Trainers' Manual

Maternal,Child Health & Women Empowerment

राग्रावि पंरास
NIRDPR
National Institute of Rural Development
& Panchayati Raj
Rajendranagar, Hyderabad - 500 030

Global Health Strategies
New Delhi

Trainers' Manual
Maternal, Child Health and Women Empowerment

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FOREWORD

One of the key reasons why increase in women's empowerment lead to improvement in child nutrition and health status is that women with greater status have better nutritional status, are better cared for and, for the most part, provide higher quality care for their children. Raising women's status is a powerful force for improving the health and productivity of families, communities and villages.

Empowering women, especially at the community level, is essential both to reduce the number of deaths among children under five and to reach Sustainable Development Goal 3-good health and wellbeing by 2030. The health and well-being of mothers and children are important indicators of the society's overall development and progress. Maternal deaths and illness reflect not only on how well the health system is functioning, but also the degree of equity in public service delivery, and utilisation of services. Maternal health is a key indicator of the social status of women and their decision-making power.

As on date, in India, a large number of women either do not survive their pregnancy or have to go through a traumatic experience of miscarriages or the death of their child soon after birth due to pregnancy-related complications. Maternal health is closely linked to newborn survival. Unfortunately, 50 out of every 1000 children do not live up to the age of five years. Prematurity and low birth weight, pneumonia and diarrhoea-related diseases are responsible for majority of these deaths. More than half of these deaths can be prevented by evidence-based, and cost-effective measures such as universal immunisation along with improved child care and feeding practices, antibiotics and micronutrient supplementation.

This training manual aims at Panchayat members, field functionaries, programme implementers and NGOs, and attempts to link all aspects of maternal and child health, and women's empowerment. All health officials and persons working with communities and women play a key role to ensure that inclusiveness and women's rights are prioritised in planning and implementing health services. The learning processes and exercises aim to help them enable women to view themselves as capable and responsible individuals with equal rights to health as anyone else.

We are grateful to Ms. Anjali Nayyar, Senior Vice President, Nidhi Dubey, Vice President, Ms. Sushma Kapoor, Senior Vice President, Ms. Madhubalanath, Senior Advisor and other team members of Global Health Strategies for their encouragement and continued support for this project. I would like to appreciate Dr. C. S. Singhal, Professor & Head, CPGS&DE and Dr. Lakhan Singh, Assistant Professor, CHRD and all others who contributed for preparation of this manual.

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ACRONYMS

ANC	Antenatal Care
ANM	Auxillary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
BMI	Body Mass Index
CHC	Community Health Centre
CSR	Child Sex Ratio
CMPO	Child Marriage Prohibition Officer
DLHS	District Level Household Survey
EWR	Elected Women Representative
FBNC	Facility Based Newborn Care
GoI	Government of India
HBNC	Home Based Newborn Care
HPDs	High Priority Districts
ICDS	Integrated Child Development Scheme
ICTC	Integrated Counselling and Testing Centre
IEC	Information Education and Communication
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IYCF	Infant and Young Child
IMR	Infant Mortality Rate
JSSK	Janani Shishu Suraksha Karyakaram
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MCTS	Mother and Child Tracking System
MTP	Medical Termination of Pregnancy
NBCU	Newborn Care Unit
NBSU	Newborn Stabilisation Unit
NGO	Non-Government Organisation
NFHS	National Family Health Survey
NIPI	National Iron Plus Initiative
NMEW	National Mission for Empowerment of Women
NSDP	National Skill Development Programme
NRHM	National Rural Health Mission
NYKS	Nehru Yuva Kendra Sangathan
ORS	Oral Rehydration Solution
PNDT	Pre-Natal Diagnostic Techniques
PHC	Primary Health Centre
PPT	PowerPoint Presentation
PRI	Panchayati Raj Institution
RBSK	Rashtriya Bal Swasthya Karyakram
RCH	Reproductive Child and Maternal Health
RKSK	Rashtriya Kishore Swasthya Karyakram
RMN	
CH+A	Reproductive Maternal Neonatal Child + Adolescent Health
RTIs	Reproductive Tract Infections
SDGs	Sustainable Development Goals
SHG	Self-Help Group
STIs	Sexually Transmitted Infections
SRS	Sample Registration System
UIP	Universal Immunisation Programme
UNICEF	United Nations Children's Fund
UNRC	United Nations Resource Centre
VHP	Village Health Planning
VHSNC	Village Health, Sanitation and Nutrition Committee
VPDs	Vaccine Preventable Diseases
WHO	World Health Organisation

OVERVIEW

Women empowerment at the community level is required for improvement of health practices within the family, reducing maternal mortality and lowering the number of deaths among children under five. The influence of women's empowerment and/or autonomy on children's health and well-being has proven a direct link between a woman's agency, nutritional status, feeding practices for children, treatment of illness and immunisation of children, and positive outcomes for maternal and child health.

Women with improved status have more control over resources in their households; have greater access to information, better mental health, self-confidence and self-esteem; and access health services both for themselves and their children. Conversely, women with low status tend to have weaker control over household resources, tighter time constraints, less access to information and health services and lower self-esteem.

One of the key reasons why increase in women's empowerment leads to improvement in children's nutritional and health status is that women with greater status have better nutritional status, are better cared for and for the most part, provide higher quality care to their children (Asabe Ibrahim et al., 2015). Raising women's status is a powerful force for improving the health and productivity of families, communities and villages.

The 73rd Constitutional Amendment Act[1] was a significant step towards opening up the space for women's political participation and in acknowledging their role in the development of their village/ block/district. While reservations per se provided an opportunity for the legal empowerment of women, the actual process of empowerment has not been an easy process. The prevailing patriarchal mindsets of people regarding the traditional role of women, illiteracy or low education levels among women, social restrictions, lack of comprehensive understanding of their rights, caste system, restricted primary health care system, etc., hamper their active participation in demanding and achieving optimal health for themselves and their families.

