Handbook for Field NGOs

An almanac for Managers, Supervisors and Field Workers

Reproductive and Child Health
Programme Phase II

Apex Resource Cell, NGO Division
Ministry of Health and Family Welfare
Government of India

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MESSAGE

The Government of India is committed to improve the health care services for all with particular focus on women and children living in the un-served and under-served areas of the districts of the country, under the mandate of National Health Policy and National Population Policy. The National Rural Health Mission (NRHM) and Reproductive and Child Health (RCH) II, has taken up steps to achieve objectives with partnership of various stakeholders. Non-Governmental Organizations, (NGO) like Mother NGO (MNGO)/field NGO (FNGO)/Service NGO (SNGO), commonly known as Mother NGO Scheme, has started playing a major role in complementing and supplementing the efforts of the Government in this process.

The scheme aims at strengthening the role of these NGOs not only in awareness and demand generation but also the service delivery for contributing towards reducing the Infant Mortality Rate (IMR), Maternal Mortality Ratio (MMR) and Total Fertility Rate (TFR).

The NGO division of this Ministry with support of Apex Resource Cell (technical wing) has been working on the capacity building and skill development of the Regional Resource Centres (RRC), MNGOs, and FNGOs to achieve desired results. Training of Trainers' Manual (TOT) has been developed and placed in the Ministry's website. The division has now developed Handbook for field NGOs. This handbook will act as an almanac for Managers, Supervisors and Field Workers and MNGOs will be able to use this in training FNGOs, while FNGO staff will be able to use as ready reference.

I wish the NGO division and ARC very best in their endeavor to achieve the programmatic goals.

(NARESH DAYAL)
Secretary to the Government of India.

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PREFACE

The Ministry of Health & Family Welfare (MOHFW) has been supporting NGO involvement in different activities of this ministry and specially Reproductive and Child Health programs since the early 1980s. In 1998, this ministry launched the Mother NGO (MNGO) scheme as an effort towards forging partnership and collaboration with Non-Governmental Organizations. The MNGO scheme under RCH II/NRHM is decentralized to State and District level and provides ample scope for MNGOs and FNGOs to work in un-served and under-served areas of the districts of the country. The scheme also addresses the issue of capacity building of NGOs. This has been achieved through establishing institutional mechanism such as Apex Resource Cell (ARC) at the NGO division of the Ministry, and Regional Resource Centres (RRCs) in the States. A standardized cascading model for training is in place with ARC providing leadership, technical support and training for the RRCs, who in turn build capacities of MNGO and through them FNGOs.

Training of Trainers' Manual (TOT) has been developed by ARC and NGO division in collaboration with UNFPA and RRCs, and placed in the Ministry's website. This manual is being effectively utilized by RRCs for training the MNGOs.

During visits and meetings with MNGOs an important felt need that arose was lack of uniformity in understanding and conceptualizing RCH issues and disseminating these to the community by the FNGO staffs. It was felt that the FNGOs working in the underserved areas need constant handholding and guidance on RCH and NRHM issues. Keeping this in mind a handbook for FNGOs (an almanac for Managers, Supervisors and Field Workers) has been developed. The focus of this handbook is on program management, supervision and facilitating service delivery. The present handbook can be used by the MNGOs while training FNGOs and is also a ready reference for the FNGO staff.

I wish the partners working in the scheme the very best in their efforts to achieve the programmatic goals of positive change in the under-served areas.

(S. Jalaja)

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ACKNOWLEDGEMENT

It is a matter of great satisfaction to lead a team that made the Non Government Organizations (NGOs) partner in the Reproductive & Child Health (RCH) II and National Rural Health Mission. The response of the NGOs and the UNFPA has been most satisfying. Lot of work need to be done to bring the faith of mothers of the under-served areas that they can have safe delivery and their new born can grow healthy. This handbook is dedicated to them.

I acknowledge the support of Shri Prasanna Hota, Ex-secretary (H&FW) and Shri Naresh Dayal, the present Secretary (H&FW) in bringing out this handbook for Field NGOs. I must express the gratitude for the continuous guidance and support of Ms. S. Jalaja, Mission Director & Addl. Secretary Min. of Health & Family Welfare. I shall be failing in my duty if I do not acknowledge the support and freedom to work provided by Shri K. Ramamoorthy, Jt. Secretary.

I deeply appreciate the role of Dr. (Mrs.) Vasanthi Krishnan, Ms. Charu Chopra and Ms. Kuldeep Pahwa, my colleagues of ARC for their support in designing and conceptualizing the handbook and content modification as per feedback and in line with RCH II and NRHM.

Special mention needs to be made regarding the contribution of all the staff members of Regional Resource Centres and NGO division, UNFPA team, consultants for their continued support in completing this mammoth task.

I acknowledge the support of UNFPA to agree to arrange printing this handbook.

15/03/07

(Dr. P. C. Das)

Healthy Village, Healthy Nation

स्वस्थ गाँव स्वस्थ राष्ट्र

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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
APL	Above Poverty line
AWW	Anganwadi Worker
BPL	Below Poverty Line
FNGO	Field NGO
GOI	Government of India
HIV	Human Immunodeficiency Virus
ICDS	Integrated Child Development Services
JSY	Janani Suraksha Yojana
LHV	Lady Health Visitor
MNGO	Mother NGO
NGO	Non-government Organization
PHC	Primary Health Centre
RCH	Reproductive Child Health
RRC	Regional Resource Centre
RTI	Reproductive Tract Infections
STI	Sexually Transmitted Infections

How to use the Handbook

The handbook for Field Non Government Organizations (FNGOs) is designed for use by the MNGOs as a reference guide to train FNGO staff in issues pertaining to program management and facilitating service delivery. In addition the FNGOs Coordinator/ Supervisor and field workers can also use this as a reference handbook. This handbook explains in detail the basic concepts of program management, and the steps for carrying out activities in the field. These are related to the roles of the coordinator, supervisor and the field worker. It is divided into three parts-

Section 1 has been designed for Managers and Supervisors keeping in mind their roles and responsibilities, Section 2 focuses on the Field Workers while in Section 3 – the various aspects of Reproductive and Child Health have been explained in detail keeping in mind the field workers.

Suggested uses of the FNGO Handbook are**:**

- As a training guide for the workers
- As a reference tool for Managers and supervisors
- For developing communication materials
- To communicate with village women who are peer educators

Section 1 – Managers and Supervisors

1. Introduction

Under the MNGO Scheme, FNGOs are responsible for implementation of RCH program in underserved and unnerved areas in the districts. A team consisting of Project Coordinator, 2 field staff (supervisor and field worker or 2 field workers) 1 part-time accountant will ably perform this task. The capacity of this team is to be built by the MNGOs.

To a large extent, the implementation of FNGO projects will depend on the team's knowledge, skills, enthusiasm, dedication and the support they receive from their MNGOs and block authorities.

For many of the Coordinators and Supervisors working on reproductive health issues this might be a first time experience. In order to maintain uniformity across the board in terms of: project implementation and its monitoring it is necessary that the MNGO build the capacity of the FNGO Coordinators and Supervisors, using the handbook.

The contents of this section have been developed keeping in mind the basic requirements of the Managers and Supervisors for enhancing knowledge and developing their skills in leadership, supervision, financial and administrative management and monitoring and evaluation. They are also free to use other training materials and visual aids while conducting training programs. The FNGO Coordinators and Supervisors should use this handbook as reference and for training their field workers.

2. The FNGO Team, roles and responsibilities

The FNGO Team Members

In most cases the FNGO team will consist of a Project Coordinator/Supervisor and 2-3 field level workers. Given below are some suggested qualifications, work experiences for selection of Program Coordinators/Supervisors and Field Workers and their roles and responsibilities. The proposed staffing pattern may vary from state to state.

Program Coordinator/Supervisor

Qualifications: Graduate in social work, home science, sociology, medical social work with 3 years experience in RCH program. Ability and knowledge of computers (MS Office, Internet)

Experience: Previous experience of working with NGO Sector in women's health, Integrated Child Development Services (ICDS) program, adolescent program at block and community level for 3-5 years.

Competencies: Ability to be work in a team, Good written and spoken communication skills in local language and English. Capable of handling overall project and establish liaison and networking with Government and other stakeholders. Willing to travel extensively within district and block. Willing to learn and work as a team member.

Roles and responsibilities of the FNGO Coordinator/Supervisor

The FNGO Coordinator has the following roles and responsibilities:

1. As a team leader – lead the team and support them in the decisions taken for project implementation
2. Work with the team members to guide and mentor them on different aspects of the project
3. Coordination and networking with Block and District level health officials for developing an action plan for providing services in their field area
4. Ensure that the team members' capacity is built through trainings/ exposure visits etc. that will be mainly conducted by the MNGOs.
5. Review with supervisor monthly and quarterly reports received from field workers and provide feedback
6. Submission of monthly and quarterly progress reports to the MNGO and the District officials
7. Submission of quarterly statement of Expenditure (SOEs) to the MNGO
8. Support and supervise work of the field workers
9. Train the field workers in planning and organizing work, community mobilization, developing village health plans, other RCH issues
10. Hold periodic meetings with village leaders on project progress
11. Advocacy with community leaders on the program and necessary support to field workers

The responsibilities include proper and timely implementation of project followed by periodic monitoring; Ensure good coordination and networking with the government officials, panchayat members; problem solving and supportive supervision for any necessary action; timely submission of monitoring reports to the MNGO and the Block health officials. Ensure that the FNGO staff undergoes periodic trainings.

Field Workers

Qualifications: Minimum requirement is 8th class pass.

Experience: working with women groups in health or related program, interested in working with women and children, adolescent population.

Other qualities- She should be preferably daughter-in-law of the village, resident of near by villages, willing to devote 2-3 hours per day to the project work. Good communication skills – both written and spoken. Pleasant manners and accepted by the women groups.

Roles and responsibilities of the field workers

1. Planning and implementation of various activities in the field
2. Identify and train potential peer educators from different villages
3. Disseminate information on reproductive and child health using multimedia approach
4. Coordinate with panchayat leaders, dais, Auxiliary Nurse Midwife (ANM) and Anganwadi workers for facilitating service delivery in the area
5. Submit monthly and quarterly progress reports
6. Member of Village Health Committee and be involved in preparation of Village Health Plan

Responsibilities

- Implement the various activities of the project in the allotted villages through coordination and networking with ASHA, women groups, ANM, Anganwadi Worker (AWW), panchayat members.
- Providing field information to the supervisor and manager to readdress project implementation plan, if required
- Organize periodic trainings for the peer educators
- Monitoring project implementation on a monthly basis and providing feedback to the community

3. Supportive Supervision

What is Supervision?

Supervision is observation and providing feedback to ensure the quality of the program and to enable the staff to perform to their maximum potential. Traditional approaches to supervision emphasized on 'inspecting' facilities and controlling individual performance. A supervisor is often mistaken to be a faultfinder or an inspector.

