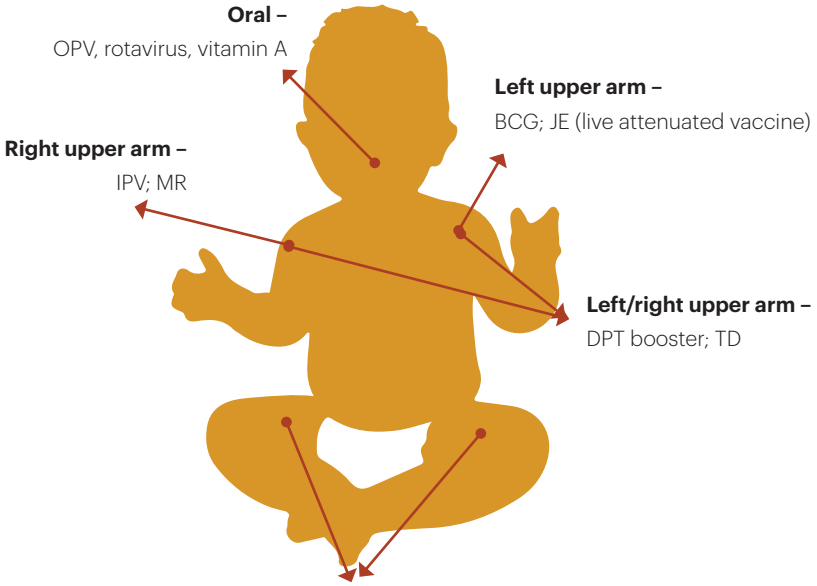


Figure 25: Sites for vaccine administration

  - **16–24 months:** DPT 1st booster-, MR-2nd dose, OPV booster, JE-2nd dose, vitamin A-2nd to 9th dose (At 16 months, then one dose every 6 months up to the age of 5 years)
  - **5–6 years:** DPT 2nd booster
  - **10–16 years:** Td
- Emphasize that the child should be **fully immunized as per the schedule**. Also, after each vaccination, mother/ parents should ask for the due date of next vaccination
- Inform about health facilities or sites in the community, including fixed day services, where immunization can be given
- Explain that even if the child is having minor ailments, such as mild fever, cough, cold etc., s/he can be given the due vaccines
- Counsel about the **expected effects** after taking a vaccine. The child may have slight fever or become a little restless. This is normal and the parents should not be worried about it
- Address the concerns and myths related to vaccines (Refer Chapter: Bursting Myths and Misconceptions)
- Advise to bring the MCP card every time the child is brought for immunization
- Identify the children who missed the immunization dose: It is necessary to vaccinate them at the earliest and complete the primary immunization before the child reaches his/her first birthday

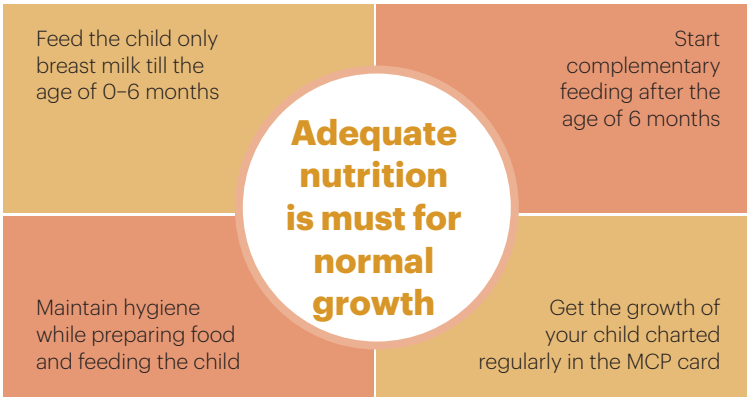
- **Child <5 years who has not been immunized at all**: encourage the parent to get the child immunized with appropriate vaccines at the facility on the same visit
- If the child has received first doses of appropriate vaccines but missed subsequent doses, encourage the parents to get their child fully immunized by taking the remaining vaccines too. The next does can be given on the day of the visit itself
- **Child brought late for a dose**:
  - Explain the parents that there is no need to re-start the schedule all over again even if the child is brought late for a dose
  - Refer the child to a Staff nurse/ ANM/ CHO (with nursing background). Vaccination is provided from where the schedule was left off
  - If the reason for missing immunization is that the family cannot bring the child to the facility, encourage them to get in touch with the concerned CHO/ ANM/ ASHA for getting the child immunized

6.3 Nutrition

Proper nutrition is required for a child to grow, develop and remain active. Adequate nutrition means that the child receives nutrients such as carbohydrates, fats and proteins that are required in large amounts (macro-nutrients) and other nutrients such as vitamins and minerals (including iron, calcium, iodine etc.), that are required in minimum amounts (micro-nutrients). Undernutrition is a condition caused by less intake of nutrition and is an underlying cause for more than 50% of child deaths due to common childhood illnesses. Children have different nutritional requirements in different ages. Undernutrition in the first two years of life has permanent effects on a child's growth and limits the growth potential. Hence, age appropriate feeding is crucial.

In order to provide adequate nutrition, **Infant and Young Child Feeding (IYCF)** practices must be followed. These improve child health and survival, prevent undernutrition and reduce child mortality.

The IYCF practices include (1) initiation of breastfeeding within one hour of birth and colostrum feeding, (2) exclusive breastfeeding for the first six months of life and (3) appropriate complementary feeding starting on completion of 6 months of age and (4) continued breastfeeding for two years or beyond.



6.3.1 Complementary Feeding

Once the infant is six months old, breastmilk alone is not enough to fully meet his/her nutritional requirement for rapid growth and development.

Complementary feeding means giving semi-solid, soft foods, along with milk, to the child after 6 months of age. Failure to introduce complementary foods or giving them insufficient quantity between 6–24 months of age usually lead to growth faltering, micronutrient deficiency, undernutrition and susceptibility to infections. Breastfeeding, however, should be continued for 2 years or beyond as it is an important source of energy and contains high quality nutrients. These nutrients may not be easily available from the family diet.

6.3.1.1 Advantages of appropriate and timely complementary feeding

- Prevents growth faltering
- Decreases risk of nutritional deficiencies
- Lessens risk of illnesses
- Helps in proper development of the child

6.3.1.2 Essentials of complementary feeding

- **Ideal time to start complementary feeding**: Introduced at completion of six months when requirement for energy and nutrients exceeds that provided by breastmilk alone
- **Frequency**: (As per HBYC guidelines) *(Refer to Annexure 16)*

  The number of feeds will increase gradually with increase in age of the child.
  - **6–8 months breastfed infant:** 2–3 meals/day
  - **9–23 months breastfed child:** 3–4 meals/day
  - **6–23 months non-breastfed child:** 4–5 meals/day
- **Quantity:** The feeding starts with 2–3 table spoonful and gradually increased to half (½) to 1 cup (250 ml cup)
- **Consistency**: Depends on age of the child and readiness to chew and swallow
- Initially soft and mashed foods (that can be chewed, munched, swallowed) are included and gradually the foods with appropriate thick consistency are added
- **Density**: Oil/ ghee or sugar/ jaggery should be added in food, to increase the dietary energy levels and address the issue of small stomach size
- **Variety**: Child should be fed variety of foods at each meal preferably from the 4 or more food groups which are (1) grains, roots and tubers; (2) legumes and nuts; (3) dairy products; (4) flesh foods (meat fish, poultry); (5) eggs; (6) vitamin A rich fruits and vegetables; (7) other fruits and vegetables

Counselor should counsel the parents/ caregivers about adequate nutrition and various type of feeds and its impact on child development.

- Emphasize on the following messages while counseling:
  - Importance of continuation of breastfeeding for at least 2 years of age
  - Role of timely initiation of complementary feeding in child's growth and development
- Encourage the **active/ responsive feeding practices** – like
  - Being patient and actively encouraging the child to eat
  - Using a separate plate to feed the child so that the parents know how much the child has eaten and helps the child to develop an individual identity
  - Self-feeding despite spillage

- Inform about the five essentials of complementary feeding – frequency, quantity, consistency, density and variety
- Encourage for better intake of food but child should not be forced to eat more. A growing child needs frequent meals
- Explain that **at one-year, the nutritional requirement of child is half of the mother's nutrition**
- Educate that homemade, local, non-spicy family foods with a thick, soft consistency (foods that stay easily on the spoon), nourish and fill the child. Use of mixers/ grinders to make food semisolid or pasty is discouraged. Iodized salt should be used for cooking. Bottle feeding should be discouraged and use of katori and spoon to be encouraged
- Educate that dark green leafy vegetables and orange/ yellow-colored fruits and vegetables help the child to have healthy eyes, fewer infections and prevents anaemia
- Advise to remove a food item from diet that the child dislikes for some time and re-introduce it at a later stage or mix the food with another food that the baby likes
- Avoid junk food, processed foods and low nutritive drinks like tea, coffee
- Counsel about **feeding during illness:**
  - During illness the energy requirement increases, therefore the food should be given in small amounts but more frequently
  - Simple home-cooked food should be given, which is easily digestible
  - Mothers should continue breastfeeding more frequently for a few days after an episode of illness.
- Counsel about feeding after illness:
  - Give one extra feed per day for 2–4 weeks after recovery from illness
- Educate about hygienic practices to be followed while handling the child. Washing hands with soap and water is necessary before feeding, preparing food, after handling baby's stools or after using the toilet
- **Counseling for Anaemia in children 6–59 months:**
  - Inform the mother that anaemia in children can impair cognitive development, stunt growth, and increase morbidity from infectious diseases.
  - At 6 months of age, introduce one feeding per day of food rich in iron such as green leafy vegetable puree, jaggery, mashed boiled egg etc. and cut/ mashed fruits rich in vitamin C such as orange, guava, amla etc. preferably along with meals which will increase iron absorption.
  - Start prophylactic bi-weekly, 1 ml IFA syrup (using an auto-dispenser). In case the child is anaemic, therapeutic IFA supplementation is given as advised by the health-care provider. *(Refer to Annexure 4)*

Table 10: Age specific complementary feeding

Age	Type of Food	Frequency	Average Amount of Each Meal
6 months	Soft porridge, well mashed vegetable, meat, fruits	2–3 meals per day plus frequent breastfeeds	2–3 table spoonful
7–8 months	Mashed foods	3 times per day plus frequent breastfeeds (milk if BF not possible)	Increasing gradually to 2/3 of a 250 ml katori/ bowl
9–11 months	Finely chopped or mashed foods, and foods that baby can pick up	3 meals plus 1 snack between meals plus breastfeeds (milk if BF not possible)	3/4 of a 250 ml katori/ bowl

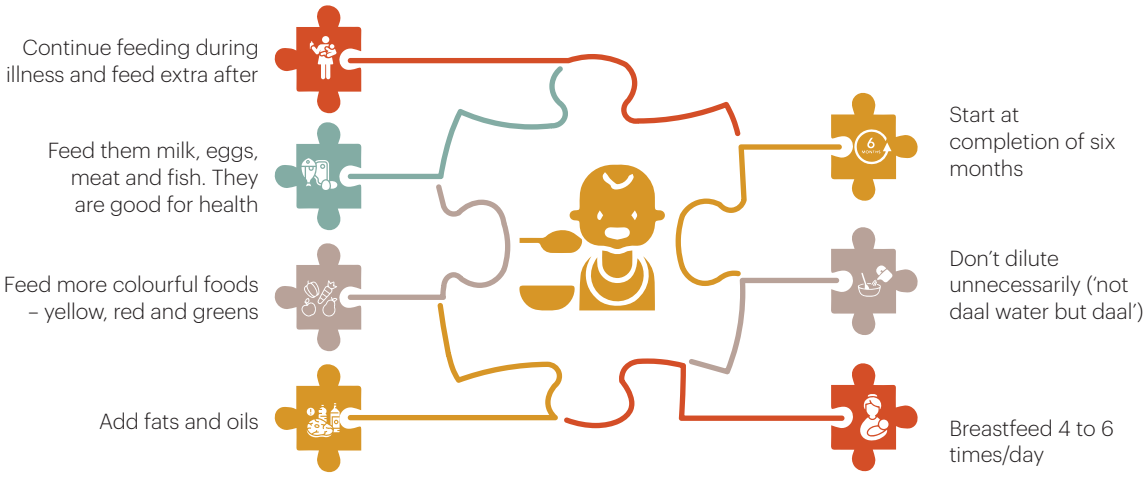


Figure 26: Seven messages of complementary feeding

Age	Type of Food	Frequency	Average Amount of Each Meal
12–24 months	Family foods, chopped or mashed if necessary	3 meals plus 2 snacks between meals plus breastfeeds (milk if BF not possible)	A full 250 ml katori/ bowl or more

6.3.2 Growth Monitoring

Regular growth monitoring is very important to assess the progress of child's growth. The counselor should counsel mothers with young children about the importance of regular growth monitoring of the child and tell them where they can get it done.

Growth monitoring is done – on a monthly basis at the Anganwadi Centres by the AWW and ANM. It is done by measuring the weight and height/ length of the child and plotting them on growth chart section of the MCP card. *(Refer to Annexure 2).*

See if the child's growth is in the normal range, below the normal range or above it. Below normal growth indicates growth faltering. It also means there is risk of malnutrition in the child, which needs to be corrected for adequate growth and development of the child.

6.3.3 Early Childhood Development (ECD)

Early childhood is the period between birth and two years of age. **Early Childhood Development (ECD)** refers to the physical, psychological, cognitive and social development that a child experiences between birth and school going age. ECD focuses on understanding the important stages during early years of a child's life and emphasizes on special role of parents in the child development.

ECD represents continuum of care that begins from planning of pregnancy to at least the first 2–3 years of a child's life. 90% of critical human brain development occurs during pregnancy and during the first 2 years of life. Hence, first 1000 days (270 days of pregnancy and 730 days of first 2 years) of child's life are very critical for development.

The parents have a very special role in social, physical, and cognitive development of the child. Involvement of family members provides support to the mother in taking adequate rest and provides her time to engage in other activities. What the parents and caregiver do, in the first 1000 days makes a difference to the rest of child's life. Measures for ECD begin in pre-pregnancy/ pregnancy phase with quality of ANC, adequate nutrition

for mother, labour-quality of intrapartum care, and continue with the child rearing practices during the first two years of life (developmental care, health care, immunization, feeding pattern and choices, and early stimulation).

The counselors should explain to the parents/ family members the importance of ECD and role of appropriate communication with the child in ensuring proper growth and development

- Show the **revised MCP card** to them and explain the section on age appropriate milestones and parenting tips with pictorial descriptions. Further, ASHA would support them in using the card during HBNC and HBYC visits *(Refer to Annexure 16)*
- Inform about the availability of mobile app "Ayushman Bhava" in Hindi on how to use MCP card. MCP card may be used as counseling tool as it covers all important aspects of maternal and child health
- Inform them about RBSK – ECD call centre facility and encourage them to avail it during pregnancy/ for children below 2 years
- Encourage to seek support from RBSK mobile health teams and DEICs in identification and management of child development delays

Key messages for the first 1000 days

During pregnancy

- **Avoid maternal stress.** Family members to keep mother happy
- **Avail regular ANC** with regular testing of Blood pressure and blood sugar
- **Eat healthier foods.** Eat green vegetables and a variety of foods so that baby will attach to flavor to food. Soak fruit and vegetables in warm salt water to remove pesticides; cook all food well
- **Avoid infection: Ensure hygiene** – Wash hands before food and after toilet, regular brushing of teeth
- **Follow healthy behaviours** – Avoid Smoking and alcohol
- **Interact with fetus:** It is important to interact (talk, sing, listen music, tell story, to pat and hold to sooth) with fetus
- Choose a **birth companion** to accompany the mother during childbirth
- Allow pregnancy to complete at least 39 weeks for complete brain maturity, If there is no medical complication
- **Get adequate rest**
- **Plan for appropriate FP method** to be used after delivery
- Avoid keeping cell phone near body, use speaker

Day of birth

- Ensure that the **birth companion** is with the husband/ mother and privacy assured in delivery
- **Discourage quick/ painless delivery** as this would lead to induction and augmentation of labor
- **Skin to skin contact:** After delivery keep the baby on mother's breast for skin to skin contact without separation
- Family to support **delayed umbilical cord clamping** for improved maternal and infant health and nutrition outcome
- **Early breast feeding:** Ensure that the baby gets the initial thick, yellow colored milk within the first hour
- Mother should know to give 8–12 feeds and baby will pass 1–2 black or dark green stools in first 24 hours. (If the baby pass stool on the table at the time of delivery baby may not pass stool in the 1st 24 hours)
- The newborn will sleep about 16 hours a day, evenly spaced between feedings
- Any rashes or birthmarks on baby's skin will fade away quickly without treatment
- Adoption of FP method for ensuring healthy timing and spacing between births

Baby's second year

- The first years last forever, so all related activities of first year need to be carried out in year two
- **During this period, a baby's brain is twice as active as an adult's brain**
- Parents are at the centre of the child's universe, thus parents to follow consistent guidelines and rules
- Child needs guidance, a balanced experience of freedom and limits, to be exposed to a diverse environment filled with languages, play, exploration, books, music, stories and appropriate toys
- **Children should get a stimulating environment,** which encourages exploring, problem solving and promotes learning
- Parents should **ensure the baby's safety and free from abuses**
- Raising child in a **loving, supporting and respectful environment** enhances self-esteem and self-confidence
- Try to create a 'village' around the family as neighbors' has a great influence on child's socialization. Since it is hard to raise a child on your own, seek support from your family, other parents, friends and community

Baby's first year

- Behave consistently with child without personal prejudice that **boost confidence in child**
- Child recognize mother by body smell, so **use mother's old clean cotton cloth to wrap**
- Use a **traditional pillow** made of mustard seeds which supports head and its proper growth
- **Ensure exclusive breastfeeding for 6 months** and continue till 2 years, start **complementary foods at 6 months** with diversity in color-taste-smell, use of finger foods by 9 months. **Don't force child to eat**
- Do **interact and communicate** with child a lot. Give child a warm, loving and secure environment
- **Engage with child** in face-to-face communication and storytelling. Child reciprocates with smile
- Give children **safe and traditional toys** or household objects to play. Toys should be supportive in social, cognitive, sensory and physical development. Avoid violence prone toy like a gun
- **Do not shake/ toss a baby in air,** as it can cause serious physical and mental damage, even death
- **Do not use video games, smartphones, television etc. for engaging child even for feeding**

- Counsel for active participation of all family members/ caregivers like father, mother-in-law, father-in-law and other family members. This is important for growth and development of the child and builds a strong, healthy relationship between family members/ caregivers and the child
- Inform about the role of ASHA, AWW, CHO, ANM/ MPW in growth and development of child and importance of listening carefully to their suggestions and accepting the care provided by them
- Inform about various MCH services available free of cost for them at different level during various stages

6.4 Childhood Diseases

Children under five years age are vulnerable to **infectious diseases** which may even lead to death, if not managed/ treated in time. Acute respiratory infections like pneumonia and diarrhoea are most common causes of death in children. Other causes include malaria and neonatal infections.

In addition, **malnutrition** resulting from low birth weight or poor feeding may increase the risk of death in infants and children. These severe illnesses, and subsequent deaths, can be easily prevented through simple care practices and seeking expert care as soon as danger signs appear. Hence, timely identification and management of these conditions is critical for survival/ well-being of the child.

6.4.1 Diarrhoea

Diarrhoea is defined as the passage of three or more loose or liquid stools per day (or more frequent passage than is normal for the individual). The normally frequent or semi-solid stools of a breastfed baby is not diarrhoea. Severe diarrhea can cause the body to lose a lot of water and minerals which it can be dangerous, if the fluid loss is not replenished.

6.4.1.1 Prevention of diarrhoea

Prevention of diarrhoea demands intensive awareness generation on various aspects of hygiene and diarrhoea management. Diarrhoea is one of the key programmatic priorities for India and the country aims at achieving zero child deaths due to diarrhoea. (Refer to Annexure 16)

Counselor should focus on giving the following key messages for prevention of diarrhoea:

- Exclusive breastfeeding for the first six months
- Proper hand washing – before cooking food and feeding the child
- Use of clean vessels for preparation and feeding the child
- Washing fruits and vegetables before cutting
- Keeping the prepared food covered
- Consumption of freshly prepared food
- Use of a safe source of drinking water and keeping drinking water covered
- Keeping the house and neighboring area clean and properly disposing waste including child's stools that houseflies can't breed on
- Use of the sanitary latrines constructed in the households
- Hand washing before and after cleaning the child and after handling stools

Figure 27: Strategies for diarrhea management

6.4.1.2 Management of diarrhoea

Three-pronged strategy for managing diarrhoea:

- **Maintaining fluid intake:** The child with diarrhoea should be given more fluids. Giving fluids orally for an effective treatment of diarrhoea is termed as oral rehydration therapy. Fluids can be oral rehydration solution (ORS) or home prepared/ home available fluids. ORS is a readymade mixture available in packets at all health facilities and with CHO, ANMs and ASHAs

Preparation of ORS:

Wash Your hands thoroughly with soap and water | Pour all the ORS powder from a packet into clean container | Pour 1 litre of clean drinking water into the ORS powder | Mix until ORS powder is fully dissolved | Taste ORS solution before giving it to the child (tastes like tears)

STEPS FOR ORS PREPARATION

- In coordination with facility based ANM/ CHO and facility head, distribute ORS to mothers
  - Explain and demonstrate how to prepare and give ORS (1 teaspoon full every 1–2 minutes). Caution: Once prepared, the ORS should not be used beyond 24 hours of preparation
  - If the child vomits, wait for 10 minutes and then continue, but slowly
- Also explain that it is important to give fluids after each loose stool and between them (for children <2 years: 50–100 ml; >=2 years: 100–200 ml)
  - Plain clear water (preferably given with food), lemon water, soups, coconut water are classified as home available fluids. These fluids should be used along with food as they are sufficient in providing all the minerals that are lost in stools
  - The home-prepared fluids can include rice water, dal or dal water with salt, butter milk (lassi) with salt and soups with salt
  - Consumption of aerated drinks, sugary drinks or plain glucose water is dangerous and should be avoided
  - Zinc should be given for 14 days to a child suffering with diarrhoea as it helps in early recovery (less watery stools, less frequency of stools) and reduction in child deaths and hospitalization. The dose of zinc to be used along with ORS:
- For infants aged 2–6 months – ½ dispersible tablet (10 mg) in expressed breast milk for 14 days
- For children 6 months to 5 years of age– one dispersible tablet of zinc (20 mg) for 14 days

- **Continue feeding:** If the child is breastfed, continue breastfeeding more frequently; if the child has started consuming complementary foods, continue feeding small quantities of these items. Once the child recovers and normal appetite reappears, the child may be given more food than normal to regain lost weight (one extra meal for next 2 weeks)

- **Timely care seeking and referral:** Explain the danger signs/ symptoms of dehydration to the mother and/ or family and counsel them to take the baby to a health facility immediately if any danger signs/ symptoms appear (as indicated in the table below)

Table 11: Classification for appropriate management for different types of dehydration in children (Source: HBYC Handbook)

Signs/Symptoms	Status	Action to be Taken by Counselor
Two of the following signs: - Lethargic or unconscious - Sunken eyes - Not able to drink or drinking poorly - Skin pinch goes back very slowly	Severe dehydration	Refer URGENTLY to the hospital with the mother/ caregiver giving frequent sips of ORS/ fluids on the way
Two of the following signs: - Restless and irritable - Sunken eyes - Drinks eagerly, thirsty - Skin pinch goes back slowly	Some dehydration	Refer to a health facility to treat 'some dehydration' with ORS (as per Plan B) - Clinically recommended ORS is given over 4 hours period and condition assessed after 4 hours – If no dehydration, home treatment given. If severe dehydration, urgently refer to higher facility with the mother/caregiver giving frequent sips of ORS/ fluids on way - Give extra fluids, give zinc supplements - Continue feeding - Inform about danger signs - Follow-up in 2 days if not improving
Not enough signs to classify as some or severe dehydration Passing urine normally	No dehydration	Give fluids (home-available fluids/ breast milk) and food to treat diarrhoea at home (Plan A). - Give extra fluids, ORS - Give zinc supplements - Continue feeding - Inform about danger signs – child become sicker, not able to drink/ breastfeed, drinking poorly develops fever, blood in stool etc.
Blood in the stool	Dysentery	Refer for further management

The counselor should discuss with all parents/ caregivers of young children about the danger associated with diarrhoeal diseases, their preventive measures and how to take care of their child, and give ORS, if the child has diarrhoea. This awareness regarding diarrhoea should be specially started well before seasonal local outbreaks.

6.4.2 Acute Respiratory Infections

Acute Respiratory Infections (ARI) is another important cause of illness and death in children. Most children up to the age of five years are susceptible to ARI and if not treated timely, they may develop pneumonia, which can result in death. The child may have few or all the symptoms: fever with coughing and/or fast breathing and/ or chest in drawing.

The counselor should counsel mothers on prevention of respiratory illnesses, when and how to provide home care and seek timely services for children:

- **Prevention of ARI**

  For prevention of ARI, the following measures need to be emphasized:

  - Ensuring full immunization of the child, as per age
  - Ensuring hygiene – hand washing with soap
  - Safe drinking water and sanitation
  - Efforts to reduce household air pollution

> Any child with fever and difficulty in breathing and/ or breathing fast should receive timely care at a health facility.