The frontline health care cadre is the main link bringing health care closer to women, families and communities. The ASHA and VHSNC are starting points for community engagement, but for this action on gender equity, addressing patriarchy and gender stereotypes, engaging women from all sections and castes and empowering women's groups are essential. Women's involvement in planning and accountability of health services is essential for sustained collective community action for health. The Gram Panchayat and PRIs have a significant role in addressing inequities and encouraging women's participation by providing support to the primary health care teams.

This training manual aims at Panchayat members, field functionaries, programme implementers and NGOs in an attempt to link all aspects of maternal and child health to women's empowerment. All health officials and persons working with communities and women play a key role in ensuring that inclusiveness and women's rights are prioritised in planning and implementing health services. The learning processes and exercises aim to help them enable women to view themselves as capable and responsible individuals with equal rights to health, as anyone else.

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1. 73rd and 74th Constitutional Amendments to the Indian Constitution provide for 33 per cent reservation of seats for women in Panchayati Raj Institutions and urban local bodies.

USING THIS MANUAL

How to Use this manual?

This training manual aims to help improve the awareness and understanding of the linkages between women's empowerment and maternal and child health. It is intended to serve as a resource for trainers with background knowledge or experience in planning and working with communities within health programmes or those within the Primary Health Care system, and involved in community mobilisation and participatory training.

The Objectives of this Training are to:

- Provide an overview of maternal and child health in India
- Create an awareness of the linkages between women's empowerment and maternal and child health
- Develop strategies to address maternal and child health issues involving active participation and involvement of women

Potential Workshop Participants include:

- Panchayat members, elected women representatives
- Field functionaries including the ASHA, ANMs, programme implementers
- NGOs and other organisations working on maternal and child health

Design and Agenda

The training exercises in this manual provide a flexible framework that should guide, but not dictate the trainer's agenda for a particular set of participants. Agenda suggests for a five and three day residential training programme. Each trainer may choose the combination of units/sessions that suit the needs of his or her group. Additional reading materials and research studies have been suggested in the manual, but trainers should emphasise on drawing upon the knowledge and experience of the participants as well.

Expected Outcomes

The primary goal of this manual is to facilitate anunderstanding of the significance of women's empowerment among those involved in planning and implementing health programmes for women and children. The importance of gender inclusiveness and equity in health programmes to enable health for women as a fundamental right has been emphasised. The secondary goal of this manual is to promote women's participation and active involvement in health programmes for better outcomes, accountability and fulfillment of local needs.

Block and Unit Plans and Training Schedules

Complete plans for each block and its units with information, activities, methodology to be followed and resource materials required are listed in detail. Participatory techniques and discussion cues have been outlined in this manual to make learning as hands-on as possible. Handouts and annexures have also been provided to aid in conducting the training. The duration of the training programme may be five or three days based on the situation and participants. Facilitators may tailor the training programme according to the time, background of participants and resources available. The summary of block plans and indicative schedules for five and three days are provided further.

Table-1: Summary of Blocks and Unit Plans

Time	Session	Content	Methodology	Resource Materials
1.5 hrs	Registration and Introduction	Introductions, overview of workshop and objectives; setting the rules	• Sharing of information • Interactive group activity	Printed copies of summary plans, charts, markers
Block 1: Overview of Maternal and Child Health in India				
1.5 hrs	Unit 1.1: Status of Maternal Health, Child Health and Immunisation	• Status of key health indicators related to maternal health, child health and immunisation • Factors leading to preventable maternal and child deaths • Status of utilisation of maternal health, child health and immunisation services	• Sharing of stories on maternal and child deaths by participants • Interactive PowerPoint Presentation • Participatory activity	Flip charts, board and chalk, PowerPoint Presentation on Status of Maternal and Child Health in India (annexure 1) along with printed handouts of presentation for all participants, printed copies of DLHS fact sheets on the States the participants belong to
1.5 hrs	Unit 1.2: Social And Cultural Determinants of Maternal Health, Child Health, Immunisation and Adolescent Health	• Impact of social and cultural factors on health status • Gender roles and their impact on women's health and overall development • Myths related to maternal and child health	• Participatory exercises • Discussion in small groups and presentations by each group • Flip chart/slide presentation by facilitator	Flip chart, chalkboard, marker, chart papers, slide projector, copies of table for Activity 2-Slide: Determinants of Health **Handout:** Social Determinants of Health (page H14)
1 hr	Unit1.3: International Commitments to Maternal Health, Child Health and Immunisation	• Overview of MDGs, SDGs and other global commitments towards maternal and child health • Gender sensitive programme planning and implementation	• Information sharing • Group discussion	Printed hand outs for all participants on : Policy Brief: Priorities for the Post-2015 Development Agenda

1.5 hrs	Unit 1.4: Government Programmes and Polices Focused on Maternal Health, Child Health and Immunisation	• Overview of major programmes and their entitlements • Community involvement and women's participation in health programmes	• PowerPoint Presentation • Participatory exercises • Discussion in small groups and presentations by each group • Flip chart/ presentation by facilitator	Slide projector, flip chart, chalkboard, marker, chart papers, Hand-outs: Details of various health programmes
Block 2: Strategies to Address Maternal, Child Health and Immunisation				
1.5 hrs	Unit 2.1: Continuum of Care Approach From Pre-Pregnancy to Children under Five	• Evolution of maternal and child health programmes in India • RMNCH+A: The continuum of care approach • Key challenges in implementing the RMNCH+A interventions • Increasing demand and utilisation of services across the continuum of care	• PowerPoint Presentation • Quiz • Group discussion	PowerPoint Presentation on RMNCH+A, chart papers, printed copies of handouts
Unit 2.2: Strategies to Reduce Maternal Mortality				
1 hr	A. Ante-Natal and Post-Natal Care	• Priority ANC and PNC interventions • Local level experiences in universalising ANC and PNC care	• Sharing of information • Group discussions • Question-answer sessions • Role play	Chart papers/flip charts, marker pens and writing board, copies of hand-outs 1 and 2
1 hr	B. Family Planning	• Overview of family planning services offered through the RMNCH+A • Family planning: Unmet need and other challenges • Strategies to increase uptake of family planning measures	• Sharing of information • Group discussions • Question-answer sessions • Role play	Chart papers/ flip charts, marker pens, writing board and copies of handouts

