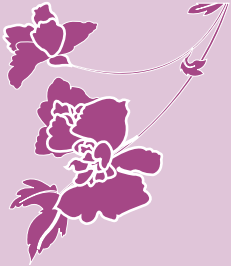
सत्यमेव जयते

Handbook for Reproductive, Maternal, Neonatal, and Child Health (RMNCH) Counsellors

October 2012

Family Planning Division
Ministry of Health and Family Welfare
Government of India

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन



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Conceived, developed and designed by the Family Planning Division, Ministry of Health and Family Welfare, Government of India.

NATIONAL RURAL HEALTH MISSION
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निर्माण भवन, नई दिल्ली - 110108
Government of India
Ministry of Health & Family Welfare
Nirman Bhavan, New Delhi - 110108

Foreword

NRHM with its aim to provide effective healthcare to rural population especially women and children has launched various schemes which has helped to increase the institutional deliveries over the past seven years. Increased institutional deliveries provides an opportunity and a suitable platform to inform more and more women, couples and family members about key maternal, new born, child health and family planning issues to improve the health of mothers and newborns.

It has been observed that the good practices related to mothers, newborns and child health and family planning are adopted and continued, when clients make decisions by themselves based on accurate information. Effective counselling is a means, which empowers clients to seek what is best for them and to exercise their rights to good quality maternal, newborn, child health and family planning services. A need was therefore felt to strengthen the counselling on family planning, maternal and child health issues to address the individual needs of the clients. Keeping this in mind, the Reproductive, Maternal, Newborn and Child Health (RMNCH) counsellors have been appointed for the district level facilities and above, where deliveries are conducted. However, the counsellors will be able to effectively execute their responsibilities once they undergo good quality, standardized training.

This 'Handbook for Reproductive, Maternal, Neonatal and Child Health Counsellors' has therefore been developed to embrace the critical areas of counselling in family planning, maternal, newborn and child health. The handbook includes essential knowledge and guidance for skills that are required to provide effective counselling; critical areas such as family planning including postpartum family planning, postpartum IUCD counselling; and essentials of maternal newborn and child health, to respond to the needs felt in the field.

The content of the handbook can be used and adapted by trainers and counsellors alike in order to build their capacity in quality counselling.

The effort of the Family Planning division in developing the handbook, which gives overview of counselling in RMNCH, is commendable.

I hope that this handbook will be useful for the trainers, counsellors and health workers.

(Anuradha Gupta)

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Acknowledgment

The 'Handbook for Reproductive, Maternal, Neonatal and Child Health (RMNCH) Counsellors' has been developed based on the felt need for such a manual in order to strengthen effective counselling to women, who deliver and stay at the facilities for 24-48 hours after delivery, and their family members.

We express our sincere gratitude to Ms. Anuradha Gupta, Additional Secretary and Mission Director, NRHM, for being the inspiring force behind this initiative. We are also thankful to Shri Sundeep Kumar Nayak, Joint Secretary (Family Planning), for providing important insights.

The endeavour has been made possible through contribution from the Jhpiego team comprising of Dr. Somesh Kumar, Dr. Saswati Das, Dr. Rashmi Asif, Dr. Vikas Yadav and Dr. Vivek Yadav under the leadership of Country Director, Dr. Bulbul Sood. The contribution of Ms. Celine Gomes, who has designed and formatted, and Ms. Kanika Bajaj, who has proof-read the draft is also acknowledged.

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Special appreciation goes to Dr. Sushma Dureja, DC (FP) and Dr. Nimisha Goel, Consultant Family Planning Division, for reviewing the technical content of the handbook. We are also thankful to the RCH Program Divisions namely Maternal Health, Child Health and Immunization Division for providing comprehensive inputs towards development of this handbook.

Appreciation is also extended to other members of the Family Planning Division, namely Dr. Teja Ram, DC, Shri Rahul Pandey, Dr. Renuka Patnaik and Dr. Mithila Dayanidhi, for their support in preparation of this handbook.

(Dr. S K Sikdar)

Table of Contents

Acronyms and Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal Clinic
ASHA	Accredited Social Health Activist
COCs	Combined Oral Contraceptives
EC	Emergency Contraception
ECPs	Emergency Contraceptive Pills
FP	Family Planning
FW	Family Welfare
HIV	Human Immuno-deficiency Virus
LAM	Lactational Amenorrhea Method
LBW	Low Birth Weight
LR	Labour Room
MEC	Medical Eligibility Criteria
PNC	Postnatal Care
PPFP	Postpartum Family Planning
PPIUCD	Postpartum Intra-uterine Contraceptive Device
RMNCH	Reproductive, Maternal, Neonate and Child Health
RTIs	Reproductive Tract Infections
STIs	Sexually Transmitted Infections
VPDs	Vaccine Preventable Diseases
WHO	World Health Organization

Introduction

Counselling is a critical public health intervention and service, which when delivered appropriately and effectively, can go a long way in addressing the barrier created by lack of awareness among the clients about the availability of various reproductive, maternal, new-born, child health and family planning services in the public sector health facilities in India.

The Ministry of Health and Family Welfare, Government of India, has implemented various programs for increasing the access to quality reproductive, maternal, new-born, child health and family planning services in the country. To ensure that these services are accessed by the communities uniformly and appropriately, it is important that awareness be created about the availability of these services at the public sector health facilities. Towards this objective, a dedicated RMNCH Counsellor is being placed at the public sector health facilities under the National Rural Health Mission. It is envisioned that the counsellor will play a key role in increasing awareness and generating demand for the various RMNCH services provided at the facilities. The counsellor is expected to ensure that all the women, children and families coming to the health facilities are given appropriate information about the available RMNCH services at the facility.

The counsellors are expected to approach each client and his/her family in a holistic manner, recognizing that clients may have needs that may be inter-related, encompassing a range of reproductive, sexual, maternal, new-born or child health needs. The counsellor should ensure that each client and his/her family is provided support in terms of relevant information about the available services, facilitate decision making and provide emotional support.

Following are the expected roles and responsibilities of the Counsellors:

- Identify the needs of the clients and their families, especially those related to reproductive, maternal, new-born and child-health.
- Provide accurate and appropriate information on the available RMNCH services corresponding to the needs of the clients/their families.
- Provide accurate information to the clients on their entitlement to the RMNCH services available at the public sector facilities and in outreach.
- Provide information to the pregnant women on the essential care which is to be availed during the ante-natal period, especially when they are coming to the facilities during their antenatal period.
- Provide information to the women and her family about the essential maternal, new-born and family planning care and services that is available and is to be availed during and just after childbirth.

- Provide information to the mothers and their families about the appropriate care that is to be provided to the mothers and the new-borns during the immediate and extended post-partum period.
- Educate mothers and families on early initiation of breastfeeding, i.e. within 1 hour of giving birth; keeping the new-born warm and cord care
- Provide information to mothers and their families about the need and availability of immunization services under the Universal Immunization Program of India.
- Provide information to the pregnant women, mothers and their families on the essential aspects of appropriate nutrition of the women and children.
- Provides Family Planning Messages to the Clients by providing up to date unbiased information to the clients, regarding all the applicable Family Planning methods, including their benefits and adverse effects.
- Dispels myths and misconceptions of the clients regarding the various family planning methods
- Helps the clients to take informed decisions on accepting Family Planning methods
- Understands the social, cultural and emotional factors that determine a woman's decision to accept a family planning method
- Encourages the clients to ask questions
- Ensures that the client is fully informed
- Have respect for the values and attitudes of clients and respects the rights of the clients
- Supports the targeted facilities in development, translation, production and display of all BCC material for PPFP/PPIUCD services

Section I

Counselling Skills

Chapter 1

Counselling and Effective Communication

Major components of this section:
- Concept of Counselling
- Components of counselling
- Skills of an effective counsellor
- Rights of clients

What is Counselling
- Counselling is a two-way communication between a health care worker and a client, for the purpose of confirming or facilitating a decision by the client, or helping the client address problems or concerns.

Key components of Counselling
- Mutual trust is established between client and provider. The provider shows respect for the client and identifies and addresses her/his concerns, doubts, and fears regarding the use of contraceptive methods.
- The client and service provider give and receive relevant, accurate, and complete information that enables the client to make a decision about RMNCH services.

Tasks involved in counselling
- Helping clients assess their own needs for a range of health services, information, and emotional support
- Providing information appropriate to clients' identified problems and needs
- Assisting clients in making their voluntary and informed decisions
- Helping clients develop the skills they will need to carry out the decision

Benefits of Counselling
- Good counselling results in higher client satisfaction
- Clients who receive good counselling are more likely to use RMNCH services more successfully

Counselling should be CLEAR:
- Communicate clearly
- Listen
- Encourage and Empathize
- Ask
- Respect

Essentials of effective communication (figure 1)

Effective Communication

Communication is a two-way interaction between two or more people. Good communication means both good verbal communication (words & tone of voice) and good **non-verbal communication (body language)**

Verbal communication

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

Non-verbal communication

Refers to actions, gestures, behaviours, and facial expressions which express feelings. It is largely unconscious and often reveals to the observant the real feelings or message being conveyed

Verbal communication skills:

- Active Listening
- Verbal encouragement
- Positive tone of voice
- Using simple language
- Giving feedback
- Empathy
- Being non-judgemental

Positive non-verbal cues:

- Leaning towards the client
- Smiling, not showing tension
- Presenting facial expressions which show interest and concern
- Maintaining eye-contact
- Nodding

Negative non-verbal cues:

- Reading from a chart
- Glancing at one's watch
- Yawning or looking elsewhere
- Frowning
- Fidgeting

Desired characteristics and skills of effective counsellor

Counsellor Characteristics

- An effective counsellor:
- Believes in and is committed to the basic values and principles of family planning and client rights
- Is accepting, respectful, non-judgmental, and objective when dealing with clients
- Is aware of her/his own values and biases and does not impose them on clients
- Understands and is sensitive to cultural and psychological factors (such as family or community pressures) that may affect a client's decision to adopt family planning
- Always maintains client's privacy and confidentiality

Counsellor Skills

An effective counsellor possesses strong technical knowledge:

- Knows all technical aspects of concerned service thoroughly
- Is prepared to answer questions comfortably on subjects such as myths, rumours, sexuality, reproductive and personal concerns
- Is able to use visual aids and explain technical information in language that the client understands
- Is able to recognize when to refer the client to a specialist or other provider

GATHER Approach for counselling:

G: Greet

- Express respect and friendliness
- Give clients your full attention as soon as you meet them
- Be polite, friendly and respectful: Greet clients, introduce yourself, and offer them seats
- Ask how you can help. Determine purpose of visit
- Explain what will happen during the visit
- Assure the client that all information discussed will be confidential
- Talk in a private place, where no one else can hear

A: Ask

- Ask about their problems as well as listening to any measures they have already taken to solve the problem
- Ask them how they believe that you can help them
- Ask for all the information needed to complete client records
- Listen to the answers to these questions which will guide the provider/ counsellor to methods most appropriate for the client's current needs
- Help clients express their feelings, needs, wants, and any doubts, concerns, or questions
- Keep questions open, simple, and brief. Look at your client as you speak
- Show your interest and understanding at all times. Express empathy. Avoid judgments and opinions

T: Tell

- Tell the client about the available methods and possible choices that would best meet the client's current needs based on their responses to the questions asked above
- Information should be personalized—that is, put in terms of the client's own life
- Ask if the client wants to learn more and answer client concerns and questions

H: Help

- Help them to make their own decisions and guide them to look at various alternatives
- Help them to choose solutions which best fit their own personal circumstances
- Help clients think about the results of each possible choice
- Ask if the client wants anything made clearer. Reword and repeat information as needed
- Check whether the client has made a clear decision. Specifically ask, "What have you decided to do?" Wait for the client to answer

E: Explain

- Explain any misunderstandings.
- Ask some questions in order to check your understanding of important key points and repeat those key points in their own words if necessary.
- If the method or services cannot be given at once, tell the client how, when, and here they will be provided
- Explain how to use the method
- Describe possible side effects and what to do if they occur
- Explain when to come back for routine follow-up or more supplies, if needed
- Explain any medical reasons to return

- Ask the client to repeat instructions. Make sure the client remembers and understands
- If possible, give the client printed material to take home
- Thank the client for coming and invite her back whenever she wishes, or if side effects bother her

R: Return

- Schedule and carry out return visit and follow-up of client
  At a follow-up visit:
- Ask if the client has any questions or anything to discuss. Treat all concerns seriously
- Ask if the client is satisfied. Have there been problems?
- Help the client handle any problems
- Ask if any health problems have come up since the last visit. Check if these problems make it better to choose another method or treatment. Refer clients who need care for health problems
- Check if the client is using the method or treatment correctly
- If a follow-up visit is not appropriate then you should give them the name of someone they can contact if they need help

Rights of Clients

To be effective, counseling must be based on the establishment of trust and respect between the client and counsellor. This can be easily developed if the counselors are aware of the rights of clients, which are as follows:

- **Information:** Clients have a right to accurate, appropriate, understandable and unambiguous information related to reproductive health and sexuality, and to health overall.
- **Access to services:** Services must be - available at times and places that are convenient to clients, without physical or social barriers
- **Informed Choice:** A voluntary decision that an individual makes on the basis of options, information, and understanding represents his or her informed choice. It is the provider's responsibility either to confirm a client's informed choice or to help him or her reach one.
- **Safety of services:** Safe services require skilled providers, attention to infection prevention, and appropriate and effective medical practices. This right also refers to the proper use of service-delivery guidelines, the existence of monitoring, supervision, and quality assurance mechanisms within the facility, counseling and instructions for clients, and recognition and management of complications related to medical and surgical procedures.
- **Privacy and confidentiality:** Clients have a right to privacy and confidentiality during delivery of services –for example, during counseling and physical examinations and in staff's handling of clients' medical records and other personal information.
- **Dignity, comfort, and expression of opinion:** All clients have the right to be treated with respect and consideration. Providers need to ensure that clients are as comfortable as possible during procedures. Clients should be encouraged to express their views freely, especially when their views differ from those of service providers.
- **Continuity of care:** All clients have a right to continuity of services, supplies, follow-up and referral.