- **Management of ARI**

  For a child having ARI without any signs of pneumonia, home care can be advised as follows:

  - Keep the child warm
  - An infant below 6 months who is exclusively breastfeeding should not be given any home available fluids or home remedy. Breastfeeding to be continued during the illness as breast milk is the best remedy in this situation
  - Beyond 6 months, continue age – appropriate feeding
    - Give plenty of fluids and continue age-appropriate feeding
    - Increase feeds after the child recovers
    - Ensure that the child takes enough rest
    - Counsel about home care for cough and cold (if child is >6 months (e.g.: safe home-made soothing cough remedy like honey, tulsi, ginger etc. Avoid cough syrup)
  - Identify danger signs: The child should be taken to the nearest health facility and ASHA/ ANM/ CHO to be contacted if any of the following danger signs appear:
    - Child is not able to drink or breastfeed
    - Has fast breathing/ difficulty in breathing
    - Child is lethargic and develops fever

Protect, Prevent & Treat (PPT) approach for management of childhood pneumonia: Deaths due to pneumonia are largely preventable if PPT interventions are adequately followed. Majority of these PPT interventions are at family and community levels and requires strong linkages with equipped health facilities. The PPT approach for management of childhood pneumonia is as follows:

- Protect children from pneumonia by promoting exclusive breastfeeding and adequate complementary feeding
- Prevent pneumonia with vaccinations, hand washing with soap, safe drinking water and sanitation and reducing household air pollution
- Treat pneumonia focusing on making sure that every sick child has access to the right kind of care – either from a community-based health worker, or in a health facility if the disease is severe – and can get the antibiotics and oxygen therapy

Fever

Fever is a common symptom of many diseases, which may be simple or serious. It is the symptom of a disease and is not a disease itself. Measuring the body temperature of the child can identify the severity of fever.

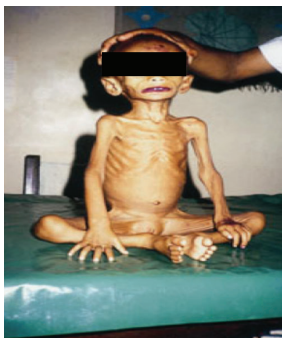
- Mild fever is a body temperature of 37°C–39°C (98.6°F–102.2°F)
- Moderate fever is 39°C–40°C (102.2°F–104°F), and
- Severe fever is fever above 40°C (>104°F)

Some mild fevers subside without any treatment/ treatment at home – e.g. fever with no cough/ running nose/ ear discharge/ with no rash/ without diarrhoea/ without any obvious infection etc. However, in many children it may be a symptom of an acute severe illness. High fever may be harmful and lead to several complications

The counselor should explain to the parent/ caregiver what needs to be done if child has fever:

- Get the temperature measured if child is running fever (can be done at a health facility)
- Do tepid water sponging in case of high fever and take the child to the health facility for proper treatment
- Give enough water and fluids to drink
- Continue feeding the child even during fever
- Give light meals like khichdi, dal-rice, curd, dalia that are easily digested
- Also educate on deworming, importance of sleeping under bed nets in malaria endemic area
- Counsel the mother that the child should be given complete treatment, for the diagnosed medical conditions

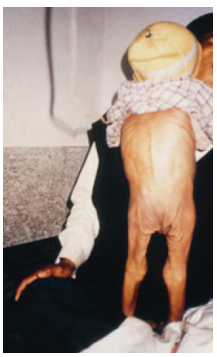
6.4.3 Severe Acute Malnutrition (SAM)



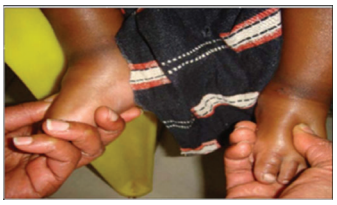
Children with very low weight-for-height/ length (below–3SD of the median WHO child growth standards), or presence of nutritional oedema are said to have Severe Acute Malnutrition (SAM). Children with SAM are nine times more likely to die than well-nourished children. It can be an indirect cause of child death by increasing the mortality in children suffering from common illnesses such as diarrhoea and pneumonia.

Counselor must know that:

- A child with visible severe wasting is very thin, has no fat, and looks like skin and bones. Some children are thin but do not have visible severe wasting
- Assessment for severe wasting:
  - Remove child's clothes and look for severe wasting of muscles of the shoulders, arms, buttocks and legs
  - Look at the child from side to side if the fat of the buttocks is missing. When wasting is extreme, there are many folds of skin on the buttocks and thigh
  - Examine child's abdomen for distension as the face of a child with visible severe wasting may still look normal



- Look for sign of oedema (swelling due to fluid retention) by pressing your thumb gently for a few seconds on the upper surface of each foot. (The child has oedema if a pit (dent) remains in the foot when you lift your thumb). In severe malnutrition child may have nutritional oedema



- Such children will require prompt hospitalization at a facility which manages such cases (NRC/ District Hospital)

Nutritional Rehabilitation Centres (NRC) are facility-based units providing medical and nutritional therapy to children with SAM under 5 years of age with medical complications. In addition, there is special focus on improving the skills of mothers on child-care and feeding practices so that the children continue to receive adequate care at home.

SECTION IV

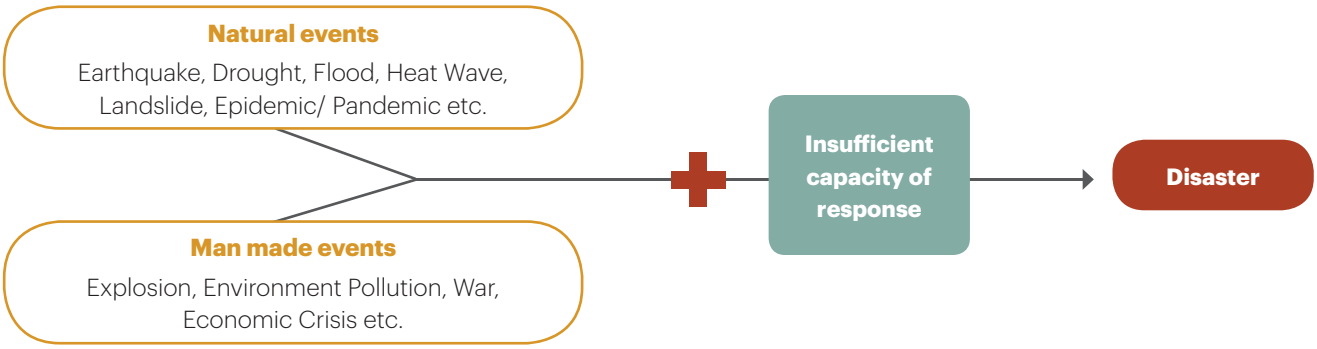
Counseling during Disaster Situations

07

Ensuring RMNCAH+N Services during Disaster Situations – Role of Counselors

7.1 Introduction

A disaster is an occurrence disrupting the normal conditions of existence and causing a level of suffering that exceeds the capacity of adjustment of the affected community (WHO). It can occur due to natural or man-made causes as outlined in figure.



A pandemic is an epidemic occurring worldwide/ over a very wide area crossing international boundaries and affecting a large number of people. Pandemic situation under vulnerable conditions (like poor public health infrastructure, economic crisis etc.) can be a disaster i.e. capacity of addressing the pandemic gets affected. Any disaster can lead to loss and displacement of human life and presents an unprecedented challenge to public health, education, food systems and the livelihood.

7.2 Impact of Disaster Situations on RMNCAH+N Services

The disaster situations can adversely impact all health services including the sexual and reproductive health. These impacts may be in relation to the availability of various RMNCAH+N services (e.g. limited availability of services) or/ and availability and accessibility of SRH commodities (e.g. contraceptives, sanitary napkins etc). For e.g.: During a pandemic, curative health care systems are required to handle the crisis, and the government health facilities (hospitals and their staff) are often repurposed to manage these problems. Thus, in view of this competing priority of handling the pandemic situation, availability of essential RMNCAH+N services like maternity services, abortion, contraception, immunization etc. may be adversely impacted. It not only affects an individual but the entire family and community at large across all age groups. The impact can result in poor health outcomes – increased risk of mortality; increased morbidities including injuries, disabilities, nutritional deficiencies; mental health impacts due to stress, violence etc.; poor access to routine health services due to disruption of the health system.

7.2.1 Impact on Adolescent Health Services

The adolescents and young people especially those who are unmarried, face specific barriers to information and care. The adolescents, who already have poor negotiation capacity, and little say in their own health, are one of the most adversely affected groups during disaster situations. Home confinement due to lock downs and any restrictions on mobility increases their vulnerability and make it even more difficult for them to access quality, respectful, and confidential care. This accentuates the risk of sexual and gender-based violence (SGBV) and early marriages, contributing to unwanted pregnancies and unsafe abortions and increased incidence of RTIs/ STIs. Also, mental health issues may emerge.

7.2.2 Impact on Reproductive Health Services

One of the first casualty in a disaster situation (including pandemics) is disruption of reproductive and sexual health of young married and unmarried couples. This not only impacts the delivery of health services by the health system but also adversely affect the accessibility of essential sexual and reproductive health services by restricting the movement of people. Reproductive age population is in continuous need of reproductive health services and commodities ranging from sanitary pads for menstrual hygiene to services for family planning, abortion, antenatal and delivery and management of RTI/ STI. The unavailability/ inaccessibility of any/ all services can have dire consequences like maternal and child mortality and morbidity. These effects may be more amplified in a resource constraint setting. E.g. unavailability of family planning commodities, increased incidents of sexual assaults and gender-based violence may lead to higher risk of unwanted pregnancies and thereby increases the need for abortion services. Unavailability of services due to competing priorities and reduced accessibility may result in unsafe abortion/ incomplete abortions contributing to the overall burden of maternal mortality and morbidity.

7.2.3 Impact on Maternity Care and Services

During disaster situations (including pandemics), already pregnant women and those who conceive during these situations are often seen to develop stress and anxiety regarding their antenatal care, obstetric care (normal and emergency) as well as care of the newborn babies. This is because these women have poor access to health services (due to possible movement restrictions/ home confinements), are at an increased risk for developing severe preventable illnesses (anaemia, hypertension etc) together with increased risk of adverse newborn and child health outcomes such as preterm birth (delivering the baby earlier than 37 weeks), sepsis due to compromised care at home.

- Understand emotional stress of the clients, including the most vulnerable ones
- Help the clients deal with stressful events (including loss of loved ones) by listening, comforting & reassuring
- Recognize the signs of psychological distress requiring specialized aid (specialist/ mental health counselor)
- Bust the myths & rumors related to disaster/pandemic by telling the facts (for this the counselor should have correct knowledge as per authentic government guidelines)
- Develop new strategies like providing online/ telephonic counseling to reach the clients across a wide geographical area, if possible., to support clients who are unable to visit the health facility. Also give information about alternate sources of services/ commodities

7.2.4 Impact on Newborn and Child Health Services

Lack of routine essential services during disasters (including pandemics) impacts newborn and child health in multiple ways. Movement restrictions hamper the facility-based treatment and community-based management of illnesses like diarrhoea, ARI, malaria, sepsis etc. as well as routine immunization services, rendering the newborn and children at a greater risk of long-standing morbidities and mortalities. Additionally, obstruction in the community and school-based nutrition programmes increase the chances of developing malnutrition (and associated threats like stunting, wasting and undernutrition). These threats are often found to be more pronounced in children with disabilities, who often need specialized care.

7.3 Role of Counselors during Disaster Situations

Disasters often burden the public health system in unprecedented proportions. Counselors, thus, have an important role to play in educating the community with accurate information regarding the crisis. The counselors should have proper information and knowledge as well as be effectively equipped to provide support to the clients in their RMNCAH+N needs. Moreover, every counseling should emphasize on preventive measures against spread of infections in the individual & family (relevant in context of the type of disaster. For e.g.: During the COVID pandemic, the counselor should be well-equipped with the essential information on the availability of all services and commodities, knowledge on reproductive and COVID-19 health practices and precautions, vaccination, availability of transport services etc. The counselor should act as a one-point contact to help and guide the community on essential health-promotive and preventive services and assist them in availing the curative services in the health facility it is being provided.

Therefore, the counselor should play the following roles:

7.3.1 Anxiety Management

- Normalize and alleviate clients' fears and talk to them about the factors that they can and cannot control. Emphasize on the factors that clients can control which include adopting a healthy behaviour. For e.g.: In pandemic situations, following activities can allay anxiety – regular exercise, taking nutritious food, making plans to meet with friends and loved ones over virtual platforms/ connecting with them over phone, determining their exposure to news sources, practising good personal hygiene, and limiting the time spent in places where there may be larger crowds etc.
- Help the client address their health needs by referring them to the concerned doctor. E.g. Client may have headache, insomnia, giddiness etc.
- If clients appear stressed and anxious about the situation, help them by providing facts and preventive measures. Support them in determining their risks in consultation with their health-care providers and take reasonable precautions
- Assist the clients in developing and enhancing adaptive coping skills, such as grounding techniques or breathing exercises, so that they can effectively manage their anxiety

7.3.2 Resource of Updated Information

Counselor should know the updated information on possible health impacts and possible common infections/ diseases during the disaster and also be aware of the latest information available on the pandemic outbreak/ disaster through the local public health authorities and on websites of state government/ Government of India, as well as stay in touch with others technical partners, for updated information. The counselor should also be aware of the prevailing common myths pertaining to health during the disaster and should help in addressing them. Besides there should be an emphasis on the need for coping with stress during the crisis, practising food safety and staying healthy.

E.g.: For COVID pandemic *(Refer to Annexure 15),* they should be well acquainted to provide information related to:

- The disease causing the pandemic – what is the disease, how it spreads/ mode of transmission, preventive measures, tests required, what are the common presentations (symptoms & signs), what is likely to be the course of the disease, what are the danger signs and where to go in emergency, availability of vaccines, advantage of vaccination and its schedule
- Various government initiatives for the public to cope up with the crisis and various support made available like financial support, insurance schemes, safeguarding livelihoods, one stop centre for assisting women/ children affected by violence etc.
- Protecting oneself and others from getting sick, considering that everyone can transmit infection.
- Explain measures for protection for COVID-19
  - **Wearing a mask whenever stepping out**: Wearing a well-fitted mask reduces the chances of transmission of infection from one person to another. It is therefore advisable for both the infected as well as the healthy person to wear a mask while stepping out of the house
  - **Hand washing/ sanitizing regularly**: Washing hands with soap and water for at least 20 seconds or using a hand sanitizer (if soap and water are not available) with at least 60% alcohol needs to be carried out regularly to kills viruses that may be on hands
  - **Maintain social distance**: Maintaining a distance of at least one metre from people, especially from those who are coughing or sneezing (coughing and sneezing leads to spread of small liquid droplets that may contain virus)
  - **Avoid touching eyes, nose and mouth**: Hands may get contaminated with virus as it touches many surfaces. Therefore, it is best to avoid touching the eyes, nose or mouth to prevent spread of virus
  - **Follow good respiratory hygiene:** Covering mouth and nose with bent elbow (even if wearing a mask) or a tissue while coughing or sneezing. The used tissue must be disposed off in a waste bin immediately. It prevents the spread of viruses such as cold, flu and COVID-19
  - **Restricted movement:** Staying home/ avoiding contact with people in case feeling unwell. If someone is experiencing any symptoms (fever, difficulty in breathing, coughing, cold, sneezing, headache, diarrhea etc.), seek medical attention and call the health-care provider in advance to be quickly referred to the right health facility. This will help in early management and prevent spread of viruses and other infections
  - **Self-isolation and quarantine:** If anyone visited areas where the pandemic is spreading within past 14 days, self-isolation is advised. Follow the guidance of your health-care provider/ ASHA/ ANM/ CHO
    - Self-isolate by staying at home if feeling unwell (not coming in contact with family members and wearing a mask), even with mild symptoms such as headache, low grade fever (37.0 degree centigrade or above) and slight runny nose, until recovered
    - If experiencing symptoms like fever, cough and difficulty in breathing, seek medical advice promptly as this may be due to a respiratory infection or other serious condition

7.3.3 Link between the Client and Health Facilities/ Service Providers

The counselors should act as a bridge between the individuals and the service providers, so that the persons in need can get the service(s) easily. The counselor should have the information regarding the availability of the service providers, services and health facilities to guide and help the clients in availing the regular services (like NCD, maternal and child health, family planning, etc.) as well as pandemic related promotive, preventive and curative services. They should also have information about the pharmacies/ alternate delivery

mechanism for essential drugs, contraceptives, sanitary napkins etc. so that guidance can be given to the persons who are in need for these medicines/ commodities.

7.4 Key Messages for Various RMNCAH+N Services in Disaster Situation

7.4.1 Reducing the Risk of Getting Infection (Specifically during Pandemic)

- Physical distance from the people who might have been exposed to or who might be infected within the household
- Other precautionary measure- provide counseling messages as per the guidelines
- If sick or were exposed to the infection, get in touch with health-care provider within 24 hours
- Identify and dispel any myths and misconceptions related to the pandemic (Refer Chapter: Busting Myths and Misconceptions with Facts)

7.4.2 Care during Pregnancy

As far as possible ensure that key health messages for pregnancy care are delivered as per the guidelines. These include:

- **ANC visits:** Visit the health-care provider as per the ANC schedule and if concerned about the risk of infection, get in touch with the health-care provider for taking separate visits and following all necessary protocols. The pregnant women may utilize the telemedicine platforms like e-sanjeevani for teleconsultation from home in non-emergency situations
- **Get tetanus toxoid vaccine to** help protect self and baby
- **Take recommended IFA and calcium supplementation and adequate nutritious diet**
- **Call ASHA/ ANM/ CHO or other health-care provider for any concerns** related to pregnancy or if contracted the infection
- **Avoid delay in getting emergency care because of the infection**

7.4.3 Postpartum Care of the Mother and Newborn

Mother: Counselors should appraise and counsel the client's partner and other family members about:

- The risk of the woman developing additional stress and tiredness due to fear of the crisis
- Importance of avoiding courtesy visits of the friends and relatives to the house and hospital for enquiring about the well-being of the newborn and mother. There should be no crowding in the room as well as around the newborn and mother
- The benefits of breastfeeding substantially outweigh the potential risk of transmission – in case of concerns about the risk of transmitting the infection to the baby through breastfeeding. Also, the precautionary measures to be adopted by mother during breastfeeding
- The importance, timing and place of immunization of the baby
- Requirement of adequate quality sleep for both the mother and the baby
- Maintaining mother's social, emotional, and mental health and share tips to cope with anxiety and stress.
- Contacting the counselor or the health-care provider in case of any sign or symptom of postpartum depression

Newborn: Counselor should educate the mother and other family members on the importance of breastfeeding and immunization in preventing life-threatening diseases.

- Exclusive breastfeeding for 6 months to be encouraged. Complementary feeding can start after 6 months and, if possible, the baby should be given clean home-cooked food (in form he/she can eat) along with breastfeeding. Avoid top feeds (donated formula milk) and encourage breastfeed
- Emphasize on maintaining hygiene to prevent diseases/ infections
- Specific precautions in the context of prevailing crisis. For e.g.: During COVID pandemic, the caregiver feeding the baby should wear a mask and sanitize hands before and after feeding or touching the baby. Emphasize on limiting the number of visitors to see the new baby and educate about possible signs and symptoms of infection among the babies
- Educate about the danger signs and when to contact health-care provider and facility

7.4.4 Care for Women with Unwanted Pregnancies Seeking Abortions

Counselors in these situations have double responsibility of allaying the anxiety and stress due to unwanted pregnancies and also providing appropriate counseling for abortion services, including where to avail them during the disaster situation.

The counselor should therefore support the women by:

- Discussing the routine counseling messages related to abortion
- Providing the information on the availability of comprehensive abortion care, service providers and health facilities in the nearby areas and guide the women accordingly

7.4.5 Information and Services for Contraception and Availability of SRH Commodities

- Provide information regarding family planning options and various self-care methods
- Provide information about the availability of sanitary pads, IFA tablets
- If services for long acting contraceptives are disrupted, encourage them use of short acting methods like condoms, oral pills
- Ensure that walk- in clients can avail contraceptive services including IUCD and Injectable MPA, if possible
- Coordinate with ASHAs/ ANMs/ CHOs for home delivery of contraceptives and other SRH commodities.
- Coordinate with various health-care facilities both at the public and private/ NGO sectors where the services for IUCDs, injectable MPA and sterilization are provided and guide the clients accordingly
- Encourage clients to use the services of help line for tele-counseling/ tele-consultation to keep their privacy

  Also educate the clients on following key FP messages:

  - All modern methods of contraception are safe to use, during the pandemic
  - There are no medical problems caused by delaying removal of long acting methods such as IUCDs. Client should not try to remove the IUCD and wait until there is access to a trained provider
  - ECP is not a regular contraceptive and should only be used in case of emergencies/ unprotected sexual intercourse
  - ECP is not an abortifacient
  - Condoms are effective in preventing unwanted pregnancies, RTIs/ STIs including HIV and AIDS and may be easily used by new users without any consultation with providers

SECTION V

Busting Myths and Misconceptions

08

Busting Myths and Misconceptions with Facts

8.1 Adolescent Health Issues

S.No	Myths and Misconceptions	Facts
1	It is wrong to masturbate as it is a sin	Masturbation is a stimulation of genitals for sexual pleasure without penetrative sex. It is not a sin and is completely normal
2	Too much masturbation during adolescence affects sex life in an adult	Masturbation does not affect sex life. However, it is important to consult the counselors or doctors if it's becoming a habit
3	Most boys masturbate, but very few girls masturbate	It is natural for both girls and boys to masturbate as both have sexual urges
4	Most people stop masturbating after they get married	People may or may not continue to masturbate after marriage. It is quite normal
5	Masturbation and sexual thoughts can cause pimples, acne, and other skin problems among adolescents	Masturbation and sexual thoughts have no role to play in skin problems. Acne and pimples are due to oily skin and may subside within few years. During puberty, pimples appear because hormonal changes make the sweat glands grow more rapidly than their ducts that carry out the secretions (sweat). As a result, the pores can get clogged and closed. If not kept clean, inflammation and infections take place, resulting in blackheads and pimples.
6	Loss of semen during night falls leads to weakness of body	Night falls are a normal part of growing up and do not cause weakness or any other abnormality
7	Frequent masturbation during young age results in mental problems in later life	Masturbation does not cause mental problems. However, some adolescents who feel guilty of masturbating a lot may talk to their counselor/ doctor
8	Masturbation is a dangerous activity	Masturbation is not dangerous. It is a safe way to satisfy one's sexual urge as it does not cause pregnancy or STI/ HIV infection
9	Menstruation is unclean and unhealthy	Menstruation is a normal and natural process in the life of a girl or a woman. This involves the preparation of the uterus for the implantation and growth of the fertilized ovum in case conception was to occur. However, if fertilization does not occur, the inner layers of the uterus are shed along with blood. This is called menstruation. Maintaining hygiene is important especially during menstruation
10	Adolescent girls should not eat sour foods like curd, tamarind and pickles as they disturb the menstrual cycles	There are no scientific evidences that sour food like curd, tamarind, and pickles are associated with any disturbance in menstrual cycles. The early years of the menses are naturally irregular or heavy due to hormonal effects, it is not due to food

S.No	Myths and Misconceptions	Facts
11	Giving adolescents' information regarding sexual health and contraception will encourage sexual activity and risk-taking behavior among them	Adolescents who have access to correct and complete information about their body, changes and sexuality, are equipped to take informed decisions that safeguard their health and well-being
12	Exercise or physical activity increases the amount of menstrual bleeding	Exercise or physical activity is recommended during menstruation because it helps to relieve pain during menses due to production of some pain blocking chemicals in the body. Unless woman has severe cramping (dysmenorrhea) or excessive blood flow (menorrhagia) that interferes with her ability to participate in physical activities, there's no reason to refrain from mild exercise or regular activities
13	Easy availability of Emergency Contraceptive Pills (ECPs) will encourage irresponsible sexual activity	ECPs plays a very important role in cases of inability to negotiate safe and protected sex, contraceptive failure, limited or no access to other contraceptive options. Therefore, its easy, wide availability and access is essential to safeguard against unwanted pregnancy
14	HIV spreads from sharing public toilets, swimming pool and having food together	HIV does not spread from sharing public toilets, swimming pool and having food together as there is no direct contact with any of the body fluids
15	A person suffering from Sexually Transmitted Infection (STI) should never talk about/disclose it to others	STI are like infections of any other part of the body and one should seek medical advice for them as timely management can lead to complete cure for most infections
16	Single sexual act cannot result into pregnancy	Pregnancy can occur even after one act of unprotected sexual intercourse
17	Adolescents do not have mental health issues	Adolescents may have mental health issues. Mental health issues are often overlooked in adolescents confusing it with phases of growth. There may be various environmental and biological reasons for mental health problems

8.2 Family Planning

S.No	Myths and Misconceptions	Facts
Misconceptions about all Oral Contraceptive Pills (COCs/ POPs/ Centchroman)		
1	OCPs are to be taken only when sleeping with husband/ partner	OCPs are to be taken every day/ once a week (as per schedule) irrespective of the sexual intercourse as only then they can protect against pregnancy. Missing OCPs can lead to pregnancy
2	Rest/ break should be taken after regular use of OCPs for some time	Taking rest/ break after regular use is not recommended. In fact, taking a "rest" from OCPs can lead to unintended pregnancy
3	Woman taking OCPs become infertile	Woman does not become infertile after taking OCPs. In some women return of fertility may take 1 to 3 months after stopping the OCPs
4	OCPs cause abortion	OCPs provide protection against conception but do not disrupt an existing pregnancy
5	Getting pregnant while on the OCPs will lead to birth defects	A baby will not have birth defects if a woman becomes pregnant while on OCPs or accidentally starts to take OCPs, when she is already pregnant