1 hr	C. Adolescent Health	• Statistics related to Adolescent health issues in India • Overview of RM-NCH+A interventions targeted at adolescents		
Unit 2.3: Strategies to Reduce Infant and Under-5 Mortality				
1 hr	A. RMNCH+A: Strategies Targeted at the 0-5 years Age Group	• Overview of the essential RMNCH+A interventions targeted at reducing infant and under-5 child mortality • Assessment of local level issues implementation issues and challenges	• Information sharing • Quiz • Group work	Black or white board, chalks or markers, duster, spiral notepads and pens for the participants, charts on food groups, nutrients and sources of nutrients and a few prizes for winners
1 hr	B. Infant And Young Child Feeding (IYCF)	• Overview of key IYCF recommendations and practices • Strategies to promote optimal IYCF behaviour among the community		
1.5 hrs	Unit 2.4 Immunisation	• Coverage and importance of Immunisation Programme, Mission Indradhanush and new initiatives • Reasons for low of coverage of immunisation and strategies to overcome them • Role of health functionaries and PRIs in organising and promoting Immunisation Programme • Role play focusing on behaviour change to motivate families to immunise their children (optional)	• Lecture and discussion • Participatory techniques • Role play • Group discussion	Chart papers, marker pens, story cards, writing board, story cards, printed copies of handouts

Block 3: The Link between Women's Empowerment and Maternal & Child Health				
1.5 hrs	Unit 3.1: Impact Of Women's Empowerment On Maternal, Child and Adolescent Health and Immunisation Seeking Behaviour and Outcomes	• What is Power? Understanding the concepts of vulnerability and empowerment • Understanding the concept of women's empowerment • Statistics on women's empowerment in India • Experience sharing: Women's empowerment strategies • Impact of women's empowerment on child health and survival	Information sharing through charts and hand outs group discussions and presentations	Flip charts, 4-5 print copies of article as a handout
1 hr	Unit 3.2: Experiences in Strengthening Maternal, Child and Adolescent Health and Immunisation through Women's Empowerment	• Case studies: Innovative community and NGO-led programmes • Creating a vision statement for improving maternal and child health in a selected geographical area	Discussion and analysis of case studies Small group work to develop health related vision and goals	Copies of the case studies as handouts
1 hr	Unit 3.3: Participatory Planning to Empower Women and Improve Health Outcomes	• Developing a village/ block level action plan to address the vision statement defined above	Sharing of information Small group work and discussions	Flip charts, markers, handouts
1 hr	Group pesentations			

Optional Units				
1.5 hrs	Unit 4.1: Gender Discrimination (Sex Selection and Son-Preference Leading to Declining Child Sex Ratio)	To be clubbed with Unit 1.2	Sharing of information, discussion, game on 'access and power' small group work and viewing audio visuals	Chart papers/flip charts, marker pens and writing board, copies of hand out 1 and case study, projector and screen for viewing video
1.5 hrs	Unit 4.2: Early Marriage and Its Impact on Maternal, Child and Adolescent Health	To be clubbed with Unit 2.2 – Adolescent health, time permitting	Group work on causes and consequences framework and presentation	Flip charts, markers, charts for group work, projector and screen, printed copies of hand outs
1 hr	Unit 4.3: Dealing with Myths and Traditions	To be clubbed with Unit 2.3 - IYCF, time permitting	Sharing of information, interactive discussions, small group work	Blackboard and chalk, chart papers and markers and printed copies of hand outs

Table-2: Indicative Schedule for Five-day Training

Day	Time	Session
Day 1	09.00 – 9.30	Registration
	09.30 – 10.30	Introductions, overview of workshop and objectives, setting the rules
	10.30 -11.00	Review of the day
	11.00 – 12.30	Block 1: Unit 1.1 – Status of Maternal Health, Child Health and Immunisation
	12.30 – 2.00	Unit 1.2 - Social and Cultural Determinants of Maternal Health, Child Health, Immunisation and Adolescent Health
	3.00 – 4.30	Optional unit- Gender Discrimination (Sex Selection and Son-Preference Leading to Declining Child Sex Ratio)
	4.30 – 5.00	Recap
Day 2	10.00 – 10.30	Review of day - 1
	10.30 – 11.30	Unit 1.3 - International Commitments to Maternal Health, Child Health and Immunisation