Difference between Supervision and Inspection/Policing

The main difference between the above two are that a supervisor needs to move away from the image of an inspector to that of a facilitator. As a supervisor you need to be oriented towards teamwork where problem solving is the main focus of the interaction and supervisors become on-the-job trainers who support their staff. This process is referred to as 'Supportive Supervision'

How to be an Effective Supervisor

Rather than only being a Supervisor try and be a 'Facilitator'- One who helps his team in achieving the goals and objectives and shares the blame for inconsistencies of the team and also the credit of the success.

To be an effective Supervisor at the grass root level one must:

- Establish clarity and understanding about various service delivery initiatives right from the start.
- Involve teammates in planning the program and developing individual work plans.
- A two way communication with your teammates will help in better commitment and ownership of the program by all team members.
- Assign responsibilities to your teammates and discuss clearly with them as to what is expected of them. Jointly develop a work plan for the various jobs to be done as per the timelines and the responsible individuals for each activity.
- Listen to your team members and try to understand their problems, for example: if a field worker has a small baby who needs to be breast fed several times a day, then try to help her by giving her jobs that will require her to stay in the office or near to the field office so that she can feed the baby at regular intervals.
- Provide open channels for feedback for example- conduct regular meetings, performance evaluations and personal visits to the field with your field workers and have one to one discussions.
- Providing feedback and not criticism should be the motto of a supportive supervisor.
- Learn to delegate duties as this reflects a sign of a good supervisor. Never try to centralize any work because it will not only limit the supervisor's creativity but also make the team members feel left out and inferior.

Feedback and Supportive Supervision

There is a very close link between the above two concepts. Feedback can only be effective if given timely in a positive and descriptive manner. A Supervisor giving feedback needs to know that this is a mechanism whereby supervisors provide information to the teammates for improving and mastering their skills and achieving the objectives of the program. Feedback however can only be effective if complemented by supportive supervision.

While giving feedback is important, receiving feedback is equally important for any supervisor. Therefore a conducive environment needs to be built between supervisor and the rest of the team members for giving and receiving feedback in the correct spirit and without feeling offended or trying to justify it.

Success of any program is hugely dependent on the efforts of the team and its supervisor!

4. Administrations and Financial Management

As Managers and Supervisors of a field level program two important functions that need to be performed are: Financial and Administrative Management. No project planning is complete till it is in sync with the financial management system and vice versa. It is important to have a clear understanding about the system of financial policies and

procedures when implementing programs or projects. Many managers and supervisors fail to do so as they are not updated and informed about the latest rules and statutory obligations. It is with this objective that the following financial guidelines prepared for the MNGO scheme must be known to all MNGO/FNGO Coordinators and Supervisors.

MNGO / FNGO FINANCIAL GUIDELINES

MNGOs Role (financial)

- Capacity building of FNGOs, Technical support to FNGO for financial management
- Monitor performance of FNGO budget and forecast
- Submit quarterly financial & project progress report to State RCH society through State NGO Coordinator (SNGOC) and District RCH society.
- Submit statement of expenditure and utilization certificates as per MOU

FNGOs Role (financial)

- Timely submission of quarterly progress & financial reports, Utilization Certificates as per agreement
- Maintenance of records and registers.

Fund flow

State RCH Society to MNGO:

Upon receipt of Sanction letter and signed MOU from District RCH Society through SNGOC, MNGO is sanctioned a project for a period of three years. The fund is released in 3 Installments.

- 1st. Release - for 18 months
- 2nd Release - for 16 months (based on favorable evaluation report and UC for first 12 months or end of FY whichever earlier. The evaluation will be at the end of year 1 and 3.
- 3rd installment - 2 months on receiving all completed UC, Audited accounts and project completion report.

The MNGO has the responsibility to further disburse the funds to the FNGOs.

Funding pattern for MNGO:

- 1 lakh for preparatory phase (for identification of un-served and underserved areas, and FNGOs, conducting base line survey and facilitating the development of FNGO proposals and MNGO composite proposals).
- MNGO gets an annual allotment 5-15 lakhs per district
- Allowed to retain 20 % of total project cost for administration, management, travel and FNGO capacity building.
- Non- recurring grant of max 1.5 lakhs for purchase of assets during first 6 months of the project. This expenditure is allowed as a one-time expenditure in the life of the project and is part of the 20% of the project cost retained by an MNGO. This is for clinical equipment and training materials as required by the project (example of suggested items

are: examination table, mattress, stool, BP instruments (2), foetoscope, Stethoscope (2), weighing machine, Ambu bag and masks, anatomical dummies – pelvis, fetus for demonstration; OHP, white/black board, tables, chairs, durries). Office equipment can include office furniture such as table, chairs, storage, cabinets, computer, and printer[1].

- An emergency-rolling fund of Rs.1 lakh can be made available to the MNGO to meet exigencies such as non-receipt of drugs, vaccines and contraceptives. This is subject to a no objection certificate from Dist. RCH officer.

Reporting by MNGO

- Quarterly financial and project progress reports to State RCH Society and District RCH society
- Annual audited Accounts i.e. Balance Sheet; Receipt and Payment Accounts; &Income and Expenditure.
- Utilization certificate GFR 19A

FNGO fund flow

Duration of FNGO grant is for 3 years released in 4 instilments.

- The first Installment is for 18 months
- Next installment for 12 months - based on favorable report by MNGO and UC for first 12 months or end of FY whichever earlier
- Next 4 months - based on UC of next 12 months and report
- Final 2 months on receipt of all UCs, Audited accounts and completion report
- Project evaluated annually by the MNGO and MO, Block PHC.

Maintenance of Organizational, Administrative and Financial records and Other Obligations

Records that are to be maintained are Organizational Records, Administrative Records and Financial Records

Organizational Records Include:

- Registration Certificate (Society/Trust/Company)
- Memorandum of Association and Bye laws; Registration Under Section 12 A (a) IT Act
- Registration Under Section 80 G and Copy of PAN / TAN
- Minutes Book – Recording (time, data, place of meeting, members present, records of decisions taken, Resolutions Passed - Serially numbered and each page signed and attested by Chairperson.
- Records of Filing of Annual Returns With Registrar of Societies and Income Tax Returns - 3A / 24 / 26

[1] Page 19, NGO Guidelines, Ministry of Health and Family Welfare, Government of India, 2003

Administrative Records:

- Service Rules if any, Appointment orders, attendance, leave rules & records
- Provision of TA/DA; Log Book - Vehicle, Telephone; Movement Register - Staff, Assets; Inward / Outward registers; Contract/Agreement (lease/rent) deed of premises used for program

Financial Records:

- Cash Book; General ledger / sub ledger; Stock Register – Consumables; Fixed Asset Register - GFR 19; Vouchers, Bank Pass books, Cheque Book; Copy of Bond
- Copy of Certificate / Undertaking; Sanction letters
- In case of MNGOs - QPR received from FNGOs and UCs
- Copy of reports and UCs sent to State RCH Society
- In case of FNGOs - QFR and UCs sent
- Copies of Final audited Accounts; Receipts & Payments Account; Income & Expenditure Account; Balance Sheets
- Printouts of Account Books (10 yrs)
- Irrespective of the date of release of funds, financial records have to be maintained as per the financial year starting April 1st and ending on March 31st.
- Quarterly financial statements need to be prepared for quarters ending on the last day of June, September, December and March

Statutory Obligations of MNGOs and FNGOs:

- Execute Bond in prescribed format with two sureties to the effect that the grantee will abide by all conditions of the grant
- Furnish Certificate that the person signing the undertaking is duly authorized to do so
- Furnish certificate - grantee has not been sanctioned grant-in-aid for the same purpose by any other department of Central/State government during the period to which grant is related
- Without prior sanction of GOI- will not dispose of or divert used of assets created or acquired
- Utilize Grant in aid only for the purpose specified in the sanction letter
- If proposed to be utilized for a purpose other than that sanctioned then prior approval must be obtained.
- Variation of 10% permitted within overall budget without touching Salaries & Travel
- Can't utilize savings in Salaries & Travel
- Can't transfer Grant to any other sister concern
- In the event of failure to abide by the terms and conditions to repay back the entire grant with interest thereon
- Separate Saving Bank Account for grant - Interest earned to be reflected
- Make available records for scrutiny by audit or **any other** person authorized on behalf of the Government
- To furnish UC in Form GFR 19A, along with annual Audited R&P; I&E and Balance Sheet not later than six months of the closing of the year

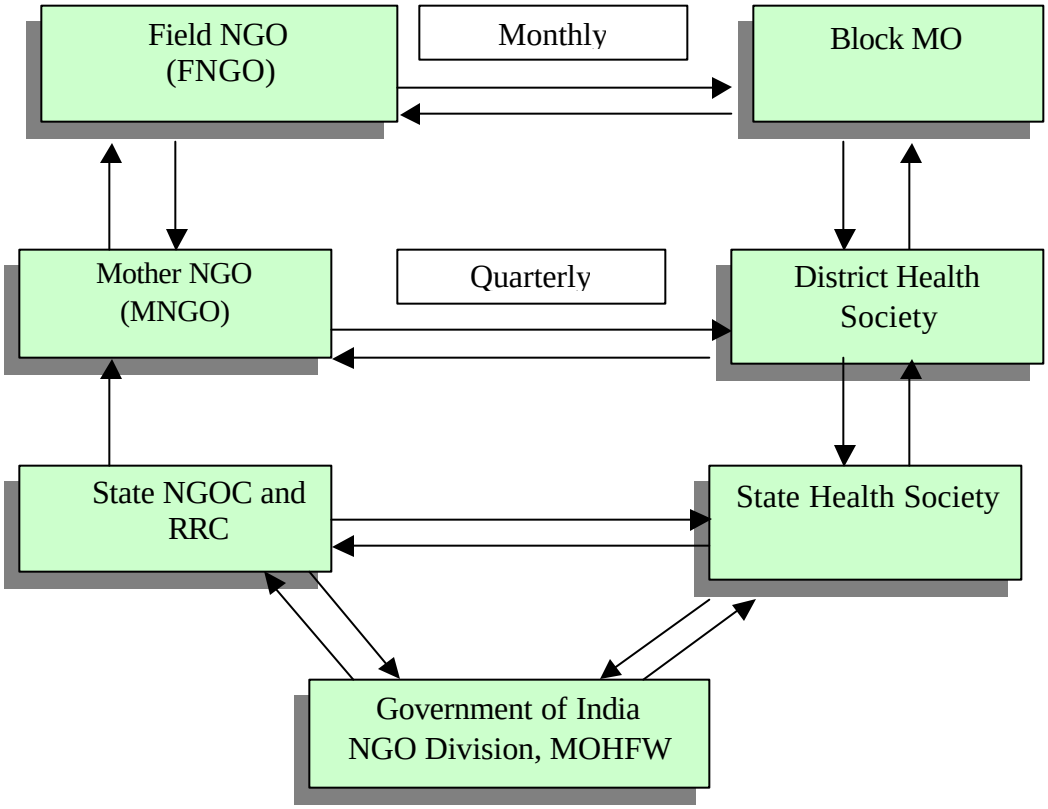
5. Monitoring and Evaluation

Through out the year we need continuous information on project performance. This is carried out by routine monitoring which can help identify problems early, so that timely action can be taken. Using indicators we can check on what was planned and agreed at the start of the project activity and what was achieved. The promoting and inhibiting factors can be then identified which will help in making a mid course correction.