(Source: AVSC International, 1999)

Section II

Counselling for Family Planning

Chapter 2

Counselling for Family Planning: Principles, Approaches and Techniques

Major components of this section:
- Principles of counselling for family planning
- Settings and types of counselling for family planning
- Approaches for family planning
- Rights of clients and informed choice

In the context of family planning services, counselling is a process that helps a client to decide if s/he wants to practice family planning. If s/he does, counselling helps her/him to choose a contraceptive method that is personally and medically appropriate and that s/he wants, understands how to use, and is able to use correctly for safe and effective contraceptive protection.

Principles of FP Counselling

1. Counsel in a private quiet place where your conversation with the client is not overheard and allow sufficient time to ensure that all necessary information, client's concerns and needs are discussed and addressed.
2. Ensure confidentiality, both in the process of counselling and the handling of client records to gain the trust of the client.
3. Be non-judgmental, accepting, and caring.
4. Use simple culturally appropriate language, which the client is able to understand easily
5. Use good interpersonal communication skills (see figure 1).
6. Be brief, simple, and specific with key messages.
7. Encourage the client to ask questions and express any concerns.
8. Use audio-visual aids, anatomic models and contraceptive samples as appropriate to help the client better understand the content of the session.
9. Provide feedback during the session, repeat key information shared by the client; show and confirm that you understand correctly what they are saying.
10. Always verify that the client has understood what has been discussed by having the client repeat the key messages or instructions.

Setting for FP Counselling

Individual Counselling

- Appropriate when privacy and confidentiality are necessary
- Ask about client's reproductive health and medical history
- Ask client what they know about family and explain family planning methods, including advantages, disadvantages, and possible side-effects
- Encourage questions and help client choose method
- Explain to client how to use their chosen method
- Ask client to repeat back key information

- Schedule a return visit

Group Counselling

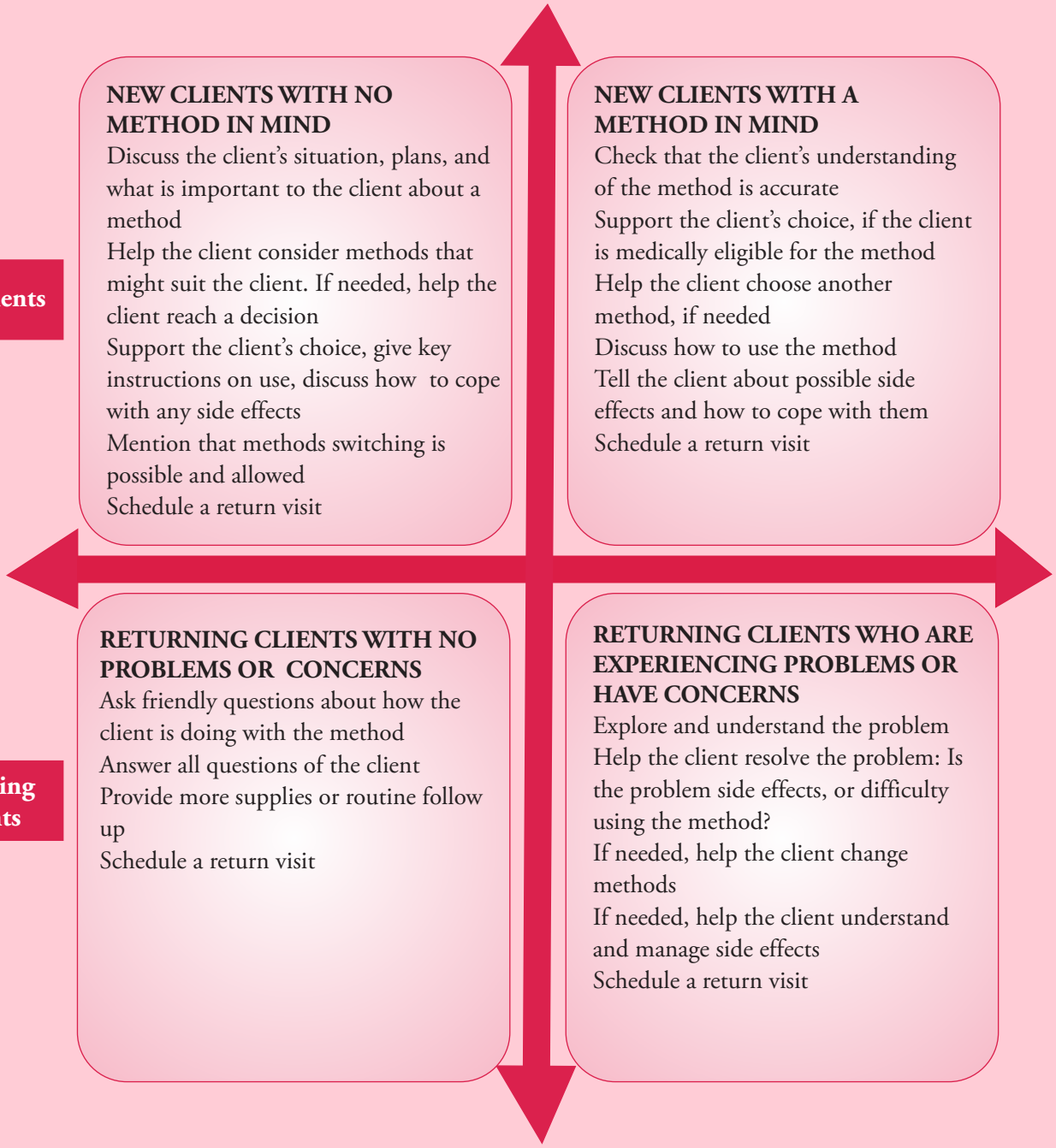
- Appropriate when clients are more comfortable in a group situation or when individual counselling is not feasible
- Introduce benefits of family planning
- Elicit and discuss rumours and concerns about family planning
- Discuss family planning methods and encourage questions and group discussion
- Discuss how to obtain appropriate methods

Types of Family Planning Counselling

Counselling for family planning is of three types:

1. **General Counselling**
   - Usually takes place as a first step of family planning counselling to orient the client to benefits of and methods available for family planning
   - Reproductive goals and needs of clients discussed
   - Client concerns addressed
   - General information about methods/options given
   - Questions answered
   - Misconceptions/myths discussed and clarified
   - Decision-making and method choice begins
2. **Method-specific Counselling**
   - Decision-making and method choice made
   - More information on method choice given
   - Screening process and procedures explained
   - Instructions about how and when to use the method given
   - Problems and common side effects discussed
   - What to do if there are problems, discussed
   - When to return for follow-up, discussed
   - Client should repeat back key instructions to demonstrate she has understood the key points of the method use correctly
   - Client given hand outs/information to take home when available
   - Myths and misconceptions are discussed and clarified
3. **Return/Follow up counselling**
   - Elicit client experience and satisfaction with the method
   - Problems and side effects discussed and managed
   - Continuing use encouraged unless major problems exist
   - Key instructions should be repeated
   - Questions answered and client concerns addressed
   - Encourage satisfied clients to talk to other couples to adopt this method

Counselling the four types of FP clients



Chapter 3

Counselling and Motivating Men

Counselling and Motivating Men

Many times the decision to adopt a family planning method is made by a woman in consultation with her husband. Hence it is always useful to involve a woman's husband during the counselling session. This gives an opportunity to discuss how they can act to protect their health and the health of their wives and children.Men have special counseling needs and should receive special attention from providers to motivate them to make responsible choices regarding reproductive health practices.

Men's Special Counseling Needs

- Men need to be encouraged to support women's use of family planning methods or to use family planning themselves (condoms or vasectomy).
- Men often have less information or are more likely to be misinformed about family planning methods, male and female anatomy, and reproductive functions because they tend to talk less about these issues than women.
- Men often have serious misconceptions and concerns that family planning methods will negatively impact their sexual pleasure and/or performance.

Many men do not know how to use condoms correctly. Providers should always demonstrate correct condom use, using a model, when possible.

Chapter 4

Family Planning Choices

Major components of this section:
- Importance of family planning for improving maternal, new-born, and child health
- Different family planning choices

Importance of Family Planning for Improving Maternal, Newborn and Child Health

- Family planning means that the couples decide and plan when and how many children they want to have.
- Family planning methods help to prevent unwanted pregnancies and preventable deaths due to childbirths happening too soon and too many and hence have a potential to significantly impact maternal, newborn, and child health. Therefore, family planning is considered as a maternal and child health intervention along with population stabilization.

Healthy Timing and Spacing of Pregnancy

Family planning can have different meaning, based upon the client's need, such as planning to delay the birth of first child, planning for healthy spacing between two children and planning to limit the number of children once the desired family size is achieved.

- Delaying the age of the first child provides time for the mother to reach the necessary development age for a healthy childbearing. It also provides time for the couple to plan and prepare themselves for child rearing.
- Healthy spacing between children leads to better health and nutritional outcomes for the children and also reduces the risk for maternal death and complications following delivery.
- Limiting methods enables the couples to complete the family size and hence focus on growth and development of the children.

Key messages for healthy timing and spacing of pregnancy
- Girls should wait until they are 19 before they conceive
- The recommended interval before attempting the next pregnancy after a live birth, is at least 24 months.
- The recommended interval before attempting the next pregnancy after an abortion is at least 6 months.

Principles of informed choice

- Clients have the right and ability to make their own decisions
- Clients are individuals with different needs and circumstances
- Clients need reliable, timely, and understandable information, including risks and benefits

- Clients have the right to a choice of methods, whether through clinics, pharmacies or community distributors
- Clients must be able to decide freely—without stress, pressure, coercion, or incentives

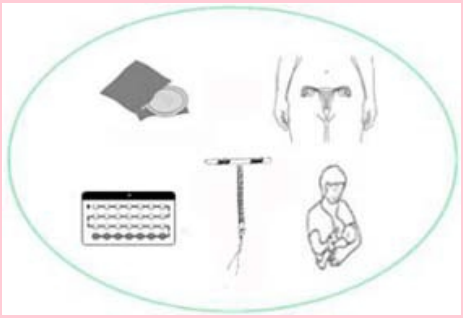
Consequences of NOT ensuring informed choice

- Unwanted pregnancy from improper method use
- Fear and dissatisfaction with side effects, leading to discontinued use of FP method
- Potential health risks caused by failure to recognize serious warning signs, or by insufficient focus on prevention of STIs in method selection
- Dissatisfaction with quality of services or with method given, leading to drop out, poor word-of-mouth, low service utilization

Basket of Contraceptives

- A range of family planning methods – both spacing and limiting, are available. Clients and their situations and needs differ and a single method may not be suitable for all. Considering the preference and suitability, the counsellor may help the client to choose a particular method.

A classification of appropriateness of various available contraceptive methods for different needs is given below.



Delaying the first child	• **Condoms** • **Oral contraceptive pills** • **Intra Uterine Contraceptive Devices (IUCD)** • **Emergency contraceptive pills (not to be used routinely**
Healthy spacing between two deliveries	• **Condoms** • **IUCDs** • **OCPs (need to be related to breastfeeding)** • **Lactational Amenorrhoea Method (needs to be followed-up by other methods 6 months after delivery)**
Limiting methods	• **Female sterilization** • **Male sterilization/ Vasectomy**

- The contraceptive methods available in India are listed below in the tables.

Characteristics of various family planning options under the National Family Welfare Program:

1. Condoms

MECHANISM OF ACTION	FAILURE RATE (expressed in no. of pregnancies per 100 women using the method over the first year)	EFFECTIVENESS AND BENEFITS	LIMITATIONS/ SIDE EFFECTS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Condoms ▪ Condoms are barrier methods that physically prevent sperms from uniting with the egg as they do not allow ejaculated semen to be deposited in the vagina ▪ There are both male and female condoms* ▪ Condoms are made of latex and are worn on the erect penis	▪ Condoms: Consistent and correct use: 2 Typical use: 15	▪ Moderately effective ▪ Effective immediately ▪ Only method that prevents STIs, including HIV/AIDS, as well as pregnancy (dual protection), when used correctly during intercourse ▪ No effect on breast milk production ▪ No hormonal side effects ▪ Can be stopped at any time ▪ Easy to keep stock handy, can be used by men of any age ▪ Can be used without initially seeing a health care provider ▪ Enables a man to take responsibility for preventing pregnancy and disease ▪ Condoms are -readily available free of cost at the government health facilities or home delivered by ASHA at a nominal cost.	▪ Condoms should not be reused and should be discarded after every act of intercourse ▪ Supplies must be readily available before intercourse begins ▪ Some men or women may feel that it interferes with their sexual pleasure ▪ Latex condoms may cause itching for a few people who are allergic to latex	▪ Men - of all reproductive ages are good candidates for using condoms.	▪ People allergic to latex

Note: *Female condoms are also available nowadays in the market, but it is not included in Government of India's family welfare program.