	11.30 – 1.00	Unit 1.4 - Government Programmes and Polices Focused on Maternal Health, Child Health and Immunisation
	2.00 – 3.30	Block 2: Unit 2.1: Continuum of Care Approach from Pre-Pregnancy to Children Under Five
	3.30 – 4.30	Unit 2.2: Strategies to Reduce Maternal Mortality a. Ante-Natal and Post-Natal Care
	4.30 – 5.00	Recap
Day 3	10.00 – 10.30	Review
	10.30 – 11.30	Family Planning
	11.30 – 12.30	Adolescent Health
	4.00 - 5.30	Early Marriage and Its Impact on Maternal, Child and Adolescent Health
Day 4	10.00 – 10.30	Review
	10.30 – 11.30	Unit 2.3: Strategies to Reduce Infant and Under-five Mortality a. Essential RMNCH+A Interventions (0-5 Years Age Group)
	11.30 – 12.30	b. Infant and Young Child Feeding Practices (IYCF)
	12.30 – 02.00	c. Dealing with Myths and Traditions
	03.0– 4.30	Unit 2.4: Immunisation
	4.30 – 5.00	Recap
Day 5	10.00 – 10.30	Review
	10.30 – 12.00	Block 3: Unit 3.1: Impact of Women's Empowerment on Maternal, Child and Adolescent Health and Immunisation Seeking Behaviour and Outcomes
	12.00-1.00	Unit 3.2: Experiences in Strengthening Maternal, Child and Adolescent Health and Immunisation through Women's Empowerment
	2.00 – 3.00	Unit 3.3: Participatory Planning to Empower Women and Improve Health Outcomes
	3.00 - 4.00	Presentations
	4.00- 5.00	Wrap up and closing ceremony

Table-3: Indicative Schedule for Three-day Training

Day	Time	Session
Day 1	09.00 – 9.30	Registration
	09.30 – 10.30	Introductions, overview of workshop and objectives, Setting the rules
	10.30 – 12.00	Block 1: Unit 1.1 – Status of Maternal Health, Child Health and Immunisation
	12.00 – 1.30	Unit 1.2 - Social and Cultural Determinants of Maternal Health, Child Health, Immunisation and Adolescent Health
	2.30 – 3.30	Unit 1.3 - International Commitments to Maternal Health, Child Health and Immunisation
	3.30 – 5.00	Unit 1.4 - Government Programmes and Polices Focused on Maternal Health, Child Health and Immunisation
	5.00 -5.30	Recap
Day 2	9.30 – 11.00	Block 2: Unit 2.1: Continuum of Care Approach from Pre-Pregnancy to Children Under Five
	11.00 – 12.00	Unit 2.2: Strategies to Reduce Maternal Mortality b. Ante-Natal and Post-Natal Care
	12.00 – 1.00	c. Family Planning
	1.00 – 2.00	Adolescent Health
	3.00 – 4.00	Unit 2.3: Strategies to Reduce Infant and Under-Five Mortality d. Essential RMNCH+A Interventions (0-5 Years Age Group)
	4.00 – 5.00	e. Infant and Young Child Feeding Practices (IYCF)
	5.00 – 5.30	Recap
Day 3	9.30 – 11.00	Unit 2.4: Immunisation
	11.00 – 12.30	Block 3: Unit 3.1: Impact of Women's Empowerment on Maternal, Child and Adolescent Health and Immunisation Seeking Behaviour and Outcomes
	12.30-1.30	Unit 3.2: Experiences In Strengthening Maternal, Child and Adolescent Health and Immunisation through Women's Empowerment
	2.30 – 4.00	Unit 3.3: Participatory Planning to Empower Women and Improve Health Outcomes + Presentations
	4.00- 5.00	Wrap up and closing ceremony

Developing a Workshop

Conducting the Training – Some Tips for the Facilitator

In a productive training programme, the facilitator's role is to:

- Use the training manual as a ready reference and adapt the material as per the participant's needs and local context
- Help participants think about the topics in a holistic and inclusive manner
- Provide an opportunity to hear other ideas and information for learning
- Ensure gender-friendly behaviour and proactive encouragement of participants who are less participative
- Give adequate opportunities to 'test' learning or practice it

To arouse interest, learners need a bridge into the topic. Do this by using several approaches, e.g., a discussion, interesting input or a good icebreaker

Agree upon the ground rules. Set out and agree with the learners the way facilitators and learners relate to each other, how the training event will operate and what is acceptable behaviour during the event? Some sample ground rules:

- Being on time for all the sessions
- Keeping the sessions interactive by asking questions and seeking clarifications
- Avoiding side-conversations and use of mobile phones
- Being open to new ideas
- Being respectful and non-judgmental
- Co-operation during activities and group discussions
- Have fun!

Try keeping the sessions as participatory as possible. It is helpful to minimise the one-way lecture style communication and focus on information sharing between the facilitator and the participants. The overall objective of this training programme is to encourage the participants to visualise the linkages between women's empowerment and health and sensitise them about their role as change makers within their communities and work spaces. This will be best achieved by stimulating guided discussions with and between the participants.

Clearly state the objectives of each session and begin by understanding the participants' knowledge and beliefs about the topic and end by a crisp, quick recap of the key messages emerging from the session.

Equipment and supplies: Arrangements should be made well in advance of the training to secure availability of all the necessary materials and supplies at the training site during the training. Suggested equipment for the training includes the following:

- Flip charts with stand
- Flip chart markers of different colours

- Laptop computer, projector and screen
- Extension cord
- Double-sided tape for posting flip chart on the wall
- Notepads (for every participant)
- Pens and pencils (for every participant)
- Folders or bags for participants to carry the materials back home
- Adequate number of copies of pre and post-test questionnaires for participants
- Adequate number of copies of course evaluation forms for participants

Preparation for the Trainers Prior to the Training:

The trainer should:

- Master the content of the training manual
- Review the training goals, session outline, training activity for each session (learning objectives, time, resource materials needed and instructions for trainers) outlined in this trainers' manual
- Review and become familiar with the slides for the sessions (that include presentations)
- Review the pre/post-test and course evaluation form and make copies for each participant
- Make copies of relevant handouts, role play situations, checklists to be distributed in the training
- Check all audio-visual equipment
- Check training venue for sitting arrangement, lights, fans/air cooling (in summer)
- Ensure arrangements have been made for lunch, tea, drinking water, etc.
- Prepare participant packets, including handbooks, job-aids, notebooks, pencils/pens, handouts, etc.
- Prepare attendance sheets and name tags
- Prepare flip charts according to sessions. Write agenda for each day on the flip charts

Facilitation Methods

Trainers should utilise principles of adult learning while recognising the level of experience that participants have in the areas of public health and programmes. An effective trainer will draw on the skills and personalities in the group to conduct an engaging and effective workshop. The following participatory training methods might be helpful to the trainer:

Experience Sharing

This involves giving selected participants or invited speakers the opportunity to share parts of their life histories relevant to the topics at hand. This is a way to give a human side to the topics addressed. Care should be taken to ensure that speakers stick to the topic and time allocated.