S.No	Myths and Misconceptions	Facts
6	Taking OCPs result in weight gain	There may be slight weight gain 1–2 kg with hormonal OCPs. However, if there is significant weight gain then medical consultation need to be sought to explore reasons of weight gain
7	Taking OCPs change mood or sex drive	There are no scientific evidences that show OCPs affect woman's mood or sexual behaviour. Although some women using OCPs have reported either an increase or decrease in sexual interest and performance, it is difficult to say whether such changes are a result of OCPs or other life events
8	Taking OCPs cause weakness	There is no scientific evidence that show OCPs causes weakness. Woman should consult a doctor to find out the reason of weakness and keep taking her OCPs regularly
9	Taking OCPs increase the chances of cancer	OCPs are found to be protective against various cancers like ovarian and endometrial cancer
10	OCPs causes the birth of twins or triplets	OCPs do not result in developing tendency of multiple births. The tendency to have twins usually runs in families. Multiple births may also be triggered by fertility medication or by drugs taken to induce pregnancy
11	OCPs can be started without medical consultation	OCPs should be taken after consultation with a trained health provider (Doctor/ Nurse/ ANM/ CHO/ LHV). Once screened by health provider and found eligible, subsequent doses may be collected from nearest health facility or ASHA
Misconceptions about POPs		
12	POPs are not safe for breastfeeding mother and child	POPs are safe for both the mother and the baby, as they do not affect the quality & quantity of milk
13	POPs, can be continued after breastfeeding is stopped	POPs can be continued after breastfeeding is stopped. However, POPs are less effective in protecting pregnancy after breastfeeding is stopped. Switching to another contraceptive is advisable
Misconceptions about COCs		
14	COCs can be taken by women while breastfeeding	COCs should not be taken by breastfeeding women as it affects the quality and quantity of breast milk
Misconceptions about Centchroman (Chhaya)		
18	Chhaya is not safe for breastfeeding women	Chhaya is a non-hormonal, non-steroidal OCP and safe for breastfeeding mothers as it does not affect quality and quantity of milk
Misconceptions about EC Pills		
19	ECPs can be taken as a regular contraceptive and protect a woman from future pregnancies	ECPs is not a regular contraceptive and used only in emergency conditions like coerced sex, condom tear etc. It can provide protection against pregnancy only from current unprotected sex
20	ECP is not safe for adolescent girls	Studies have shown that ECP use among adolescent girls is safe
21	Chances of ectopic pregnancy increase if ECP fails to prevent pregnancy after an act of unprotected sex	There is no evidence that ECPs increase the risk of ectopic pregnancy

S.No	Myths and Misconceptions	Facts
22	ECP cannot be used correctly by women who buy them over the counter	Taking ECPs is simple and medical supervision is not needed. ECP package contains information and instruction on its use. Client may ask a provider or pharmacist to explain its use
23	ECP cannot be purchased without medical prescription.	ECP are available for sale without prescription and can be bought directly from the shop
Misconceptions about Condoms		
24	Condoms often break or slip off easily during sex	Condoms do not break/ slip off easily if worn correctly. Thus, it is important to teach people the right way to use condoms
25	Condom use requires consultation with provider.	Condom use does not require any consultation if the technique of correct use is known
26	Wearing 2 or 3 condoms offers greater protection than single condom	Correct use of a condom provides protection and it is generally not recommended to wear 2–3 condoms because friction between the condoms can increase the chance of breakage
27	Condom use causes impotency in men	Impotence has many causes like physical, emotional etc. Condoms themselves do not cause impotency
28	Condoms can be reused after washing	Condom should not be reused after washing. It should be discarded after each act
29	Condoms have holes through which HIV can pass	Condoms does not have holes. In fact, condoms give protection against HIV
30	Condoms can be flushed or burnt after use.	Condom should not be flushed in toilet or burnt after use. It can be wrapped in a paper/ packet and put in waste bin.
31	There is no way to check if a pack of condom is safe to use	Condom pack is safe to use before its expiry date and when it has been properly stored – away from dampness, direct heat or sunlight
32	There is no need to use condom if woman is on OCPs	Condom is the only contraceptive which protects against STIs. Condoms may be therefore used even if woman is taking OCP. Hence it is advisable to use
33	Condom should be worn only during vaginal sex and not oral or anal sex	Condom protect against sexually transmitted infections therefore should be used during unprotected and unsafe sexual practice
Misconceptions about Injectable Contraceptive MPA		
32	Irregular bleeding with MPA use means something harmful has happened.	Irregular bleeding with MPA use occurs due to the way the method works. It is not a sign of illness and it is harmless. Irregular bleeding occurs only in the first few months of injection use because amenorrhea sets in after that
33	Stoppage of periods with MPA use means it has failed and pregnancy has occurred	Stoppage of periods does not mean that MPA has failed and resulted in pregnancy. MPA is a very effective method with correct and consistent use (every three months). Periods stop due to effect of hormone in injection which is temporary and reversible once the MPA is discontinued
34	Dirty blood collects in body due to stoppage of monthly bleeding	Menstrual blood is normal blood and is not dirty. Monthly bleeding occurs because every month the inner lining of uterus becomes thick and soft with increased blood supply in preparation for pregnancy and this blood is flushed out of her body (if woman does not conceive that month). During pregnancy, foetus is nurtured with this blood, so how can it be dirty? With MPA, monthly bleeding stops because the bodily preparation for conception every month stops. When the woman discontinues using MPA, body again starts preparing for conception and monthly bleeding (periods) is resumed

S.No	Myths and Misconceptions	Facts
35	Stoppage of periods weakens eyesight	There is no connection between a woman's eyesight and period
36	MPA use makes bone weak	MPA use doesn't lead to weakening of bones. It is seen that with five years of MPA use, there is 5% to 6% Bone Mineral Density loss and this loss is reversible. WHO study also recommends that there should be no restriction on the use of MPA, including no restriction on duration of use, among women aged 18–45, who are otherwise eligible to use the method
37	Stoppage of periods means untimely menopause	MPA does not cause menopause. There is stoppage of periods due to effect of hormone which is temporary and reversible. Once MPA use is discontinued, periods resume after few months
38	MPA use causes infertility	MPA does not cause infertility. A woman can become pregnant after discontinuing MPA. Pregnancy usually occurs 7–10 months from date of last injection (Average 4–6 months after 3 months effectiveness of last injection is over)
39	MPA causes cancer	MPA does not cause cancer. In fact, it has been demonstrated that it protects against endometrial cancer
40	MPA causes nausea	Nausea is not common with MPA
41	MPA is not safe in breastfeeding women	A breastfeeding woman can safely use injectable contraceptive at 6 weeks after delivery as it does not affect the timing, quality and quantity of milk production and does not harm baby and mother
42	MPA causes defects in babies	There is no scientific evidence that MPA causes any abnormalities in babies born to a MPA user mother of if mother gets an injection accidentally during pregnancy
43	Women should stop using MPA and have a 'rest' after several Injections	There is no limit to the number of years MPA can be continuously used. It can be given until menopause, when contraception is no longer needed
44	MPA causes abortion	MPA prevents ovulation (egg release). If no egg is released, no fertilization takes place hence there are no chances of abortion
Misconceptions about IUCD		
45	IUCD thread can trap the penis during intercourse	The strings of IUD cannot trap the penis, because they lie high up in the vagina and are too short to wrap around the penis
46	IUCDs prevent pregnancy by causing abortion	IUCDs does not prevent pregnancy by destroying a fertilized egg. It is effective before fertilization of egg and sperm, once pregnancy takes place, it doesn't disrupt pregnancy
47	IUCD user cannot do heavy work	Using an IUCD should not stop a woman from carrying out her regular activities in any way. There is no correlation between the performance of chores or tasks and the use of an IUCD
48	The IUCD might travel inside a woman's body to her heart or her brain	The IUCD never travels to the heart, brain, or any other part of the body outside the abdomen. The IUCD normally stays within the uterus. Rarely an IUCD may come through the wall of uterus into the abdominal cavity, which can happen due to incorrect insertion technique. If the IUCD is accidentally expelled, it comes out of the vagina, which is the only passage to the uterus
49	The IUCD causes ectopic pregnancy	No. In fact, IUCDs greatly reduce the overall risk of ectopic pregnancy by almost eliminating the chances of pregnancy during its use. On the rare occasions that the IUCD fail, ectopic pregnancy is possible

S.No	Myths and Misconceptions	Facts
50	IUCD leads to the rotting of the uterus	The IUCD is made up of materials that cannot deteriorate or rot. Hence there is no question of rotting of uterus by IUCD. Many women have used it for years together and nobody had such effect
51	IUCD can cause infection in users	IUCD does not cause infection if all aseptic precautions are used during insertion by the provider
52	IUCD can lead to infertility	IUCD use does not lead to infertility. In fact, the return to fertility is immediate after IUCD removal
53	IUCD insertion after delivery can cause perforation in uterus	IUCD can be safely inserted by a trained provider within 48 hours of delivery known as Postpartum IUCD (PPIUCD). It is safe and effective method. After delivery is the best time to use as the uterine wall that prevents any perforation
54	IUCD provides protection against STI/ RTI	IUCD does not protect against STI/ RTI. Use of condom by partner is encouraged to prevent infection
55	IUCD insertion is painful	An IUCD insertion is usually well tolerated by most women. Some women may experience pain and dizziness after insertion, which usually settles after resting for a short time
Misconceptions about Female Sterilization		
56	Female sterilization changes a woman's monthly bleeding or stop her monthly bleeding stop	Female sterilization acts by preventing fertilization as fallopian tubes are either blocked or ligated thus preventing egg to meet sperms. As a result, the menstrual cycle remains unaffected after sterilization
57	A woman who has undergone sterilization loses all desire for sex (becomes frigid)	Tubal ligation does not affect a woman's desire or ability to have sex. It has no physiological effect on the woman other than preventing the egg from meeting the sperm. The ovaries will still release eggs and produce hormones, and the woman will still menstruate, but she will no longer get pregnant
58	A woman may become fat after undergoing sterilization	The procedure has nothing to do with weight gain. There can be various other reasons of gaining weight, like eating habits, sedentary lifestyle etc.
59	A woman who has undergone sterilization becomes sick and unable to do any work	A woman who has been ligated can resume regular activities as soon as she is free from discomfort after surgery. It does not affect her ability to work or make her weak or "sick". In fact, it may improve her health/ stamina by preventing further pregnancies
60	A woman who undergoes sterilization needs to stay for few days in the hospital	Hospital stay is not required after female sterilization. The woman is discharged after 4 hours of the operation once the vital signs are stable and allowed to go home when accompanied by the family member
61	Sterilization shortens the life span of a woman and may cause early menopause	There is no medical reason for a ligated woman to have a shorter life span. Infact it is just the opposite that her life will be probably prolonged by preventing unwanted pregnancy Ligation will not hasten menopause. A ligated woman will continue to ovulate and menstruate (although she will no longer get pregnant) until she naturally reaches menopause
62	Female sterilization is effective immediately after operation	Female sterilization operation is not effective immediately. A negative pregnancy test or reporting on resumption of periods after one month establishes the success of sterilization. A certificate of sterilization is issued after this follow up

S.No	Myths and Misconceptions	Facts
63	Sterilization causes abdominal pain as all reproductive organs are removed	In sterilization, only fallopian tubes (tubes connecting ovary to uterus) are only blocked and no reproductive organ is removed. The cause of the pain in abdomen should be ascertained by health-care provider
Misconceptions about Male Sterilization		
64	Vasectomy is the same as castration. A man who undergoes vasectomy has his manhood taken away and he will no longer enjoy sex. (loss of libido)	Vasectomy is not castration. In vasectomy, the vas deferens are cut and tied so that sperm cannot mix with the semen. The semen ejaculated during sexual intercourse no longer contains sperm and will no longer make a woman pregnant. After vasectomy, man's testes continue to produce male hormones, so he remains "masculine". Many men enjoy sex more after a vasectomy because they no longer need to worry about getting a woman pregnant
65	Vasectomy makes a man lose his sexual ability and makes him weak	After vasectomy, a man will look and feel the same as before. He can have sex the same as before. He will continue to have erections and ejaculate semen. Only difference would be absence of sperms in semen
66	A man becomes weak and cannot do hard work after vasectomy	A man does not become weak and can do hard work in the same manner as he was doing before vasectomy. It is a small procedure of 10–15 minutes & man can go home walking after the procedure. One can go back to work anytime as she feels comfortable however it is advisable to resume normal work after 48 hours and return to full activity, including cycling, after one week following surgery
67	Sperm that is not ejaculated during intercourse will collect in the scrotum and cause the scrotum to burst or will cause other problems in the body	Sperms within a male's body have a life span of 90 days after which they die. The sperms that are not ejaculated are absorbed by the body. It cannot collect in the scrotum or cause harm to a man's body in any way
68	Sterilization be easily reversed if one decides to have child	Sterilization is a permanent method. Surgery to reverse sterilization is possible but is difficult and chances of success is limited
69	Male sterilization is effective immediately after operation	A sterilization operation is not effective immediately Semen examination at 3 months is advisable to confirm success by absence of sperm in semen. A certificate of sterilization is issued after this examination
Misconceptions Related to Breastfeeding and Pregnancy		
70	Woman cannot get pregnant if breastfeeding	No, this is not true for all breastfeeding women. A breastfeeding woman remains protected from pregnancy only if she is exclusively breastfeeding her child, baby is less than 6 months & her monthly periods have not resumed (three criteria of LAM), otherwise she can become pregnant even if she is breastfeeding
71	One cannot get pregnant unless menses resume after childbirth	A woman can become pregnant even before resumption of menses. It is seen that ovulation may occur even before resumption of monthly period. Hence a woman may become pregnant if the couple is not using any contraceptive method

8.3 Maternal and Child Health

S.No	Myths and Misconceptions	Facts
1	One cannot know about fertile days in a monthly menstrual cycle	There is a calendar method to know fertile days and safe period. The days near to the ovulation are the most fertile days. In case of typical cycle of 28–30 days, the ovulation occurs between 11th to 21st day. The egg is only available for 12 to 24 hours for conception
2	There is no risk of pregnancy after delivery	A woman can become fertile as early as within 4 weeks of delivery even before resumption of menses
3	There is no risk of pregnancy when a woman is having her periods	The chances to get pregnant during monthly bleeding are there but are minimal. In the first several days of bleeding the chances of pregnancy are lowest. The most likely time to get pregnant is just before or during ovulation (when an egg is released). However unprotected sex at any time can cause pregnancy
4	There is no way to detect pregnancy without consultation with doctor	Pregnancy testing kits can be used at home to detect pregnancy. However, once test is positive it is advisable to seek medical consultation to ascertain pregnancy
5	Pregnancy testing kits may be reused	Pregnancy testing kits should not be reused as pregnancy testing kits have a dye to give color on the positive result. This reaction is non-reversible
6	Negative pregnancy test confirms that there is no pregnancy	The pregnancy testing kits may rarely show a false negative result which can be due to low levels of pregnancy hormones in the body, ectopic pregnancy or incorrect usage of the kit. One can contact the doctor in case there are other symptoms of pregnancy
7	There is no risk of pregnancy after an abortion	The woman can conceive as early after within 10 days of abortion if no contraception is used
8	One should try to get pregnant as early as possible after an abortion	One should wait for at least 6 months after an abortion before conceiving as it gives enough time to recover and ensures healthy outcomes from next pregnancy
9	Abortion causes infertility	Abortion conducted by trained provider at designated health facility is safe and does not result in infertility
10	Abortion increases risk of cancer	There is no scientific evidence that suggest abortions increase the chances of any cancer
11	Abortion can be opted as a method or an alternative to contraceptive	Abortion should not be opted as an alternative to contraceptive use. As far as possible unwanted pregnancies should be avoided with regular use of contractive and abortion should only be opted when there is unwanted and untimed pregnancy due to missed pill, contraceptive failure, coerced sex, non-contraceptive use etc).
12	Having an abortion has higher health risks than continuing a pregnancy and going through childbirth	Continuing a pregnancy and going through childbirth has greater risk to a woman's health than having an abortion. Abortions are very safe when performed by trained doctor
13	No contraceptive method can be taken up immediately after the abortion procedure	All the available contraceptive methods, both the spacing and permanent methods can be taken up following the abortion procedure
Myths about Postpartum Period and Pregnancy		
14	Woman in labor should drink lot of ghee as it eases delivery	No, this is neither true nor recommended. Oral intake of ghee cannot reach the uterus to "lubricate" it. Woman in labor needs light, easy to digest nutritious food

S.No	Myths and Misconceptions	Facts
15	After caesarian delivery, milk, curd, or fish should not be given to a woman, as it causes pus formation in the wound!	This is not true. Pus is caused by infection due to microbial organisms and not any food. A nutritious diet is necessary for proper wound healing
16	Consuming IFA tablets during pregnancy will darken the skin colour of the baby	There is no evidence that IFA consumption during pregnancy has any effect on the colour of the baby, rather It aids in brain development of the child and reduces chances of Infection
17	Consuming IFA tablets will enlarge the size of the baby in-utero and will lead to complicated delivery	Consuming IFA tablets will reduce the chances of complicated delivery, which can occur due to anaemia during pregnancy. There is no evidence available that it affects the size of the baby in-utero
18	Consuming IFA tablets will always cause nausea, vomiting, giddiness etc.	These side-effects may be observed in some cases during the initial days (esp. if taken on an empty stomach) and subsides with regular consumption. The side effects can be easily avoided by taking IFA tablet one hour after meal
19	IFA tablets are given as family planning measure and will lead to impotency	IFA tablets have no role in contraception and its consumption does not lead to impotency. It increases the haemoglobin level in the blood which in turn reduces the complications during delivery and also aids in cognitive development of the child
20	Iron supplements can be stopped (before 180 days or as per prescription) once you start feeling better	Prophylactic IFA supplements have to be continued as per the the prescribed dosage as it builds up the iron store in your body and prevents anaemia
Myths Related to Newborn		
21	Breast colostrum should not be given to newborns and giving honey/ jaggery is useful	Colostrum is rich in antibodies which protect from infections and has all the nutritional elements that a newborn needs after birth. On the other hand, honey/ jaggery does not fulfill the nutritional needs of the newborn and may be harmful and may cause infections
22	Giving ghutti (pre colostrum feed) is good for growth and digestion of the baby	Ghutti (pre-colostrum feed) has unverified ingredients which may be harmful to the baby and may cause infections. Breastfeeding is best option for the baby and it should be promoted as the gold standard feeding option for babies
23	A baby suffering from diarrhea should not be breastfed	Breastfeeding should be continued during diarrhoea or any other illnesses. It helps the child to get optimal nutrition and recover from the illness faster
24	If the child is breastfeeding there is no need for complementary feeding	Breastmilk alone is not enough to meet the needs of rapid growth and development in the young child after six months of age. Emphasize timely, adequate and appropriate complementary feeding for children on completion of six months and continued breastfeeding up to two years of age
25	It is not necessary to vaccinate so early in life	It is important to vaccinate the newborn as per recommended immunization schedule as these vaccines prevent the diseases that are deadly in very young and delaying vaccines can put child at risk
26	Children contract the disease after vaccination	Vaccines have inactivated or killed virus/ bacteria. They just stimulate child's immune system to produce antibodies. They don't cause disease
27	Natural immunity is better than the acquired immunity	The side effects of the natural infection can be severe. Vaccine-induced immunity has much lower risk of side effects
28	A child having cold or fever cannot be vaccinated	It's safe for a child to receive vaccinations while fighting off a cold or fever. It is advisable to talk to health-care provider regarding the same

8.4 RMNCAH+N Services during Pandemic

S.No	Myths	Facts
1	Respiratory illness like swine flu, COVID-19 affects only urban population	Respiratory illnesses like swine flu and COVID-19 affects people of all age group, caste, creed ethnicity and does not discriminate between urban and rural population
2	Respiratory illnesses like swine flu, COVID-19 is a disease of developed country	Respiratory illness like swine flu, COVID-19 may affect population of any country, whoever meets the infection source
3	Adolescents do not get affected with any illness during lockdown and do not require any services	Adolescents may suffer with mental and emotional illness during lockdown due to complete stoppage of social activities and restrictions of movement. Their physical, mental and emotional health requires vigilance and help may be sought from a Counselor or provider
4	There is no need of sexual and reproductive health services during a pandemic	There is higher need of SRH services during pandemic as there is limited access to supply and services and higher chances of unsafe contact and unwanted pregnancies
5	Short term spacing options are safer than long term methods like (IUCD and injectable MPA) during pandemic	All options are equally safe if taken with all precautions. In fact the IUCD and injectable services provide longer protection with minimum requirement of follow up and replenishing supplies
6	Children should not be immunized during pandemic as it may increase chances of contracting infection	Children should be immunized during pandemic as it prevents against many diseases and builds immunity to fight against other infections
7	Home deliveries should be opted during pandemic	Institutional deliveries in nearest health care facility should be opted. However, in remote areas where access to health facility during pandemic is not possible home deliveries by skilled birth attendant may be opted
8	Mothers should avoid breastfeeding during pandemic like COVID	Mothers should maintain hygiene, use mask and handwash prior to breastfeeding her child. However, expressed milk may be offered if breastfeeding is not possible

SECTION VI

Programme Management and Capacity Building

09

Technical and Programmatic Aspects for Training on RMNCAH+N Counseling

9.1 Introduction

Counseling of couples across all stages of life cycle is crucial for improving maternal, newborn and child health outcomes. Focusing early on reproductive and other important health issues (during adolescence) is essential for healthy growth of an individual and community.

Integrated RMNCAH+N counseling at health facilities is envisioned to strengthen quality of services and to complement efforts provided by service providers. Presence of trained counseling personnel at high delivery case load facilities will strengthen reproductive, maternal, newborn, child health and nutritional services and help in achieving SDG goals.

This chapter details information on programme management and capacity building on same.

9.2 Determinants of Services

It is important that programme managers plan for capacity building of counselors and ensure knowledge, skills and attitude for addressing issues related to RMNCAH+N services while ensuring the essential supplies/ reporting formats/ counseling job aids/ adequate budgetary provision for service provision. Importance of an integrated approach on RMNCAH+N counseling should be emphasized and monitored regularly. State and district programme managers may utilize this manual to train other service providers also.

Essential supplies for RMNCAH+N counseling:

- Relevant programme specific IEC/ BCC material and job aids
- Samples for contraceptives, uterine model, penile model
- Height and weight scales
- Samples of IFA tablets, calcium tablets, zinc tablets, ORS packets
- Samples of growth chart/ MCP cards

9.3 Assessment of Training Needs

A situational analysis to assess/ gauge the current status/ knowledge related to RMNCAH+N services and counseling skills of counselors/ health-care providers who will be attending counseling training at the different

Note: Trainings for RMNCAH+N Counselors

Any counselor appointed in public health system should undergo a base training on Integrated RMNCAH+N counseling to develop an insight on counseling aspects across all pillars of RMNCAH+N.

The counselors trained in Integrated RMNCAH+N Manual may further undergo various programmatic trainings. For e.g.: Adolescent health training, IYCF training, facility-based care of SAM, Gestational Diabetes etc., if needed.

levels of health facilities in the district will help in identifying their training needs. Assessing the training needs helps to determine and plan the most appropriate interventions, such as 'Training of Trainers' to develop a core group of 'trainers' and counselors at various levels. The state programme managers need to coordinate with the district Chief Medical Officers (CMO) to identify personnel required for providing counseling services in identified high case load facilities, in their respective districts. Based upon the need of the districts, the trainings may be organized. The training load can be calculated using the RAG analysis.

Training on Integrated RMNCAH+N counseling	R (Required)	A (Available)	G (Gap)

9.3.1 General Aspects of Training

9.3.1.1 Selection of Training Site

- The facility for training should have a comfortable clean training hall of adequate size to accommodate approximately 30–40 participants
- Availability of chairs, tables, light source, cooling system (fans/ AC/ cooler), audio-visual facility and alternate source of power
- Space for providing refreshments
- Clean toilet facilities
- Availability of at least two trainers for the respective training site

Identification and designation of these training centres at state and district level will be the responsibility of SQAC/ Director, Family Welfare and DQAC/ CMO respectively, whichever is applicable.

> Note: Training site may be a health facility or space adjoining a health facility where RMNCAH+N services are offered, so that the counselors have an opportunity to get an overview and practice on clients.

9.3.1.2 Eligibility of Trainee

The counselors or other service providers like ANM/ CHO/ LHV/ SN/ MO as nominated by state/ district/ facility in-charge may undertake this training.

While selecting trainees, priority should be given to service providers from institutions who are committed to provide RMNCAH+N services.