2. Lactational Amenorrhea Method (LAM)

MECHANISM OF ACTION	FAILURE RATE (expressed in no. of pregnancies per 100 women using the method over the first year)	EFFECTIVENES S AND BENEFITS	LIMITATIONS/ SIDE EFFECTS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Lactational Amenorrhea Method (LAM) (Use: Can be used for the first 6 months postpartum as long as ALL three criteria for LAM are met) (1) if woman exclusively breastfeeds her baby including night feeds (2) less than six months after delivery (3) the woman's menses have *not* returned.	Failure rate: ▪ Consistent and Correct Use (for 6 months): 0.9 ▪ Typical Use: 2	▪ Effective (1 to 2 pregnancies per 100 women during first six months of use) ▪ Immediate breastfeeding provides additional protection against infections for the newborn ▪ Exclusive breast feeding (EBF) promotes health benefits to the infant and increases survival ▪ Promotes mother and infant bonding ▪ Helps mother's uterus return to normal size quicker than non-breastfeeding women ▪ Effective immediately ▪ Does not interfere with intercourse ▪ No systemic side effects ▪ No medical supervision necessary ▪ No supplies required ▪ No cost ▪ Helps reduce the amount of bleeding after delivery by keeping the uterus contracted	▪ All three criteria need to be met for effectiveness ▪ May be difficult to practice due to social circumstances, like lack of privacy for breastfeeding in a joint family, working woman ▪ Does not protect against STIs and HIV ▪ Women who are infected with HIV or who have AIDS or taking antiretroviral (medicines for AIDS) can use LAM, however there is a chance that some percentage of infants will get HIV through breast milk.	▪ Women who are fully breastfeeding, whose menses have not returned, and who are less than six months postpartum ▪ Women with HIV who use LAM should also be encouraged to use condoms	▪ Women who are not exclusively breastfeeding ▪ Postpartum women whose menses have returned ▪ Women who are more than six months postpartum

3. Oral Contraceptive Pills (OCPs)

MECHANISM OF ACTION	FAILURE RATE (expressed in no. of pregnancies per 100 women using the method over the first year)	EFFECTIVENESS AND BENEFITS	LIMITATIONS/ SIDE EFFECTS	WHO CAN USE THE METHOD	WHO SHOULD NO T USE THE METHOD
Oral Contraceptive Pills (OCPs) (Use: The pills should be taken starting from the second day of the menstrual cycle. Woman should take one pill each day, preferably at a fixed time. If a pill is missed, she should take the missed pill as soon as possible and keep taking pills as usual, one each day. In case more pills are missed, a backup method such as condom should be used and a health care provider should be contacted) ▪ OCPs contain the hormones estrogen and progesterone, which suppress ovulation	Failure rate: ▪ Consistent and Correct Use: 0.3 ▪ Typical Use: 8	▪ Effective (almost 100%) if used according to directions ▪ Highly effective, reversible, easy to use ▪ Effective within first 2 weeks ▪ Safe for most women ▪ Regulate the menstrual cycle ▪ Reduce menstrual flow (which may be useful to anaemic women) ▪ Decrease the risk of ovarian and uterine cancer, benign breast disease, and incidence of acne ▪ Do not interfere with sexual intercourse ▪ Pelvic exam not required before use ▪ Can be provided by trained non-medical staff ▪ Immediate return of fertility on discontinuation.	▪ Must be taken every day ▪ Require regular/ dependable supply ▪ Pills may cause side effects in some women, such as nausea, headache, bleeding between menses or mid-cycle bleeding, or weight gain ▪ Do not protect against STIs and HIV ▪ Risk of developing cardiovascular disease in women over 35 years of age and who smoke	▪ Women and couples who want an effective, reversible method ▪ Adolescents ▪ Women having anaemia due to heavy menstrual bleeding ▪ Women with an irregular menstrual cycle ▪ Women with family history of ovarian cancer ▪ Women with HIV/AIDS ▪ Women who are on ARV drugs	▪ Breastfeeding women < 6 months postpartum ▪ Non-breastfeeding women < 3 weeks postpartum ▪ With advice of clinician, in case of following conditions: - Women with hypertension (BP 140/90 or worse) - Diabetes, (advanced or long standing), with vascular problems, or central nervous system (CNS), kidney, or visual disease ▪ Women who smoke > 15 cigarettes/day ▪ Women with the following conditions: – Deep vein thrombosis (DVT) – Heart disease – Bleeding disorders – Liver disease or tumours – Recurrent migraine headaches with focal neurological symptoms – Unexplained vaginal bleeding – Breast cancer – Currently taking anticonvulsants for epilepsy

4. Intrauterine Contraceptive Device (IUCD)

MECHANISM OF ACTION	FAILURE RATE (expressed in no. of pregnancies per 100 women using the method over the first year)	EFFECTIVENESS AND BENEFITS	LIMITATIONS/ SIDE EFFECTS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Intrauterine Contraceptive Device (IUCD) (Use: can be inserted in a woman immediately after childbirth upto 48 hours of delivery or after 6 weeks of childbirth) ▪ IUCDs (Copper IUCD 380A and Cu IUCD 375) prevent fertilization of ovum by sperms. ▪ A long-acting reversible method. ▪ CuIUCD380 A - Effective for 10 years ▪ Cu IUCD 375 is effective for five years	Failure rate: ▪ Consistent and Correct Use: 0.6 ▪ Typical Use: 0.8	▪ Highly effective, reversible FP method can be used for spacing or limiting with pregnancy rates of less than 1%) ▪ Available free of cost at government health facilities ▪ Independent of sexual activity ▪ Does not interfere with sexual intercourse ▪ Immediately reversible with no delay in return to fertility ▪ Does not interfere with breastfeeding ▪ No interactions with any medicines ▪ Initial follow-up visit required after next periods or 6 weeks of postpartum insertion followed by visits at 3 and 6 months (to ensure retention as this is the period of maximum spontaneous expulsion) then the woman needs to return to the clinic only if she has a problem ▪ Women do not need to purchase any supplies ▪ Can act as emergency contraceptive method when inserted within 5 days of unprotected sex	▪ Possibility of minor side effects which decrease after initial few months: – Longer and heavier menstrual periods – Bleeding or spotting between periods – More cramps or pain during periods ▪ Does not protect against STIs and HIV ▪ Requires a trained health care provider to insert and remove the IUD ▪ May be expelled spontaneously, in a few cases	Women who: ▪ Want a reliable, long-term reversible method ▪ Can be used for spacing or limiting ▪ Have just had a delivery or an abortion (if no evidence of infection) ▪ Are breastfeeding ▪ Have or had breast cancer ▪ Have headaches ▪ Have high blood pressure (>140/90 mm hg) ▪ Have diabetes ▪ Have liver or gallbladder disease ▪ Have epilepsy ▪ Have non-pelvic tuberculosis ▪ Are HIV positive and/or have AIDS who are clinically well	Women with the following conditions: ▪ Pregnancy ▪ Current or high risk for PID, gonorrhea, or chlamydia ▪ Women with AIDS who are not clinically well ▪ Immediately after aseptic abortion ▪ Pelvic tuberculosis ▪ Distorted uterine cavity ▪ Unexplained vaginal bleeding ▪ Genital tract cancer ▪ Puerperal sepsis ▪ 48 hours to less than 6 weeks postpartum ▪ Malignant trophoblastic disease ▪ Pelvic infections ▪ Puerperal sepsis ▪ Prolonged rupture of membranes for more than 18 hours ▪ Unresolved postpartum haemorrhage ▪ Substantial genital trauma from the delivery

5. Female Sterilization

MECHANISM OF ACTION	FAILURE RATE (expressed in no. of pregnancies per 100 women using the method over the first year)	BENEFITS	LIMITATIONS/ SIDE EFFECTS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Female Sterilization (Time: can be done by trained and skilled providers within 7 days of delivery; and anytime 6 weeks or more after delivery) ▪ Blocks the fallopian tubes by ligation, clips, or bands and/or cut to prevent sperms and egg from uniting ▪ A permanent method that is not easily reversible ▪ Written consent of the woman undergoing the procedure is required ▪ Two methods: Minilap and laparoscopic ▪ Women should know that other effective, reliable, safe and long-term reversible methods are also available	Failure rate: 0.5	▪ Very effective &simple surgery performed on women under local anaesthesia ▪ Permanent procedure ▪ Effective immediately ▪ Nothing to remember, no supplies needed, no repeat clinic visits required after initial follow-up visits on 7th day to remove the stitches ▪ Does not interfere with sexual intercourse ▪ No effect on breast milk production ▪ No known long-term side effects or health risks ▪ Can be performed: o any time during the menstrual cycle when it is reasonably sure that the woman is not pregnant , o within 7 days of delivery o Post abortion, after ruling out infection	▪ Short-term discomfort/pain following procedure ▪ Uncommon complications of surgery include: ▪ Bleeding from surgical site ▪ Infection ▪ Injury to internal organs ▪ Requires a trained provider and health facility providing the service ▪ Does not protect against STIs and HIV	▪ As per national guidelines, any woman who fulfils following criteria:- ▪ Married woman (ever married) ▪ Woman is above 22 years and below 49 years of age ▪ Has at least 1 child of age more than 1 year, if the procedure is not being done for any medical reason ▪ Women who have completed their families ▪ Women who are breastfeeding ▪ Women with HIV or AIDS, who are clinically well, can undergo sterilization if they have chosen a permanent method. Special arrangements are needed to perform female sterilization for women with AIDS	▪ Women who are not sure of their reproductive goals ▪ Women who have not been counselled and do not understand the permanent nature of the procedure and may regret later ▪ Women with any of the following conditions should delay tubal ligation until the condition is resolved: – Current thromboembolic disorder – Current ischemic heart disease – Prolonged immobilization or leg surgery – Unexplained vaginal bleeding – Genital cancer – Current PID or treated within the past 3 months – Active viral hepatitis – Iron-deficiency anaemia with a haemoglobin less than 7 g/dl – Acute bronchitis or pneumonia – Prolonged rupture of membranes – Severe haemorrhage, sepsis, fever during or right after delivery – Should not be performed on a woman with HIV/AIDS who is not clinically well

6. Vasectomy

MECHANISM OF ACTION	FAILURE RATE (expressed in no. of pregnancies per 100 women using the method over the first year)	EFFECTIVENESS AND BENEFITS	LIMITATIONS/ SIDE EFFECTS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Vasectomy ▪ Highly effective permanent method for men ▪ Blocks the vas deferens (tubes carrying sperms in the man) and prevents sperms from entering the semen ▪ A method that is not easily reversible. ▪ Written consent is required from the man undergoing the procedure ▪ Methods: – Conventional – No Scalpel Vasectomy (NSV)	Failure rate: 0.2	▪ Very effective, permanent procedure ▪ Not effective immediately after the procedure. The couple needs to use a backup method such as condom for the first 3 months after the procedure for the semen to be sperm free ▪ Does not interfere with sexual intercourse/sexual pleasure ▪ Simple surgery performed under local anaesthesia by trained providers ▪ No known long-term side effects. ▪ No repeat clinic visits required, no supplies needed, except the use of backup method/condoms for the first 3 months ▪ Easier to perform than female sterilization ▪ No change in sexual function. ▪ No effect on hormone production	▪ Is permanent ▪ Delayed effectiveness (requires at least 3 months or 20 ejaculations for procedure to be effective) ▪ A minor surgery by a trained provider ▪ Does not protect against STIs and HIV ▪ Scrotal support to be maintained for the initial few days to prevent pain - at the operation site	As per national guidelines, any man who fulfils following criteria:- ▪ Men who want to limit their families ▪ Men below 60 years of age ▪ Men who have completed their families ▪ Men with HIV, AIDS or who are on ARVs can safely undergo vasectomy. ▪ Special arrangements are needed to perform male sterilization for men with AIDS	▪ Men with any of the following conditions should delay vasectomy until the condition is resolved: – Current STI – Scrotal skin infection – Acute genital tract infection – Acute systemic infection – Men with AIDS who are not clinically well ▪ The following conditions require a provider with extensive experience and skills in performing the vasectomy: – Previous scrotal surgery – Undescended testes and proven fertility – Inguinal hernia – Large varicocele