Presentation by Facilitator

This method is commonly referred to as "lecture method". Though this method has been criticised for being teacher/facilitator centered and reducing participants to passive listeners,

it is nevertheless suitable, especially when introducing topics that may be new or outside the experience of the participants. However, the facilitator should present the information in a manner that elicits responses from the group, thereby initiating an interactive learning process. The presentation by the facilitator can be enhanced through use of anecdotes/humor/providing handouts, use of PowerPoint or overhead projectors, use of audio-visual resources or YouTube videos and asking questions and eliciting responses from participants.

Small Group Discussion

The main objective of small group discussions is to ensure maximum participation of all those involved and to help them develop new insights. Small groups of four or five people are best because participation is maximised and conversations are more meaningful.
This is because:
Participants interact at a more personal level in a small group than in a large group.
Participants are less intimidated to speak in front of fewer people.

Participants may more readily exchange and discuss ideas. The following areas should be considered in group work/discussion sessions:

- The topic
- The objective
- Tasks to be assigned to the groups
- Desired level of participation
- Resources available
- Time management
- Composition of the group, including gender
- Seating arrangements

Each group should have a chairperson and a note taker. The gist of the proceedings should be recorded on a flip chart for ease of reporting. The groups should then report back to the larger group using the flip chart, and the facilitator should synthesise and clarify any issues that have come up.

Role Play

Another method that facilitates participation and enhances creativity is role play, in which a situation is 'simulated'. Participants are given a hypothetical situation and are expected to act as their 'character' would in a real situation. Participants who are not acting out roles serve as critics as well as the audience. At the end of the role play, the facilitator guides the group discussion. It helps to quickly let participants decide on who should play which role.

Establish a time frame for the exercise: 5 to 10 minutes is usually sufficient for a role play. The takeaways from the role play should be listed on a flip chart.

Case Study

The case study involves a real-life or imaginary case, which is often examined in small groups before it is discussed in the larger group. The facilitator presents the facts of the case and the

participants are asked to suggest solutions and give their opinions. The facilitator should not dictate the best solution or criticize the contributions from the group.

Brainstorming

Brainstorming involves quick group discussion about a topic. It encourages creativity and quick generation of ideas. It is effective in building consensus around contentious issues. The issues raised in a brainstorm exercise are often written on a flip chart.

Pre-test/Post-test Self-evaluation Form for the Participants

This questionnaire should be completed by all workshop participants before any sessions are conducted and again after they have completed the workshop. The questionnaire should be given so that participants can respond anonymously. Either names can be left off and the scores can be added up to see if the group as a whole improves, or unique symbols can be written on each pre-test questionnaire and participants can be asked to remember their symbol to match the post-test questionnaire. Participants can then examine and discuss any changes in their responses from the pre-test.

Time: 30 minutes

Make copies of pre-test questionnaire for all participants.

Step 1:

Ask participants to create a two-letter, two-number code that they will remember at the end of the workshop. Instruct them to record this code, not their names, on the questionnaire. Explain that this is to keep their responses confidential and anonymous, while enabling documentation of the workshop's impact.

Step 2:

Distribute the questionnaire to the participants. Explain the purpose of the questionnaire: to document the impact of the workshop through before-and-after/pre and post-workshop questionnaires. Give them about 10-15 minutes to complete it.

Step 3:

Collect the questionnaire from each participant before beginning workshop sessions. Refer to the highlighted correct answers and total the number of correct responses in each section. Keep this score for comparison with the post-test questionnaire.

Print copies of the following questions for all participants:

For each of the following questions, please choose the right option or options.

1. Women's empowerment involves which of the following components:
   - Domestic decision making autonomy
   - Access to or control over resources
   - Freedom of movement- to visit hospitals, markets and family
   - Freedom from violence

- Literacy and education level
- Age at marriage and difference in spousal age
- None of the above
- All of the above

2. Women with a higher level of overall empowerment are:
   - less likely to have a low-birth or stunted child
   - more likely to use maternal and child health services
   - Less likely to have children dying before the age of five years due to common illnesses
   - More likely to have their children fully immunised
   - None of the above
   - All of the above

State whether the following statements are myths or facts:

3. It is unsafe to vaccinate children if they are suffering from cough or fever: **Myth**
4. Profuse bleeding after delivery may be viewed as a good sign linked to the purification of the uterus: **Myth**
5. Infants should not be fed anything except mothers' milk for the first six months of life, not even water: **Fact**
6. Only three States in India have so far managed to reduce maternal mortality rate to less than 109 deaths per 1,00,000 live births—a Millennium Development Goal (MDG) for 2015: **Fact**

State whether the following statements are true or false:

7. A mother who works outside her home cannot continue to breastfed her child and will have to rely on baby foods: **False**
8. 20 per cent of children less than five years of age suffer from wasting due to acute under nutrition: **True**
9. Pneumonia and diarrhea, are directly responsible for 50 per cent of the deaths occurring among children under five years of age in India: **True**

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Block 1: Overview of Maternal and Child Health in India

Unit 1.1: Status of Maternal Health, Child Health and Immunisation

Key Facts

- Less than half of all the births in India are assisted by trained medical personnel while only 40 per cent deliveries are institutional (at the PHC or CHC). Complications that arise during home deliveries without the supervision of medical officers or trained village health workers are a major cause of maternal and child deaths.
- Complete and timely immunisation as per the recommended schedule helps protect children from many life-threatening diseases. However, only 65 per cent of children in India are fully immunised.
- Diarrhoea and pneumonia are among the leading killers of children under five years of age. Diarrhoea can be easily managed by giving ORS; however, only about 25 per cent of children who suffer from diarrhoea are given ORS. Almost 24 per cent of all deaths among children under five years of age can be attributed to pneumonia.