9.3.1.3 Criteria for Designation of 'Trainers'

- Trained service providers (MBBS and above, AYUSH, staff nurses) with some training experience and good communication skills, well-versed with training skills and technique of adult learning principles. They should have competency/ proficiency in the skills of counseling
- Can spare time and are willing to conduct training and follow-up monitoring visits, for on-site support/ handholding, if required
- Can be designated as a trainer by SQAC/ Director, Family Welfare at the state level and by DQAC/ CMO at the district level

9.4 Training Goal and Learning Objectives

9.4.1 Goal of the Training

To build the competency of trainees on effective counseling of women, couples, adolescent girls and boys and family members on healthy behaviours and essential health services, relevant to their specific situation, and to equip them in supporting the clients in adopting services for improved maternal, neonatal, child and adolescent health outcomes.

9.4.2 Objectives of the Training

Training objectives are as follows:

- To build participants' knowledge and understanding on reproductive, maternal, newborn, child and adolescent health and nutrition related issues and services
- To build communication and effective counseling skills of the participants on RMNCAH+N related issues and services
- To build participants' skills in addressing client's issues and concerns effectively
- To build their capacity in making appropriate referrals whenever required

Learning objectives: At the end of competency-based training, participants will be able to:

- Explain the importance of 'Life Cycle Approach' for RMNCAH+N services
- Provide key counseling messages and information related to each aspect of RMNCAH+N services
- Demonstrate appropriate counseling skills related to each RMNCAH+N service
- Dispel myths and clear misconceptions on RMNCAH+N issues effectively
- Demonstrate how to maintain correct records of RMNCAH+N clients and their reporting

9.5 Number of Trainees Per Batch

30–40 per batch

9.6 Duration of Training

Type of Training	Duration	Topics Covered	Selection of Trainees
Manual Trainings			
Training of trainers *(Refer to Annexure 17)*	Three days	Orientation to the training package including session plan, training skills, knowledge update, training practice, records, and reporting	Priority should be given to service providers from institutions/ health facilities providing RMNCAH+N services
Training of the counselors/ service providers *(Refer to Annexure 18)*	Six days	All components of the curriculum, practice sessions	RMNCAH+N Counselors and other service providers in the public health system
e-Module Trainings			
Training of the counselors/ service providers (Annexure 19)	Four days	All components of curriculum in AV mode	RMNCAH+N Counselors and other service providers in the public health system. This can also be used for refresher trainings.

Agenda for ToT, and Training course (physical and e-module) is placed at Annexure 17, 18, 19

9.7 Training Approach and Methodology

The competency based participatory training methodologies, are used during the training activities and explained in detailed session plan for facilitators. A variety of participatory training methodologies like interactive presentation, brainstorming, group activities, case studies and role-plays have been included on principles of adult learning. A conducive learning environment is created that fully engages participants, facilitates effective learning and prepares participants to translate learnings into action. The key focus of the training is to build the competency of participants through repeated simulated practice of counseling in the classroom and hospital setting, using simple job aids and counseling skills checklists (as provided in technical manual) for various services

Classroom training (manual) and E-training package may be utilized, as per the existing pandemic situation.

9.8 Equipment and Training Material for Conduction of Training

All the necessary equipment and material that will be needed during the training should be arranged/ kept ready well in advance at the training site.

Suggested material for the training includes the following:

- Reference Manual for Integrated RMNCAH+N Counselling
- Available job aids under national programme for various services
  - Samples of IFA, deworming tables, ORS, PTK, sanitary napkins under menstrual hygiene programme
  - Contraceptive basket with samples of all FP options under NFPP along with penile and uterine models
  - Immunization schedule
  - Nutrition charts
  - Informative charts depicting male and female reproductive organs, menstrual cycle, breastfeeding positions, KMC etc. – may also be arranged & provided to trainees
  - Flip books/ charts/ IEC material under various national programmes
- Reporting and recording formats under RMNCAH+N – MCP card, IUCD card, MPA card, MMA card, Reporting formats etc.
- Formats with role plays and case studies, pre/ post-test formats *(Refer to Annexure 19,20)*, training evaluation formats (Annexure 22), adequate no. of copies of course evaluation forms for participants, certificates of completion
- Laptop, LCD projector and screen for power point presentation, extension board, power back up, flip chart, flip stands, coloured markers, double sided tape for posting flip chart on the wall
- Note pads (for each participant), pens and pencils (for each participant), folders or bags for participants to carry back the materials

(The details of resource materials required for each session are mentioned in detailed session plan and training activity for the session).

9.8.1 Tips for the Trainers

Tips for advance preparation of the training:

- Meet with co-facilitator/s before each training workshop for assigning responsibilities and to clarify any doubts, concerns or reservations

- Study the Reference Manual for Integrated RMNCAH+N Counseling to have a good understanding of the content to be covered in the training
- Review the training goals, session outline, training activity for each session (learning objectives, time, resource materials needed and instructions for trainers) given in this facilitators' guide
- Prepare the session plans well and make necessary preparations
- Review and become familiar with the sessions that include presentations
- Check the training site (hall) and get it prepared, with a seating arrangement which is informal, preferably in a semi-circle, without any podium for the trainers

Tips for the training:

- Trainers to be present in the training hall at least 30 minutes before it starts and check all the equipment and material
- Welcome the participants and adopt a warm, friendly attitude towards them for creating a non-threatening learning atmosphere so that the training is very effective
- Respect each person's individuality, experience and participation, without any bias. Take care not to ridicule any trainee
- Work together with co-facilitator/s as cohesive a training team, subtly supporting each other in every session
- Explain, demonstrate, answer questions, talk with participants about their answers to exercises, facilitate role plays and analyze them, lead group discussions, organize and supervise clinical practice in outpatient facility and generally give participants any help they need to successfully complete the course
- Encourage each trainee to participate actively, do not let one or two of them dominate
- Use leading questions, draw the relevant information related to the session from participants and fill in the gaps, where necessary. This will help trainees to assimilate the knowledge and experiences
- Conduct wrap-up session at the end of each training day and start the next day with a recap session to provide continuity in the training
- Be mindful of time management to cover all the training sessions and achieve its goal & objectives
- Have a debrief meeting amongst trainers at the end of each training day to brainstorm and briefly discuss what went well and if any changes are required for next day

9.9 Post Training Follow-Up at Worksite

It is recommended that, within two to three months of the induction training, the participants need to be observed and assessed working in their facility by a course trainer or skilled provider using the post training follow up checklist. *(Refer to Annexure 21)* This post-training follow-up is particularly important for the newly trained counselors as it provides the opportunity to discuss any initial problems or constraints to service delivery.

9.10 Records and Reporting System for RMNCAH+N Counseling

Record keeping and reporting is one of the most important components to measure the progress of any National programme. Correct and timely reporting supports in effective monitoring of the programme, identification of gaps and effective implementation of the strategies.

Suggestive information that can be captured by the counselor (besides programme specific requirement) are:

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
S No	Name of the Client	Age (years)	Sex (M/F/ Others)	Date (DD/MM/YY)	Address	Contact number	Referred from (ANM/ ASHA/ Peer educator/ AWW/ School/ College/ NGO or Walk in client/Others)	Marital status (Married/ Unmarried/ Divorced/ Separated)	Type of client (Pregnant, Non-Pregnant, Postpartum, Breastfeeding, Non-Breastfeeding, Others (specify))	Purpose of visit (General Ailment/ ANC/ PNC/ FP/ IMM/ CH/ General Information)	Counseled for (Nutrition/ Abortion/ FP/ HIV/ RTI/ STI/ ANC/ PNC/ Sexual problem/ Substance abuse/ others (specify))	Clinical service availed (Yes/ No)	Place of counseling (OPD/ IPD/ Postnatal ward/ AFHC/ Waiting Area)	Referral required (Yes/ No/ NA)	Referred to (Inside hospital – Gynec department, ICTC, RTI, STI, Psychiatric department/ Outside hospital/ NA)	Follow up visit suggested (Yes/ No/ NA)	Follow up due date (if suggested)	Remarks

Instructions for filling the format:

Column 1: Write serial number of the client being counselled.

Column 2: Write the full name of the client.

Column 3: Write age in completed years as mentioned by the client.

Column 4: Write sex of the client as male/ female/ others as per observation of the counselor.

Column 5: Write the date when the client is being counseled in the format Date/Month/Year.

Column 6: Write complete address as detailed by the client.

Column 7: Write the contact number of the client, if provided. Explain it is important for follow up (if consented by the client).

Column 8: Write from the options provided place or person from where client is referred – ANM/ ASHA/ Peer educator/ AWW/ School/ College/ NGO/ Walk-in client/ Others.

Column 9: Write the marital status as revealed by the client – Married/ Unmarried/ Divorced/ Separated.

Column 10: Write the type of client if the counseled client is a women – Pregnant, Non-Pregnant, Postpartum, Breastfeeding, Non-Breastfeeding, Others (specify). Write NA if client is male.

Column 11: Write the purpose of visit of the client as mentioned by the client (General Ailment/ ANC/ PNC / FP/ IMM/ CH/ General Information).

Column 12: Write the services for which the client is counseled for (Nutrition/ Abortion/ FP/ HIV/ RTI/ STI/ANC/ PNC/ Sexual problems/ Substance misuse/ others (specify)).

Column 13: Write if the services are availed by the client.

Column 14: Write the place of counseling (OPD/ IPD/ Postnatal ward/ AFHC/ Waiting Area).

Column 15: Write whether client requires referral (Yes/ No).

Column 16: If yes in column 15 then write the place of referral (Inside hospital- Gynaecology department, ICTC, RTI, STI, Psychiatric department/ Outside hospital).

Column 17: Write Yes/ No/ NA according to the requirement of follow up.

Column 18: If yes is written in column 17, write the due date of Follow up suggested to the client.

Column 19: Write additional information if any in this remarks column.

SECTION VII

Annexures

Annexure 1

Phases of Menstrual Cycle Showing Safe and Unsafe Periods

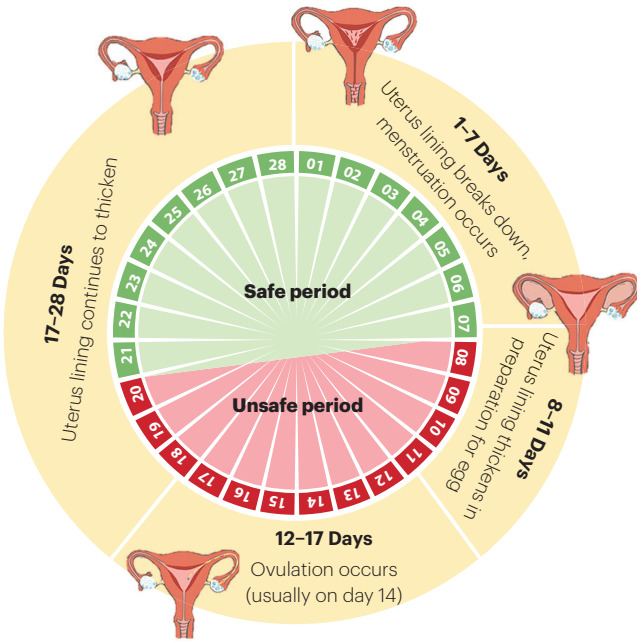
By the time a girl reaches the age of 10–13 years, several changes start to occur in her body, preparing her for the complex childbirth process.

The normal menstrual cycle has the following characteristics:

- Duration of bleeding: 2–7 days
- Average duration of menstrual cycle is 28 days; however, it may last from 21 to 35 days (upto 45 days during early years after menarche). (Counted from the 1st day of the menstruation)

In a regular 28-day menstrual cycle, 7th to 20th days of the cycle are fertile period during which pregnancy can occur (also called unsafe period).

A woman can become pregnant as early as at the age of 12–13 years (when her periods begin), which is called menarche and up to 45–55 years (when periods stop), which is called menopause.



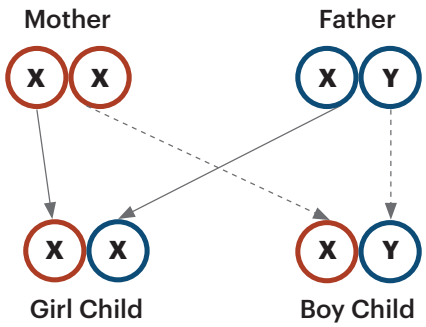
How Reproduction Occurs

Females produce one mature 'egg' in each cycle and males produce countless 'sperms'. The egg can live up to 24 hours while sperm can survive for 5 days.

During sexual intercourse, sperms are deposited inside woman's vagina and travel up into the womb, through its opening in the vagina. If an egg is present in the womb at that time, a sperm unites with it and a foetus is formed, which grows inside the womb into a baby.

Sex chromosomes are of 2 kinds, X & Y. Women have two X chromosomes hence all the eggs have X chromosome only. Men have one X and the one Y chromosome. Therefore, each time semen is ejaculated, it has sperm, half of which have X chromosomes and other half have Y chromosome.

Only one sperm is required to fertilize the egg. If sperm carrying X chromosome meets egg, it results in a baby girl and if sperm with Y chromosome meets egg, result is a baby boy. Neither the man nor the woman can do anything to make sure that either a boy or girl is born – this happens completely by chance depending on whether boy sperm (Y) or girl-sperm (X) meet with the egg. Hence it is wrong to blame a woman for not giving birth to a baby boy, as is generally done in our society.



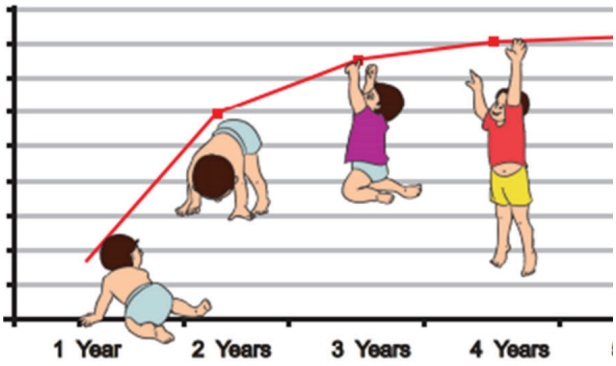
Annexure 2
Growth Monitoring and Body Mass Index

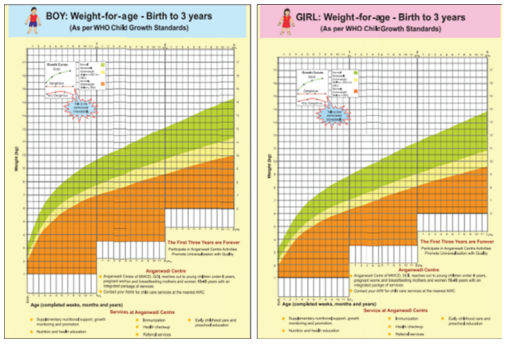
Growth Monitoring in 0–5 years Age

The growth of a child depends on several factors (nutrition of the child, mother's nutrition etc.) and hence, it varies from one child to another. Despite these differences, there is a standard range of age appropriate height and weight for children up to 5 years, which tells us whether the child is exhibiting a healthy growth pattern.

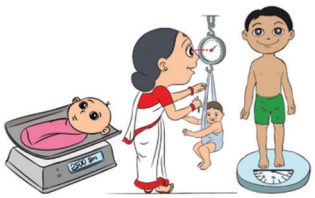
MCP card contains growth chart for both girls and boys. ANM and AWW conduct regular growth monitoring by measuring weight and height of a child.

Consumption of adequate food promotes growth in a child

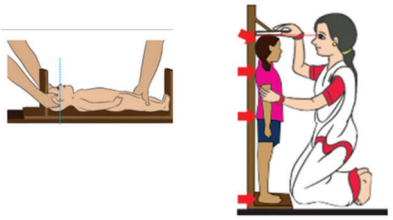




Growth Charts in MCP Card



Measuring weight of a child



Measuring height of a child

The table below provides the reference weight and height for identifying underweight and stunting

Age (month) (0–5 years)	Reference Weight for Identifying Underweight Child				Reference Height for Identifying Stunted Child			
	Boys		Girls		Boys		Girls	
	If less than this then child has low weight	Ideal weight (kg)	If less than this then child has low weight	Ideal weight (kg)	If less than this then child is stunted	Ideal height (cm)	If less than this then child is stunted	Ideal height (cm)
0	2.5	3.3	2.4	3.2	46.1	49.9	45.4	49.1
3	5	6.4	4.5	5.8	57.3	61.4	55.6	59.8
6	6.4	7.9	5.7	7.3	63.3	67.6	61.2	65.7
9	7.1	8.9	6.5	8.2	67.5	72	65.3	70.1
12	7.7	9.6	7	8.9	71	75.7	68.9	74
15	8.3	10.3	7.6	9.6	74.1	79.1	72	77.5
18	8.8	10.9	8.1	10.2	76.9	82.3	74.9	80.7
21	9.2	11.5	8.6	10.9	79.4	85.1	77.5	83.7
24	9.7	12.2	9	11.5	81.7	87.8	80	86.4
27	10.1	12.7	9.5	12.1	83.1	89.6	81.5	88.3
30	10.5	13.3	10	12.7	85.1	91.9	83.6	90.7
33	10.9	13.8	10.4	13.4	86.9	94.1	85.6	92.9
36	11.3	14.3	10.8	13.9	88.7	96.1	87.4	95.1
39	11.6	14.8	11.2	14.4	90.3	98	89.2	97.1
42	12	15.3	11.6	15	91.9	99.9	90.9	99
45	12.4	15.8	12	15.5	93.5	101.6	92.5	100.9
48	12.7	16.3	12.3	16.1	94.9	103.3	94.1	102.7
51	13.1	16.8	12.7	16.6	96.4	105	95.6	104.5
54	13.4	17.3	13	17.2	97.8	106.7	97.1	106.2
57	13.7	17.8	13.4	17.7	99.3	108.3	98.5	107.6
60	14.1	18.3	13.7	18.2	100.7	110	99.9	109.4

https://icds-wcd.nic.in/nnm/NNM-Web-Contents/LEFT-MENU/ILA/Modules/NNM-ILAmodule-08-Assessment_Growth.pdf

Monitoring Body Mass Index (>5 years of Age):

Body Mass Index (BMI) is an anthropometric index of weight and height that is defined as body weight in kilograms divided by height in meters squared.

Body Mass Index (BMI) = Body weight in kilograms/ (Height in meter)^2

BMI correlates with their proportion of body fat. Accordingly, it can be accessed if the individual is underweight, normal, overweight or obese. Both obesity and underweight are associated with health risks.

BMI Chart for 5–18 Years Age								
Age (in years)	Boys				Girls			
	Under-weight	Normal	Over-weight	Obese	Under-weight	Normal	Over-weight	Obese
5.0	<=14.7	14.7–15.7	15.7–17.5	>=17.5	<=14.3	14.3–15.5	15.5–18.0	>=18.0
6.0	<=14.9	14.9–16.0	16.0–17.8	>=17.8	<=14.5	14.5–15.9	15.9–18.6	>=18.6
7.0	<=15.1	15.1–16.3	16.3–18.2	>=18.2	<=14.9	14.9–16.4	16.4–19.3	>=19.3
8.0	<=15.5	15.5–16.7	16.7–18.8	>=18.8	<=15.3	15.3–16.9	16.9–20.1	>=20.1
9.0	<=15.9	15.9–17.3	17.3–19.6	>=19.6	<=15.8	15.8–17.6	17.6–21.0	>=21.0
10.0	<=16.4	16.4–18.0	18.0–20.5	>=20.5	<=16.5	16.5–18.4	18.4–21.9	>=21.9
11.0	<=17.0	17.0–18.7	18.7–21.5	>=21.5	<=17.2	17.2–19.3	19.3–23.0	>=23.0
12.0	<=17.7	17.7–19.5	19.5–22.6	>=22.6	<=18.0	18.0–20.2	20.2–24.1	>=24.1
13.0	<=18.2	18.2–20.2	20.2–23.4	>=23.4	<=18.8	18.8–21.1	21.1–25.2	>=25.2
14.0	<=18.7	18.7–20.8	20.8–24.2	>=24.2	<=19.4	19.4–21.8	21.8–25.9	>=25.9
15.0	<=19.3	19.3–21.4	21.4–24.9	>=24.9	<=19.9	19.9–22.3	22.3–26.3	>=26.3
16.0	<=19.9	19.9–22.0	22.0–25.5	>=25.5	<=20.3	20.3–22.6	22.6–26.5	>=26.5
17.0	<=20.5	20.5–22.6	22.6–26.0	>=26.0	<=20.6	20.6–22.9	22.9–26.7	>=26.7
18.0	<=21.1	21.1–23.2	23.2–26.6	>=26.6	<=21.0	21.0–23.2	23.2–26.8	>=26.8

Reference from IAP Growth Charts

BMI Interpretation for adults

Classification	BMI (Kg/m2)	Risk of Co-Morbidities
Underweight	<18.5	Low (but risk of other clinical problems increased)
Healthy weight	18.5–24.9	Average
Overweight	25–29.9	Increased
Obesity (class I)	30–34.9	Moderate
Obesity (class II)	35–39.9	Severe
Obesity (class III)	>=40	Very Severe

Reference from NPCDCS Guidelines

High BMI (overweight/ obesity) is a risk factor for pregnancy. Weight gain during pregnancy may differ as per the pre-pregnancy BMI status of a woman.

Annexure 3

Nutritional Requirements across Various Life Stages

Balanced diet: A balanced diet contains different types of foods (from all food groups) in such quantities and proportions that the person needs for the nutrients such as carbohydrates, proteins, fats, vitamins, minerals, water, and fiber are adequately met.

Cereals:

- Cereals are foundation of the daily diet and are rich in carbohydrates
- Foods with complex carbohydrate- Brown rice, whole wheat bread/ roti, oatmeal, beans, peas, lentils, sweet potato have high fibre (maintain regular bowel/ prevent constipation) and nutrients and low glycemic index (reduce risk of diabetes and high BP)
- Foods like sugar, jaggery, honey, fruit juice, sugar drinks, jams and jellies are low in fibre and nutrients and have high glycemic index

Pulses and legumes:

Pulses are rich in proteins which are essential for growth and repair of muscles, internal organs and skin.

Milk and milk products:

- Includes milk, yoghurt, curd, cottage cheese (paneer) etc.
- Curd and yoghurt are good for digestion as they contain probiotics

Fruits and vegetables:

- Vegetables and fruits are excellent sources of essential vitamins, minerals and antioxidants which help in protecting against infections and strengthen the immune system. Whole fruits should be preferred instead of fruit juices as it contains dietary fiber
- At least 5–7 servings of different coloured fruits and vegetables should be consumed daily

Eggs, poultry, meat and fish:

- Eggs, poultry, meat and fish are rich in protein
- Consumption of excessive fatty/ processed meat increases risk of heart diseases; eating raw egg is not advisable because of risk salmonella infection which can cause food poisoning

Fats, oils and sweets:

- Fats and oils are essential for absorption of nutrients and normal functioning of body and between 15–30% of total calories in the diet should be provided in the form of fats
- High intake of saturated fats and trans-fats increases the risk of heart diseases

Life stage	Nutritional Requirements and Diet
Infant	**First 6 months** – **Exclusive breastfeeding**. Breastfeeding is started within an hour after delivery (Early initiation of breastfeeding and colostrum feeding). The colostrum should not be discarded. Infants should be breastfed continuously until 2 years of age and beyond. **From 6 months of age**, breast milk should be complemented with a variety of adequate, safe and nutrient dense complementary foods. **Complementary foods** can be prepared at home from commonly used food materials (easy to swallow) such as cereals (wheat, rice, jowar, bajra, etc.); pulses (grams/ dals), nuts and oilseeds (groundnut, sesame, etc.), oils (groundnut oil, sesame oil etc.), sugar/ jaggery, soft foods like potatoes, porridge, cereals, or even eggs. (Observe hygienic practices while preparing and feeding the complementary food for infants.) Infants cannot eat large quantities of food at a single time so they should be fed **small quantities at frequent intervals** (3–4 times a day). A balanced diet is the key to protect child against nutritional deficiencies. ***Protein Energy Malnutrition more commonly affects children between the ages of 6 months and 5 years. Malnutrition is defined as "a state of poor nutrition caused by insufficient or unbalanced diet"***.
Growing child/ adolescents	Childhood is the most critical time for growth as well as for development of the mind and to fight infections. So, it is very essential that the children get a good dose of energy, proteins, vitamins and minerals. Children should never be starved. Development of bone mass is going on during this period **dairy products (milk, cheese, yoghurt) and vegetables** like spinach, broccoli which are **rich in calcium** must be added. Children require good amount of **carbohydrates and fats** for energy, therefore, it is important to include **energy rich foods** as whole grains (wheat, brown rice), nuts, vegetable oils, vegetables like potatoes, sweet potatoes, fruits like banana.
	Proteins are essentials for muscle building, repair and growth and building antibodies so dal, sprouts, beans, nuts, meat, eggs, fish and dairy products must be added in diet. **Vitamins** are needed for the body to function properly and to boost the immune system. Variety of fruits and vegetables of different colours can be added. **Vitamin A** is essential for vision and a deficiency of the same can lead to night blindness (difficulty in seeing in night). Dark green leafy vegetables, yellow, orange coloured vegetables and fruits (such as carrots, papaya, mangoes) are good sources of vitamin A. **Vitamin D** helps in bone growth and development and it is essential for absorption of calcium. Children get most of their vitamin D from sunlight and a small amount from some food items like (fish oils, fatty fish, mushrooms, cheese and egg yolks). **Teenage girls** experience more physiological changes and psychological stress than boys because of onset of menarche (onset of menstruation). Therefore, **teenage girls should eat diet which is rich in both vitamins as well as minerals to prevent anaemia**. Iron rich food like green leafy vegetables, legumes and dry fruits, meat, fish and poultry products should be included in diet. Also, vitamin C should be included in diet (amla, guava, lemon etc.) as it increases absorption of iron.