Everyone should be responsible for monitoring. This includes the MNGO coordinator and staff, FNGO coordinator/ supervisor, field workers. Even community members can undertake simple monitoring activities. Monitoring is a program management function and is done in all phases of programme implementation. Through monitoring mechanisms such as field visits, meetings, performance evaluations, periodic reports and documentation, progress made in the program can be measured and suitable modifications can be made.

Information flow and feedback

Information collected at the field level is expected to reach the MNGO who will be responsible for further compilation and submitting the consolidated monthly and quarterly report to the District CMHO.



Field workers are responsible for community mobilization and facilitating service delivery. All reports compiled at the FNGO level are based on quantitative and qualitative information generated in the project area. In order to keep a log of the various activities carried out in the field and identify problem areas, achievements, the field workers will be required to record their respective activities in daily diaries as well as monitoring and reporting formats. In order to obtain information on all aspects of the project, monitoring forms to be used by field workers, FNGO supervisors and MNGOs have been prepared, pre-tested and circulated to all Regional Resource Centres and State NGO Coordinators.

Samples of MNGO Monitoring Register, FNGO Monitoring Register, Field Worker Register and Immunization Register are placed as annexure 1,2 3 and 4. Once trained in the use of these forms, the field workers and other FNGO/ MNGO staff can fill the forms as well as analyze the data. Besides gathering quantitative information through these methods, qualitative methods of monitoring should also be put in place. These include periodic field visits to project area and documentation of interesting case studies and success stories in the project area.

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Section 2 – Field Workers

1. Introduction

A cadre of field workers is being created through the MNGO scheme. To a large extent, the implementation of FNGO projects will depend on the workers knowledge, skills and understanding of Women's reproductive health, their enthusiasm and dedication as field workers and the support they receive from their supervisors and coordinators.

Field workers are persons, who will be able to volunteer their time to the project, live in the community settings and have a certain level of education so that they can understand and impart health messages to other community women and men. For many of the field workers, working in a project or stepping out of their house to work on health related issues might be a first time experience.

In order that uniformity in project implementation, including networking, communication with women groups, coordination with ANMs, AWWs and ASHAs, other development workers is maintained, it is necessary that the FNGO build the capacity of the field workers slowly but steadily. This can be achieved through classroom training, on-the-job training, review of work during field visits, and refresher training.

The contents of this section have been developed keeping in mind the basic requirements of the workers for enhancing their knowledge and skills. While training field workers, FNGOs are encouraged to base the trainings on the contents mentioned in the following pages. They are also free to use other training materials and visual aids while conducting training programs.

2. Roles and Responsibilities of Field Workers

The successful implementation of any program or project is largely dependent on the quality of fieldwork and the commitment, enthusiasm of the field workers. They are the most important link between the project and the community. A field worker has to work as a change agent in the community. It is very important that roles and responsibilities of field workers are clearly discussed with them at the start of the program and periodically during the project period.

The key roles of the field workers are:

1. Provide leadership and guidance to community men and women in identifying their health needs
2. Select peer educators from among community groups and train them in community mobilization, reproductive and child health issues
3. Register all pregnant women and ensure complete antenatal care is provided to all pregnant women
4. Ensure that peer educators counsel the pregnant women and husband, mother-in-law about the danger signs during pregnancy, delivery and postnatal period
5. Work with select community group members, ASHA, panchayat, local police, boat men, other transporters for developing a quick transport system from the village to the First Referral Unit (FRU)
6. Ensure that the pregnant women and families shift to institutional deliveries and are benefited by the Janani Suraksha Yojana (JSY) Scheme

7. Follow-up with postnatal mothers and register all newborns
8. Develop depots at village level for ORS, Condoms and Oral pills
9. Support the ANM during her monthly immunization days and Ante Natal Care (ANC) clinics
10. Maintain daily diary and monthly monitoring report
11. Record success stories from the villages and report these in the monthly report
12. Work with Adolescent girls and boys groups and create awareness regarding sexual reproductive health

Responsibilities of the field worker are:

Implement project activities at village level as per the time line

An important responsibility of the field workers is village mapping and preparing 6 months to one-year village or cluster wise activity plan.

Training of peer educators

Field workers will be responsible for training the peer educators identified in the villages. Once selected, these peer educators will work closely with the community groups on different reproductive and child health issues. The field workers and peer educators should form a team and work at the village level

Counseling of clients

Field workers have an important responsibility of communication and counseling clients. These clients can be women, adolescent girls, boys, or men. Complete and correct information should be given to the clients. They should be trained by the FNGO. With the help of the peer educators, the field workers should use different local media for communicating key messages to the women and men in the communities.

Coordination with other field workers

Field workers will be responsible for coordination and networking with the ANM and ASHA, the Anganwadi worker, the Panchayat leaders, peer educators in developing user-friendly counseling centers and clinics where community members can avail RCH services. In cases where projects are working with Adolescent girls and boys, the field workers should work towards establishing Adolescent and Youth Friendly Services.

Monitoring and Reporting

The field worker should maintain a system of monitoring and reporting the activities carried out by them. Records of daily and monthly activities can be noted in diaries. In addition, the field worker is expected to fill a monthly monitoring form giving details of the different services availed by the community members. The field worker is also responsible for maintaining stocks of essential supplies and contraceptives distributed in her/his field area.

3. Planning for field work

The Field NGOs work in unserved /underserved area covering 10-15 000 population of two sub-centres. In the case of plain areas this population will be spread over 10-15 villages (1000 population per village) while in the hilly areas, the number of villages will be between 20-30 villages (500 population per village). On an average, 3-4 field workers will be involved in any project and each worker should be allotted 4 villages in the plain areas and 6 villages in the hilly areas. The field workers will need to be trained by the FNGO in planning and organizing their work for efficient use of time and program effectiveness. Please refer to the sample microplan exercise for a FNGO placed at Annexure 5 of the handbook.

Project Implementation plan

Planning is the process of quantifying the amount of time and funds required for a project. The output of the project planning process is a project plan that a manager can utilize to track the project team's progress. Prior to starting the project implementation, the MNGO should hold a workshop on project implementation plan with the FNGO staff, government functionaries and select panchayat leaders. The objective of this exercise is to gain a common understanding of the field area, the community characteristics, existing demographic profile and present health seeking behaviors of the population. Any additional information as required by the project teams can be included. Most of the information for this exercise will be available in the baseline survey, focus group discussions, as well as from secondary data, obtained at the panchayat and block level. Details of the villages can be obtained from the participants themselves.

The MNGO/FNGOs must provide a project brief (objectives, strategies, activities) to all the participants at the start of the workshop. Given this background, the participants can be divided into smaller groups of 5-7 persons and asked to work on developing a time line and activity plan at the village level.

Table –1 Sample activity and time line

Name of the Village:												
S.No	**Sample Activities**	**Time line**										
		M 1	**M2**	**M3**	**M4**	**M5**	**M6**	**M7**	**M8**	**M9**	**M10**	**M11**	**M12**
1	Village mapping												
2	Household listing												
3	Formal launching of project at the village level												
4	Forming women groups and identification of peer educators												
5	Establishing counseling site for Pregnant and lactating women												
6	Coordination with ANM and AWW												
7	Meeting with adolescent girls												
8	Organizing ANC Clinics												

As part of this planning exercise, the participants should list the possible constraint or events that will effect the project activities e.g. sowing season, harvest season, rains and floods, season for marriages, festivals. Also some events can be used for mass communication- e.g. village haat or market days for setting up of booths for information regarding clinics and camps in the nearby villages.

Allotment of area of work to field worker

Another important activity during planning is the allocation of area of work or number of villages to be covered by each field worker. On an average, field workers working in plains will

work in approximately 4 villages, while those in the hills will be working in 6 villages. While allotting villages, keep in mind the location of FW village and the radius that she /he will have to cover.

Monitoring activity plans

FNGOs should give the field workers diaries for entering their daily report of activities carried out in the field and the achievements at the end of the month. Besides this the field workers will also be filling up their monthly reporting format to submit to the FNGO. These monthly reports and the daily diary when reviewed will give the FNGO and the field worker a fair idea of the work accomplished in a month, which activities are taking more time and the reasons thereof. The time line prepared by the field worker can thus be modified on a quarterly or 6 monthly basis.

4. Communications and counseling

Communication –is exchange of information between any two persons. The person sending the message is called the 'Sender' and the person to whom this message is sent to is called 'Receiver'. During the course of communication, there can be one 'sender' and many 'receivers' as in the case of groups, or it could be one 'sender' to one 'receiver'. The position of 'sender and 'receiver' is interchangeable. This is so because on receiving a message, the receiver replies and thus becomes the 'sender' while the sender receives the message.

Types of communication

There are two types of communication – verbal and non-verbal and these are further divided into one- to –one or group communication.

The term 'verbal' refers to the use of language and speech for communication. Verbal communication is commonly in use while talking to a person, holding a counseling session, or discussions with groups.
The second type of communications is Non-verbal. In this language and speech is not used, instead body language, drawings, sign language, artwork are commonly used. Among the different examples of body language are - facial expressions, eye movements, gestures by hand, body movements, emotions, which are commonly used to communicate messages.

Mode of communication

This refers to the use of language and if communication is written, spoken or through sign and body language.

Media of communication

In olden days, messages were sent from one village to another by a person caller a 'runner', it was a common practice used by the postal department, till modern methods and railways, road

transport systems were developed in the country. Birds such as pigeons, falcons, and eagles have been used in the past for communicating messages.

Among tribal populations the media of communication that still exists are drum beating, smoke signals and different sounds using pipes, bugles, and any such acoustics instruments.

Different types of media used in Health communication include:

- Print e.g. newspaper, posters, flipbooks, flashcards, flyers, banners etc.
- Audio e.g. Mikes, Loudspeakers, tape recorders, cassette players, CD players, Telephone etc
- Audio-Visual e.g. Drama, Television, Cinema, Documentary, Street Plays

Counseling clients

Counseling is the process of helping clients confirm or make informed and voluntary decisions about their individual care. It is a two-way exchange of information that involves listening to clients and informing them of their options. Counseling is always responsive to each client's individual needs and values. All providers regardless of their professional background and education need special training in counseling and informed choice.

For good counseling, there are 6 principle topics and steps in the counseling process.