Source: *International Institute for Population Sciences (IIPS) and Macro International, 2007. National Family Health Survey (NFHS-3), 2005-06, Mumbai: IIPS.*

Introduction

The health and well-being of mothers and children are important indicators of society's overall development and progress. Maternal death and illness reflect not only on how well the health system is functioning, but also the degree of equity in public service delivery, and utilisation of services. Maternal health is a key indicator of the social status of women and their decision-making power.

Even today in India, a large number of women either do not survive their pregnancy or have to go through the traumatic experience of miscarriages or the death of their child soon after birth due to pregnancy-related complications. Maternal health is closely linked to newborn survival. Unfortunately, 50 children out of every 1,000 children do not live up to the age of five years. Prematurity and low birth weight, pneumonia and diarrhoeal diseases are responsible for majority of these deaths among children. More than half of these deaths can be prevented by evidence-based, cost-effective measures such as universal immunisation along with improved child care and feeding practices, antibiotics and micronutrient supplementation. India managed to bring down under-five mortality by almost 54 per cent between 1990 and 2012 (compared with a global reduction of 44.8 per cent). However, deficits in coverage of development programmes and health inequities persist reflecting high under-five mortality and neonatal mortality rates.

In this unit, the overall health status of mothers and children in India is described in terms of mortality, nutritional status and utilisation of key maternal and child health services, particularly immunisation coverage. The emphasis is not so much on actual data as it is to highlight gaps and unmet needs of women and their families.

Learning Objectives

Participants will be able to:

- Describe the significance of maternal health, child health and immunisation.
- Examine major risk factors contributing to the health issues of the mother and child.
- Understand the maternal and child health indicators as well as their magnitude, in India as well as locally.
- Understand the influence of women's autonomy and decision-making ability on the health of their children and their own health-seeking behaviour.

Session Plan

Time	Session	Content	Methodology	Resource Material
1.5 hrs	Unit 1.1: Status of Maternal Health, Child Health and Im munisation	• Status of key health indicators related to maternal health, child health and immunisation • Factors leading to preventable maternal and child deaths • Status of utilisation of maternal health, child health and immunisation services	• Sharing of stories on maternal andchild deaths by participants • PowerPoint presentation • Screening of films • Group activity to identify local health priorities	• Flip charts, PowerPoint presentation (Annexure 1) printed handouts of presentation for all participants • Printed copies of NFHS fact sheets on the States which the participants belong to, projector and screen for short film (Annexure 2)

Tips for the Facilitator

This unit will help develop an understanding on the health issues affecting mothers and children in India. It will also encourage an exploration of the major risk factors leading to these health issues. Update the data on maternal and child health in the PPT depending on availability of latest data and location.

Step 1

Ask participants to share stories of maternal or child deaths that they have encountered or heard about in the area. For many women who lack access to regular antenatal checkups, a trained birth attendant (dai) during delivery to post-natal care, the special joy of motherhood is often overshadowed by the life-threatening risks faced by both the mother and child.

Encourage participants to share their thoughts on the causes of these deaths. Participants might often mention medical causes or 'direct' causes. Explain the social nature of poor maternal and child outcomes, describing how socio-economic factors, women's status in society and cultural beliefs related to pregnancy and child-care are often the 'indirect' causes.

Spend between 10 to 15 minutes on this activity, giving three to five participants a chance to share stories. Note down the major causes or obstacles that cause these tragedies on a flip chart or a board. Many communities and families may not be aware of the services available in their area, or have no access to them or do not receive care in time.

Step 2

Explain the obstacles that occur during pre-delivery to post delivery. These obstacles are known as the Three Delays - delays in deciding to seek care, delays in reaching care, and delays in receiving care - and they can occur during the antenatal period, at the time of labour and delivery, and during the postnatal period. (Slide 2)

Highlight the collective social responsibility of mothers' groups, self-help groups and panchayat leaders in the community, in ensuring that basic health services are accessible and available for all women and children. The benefits of ensuring optimal health for everyone, particularly mothers and children, which translates to better health outcomes for communities. Share the short YouTube film with the participants on Mission Indradhanush and the key role played by ASHAs (Annexure 2).

Step 3

Introduce concepts such as mortality, morbidity rates, nutritional status, gender discrimination, vaccine preventable diseases and outline the major risk factors that lead to high rates of ill health and death among mothers and children. Point out that health is predominantly a State subject and that various States take different levels of initiative. Share a few statistics with participants describing the scale of maternal and newborn mortality in India, focusing on the States to which the participants belong (Annexure 1, slide 4). Share Handout 1.

Emphasise that if women have access to health care and medical advice during pregnancy, during delivery and after delivery, many risks in pregnancy and childbirth can be avoided. All women have the right to basic services of a skilled birth attendant such as a doctor, nurse or midwife, and to emergency obstetric care if needed. Quality health care enables women to make informed decisions about their health. It should be easy for women who need maternal care to reach the health facility, avail services at the PHC or CHC and get access to quality treatment provided at fair costs.

Activity 1

Tell the participants that they are going to imagine some ideal scenarios! Ask them to imagine that they have a magic lamp *(Aladdin's Chirag)*. With its help, they would be able to offer complete and comprehensive healthcare for mothers and children in their community. What would such care and services include? Explain that making this list does not mean that all services can be made available, rather, this list of the health needs of women and children will help the community to: a) Identify local needs b) Select priority areas for possible interventions.