Life stage	Nutritional Requirements and Diet
	Tea should not be consumed within 30 minutes of eating meals as it prevents absorption of iron and calcium. In addition to consumption of a nutritious well-balanced diet, **appropriate lifestyle practices and involvement in outdoor activities** should be encouraged. **Regular physical exercises** increase strength and stamina and are necessary for good health and well-being. **Exposure to sunlight** is essential as it helps maintain vitamin D which helps in calcium absorption. **Plenty of fluids** should be taken during illness, especially during and after episodes of infections. Drinking 2–2.5 liters of water to hydrate the body is important. It is preferred to have water/ buttermilk/ lassi/ fruit juices/ coconut water over soft drinks and other packaged drinks.
Pregnant and lactating mother	During pregnancy and lactation, the nutritional requirement increases. The nutritional requirement of a pregnant woman keeps changing depending upon the various trimesters of pregnancy. **A pregnant woman requires an extra of 200–300kcal/ day (from second trimester) in addition to the regular diet.** Apart from regular dietary intake with adequate whole grains, protein sources, vegetables, fruits and fats pregnant and lactating woman require additional considerations. **Micronutrients (like folic acid/ iron tablets)** are especially required in extra amounts to reduce the risk of malformations in baby and increase birth weight of baby and to prevent anaemia in expecting mothers. Nutritional intake is in addition with routine IFA supplementation. **Green leafy vegetables, legumes, nuts, jaggery and liver are good sources of folic acid and should be consumed especially 3 months before conception, and during the first 3 months of pregnancy to protect the baby from birth defects**. The daily requirement of folic acid is 400 mcg. Sources of iron include green leafy vegetables, legumes and dry fruits, meat, fish and poultry products. Apart from this **vitamin C – rich fruits** like gooseberries (amla), guava, lemon, oranges and citrus rich fruits are required for better absorption of iron from your diet. Diet should contain **calcium – rich foods** such as milk, yogurt, cheese, green leafy vegetables, legumes and seafood. At least 2 glasses of milk, or curd or 60 gm paneer/day Iodine deficiency during pregnancy results in still births, abortions and cretinism, therefore, use of **iodized salt** in food is recommended. **Vitamin A** (mango, papaya, eggs, tomato, carrot, orange, fenugreek leaves, milk and milk products) **is required during lactation to improve child survival. Vitamin B12** (fish, egg yolk, milk, cheese, yoghurt) **and C are also needed to be taken by lactating mother**. Pregnant woman should be encouraged to eat more food both in quality and quantity. Adequate water intake is important (at least 10–12 glasses a day) Emphasize – Do not consume alcohol and tobacco. It is harmful for the health of mother as well as child. Papaya fruit is strongly suspected to lead to abortion, though there is no scientific basis.
Adult male and female	A healthy diet for adults contains: Fruits, vegetables, legumes (e.g. lentils, beans), nuts and whole grains (e.g. unprocessed maize, millet, oats, wheat, brown rice). **At least 400 grams (5 portions) of fruits and vegetables a day**. Potatoes, sweet potatoes, cassava and other starchy roots are not classified as fruits or vegetables. **Unsaturated fats** (e.g. found in fish, avocado, nuts, sunflower, canola and olive oils) are preferable to saturated fats (e.g. found in fatty meat, butter, palm and coconut oil, cream, cheese, ghee and lard). Industrial trans fats (found in processed food, fast food, snack food, fried food, frozen pizza, pies, cookies, margarines and spreads) are not a part of a healthy diet.

Life stage	Nutritional Requirements and Diet
	Less than 5 g of salt (equivalent to approximately 1 teaspoon) per day and use iodized salt. Salt usage should be in moderation as high intake of salt might lead to high blood pressure and can weaken bones due to leaching of calcium. **Preserved foods such as pickles/ papads and also canned foods should be avoided** as it contributes to higher intake of salt. **An adult female should take a diet which is rich in calcium** (milk & other dairy products) as well as iron (green leafy vegetables-spinach etc.). Usage of saturated fats and trans-fats such as ghee, butter, cheese, vanaspati ghee should be limited and diet should contain more of fibrous food in the form of whole grains, vegetables and fruits.
Elderly people (>60 years age)	Elderly people need more of vitamins and minerals (calcium, iron, zinc, vitamin A and antioxidants to prevent age-related degenerative diseases and for healthy ageing) to be healthy and active and less calories as their lean muscle mass and physical activity decrease with ageing. Regular exercise as it helps to regulate body weight and flexibility in the joints and reduces risk of degenerative diseases Diet for elderly should be soft, less salty and spicy, with inclusion of dietary fibers, fruits and vegetables and calcium rich foods (low fat milk etc.) to maintain bone health and prevent osteoporosis and bone fractures. To prevent wear and tear of tissues consumption of pulses, toned milk, egg-white etc. in good quantities can be encouraged as they are rich in proteins. In addition, saturated fats, sweets, oily food, spicy food, salt and sugar should be cut down. Eat small quantities of food at more frequent intervals

Do's and don'ts for cooking/ eating food

Do's	Don'ts
Wash your hands with soap before you begin cooking, serving or eating.	DO NOT keep raw or cooked food at room temperature for longer than 2 hours.
Wash all utensils before use. You can use one tsp of household bleach in 1 liter of water to clean them. Rinse utensils well.	DO NOT keep cooked food in the fridge for more than 2 days. Reheat food well before eating it.
Soak all vegetables and fruits in salt water for some time, rinse and wash, before peeling and cutting. Throw the salt water used for soaking.	Limit the intake food with very high content of fat, sugar, or salt, like potato chips, achar, mithai, samosa, kachori, deep fried foods. DO NOT re-use or overheat oils. Limit use of Dalda.
Eat 3 meals and 2–3 snacks every day that are low in sugar and salt.	Avoid foods containing trans-fat, such as packaged namkeens, chips, cakes etc.
Enjoy variety of foods from 4 food groups everyday – **grain products (wheat, rice, ragi, bajra, jowar), milk and alternatives, vegetables and fruits, fish/ meat or soybeans/ mushrooms/ lentils**.	DO NOT consume raw or half boiled eggs/ unboiled milk.
Use a mixture of mustard oil and rice bran oil or mustard oil and groundnut oil, to ensure adequate amount of Omega 3 and Omega 6 fatty acids in your diet.	DO NOT take more than 2 cups of tea or coffee in a day.

Annexure 4

Nutritional Anaemia*

Anaemia is a condition in which the number of red blood cells or their oxygen-carrying capacity is insufficient to meet the body's physiological requirements. The manifestations of anaemia vary by the severity and range from fatigue, weakness, dizziness and drowsiness to impaired cognitive development of children and increased morbidity. Anaemia in pregnancy is associated with postpartum haemorrhage, neural tube defects, low birth weight, premature births, stillbirths and maternal deaths. In malaria endemic regions, anaemia is one of the most common preventable causes of maternal and child deaths. In its most severe form, anaemia can also lead to death. There are many causes of anaemia, out of which iron deficiency is most common.

Anaemia may be categorized as mild, moderate and severe.

Particulars	Anaemia (HB level)		
	Mild	Moderate	Severe
Children 6–59 months of age (under 5)	10–10.9	7–9.9	<7
Children 5–11 years of age	11–11.4	8–10.9	<8
Children 12–14 years of age	11–11.9	8–10.9	<8
Non-pregnant women (>=15 years of age)	11–11.9	8–10.9	<8
Pregnant women	10–10.9	7–9.9	<7
Men (>=15 years of age)	11–12.9	8–10.9	<8

Prophylactic Iron and Folic Acid (IFA) supplementation:

Particulars	IFA Supplementation
Children 6–59 months	IFA syrup (1 ml), biweekly Each ml containing 20 mg elemental iron + 100 mcg of folic acid
Children 5–9 years	Weekly IFA (pink) tablet Each tablet containing 45 mg elemental iron + 400 mcg folic acid
Adolescents 10–19 years	Weekly IFA (blue) tablet Each tablet containing 60 mg elemental iron + 500 mcg folic acid
Women of reproductive age (non-pregnant and no-lactating)	Weekly IFA (red) tablet Each tablet containing 60 mg elemental iron + 500 mcg folic acid
Pregnant and lactating women	Daily, 1 IFA tablet starting from the fourth month of pregnancy, continued throughout pregnancy (minimum 180 days during pregnancy) and to be continued for 180 days, postpartum

*Source: Operational Guidelines Anaemia Mukt Bharat

Prophylaxis with iron should be withheld in case of acute illness (fever, diarrhoea, pneumonia, etc.)

Deworming:

Particulars	Deworming Protocol
Children 12–59 months	Biannual dose of 400 mg albendazole (½ tablet to children 12–24 months and 1 tablet to children 24–59 months)
Children 5–9 years; Adolescents 10–19 years; Women of reproductive age (non-pregnant and non-lactating)	Biannual dose of 400 mg albendazole (1 tablet)
Pregnant and lactating women	One dose of 400 mg albendazole (1 tablet), after the first trimester, preferably during the second trimester

Anaemia Management protocol:

Particulars	Anaemia Management	
	Mild and Moderate Anaemia	Severe Anaemia
Children 6–59 months	3mg of iron/ kg/ day for 2 months ✿ 6–12 months (6–10.9 kg): 1 ml IFA syrup, once a day ✿ 1–3 years (11–14.9 kg): 1.5 ml IFA syrup, once a day ✿ 3–5 years (15–19.9 kg): 2 ml IFA syrup, once a day Refer if no response after 2 months Follow up – every month by ANM/ CHO	Refer urgently to DH/ FRU
Children 5–9 years	3mg of iron/ kg/ day for 2 months Refer if no response after 2 months Follow up – after 30 days and 60 days at nearest health facility	Refer urgently to DH/ FRU
Adolescents 10–19 years	Two IFA tablets once daily for 3 months after meals Refer if no response after 3 months Follow up – after 45 days and 90 days at nearest health facility	Refer urgently to DH/ FRU
Pregnant and lactating women	Two tablets of IFA tablet daily, orally Parental iron may be considered as the first line of management in whom compliance is likely to be low (high chance of lost to follow-up) Refer if no response after 1 month (mild cases); 2 months (moderate cases) Follow up – every 2 months by health provider	Refer immediately (immediate hospitalization is needed)

Annexure 5
Non-Communicable Diseases

Background

In past years there has been an increasing trend of non-communicable diseases, also called as lifestyle diseases. Diet and lifestyle are two major factors thought to influence susceptibility to many diseases. Drug misuse, tobacco use, smoking and alcohol drinking, as well as lack of exercise may increase the risk of developing certain diseases, especially in the middle age or beyond.

There is a common misconception that NCDs do not affect adolescents, however, NCDs and their risk factors have an enormous impact on the health of adolescents. Adolescents are often targeted by companies advertising fast food, tobacco or alcohol, and many grow up today in environments that are not conducive to them adopting healthy lifestyles (e.g. parental use of tobacco and alcohol, peer pressure). Many health-related behaviours that usually start in adolescence (tobacco and alcohol use, obesity, and physical inactivity) contribute to the epidemic of non-communicable diseases in adults.

Adolescence is also the time when vast majority of risk behaviours and addictions set in, resulting in acquiring NCDs in later life. A life-course approach is thus a cornerstone to effectively prevent NCDs in adults.

Key non-communicable diseases:

- Cancers
- Cardiovascular diseases (CVD) including hypertension
- Chronic respiratory diseases including asthma
- Diabetes
- Obesity

Risk factors for non-communicable diseases

Modifiable Risk Factors	Non-Modifiable Risk Factors
Tobacco use (in any form) Alcoholism Physical inactivity or sedentary lifestyle Overweight/ obesity High blood pressure High cholesterol levels High blood glucose level Unhealthy diet, (lack of fruits and vegetables) Stress Certain infections that can lead to cancer Environmental pollution Occupational exposures to toxins	Age Sex Family history Genetic factors and Type A (anxious) personality

Diseases	Modifiable Risk Factors
Heart disease	Smoking, Hypertension, High fatty diet, Diabetes, Obesity, Sedentary habits, Stress
Cancers	Smoking, Alcoholism, Solar radiation, Ionizing radiation, Environmental pollution, Infectious agents, Dietary factors, Obesity
Stroke	High BP, Elevated cholesterol, Smoking, Obesity/ overweight
Diabetes	Obesity, Diet

Tobacco use

Adolescent smokers have 2–3 times higher risk of Coronary Heart Disease (CHD), 1.5 times of stroke, 1.4 times of Chronic Obstructive Pulmonary Disease (COPD) and 12 times higher risk of lung cancer.

Alcohol use

During adolescence, many people begin to experiment with alcohol. It has been particularly linked to cancer, cardiovascular diseases, liver disease and mental disorders in extreme cases.

Physical inactivity

Evidences reveal that physical inactivity increases the risk of many NCDs such as heart diseases, type 2 diabetes, breast and colon cancers. This results in shortened life expectancy.

Food habits

The main eating disorders include dieting, fasting and avoiding food for achieving intended body type (may be termed as Anorexia). While there is no one cause of eating disorders, genetic vulnerabilities, psychological factors like low self-esteem, cultural factors (one that promotes thinness and dieting) and stress appear to play a role in the development of eating disorders.

Food disorders among the adolescent may manifest in following forms:

- **Physical changes**: Weight gain/ loss, general lethargy, looking pale and gaunt, feelings of dizziness, dehydration, sleep difficulties, dental decay, and disturbed menstruation in females.
- **Behavioural changes:** Frequent weighing, secret eating habits, wearing loose clothes to conceal weight loss, denial of the problem, attempting to harm oneself, withdrawing from social and family life.
- **Psychological signs:** Expressing fear of gaining weight, foods and bodily changes, self-loathing, expressions of guilt, changes in mood and loss of motivation and enthusiasm for life.

Annexure 6

Right Sequence of Conversation with Adolescents (HEADS Assessment)

Counselors should always start the conversation with the most non-threatening issues. Ask about name, residence, family, education etc. before proceeding on to other questions.

It is also important that counselors go through step by step or directly on the concerned issues based on their primary observations and understanding with the adolescent.

H	Home	Where do they live? With whom do they live? Whether there have been recent changes in their home situation? How they perceive their home situation?
E	Education/ Employment	Whether they study or work? How do they perceive their performance? How do they perceive their relationship with their teachers/ fellow students/ employees/ colleagues? Has there been any recent change in their situation? What do they do during breaks?
	Eating patterns/ Habits	How many meals do they have on a normal day? What do they eat for each meal? What do they think and feel about their bodies?
A	Activity and leisure time	What activities are they involved in outside study/ work? What do they do in their free time-during weekdays and on holidays? Whether they spend some time with family members and friends?
D	Drugs/ Substance misuse	Do they use tobacco, alcohol or other substances? Whether they inject any substances? If they use any substances, how much do they use; when and where and with whom do they use them?
S	Sexuality/ Sexual and Reproductive Health	What do they know about sexual and reproductive health? What do they know about their menstrual period? Any questions and concerns that they have about their menstrual period? What are their thoughts and feelings about sexuality? Are they sexually active; if so, the nature and context of their sexual activity? Are they taking steps to avoid sexual and reproductive health problems? Have they encountered any problems such as unwanted pregnancy, infection, sexual coercion? If so, they have received any treatment for it? What is their sexual orientation?

Annexure 7

Summary of Contraceptive Basket under National Family Planning Programme

Name of Method	Spacing/ Limiting	Type of Method	How to Use	Benefits	Side Effects/ Limitations	Who can Use
Female Contraceptives						
Combined Oral Contraceptive Pill (CoCs) **(MALA-N)**	Spacing: Short term, reversible method	Hormonal method Contains Oestrogen and Progesterone hormone	Daily oral pill **Interval:** Anytime of menstrual cycle, if not pregnant **Postpartum:** after 6 months **Post abortion:** Immediately	Protects against anaemia, cancer of the genital tract, PCOD (Poly cystic ovarian disease)	✿ Menstrual changes like irregular periods. These are temporary changes and settle down in few months. ✿ Cannot be used by breastfeeding women till 6 months after delivery ✿ Does not protect against RTI/ STI including HIV/ AIDS	✿ Women of any age including those ■ having anaemia due to heavy menstrual bleeding ■ an irregular menstrual cycle ■ have just had an abortion/ miscarriage
Centchroman **(Chhaya)**	Spacing: Short term, reversible method	Non-hormonal Does not contain hormone	Weekly oral pill **Interval:** Any time, if not pregnant **Postpartum:** as soon as comfortable after delivery **Post abortion:** Immediate	Can be used by women who cannot tolerate hormonal methods	✿ Causes delayed periods. These are temporary changes and settle down in few months. ✿ Does not protect against RTI/ STI including HIV/ AIDS	✿ Women of any age including those ■ Just had delivery or abortion ■ have not had children ■ Have just had an abortion/ miscarriage ■ Breastfeeding women ■ Smokers, regardless of age

Name of Method	Spacing/ Limiting	Type of Method	How to Use	Benefits	Side Effects/ Limitations	Who can Use
Emergency Contraceptive Pill **(Ezy Pill)**		Hormonal Contains Levonorgestrel	Within 72 hours of unprotected sexual intercourse	Can be used by women in cases like condom tear, missed pill etc.	✿ Not a regular method of contraception ✿ Does not protect against RTI/ STI	Women of any age who need contraception in emergency.
Progestin Only Pills **Introduced in pilot states only**	Spacing: Short term, reversible method	Hormonal Contains levo norgestrol/ desogestrol	Daily oral pill **Postpartum:** as soon as possible after delivery within 4 weeks of delivery Effective with breast feeding and therefore require switching after 6 months of delivery	✿ Can be used while breastfeeding ✿ Can be stopped any time without provider's help ✿ Are controlled by the woman ✿ Do not interfere with sexual intercourse ✿ Pelvic exam not required before use	✿ May cause changes in menstrual pattern in form of irregular/ prolonged/ no bleeding. ✿ May also cause other side effects, like headache, dizziness, breast tenderness abdominal pain etc. which are not harmful ✿ Does not provide protection against RTI/ STIs including HIV ✿ Must be taken every day & at same time ✿ Require regular/ dependable supply	Nearly all women can safely use, including women who: ■ Are breastfeeding ■ Have or have not had children ■ Smoker, regardless of age
Intra Uterine Contraceptive Device (IUCD): IUCD 380A IUCD 375	Spacing: Long term Reversible Method	Non-hormonal Copper bearing device	One-time method inserted in uterus by trained provider **Interval:** Anytime if not pregnant **Postpartum:** with 48 hour (PPIUCD) **Post Abortion:** Within 12 days of completion of abortion	✿ Can be used for spacing or limiting ✿ Provides protection from pregnancy: IUCD 380A- protect for 10 years IUCD 375-protect for 5 Years ✿ Long-term, highly effective reversible protection against pregnancy ✿ Effective immediately after insertion	✿ Increase in the duration/ amount of menstrual bleeding or spotting or abdominal cramps during the first few days or months after insertion. These are temporary changes and settle down in few months. ✿ Does not protect against RTI/STI ✿ Immediate return of fertility upon removal of IUCD ✿ No drug interaction ✿ May help protect against endometrial and cervical cancer	Nearly all women can safely use, including- ✿ Have just had a delivery (PPIUCD) or an abortion (PAIUCD) (if no evidence of infection) ✿ Breastfeeding women

Name of Method	Spacing/ Limiting	Type of Method	How to Use	Benefits	Side Effects/ Limitations	Who can Use
				✿ Suitable for use by most women ✿ Safe for use in breastfeeding women ✿ One-time cost-effective procedure ✿ No requirement of daily attention or special attention before sexual intercourse		
Injectable MPA (**Antara Programme)**	Spacing: Long Term Reversible Method	Hormonal Contains Progesterone	3 monthly Intramuscular Injection **Interval:** Anytime, if not pregnant **Postpartum:** at 6 weeks after delivery **Post Abortion:** Immediate	✿ Provides protection from pregnancy for 3 months ✿ Improves anaemia, menstrual cramps, pelvic inflammatory disease	✿ Menstrual Changes like irregular/ prolonged bleeding, and eventually amenorrhea. These are temporary changes and settle down on discontinuation of method. ✿ Decrease in bone mineral density however, this is reversible and normalizes upon discontinuation. ✿ Does not provide protection against RTI/STIs/HIV.	✿ Women of any age including those ■ Have or have not had children ■ Married/Unmarried women ■ Have just had an abortion/ miscarriage ■ Breastfeeding women ■ Smokers, regardless of age
Female sterilization	Limiting: Perma-nent method	Surgical	One-time surgical procedure **Interval:** Anytime if not pregnant **Postpartum/ Post Abortion:** immediately or within 7 days of delivery/abortion	Provides life-long protection from pregnancy	✿ No method related side effects	✿ Women who have completed their families or have at least one child whose age is above one year ✿ Breastfeeding women ✿ Undergone delivery or abortion

Name of Method	Spacing/ Limiting	Type of Method	How to Use	Benefits	Side Effects/ Limitations	Who can Use
Male Contraceptives						
Condoms	Spacing	Non-hormonal Rubber covering made of latex	Worn on penis before sexual contact	✿ Provides dual protection from pregnancy and STI/ RTI including HIV/ AIDS ✿ Easy to keep stock handy, ✿ may be used without consulting health provider ✿ improves male participation	✿ Latex condoms may cause itching for a few people who are allergic to latex ✿ Some men or women may feel that it interferes with their sexual pleasure ✿ A new condom is required for every act of intercourse because it cannot ✿ Supplies must be readily available, to be used before intercourse	✿ Men of all reproductive ages
Male sterilization	Limiting: Perma-nent method	Surgical	One-time surgical procedure	✿ Very effective, permanent procedure ✿ Does not interfere with sexual intercourse/sexual pleasure ✿ No repeat clinic visits, no supplies needed ✿ No change in sexual function/ desire	✿ Not effective immediately after the procedure. The couple needs to use a backup method such as condom for the first 3 months after the procedure for the semen to be sperm free ✿ A minor surgery by a trained provider ✿ Does not protect against STIs and HIV ✿ Scrotal support to be maintained for the initial few days to prevent pain at the operation site	✿ Men who have completed their families and have at least one child whose age is above one year

Annexure 8

Application cum Consent Form for Sterilization Operation

An informed consent is to be taken from all clients of sterilization before the performance of the surgery as per the consent form placed below

Name of Health Facility: .....

Client Hospital Registration Number: .....

Date: ...../..... /20.....

1. Name of the Client: Shri/Smt .....
2. Name of Husband/Wife: Shri/Smt .....
3. Address .....
4. Contact No: .....
5. **Names of all living, unmarried dependent children**
   - i) ..... Age .....
   - ii) ..... Age .....
   - iii) ..... Age .....
   - iv) ..... Age .....
6. Father's Name of beneficiary: Shri .....
7. Address: .....
8. Religion/Nationality: .....
9. Caste- SC/ST/General: .....
10. Status- APL/BPL: .....
11. Educational Qualifications .....
12. **Business/Occupation:** .....
13. **Operating Centre:** .....

I, Smt/Shri ..... (client) hereby give consent for my sterilization operation. I am ever married. My age is ..... **years** and my husband/wife's age is ..... **years**. I have ..... (Nos.) male and ..... (Nos.) female living children. The age of my youngest living child is ..... years.

I am aware that I have the option of deciding against the sterilization procedure at any time without sacrificing my rights to other reproductive health services.

a) I have decided to undergo the sterilization / re-sterilization operation on my own without any outside pressure, inducement or force. I declare that I / my spouse has not been sterilized previously (**may not be applicable in case of re-sterilization**).

b) I am aware that other methods of contraception are available to me. I know that for all practical purposes this operation is permanent and I also know that there are still some chances of failure of the operation for which the operating doctor and health facility will not be held responsible by me or by my relatives or any other person whomsoever

c) I am aware that I am undergoing an operation, which carries an element of risk.

d) The eligibility criteria for the operation have been explained to me and I affirm that I am eligible to undergo the operation according to the criteria.

e) I agree to undergo the operation under any type of anesthesia, which the doctor/health facility thinks suitable for me and to be given other medicines as considered appropriate by the doctor/health facility concerned. I also give consent for any additional life-saving procedure, if required

f) If, after the sterilization operation, I experience a missed menstrual cycle, then I shall report within two weeks of the missed menstrual cycle to the doctor/health facility and may avail of the facility to get an MTP done free of cost.

g) **In case of complications attributable to sterilization operation, including failure and the unlikely event of death attributable to sterilization, I/my spouse and dependent unmarried children will accept the compensation as per the existing provisions of the Government of India "Family Planning Indemnity Scheme" as full and final settlement and will not be entitled to claim any other compensation including compensation for upbringing of the child, if any, born on account of failure of sterilization, over and above the one offered, from any court of law in this regard**.

h) I agree to come for follow-up visits to the Hospital/Institution/Doctor/health facility as instructed, failing which I shall be responsible for the consequences, if any.

i) I understand that Vasectomy does not result in immediate sterilization. *I agree to come for semen examination **3 months after the operation** to confirm the success of sterilization surgery (Azoospermia) failing which I shall be responsible for the consequences, if any. (* **Applicable for male sterilization cases**)

I have read the above information.