The 6 Principles are:

1. Treat each client well- Be polite, show respect and trust
2. Interact- As a provider listen, learn and respond to the client
3. Tailor information to the client- listen to the client and learn what information each client needs. Also the stage of the person's life suggests what information may be most important
4. Avoid too much information –Clients' need information to make informed choices. But no client can use all information about every family planning method. Too much information makes it hard to remember really important information
5. Provide the method that the client wants- Help client make their own informed choices. Most new clients already have a family planning method in mind. Good counseling about method choice starts with that method. Counseling also addresses advantages and disadvantages, health benefits and side effects
6. Help the client understand and remember- the provider shows sample family planning materials, encourages the client to handle them and show them how they are used. The provider shows and explains using flip charts, posters or simple pamphlets or printed pages with pictures.

Steps in counseling new clients

The example used is for counseling clients on family planning. However, the principles and steps for counseling are applicable in all situations.

Deciding on a family planning method and using it involve a step-by-step approach. The process of counseling new clients consists of 6 steps. The 'GATHER' steps for counseling are:

G-Greet the client
A-Ask clients about themselves
T-Tell clients about their choices
H-Help clients choose
E-Explain what to do
R-Return for follows up

G- Greeting the client
'Namaste'. Make the client comfortable and ask them to sit either on the chairs or mats or charpuoy, as available in your room. Tell them that you will not disclose to anyone what they have told you. Also tell them that you will give them simple and basic information and they can get more information during their meeting with the ANM, LHV, or doctor where they shall be taken on a fixed date and time.

A – Ask clients' about themselves
Ask the clients why they have come and what assistance do they require. Help clients talk about their family planning and reproductive health experiences, their intentions, wishes, current health and family life. Ask if they have a particular method in mind. Ask simple questions. Listen to the client's views, words, gestures and expressions.

T-Tell the clients about the possible choices
Using the flipbook, provide the clients with information on all the different family planning methods. Focus on methods that most interest the clients, but also talk to them about the other methods, their advantages and disadvantages.

H- Help the clients choose
Encourage the client to express opinions and ask questions. Respond fully and openly. Avoid taking the decision on behalf of the clients. Tell them that they have to choose, keeping in mind their family situation. When you take them to the ANM or LHV/Doctor, they should be in a position to state their choice.

E- Explain what they have to do
On the chosen method the ANM, LHV, Doctor will give them more information about what they are supposed to do and what they should not be doing.

R- Return visit for follow up
This is important. Check with the client during your next visit to her village. Enquire how she and her husband are comfortable with the chosen method. Accompany them to the service facility when they go next to meet with the ANM, LHV, or Doctor.

Any woman/man or couple who seek counseling or any other service is called a 'client'. They have the following right to:

- Information,
- Access to services,
- Informed choice,
- Safe services,
- Privacy and confidentiality,
- Dignity comfort and expression of opinion

The FNGO should train their workers in counseling and use of information materials in the different aspects of maternal, child health, adolescent health and family planning. The MNGO should identify different flyers, flipbooks, charts that are simple and easy-to-use for field workers.

Although the main task of counseling and providing service to the woman or couple rests with the ANM, LHV and the doctor, training FNGO health workers in counseling can be of benefit to the community as they have closer rapport with the young couples, adolescent girls and boys in the villages.

5. Working with groups

Introduction

In social empowerment projects such as Health, education, water and sanitation, nutrition, adolescent health etc, community participation and involvement plays a very important role. The involvement of communities begins from the time of Baseline surveys, when information is gathered from selected households and Focus group discussions are held to identify the existing community problems and seek their solutions from within.

In unserved underserved areas, outreach services are few and far between; hence community perception or felt needs are also not raised. Therefore when field workers enter the villages, they will be facing an uphill task of working with the communities in the villages assigned to them.

What is a community?

Community is defined as 'A group of people with a common characteristic or interest living together within a larger society'. People living in one village may belong to separate communities and people living in two or more villages may belong to one community. Still when each of these communities interacts with each other – there is a social, political and economic relationship between and amongst these communities. A community in some senses may not even have a physical location, but be demarcated by being a group of people with common interest, skill or religion. All Communities are divided on a hierarchical base these being: Caste / Class based; Age based.

What do we look for in a community setting?

Let us look at community settings in a village. This is made up of a group of houses spread over a sizeable area, with more than one source of natural water (e.g. ponds, water tanks, wells, hand pumps) and agricultural land or forest near by on which the community is dependent. Houses are either 'Pucca', (walls made from bricks, and concrete roof), semi pucca (walls brick and roof-thatched), 'kucha' –only mud walls and thatched roofs.

As part of daily routine work, the field worker should interact with different households, and gather information about the household members, their access to education, water, health care, electricity, transport and food. He/She should also note down the various means of livelihood for men and women members in the household. This information can be noted in a simple tool called the 'Household survey register'.
Another task for the field workers is 'mapping of the villages' giving the placement of the houses, water, river, land, school building, Subcentre and any other key items.

Both the data and the map will give the field workers a fair idea of the village setting; number of Below Poverty Line (BPL) families and those in Above Poverty line (APL); average family size, number of eligible couples; number of children 0-5 years; families accessing various services; caste breakup; social constraints within the larger community; gender relations and distribution of household chores, work between men and women, girls and boys.

Launching the project

The FNGO worker and supervisor should identify a suitable date and place for launching the project in a cluster of villages. Trying to initiate work in the entire project area at the same time may lead to bottlenecks. During the launch of the project, District or PHC MO, Block Development officer, panchayat leaders, religious leaders and important women leaders in the near by villages should be invited. People should be informed about the FNGO project and need for people's participation.

Forming groups

Bringing together women, men or adolescent population, can constitute groups. Mixed groups are very rarely seen in village settings. Depending on the project and the identified target (women, men, adolescents), the field worker will have to go about forming groups in the villages. Usually there will be 1-2 groups per village with 15-20 members in a group. The group members will need to identify a space for their regular monthly meetings fix timings and maintain a record of their meetings. The FNGO should train the field workers in the technique of group formation. Simultaneously, the MNGOs should identify relevant IEC materials for discussion with the groups.

Identification of change agents from within the group

In 4-6 weeks, the group members will become friendly and more cohesive with an exception of a few members who may still be aloof or very quiet. Such members must be spoken to separately

and encouraged to participate. This will a good time to ask the group members to identity a representative from amongst them whom they feel will be able to work for the welfare of the group. In addition, it will be advantageous if the person identified is a daughter-in-law of the village, 25-35 years of age, literate and studied up to class VIII. Such identified representatives are the future peer educators or change agents of the groups.

Training of Peer educators

The MNGO/ FNGO have the task of organizing simple and short training programs for the peer educators or change agents. In consensus with them, the norms of group activities can be laid down, such that it does not interfere with the daily routine work of the village women and their wages. The peer educators should be informed that this is a voluntary work but would open future avenues and give them ample opportunities to learn new skills.
Once they are confident with the basic information package on Health and the performance of health indicators in their villages improve, the FNGO will try to give them additional responsibility of social marketing of contraception, becoming depot holders, formation of micro credit groups, and link their groups with other block development activities which will enable the women to earn additional income.

Follow up of the group activities and utilization of services

The field worker has the responsibility of following up with the several groups in the project area. The groups should be encouraged to attend the meetings, maintain a record of their group activities; discuss key RCH issues; utilize the clinical services and camps being organized in the vicinity of their villages.

The field worker should identify a fixed day and time to visit the different villages for the meetings and also listen to the progress made by the groups. Some groups may bring their problems to the Field worker. In such cases, the field worker is encouraged to inform the supervisor who will have to accordingly handle the same.

6. Monitoring and Reporting

Introduction
Monitoring is the term used for gathering continuous information on the performance of project interventions using indicators.
In most RCH projects, issues of creating a demand and providing the necessary service delivery need to be addressed. 'Demand' creation is through the Behavior change communication strategy while 'supply' is primarily through improving service delivery.

As a field worker, you are responsible for the implementation of the day-to-day activities of the project at the village level, maintaining a record of the various activities and utilization of these activities.

Examples of activities are:

1. Meetings with the village leaders and PRI members
2. Formation of women groups
3. Strengthening of existing women groups
4. Developing street plays, puppet shows on different aspects of RCH
5. Training of peer educators in RCH
6. Counseling Antenatal women
7. Referral services for women and children

Monitoring tools

These are required for monitoring activities at (a) community level and (b) service delivery.

(A) Community level monitoring

In this, members of the community should be involved right from the beginning. The field worker should discuss with key group members or the peer educators and come up with an agreed plan on the following:

- Periodicity of meetings for discussing the progress made in the different activities undertaken in the project
- Identify and select monitoring group members
- Design with the group members the simplest and easy to understand monitoring tools (colors code- green for good, yellow for average and red for poor; use of numbers and grading - for e.g. 0-3- poor, 4-7 -average, 8-10 –excellent)
- Information sharing with the rest of the community as well as the project staff.

The field worker should maintain a daily diary for recording His/her visits to villages; meetings with Sarpanchs; meetings with women and other beneficiary groups; any meeting with block officials or ANM visit; information on difficult groups. In addition, important telephone numbers –e.g. Block medical officer, nearest PHC medical officer, nearest Ambulance services will be useful for any emergencies. The FNGOs are encouraged to give the field worker a diary at the end of the monitoring training.

(B) Monitoring of Service Delivery activities and utilization

Village Field Worker Register

This has already been prepared by the Apex Resource Cell, NGO Division, Government of India (GOI) in line with the NRHM and is appended as annexure 3. It is available with all Regional Resource Centres and State NGO Coordinators. All field workers are to be trained on the use of this register. Monthly recoding of information on different aspects of service delivery should be recorded and shared with the supervisor. The FNGO supervisor will give the cumulative figures for the project area to the Block Primary Health Centre (PHC) medical officers.

Immunization Register

This too has been prepared by the Apex Resource Cell, NGO Division, GOI in line with the NRHM and is appended as annexure 4. It is available with all Regional Resource Centres (RRCs) and State NGO Coordinators. All field workers are to be trained on the use of this

register. Village wise information on immunization status of children can be obtained through this register. The FNGO supervisor will give the cumulative figures for the project area to the Block PHC medical officers.

Consolidated Monthly or Quarterly Report

Besides collecting information through the above registers, the field workers should be encouraged to make 1-2 page monthly or quarterly reports where they are able to give a summary of the important activities held in their area. They should be able to write success stories of referral to the nearest hospital, benefits from the project as narrated by the women, how women are benefiting from Janani Suraksha Yojana.

The FNGO supervisor or coordinator can also record photographs of important events and community persons who are utilizing services or participating in project implementation. All this can be compiled and sent to the Regional Resource Centre for placing in their website or newsletter.

Feedback

An important aspect of monitoring that is usually weak is feedback to the field workers and supervisors. It is necessary that the FNGO hold regular meetings at field level or at their headquarters for project review and feedback. Continuing education of field workers on different issues can also be a part of these meetings.