Give the groups 10 minutes to prepare their lists on charts and put them up in the room. Encourage all participants to take a walk and read the health needs of each group. Then ask them to reassemble.

Before pregnancy	Safe sex, preventing unwanted pregnancy and good nutrition
During pregnancy	Registration of pregnancy, regular ante-natal checkups, good nutrition including supplements and tetanus immunisation
During childbirth	Access to PHC/CHC or trained birth attendant, clean and safe delivery, emergency obstetric care for both mother and baby and immunisation at birth
During early childhood	Routine immunisation, growth monitoring and breast-feeding

Discuss with the group whether the services they wished for with regard to the health needs of women and children are available in their village/block/district? Encourage three to four participants from different States to comment on maternal health schemes and programmes in their State. Ask participants the following questions to encourage discussion:

- Are the health facilities equipped with the desired quality of services and adequate equipment to meet the requirements of the people?
- Are communities aware and sensitised about availing the above services?
- Is the poorest woman able to access and avail the services?
- Is the service comprehensive and available to all women irrespective of their economic status, caste and religion?

Some common challenges will emerge: Inaccessible terrain, lack of transport, no qualified doctors or midwives, problems of supplies (drugs and medicines), malfunctioning of equipment, inadequate human resources, religious and socio-cultural factors, lack of decision-making on the part of the woman (in particular, the adolescent mother-to-be), cost of care.

Call for the participants' commitment to strive for improvement in maternal and child health, wherever they are located. Discuss how they will help to do so within their official roles. A key initiative is making communities, especially women so that they are more aware of their rights and available services. Simple strategies such as discussing the right to health and demanding related services in meetings of women's groups, Gram Sabha and self-help groups will raise awareness among women about good quality care. It will give them the confidence to demand accountability in the health delivery process by highlighting lapses. PRIs can facilitate the enrollment of maximum number of children in school, especially girls, as a long-term measure to improve maternal and child health.

Summing up

Improving maternal health not only saves mothers, but the lives of their babies. Many of the health issues and deaths of both mothers and children can be prevented through easy access to health facilities and home-based care via ANMs/ASHAs/trained village health workers.

- Women's low status results in their own health outcomes being compromised, which in turn leads to lower infant birth weight and may affect the quality of infant care and nutrition. Women who have greater autonomy in domestic decision-making are more likely to use maternal and child health services including contraception, health check-ups during pregnancy, safe delivery and immunisation (Bloom, S.S., et al., 2001).
- Study after study shows that educated women are better equipped to earn and to support their families, more likely to invest in their children's health care, nutrition and education and more inclined to participate in civic life and to advocate for community improvements. Educated moth- ers are also more likely to seek proper healthcare for themselves and their families.
- Complete and timely immunisation as per the recommended schedule helps protect children from many life-threatening diseases. However, only 65 per cent of children in India are fully immunised

Handouts

Handout 1: Definitions of some health indicators

Under-five mortality rate: Probability of dying between birth and exactly 5 years of age, expressed per 1,000 live births.
Infant mortality rate: Probability of dying between birth and exactly 1 year of age, expressed per 1,000 live births.
Neonatal mortality rate: Probability of dying during the first 28 days of life, expressed per 1,000 live births.
Maternal mortality ratio: Number of maternal deaths during a given time period per 1,00,000 live births during the same time period.
Maternal mortality rate: Number of maternal deaths in a given period per 1,000 women of reproductive age during the same time period.

Handout 2: Printout of PowerPoint slides and key facts from Annexure 1.

Know Your Progress

Questions

1. What do you understand by 'nutritional status'?
2. What is Maternal Mortality Ratio (MMR)? What is the MMR for India and your State?
3. Explain the 'three delays' that cause maternal and child mortality.

Model Answers

1. Nutritional status measures the availability of energy and different types of nutrients in the body which are required for proper functioning, growth and development. Inadequate quantity of diet, poor quality of diet and/or inadequate absorption of nutrients by the body can lead to a nutrition deficient state in the body. Poor nutrition in the form of under-weight or deficiency of specific nutrients leads to stunted physical and mental growth and frequent illnesses due to increased risk of infections.

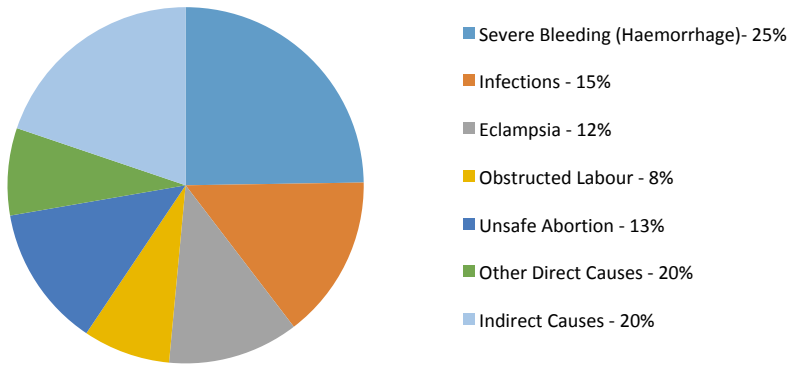
2. The number of women who die while pregnant or within the first 42 days after childbirth or termination of pregnancy, from any causes related to or aggravated by pregnancy per 1,00,000 live births in a given year. https://data.gov.in/keywords/mmr.

3. The delays leading to maternal health complications or even death can be divided into: Delay 1: Delay in deciding to seek care, Delay 2: Delay in reaching the health facility and Delay 3: Delay in receiving treatment at the health facility.