7. Emergency Contraceptive Pill (ECP) (Can be used any time after 4 weeks of childbirth

MECHANISM OF ACTION	FAILURE RATE (expressed in no. of pregnancies per 100 women using the method over the first year)	EFFECTIVENESS AND BENEFITS	LIMITATIONS/ SIDE EFFECTS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
EC Pills *This is not a regular Family Planning Method* It works by possibly inhibiting ovulation, thickening cervical mucus and affecting transport of sperm or egg depending on the phase of the menstrual cycle. ▪ Progestin only single dose as soon as possible after unprotected intercourse	Consistent and Correct Use: 1 .	▪ Moderately effective (ECPs should be taken within 3 days (72 hours) of unprotected sex. ECPs can prevent pregnancy if taken up to 3 days of unprotected sex, the sooner it is taken after unprotected sex, the better they prevent pregnancy. Can help prevent pregnancy after unprotected sex, contraceptive method failure or rape. ▪ Can be taken up to 3 days after unprotected intercourse. Taking it sooner the better. ▪ Is available over-the-counter without prescription ▪ Is available at all government health facilities free of cost/ supplied by the ASHA at the doorstep at a nominal cost (in selected districts)	▪ Must be taken within 3 days of unprotected intercourse ▪ Does not protect against STIs and HIV ▪ Possibility of side effects like nausea, vomiting, headache, dizziness, fatigue and breast tenderness. These side effects generally do not last more than 24 hours ▪ Does not protect unwanted pregnancy from unprotected intercourse after taking the ECPs even if it is on the next day	All women who have had unprotected intercourse for any reason	▪ Anyone with a known pregnancy since emergency contraception will not interrupt a pregnancy ▪ There are no contraindications

Obtaining the services:

The clients may be referred to the following public health facilities to obtain various family planning services:

<table>
<tr><th>Sub Centre</th><th>Primary Health Centre</th><th>Community Health Centre</th><th>District Hospital</th></tr>
<tr><td colspan="4">SERVICES</td></tr>
<tr><td>Counselling</td><td rowspan="6">All the services available at SHC +</td><td rowspan="5">All the services available at PHC +</td><td rowspan="8">All the services available at CHC/FRU on Daily basis</td></tr>
<tr><td>IUCD insertion</td></tr>
<tr><td>OCP distribution</td></tr>
<tr><td>Condom distribution</td></tr>
<tr><td>ECP distribution</td></tr>
<tr><td>Follow up of acceptors</td></tr>
<tr><td></td><td>Minilap sterilization including PPS (fixed day basis/ camps)</td></tr>
<tr><td></td><td>NSV (fixed day basis/ camps)</td></tr>
<tr><td></td><td>Referral linkages</td></tr>
<tr><td></td><td></td><td>Lap. Sterilization (fixed day basis/ camps)</td></tr>
<tr><td></td><td></td><td>PPIUCD insertion</td></tr>
<tr><td></td><td></td><td>Management of complications</td></tr>
</table>

Chapter 5

Postpartum Family Planning

Major components of this section:
- Return to Fertility
- Importance of post-partum period for family planning
- Appropriate Postpartum Family Planning Methods during various phases of postpartum period

Return to Fertility

- Return of fertility after delivery and abortion is very unpredictable and may be different for different women
- Fertility can return as early as four weeks after delivery, even before the return of menses.
- Period of infertility is longer if exclusively breastfeeding
- If a woman or a couple does not practice family planning after delivery or an abortion, then they are at a high risk of unwanted pregnancy

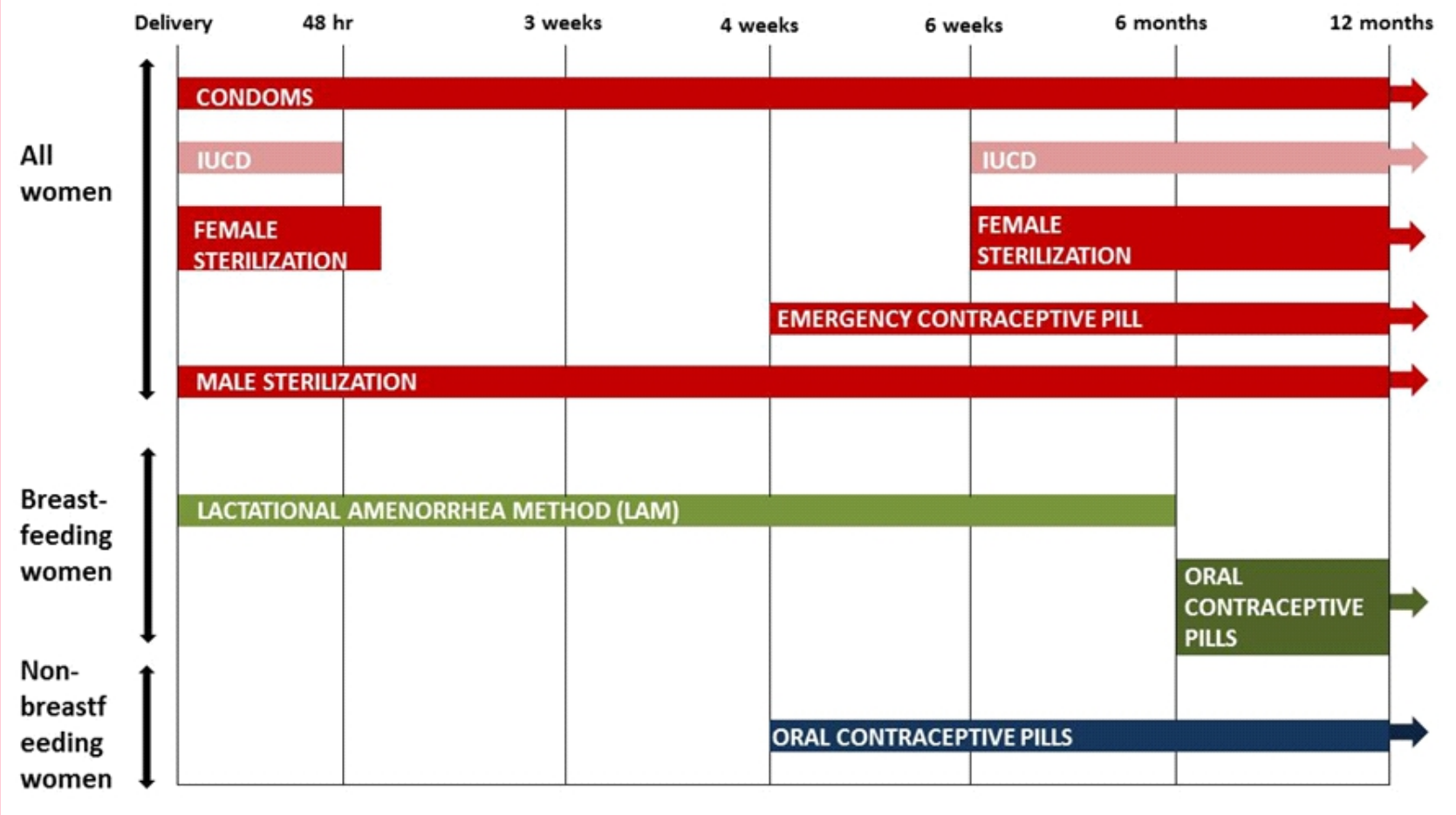
Postpartum Family Planning (PPFP):
Postpartum family planning is the initiation and use of family planning methods during the first year after delivery.

Importance of Postpartum and Post-abortion Family Planning (PPFP)

- There is a high unmet need for family planning during postpartum period.
- The woman is most receptive to prevent an early future pregnancy at this time.
- The woman comes in contact with the health system many times during the immediate and extended postpartum period, giving an opportunity to receive a contraceptive method of her choice.
- Conception during the first year postpartum will lead to sub-optimal inter-pregnancy interval, which may then result in poor maternal and neonatal health outcomes.

Postpartum Family Planning Method Choices:

Figure. (below) shows the methods that are most appropriate for postpartum women in the immediate and extended postpartum periods, depending on whether or not women are breastfeeding



Chapter 6

Common Misconceptions about Contraceptive Methods*

Misconceptions about OCPs	
Misconceptions	**Facts & Realities:**
I only need to take the Pill when I sleep with my husband.	A woman must take her pills every day in order not to become pregnant. Pills only protect against pregnancy if she takes them every day. If she misses one pill, she should take two as soon as she remembers.
I will face difficulty in getting pregnant again if I have been using it long enough.	A woman is only protected for as long as she actually takes the pill every day. (Reinforce this by using an analogy or personal example.)
Pills make you weak	Sometimes women feel weak for other reasons, but they are also taking the Pill, so they think it is the Pill that causes the weakness. If a woman feels weak, she should keep taking her pills every day and go to see a doctor. Pills do not make a woman weak. A doctor should be seen to try to find out what else is causing weakness in a woman. If a woman is feeling "weak", a pregnancy would almost certainly make her feel much worse than taking the Pill.
The Pill is dangerous and causes cancer.	Numerous studies have disproved this rumor. The Pill has been used safely by millions of women for over 30 years and been tested more than any other drug. In fact, studies show that the Pill can protect women from some forms of cancer, such as those of the ovary, endometrium, and cervix.
The Pill causes the birth of twins or triplets.	The Pill has no effect on the tendency toward multiple births. The tendency to have twins usually runs in families. That is, if there have been multiple births in either the man's or woman's family, then the chances of having twins are greater. Multiple births may also be triggered by fertility medication or by drugs taken to induce pregnancy.

Misconceptions about Condoms	
Misconceptions	**Facts & Realities:**
If a condom slips off during sexual intercourse, it might get lost inside the woman's body.	A condom cannot get lost inside the woman's body, because it cannot pass through the cervix. If the condom is put on properly, it will not slip off. The condom should be rolled down to the base of the erect penis. (If it comes off accidentally, instruct the client to pull it out carefully with a finger, taking care not to spill any semen which may lead to an unwanted pregnancy).
There is too much danger of condoms breaking or tearing during intercourse.	Condoms are made of thin but very strong latex rubber and they undergo extensive laboratory tests for strength. Condoms are meant to be used only once. There is less chance that a condom will break or tear if it is stored away from heat and placed on the erect penis leaving enough space at the tip for the ejaculate. A condom is more likely to break if the vagina is very dry, or if the condom is old (past the expiration date).

Misconceptions about IUCD	
Misconceptions	**Facts & Realities:**
The thread of the IUD can trap the penis during intercourse.	The strings of the IUD are soft and flexible, cling to the walls of the vagina and are rarely felt during intercourse. If the string is felt, it can be cut very short, (leaving just enough string to be able to grasp with a forceps). The IUD cannot trap the penis, because it is located within the uterine cavity and the penis is positioned in the vagina during intercourse. The string is too short to wrap around the penis and cannot cause injury to it.
A woman who has an IUD cannot do heavy work.	Using an IUD should not stop a woman from carrying out her regular activities in any way. There is no correlation between the performance of chores or tasks and the use of an IUD.

Misconceptions about IUCD	
Misconceptions	**Facts & Realities:**
The IUD might travel inside a woman's body to her heart or her brain.	There is no passage from the uterus to the other organs of the body. The IUD is placed inside the uterus and unless it is accidentally expelled, stays there until it is removed by a trained health care provider. If the IUD is accidentally expelled, it comes out of the vagina, which is the only passage to the uterus.
The IUD causes ectopic pregnancy.	There is no evidence that the use of an IUD increases the risk of an ectopic pregnancy.
Placement of IUCD in Uterus lets to the rottening of Uterus	The IUD is made up of materials that cannot deteriorate or "rot. Hence there is no question of rottening of Uterus due to IUCD.

Misconceptions about Female Sterilization	
Misconceptions	**Facts & Realities:**
A woman who has undergone sterilization loses all desire for sex (becomes frigid).	Tubal ligation does not cause a woman to lose or change any of her feminine characteristics. Tubal ligation has no physiological effect on the woman other than that of preventing the egg from being fertilized by sperm. The ovaries will still release eggs and produce hormones, and the woman will still menstruate, but she will no longer get pregnant.
A woman who has undergone sterilization becomes sickly and unable to do any work.	A woman who has been ligated can resume regular activities as soon as she is free from post-surgical discomfort. It does not affect her ability to work or make her weak or "sick".
A woman who undergoes sterilization has to be hospitalized.	There is no need for hospitalization with a female sterilization ligation. The procedure takes approximately 15 minutes. After the operation, the woman should rest for a few hours and then be allowed to go home in the company of a family member.

Misconceptions about Female Sterilization	
Misconceptions	**Facts & Realities:**
Sterilization shortens the life span of a woman and may cause early menopause.	There is no medical reason for a ligated woman to have a shorter life span--just the opposite; her life will probably be prolonged by preventing unwanted pregnancies. Ligation will not hasten menopause. A ligated woman will continue to ovulate and menstruate (although she will no longer get pregnant) until she naturally reaches menopause.

Misconceptions about Vasectomy	
Misconceptions	**Facts & Realities:**
Vasectomy is the same as castration. A man who undergoes vasectomy has his manhood taken away and he will no longer enjoy sex.	Vasectomy is not castration. In vasectomy, the vas deferens are cut and tied so that sperm cannot mix with the semen. The semen ejaculated during sexual intercourse no longer contains sperm and will no longer make a woman pregnant. Vasectomy does not interfere with any other physiological functions; neither does it cause any other types of changes. After a vasectomy a man will continue to produce male hormones, be "masculine" and heterosexual. Many men enjoy sex more after a vasectomy because they no longer need to worry about getting a woman pregnant.
Sperm that is not ejaculated during intercourse will collect in the scrotum and cause the scrotum to burst or will cause other problems in the body.	Sperm that is not ejaculated is absorbed by the body. It cannot collect in the scrotum or cause harm to a man's body in any way.

*__Adapted from:__ Comprehensive Reproductive Health and Family Planning Training Curriculum, Module 3: Counselling for Family Planning Services, Cathy Solter Pathfinder International, March 2000.