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Section 3 – Facilitating Service Delivery

1. Introduction

In India, women of reproductive age (15-49 years) and children (less than 15 years) constitute 60% of the total population. They comprise the vulnerable fraction of the population due to the risks connected with childbearing in case of women; and growth, development and survival in case of infants and children. This handbook on facilitating service delivery will enable FNGOs to:

1. Improve the knowledge and understanding of the FNGO TEAM (Coordinator, Supervisors and Field workers) regarding the kind of RCH services for adolescents, women and children.
2. Educate men, women, families and dais about pregnancy, childbirth and care.
3. Counsel women, families and dais in handling emergency situations during pregnancy, childbirth and for children 0-5 years.
4. Generate awareness among young adolescent population regarding their Sexual Reproductive Health.
5. Counsel adolescents and couples regarding Reproductive Tract Infections and Sexually transmitted Infections.
6. Counsel adolescents and couples on Client's rights', various contraceptive methods and making the reproductive choices.
7. Enable women and their families to utilize outreach services provided either by the FNGO or the District authorities.

A. Care of a pregnant woman

Early registration

Timing of the registration

- The registration of a pregnant woman for ANC should take place as soon as the pregnancy is suspected.
- Every married woman in the reproductive age group (15-49 yrs) should be encouraged to visit her health provider (ANM) or inform you if she believes herself to be pregnant.
- Ideally, registration should take place in the first three months of pregnancy i.e. before or at the 12^{th} week of pregnancy.
- However, if a woman comes late in her pregnancy for registration, she should be registered, and care given to her according to the number of weeks or months of pregnancy.
- An antenatal card should be duly completed for every woman registered by you. The card should be handed over to the woman. She should be instructed to bring the card with her for all subsequent check-ups/visits, and should also carry it along with her at the time of delivery.

- This information should also be recorded in your antenatal register.

As soon as you come to know of a pregnant woman in the village, register her with the ANM. Ensure registration of all pregnant women before or at the 12th week of pregnancy.

Calculation of Expected Date of Delivery from Last Menstrual period

- To estimate the expected number of pregnancies that should be registered with you annually, you must know the birth rate and the population size of the area under our jurisdiction.
- The expected number of live births in a year in a given area can be calculated by multiplying the birth rate (per 1000 population) with the population of the area, and then dividing it by 1000. As some of the pregnancies may not result in a live-birth (i.e. abortions and stillbirths may occur), the expected number of live births is an underestimation of the total number of pregnancies. Hence, a correction factor of 10% is required, i.e. add 10% to the figure obtained above. This will give the total number of expected pregnancies.
- As far as possible, you should use the local birth rate. If that is not known, the district-level, state-level or national-level figures can be used (in that order of preference).
- Use the latest census report to know the exact population of the area under your jurisdiction.

Birth rate	= 25/1000 population
Population under the subcentre	= 5000
Therefore, expected number of live-births	= (25x5000)/1000 = 125 births
Correction factor	= 10% of 125 (i.e. [10/100] x125) = 13
Therefore, total number of expected Pregnancies in a year in that subcentre	= 125+13 = 138

- As a rule of thumb, in any given month, approximately half the number of pregnancies estimated above should be in your records.
- If the number of women registered with you is less than expected, then you should approach the community leaders and key people, as mentioned earlier, to ensure that more pregnant women are registered and come for ANC.

- It is possible that some women may be receiving ANC from the private sector. At least ensure that their names are mentioned in your antenatal register. Attach a note giving the name of the facility from where they are getting ANC.
- Estimation of the number of pregnant woman will also help you and your PHC in calculating the requirement of TT vaccine, iron-folic acid (IFA) tablets and disposable delivery kits (DDKs).
- Date of the last menstrual period (LMP) – **Remember that the LMP refers to the FIRST day of the woman's last menstrual period**. Ensure that the woman, while telling you her LMP, is NOT referring to the date of the first MISSED PERIOD. This mistake will lead to miscalculation of the gestational age and expected date of delivery by 4 weeks.
- Duration of pregnancy in a woman is for 40 weeks or 10 Lunar months.
- This is calculated from the start date, month of the last menstrual period (e.g. 3 April 2005). Counting nine months from April and adding 10 days to the date, calculate expected date of delivery, which, in this case is 13 January 2006.

Field workers must know the months in the local language as well as the important festivals celebrated in their villages. This is a useful when calculating the expected date of delivery.

Antenatal care

Antenatal care or ANC as it is commonly referred to is important for both the mother and her baby. Through an antenatal checkup, complications can be detected at an early stage before they become life-threatening emergencies. Hence, every pregnant woman needs special care.

Good quality antenatal care consists of 3 or more check ups. The first check up is during the first three months of pregnancy when her name is registered with the ANM; second check up is during 4-6 months of pregnancy and third checkup is during 7-9 months of pregnancy.

As a field worker it is important that you:

- Educate the village women about Antenatal checkup and its importance.
- During the Antenatal visit, the ANM will enquire from the pregnant woman about her present pregnancy, her past pregnancies, deliveries and her general health. She must be informed about the name of the pregnant woman, age, her husband's name,

number of living children, the date and month of her last menstrual period for calculating the expected date of delivery.

- The pregnant woman and her family must also inform the ANM about any problem faced during the present pregnancy, previous pregnancies, and details of the past deliveries. The ANM must be informed if she has suffered from any prolonged illness in the past.
- The ANM will examine the pregnant woman and record her weight, blood pressure, examine her eyes and tongue for signs of anaemia and jaundice, carry out an abdominal examination for assessing the duration of the pregnancy and growth of the baby in the womb through an abdominal examination. In some subcentres, blood and urine sample of the pregnant women are also routinely tested.
- Ensure that all pregnant women in your area avail of the ANC services being provided.
- Make special efforts to reach the women of BPL, SC/ST and other marginalized groups.
- Ensure that all women pregnant for the first time and or in the age group of 13-18 years of age undergo the antenatal care.
- Take the help of the Anganwadi didi, women's groups, ASHA trained dais and other community partners to reach out to each pregnant woman, especially the above-mentioned groups.
- Contact the ANM and organize a fixed day ANC clinic either at the nearest subcentre or an alternative place e.g. panchayat ghar.

Recognize that ' Every pregnancy is at risk'. This is because even with the best care during the pregnancy period, it is difficult to predict which woman will develop pregnancy-related complications.

Rest, work and diet during pregnancy

These are important aspects of pregnancy that women tend to neglect during the antenatal period. As a field worker, you must counsel the pregnant women and her family on the following points:

- All pregnant women must get 8 hours of rest at night and rest for another 2 hours during the day.
- While lying down, they should lie on their side and not on their back as it improves the circulation of blood to the unborn baby.
- While sitting, they must keep their feet on a stool so as to prevent any swelling of their feet.

- Pregnant women should be discouraged from doing heavy work, especially lifting heavy weights. She should be helped by the other women in the household for carrying out the routine household chores.
- A pregnant woman should be advised to eat twice the amount that she normally eats. Her husband and mother-in-law should also be taken into confidence and counseled regarding the recommended diet for the pregnant woman.
- Her diet should include rotis, chappatis, rice, milk, curd, cheese or paneer, green leafy vegetables like palak, cholai, all types of pulses or dals, nuts (esp. groundnuts) jaggery, fruits, eggs, meat, fish, chicken if woman is non-vegetarian. She should be advised to eat locally available, affordable and seasonal fruits and vegetables.
- She should avoid tea, coffee or taking tobacco especially within 1 hour of meal as it interferes with iron absorption. Ideally, women should refrain from chewing or smoking tobacco during pregnancy and after delivery.
- She must take fruits like amla, oranges, guava, lemon as it helps in iron absorption
- Throughout her pregnancy, women should be advised to avoid smoking and drinking of alcohol.

Normally a woman should gain 9-11 kg during her pregnancy. After the first three months, a pregnant woman gains around 2 kgs every month or 0.5 kgs per week

B. Birth Preparedness and Complication Readiness

Delays and danger signs

As mentioned earlier 'every pregnancy is at risk'. It is difficult to predict which pregnancy, delivery or post delivery period will experience some complication, hence it is very necessary that families and field workers are prepared for handling any emergency that arises. There are 3 delays leading to death of a pregnant woman or her unborn or newborn baby. These are divided into:

- Delay 1: Delay in deciding to seek care
- Delay 2: Delay in reaching the health centre, and
- Delay 3: Delay in receiving treatment at the health centre

Identification of danger signs, and quick decision making to seek care from Skilled Birth Attendants at Institutions (Hospitals) will save the lives of countless women and newborns.

Table 2: Various danger signs and simple first aid at village level

S.No	Danger Signs in Antenatal Period, during delivery or post delivery period	Action required by Field worker and family of pregnant woman
1.	Excessive vomiting especially after the first 3 months of pregnancy- can lead to dehydration	Calm the pregnant woman Give her Oral Rehydration salt solution Rush woman to the hospital
2.	Bleeding or spotting at any time prior to delivery	Ask for history of violence, fall Do not allow dai or relative to place any cloth inside the birth canal Family or friend should be prepared to donate blood Rush woman to the hospital
3.	Leaking of watery fluids through birth canal before the due date	Calm the pregnant woman Make her lie down on a charpoy/cot Raise the foot end of the charpoy/cot Rush woman to the hospital
4.	Generalized swelling and puffiness of the face with or without fits	Rush woman to the hospital. She may require admission
5.	Fever (esp. in malaria endemic areas)	Wet cloth over forehead Give lots of fluids Rush woman to the hospital
6.	Decreased or absent movements or heart sounds of the unborn baby	Calm the pregnant woman Do not do any abdominal massage or push the baby down Rush woman to hospital
7.	Woman in labour for more than 12 hours	Inform the family about the status of the labour and rush her to the nearest hospital
8.	Baby delivered but placenta not delivered even after half an hour interval	Do not pull the cord or exert any abdominal pressure Baby to be put to the breast Move woman to hospital
9.	Uterus ruptured and no movements of the baby felt	Rush woman to the hospital

Counsel the pregnant women and their families on the danger signs during the pregnancy, delivery and post delivery period and the first aid that will be subsequently required. In all these conditions, transport (e.g. boat, jeep, tractor trolley, palki), emergency funds at household and village level, name and distance of the nearest hospital *(where doctor, nurse, medicines and emergency facilities are available all round the clock)* from the village, motor able roads, are a MUST, for saving the lives of these people. This is a working referral system.

Who should conduct the delivery?

- A health provider who is either an ANM, LHV, Nurse midwife or a Doctor trained in conducting normal labour and deliveries, identifying and managing complications and taking decisions for further referral to the higher centers is the best choice for conducting the delivery. Such a health provider is called a Skilled Birth Attendant.
- If a Skilled Birth Attendant is not available in the nearby area, then the family can engage a trained Dai. *(Remember, that the trained dai however well trained is not a skilled birth attendant. The Supervisor and field worker must spend time with the dai and discuss the important danger signs with her and ensure that in the event of an emergency the woman and her baby are shifted to the hospital).*
- At no cost should the families engage an untrained dai or a relative for conducting the delivery.