The above information has been read out and explained to me in my own language and that this form has the authority of a legal document.

Date: ..... Signature or Thumb Impression of the Client

Name of client:.....

Signature of Witness (Clients side):

Full Name:.....

Full Address.....

I am aware that client is ever married and has 1 living child over one year of age

Signature of Motivator/ ASHA/ Counselor: .....

Full Name:.....

Full Address.....

I certify that I have satisfied myself that–

a. Shri/Smt..... is within the eligible age-group and is medically fit for the sterilization operation.

b. I have explained all clauses to the client and that this form has the authority of a legal document.

c. I have filled the Medical record-cum-checklist and followed the standards for sterilization procedures laid down by the Government of India.

Signature of Operating Doctor — Signature of Medical Officer in-charge of the Facility

(Name of Operating Doctor) — (Name of Medical Officer in-charge of the Facility)

Date: ..... **Date:** .....

Seal **Seal**

DENIAL OF STERILIZATION

I certify that Shri/Smt.....is not a suitable client for sterilization/resterilization for the ATTRIBUTABLE TO reasons:

1. .....

2. .....

He/ She has been advised the ATTRIBUTABLE TO alternative methods of contraception.

1. .....

2. .....

Signature of the Doctor making the decision

Date: ..... **Name and full Address: .....**

Annexure 9

Sterilization Post-Operative Instruction Card

Name and Type of Hospital/ Facility	
Client's name	
Father's name	
Husband's name/Wife's Name	
Address	
Contact number (if available)	
Date of operation	/ / (D/M/Y)
Type of operation	Minilap/ Postpartum/ Laparoscopic (SP/DP)/ Conventional Vasectomy/ NSV

1. Follow-up:
   a) After 48 hours, first contact is established
   b) On the 7th day for stitch removal
   c) **Female sterilization**: After one month or after first menstrual period, whichever is earlier **Male sterilization**: After 3 months, for semen examination for sperm count
   d) In an emergency, as and when required to the nearest health facility
2. Medication as prescribed:
3. Return home and rest for the remainder of the day.
4. **Female sterilization:** Resume only light work after 48 hours and gradually return to full activity in two weeks following surgery.
5. **Male sterilization:** Scrotal support or snug undergarment for 48 hours; Resume normal work after 48 hours and return to full activity, including cycling, within one week following surgery.
6. Resume normal diet as soon as possible.
7. Keep the incision area clean and dry. Do not disturb or open the dressing.
8. Bathe after 24 hours following the surgery. If the dressing becomes wet, it should be changed so that the incision area is kept dry until the stitches are removed.
9. **Sexual intercourse:** Vasectomy/ Tubectomy does not interfere with sexual pleasure, ability, or performance

   Female sterilization: In the case of interval sterilization, the client may have intercourse one week after surgery, or whenever she feels comfortable. In the case of postpartum sterilization (after caesarian or normal delivery), the client may have intercourse two week after surgery or whenever she feels comfortable.

Male sterilization: The client may have intercourse whenever he is comfortable after the surgery but must ensure use of condom if his wife/ partner is not using contraception

10. Report to the doctor or clinic if there is excessive pain, fainting, fever, bleeding or pus discharge from the incision, or if the client has not passed urine, not passed flatus and experiences bloating of the abdomen.
11. Contact health personnel or a doctor in case of any doubt.

    Female sterilization: Return to the clinic if there is any missed period/suspected pregnancy, within two weeks to confirm pregnancy.

    Male sterilization: Return to the facility after three months for semen examination to see if azoospermia has been achieved.

Follow-up report

Follow Up	Time after Surgery	Date of Follow-Up	Complications, if Any	Action Taken
1st	48 hours			
2nd	7th day			
3rd	1 month after surgery or after the first menstrual period, whichever is earlier (Female sterilization)			
	After 3 months for semen examination (Male sterilization)			
Emergency				

Comment

Result of Semen Examination:

Name.....

Designation.....

Signature of the person filling out the report

Annexure 10
Sterilization Certificate

Hospital Registration No. (IPD/OPD) _____

1. This is to certify that Smt/ Shri.....

   S/O; W/O Shri.....

   working as.....

   residing at ..... has undergone Minilap Tubectomy – (Interval/ Post-Partum/ Post Abortion/ Concurrent with other procedures)//Laparoscopic Tubal Occulsion (Interval/ Post Abortion/ Concurrent with other surgeries)/ Vasectomy Conventional/ NSV) in this facility hospital .....

   (Name of facility/Hospital) on.....

   by Dr .....

For Female Sterilization:

2. She has resumed her menstrual Cycle (LMP.....)/ completed one month after sterilization (applicable in case of postpartum sterilization)/negative pregnancy test (in case where no menstruation after one month of interval sterilization).

For Male Sterilization:

3. His semen examination undertaken on (Date) ..... revealed no sperm (azoospermia)

*Strike out whichever is not applicable

She/ He is therefore certified to be sterile

Signature of Medical Officer I/c

Name.....

Date .....

Seal .....

Note:

- Client should acknowledge 'received' on the duplicate copy before receiving the original copy. The duplicate to be maintained as a record in the facility as per state norms.

Annexure 11

Changes and Essential Care during All Three Trimester of Pregnancy

Trimester	Development of Foetus/ Baby	Trimester Wise Changes in Mother	Education and Counseling Regarding Care during Pregnancy
First Trimester Week 1–Week 12	✿ The baby is conceived when a sperm enters the egg. The sex of the baby is determined at this stage ✿ **The first trimester is the most crucial for baby's development.** During this period, baby's body structure and organ systems develop. ✿ The spinal cord, brain, heart, and lungs grow and develop rapidly during the first trimester. In addition, the mouth, nose, eyes, ears, toes, and fingers begin to form. Baby's heart will begin to beat around week 6. However, it sometimes cannot be heard until around week 10–12.	✿ Tiredness ✿ Tender, swollen breasts, nipples might also stick out. ✿ Upset stomach with or without throwing up, nausea (morning sickness) ✿ Cravings or distaste for certain foods ✿ Mood swings ✿ Constipation (trouble having bowel movements) ✿ Need to pass urine more often ✿ Headache ✿ Heartburn ✿ Weight gain or loss	✿ As the woman's body changes, she might need to make changes in her daily routine, such as going to bed earlier or eating frequent, small meals. Fortunately, most of these discomforts will go away as the pregnancy progresses. **Note:** Some women might not feel any discomfort at all. If women have been pregnant before, she might feel differently in next pregnancy. Just as each woman is different, so is each pregnancy. ✿ **Diet:** Two meals, breakfast and evening snacks. Rich in proteins, iron, calcium, vitamins, inclusion of sprouted legumes, pulses, green leafy and other vegetables, seasonal fruits, milk and milk products. ✿ **Eat small and frequent meals which is less spicy** ✿ Consumption of Iodized salt ✿ Consumption of folic acid tablets in first 12 weeks, IFA tablets after 12 weeks for 180 days for anaemia prophylaxis.

Trimester	Development of Foetus/ Baby	Trimester Wise Changes in Mother	Education and Counseling Regarding Care during Pregnancy
	✿ Baby may begin to move, but fetal movements cannot be felt in first trimester. ✿ **Most miscarriages and birth defects occur during this period.**		✿ Tetanus Toxoid 2 doses/ booster dose. ✿ One tablet twice a day (total 1 gm calcium daily) from second trimester (14 weeks) onwards throughout pregnancy for 6 months (360 tablets) and continued for 6 months after delivery (360 tablets) ✿ **Rest:** 2 hours in afternoon and 8 hours at night in lateral position. ✿ **Exercise:** Walking for 30 minutes daily. ✿ **Habits:** Avoid tobacco in any form, avoid alcohol. ✿ Practice safe sex. ✿ **Self-reporting of danger signals,** e.g. Abdominal pain, severe headache, giddiness, palpitations, easy fatigability, breathlessness, fever, generalized edema, vaginal bleeding, watery discharge per vaginum, blurred vision
Second Trimester Week 13 – Week 28	✿ In the second trimester, baby's hair, including eyebrows and eyelashes, begins to grow. Muscles and bones continue to develop, allowing more movement. ✿ By second trimester all essential organs have formed	✿ Body aches, such as back, abdomen, groin, or thigh pain ✿ Stretch marks on abdomen, breasts, thighs, or buttocks ✿ Darkening of the skin around nipples ✿ A line on the skin running from belly button to pubic hairline	✿ The second trimester of pregnancy is often called the "golden period" because many of the unpleasant effects of early pregnancy disappear. ✿ During the second trimester, woman is likely to experience decreased nausea, better sleep patterns and an increased energy level.

Trimester	Development of Foetus/ Baby	Trimester Wise Changes in Mother	Education and Counseling Regarding Care during Pregnancy
	✿ Woman may begin to feel movement of baby during the fifth month (18–22 weeks) ✿ By about week 18, babies' heartbeat can be heard (Fetal heart sound)	✿ Patches of darker skin, usually over the cheeks, forehead, nose, or upper lip. Patches often match on both sides of the face. This is sometimes called the mask of pregnancy. ✿ Numb or tingling hands, called carpal tunnel syndrome ✿ Itching on the abdomen, palms, and soles of the feet. ✿ Swelling of the ankles, fingers, and face. ✿ Kicking or movement of baby	Emphasize on following messages: ✿ Avoid heavy work and jerky travel on bad roads. ✿ IFA and calcium supplementation ✿ Adequate rest, regular exercise ✿ Identification of danger signs ✿ Importance of institutional delivery, safe delivery, inform Toll Free No.102 and 108 for free ambulance service, JSY, JSSK and other benefits, plan for place of delivery, preparation for delivery. ✿ Importance of early initiation of colostrum feeding within one hour of birth & exclusive breastfeeding for 6 months, child immunization ✿ Educate on contraception especially postpartum contraceptive choices. ✿ Identify birth companion and prepare birth preparedness plan
Third Trimester Week 29 – Week 40	✿ Early in the third trimester, the baby may begin to recognize the sound of mother and father. ✿ There will be a lot of moving during the third trimester. ✿ Woman should be able to feel about 10 movements per hour. ✿ Babies begin "practising" breathing during the third trimester by moving their diaphragm. ✿ Woman may find that baby gets the hiccups from time to time.	✿ Body aches, such as back, abdomen, groin, or thigh pain ✿ Stretch marks on your abdomen, breasts, thighs, or buttocks ✿ Darkening of the skin around your nipples ✿ A line on the skin running from belly button to pubic hairline ✿ Patches of darker skin, usually over the cheeks, forehead, nose, or upper lip. Patches often match on both sides of the face. This is sometimes called the mask of pregnancy.	Emphasize on following messages: ✿ IFA and calcium supplementation ✿ Importance of institutional delivery, safe delivery, inform Toll Free No.102 and 108 for free ambulance service, JSY, JSSK and other benefits, plan for place of delivery, preparation for delivery. ✿ Adequate rest, regular exercise ✿ Identification of danger signs ✿ Importance of early initiation of colostrum feeding within an hour of birth & exclusive breastfeeding for 6 months, child immunization

Trimester	Development of Foetus/ Baby	Trimester Wise Changes in Mother	Education and Counseling Regarding Care during Pregnancy
		✿ Numb or tingling hands, called carpal tunnel syndrome ✿ Itching on the abdomen, palms, and soles of the feet. ✿ Swelling of the ankles, fingers, and face. ✿ Constipation (trouble having bowel movements) ✿ Need to pass urine more often	✿ Educate on contraception especially Postpartum contraceptive choices. ✿ Identify birth companion and prepare/ revisit birth preparedness plan **A pregnancy that goes beyond 42 weeks is considered past the due date. At this time, the doctor may induce labor. If the pregnancy has gone beyond 40 weeks, the woman should contact doctor/ health-care provider.**

High Risk Pregnancy: Though complication/s could develop during any pregnancy, childbirth or postpartum period, but in pregnancies with high-risk factors, there are higher chances of complications to develop and endanger the lives of mothers and their babies. Some common high-risk conditions of pregnancy are:

- ✿ SEVERE ANAEMIA (HB LESS THAN 7GM/DL)
- ✿ PREGNANCY INDUCED HYPERTENSION, PRE-ECLAMPSIA, PRE-ECLAMPSIC TOXEMIA
- ✿ SYPHILIS/ HIV POSITIVE
- ✿ Gestational Diabetes Mellitus
- ✿ HYPOTHYROIDISM
- ✿ YOUNG PRIMI (LESS THAN 20 YEARS) OR ELDERLY GRAVIDA (MORE THAN 35 YEARS)
- ✿ TWIN/ MULTIPLE PREGNANCY
- ✿ MALPRESENTATION OF FOETUS
- ✿ PREVIOUS CAESARIAN DELIVERY
- ✿ LOW LYING PLACENTA, PLACENTA PREVIA
- ✿ BAD OBSTETRIC HISTORY (HISTORY OF STILL BIRTH, ABORTION, CONGENITAL

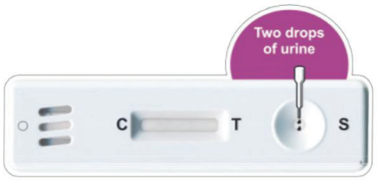
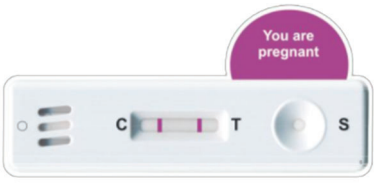
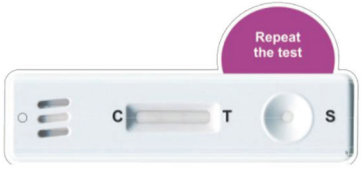
Annexure 12

Tools and Techniques for Ascertaining Pregnancy

1) Pregnancy testing kit

The Nishchay kit contains the following:

- A test card
- A disposable dropper
- A moisture absorption packet (not required for testing)

	✿ Collect the morning urine in a clean and dry glass or in a plastic bottle ✿ Take two drops of urine in the sample well ✿ Wait for 5 minutes
	✿ If two violet colour lines come in the test region (T), the woman is pregnant ✿ If she wants to continue with the pregnancy, advise her to undergo antenatal care ✿ If she does not want to continue with the pregnancy this time, advise her for safe abortion
	✿ If the violet colour line in the test region (T) is one only, the woman is not pregnant ✿ Tell her about family planning methods and help her in choosing the most appropriate one
	If there is no colour line in the test region (T), repeat the test next morning using new Pregnancy Test Card

2) Pregnancy checklist

Yes	1. Did your menstrual period start within past 12 days?	No
Yes	2. Have you abstained from sexual intercourse since your last menstrual period, delivery, abortion or miscarriage?	No
Yes	3. Have you been using a reliable contraceptive method correctly and consistently since your last menstrual period, delivery, abortion or miscarriage?	No
Yes	4. Have you had a baby in last 4 weeks?	No
Yes	5. Do you have a baby less than 6 months old? Are you fully/ nearly fully breastfeeding, and have you not had menstrual bleeding since then?	No
Yes	6. Have you had abortion/ miscarriage in last 12 days?	No

If client answered YES to any of the questions and is free from signs and symptoms of pregnancy, you can be reasonably sure that she is not pregnant.

If client answered NO to all the questions 1–6, pregnancy cannot be ruled out. The client should be asked to get a pregnancy test done.

Annexure 13
Technique for Expression of Milk

In some situations when the baby is not sucking the milk properly from the breast due to his/her illness, low birth weight, inappropriate breast conditions or if the mother is working, there is a need to express her breastmilk.

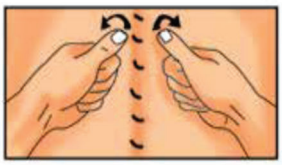
Counselor can help her in identifying these situations and the correct technique of expressing breastmilk.

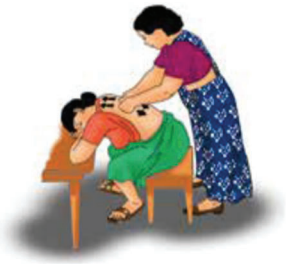
The situations requiring expression of breastmilk are:

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

Manual expression is one of the easiest and safest methods to express breastmilk. Mother should express the breastmilk herself.

1. **Build mother's confidence**
   - If possible, keep the baby in the mother's lap
   - Try to reduce any source of pain and anxiety
   - Help her in thinking lovingly about her baby
2. **Preparation of the vessel/container**
   - Choose a cup, glass, bowl/ katori with a wide mouth
   - Wash the cup with soap and water
3. **Prepare mother for expression**
   - Sit quietly in a separate room with a supportive friend/ helper.
   - Take a warm soothing drink. The drink should not be coffee.
   - Wash breasts with luke warm water
   - Wash hands thoroughly.
   - Massage the breast lightly.
   - Stimulate her nipple to activate the oxytocin reflex.
   - Ask her helper to rub her back from neck on downwards on both sides of the spine



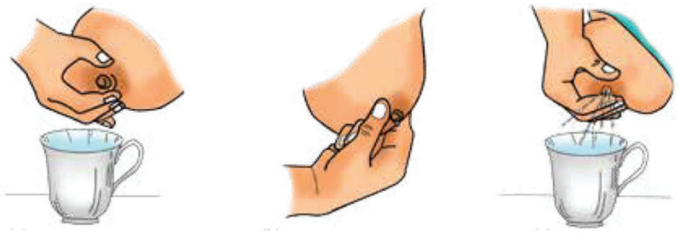


Helper rubbing a mother's back to stimulate the oxytocin reflex.

4. Expressing by hand

- Sit or stand comfortably and hold the container near the breast.
- Put her thumb on her breast ABOVE the nipple and areola, and her first finger on the breast BELOW the nipple and areola, opposite the thumb. She should support the breast with other fingers (Figure A).
- Press her thumb and first finger slightly inwards towards the chest wall. She should avoid pressing too far, because that can block the milk ducts (Figure B).
- Press and release. Again, press and release.
- Do this alternatively till the flow of milk starts (Figure C).
- Press the breast in same way from all sides so that milk flows from all segments.

How to express breast milk



A B C

- Express milk from one breast for at least 3–5 minutes, then from the other breast. Repeat the process.
- Explain to the mother that generally it takes about 20–30 minutes to get enough milk for the baby.
- Expressed milk can be stored for 8 hours in a clean container without boiling.
- DO NOT squeeze the nipple.
- DO NOT express milk quickly.
- DO NOT rub or slide thumb and finger along the skin.

It takes about 20–30 minutes to express the breastmilk especially during the first few days since only little milk may be produced.

Storing of Express Breast Milk:

Advise mother that expressed breast milk can be stored in a covered container at room temperature (<250c) for up to 6 hours or in compartment of a regular refrigerator (2°c to 8°c) for 24 hours. Raw milk should be stored in the back of the main body of the refrigerator.

Annexure 14

National Immunization Schedule (NIS) for Infants, Children and Pregnant Women (Vaccine-Wise)

Vaccine	Timing	Dose	Route	Site
For Pregnant Women				
Tetanus Toxoid (TT)/ Tetanus & adult Diphtheria (Td)-1	Early in pregnancy	0.5 ml	Intra-muscular	Upper arm
TT/Td-2	4 weeks after TT/Td-1	0.5 ml	Intra-muscular	Upper arm
TT/Td- Booster	If received 2 TT/Td doses in a pregnancy within the last 3 yrs*	0.5 ml	Intra-muscular	Upper arm
For Infants				
Bacillus Calmette Guerin (BCG)	At birth or as early as possible till one year of age	0.1ml (0.05ml until 1month age)	Intra-dermal	Left upper arm
Hepatitis B – Birth dose	At birth or as early as possible within 24 hours	0.5 ml	Intra-muscular	Antero-lateral side of mid-thigh
Oral Polio Vaccine (OPV)-0	At birth or as early as possible within the first 15 days	2 drops	Oral	Oral
OPV 1, 2 & 3	At 6 weeks, 10 weeks & 14 weeks (OPV can be given till 5 years of age)	2 drops	Oral	Oral
Pentavalent 1, 2 & 3	At 6 weeks, 10 weeks & 14 weeks (can be given till one year of age)	0.5 ml	Intra-muscular	Antero-lateral side of mid-thigh
Pneumococcal Conjugate Vaccine (PCV)^	Two primary doses at 6 and 14 weeks followed by Booster dose at 9–12 months.	0.5 ml	Intra-muscular	Antero-lateral side of mid-thigh
Rotavirus (RVV)#	At 6 weeks, 10 weeks & 14 weeks (can be given till one year of age)	5 drops (liquid vaccine) 2.5 ml (lyophilized vaccine)	Oral	Oral

Vaccine	Timing	Dose	Route	Site
Inactivated Polio Vaccine (IPV)	Two fractional doses at 6 and 14 weeks of age	0.1 ml	Intra dermal two fractional doses	Intra-dermal: Right upper arm
Measles Rubella (MR) 1st dose	9 completed months–12 months. (Measles can be given till 5 years of age)	0.5 ml	Sub-cutaneous	Right upper arm
Japanese Encephalitis (JE)– 1**	9 completed months–12 months.	0.5 ml	Sub-cutaneous (Live attenuated vaccine) Intramuscular (Killed vaccine)	Left upper arm (Live attenuated vaccine) Anterolateral aspect of mid-thigh (Killed vaccine)
Vitamin A (1st dose)	At 9 completed months with measles-Rubella	1 ml (1 lakh IU)	Oral	Oral
For Children				
Diphtheria, Pertussis & Tetanus (DPT) booster-1	16–24 months	0.5 ml	Intra-muscular	Antero-lateral side of mid-thigh
MR 2nd dose	16–24 months	0.5 ml	Sub-cutaneous	Right upper arm
OPV booster	16–24 months	2 drops	Oral	Oral
JE-2	16–24 months	0.5 ml	Sub-cutaneous (Live attenuated vaccine) Intramuscular (Killed vaccine)	Left upper arm (Live attenuated vaccine) Anterolateral aspect of midthigh (Killed vaccine)
Vitamin A*** (2nd to 9th dose)	At 16 months, then one dose every 6 months up to the age of 5 years.	2 ml (2 lakh IU)	Oral	Oral
DPT Booster-2	5–6 years	0.5 ml.	Intra-muscular	Upper arm
TT/Td	10 years & 16 years	0.5 ml	Intra-muscular	Upper arm

*One dose if previously vaccinated within 3 years

**JE Vaccine is introduced in select endemic districts after the campaign.

***The 2nd to 9th doses of vitamin A can be administered to children 1–5 years old during biannual rounds, in collaboration with Anganwadi services.

^PCV in selected states/ districts: Bihar, Himachal Pradesh, Madhya Pradesh, Uttar Pradesh (19 districts) & Rajasthan.

#RVV: lyophilized vaccine in 11 states (D&N Haveli, Daman & Diu, Goa, Gujarat, Jharkhand, Karnataka, Kerala, Maharashtra, Puducherry, Telangana, West Bengal). Liquid vaccine in remaining 25 states

Full immunization (i.e. one dose of BCG, three doses each of Pentavalent, and OPV and one dose of vaccine for Measles and Rubella before the age of one year) gives a child the best chance for a healthy childhood and healthy life.

Annexure 15
Information on COVID-19 Pandemic

COVID-19 is the infectious disease caused by the most recently discovered coronavirus. This new virus and disease were unknown before the outbreak began in Wuhan, China, in December 2019. That is why it was called the Novel (new) Coronavirus. NCoV. It was found in 2019

Symptoms

- The most common symptoms of COVID-19 are fever, cough and difficulty in breathing
- Other symptoms are: aches and pains, nasal congestion, runny nose, sore throat, diarrhoea. These symptoms are usually mild and begin gradually
- Asymptomatic: Some people become infected but don't develop any symptoms and don't feel unwell. Most people (about 80%) recover from the disease without needing special treatment. Around 1 out of every 6 people who gets COVID-19 becomes seriously ill and develops difficulty in breathing
- Older people, and those with underlying medical problems like high blood pressure, heart problems or diabetes, are more likely to develop serious illness. People with fever, cough and difficulty in breathing should seek medical attention immediately

Spread of COVID-19

The disease is primarily airborne, i.e. it can spread from person to person through small droplets from the nose or mouth when a person with COVID-19 coughs or exhales. These droplets land on objects and surfaces around the person. Other people then catch COVID-19 by touching these objects or surfaces, then touching their eyes, nose or mouth. People can also catch COVID-19 if they breathe in droplets from a person with COVID-19 who coughs out or exhales droplets. Therefore, it is important to maintain a safe distance.

Prevention/ Precautions for COVID-19

To prevent infection following can be done:

- Wash your hands regularly with soap and water or clean them with alcohol-based hand rub
- Wear a mask
- Maintain a safe distance between you and people coughing or sneezing
- Avoid touching your face
- Cover your mouth and nose with your left elbow when coughing or sneezing
- Stay home if you feel unwell
- Refrain from smoking and other activities that weaken the lungs
- Practice physical distancing by avoiding unnecessary travel and staying away from large groups of people

Annexure 16
Schemes under RMNCAH+N

A. Adolescent Health Programme

A.1 Rashtriya Kishor Swasthya Karyakram (RKSK)

Rashtriya Kishor Swasthya Karyakram (RKSK) aims to reach out to adolescents – male and female, rural and urban, married and unmarried, in and out-of-school adolescents with special focus on marginalized and undeserved groups. The programme expands the scope of adolescent health programming in India – from being limited to sexual and reproductive health, it now includes in its ambit nutrition, injuries and violence (including gender-based violence), non-communicable diseases, mental health and substance misuse.