Section III

Counselling for Maternal and Newborn Health

Chapter 7

General Care During Pregnancy

This topic is about the care a woman needs during pregnancy – focusing on pregnant woman who do not appear to have problems or complications.

The role of a RMNCH counsellor is to communicate and counsel effectively with women and her family members about the care of a pregnant woman.

Care during Pregnancy:

A pregnant woman should

- Visit health center/hospital at least 4 times during pregnancy for antenatal check-up.
- Go to the health center/hospital, if there is any concern related to the health of the pregnant woman or the baby inside uterus.
- Carry her maternal card/record in every visit to the health center/hospital.
- Eat healthier foods including more vegetables and fruits, bean, meat, fish, eggs, cheese, milk.
- Take iron tablets every day as explained by the health provider.
- Take rest when she can. Should avoid lifting heavy weights.
- Sleep under a bednet.
- Not take any medication unless prescribed by the hospital/health centre.
- Not drink alcohol or smoke.
- Practise safe sex, including use a condom correctly in every sex act to prevent STIs or HIV/AIDS, if she or her partner is at risk of infection.
- Know the signs of labour – painful contractions every 20 minutes or less; bag of waters break; bloody sticky discharge.
- Know the danger signs and when to seek care.

The RMNCH counsellor needs to consider which information should be shared with her partner and other family member, like mother/mother-in-law/other women, and ladies accompanying pregnant women in the hospital/health center.

The above messages can be given in group counselling for antenatal (pregnant) women with or without their family members.

Facts about Antenatal Check-up (Check-up during Pregnancy):

Regular antenatal check-up (ANC) visits protect woman and her baby in uterus from complications and ensures healthy mother and child.

How many antenatal check-ups?

Registration and 1st ANC check-up: As soon as period is missed or within first 3 months of missing the period.

2nd ANC check-up: In 4th to 6th month of pregnancy

3rd ANC check-up: In 7th to 8th month of pregnancy

4th ANC check-up: In 9th month of pregnancy

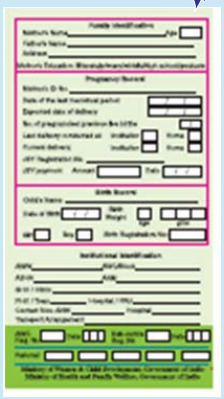
It is also advised to pregnant women to visit the doctor at the nearest health facility for an ANC during 7th to 8th month (i.e, 3rd ANC check-up), even if there is no complication.

Minimal Packages Offered during Antenatal Care at the Hospital/Health Center

- Registration (within 12 weeks)
- Physical examination, weight, BP and abdominal examination
- Identification and referral for danger signs

- Ensuring consumption of at least 100 IFA tablets (for all pregnant women) / 200 (for anaemic women). Severe anaemia needs referral.
- Essential lab investigations for Hb%, urine for albumin/ sugar, pregnancy test for unconfirmed pregnancy.
- TT immunization i.e two doses at interval of one month
- Counselling on nutrition, birth preparedness, safe abortion, family planning and institutional delivery
- Assured referral linkages for complicated pregnancies and deliveries

Where are ANC services provided?



At the village level, the nearest place for ANC services for a woman is at the Anganwadi center during the monthly VHND. The pregnant woman could also go to the Sub-Centre, where the ANM will provide ANC services. ANC services are also provided at the PHC, Community Health Centre (CHC), district hospitals, and medical college hospitals.

Registration of the pregnant woman:

During the 1st ANC visit, the Maternal and Child Protection Card and the antenatal register should be filled up. Counsellor should inform the pregnant woman about her expected date of delivery (EDD) and also of her subsequent antenatal visits. Counsellors should emphasize the importance of having all antenatal check-ups on time.

Iron Folic Acid (IFA) supplementation:

- Take one tablet of IFA tablet a day for at least for 3 months from the fourth month.
- If anaemic, the pregnant woman should take two IFA tablets daily, one tablet in the morning and one in the evening. Same doses need to be continued after delivery.
- Iron tablet should not be taken with tea as that reduces its absorption. IFA tablets should preferably be taken in empty stomach, however if it causes nausea, it can be taken after meals

Nutrition advice for pregnant woman:

- The pregnant lady needs to eat one extra meal a day during pregnancy
- Consume milk and dairy products like curd, buttermilk, paneer - these are rich in calcium, proteins and vitamins
- Eat fresh/ seasonal fruits and vegetables as these provide vitamins and iron. Cereals, whole grains and pulses are good sources of proteins
- Green leafy vegetables are a rich source of iron and folic acid
- A handful (45 grams) of nuts and at least two cups of daal provide daily requirement of proteins in vegetarians
- For non-vegetarians, meat, egg, chicken or fish are good sources of proteins, vitamins and iron.

Advice for rest during pregnancy

- Have 8 hours sleep at night and at least 2 hours rest during the day
- Lie on your left side as it increases the blood supply to the fetus
- Avoid hard work such as lifting heavy weight
- Adequate rest gives physical and mental relaxation which is good both for mother and the baby.

Chapter 8

Birth Preparedness for Safe Delivery and Emergency Planning

This topic is about the essential preparations for birth in advance by the pregnant woman and her family for a safe and comfortable delivery, for care after delivery and for the possibility of an emergency.

The role of RMNCH counsellor is to interact and counsel pregnant woman (with her family member or husband) attending the health facility to support her in developing plans for birth and emergencies. A pregnant woman should be well informed about her condition, all maternity schemes available, the distance to the health care facility for routine & emergency services and transport facilities. A pre identified facility helps in saving time by going to the right facility.

What is birth preparedness and emergency plan?

In order to ensure safe delivery and care after delivery, the woman and family must think out and plan several elements in advance. This is called birth preparedness plan.

Most women have a healthy, normal pregnancy, childbirth and postpartum period. However, some women and newborn babies will have complications that require care at a higher level. In many cases, it is not possible to identify in advance which women or babies will have the complications. In order for the woman to reach and receive the care she needs in an emergency, the woman and family must also prepare and emergency plan in advance.

All women should give birth with a skilled birth attendant (SBA). A pregnant woman should be well informed about her condition, all maternity schemes available, the distance to the health care facility for routine & emergency services and transport facilities. A pre identified facility helps in saving time by going to the right facility.

Who is a Skilled Birth Attendant?

A Skilled Birth Attendant (SBA) is defined as "an accredited health professional - such as ANM , doctor or nurse - who has been educated and trained to achieve proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and immediate postnatal period and in the identification, management and referral of complications in women and newborns".

Government of India considers the “Skilled Birth Attendant” as a person who can handle common obstetric and neonatal emergencies, recognize when the situation reaches a point beyond her/ his capability and refers the woman or the newborn to a First Referral Unit/ appropriate facility without delay.

Maternal Health Schemes:

Government of India launched 2 schemes to support maternal and newborn health and improve institutional deliveries.

Janani Suraksha Yojana (JSY)

This scheme aims to reduce deaths and illnesses in mothers and newborns by promoting institutional deliveries for pregnant woman from poor and marginalized families with a cash assistance for delivering and post-delivery care in the institution.

Benefits under JSY

- There are costs involved in transport, diet and medical care that poor families have to meet in order to have the delivery in health facility.

Place of delivery	Rural		Urban	
Institutional Deliveries in	Package for mothers	ASHA Package	Package for mothers	ASHA Package
#Low Performing States	1400	600* (200+250+150)	1000	200
#High Performing States	700	200	600	200
Home Deliveries	500	Nil	500	Nil

the counsellor should find out whether their state is low or high focus

- *ASHA benefit for referral transport (RT) is only given if there is no assured RT under JSSK
- This scheme also provides incentive to ASHA for promoting institutional delivery, and guide and support the pregnant woman to seek appropriate care.
- Another benefit of this scheme is that where Government specialists are not available in the Govt's health institution to manage complications or for Caesarean Section, assistance up to Rs. 1500/- per delivery could be utilized by the health institution for hiring services of specialists from the private sector.

Who can avail this scheme?

- All pregnant women who deliver in a government health centre such as sub centre, primary health centre, community health centre or FRU or district/ state hospital.
- There is no restriction for age or parity
- There is no need to produce a BPL or SC/ST certificate if the delivery is in a government facility
- All pregnant women who deliver in accredited private institution are also eligible
- The beneficiary is required to carry a referral slip from ASHA, ANM or MO and a Janani Suraksha Yojana or Mother and Child Protection card.

How and Where to avail this scheme?

This scheme is available in all the public health institution across the country.

Janani Shishu Suraksha Karyakram (JSSK):

Government of India has launched this cashless scheme on 1st June, 2011 with utmost emphasis on entitlements and elimination of out of pocket expenses for both pregnant women and sick neonates.

Benefits of this scheme:

- The initiative entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery, including caesarean section.

- The entitlements includes free drugs and consumables, free diagnostics, free blood wherever required, and free diet for 3 days during normal delivery and 7 days for C-section. This initiative also provides for free transport from home to institution, between facilities in case of a referral and drop back home.
- Similar entitlements have been put in place for all sick newborns accessing public health institutions for treatment till 30 days after birth

Who can avail this scheme?

This scheme is applicable to all pregnant women and sick newborns up to 30 days of birth accessing public health facility.

Important Guidelines and documents to be carried by pregnant women:

- Mother and child protection card
- Safe Motherhood booklet

Content of a birth preparedness and complication readiness plan

1. Preferred health facility /SBA identified for birth.
2. Health facility identified in case of emergency.
3. Companion identified to accompany during birth, 24 hours after birth and in case of emergency.
4. Support person identified for care of the home and children during birth or in case of emergency.
5. Transportation to the health facility identified including costs.
6. Estimated costs of care in case of emergency identified.
7. Arrangements made to cover costs.
8. Supplies for birth – Soft clean cotton clothes, blankets for mother and child, clothes for baby, socks and cap for baby, etc.
9. Possible blood donors identified in case of haemorrhage/emergency.
10. Danger signs during antenatal, intranatal and in postpartum period when a mother or a newborn need to be referred to the appropriate health facility immediately

Every pregnant woman and her family should have a birth preparedness and complication readiness plan made in advance.

What are the options available to woman for selecting the place of giving birth?

Situation	Choice
1. In case of any danger sign or complication	▪ Nearest CHC (Community Health Center)/FRU or District Hospital – Which provides comprehensive emergency obstetric care (CEmONC) ▪ ANM and ASHA can help the woman in identifying such facility in nearby area
2. If there are no complications	▪ 24 × 7 PHC – A team of doctors, nurses or ANMs conduct the delivery, provide care for the mother and newborn - These facilities can manage some complications and transfer immediately to a higher facility if there is requirement of surgery or blood transfusion. ▪ The list of such places can be obtained from the ANM. ▪ The woman would have to stay there for 24-48 hours after delivery.
3. If there are no complications and woman and her family are reluctant or unable to go to the 24 × 7 PHC or if it is too far away	▪ Sub-center, provided it is accredited as a delivery center, which means that ANM has been trained as a SBA and is available, and the minimum facilities for delivery are there.
4. If there are no complications or not a high risk case for developing complications and the mother and family insist on delivering at home, despite counselling them for institutional delivery.	▪ Delivery by trained ANM at home – ASHA or ANM can help in identifying trained ANM available in that area. ▪ Family should be able to organize transport and money at very short notice. ▪ The identified SBA should be able to arrive within 30 minutes of the onset of labor, should able to stay through the process of labor and for a few hours afterwards.

Chapter 9

Danger Signs in Pregnancy

This topic is about the information that needs to be shared with women and their families about the early detection and recognition of danger signs and complications as part of birth preparedness and emergency planning.

The RMNCH counsellor's role is to communicate with pregnant women and their family members, who came to the health facility for antenatal check-up, what the danger signs are and help them to think about and decide where they will go if they experience one or any of these signs.

Danger Signs during Pregnancy

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

- Vaginal bleeding

- Convulsions/fits

- Severe headaches with blurred vision
- Loss of fetal movement
- High fever and too weak to get out of bed

- Severe abdominal pain
- Fast or difficult breathing
- High blood pressure (⩾140/90 mm of Hg) with or without proteins in the urine
- Decreased or absent foetal movement

Identification of problem and where to go

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

Government encourages all women to come to facilities for delivery including those who do not have any danger sign or complication or risk. It is not always possible to predict who will have complication and who will not. Women and family members need to know when to seek care from an appropriate place or provider. For example, bleeding requires immediate transport to a health facility because a woman, particularly with anemia, can die in a matter of hours.

Chapter 10

Counselling for Preventing Anemia

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

Counselling messages for pregnant woman with anemia to be discussed with anemic pregnant woman and her family members:

- Take iron-rich foods such as green leafy vegetables, whole pulses, ragi, jaggery, meat and liver.
- Encourage the woman, where possible, to take plenty of fruits and vegetables containing vitamin C (such as mango, guava, orange and sweet lime) as these enhance the absorption of iron.
- Counsel the women on the necessity of taking IFA, the dangers associated with anaemia, and inform the women that these side-effects are common and not serious, and will reduce over time.
- IFA tablets must be taken regularly, as directed by the health provider for minimum 100 days. If the woman has nausea and pain in abdomen, she may take the tablets after meals or at night. This will avoid nausea.
- Dispel the myths and misconceptions related to IFA and convince the woman about the importance of taking it. An example of a common myth is that the consumption of IFA may affect baby's complexion.
- Many women do not take IFA tablets regularly due to some common side-effects such as nausea, constipation and black stools. Tell women not to worry about passing black stool while consuming IFA. It is normal.
- In case of constipation, the woman should drink more water and add roughage (plenty of green leafy vegetables) to her diet.
- IFA tablets should not be consumed with tea, coffee, milk or calcium tablet as it reduces the absorption of iron.
- IFA tablets may make the woman feel less tired than before. However, despite feeling better, she should not stop taking the tablets and must complete the course as advised by the healthcare provider.
- Ask the woman to return to health provider if she has problem taking IFA tablets.