Choosing the place for the delivery

Even today most of the deliveries are being conducted at home and many amongst these are in cowsheds and under unhygienic conditions. Some examples of delays occurring at home and by trained or untrained dais/relatives resulting in death of the mother and or the newborn: -

- The dais not being able to identify a danger sign in the initial stage and poor decision making skills for shifting the woman to the hospital. (Delay 1)
- The villages are situated too far away from hospitals and it is difficult to reach the hospitals due to poor road conditions and transport problems (Delay 2)
- Difficulty in arranging for a transport at the last minute (Delay 2)
- Little or no emergency money for payment against hired transport for shifting the woman and her baby (Delay 2)
- As they reach late, the condition of the woman or her baby is very critical, or doctor is not available or there may be no blood in the hospital (Delay 3)

Therefore, save the lives of women and newborns by counselling every pregnant woman and her family to go for an institutional delivery.

Safe delivery practices

Ideally, all births should take place in a health center or hospital and by a skilled birth attendant. However, in situations or conditions wherein these are not possible, it is necessary that the birth attendant adapt safe delivery practices.

By safe delivery practices we are referring to the use of clean place, clean hands, a disposable delivery kit by the person who conducts the delivery and clean birth outlet.

- First clean is: choosing a 'Clean Place' in the home for conducting the delivery. The birth attendants as well as family members should be dissuaded from using cowsheds as birthing places. In many villages in India this continues to be a

traditional practice. As a field worker you should counsel them to stop this harmful practice. Educate and counsel the families about the risk of tetanus infection that the mother and newborn could be exposed to.

- Second clean is the use of 'Clean Hands: the person conducting and the person assisting in the delivery should both wash their hands (up to the elbow) with soap and water. They should not use any towel to dry their hands after washing. Bucket of water and soap should be made available, for hand washing.
- Third clean is a 'Clean Birth Outlet': the birth attendant should use a new blade and razor for shaving the opening of birthing passage (perineum) and using lukewarm water, clean cloth or cotton wool wipe the same before delivery of the head of the baby.
- Fourth clean is - 'Clean Cloth'- explain to the pregnant women and the families that they must keep ready soft clean cloth, which can be used for wrapping the baby. A small bag containing 2 sets of washed clean clothes for the mother, old clean cotton clothing to wrap the baby should be kept ready.
- Fifth and sixth clean are 'Clean Blade and Clean Cord Tie'- these are always available in the disposable delivery kit. The field NGO through the field worker should give the pregnant women one disposable delivery kit (DDK). This may be procured through Government supply or from the subcentres. The DDK as it is commonly referred to has a new blade for cutting the cord, clean cord tie, new soap for hand washing, clean gauze for wiping the eyes of the new born.

In addition to the above, as a field worker you should:

- Initiate small savings in Self-Help Groups for emergency health care
- Ensure maternity card is provided to Pregnant women by ANM.
- Provide the updated list of BPL families to the ANM.
- Educate the women and families regarding the Janani Suraksha Yojana.
- Identify group of male volunteers who will organize an emergency transport.
- In blocks where villages are prone to be cut off from the main roads due to floods, landslides or other natural calamities women in late stage of pregnancy should be moved to the nearest delivery center a few days in advance.

C. Post delivery care

In the entire world, half of all maternal deaths take place within day one of delivery and 70% of maternal deaths occur within the first week. During the National Health Survey (NFHS-II) it has been recorded that only 16.5% women received a post-delivery check up within two months of delivery. Of these, less than one third were seen within the first 7 days after giving birth to the baby-a very critical period for the survival of both mothers and newborns. In unnerved/underserved areas, these figures will be still lower.

As a large proportion of births especially among the poor may continue to occur at home and even the institutionally –delivered babies and their mothers are likely to be discharged within a day or so after delivery, the field worker should be able to counsel women and families on care of the mother and the baby after delivery

All women should be counseled on the following:

i) They will be visited by either a trained dai or ANM, LHV, Doctor on the

1. First day and within the first 24 hours after delivery
2. Within the first 7-10 days

ii) During these visits the women will be asked the following questions:

- Details of delivery and who conducted the same.
- The number of pads or cloth pieces getting soaked with blood. If a woman bleeds heavily, she will soak a pad or cloth in less than 5 minutes- this amount of bleeding is a serious threat to her life. She will require urgent management and referral.
- Any fever, foul smelling discharge, abdominal pain or convulsions.

Some enquiries will be made about the newborn baby:

- History of birth, when the baby has passed urine and or meconium (first stools). Ideally, a newborn should pass urine within 24 hours and meconium within the first 48 hours
- Any Fever
- Difficulty in suckling and acceptance of feeds
- Breathing – normal or with difficulty

In the second visit, the trained dai or ANM, LHV, Doctor will repeat the above questions and also ask the mother about her general well being and happiness. The health worker should again check the mother for:

- Continued bleeding (delayed PPH)
- Foul smelling discharge from the birth canal
- Swelling of breasts or engorgement of the breasts
- Pain or problem while passing urine

They will check the newborn for:

- Cough or cold
- Loose stools
- Fever
- Suckling
- Condition of the umbilicus and any redness or pus discharge from the umbilicus

(iii) Counsel the women and families about the need for

- Extra intake of 550 kcal in a day for the first six months (An extra meal consisting of 2 chapattis or 1 cup rice, 1 cup dhal, 1 cup cooked vegetables, 1 glass milk and 1 cup tea is equivalent to taking 550 K Calories). This intake can be reduced to 400 kcal for the next six months.
- Adequate rest after delivery to regain her strength.

(iv) Newborn care and feeding:

- Baby to be kept warm and dry
- Delay bathing the baby
- Avoid prelacteal feeding (honey, diluted goat milk, water)
- Colostrum feeding within the first 2 hours of birth and continued breast feeding
- Exclusive breastfeeding for 6 months
- Demand feeding should be encouraged
- No bottle feeds

(v) Contraception

Remind the mother that whenever she restarts her menses and or stops exclusive breastfeeding she can conceive even after a single act of unprotected sex. The various choices of contraceptives available should be told to the couple so that they can make an informed choice.

D. Newborn and Infant Care

Children are the building blocks of a nation. Survival of newborns and infants is directly related to the maternal health, nutrition status and the management of complications during delivery and post delivery period. The present Infant Mortality Rate in India has reduced from 65 per 1000 live births in 2002 to 56 per 1000 live births in 2005.
(Ref: http://www.unicef.org/infobycountry/India India statistics.html)

Infant mortality is death of a baby aged 0-1 year. Of these almost 66 percent deaths occur in the first month of life. Among those who die in the first month, over 66 percent die in the first week of life. Of those who die in the first week, almost 66 percent die in the first 24 hours of life. Deaths in the first one-month of life are known as neonatal deaths. The causes of neonatal deaths are:

- Neonatal sepsis (infection and fever)
- Pneumonia (congestion in the lungs)
- Birth asphyxia (baby fails to start and sustain breathing at birth)
- Premature birth (birth before completing 37 weeks of gestation)
- Low birth weight (babies born with birth weight less than 2,500gms)

Infant mortality includes all causes of deaths occurring to babies from birth to one year of age. The major causes of infant mortality are:

- Low birth weight
- Infections (acute respiratory infections, tetanus, pneumonia, malaria during pregnancy)
- Diarrhoea
- Measles
- Accidental causes- drowning in a tub of water, fall from a height
- Congenital anomalies or birth defects

- Cot deaths- death of the baby when asleep – reason could be suffocation, vomiting of milk or unknown causes.

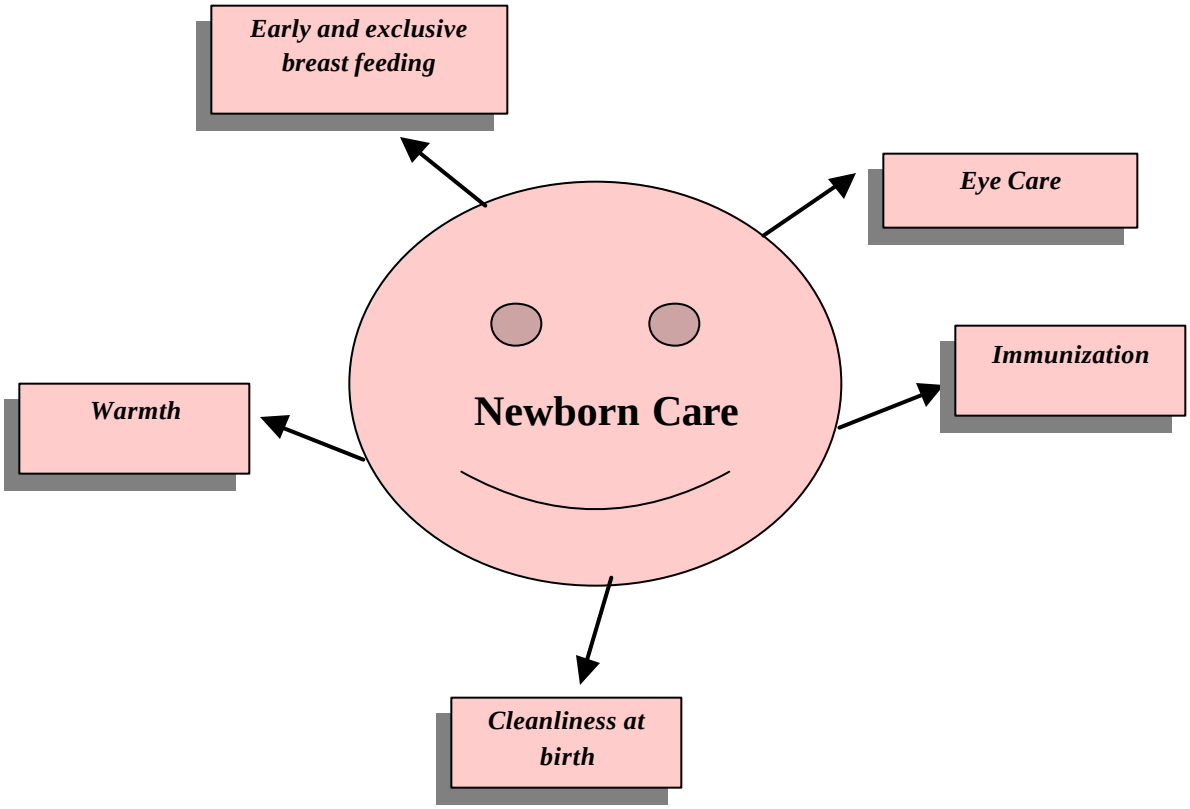
Love is not enough- they need the right care too- WHO 2005

A field NGO worker can play a major role in saving the lives of these babies through:-

- Counseling women groups in newborn care, including exclusive breastfeeding, immunization, complementary feeding
- Weighing of all newborns and follow up
- Registration of all births
- Early identification and quick referral of sick babies
- Managing a depot for Oral Rehydration Salts and training mothers in use of ORS
- Coordination with women groups, local panchayat, Anganwadi worker, ASHA or link worker and the ANM

(a) Newborn care

Counsel the trained dai and the families of pregnant women about basic newborn care. These include:



(i) **Cleanliness at birth**

- Washing hands with soap and water before conducting the delivery
- Using a clean surface for the delivery
- Using clean razor blades and cord ties for the cord
- Washing of hands before handling a newborn baby

In addition babies being with their mothers in a separate room reduces the chances of any infection to them from others.