Key drivers of the programme are community-based interventions like, outreach by counselors; facility-based counseling; Social and Behaviour Change Communication; and strengthening of Adolescent Friendly Health Clinics across levels of care.

A.2 Weekly Iron Folic Acid Supplementation

Weekly Iron and Folic Acid Supplementation (WIFS) programme aims at meeting the challenge of high prevalence and incidence of anaemia amongst adolescent girls and boys through supervised weekly ingestion of IFA supplementation and biannual helminthic control. The programme, implemented across the country both in rural and urban areas.

Key interventions include:

- Administration of supervised weekly IFA supplements of 100 mg elemental iron and 500 ug folic acid using a fixed day approach.
- Screening of target groups for moderate/ severe anaemia and referring these cases to an appropriate health facility.
- Biannual de-worming (Albendazole 400 mg), six months apart, for control of helminthic infestation.
- Information and counseling for improving dietary intake and for taking actions for prevention of intestinal worm infestation.

A.3 Menstrual Hygiene Scheme

The scheme has been implemented for promotion of menstrual hygiene among adolescent girls in the age group of 10–19 year in rural areas by:

Increasing awareness among adolescent girls on menstrual hygiene, increasing access to and use of high-quality sanitary napkins to adolescent girls in rural areas and ensuring safe disposal of sanitary napkins in an environmentally friendly manner.

ASHA distributes sanitary napkins in the community and receives incentive @ Rs 1 per pack sold and a free pack of napkins every month for her own personal use. ASHA and AWW also convene monthly meetings at the Aanganwadi Centres for adolescent girls to focus on issue of menstrual hygiene and also serve as a platform to discuss other relevant SRH issues.

B. Family Planning Programme

B.1 Mission Parivar Vikas

The Government has launched Mission Parivar Vikas in 2016 for substantially increasing uptake of family planning services in146 high fertility districts with Total Fertility Rate (TFR) of 3 and above in seven high focus states. These districts are from the states of Uttar Pradesh (57), Bihar (37), Rajasthan (14), Madhya Pradesh (25), Chhattisgarh (2), Jharkhand (9) and Assam (2).

Several initiatives and promotional schemes are functional in these districts to enhance contraceptive usage. Demand generation and awareness activities like 'Saas Bahu Sammelans', 'Nayi Pehel Kits' for newly-weds and 'Saarthi – Awareness on Wheels' are some of the noteworthy initiatives taken in these districts.

B.2 Home Delivery of Contraceptives by ASHA

Under this scheme ASHA distributes contraceptives (Nirodh (condom), Mala-N (COC), Ezy Pill (EC pill) Chhaya (Centchroman pill)) at the doorstep of beneficiary.

B.3 Ensuring Spacing at Birth

Under this scheme ASHA is given a cash incentive of Rs.500/- for each couple who have either delayed the first pregnancy by two years or ensured spacing of three years between two children. Additional incentive of Rs.1000/- is provided to ASHAs for each couple who have chosen to limit their family with two children.

B.4 Pregnancy Testing Kits (PTK) Scheme

Aim of this scheme is to make available the Pregnancy Testing Kits (PTKs) with ASHAs and at the subcenter level for early detection of pregnancy.

B.5 Sterilization Compensation Scheme

For Public Health Facilities:

States		Acceptor	ASHA/ Health Worker	Others	Total
11 High focus states (UP, BH, MP, RJ, CG, JH, OD, UK, AS, HR, GJ)	Vasectomy	2000	300	400	**2700**
	Tubectomy	1400	200	400	**2000**
	PPS	2200	300	500	**3000**
Mission Parivar Vikas Districts	Vasectomy	3000	400	600	**4000**
	Tubectomy	2000	300	500	**2800**
	PPS	3000	400	600	**4000**
Other High focus states (NE states, J&K, HP)	Vasectomy	1100	200	200	**1500**
	Tubectomy	600	150	250	**1000**
Non-High focus states	Vasectomy	1100	200	200	**1500**
	Tubectomy (BPL + SC/ ST only)	600	150	250	**1000**
	Tubectomy (APL)	250	150	250	**650**

For Accredited Private/NGO

Facilities:

States		Acceptor	ASHA/ Health Worker	Others	Total
11 High focus states (UP, BH, MP, RJ, CG, JH, OD, UK, AS, HR, GJ)	Vasectomy	1000		2000	**3000**
	Tubectomy	1000		2000	**3000**
Mission Parivar Vikas Districts	Vasectomy	1000		2500	**3500**
	Tubectomy	1000		2500	**3500**
	PPS	1000		3000	**4000**
Clinical Outreach Teams (COT) in MPV States	Vasectomy	3000	400	1600	**5000**
	Tubectomy	2000	300	2200	**4500**
Other High focus states (NE states, J&K, HP)	Vasectomy		200	1300	**1500**
	Tubectomy		150	1350	**1500**
Non-High focus states	Vasectomy		200	1300	**1500**
	Tubectomy (BPL + SC/ ST only)		150	1350	**1500**

B.6 Scheme for Ensuring Drop Back Services to Sterilization Client

Under this scheme drop back services are provided to clients after sterilization.

B.7 Mobile Teams Dedicated for FP Services has been introduced in high focus states to provide sterilization services where there is dearth of service providers.

B.8 National Family Planning Indemnity Scheme

The clients are insured in the unlikely events of deaths, complications and failures following sterilization.

B.9 PPIUCD/ PAIUCD Incentive Scheme

Under this scheme the service provider and ASHA (who escorts the clients to the health facility for facilitating the IUCD insertion) are eligible for Rs. 150/ insertion and the beneficiaries for Rs 300/ insertion/ client.

B.10 Injectable Contraceptive Incentive Scheme (In MPV Districts)

The beneficiary and ASHAs are incentivized at Rs.100/ dose each in the MPV districts.

B.11 World Population Fortnight

World Population Day is observed for a month-long period i.e. from 27th June to 10th July as "Population Mobilization Fortnight" & 11th–24th July as "Population Stabilization Fortnight" with a specific theme related to Family Planning.

B.12 Vasectomy Fortnight

Vasectomy Fortnight is observed to raise awareness about male sterilization and to promote the participation of men in family planning.

C. Maternal Health Programme

C.1 Suman (Surakshit Matritva Aashwasan)

This is an initiative for zero preventable maternal and newborn deaths. This initiative focuses on assured delivery of maternal and newborn health-care services encompassing wider access to free, and quality services, zero tolerance for denial of services, assured management of complications along with respect for women's autonomy, dignity, feelings, choices and preferences, etc.

All Pregnant Women/ Newborns visiting public health facilities are entitled to the following free services:

- Provision of at least 4 ANC checkup and 6 HBNC visits
- Safe motherhood booklet and mother & child protection card
- Deliveries by trained personnel (including midwife/ SBA)
- Free and zero expense access for identification and management of maternal complications
- Early initiation and support for breastfeeding
- Respectful care with privacy and dignity
- Choice for delayed cord clamping beyond 5 minutes/ up to delivery of placenta
- Elimination of mother to child transmission of HIV, HBV and syphilis
- Zero dose vaccination
- Free transport from home to health institution (dial 102/ 108)
- Assured referral services with scope of reaching health facility within 1 hour of any critical case emergency
- Drop back from institution to home after due discharge (minimum 48 hrs)
- Management of sick neonates and infants
- Time bound redressal of grievances through a responsive call center/ helpline
- Birth registration certificates from health-care facilities
- Conditional cash transfers/ direct benefit transfer under various schemes
- Postpartum FP counseling
- Counseling and IEC/ BCC for safe motherhood

C.2 Pradhan Mantri Surakshit Matritva Abhiyan

It was launched to provide fixed day assured, comprehensive and quality antenatal care universally to all pregnant women (in 2nd and 3rd trimester) on the 9th of every month. While antenatal care is routinely provided to pregnant women, special ANC services are provided by OBGY specialists/ Radiologist/ Physicians at government health facilities under PMSMA.

- A minimum package of antenatal care services is provided to pregnant women in their 2nd/ 3rd trimesters at government health facilities (PHCs/ CHCs, DHs/ urban health facilities etc.) in both urban and rural areas.
- Using the principles of a single window system, a minimum package of investigations and medicines such as IFA and calcium supplements etc. are provided to all pregnant women attending the PMSMA clinics.

- One of the critical components of the Abhiyan is identification and follow-up of high-risk pregnancies and red stickers are added on to their Mother and Child Protection cards.
- A National portal for PMSMA and a mobile application have been developed to facilitate the engagement of doctors from private/ voluntary sector.
- OBGY specialists/ Radiologist/ Physicians working in the private sector are encouraged to volunteer for the campaign and can register for the campaign through any of the following mechanisms:

  Toll Free Number– Doctors can call 18001801104 to register
  SMS- Doctors can SMS 'PMSMA <Name> to 5616115
  PMSMA Portal- Register atpmsma.nhp.gov.in
  Register using the 'Volunteer Registration' Section of the Mobile Application

C.3 Janani Shishu Suraksha Karyakaram

Institutional deliveries in India increased substantially after launched of Janani Suraksha Yojana (JSY). However, 25% women still hesitate to access health facilities for delivery due to out of pocket expenditure during stay at health facilities on drugs, diet, and diagnosis and arrangement blood etc. Janani Shishu Suraksha Karyakaram (JSSK) launched on 1st June, 2011 entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery, including caesarean section.

The entitlements include free drugs and consumables, free diagnostics, free blood wherever required, and free diet for 3 days during normal delivery and 7 days for C-section. This initiative also provides for free transport from home to institution, between facilities in case of a referral and drop back home. The entitlements extend to all antenatal & postnatal complications of pregnancy as well.

Similar entitlements have been put in place for all sick newborns and infants (up to one year of age) accessing public health institutions for treatment

C.4 Janani Suraksha Yojana

Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Health Mission for reducing maternal and neonatal mortality by promoting institutional delivery.

The scheme focuses on poor pregnant woman with a special dispensation for states that have low institutional delivery rates, namely, the states of Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Orissa, and Jammu and Kashmir. While these states have been named Low Performing States (LPS), the remaining states have been named High Performing states (HPS).

The eligibility for cash assistance under the JSY is as shown below:

LPS	All pregnant women delivering in government health centers, such as Sub Centers (SCs)/ Primary Health Centers (PHCs)/ Community Health Centers (CHCs)/ First Referral Units (FRUs)/ general wards of district or state hospitals
HPS	All BPL/ Scheduled Caste/ Scheduled Tribe (SC/ ST) women delivering in a government health centre, such as SC/ PHC/ CHC/ FRU/ general wards of district or state hospitals
LPS & HPS	BPL/ SC/ ST women in accredited private institutions

Cash assistance for institutional delivery (in Rs)

The cash entitlement for different categories of mothers is as follows:

Category	Rural Area			Urban Area		
	Mother's package	ASHA's package*	Total	Mother's package	ASHA's package**	(Amount in Rs.)
LPS	1400	600	2000	1000	400	1400
HPS	700	600	1300	600	400	1000

*ASHA package of Rs. 600 in rural areas include Rs. 300 for ANC component and Rs. 300 for facilitating institutional delivery.

**ASHA package of Rs. 400 in urban areas include Rs. 200 for ANC component and Rs. 200 for facilitating institutional delivery.

C.5 LaQshya

In order to accelerate decline in MMR, MoFHW has launched 'LaQshya– Labour room Quality improvement Initiative. LaQshya programme is a focused and targeted approach to strengthen key processes related to the labour rooms and maternity operation theatres which aims at improving quality of care around birth and ensuring respectful maternity care.

D. Child Health

D.1 Rashtriya Bal Swasthya Karyakram

Rashtriya Bal Swasthya Karyakram (RBSK) aims at early identification and early intervention for children from birth to 18 years to cover 4 'D's viz. Defects at birth, Deficiencies, Diseases, Development delays including disability.

D.2 Home Based Newborn Care

Under this initiative ASHA visits to all newborns according to specified schedule (3rd, 7th, 14th, 21st, 28th and 42nd day) up to 42 days of life. Key activities covered under HBNC visits:

- Recording of weight of the newborn in MCP card
- Ensuring BCG, 1st dose of OPV and DPT vaccination
- Registration of birth and ensuring safety of both the mother and the newborn till 42 days of the delivery

D.3 Home Based Young Care

Under Home Based Care of Young Child (HBYC) programme, the additional five home visits are carried out by ASHA with support from Anganwadi workers. ASHA provides home visits on 3rd, 6th, 9th, 12th and 15th months to promote early initiation of breastfeeding, exclusive breastfeeding till 6 months and continued breastfeeding till 2nd year of life along with adequate complementary feeding, prevention of childhood pneumonia and diarrhoea and to ensure age appropriate immunization and early childhood development . The quarterly home visits schedule for low birth weight babies, SNCU & NRC discharges is harmonized with the HBYC schedule.

D.4 Mothers' Absolute Affection

'MAA' (Mothers' Absolute Affection) is an intensified programme with a goal to revitalize efforts towards promotion, protection and support of breastfeeding practices through health systems to achieve higher breastfeeding rates.

The key strategies are:

- Build an enabling environment for breastfeeding through awareness generation activities, targeting pregnant and lactating mothers, family members and society for positioning breastfeeding as an important intervention for child survival and development
- Reinforce lactation support services at public health facilities through trained health-care providers and through skilled community health workers
- To incentivize and recognize those health facilities that show high rates of breastfeeding along with processes in place for lactation management

D.5 Intensified Diarrhoea Control Fortnight

IDCF is implemented in all states and UTs with an ultimate goal of reaching zero child deaths due to diarrhea by:

- Ensuring high coverage of ORS and Zinc use in children with diarrhoea
- Inculcating appropriate behaviour in care givers for diarrhoea prevention & management of under-five children

Special focus needs to be accorded to the high priority areas and vulnerable communities.

D.6 Micronutrient Supplementation (Vitamin A, Iron Folic Acid)

The objective is to decrease the prevalence of vitamin A deficiency to levels below 0.5% and to manage the widespread prevalence of anaemia in the country.

Vitamin A supplementation:

- 1,00,000 IU dose of vitamin A is being given at nine months
- Vitamin A dose of 2,00,000 IU after 1st year of age at six monthly intervals up to five years of age

Anaemia Mukt Bharat (AMB) Strategy: In 2018, Anaemia Mukt Bharat strategy has been launched to achieve the envisaged target of 3% reduction in anaemia prevalence every year under the POSHAN Abhiyaan. The strategy recommends 6x6x6 strategy to reduce anaemia prevalence (nutritional and no-nutritional) in six age groups namely:

i. Pre-school children (6–59 months)
ii. Children (5–9 years)
iii. Adolescent girls and boys (10–19 years)
iv. Pregnant and lactating women and
v. Women of reproductive age group (15–49 years) in programme mode through life cycle approach

The six interventions under Anaemia Mukt Bharat strategy are:

i. Prophylactic IFA supplementation
ii. Periodic deworming
iii. Intensified year-round behaviour change communication campaign including delayed cord clamping
iv. Testing and treatment of anaemia using digital methods and point of care treatment
v. Mandatory provision of iron folic acid fortified foods in public health programmes
vi. Addressing non-nutritional causes of anaemia in endemic pockets, with special focus on malaria haemoglobinopathies and fluorosis

D.7 Social Awareness and Action Plan to Neutralise Pneumonia Successfully

The initiative is being implemented to intensify the actions for reducing morbidity and mortality due to childhood pneumonia in India by creating awareness in community, dispelling myths and notion and increasing awareness of caregivers to identify pneumonia.

D.8 Management of Children with Severe Acute Malnutrition

Severe Acute Malnutrition is an important contributing factor for most deaths amongst children suffering from common childhood illness, such as diarrhoea and pneumonia. Nutritional Rehabilitation Centres (NRCs) are set up in the public health facilities for inpatient management of severely malnourished children, with medical complication, and counseling of mothers for proper feeding and once they are on the road to recovery, they are sent back home with regular follow up.

D.9 National Deworming Day

NDD is being observed bi-annually on 10th February and 10th August targeting all children and adolescents in the age group of 1–19 years (both school enrolled and non-enrolled) for giving them Albendazole tablets through a single fixed day approach.

E. Immunization

E.1 Mission Indradhanush

Mission Indradhanush (MI) was launched in December 2014 and aims at increasing the full immunization coverage amongst children to 90%. Under this drive focus is given on pockets of low immunization coverage and hard to reach areas where the proportion of unvaccinated and partially vaccinated children is highest.

Annexure 17

Three Day Agenda for Training of Trainers on Counseling

Time	Duration	Session Title and Content
Day 1		
9:00–9:30 am	30 min	**Registration**
9:30–9:40 am	10 min	Inauguration, opening remarks, welcome and introduction of facilitators participants
9:40–10:00 am	20 min	Introductory Session: Overview of training, sharing course goals, agenda of TOT and training package, setting group norms
10:00–10:20 am	20 min	Pre-course knowledge assessment
10:20–11:00 am	40 min	**Chapter 1:** Importance of Integrated Approach towards Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition
11:00–11:15 am	15 min	**Tea**
11:15–12:15 pm	60 min	**Chapter 2:** Counseling and Effective Interpersonal Communication
12:15–12:45 pm	30 min	Key counseling aspects across various RMNCAH+N
12:45–1:30 pm	45 min	**Chapter 3.** Counseling Adolescents on Healthy Life Choices and Responsible Decision Making
1:30–2:15 pm	45 min	**Lunch break**
2:15–2:45 pm	30 min	**Chapter 3:** Counseling Adolescents on Healthy Life Choices and Responsible Decision Making (To be Continued)
2:45–3:15 pm	30 min	Busting Myths and Misconceptions with facts on Adolescent Health Issues
3:15–3:30 pm	15 min	**Tea break**
3:30–4:15 pm	45 min	**Chapter 4:** Counseling Couples on Contraceptive Choices in Interval and Post Pregnancy Period
4:15–4:45 pm	30 min	**Chapter 4:** Counseling Couples on Contraceptive Choices in Interval and Post Pregnancy Period (To be Continued)
4:45–5:00 pm	15 min	Wrap up of Day 1 and assignment
Day 2		
9:30–10:00 am	30 min	Warm up and recap of Day 1
10:00–10:30 am	30 min	Busting Myths and Misconceptions with facts on Contraceptives
10:30–11:15 am	45 min	**Chapter 5:** Counseling on Essential Maternal and Newborn Care – Care during Pregnancy and Childbirth
11:15–11:30 am	15 min	**Tea break**
11:30–12:15 pm	45 min	**Chapter 5:** Counseling on Essential Maternal and Newborn Care – Care during Postpartum Period and Care of Newborn
12:15–12:45 pm	30 min	**Chapter 6:** Counseling on Child Health
12:45–1:15 pm	30 min	Busting Myths and Misconceptions with facts on Maternal and Child Health Issues

Time	Duration	Session Title and Content
1:15–2:00 pm	45 min	**Lunch break**
2:00–2:30 pm	30 min	**Chapter 7:** Ensuring RMNCAH+N Services during Disaster Situations
2:30–3:00 pm	30 min	Busting Myths and Misconception on Pandemic
3:00–3:15 pm	15 min	**Tea break**
3:15–4:00 pm	45 min	Creating positive training climate, adult learning principles dealing with challenges and effective communication and facilitation skills
4:00–4:30 pm	30 min	Small group formation & task assignment for practice sessions
4:30–5:00 pm	30 min	Small groups – to discuss preparation for practice sessions
5:00–5:15 pm	15 min	Wrap up of Day 2
Day 3		
9:30–10:00 am	30 min	Recap of Day 2
10:00–10:30 am	30 min	Small groups – final preparation for practice sessions
10:30–10:50 am	20 min	Practice presentation on **Chapter 1:** Importance of Integrated Approach towards Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition
10:50–11:00 am	10 min	Feedback on Practice Session – 1
11:00–11:15 am	15 min	**Tea break**
11:15–11:35 am	20 min	Practice presentation on **Chapter 2:** Counseling and Effective Interpersonal Communication
11:35–11:45 am	10 min	Feedback on Practice Session – 2
11:45–12:05 pm	20 min	Practice presentation **Chapter 3:** Counseling Adolescents on Healthy Life Choices and Responsible Decision Making
12:05–12:15 pm	10 min	Feedback on Practice Session – 3
12:15–12:35 pm	20 min	Practice presentation **Chapter 4:** Counseling Couples on Contraceptive Choices in Interval and Post Pregnancy Period
12:35–12:45 pm	10 min	Feedback on Practice Session – 4
12:45–1:05 pm	20 min	Practice presentation **Chapter 5:** Counseling on Essential Maternal and Newborn Care
1:05–1:15 pm	10 min	Feedback on Practice Session – 5
1:15–2:00 pm	45 min	**Lunch break**
2:00–2:15 pm	15 min	Post lunch warm up exercise
2:15–2:35 pm	20 min	Practice presentation **Chapter 6:** Counseling on Child Health
2:35–2:45 pm	10 min	Feedback on Practice Session – 6
2:45–3:05 pm	20 min	Practice presentation **Chapter 7:** Ensuring RMNCAH+N Services during Disaster Situations
3:05–3:15 pm	10 min	Feedback on Practice Session – 7
3:15–3:30 pm	15 min	**Tea break**
3:30–3:45 pm	15 min	**Chapter 9:** Technical and Programmatic Aspects for Training on Counseling
3:45–4:15 pm	30 min	Program management and important aspects of training – agenda, tips
4:15–4:35 pm	20 min	Post course knowledge assessment
4:35–4:45 pm	10 min	Answers of post course knowledge assessment
4:45–5:15 pm	30 min	Wrap up and course closure, including participants' feedback

Annexure 18

Six Day Agenda for Training on Counseling

Time	Duration	Session Title and Content
Day 1		
10:00–10:20 am	20 min	Welcome & introduction to the course
10:20–10:50 am	30 min	Pre-course knowledge assessment
Chapter 1: Importance of Integrated approach towards Reproductive, Maternal, Child and Adolescent Health & Nutrition (RMNCAH+N)		
10:50–11:20 am	30 min	Importance of integrated approach towards RMNCAH+N & linkages between different life stages
11:20–11:45 am	25 min	General aspects and principles of counseling based on rights of clients
11:45–12:00 noon	15 min	Break
Chapter 2: Counseling & Effective Interpersonal Communication		
12:00 noon–12:25 pm	25 min	Stages & process of counseling
12:25–12:50 pm	25 min	Effective communication skills
12:50–1:15 pm	25 min	Key counseling aspects for various RMNCAH+N services
1:15–2:15 pm	60 min	**Lunch break**
2:15–2:30 pm	15 min	Interactive session/ exercise on counseling & effective communication
Chapter 3: Counseling Adolescents on Healthy Life Choices and Responsible Decision Making		
2:30–3:00 pm	30 min	Growing up and normal changes during adolescence
3:00–3:20 pm	20 min	Normal sexual development and behaviour in adolescent boys
3:20–3:50 pm	30 min	Normal sexual development and behaviour in adolescent girls
3:50–4:00 pm	10 min	Wrap up of Day 1
Day 2		
10:00–10:30 am	30 min	Recap of Day 1
Chapter 3. Counseling Adolescents on Healthy Life Choices and Responsible Decision Making (contd.)		
10:30–11:00 am	30 min	Menstrual hygiene & common menstrual problems
11:00–11:30 am	30 min	Counseling sexually active adolescents: consequences of unsafe sexual activity & teenage pregnancy
11:30–12:00 noon	30 min	Reproductive Tract Infections (RTIs) and Sexually Transmitted Infections (STIs) & HIV/ AIDS in adolescents
12 noon–12:15 pm	15 min	Break
12:15–12:45 pm	30min	Counseling adolescents on nutritional issues
12:45–1:15 pm	30 min	Counseling adolescents on other issues: Non-Communicable Diseases (NCD) violence, mental health issues, substance abuse

Time	Duration	Session Title and Content
1:15–2:15 pm	60 min	**Lunch break**
2:15–2:45 pm	30 min	Bursting myths and misconceptions related to adolescent health issues
2:45–3:25 pm	40 min	Practice of counseling an adolescent – role plays, simulated practice
3:25–3:45 pm	20 min	Interactive session or exercise on counseling adolescents
3:45–3:55 pm	10 min	Wrap up of Day 2
Day 3		
10:00–10:30 am	30 min	Recap of Day 2 – Practice of counseling for adolescent health
Chapter 4: Counseling Couples on Contraceptive Choices in Interval & Post Pregnancy Period		
10:30–10:45 am	15 min	Healthy timing & spacing of pregnancies
10:45–11:15 am	30 min	Overview of contraceptives & how they work
11:15–12:00 noon	45 min	Technical/ programmatic aspects of each contraceptive under programme – continued
12 noon–12:15 pm	15 min	Break
12:15–12:45 pm	30 min	Technical/ Programmatic aspects of each contraceptive under programme
12:45–1:00 pm	15 min	Schemes under National Programme related to contraceptives
1:00–1:30 pm	30 min	Busting Myths and Misconceptions with facts about FP/ contraceptives
1:30–2:15 pm	45 min	**Lunch break**
2:15–3:00 pm	45 min	How to counsel couples about contraceptives: FP counseling – initial & follow up
3:00–3:20 pm	20 min	Interactive session or exercise on contraceptives
3:20–4:00 pm	40 min	Practice of FP counseling – role plays, simulated practice
4:00–4:10 pm	10 min	Wrap up of Day 3
Day 4		
10:00–10:30 am	30 min	Recap of Day 3
Chapter 5: Counseling on Maternal and Newborn Health		
10:30–11:00 am	30 min	Care during pregnancy – importance and timing of antenatal checkups, how to counsel about ANC check ups
11:00–11:30 am	30 min	Counseling about personal hygiene & nutrition during pregnancy, HTSP & contraceptives
11:30–12:00 noon	30 min	Birth preparedness & complication readiness
12 noon–12:15 pm	15 min	Break
12:15–1:00 pm	45 min	Care during labor and childbirth
1:00–1:30 pm	30 min	Care of mother during postnatal period
1:30–2:15 pm	45 min	**Lunch break**
2:15–3:00 pm	45 min	Care of newborn: Counseling about keeping the baby warm, care of umbilical cord, breastfeeding & initiation of immunization
3:00–3:50 pm	50 min	Abortion services and key counseling messages
3:50–4:00 pm	10 min	Wrap up of Day 4