Chapter 11

Post-Abortion Care

This session focuses on the specific counselling needs of women who have experienced an abortion.

The term abortion refers to the termination of pregnancy. A pregnancy terminates either as a spontaneous abortion (miscarriage) or elective abortion which is performed for medical or other reason.

Pre-procedure counselling:

Decision Making and General Information: To enable the woman to make a decision on actually terminating the pregnancy-

- Ask the reason for termination of pregnancy by asking relevant question related to personal, social, family and medical history and past use of contraceptive methods.
- Particularly seek history of undergoing ultrasound for sex selection in women seeking 2nd trimester abortion.
- Inform her that early abortion is safe.
- Abortion is legalised up to 20 weeks of gestation and is available in the government health facilities and therefore she should not approach an unqualified abortion providers which can pose the risk of complications and sometimes even a threat to her life.

Helping to choose the method of MTP:

- Help her to select the method of termination (medical of surgical) after she has been assessed and informed about the methods by the doctor.

Consent:

- Take consent from the woman after she has received complete information about the procedure and understood its implications.
- Help the woman to sign the consent form.

Adopting a contraceptive method:

- Help her to take a decision on adopting a contraceptive method after the procedure. If the woman is not able to decide regarding a contraceptive method, do not refuse MTP, as she may go to an illegal abortion provider.

Key Messages for Woman after an Abortion

A. Self-Care:

- Rest for a few days, especially if she feels tired.
- Change pads every 4 to 6 hours. Wash pad or dispose of it safely. Wash perineum.
- Do not have sexual intercourse until bleeding stops.
- The woman and her partner should practise safe sex and use a condom correctly in every act of sexual intercourse if at risk of STI or HIV.
- Return to the health facility as advised or in case of any problem/concern.

B. Family Planning: (refer to section I for details of post-abortion family planning counselling)

- One can become pregnant as soon as they have sexual relations. Use a family planning method to prevent an unwanted pregnancy and a condom to prevent infection with STIs/HIV/AIDS.

- Choose a family planning method which best meets their and their partner's needs.
- After an abortion, the recommended interval to the next pregnancy is at least six months both for the mother's and the baby's health.

C. **Danger signs:** If the woman has any of these signs she needs to go to the health centre immediately.DO NOT wait:

- Increased bleeding or continued bleeding for 2 days
- Fever, feeling ill
- Dizziness or fainting
- Abdominal pain
- Backache
- Nausea or vomiting
- Foul-smelling vaginal discharge

Counselling of a woman/ spouse/relative- before or after abortion, in case of referral to higher facility:

- On the reasons for referral
- To explain which facility (referral site) she has to go to.
- Which procedure will be done and by whom.
- She should report to the referral facility or to the facility from which she was referred, for follow up.

Note: The woman should be given a referral slip and referral should be recorded at the facility.

Chapter 12

Support During Labour and Chidbirth

This topic focuses on key messages for childbirth companion, so that the woman can get good social support in labour.

Women should be encouraged to have a companion of her choice during labour. Some women like to have their husband; others prefer mother or mother-in-law, relative, friend. Mamta/Yashoda, if available in hospital, can also play the role of birth companion.

The counsellor should communicate to the birth companion the value of their role and what it involves.

Research has shown that women who receive good social and emotional support during labour and childbirth, tend to have shorter labours, control their pain better, and have less need for medical intervention.

Key Support to Woman during Labor and Childbirth

- The companion should always try to be with the woman and praise, encourage and reassure her throughout the process.
- The companion can help her to breathe and relax by rubbing her back, providing sips of water as allowed, wiping her forehead with a wet cloth, or doing other supportive actions.
- Other preparation – Immediately after birth, if the baby remains naked, s/he may become cold. Hence, baby clothes should be kept ready before delivery.

It is important to tell the birth companion what they SHOULD NOT DO.

- DO NOT encourage the woman to push.
- DO NOT give advice other than that given by the health provider.
- DO NOT keep the woman in bed if she wants to move around.
- DO NOT administer any local herbs or medicine

The RMNCH counsellor can work with the woman and her companion to find out what the woman in labour wants to do and how she wants to be supported and helped throughout her labour.

Danger signs in labor and delivery:

The companion or RMNCH counsellor should remain vigilant about danger signs in labour and delivery. In case any such sign occurs, inform the doctor or nurse immediately.

Remember that these danger signs can occur any time:

- Bleeding (fresh blood)
- Swollen face and hands
- Water breaks but labour does not start within 18 hours or more
- Color of water- green or brown
- Prolonged labour – woman bearing down for more than 12 hours (8 hours in the case of women who have already had children) with the baby not coming out
- Fever
- Fits
- Retained placenta

Chapter 13

Counselling for Care of the Mother after Birth and Newborn

Postpartum is the period after delivery of the placenta up to 6 weeks after birth. This topic focuses on the key information that should be communicated to women who have just given birth and their partners and/or families.

Important Messages for Women and Family Members, Immediately Following Birth

Care of the mother:

- Stay back at the hospital/health centre (if given birth at the facility) for 24-48 hours, as adviced by the health provider
- Eat more and healthier foods including more meat, fish, oils, coconut, nuts, cereals, beans, vegetables, fruits, cheese and milk
- Take iron tablets as explained by the health provider
- Discuss breast feeding (dealt in the next chapter)
- Rest when you can, avoid hard physical labor.
- Drink plenty of clean, safe water
- Sleep under a bednet
- Do not take any medication unless prescribed by the hospital/health center
- Do not drink alcohol or smoke
- Avoid sexual intercourse until the wound in the perineum heals. Use a condom in every sexual relation, if you or your companion are at risk of sexually transmitted infections (STIs) or HIV/AIDS
- Wash all over daily, particularly the perineum. Do not insert anything into the vagina.
- Change pad every 4 to 6 hours. Wash pad or dispose it safely.

Family Planning (Postpartum family planning counselling is dealt in detail in the section I & II of this reference manual)

- She can become pregnant within few weeks after delivery if not breastfeeding exclusively
- Choose a family planning method which best meets her and her partner's needs.

When to seek care for danger signs

Come back to hospital or health center immediately, day or night, DO NOT wait if any of the following signs:

- Excessive vaginal bleeding
- Fits
- Fast or difficult breathing
- Fever and too weak
- Severe headaches with blurred vision

Come back to the hospital/health center **as soon as possible** if any of the following signs:

- Swollen red or tender breasts or nipples
- Problems urinating or leaking
- Increased pain or infection in the perineum
- Infection in the area of the wound
- Foul smelling vaginal discharge

Important Messages to Mothers, Fathers and Family Members for Care of the Newborn

Care of the baby:

- Keep the baby warm. The baby should be wrapped in several layers of clothing/woollen clothing depending upon the season. If cold, put a cap on baby's head. The baby should be kept close to mother's chest and abdomen. The room should be warm enough and free from strong wind.
- Care for the umbilical cord. Do not put anything on the stump and keep it dry, clean. It will fall off by itself in 5-7 days.
- Start breastfeeding immediately after birth. Provide nothing else not even water but breast milk day and night.
- Bathing the baby: Do not bathe the baby on first day and it is preferable not to bathe the baby for first 7 days, this is especially important for low birth weight babies (weighing <2.5 kg at birth). Keep the baby clean by wiping the baby with a warm wet cloth and dry the baby immediately. Get the initial doses of vaccines (BCG, 0 dose of Polio (OPV), 0 dose of hepatitis B) at birth before leaving the facility.
- Visit the health provider one week and six weeks after birth. At six weeks visit, the baby will be immunized.
- Let the baby sleep on his/her back or side.
- Keep the baby away from smoke.
- People who are sick with cold, cough, fever, skin infection, diarrhea etc. should not hold the baby or come in close contact with the baby.
- Too many people should not gather around the newborn baby.

Care of the babies less than 2.5 Kg:

- Provide extra warmth
- Wrap the baby well with thin sheets and blankets
- Cover the head of the baby to prevent heat loss
- Keep the baby very close to the mother's abdomen and chest (This is called kangaroo mother care)
- Warm water filled bottles wrapped in cloth may be kept on either side of the baby's blankets, when not being kept close to the mother's body.
- The baby must be breastfed more frequently.

Danger Signs for the Newborn

In addition to advising parents and the family on general care of the newborn, it is important to alert them to danger sings.

Newborns sometimes develop life-threatening problems. Families should recognize the signs of these problems early and take the baby to the nearby hospital. The signs are:

- Baby does not suck or sucks poorly at the breast
- Baby unable to cry or has difficulty in breathing
- Baby has convulsions (abnormal movements)
- Baby is excessively drowsy or cries continuously
- Baby has boils on body or umbilical redness or pus/blood oozing out of umbilicus
- Baby is cold or hot to touch

- Baby develops yellow staining of palms and soles

Advice family on the importance of birth registration and guide them to complete the process and collect the birth registration certificate.

Government's minimum package offered for postnatal care:

Mothers:

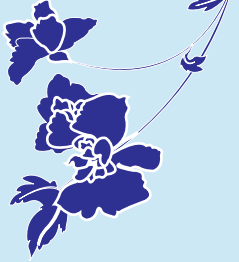
- Minimum 6 hours of stay post-delivery in sub-center & 48 hours if delivered in a PHC or FRU
- Counselling for feeding, nutrition, family planning, hygiene, immunization and postnatal check up
- Home visits on 3rd, 7th and 42nd day for both mother and baby
- Additional visits are needed for the newborn on day 14th, 21st and 28th and further visits may be necessary for Low Birth Weight (LBW) and Sick newborn.
- Timely identification of danger signs and complications and referral of mother and baby.

Baby:

- Keeping the newborn warm
- Hygiene and cord care
- Exclusive breast feeding for 6 months
- Identification, management and referral of sick neonates, low birth weight and pre term newborns
- Referral linkages for management of complications
- Care of LBW newborns <2500 gm
- Zero day immunization for OPV, BCG, Hepatitis B

Breastfeeding

Refer to Breastfeeding topic in Child Health Section.




Section IV

Counselling for Child Health

Background

- Healthy infancy and childhood make the foundation for healthy and productive adult life. Adequate nutrition plays a major part in it.
- Children can lead a disease-free and healthy life when they receive timely immunization, proper nutrition, and early care and treatment for common child hood illnesses. Most common causes of infant and child illness which often leads to death are preventable. These include acute respiratory infections (pneumonia), diarrhoea, malaria, measles, and under nutrition.
- The RMNCH counsellor's role is to bring awareness among caregivers of children under-five years of age regarding child care issues and advise specific actions in individual cases for ensuring that the child remains healthy and can achieve his/her potential for growth and development. The counsellor should also be able to guide parents on how and where to access specific services (such as immunisation, diarrhoea management, supplementary nutrition, etc.) and follow up, where possible, to see that parents been able to reach these services.

Four key messages (B I N D) for child health:

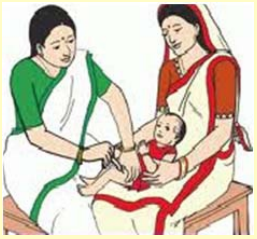
- **Exclusive Breastfeeding** and **Immunization** will protect infants against most common childhood diseases.
- Adequate and age-appropriate **Nutrition** is key to optimal physical growth and overall development of the child.
- Early identification and care for most common childhood **Diseases** will prevent morbidity and mortality among children.

Chapter 14

Complete Immunization

Major components of this section:

- Importance of Immunization
- Messages to be given to parents for Immunization
- National Immunization Schedule of the Government of India



Visits of the mothers to health facilities for antenatal, delivery, and post-partum care are appropriate times to counsel them about the importance of complete and timely immunization.

- According to a recent survey (CES 2009), nearly 40% of children of one year of age in India are still not fully immunized.
- Immunizations provided under the Universal Immunization Program (UIP) of the Government of India protect young children against major diseases of childhood.
- The vaccines given under the UIP offer protection against Tuberculosis, Polio, Diphtheria, Pertussis, Tetanus, Measles, Hepatitis B, and Japanese Encephalitis (in selected endemic districts).
- Full immunization (i.e. one dose of BCG, three doses each of DPT, Hepatitis-B and OPV and one dose of Measles vaccine before the age of one year) gives a child the best chance for a healthy childhood and healthy life.
- If a child is not given the right vaccines in time, it is necessary to get them started whenever possible and complete the primary immunization before the child reaches its first birthday.

The counsellors should:

- Be aware of the vaccines recommended under the National Immunization Schedule.
- Ensure that the mothers/caregivers of all the children coming to the health facility are informed regarding immunisation. Tell them about health facilities or sites in the community where these are administered. In case these are fixed day services, inform the parents/caregivers about it.
- Counsel the mothers that minor ailments, such as mild fever, cough, cold etc. are not a contra-indication for immunization.
- Advise the mother to bring the immunization card every time she comes with the child for immunization session.