(ii) **Warmth**

Inform the trained dais, mothers of newborns and the families that on delivery, newly born babies especially premature and small ones lose heat rapidly. Hence, they should use simple measures such as:

- A warm room for delivery
- Immediate drying of the baby
- and extensive skin-to-skin contact with the mother
- Delay bathing the baby by 7 days
- Do not rub or remove the white coat over the newborn babies skin

All these prevent loss of body warmth of the baby.

(iii) **Early and exclusive breast feeding**

- Newborns must be put to the breast immediately after birth
- Suckling of the breast will help in easy separation of the placenta and also prevent blood loss by stimulating hormone for uterine contractions
- The first milk from the breasts is known as Colostrum. This is thick in consistency and yellow in colour. It gives the baby strength and thereby the baby does not fall sick.
- Feeding should be frequent as the baby demands
- Avoid giving water, goat's milk, honey, or any such liquids to the baby.
- Do not use dirty cotton wick and cup to feed the baby cow's milk or goat milk.

All babies must be fed only on breast milk for the first six months. Bottle feeding must be totally avoided.

(iv) **Eye care**

- The eyes of the newborn baby should be cleaned with clean cotton or soft cloth dipped in luke warm water immediately after birth.
- Do not rub kajal to the eyes. This can cause infection
- Watch for any yellow discharge from the eyes
- Watch for stickiness and redness around the eyes

If discharge is thick and eyes are sticky, take the baby and mother to the nearest referral unit for check up and treatment.

Delay in eye care can affect lead to loss of sight or vision.

(v) **Immunization**

Explain and counsel the women regarding the importance of immunization for their newborn baby.

Please remember to immunize all babies (0-1 years) against the six killer diseases.

Table 3 -National Immunization Schedule

S.No	Name of the vaccine	Time when it should be given
1	BCG	At birth
2	O dose Polio drops (if hospital delivery)	At birth
3.	First dose of DPT	At 6 weeks
	First dose of Oral Polio drops	At 6 weeks
4.	Second dose of DPT	At 10 weeks
	Second dose of Oral polio drops	At 10 weeks
5.	Third dose of DPT,	At 14 weeks
	Third dose of Oral polio drops	At 14 weeks
6.	Measles	At 9-12 months

b. Complementary feeding

- At the end of six months, semi solids like cooked and mashed dal, mashed potatoes, cooked rice, kichdi, boiled egg white, fruit juices, stewed apples, chappatis soaked in dhal, dalia, suji halwa, kheer can be introduced as 'complementary feeding'
- All mothers should continue to breast feed their babies upto 2 years of age
- In case the mother has to introduce goat, cow, buffalo or dairy milk (top feeds), she must be counseled to (a) Avoid bottle feeding; (b) use cup and spoon method, katori or small container with spout for feeding her baby.
- Cover the containers with a clean plate or cloth to avoid any flies sitting on the same These precautions will reduce the chances of her baby having loose motions (diarrhoea).

c. Registration of all births

- It is important that all newborn babies in the project area should be registered. This registration is a useful record at the village level and the birth certificate that is issued will be useful for further enrollment into school as well as for other livelihood prospects later in life
- Inform families that they should register the birth or death of a newborn at the nearest office of the revenue department. This could be a local Panchayat office, post office, taluk or block office
- The place can vary from State to State
- The FNGO supervisor should find out where the registrations of newborns are done and inform the workers accordingly

d. Weighing of newborns

- All newborn babies should be weighed at birth
- If they are born in a hospital, the nurse will do this
- If they are born at home, then as a field worker, counsel the mother and her family to allow you to take the weight of the newborn baby
- If the FNGO has provided you with a weighing scale, the scale can be brought to the house of the newborn and baby weighed
- If this is not available, use the weighing scale of the Anganwadi (if there is an Anganwadi) and note the weight of the baby
- By weighing the baby no evil eye will be cast on the baby
- This weighing is a sign of the well being of the baby
- The normal weight of a newborn baby is 2700 gms to 3500 gms (2.7-3.5Kg). If the baby is less than 2500 gms or 2.5 Kg this baby is a low birth weight baby and needs more care.

e. Home –based care in diarrhoea

- Always keep packets of ORS with you at your home in the village
- These can be obtained from the nearest Subcentre and PHC
- The Supervisor of the worker to ensure regular supplies

Counsel mothers and women groups that in case of diarrhoea in a baby or an adult they must:

- Use only the ORS packets available with you
- The solution should be prepared in 1 litre of boiled and cooled water using a clean vessel
- Demonstrate this in a group setting before the start of the hot summer season and also get a few women to practice this preparation of ORS

In case of newborns and children upto 3 years:

- Continue to breast feed
- Do not give any bottle feeds
- Only cup and spoon should be used while feeding
- At half hour intervals give the feeds
- Also give solids in between feeds
- Arrange for transport and rush the baby to the nearest referral unit if diarrhoea continues even after giving the ORS
- Do not stop any feeding
- Tender coconut water can be given if diarrhoea is in older children and adults

f. Home based care in Acute Respiratory Infection (ARI)

Acute Respiratory Infections includes respiratory infections caused by viruses and bacteria. Some examples of ARI are Measles, Influenza, Pneumonia and Tuberculosis. One of the causes of child mortality is ARI.

Age wise Classification of Breathing Rate

Child's age	The child has fast breathing, if you count:
2 months –12 months	50 breaths or more per minute
13 months-5 years	40 breaths or more per minute

(Use a watch with seconds' hand to count the breath. Baby should be calm)

- In ARI, the sick baby will have a very fast breathing; the chest will be drawn inwards. Fever may or may not be present.
- This could be a sign of onset of pneumonia or severe chest infection
- Counsel the mother and her family to take the child immediately to the nearest Subcentre or the PHC
- Assist in arranging a transport

E. Working with adolescent population

Introduction

One out of every three Indians is a young person between the age group of 10-24 years. At present there are an estimated 300 million young people in India. Persons in the age group of 10-19 years are referred to as adolescents (WHO Definition).

Mentioned belowware some of the key features of the adolescent population:

- During adolescence, there are bodily changes and emotional and mental changes as well. This is a time of transition for young people.

- Puberty in girls start between ages 8-13 and in boys between 10-15 years. This is the time when an adolescent's body begins to undergo change. There is increase in the body weight and height, genitals develop, body hair appears and other physical changes are also seen in both boys and girls. Girls begin puberty about two years before boys.

- Adolescence is also the time for making friends, taking decisions and stating your mind, as well as for expanding relationships. Adolescents like to socialize, wear nice clothes and accessories (rings, chains, bands, etc) and make friends outside the family circle.

- Many of the adolescent girls and boys drop out of schools for various reasons

- Adolescents are persons with a mind of their own. They are influenced by peer (belonging to the same age group), as well as persons older to them in age (elder sister, brother, sister-in-law)

- Negative influencers easily mislead many adolescents

- Parents play a big role in guiding their children.

- They have low awareness and knowledge regarding Sexual and Reproductive Health

- Majority of adolescents are underweight and undernourished and fall prey to illnesses
- There is parental pressure on the adolescents to marry early

- Married adolescents are under pressure from their parents and in-laws for bearing children early
- They are susceptible to taking risks and experimenting with their body. This can lead to drug and substance abuse, unsafe sexual practices, unsafe abortions, repeated abortions, risk of exposure to Reproductive Tract Infections and Sexually Transmitted Diseases and HIV/AIDS

Rights of Adolescents

Right to Life
Right to Safety/ Security
Right to Information
Right to Education
Right to Health Services
Right to Participation in Decision Making
Right to Choose with Dignity

Community Sanction

Before directly starting work with the adolescents, the field worker along with his/her supervisor should hold discussions with village leaders and parents to create awareness and also seek their sanction for working with adolescents. Gaining support for the program will enhance the acceptance of the program and enable in establishing contact with the adolescents. The FNGO coordinator, supervisor and workers should explain the contents of the Adolescent Sexual Reproductive Health (ASRH) program to the elders and parents in the villages. Usually, information on reproductive health is understood as 'dirty' information. It should be clarified that the fieldworker will be educating the group to make them better aware regarding their adolescent sexual reproductive health issues.

Identification of space for adolescent group meetings

With support from community and adolescents identify suitable space or room in or around a group of villages, urban slums for holding discussions and meetings with the adolescent groups. Some examples are: school verandah, rooms, anganwadi centers and community centers.

Forming Adolescent groups

When you are working with adolescents, divide the entire groups into 10-14 years and 15-19 years. Subdivide the two groups, further into school going and non-school going. Each group will have 10-15 adolescents. Such groupings can be for boys and girls. From within the groups identify 1-2 peer educators.

Identification of peer educators

The group members should either select peer educators or accept the person/s who is willing to volunteer time for the task of a peer educator.
Once the peer educators are identified from within the groups, the field worker should train them on a basic information package for adolescent sexual reproductive health. Involve the ANM and the AWW for the training program of the peer educators.

Adolescent Sexual Reproductive Health Package

A communication and educational kit is being suggested for the different groups of adolescent girls and boys.

The MNGO with the help of the Regional Resource Centre (RRC) should be able to procure these simple low cost items and make requisite number of kits for distribution to the peer educators and the group members.