Time	Duration	Session Title and Content
Day 5		
10:00–10:30 am	30 min	Recap of Day 4
10:30–11:00 am	30 min	Key programmatic interventions and schemes related to maternal & child health
11:00–11:20 am	20 min	Busting Myths and Misconceptions with facts on maternal health issues: through role plays & case studies, small group exercises
11:20–11:40 am	20 min	Busting Myths and Misconceptions with facts on newborn issues: through role plays & case studies, small group exercises
11:40–12:00 noon	20 min	Interactive session or exercise on maternal & newborn care
12 noon–12:15 pm	15 min	Break
Chapter 6: Counseling on Child Health		
12:15–12:45 pm	30 min	Breastfeeding
12:45–1:30 pm	45 min	Child nutrition including complementary feeding
1:30–2:30 pm	60 min	**Lunch break**
2:30–3:15 pm	45 min	Immunization: importance & schedule under National Programme
3:15–4:00 pm	45 min	Childhood diseases: diarrhoea, acute respiratory infections
4:00–4:10 pm	10 min	Wrap up of Day 5
Day 6		
10:00–10:30 am	30 min	Recap of Day 5
Chapter 6: Counseling on Child Health – contd.		
10:30–11:00 am	30 min	Busting myths/ misconceptions on child health
11:00–11:15 am	15 min	Interactive session or exercise on child health
11:15–12:00 noon	45 min	Practice of counseling on child health/ case studies
12 noon–12:15 pm	15 min	Break
Chapter 7: Ensuring RMNCAH+N Services during Disaster Situations		
12:15–1:00 pm	45 min	Impact of disaster on RMNCAH+N Services, role of counselors during disaster situations
1:00–1:15 pm	15 min	Case study on COVID-19 pandemic
1:15–1:45 pm	30 min	Busting myths/ misconception on pandemic
1:45–2:45 pm	60 min	**Lunch break**
Chapter 9: Technical and Programmatic Aspects for training on RMNCAH+N Counseling		
2:45–3:15 pm	30 min	Program management and important aspects of training
3:15–3:45 pm	30 min	Record keeping and reporting for RMNCAH+N services: importance & formats
3:45–4:15 pm	30 min	How to fill record of RMNCAH+N services and reporting formats
4:15–4:35 pm	20 min	Post course knowledge assessment
4:35–4:45 pm	10 min	Course evaluation & closure

Annexure 19

Four Day Agenda for Online Training on Counseling

Time	Duration	Session Title and Content
Day 1		
10:00–10:10 am	10 min	Welcome & introduction to the course
10:10–10:30 am	20 min	Pre-course knowledge assessment
Chapter 1: Importance of Integrated Approach towards Reproductive, Maternal, Child and Adolescent Health & Nutrition (RMNCAH+N)		
10:30–11:00 am	30 min	Importance of integrated approach towards RMNCAH+N & linkages between different life stages
Chapter 2: Counseling & Effective Interpersonal Communication		
11:00–11:45 am	45 min	General aspects of counseling, rights of clients & stages & process of counseling
11:45–12:00 pm	15 min	Break
12:00–12:30 pm	30 min	Effective communication skills
12:30–1:00 pm	30 min	Key counseling aspects for various RMNCAH+N services
1:00–1:15 pm	15 min	Interactive session or exercise on counseling & effective communication
1:15–2:25 pm	70 min	**Lunch break**
Chapter 3: Counseling Adolescents on Healthy Life Choices and Responsible Decision Making		
2:25–2:50 pm	25 min	Growing up and normal changes during adolescence
2:50–3:10 pm	20 min	Normal sexual development and behaviour in adolescent boys
3:10–3:30 pm	20 min	Normal sexual development and behaviour in adolescent girls
3:30–3:50 pm	20 min	Counseling sexually active adolescents: consequences of unsafe sexual activity & teenage pregnancy
3:50–4:05 pm	15 min	Reproductive Tract Infections (RTIs) and Sexually Transmitted Infections (STIs) & HIV/ AIDS in adolescents
4:05–4:10 pm	05 min	Wrap up of Day 1
Day 2		
Chapter 3. Counseling Adolescents on Healthy Life Choices and Responsible Decision Making – contd.		
10:00–10:15 am	15 min	Counseling adolescents on nutritional issues
10:15–10:40 am	25 min	Counseling adolescents on other issues: NCDs, violence, mental health issues, substance misuse
10:40–11:10 am	30 min	Bursting myths and misconceptions related to adolescent health issues
11:10–11:30 am	20 min	Interactive session or exercise on adolescent health
11:30–11:45 am	15 min	Break

Time	Duration	Session Title and Content
Chapter 4: Counseling Couples on Contraceptive Choices in Interval & Post Pregnancy Period		
11:45–12:00 noon	15 min	Healthy timing & spacing of pregnancies
12:00–12:30 pm	30 min	Overview of contraceptives & how they work
12:30–1:30 pm	60 min	Technical/ programmatic aspects of each contraceptive under programme
1:30–2:15 pm	45 min	**Lunch break**
2:15–2:35 pm	20 min	Contraceptive choices and schemes under National Programme
2:35–3:00 pm	25 min	Busting myths/ misconceptions on contraceptives
3:00–3:40 pm	40 min	How to counsel couples about contraceptives: FP counseling – initial & follow up
3:40–3:55 pm	15 min	Interactive session or exercise on contraceptives
3:55–4:00 pm	05 min	Wrap up of Day 2
Day 3		
Chapter 5: Counseling on Maternal and Newborn Care		
10:00–10:30 am	30 min	Care during pregnancy: Importance and timing of antenatal checkups, how to counsel about ANC check ups
10:30–11:00 am	30 min	Counseling about personal hygiene & nutrition during pregnancy
11:00–11:15 am	15 min	Counseling pregnant women about healthy timing & spacing for pregnancy & contraceptives
11:15–11:45 am	30 min	Birth preparedness & complication readiness
11:45–12:00 pm	15 min	Break
12:00–12:30 pm	30 min	Care during labor and childbirth
12:30–12:50 pm	20 min	Care during postnatal period
12:50–1:30 pm	40 min	Care of newborn: Counseling about keeping the baby warm, care of umbilical cord, breastfeeding & initiation of immunization
1:30–2:15 pm	45 min	**Lunch break**
2:15–2:45 pm	30 min	Abortion services and key counseling messages
2:45–3:15 pm	30 min	Busting myths/ misconceptions on maternal and newborn issues: Through role plays & case studies, small group exercises
3:15–3:40 pm	25 min	Key programmatic interventions and schemes related to maternal & child health
3:40–4:00 pm	20 min	Interactive session or exercise on maternal & newborn care
4:00–4:05 pm	05 min	Wrap up of Day 3
Day 4		
Chapter 6: Counseling on Child Health		
10:00–10:30 am	30min	Breastfeeding & child nutrition
10:30–11:00 am	30min	Immunization: Importance & schedule under National Programme
11:00–11:30 am	30min	Childhood diseases: diarrhoea, acute respiratory infections
11:30–11:45 am	15 min	Break

Time	Duration	Session Title and Content
Day 4		
11:45–12:15 pm	30 min	Busting myths/ misconceptions on child health
12:15–12:30 pm	15 min	Interactive session or exercise on child health
Chapter 7: Counseling during Disaster Situations		
12.30–1:00 pm	30 min	Ensuring RMNCAH+N Services during Disaster Situations Role of Counselors
1:00–1:15 pm	15 min	Case study on COVID-19 pandemic
1:15–1:45 pm	30 min	Busting myths/ misconception on pandemic
1:45–2:30 pm	45 min	**Lunch break**
2:30–2:50 pm	20 min	Record keeping and reporting for RMNCAH+N services: Importance & formats
2:50–3:10 pm	20 min	How to fill record of RMNCAH+N services and reporting formats
3:10–3:40 pm	30 min	Technical and programmatic aspects for training on RMNCAH+N Counseling
3:40–4:00 pm	20 min	Post course knowledge assessment
4:00–4:10 pm	10 min	Course evaluation & closure of 4-day training course

Annexure 20

Pre and Post Course Questionnaires on RMNCAH+N for Training on Counseling

Q.1. Who all can avail services through integrated approach of Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAH+N)?

a) Women/ couples of reproductive age

b) Pregnant women and mothers

c) Newborn babies and children

d) Adolescent girls and boys

e) All of the above

Q.2 What are the benefits of Counseling?

a) After being counseled, people are more likely to adopt healthy behaviour/s or health service/s.

b) During counseling, myths and misconceptions in the mind of client are clarified

c) Counseling supports clients for correct adoption and continuation of healthy behaviour/s or health service/s, thereby safeguarding their health

d) All of the above

Q.3 While providing health services, which client's rights must be always kept in mind?

a) Client's right to be treated with respect, right to privacy and confidentiality during counseling and provision of services

b) Client's right to accurate, appropriate, understandable and clear information related to health services relevant for them

c) Client's right to voluntarily make an informed choice on the options, information, and understanding

d) All of the above

Q.4 What is Adolescence?

a) Age from 10–19 years during which a child develops into an adult

b) Age from 16–18 years during which boys and girls grow up fast

c) Age from 13–19 when they are teenagers

Q.5 Why do adolescent girls start having monthly period?

a) Adolescent girls get monthly periods as their body throw out dirty blood collected in the reproductive organs every month

b) Adolescent girls get monthly periods as their body shed the lining of uterus (developed to support pregnancy every month) which comes out of her body as menstrual blood.

c) None of the above

Q.6 What are the consequences of unsafe sexual activity in adolescents?

a) Unsafe sexual activity can lead to teenage pregnancy, which is very risky for the girl and the unborn child

b) Unsafe sexual activity can lead to higher risk of STIs including HIV/AIDS

c) Unsafe sexual activity indirectly can hamper education and career opportunities

d) All of the above

Q.7 After a childbirth, for minimum how many months should the couple wait before planning another pregnancy?

a) 6 months
b) 12 months
c) 24 months
d) 36 months

Q.8 Which contraceptive reduces quantity of breastmilk and cannot be given to a breastfeeding woman until her baby is 6 months old?

a) Weekly non-hormonal pill (Chhaya Pill)
b) Combined Oral Contraceptive Pill (Mala –N Pill)
c) MPA Injectable Contraceptive (Antara Program)
d) IUCD (Copper-T)

Q.9 What is the dosage of Chhaya Pill?

a) One pill every week
b) Two pills every week
c) Twice a week for first 3 months, then once a week from the 4th month
d) Once a week for first 3 months, then twice a week from the 4th month

Q.10 When does fertility return after taking the last injection of MPA (Antara)?

a) 7–10 months after taking the last injection of MPA
b) 5–6 months after taking the last injection of MPA
c) Immediately after stopping the injection
d) Fertility does not return as woman becomes infertile

Q.11 When can an IUCD be inserted safely?

a) Immediately after delivery or within 48 hours of normal delivery
b) During cesarean section following placental delivery
c) Within 12 days of abortion
a) Can be inserted at all above times

Q.12 After childbirth, when can female sterilization be done?

a) Only up to 48 hours after the delivery
b) Up to 7 days after the delivery
c) Up to 10 days after the delivery
d) Between 7 to 28 days after delivery

Q.13 When does male sterilization become effective after the operation?

a) Immediately after the operation, so no need to use any other contraceptive after the operation
b) After one month of operation, so couple must use another contraceptive for next one month
c) After three months, so couple must use another contraceptive for next 3 months
d) After one year, so couple must use another contraceptive for full one year

Q.14 Which statement is true for Emergency Contraceptive Pill (Ezy Pill)?

a) It is not a regular method of contraception & is to be used only in emergency ie after unprotected sex
b) One Ezy Pill (which contains 1.5 mg of levonorgestrel) should be taken, as soon as possible within 72 hours of unprotected sex
c) Nausea, vomiting & irregular bleeding can occur after taking Ezy Pill
d) All of the above

Q.15 Which of the following key counseling messages should be given to client in post abortion period?

a) Client should avoid intercourse till bleeding stops/ injury/ infection heals

b) Fertility returns quickly after abortion, even before next menstrual bleeding returns.

c) Client can choose from available family planning methods as per her eligibility

d) All of the above

Q.16 Why is it important for every pregnant woman go to health center for at least 4 antenatal check ups?

a) It can be checked that she is healthy, and her unborn baby is growing well and can be given Td injection, iron tablets

b) In case there is any complication, it can be identified in time and treated

c) Useful information can be given to her and her family members about essential care. nutrition, and on the signs of labor and possible danger signs of obstetric complication and how to prepare a birth plan

d) For all reasons given above

Q.17 Pregnant women, who are not anaemic, need to take how many iron and folic acid (IFA) tablets?

a) No need to take IFA tablet, if eating normally

b) One tablet daily for 180 days (Total 180 IFA tablets)

c) One tablet daily for 100 days (Total 100 IFA tablets)

Q.18 During counseling, what should be told to pregnant women about nutrition?

a) Adequate nutrition is important for your health and development of foetus

b) Eat one extra meal a day – eat frequently and in small portions and drink plenty of water/ fluids

c) Eat cereals, whole grains, nuts and pulses

d) Take milk and dairy products & if non-vegetarian, also eat meat, egg, chicken and fish

e) Include green leafy vegetables, fresh/ seasonal fruits in your diet

f) All above messages need to be given

Q.19 Every pregnant woman and her family should make a birth preparedness and complication readiness plan which means?

a) Deciding in advance about place of delivery

b) Where to take in case of complication

c) Arrangements for support person, transport, extra fund & possible blood donor

d) All of above

Q.20 Which vaccine/s need to be given to newborn baby before discharge from the health facility?

a) BCG vaccine only

b) Polio drops only

c) BCG & Polio Drops

d) Polio Drops & Hepatitis B vaccine

e) BCG, Polio Drops & Hepatitis B vaccine

Q.21 For child health, which key messages need to be given to parent/ care givers:

a) About breastfeeding

b) About importance of full immunization

c) About early identification of diseases and prompt treatment

d) All of the above

Q. 22 In order to provide adequate nutrition to infants and young children, what should be done?

a) Initiation of breastfeeding within one hour of birth

b) Exclusive breastfeeding for the first six months of life

c) Starting appropriate complementary feeding on completion of 6 months of age

d) Continued breastfeeding for two years or beyond

e) All of the above

Q.23 What does management of diarrhoea include?

a) Maintaining fluid intake

b) Continue feeding

c) Early identification of danger signs & seeking timely health care

d) All of the above

Q.24 What role can counselors play during a disaster/ pandemic situation?

a) Counselors can play an important role in educating the community with accurate information regarding the crisis

b) They can counsel on preventive measures against spread of infections in the individual & family, e.g. about prevention against COVID-19 infection

c) The counselors can provide support to the clients in their RMNCAH+N needs, including contraceptive counseling and provision

d) All of the above

Q.25 What is the role of vaccination in COVID-19?

a. Gives 100% protection from disease

b. Vaccination has no role because it does not provide any protection

c. Vaccination prevents severe disease and reduces chances of complications & death

d. None of the above

Annexure 21

Answer Key Pre and Post Course Questionnaires on RMNCAH for Training on Counseling

Q.1 Who all can avail services through integrated approach of Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH+N)?

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b. Pregnant women and mothers

c. Newborn babies and children

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b. Eat one extra meal a day – eat frequently and in small portions and drink plenty of water/ fluids

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e. Include green leafy vegetables, fresh/ seasonal fruits in your diet

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c. The counselors can provide support to the clients in their RMNCAH+N needs, including contraceptive counseling and provision

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a. Gives 100% protection from disease

b. Vaccination has no role because it does not provide any protection

c. Vaccination prevents severe disease and reduces chances of complications & deaths

d. None of the above

Annexure 22

Post Training Follow Up Checklist

Instructions to trainer:

- Complete one form per trainee during follow up (telephonic/ visit)
- Form has three parts: Part I – General assessment, Part II – Clinical Performance Assessment and Part III – Action Plan
- At the end of assessment review gaps identified with trainee and share the actions recommended

General assessment

State:	**District:**	**Facility name:**
Facility type:	Date of trainings:	Date of follow up:
No. of this follow up (tick (√) **one choice)**	✿ 1st ✿ 2nd ✿ 3rd	
Person conducting follow up **Name:** **Designation:**		
Name of the Trainee:		Designation:
Tainee is providing counseling services? (Tick (√) **one choice) Yes/ No**		
What are the numbers of clients counseled for?		
Counseled	**Last month**	**Last quarter**
Adolescents health issues		
Contraceptives		
Pregnancy and childbirth		
Newborn & child health issues		
If counseling is not being provided, reason stated by the counselor? Tick (√) all that apply		
1.	Lack of relevant job aids	
2.	Time constraint due to excess workload	
3.	Service is not provided in the facility	
4.	Lack of confidence in skill	
5.	Other (specify)	

Any difficulties during service provision? If yes, tick (√) accordingly	
1.	Lack of job aids
2.	Low case load
3.	High case load
4.	Lack of confidence in skill
5.	Other (specify) .....

Clinical Performance Assessment

During the visit it may be found RMNCAH+N Counselor providing counseling services to the client availing any of the listed services

1. Adolescent health
2. Contraceptives
3. Antenatal care
4. Postnatal care
5. Abortion
6. Breastfeeding/ child nutrition
7. Immunization
8. Early childhood development

Supervisor/ Trainer should assess the counselors on following key aspects while counseling clients

Adherence to Principles of Counseling

- Respectful, non-judgmental, empathetic, accepting and caring attitude of provider
- Ensuring client's privacy and confidentiality
- Actively listening to the client and encouraging the client to ask questions and express any concerns
- Providing brief, simple and specific information with key messages
- Uses simple culturally appropriate language and giving simple examples which are easily understood by the client
- Use of audio-visual aids, anatomic models, brochures, samples
- Repeating key information shared by the client, showing and confirming that you have understood correctly what they are saying
- Ensuring client's correct understanding of what has been told
- Understanding from the client if there are any barriers likely to be faced in adoption of healthy behaviour/s or health service/s and helping clients to overcome them

Use of Positive Verbal and Non-Verbal Cues

- Uses clear and simple language and speaks clearly
- Emphasizes main points
- Listens actively
- Maintains eye contact
- Shows interest and concern by nodding/ facial expression

Technical Competency

- Knows the subject thoroughly
- Able to respond to participant's queries appropriately
- Able to recognize when to refer client, for what and where
- Addresses myths and misconceptions effectively

Action Plan

Table below should be utilized by trainer for developing action plan based on gaps identified from above assessment for remedial actions and share with the trainee.

Trainers Action Plan				
S. No.	**Gaps Identified**	**Support Required**	**Timeline**	**Remarks**
1				
2				
3				
4				
5				
Signature of the trainer				

Annexure 23
Training Evaluation Form

Name.....Designation.....

Date .....District.....

Put (Tick√) in front of your response

S. No	Item	Excellent	Very Good	Good	Poor	Very Poor
1	Organization of the training					
2	Subject matter covered					
3	Duration of training					
4	Effectiveness of facilitators					
5	Overall evaluation of training					
6	Remarks or any other feedback					

Glossary

1. **Anaemia:** is a condition in which one's blood does not have enough healthy red blood cells to carry adequate amount of oxygen required by the body's tissues
2. **Abortion:** is the ending of a pregnancy by removal or expulsion of an embryo or foetus before it matures fully
3. **Beriberi:** A disease in which the body does not have enough vitamin B1 (thiamin)
4. **Comprehensive Health Care:** Providing the full range of health services to a person, i.e. diagnosis, treatment, follow-up and rehabilitation
5. **Child:** is a human being between birth and attainment of puberty (0–9 years)
6. **Coercion:** The act of compelling / intimidating an individual to do some act against his or her will, using psychological pressure, physical force, or threats
7. **Continuum of care:** Continuum of care means maintaining continuity of the medical care delivered to the patient, especially when switching between caregivers or care institutions
8. **Contraceptive:** A drug, device or technique used to prevent pregnancy
9. **Contraception:** the deliberate prevention of conception or impregnation by use of a drug, technique, or device meant for that purpose
10. **Counter referrals:** The process by which the receiving facility sends the client back to the initiating facility with information about services provided there and any needed follow- up
11. **Diphtheria:** A serious bacterial infection of the nose and throat
12. **Eligible Couple:** A currently married couple wherein the wife is in the reproductive age (i.e. 15–49 yr. of age)
13. **Fertility:** is the ability to conceive children or young
14. **Foetus:** is an unborn human being which is in in its later stages of development
15. **Gender Based Violence** is defined as violence that is directed against a person on the basis of their gender or sex, including acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty
16. **Gender:** is used to describe the characteristics of women and men that are socially constructed, while sex refers to those that are biologically determined
17. **Hemorrhage:** is excessive bleeding
18. **Haemoglobin:** is a protein found in the red blood cells that carries oxygen in your body and gives blood its red colour
19. **Hepatitis:** An inflammation of the liver
20. **Infant:** a very young child (birth to 1 year)
21. **Intra Uterine Growth Restriction:** refers to poor growth of a foetus while in the mother's womb
22. **Japanese Encephalitis:** A viral infection transmitted by bite of mosquito
23. **Labor:** is the process by which the foetus and the placenta come out of the uterus
24. **Low Birth Weight:** defined as a birth weight of less than 2500 g
25. **Mortality:** Refers the number of deaths in a certain group of people in a certain period
26. **Morbidity:** Refers to having a disease or a symptom of disease, or to the amount of disease within a population

27. **Measles:** A viral infection that is serious for small children but is easily preventable by a vaccine. Symptoms include cough, runny nose, inflamed eyes, sore throat, fever and a red, blotchy skin rash
28. **Malaria:** A disease transmitted by the bite of infected mosquitoes. Symptoms are chills, fever and sweating, usually occurring a few weeks after being bitten
29. **Newborn/ Neonate:** a baby from birth to four weeks
30. **Obstructed Labour:** difficulty in process of childbirth due to obstruction in the birth canal or abnormal lie of the baby in the womb ie transverse/oblique lie
31. **Placenta:** A temporary organ that joins the mother and foetus, transferring oxygen and nutrients from the mother to the foetus and permitting the release of waste products from the foetus
32. **Pentavalent:** A pentavalent vaccine, also known as a 5-in-1 vaccine, is a combination five vaccines for different diseases, conjugated into one
33. **Prenatal:** is the period before birth; during or relating to pregnancy
34. **Perinatal:** Perinatal period commences at 22 completed weeks (154 days) of gestation and ends seven completed days after birth
35. **Pellagra:** Pellagra is a disease caused by a lack of the vitamin niacin (vitamin B3)
36. **Postnatal:** is the period relating to or denoting the period after childbirth
37. **Pre-Term Birth:** is defined as babies born alive before 37 weeks of pregnancy are completed
38. **Pregnancy:** also known as gestation, is the time during which one or more offspring develops inside the womb
39. **Pre-eclampsia/ Eclampsia:** Seizures that occur during pregnancy or shortly after childbirth
40. **Premature Rupture of Membrane** is a rupture (breaking open) of the membranes (amniotic sac) before labor begins
41. **Rape:** is the act of sex done without the consent of an adult person; and with or without consent with a minor person
42. **Referrals:** an act of referring someone or something for consultation, review, or further action
43. **Reproductive Tract Infections:** is defined as the infection of the reproductive or genital tract which causes healthy life loss among sexually active women of reproductive age
44. **Retained Placenta** is a condition in which all or part of the placenta or membranes remain in the uterus after delivery
45. **Rickets:** Rickets is the softening and weakening of bones in children, usually because of an extreme and prolonged vitamin D deficiency
46. **Rubella:** A viral infection spread through respiratory tract
47. **Sustainable Development Goal:** The Sustainable Development Goals (SDGs), also known as the Global Goals, were adopted by all United Nations Member States in 2015 as a universal call to action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity by 2030
48. **Sexual Transmitted Infections:** an infection passed from one person to another person through sexual contact
49. **Sexuality:** is defined as sexual feelings, thoughts, attractions and behaviours towards other people
50. **Skilled Birth Attendant:** is a health professional who provides basic and emergency care to women and their newborns during pregnancy, childbirth and the postpartum period
51. **Sepsis:** when infection is in/ reaches blood
52. **Tetanus:** A serious bacterial infection that causes painful muscle spasms and can lead to death
53. **Unsafe abortion:** is defined as a procedure for terminating an unintended pregnancy, carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both
54. **Universal Health Coverage/ Care** means all people have access to the health services they need, when and where they need them, without financial hardship
55. **Whooping cough:** A severe contagious respiratory tract infection by bacteria

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