National Immunization Schedule for Infants, Children and Pregnant Women				
Vaccine	When to give	Dose	Route	Site
For Pregnant Women				
TT-1	Early in pregnancy	0.5 ml	Intra-muscular	Upper Arm
TT-2	4 weeks after TT-1*	0.5 ml	Intra-muscular	Upper Arm
TT- Booster	If received 2 TT doses in a pregnancy within last 3 years	0.5 ml	Intra-muscular	Upper Arm
For Infants				
BCG	At birth or as early as possible till one year of age	0.1ml (0.05ml till 1mth age)	Intra-dermal	Left Upper Arm
Hepatitis B	At birth or as early as possible within 24 hours	0.5 ml	Intra-muscular	Antero-lateral side of mid-thigh
OPV-0	At birth or as early as possible within the first 15 days	2 drops	Oral	Oral
OPV 1, 2 & 3	At 6 weeks, 10 weeks & 14 weeks	2 drops	Oral	Oral
DPT 1, 2 & 3	At 6 weeks 10 weeks & 14 weeks	0.5 ml	Intra-muscular	Antero-lateral side of mid-thigh
Hep B 1, 2 & 3	At 6 weeks 10 weeks & 14 weeks	0.5 ml	Intra-muscular	Antero-lateral side of mid- thigh
Measles	9 completed months-12 months.	0.5 ml	Sub-cutaneous	Right upper arm
Vitamin-A (1stdose)	At 9 months with measles	1 ml (1 lakh IU)	Oral	Oral
For Children				
DPT booster	16-24 months	0.5 ml	Intra-muscular	Antero-lateral side of mid-thigh
Measles 2nd dose	16-24 months	0.5 ml	Sub-cutaneous	Right upper arm
OPV Booster	16-24 months	2 drops	Oral	Oral
Japanese Encephalitis**	16-24 months	0.5 ml	Sub-cutaneous	Left upper arm
Vitamin-A*** (2nd to 9th dose)	2nd dose at 16 months. Then, one dose every 6 months up to the age of 5 years.	2ml (2 lakh IU)	Oral	Oral
DPT Booster	5-6 years	0.5 ml.	Intra-muscular	Upper Arm
TT	10 years & 16 years	0.5 ml	Intra-muscular	Upper Arm

*Give TT-2 or Booster doses before 36 weeks of pregnancy. However, give these even if more than 36 weeks have passed. Give TT to a woman in labour, if she has not previously received TT.

**JE Vaccine, in select endemic districts after the campaign.

***The 2nd to 9th doses of Vitamin A can be administered to children 1-5 years old during biannual rounds, in collaboration with ICDS

What to do if a child has missed Immunization as per the prescribed schedule:

1. **A child less than 5 years coming in to the facility has not received any immunization:**
   If any child has not received any immunization, encourage the parent to get the child immunized with appropriate vaccine at the facility on the same visit. If the child has received first doses of appropriate vaccines, encourage the parents to complete the immunizations.

   If the family cannot come to the facility for immunization, encourage them to get the child immunized at the local sub-centre. If possible, coordinate with the relevant ANM for getting the child immunized.

2. **A child has been brought late for a dose:**
   Tell the parents that there is no need to re-start the schedule all over again even if the child is brought late for a dose. Refer the child to a staff nurse or an ANM. They will pick up the vaccination where the schedule was left off. For example: if a child has

Key messages for parents regarding immunization

Get your newborn vaccinated with BCG, OPV and Hepatitis B

After a vaccination, always ask the vaccinator-when is the next dose due

Get your child fully vaccinated as per the immunization schedule

Do bring the vaccination card when coming for each vaccination

Contact an ANM or Staff Nurse if your child has missed any vaccination

Chapter 15

Adequate and Age-Appropriate Nutrition for the Child

Major components of this section:
- Importance of adequate and age-appropriate feeding
- Complementary feeding after 6 months
- Importance of growth monitoring

- Proper nutrition is required for a child to grow, develop and remain active.
- Adequate nutrition means that the child receives nutrients such as carbohydrates, fats and proteins that are required in large amounts (macro nutrients), and other nutrients such as Vitamins, Iron, Calcium, Iodine etc., that are required in minimum amounts (micro nutrients).
- Children have different nutritional requirements for different ages. Hence age appropriate feeding is crucial for a child's growth.
- In order to provide adequate nutrition, Infant and young child feeding (IYCF) practices must be followed. These improve child health, prevent under nutrition and reduce child mortality.
- The IYCF practices include (1) initiation of breastfeeding within one hour of birth, (2) exclusive breastfeeding for the first six months of life and (3) appropriate complementary feeding starting on completion of 6 months of age and (4) continued breastfeeding for two years or beyond.
- Under nutrition, a condition caused due to inadequate nutrition, is the underlying cause of more than 50% of child deaths due to common childhood illnesses.
- Under nutrition in the first two years of life has a permanent effect on a child's growth and limits the growth potential.

Breastfeeding

Age: 0-6 months-- Exclusive breastfeeding

Breastfeeding plays a crucial role in the health, growth and development of babies and has benefits for the mother too.

The RMNCH counsellor has a very important role in promoting optimal infant and young child feeding practices at the health facility. This includes counselling of mothers for initiation of breastfeeding within one hour of birth and exclusive breastfeeding. More importantly she should provide specific support in case the mother has problems in establishing or continuing breastfeeding.

Breastfeeding has many advantages

Benefits for the baby:

- Early skin to skin contact keeps the baby warm.
- It helps in early secretion of breast milk
- Feeding first milk (colostrum) protects the baby from infections
- Helps mother and baby to develop a close and loving relationship

Benefits for the mother:

- Helps womb to contract and the placenta is expelled easily.
- Reduces the risk of excessive bleeding after delivery.
- Lowers the risk of becoming pregnant in the first six postpartum months in women who are fully or nearly fully breastfeeding

Important messages for successful breastfeeding:

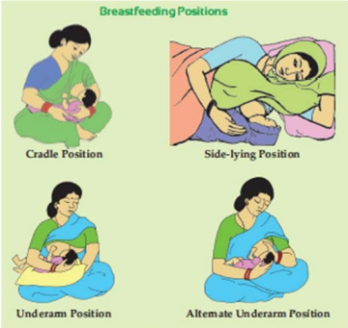
- Start breastfeeding soon after delivery or within one hour after birth. Baby should be put to the mother's breast even before placenta is delivered. It is useful for both the baby as well as the mother.
- The first milk, also called the 'colostrum' must not be discarded but fed to the baby as it protects the baby from infections.
- Exclusively breastfeeding– Exclusive breastfeeding means that an infant receives only breast milk from his or her mother or a wet nurse, or expressed breast milk, and no other liquids or solids, not even water, with the exception of oral rehydration solution, drops or syrups consisting of vitamins, minerals supplements or medicines, when required.
- Feeding the new-born with sugar water, honey, ghutti should be strongly discouraged.
- Use of feeding bottles for giving milk or fluids to babies and children should be strongly discouraged.
- Breast milk provides all the water a baby needs. Babies do not need extra water even during the summer months.
- Breastfeed as often as the baby wants and for as long as the baby wants. Baby should be breastfed day and night at least 8-10 times in 24 hours.
- Feeding more often helps in production of more milk. The more the baby sucks, more milk is produced.
- If the baby is not feeding well or if mother has complains of 'not enough breast milk', sore nipples or painful breasts examine and provide appropriate care and support.
- If further assessment and advice is required, seek help from the Lactation Management Counsellor or IYCF trained person available at the health facility.

The RMNCH counsellor can support mother in starting and maintaining breastfeeding.

Baby should be held in correct position and need to be put correctly to the breast to get maximum benefit of breastfeeding.

The baby is in the correct position when:

- While holding the baby, the mother also supports the baby's bottom, and not just the head or shoulders



- Mother hold her baby close to her body
- The baby's face is facing the breast, with nose opposite the nipple

- **The baby is put correctly to the mother's breast when:**
  - The baby's chin touches the breast
  - The baby's mouth is wide open
  - The baby's lower lip is turned outside

Giving other food or liquid may harm the baby in following ways:

- It reduces the amount of breast milk taken by the baby.
- It may contain germs from water or on feeding bottles or utensils. These germs can cause diarrhoea.
- It may be too dilute, so the baby becomes malnourished.
- Baby does not get enough iron from cow's and goat's milk and may thus develop anaemia.
- Baby may develop allergy to animal protein (eg; those present in cow or goat milk).
- Baby may have difficulty digesting animal milk; the milk can cause diarrhoea, rashes or other symptoms. Diarrhoea may become persistent.

Hygiene practice by mothers/caregivers:

- Caregiver should wash hands with soap and water before feeding the child.
- Caregiver should wash hands with soap or ash after washing baby who has defecated, and after baby's excreta has been safely disposed.

Complementary feeding

- Complementary feeding means complementing solid/semi-solid food with breast milk. It is the process of starting to give other foods and liquids along with breast milk when breast milk is no longer sufficient to meet the nutritional requirements of infants.
- Complementary feeding requires special attention as delayed and inadequate complementary feeding is the most common reason for growth faltering in children.
- The child should be fed complementary foods after six months. In the initial period, semi-solid foods prepared from the staple cereal of the family (such porridge made from *suji, atta,* or split rice etc.) or meshed fruits can be fed to the child.
- When giving complementary food, following aspects have to be taken into account:
  - **Frequency:** Give complementary food 2 times for breasted infants 6-8 months; 3 times for breastfed children 9-23 months and 4 times for non-breastfed children 6-23 months.
  - **Amount:** Start with 2-3 tablespoonfuls. Increase amount gradually to half (½) to 1 cup (250 ml cup).
  - **Thickness:** Start with thick porridge, well mashed foods. Give food that can

be chewed, munched, swallowed depending on the age of the child. Do not use mixers/grinders to make food semisolid or pasty.

- **Variety:** Try to feed a variety of foods at each meal. Give the child food from 4 or more food groups which are (1) Grains, roots and tubers, legumes and nuts; (2) dairy products; (3) flesh foods (meat fish, poultry); (4) eggs, (5) vitamin A rich fruits and vegetables; (6) other fruits and vegetables.

Use locally available food items.
Use iodised salt for cooking.

- Active/responsive feeding
  - Be patient and actively encourage the child to eat.
  - Don't force feed the child.
  - Use a separate plate to feed the child so that you know how much the child has eaten and helps the child to develop an individual identity.
  - Self-feeding should be encouraged despite spillage.

- **Hygiene:** Maintain hygiene during preparation, storage and feeding. Washing hands with soap and water is necessary before eating or preparing food and after using the toilet. Child is likely to get repeated infections if adequate hygiene is not maintained.

The counsellor should talk about the harmful feeding practices that are prevalent locally. These could be dilution of milk with water, Use of feeding bottle with nipples/ pacifiers, not starting complementary food as long as the child is breastfeeding, myths about giving certain foods to children and so on. S/he should also answer queries from caregivers, if any.

Age: 6-9 months

- The child is given 2-3 meals per day along with frequent breastfeeding.
- The child is started with 2-3 spoonfuls of thick porridge and well mashed foods that are easy to swallow. The amount can be gradually increased.
- Green leafy vegetables (about 25 grams) are cooked and added to the food or cooked along with cereals.

Age: 9 months to 12 months

- Introduce lumpy or granular foods and most tastes by about 9 to 10 months.
- The child should be fed these foods 3 to 4 times a day in addition to frequent breast feeding. The amount of food to be given is approximately ½ of a 250 ml cup/bowl.
- Add 25 grams of raw green leafy vegetables, cooked and added to the food or added to food while cooking. This will improve the iron content of the food.

Age: 12 Months to two years

- The child is given 3-4 meals per day along with breastfeeding. The food can be finely chopped or mashed. The child should be able to pick up the food and eat on his/her own.
- Add 40 grams of raw green leafy vegetables, cooked and added to the food or added to food while cooking.
- The child can be offered snacks from family foods cut into small pieces, finger foods, sliced food.
- The child should be fed these foods 4-5 times a day in addition to the breast feeding. The amount of food to be given is approximately ¾ of a 250 ml cup/bowl.

Age	Texture	Frequency	Average amount of each meal
6-9 months	Start with thick porridge, well mashed foods	2-3 meals per day plus frequent Breastfeeding	Start with 2-3 table-spoonfulls
9-12 months	Finely chopped or mashed foods, and foods that child can pick up	3-4 meals plus breastfeed. Depending on appetite offer 1-2 snacks	½ of a 250 ml cup/bowl
12-24 months	Family foods, chopped or mashed if necessary	3-4 meals plus breastfeed. Depending on appetite offer 1-2 snacks	3/4 to one 250 ml cup/bowl

The counsellors should:

- Counsel women with young children coming to the facility about the importance of complementary feeding after the age of 6 months.
- Counsel them about the age-appropriate food choices for children between 6-12 months and using a variety of foods.
- Counsel them about the need for maintaining hygiene while preparing the food and feeding the child.
- Inform them that they should wash hands before preparing the food and feeding the child, feed children fresh cooked food, keep the cooking and feeding utensils clean.

Feeding during illness

Food intake of infants and young children decreases during illness, however the energy requirement increases. Hence, it is important to know how and when the ill child should be fed.