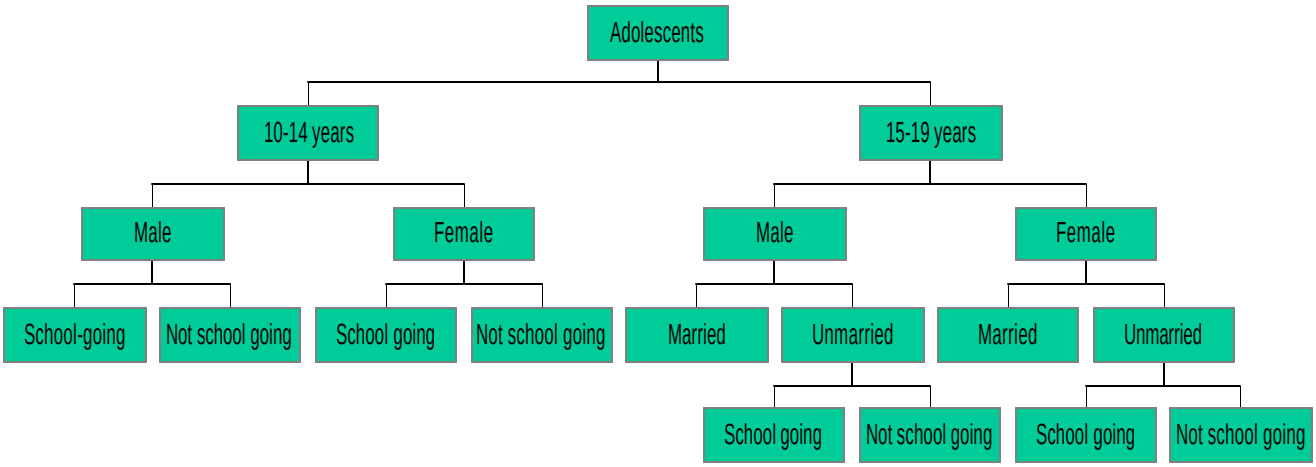
Age group 10-14 years - Girls

- CHETNA apron on menstrual cycle
- Body mapping – use blank cutouts of male and female body or map the outline of a person (volunteer lying on the floor) and draw outlines of the different organs of female body within the body outline.
- Set of two different colour beads depicting X and Y chromosome for discussion on sex determination
- Items for making sanitary napkins: Soft clean cloth- 0.5 meters, medium cotton roll, cloth tape for tying.

Age group 15-19 years Girls

The suggested kit for this group is:

- CHETNA apron on menstrual cycle
- Body mapping – use blank cutouts of male and female body or map the outline of a person (volunteer lying on the floor) and draw outlines of the different organs of female body within the body outline.
- Set of two different colour beads depicting X and Y chromosome for discussion on sex determination
- Items for making sanitary napkins: Soft clean cloth- 0.5 meters, medium cotton roll, cloth tape for tying.
- Booklet or set of flashcards, flipbook with pictures and simple explanations in local language on the following: conception, pregnancy, antenatal care, danger signs, safe delivery, post natal care, care of newborn, breastfeeding and complementary feeding of newborns and infants.
- Samples of spacing methods of contraception can be obtained from the ANM at the time of interaction with married and unmarried adolescent girls in this group.



Age group 10-14 years –Boys

- Body mapping – use blank cutouts of male and female body or map the outline of a person (volunteer lying on the floor) and draw outlines of the different organs of the Male body within the body outline.
- Set of two different colour beads depicting X and Y chromosome for discussion on sex determination

Age group 15-19 years - Boys

- Body mapping – use blank cutouts of male and female body or map the outline of a person (volunteer lying on the floor) and draw outlines of the different organs of the Male body within the body outline.
- Set of two different colour beads depicting X and Y chromosome for discussion on sex determination
- Using cards on danger signs in pregnancy and childbirth, involve the older adolescent boys for organizing emergency transport services in the village area
- Samples of spacing methods of contraception can be obtained from the ANM at the time of interaction with married and unmarried adolescent girls in this group.

The field worker can also be innovative and work with girls and boys in developing street plays and dramas on early marriage, sex determination, maternal death, discrimination against girl child, and any other topic that will generate interest in the minds of the adolescents as well as that of the village community.

Once cohesiveness is developed within the adolescent group and they recognize their own strengths and weaknesses, other life skills training packages and vocational skills packages should be introduced by the MNGO/FNGO in the project area.

F. Facilitating Family Planning services

Maintaining an Eligible Couple Register

This is a register that every field worker should maintain. The ' EC register' as it is known is already available with the ANM of the subcentre area. FNGO field workers will come across several eligible couples (women in the age group 15-49 years). In order to track them and provide them with a Family Planning service, the MNGO is encouraged to develop an EC register on the basis of the one given by the State Government to the ANM. The information thus gathered in this register can be (a) used by the field worker and (b) output can be shared with the PHC Medical officer by the MNGO/FNGO.

Counseling clients

Counseling is crucial. Through counseling, providers help clients make and carry out their own choices about reproductive health and family planning. Good counseling makes clients more satisfied. Good counseling also helps clients use family planning longer and more successfully. Further details regarding counseling are mentioned in the previous section.

Functioning as a 'Depot holder'

Before becoming a depot holder, the field worker should be trained by the MNGO/FNGO in understanding the different family planning methods, in counseling and she should also have an EC register. As a depot holder, her duties shall be (a) to keep a regular stock of condoms and oral pills and maintain a stock register. (b) This can be extended to keeping ORS packets for diarrhoea, some first aid kits for cough, minor ailments and injuries. There should be a proper display board or community members must know that they can collect their stocks from the depot and do not have to go to the PHC every time. The FNGO should meet with the concerned PHC Medical Officer and replenish the supplies from the PHC store.

Important information on the various family planning methods

MNGOs/FNGOs should involve medical officers/LHV to train their field workers on various family planning methods at District or Block PHC. The Fieldworkers should use the same information package as is given to the ANMs on the different family planning methods under RCH-II.

G. Raising awareness about Reproductive Tract Infections and Sexually Transmitted Infections among men, women and adolescent population

The term 'Reproductive tract infections' (RTIs) are infections of the Reproductive tract;
the term 'Sexually Transmitted Infections' (STIs) are those infections transmitted during sexual act or intercourse.

It is important to know that all sexually transmitted infections are not Reproductive Tract Infections and all Reproductive Tract Infections are not all Sexually Transmitted Infections.

Some important facts that health workers should know and inform communities:

- Reproductive Tract Infections are common throughout the world among both men and women.

- Among women most complaints of RTIs are not sexually transmitted, but are from within the reproductive tract itself. This happens due to the change in the normal protective layer in the tract. This change is caused by yeast and bacteria and influenced by environment, hygiene, hormonal and other factors.

- Another type of RTI, (which is again not caused by sexually transmitted diseases), but caused by infections through procedures on the reproductive tract by health workers and dais.

- Symptoms of RTI/STIs are: – vaginal discharge, Urethral discharge, Genital ulcer, backache and lower abdominal pain. Persons usually complain of having more than one symptom. All these infections can be treated only after a doctor examines the person and some laboratory tests are conducted on them.

- Apart from being serious diseases on their own, the presence of an untreated STI/RTI can increase the risk of HIV infection and transmission.

- Long –term effects of RTIs/STIs are seen mostly in women and new born babies

- Some RTIs/STIs can cause damage to the Reproductive tract and organs thus leading to tubal pregnancy (*pregnancy is in the fallopian tube instead of the uterus*) and infertility

- Women can transmit STI to their children during pregnancy and childbirth leading to disease or death of the infants.

- All the major STI/RTI are associated with premature delivery and low birth weight. In addition, babies can acquire serious eye or lung infections from mothers infected with STI/RTI.

H. HIV/AIDS among men, women and adolescent groups

What is HIV/AIDS?

- HIV (Human Immunodeficiency Virus) is a virus that causes AIDS (Acquired Immunodeficiency Syndrome)

- This is a health condition in which a person is affected by a series of diseases because of poor immunity.
- HIV by itself is not an illness and does not instantly lead to AIDS.
- An HIV-infected person can lead a healthy life for several years before he/she develops AIDS.

Gender and HIV/AIDS

- Often women are not in a position to insist on condom use or to refuse sex
- During sexual intercourse the female genitals are more vulnerable to injuries especially when it is forced sex or when she is young
- Women can transmit the virus to the baby in the womb, during delivery or by breastfeeding
- The concentration of HIV in men's semen is higher than in women's vaginal fluids
- Mostly women don't get the chance for treatment because they are financially dependent on the husband

Routes of Transmission of HIV infection

- Unprotected sexual contact with people of same sex or opposite sex (oral, anal, vaginal))
- Sharing of needles
- Transfusion of untested and or contaminated (HIV positive) blood
- Use of contaminated needles, syringes, piercing instruments, improperly sterilized hospital tools
- Infected Parent-to –Child (pregnancy, labour, delivery, breastfeeding)

The presence of an untreated STI/RTI in a person can increase the risk of HIV infection and transmission by a factor of two to nine

Ways in which HIV cannot be transmitted

Apart from the above-mentioned modes of transmission, HIV is not spread by any other way.

HIV does not spread by:

- Ordinary social contact, e.g. by shaking hands, traveling in the same bus, eating or drinking from the same utensils, hugging and kissing
- Mosquitoes and insects do not spread the virus nor does it spread through water or air
- Using toilets and urinals used by infected persons
- Sneezing or coughing
- Working with an infected person
- Using sterilized equipments and instruments for blood donation, injections and surgery
- Stepping over the urine of a HIV positive person

Preventing HIV infection

- During sex, always use a condom and be faithful. Have only one sex partner- YOUR partner
- If a woman is HIV-infected, breast milk can contain HIV, body contact between cuts, bruises and breast milk should be avoided
- Persons with discharge from the penis, abnormal vaginal discharge, blisters, sores, lumps around the genitals or anus, swollen glands in the groin, increased frequency in urination or pain, irritation or itching while doing so, should go for treatment.

Symptoms

Many people do not develop any symptoms when they first become infected with HIV. Some people, however, get a flu-like illness within three to six weeks after exposure to the virus. This illness, called Acute HIV Syndrome, may include fever, headache, tiredness, nausea, diarrhea and enlarged lymph nodes (organs of the immune system that can be felt in the neck, armpits and groin).

Diagnosis

Counseling and Testing is the gateway for Comprehensive HIV/AIDS prevention, care and treatment. Voluntary Counseling Testing Centers (VCTC) that will soon be available at district and sub-district levels throughout the country. Young people should be encouraged to visit these centers for counseling, diagnosis and treatment. In the early stages of infection, HIV often causes no symptoms and the infection can be diagnosed only by testing a person's blood. Two tests are available to diagnose HIV infection:

(a) Test for the presence of antibodies produced by the body in response to HIV
(b) Test to identify the virus itself.

Treatment

Once infected with HIV virus, this infection till date cannot be completely eliminated from the body; however, timely treatment of opportunistic infections (for example pneumonia, tuberculosis and diarrhoea) can keep one healthy for many years. The commonly available treatment for AIDS is the treatment against opportunistic infections. **HIV doesn't kill anybody directly. Instead, it weakens the body's ability to fight disease. Infections, which are rarely seen in those with normal immune systems, are deadly to those with HIV**

Anti-retroviral treatment (ART) is a combination of medicines that are given to someone who is sick with AIDS. They fight HIV in the body. ART is not a cure for AIDS. It helps make the immune system stronger so that the person can be healthier. It also helps your body to fight off and prevent illnesses such as pneumonia, tuberculosis (TB) and diarrhoea.

Life after HIV

The experience of infected people during the last two decades has shown that HIV is not the "end of the world" and that there is good quality life for several more years. Taking care of one's health, keeping in mind one's vulnerability to diseases, and a positive attitude have been found to be very useful.

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Annexures

1-MNGO Monitoring Register

2-FNGO Monitoring Register

3-Field Worker Register

4-Immunization Register

5-Microplan exercise sheet