- Breastfeeding should be continued for children who are sick and can be encouraged to eat small quantities of nutrient rich food. The food offered should be what the child likes to eat and given frequently.
- After the illness (eg; diarrhoea) the nutrient intake of child can be easily increased by increasing one or two meals in the daily diet for a period of about a month; by offering nutritious snacks between meals; by giving extra amount at each meal; and by continuing breastfeeding.

The counsellor should

- Counsel the mothers coming to the facility that feeding should be continued even during illness:
  - Food should be given in small amounts but more frequently
  - Simple home-cooked food should be given, which is easily digestible
- Counsel the mothers to continue breast-feeding more frequently for a few days after an episode of illness

Growth monitoring

- Growth monitoring is very important to assess the progress of child's growth.
- Growth monitoring is done on growth charts. This can be done at the health sub-centres if the mother comes regularly for the check-up or at local Anganwadi centres.
- Growth of the child can be assessed by plotting height and weight for the age in Mother and Child protection card. Growth monitoring should be done monthly during the first year, once every two months in the second year and once every three months thereafter till the sixth year.
- Deviation from normal growth indicates risk of malnutrition in children which needs to be corrected for adequate development of the child.The counsellor should
- Counsel mothers with young children coming to the facility about the importance of regular growth monitoring of the child.
- Counsel them about the places where they can get the growth monitoring of the child plotted.
- Counsel them to keep the growth chart safe and bring it along each time they visit a health facility or Anganwadi center.
- A child (0-3 years) is said to be growing normally if the weight for age is in the green zone; moderately underweight of the weight is in the yellow zone and severely underweight if the weight is in the orange zone.

The counsellors should:

- Counsel mothers with young children coming to the facility about the importance of regular growth monitoring of the child.
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Key messages for parents regarding age-appropriate and adequate nutrition

Feed the child only breast milk till the age of 0-6 months

Start complementary feeding after the age of 6 months

Adequate nutrition is must for normal growth

Maintain hygiene while preparing food and feeding the child

Get the growth of your child charted regularly

Chapter 16

Early Identification and Care for Major Childhood Diseases

Major components of this section:
Recognition and early care for:
- Diarrhoea
- Respiratory Infections

- Acute respiratory infections and diarrhoea are most common causes of illness and death in children.
- Deaths and severe illness from these causes can be easily prevented by performing simple care practices and seeking expert care as soon as danger signs appear.
- Hence, timely identification and management of these conditions is critical.

Diarrhoea

Ÿ Diarrhoeal diseases are a major cause of death and disease among children under five years

- Diarrhoea is defined as passage of liquid or watery stools more than three times in a day. Passage of even one large watery motion among children can be labelled as diarrhoea.
- Severe diarrhoea can cause the body to lose water and minerals. This can be dangerous for the child if the child cannot take enough water or fluids to replace this loss.
- If a child suffers from diarrhoea, severe illness and loss of life can be prevented by maintaining fluid intake of the child, continuing feeding the child, and timely care seeking or referral if danger signs arise.
- The child with diarrhoea should be given more fluids and breastfeeding should be continued. Fluids can be oral rehydration solution (ORS) or oral rehydration therapy (ORT).
- ORS is a readymade mixture available in packets. This is available at all health facilities and with ANMs and ASHAs.
- ORT is home available or home prepared fluids and can include rice water, dal or dal water with salt, butter milk (lassi) with salt and certain soups with salt. Plain clear water (preferably given with food), lemon water, soups, coconut water are classified as home available fluids. These fluids should be used along with food as they are enough by themselves in providing all the minerals that are lost in stools.
- **Plain glucose water without salt is not to be used.**
- The mother should be informed about the danger signs and told to seek care from a health provider.
- Zinc helps in early recovery from diarrhoea, less watery stools, less frequency of stools and reduction in child deaths and

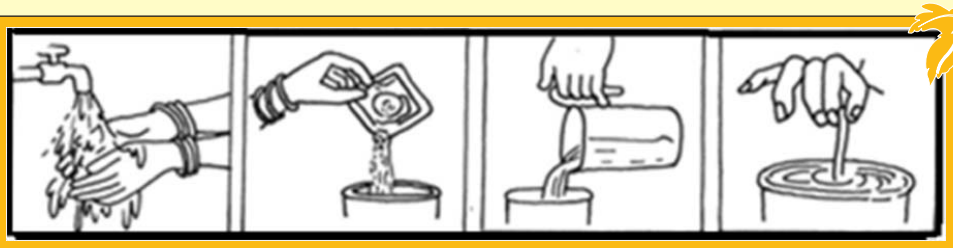
hospitalization. Zinc should be given to a child with diarrhoea for a period of 14 days.

- The dose of zinc to be used along with ORS:
  - For infants aged 2-6 months is ½ dispersible tablet (10 mg) in expressed breast milk for 14 days
  - For children 6 months to 5 years of age, one dispersible tablet (20 mg) for 14 days.

The Counsellor should

- Counsel mothers coming to facility about the danger associated with diarrhoeal diseases
- Counsel about care for children with diarrhoea:
  - If the child is breastfed, continue breast-feeding more frequently; If the child has started consuming other foods, continue feeding small quantities of these items; after the child recovers and normal appetite reappears, the child may be given more food than normal to regain lost weight.
  - Give extra fluids
  - Give ORS (Oral Rehydration Solution) Dose: 1 tea spoon full every 1-2 minutes
- Counsel mothers to give Oral Rehydration Solution (ORS). The ORS solution is available in the health facilities and with ANM, ASHA, and Anganwadi Worker.
- Guide the mothers on how to prepare ORS solution (see box below).
  - Counsel the family to take babies to a health facility immediately if the following danger signs/symptoms appear:
  - Child becomes lethargic
  - Not able to drink or breast feed
  - Blood appears in the stool
  - Does not pass urine for eight hours
- Counsel them about the ways to prevent diarrhoeal diseases in children

How to prepare ORS Solution



Wash hands thoroughly	Pour contents of ORS Packet in a 1 litre container	Pour 1 litre water in the container	Mix the contents well. Use the solution within 24 hours

- Diarrhoea can be prevented by:
  - Giving exclusive breastfeeding for the first six months
  - Washing hands before cooking food and feeding the child
  - Keeping containers for preparing the food and for feeding the child, clean
  - Keeping the food covered
  - Using a safe source of drinking water and keeping drinking water covered
  - Consuming freshly prepared food within one hour
  - Keeping the house and neighbouring area clean and properly disposing waste so that houseflies don't breed
  - Advising the families about getting the sanitary latrines constructed in the households

Acute Respiratory Infections

Ÿ Acute Respiratory Infection (ARI) is another important cause of illness and death in children.

- Most children up to the age of five years are susceptible to ARI.
- If not treated in time some of them develop pneumonia, which can result in death
- The child has some or all of the following symptoms:
  - Cough
  - Running nose
  - Fever
  - Difficulty in breathing
- Any child with fever and difficulty in breathing should receive timely care at a health facility.

The counsellor should

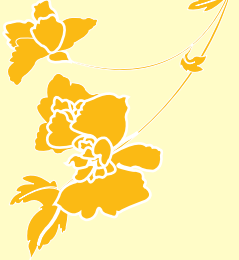
- Counsel mothers on how to prevent ARI:
  - Giving immunization to children on time for vaccine preventable diseases
  - Timely administration of Vitamin A
- Counsel mothers about caring the child common cough and cold. They should:
  - Keep the child warm
  - Give plenty of fluids and continue age-appropriate feeding
  - Increase feeds after the child recovers
  - Ensure that the child takes enough rest.
- Counsel mothers about danger signs. The child should be taken to the nearest health facility if any of the following danger signs appears:
  - Fast breathing
  - Difficulty in breathing
  - Unable to drink or breastfeed (in young children)
- Lethargy (susti)

Fever

- Fever is a common symptom of many diseases, which may be simple or serious.
- Fever is the symptom of a disease. It is not a disease in itself
- Fever can be identified by measuring the body temperature of the child. (mild fever is a body temperature of 37^{0}C-39^{0}C, moderate fever is 39^{0}C-40^{0}C, and fever above 40^{0}C is considered severe.
- Some mild fevers subside without any treatment/treatment at home e.g. fever with no cough/running nose/ear discharge/with no rash/without diarrhoea/without any obvious infection etc.
- However, in many children it may be a symptom of an acute severe illness.
- High fever may be harmful and lead to several complications

In case of fever, the counsellor should

- Counsel mothers on getting the temperature measured if they feel the child is running fever. This can be done at a health facility.
- For high fever, tepid water sponging is should be done and the child should be taken to the health facility for proper treatment.
- Counsel mother on feeding the child with fever:
  - o Child should be given enough water and fluids to drink
  - o Light meals like khichadi, daal-rice, curd, dalia that are easily digested should be given.
- Counsel mother on complete the treatment for specific conditions that are diagnosed



Section V

Summary

Expectations from a RMNCH

As a RMNCH counsellor you should:

For all clients:

- Be aware of the choices of contraceptives available in under the program in your facility
- Provide the clients with a basket of choice containing different methods and help them choose a method that suits their needs
- Take an on-going counselling approach to maximize the utilization of each contact of a woman with your facility.

Be able to communicate to every woman, in the child bearing age, regarding HTSP.

During antenatal period

1st trimester

- Discuss the signs and symptoms of pregnancy including the danger signs
- Explain the importance of early registration; timely and complete ANC visits
- Discuss supplementary nutrition including IFA supplementation
- Discuss diet, rest, exercise and personal hygiene during pregnancy
- Introduce concepts of Healthy Timing and Spacing of Pregnancy and importance of postpartum Family Planning

2nd trimester

- Explain Birth preparedness and Complication Readiness
- Reiterate the danger signs of pregnancy and where to seek help in case of complication
- Reiterate the need for continuing timely and complete ANC check-ups; adequate nutrition and diet; rest; IFA supplementation; and personal hygiene
- Reinforce information about family planning and encourage choosing an appropriate contraceptive method

3rd trimester

- Review birth preparedness and Complication Readiness
- Discuss timely start and exclusive breastfeeding (details in section IV)
- Describe Lactational Amenorrhea Method (LAM) and transition to other contraceptive options as reproductive intentions indicate
- Reinforce information about family planning and encourage choosing an appropriate contraceptive method.
- Encourage thinking about a preferred family planning method and help decision making

During immediate postpartum (within 48 hours of delivery)

- Discuss exclusive breastfeeding for 6 months
- Describe Lactational Amenorrhea Method (LAM) and transition to other contraceptive options as reproductive intentions indicate
- Describe danger signs for mother and baby in postpartum period and encourage timely care seeking
- Counsel for completing all immunization for the baby
- For women who have already made a decision for family planning, discuss the method, procedure, and related information. exclusive breastfeeding-giving (refer to section IV)

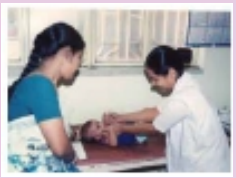
- For women who have not yet made a decision for family planning:

  A. For women who want another child:
     - Counsel for healthy timing and spacing of pregnancy
     - LAM or other contraceptive options as reproductive intentions indicate
     - PPIUCD counselling, confirmation and provision if requested
     - Discuss the importance of postnatal care for the mother and newborn

  B. For women who have completed their family, discuss options for permanent methods or long acting temporary methods

During postnatal care contact (within six weeks)

- Counsel on exclusive breast feeding and LAM
- Discuss return to sexual activity and return to fertility
- Discuss immunization status and schedule
- Ÿ Determine family planning use based on breastfeeding status and provide appropriate method



- Discuss Importance of postnatal care for the mother and the baby and return visits
- Describe danger signs for mother and baby in postpartum period and encourage timely care seeking

Child health contacts during the first year/Immunization sessions

- Discuss the importance of sanitation, immunization, age-appropriate adequate nutrition, and early identification of common childhood illnesses (see section IV).
- Discuss the importance of pregnancy spacing and encourage use of appropriate contraceptive method.

Women seeking safe abortion services:

1. Pre abortion counselling
   - Facilitate information on the procedure and the implications of the desired method
   - Facilitate consent from the women for the procedure
   - Discuss the family planning options and encourage thinking on the method of choice
2. Post abortion counselling:
   - Discuss post abortion care, possible complications, and steps to be taken in case of complications
   - Discuss family planning options and help reach a final decision on the method of choice

Annexure

Checklist to be reasonably sure that a woman is not pregnant

Ask these 6 questions:

1. Did you have a baby less than 6 months ago? If so, are you fully breastfeeding? Have you had no menstrual bleeding since giving birth?
2. Have you abstained from unprotected sex since your last menstrual bleeding or delivery?
3. Have you given birth in the last - 6 weeks?
4. Did your last menstrual bleeding start within the past 7 days (or within 12 days if you plan to use an IUCD)?
5. Have you had a - abortion in the past 7 days?
6. Have you been using a reliable contraceptive method consistently and correctly?

If client answered	Then
"No" to <u>all</u> of the questions	1) Pregnancy cannot be ruled out 2) Give client a pregnancy test if available 3) Client should await menses 4) Provide her with a back-up method such as condoms, to use till then
"Yes" to <u>any</u> of the questions *and* she is free of signs and symptoms of pregnancy	1) Pregnancy is unlikely 2) Provide client with desired method

References

The sources for information contained in this module include but are not limited to the following:

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Notes

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