Annexures

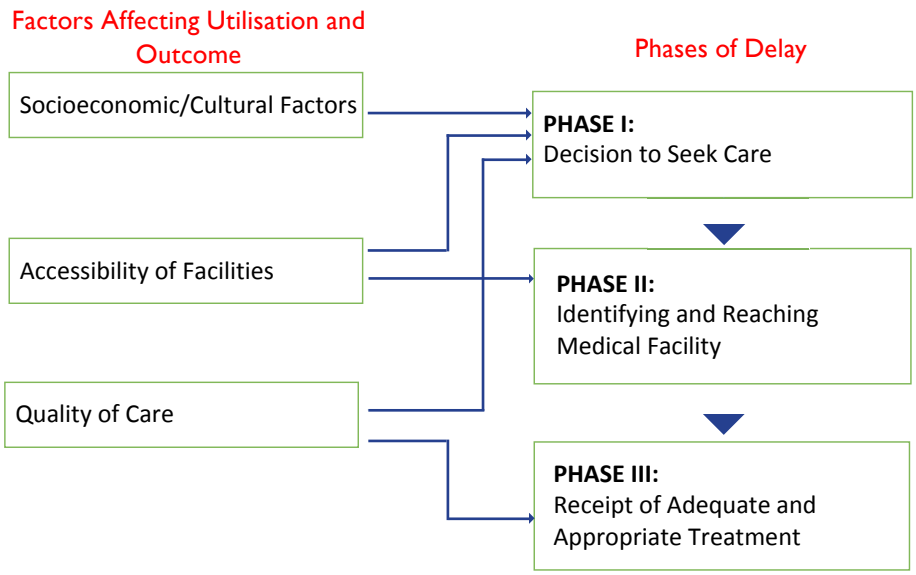
Annexure 1: PowerPoint Presentation Slides

1. Common Causes of Maternal Deaths in India



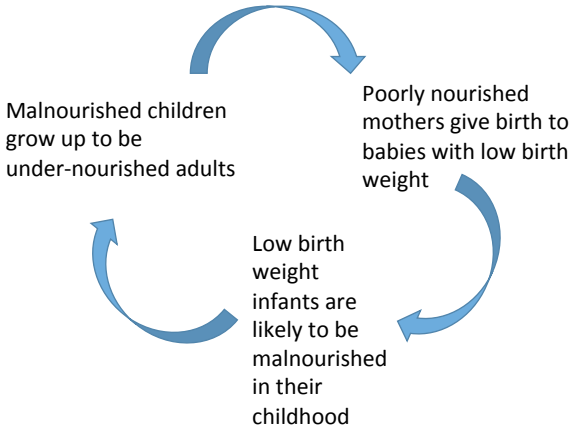
Source: *The World Health Report, 2005, Make Every Mother and Child Count, Geneva, World Health Organisation, 2005*

2. The Three Delays Model



Source: *Thaddeus, S., D. Maine. 1994. Too Far to Walk: Maternal Mortality in Context. Journal of Social Science Medicine, Vol. 38: 1091-110*

3. Maternal and Child Nutritional Status – Inter-generational Cycle



4. Key Concepts and Facts

Maternal Mortality

- In India, for every 1,00,000 women who give birth, 190 women die due to pregnancy and delivery-related problems i.e., in a year, 50,000 women die as a result of pregnancy-related complications (WHO, UNICEF, UNFPA, World Bank, 2013).
- The most common causes of maternal deaths are severe bleeding, sepsis (infections), unsafe abortions, obstructed labour and diseases like malaria and hypertension during pregnancy (Paul et al., 2011).

Child Mortality

- In a year, approximately 10 lakh children in India die before completing one year of age (infant mortality) i.e., 41 children out of every 1,000 children born, do not live to see their first birthday (UN Inter Agency Group, 2014). Of this, the majority of the deaths happen during the first 28 days of life (neonatal mortality).
- More than 13 lakh children under the age of five years die in a year in India, the highest number of under-five deaths in the world. Fifty three children out of every 1000 children born do not live up to the age of five years (UN Inter Agency Group, 2014).
- Two diseases, pneumonia and diarrhoea, are directly responsible for 50 per cent of the deaths occurring among children under five years of age (Million Death Study, 2010).
- A majority of the deaths below one month of age (80 per cent) occur due to three causes: pre-mature and low birth weight child, injuries and lack of oxygen during labour and infections (Million Death Study, 2010).

Social Causes

- Social causes that play a role in maternal and child deaths include: Age of marriage, early and repeated childbearing, gender discrimination, lack of decision-making power and autonomy

within the household, and social and cultural practices. Some harmful traditions and practices include nutritional taboos and traditional birth practices; son preference and its implications for the status of the girl child; early pregnancy; practices around breast feeding, feeding patterns during illness and immunisation among others.

Maternal Nutrition

- 33 per cent of married women are too thin, according to the Body Mass Index (BMI), an indicator derived from height and weight measurements (IIPS, NFHS- 3, 2007).
- Almost 60 per cent of mothers in the child bearing age group suffer from anae- mia due to iron deficiency (IIPS, NFHS-3, 2007).

Child Nutrition

- Almost 22 per cent of children in India are born under-weight, which puts them at an increased risk of life-threatening infections, especially in the first month of their life (IIPS, NFHS-3, 2007).
- Under-nutrition among children is measured in different ways by comparing the child's weight and height to a prescribed standard: 1) 42 per cent of children below five years of age are 'underweight' (less weight for age) and 16 per cent are severely underweight 2) Around 20 per cent children are 'thin' i.e., (less weight for height), while six per cent are 'severely thin' 3) Forty eight per cent of children are 'stunted', while more than 20 per cent are 'severely stunted' (low height for age) and suffer from effects of long-term under-nutrition (IIPS, NFHS-3, 2007).
- Almost 80 per cent of children in the age group of six months to five years suffer from anaemia due to iron deficiency (IIPS, NFHS-3, 2007).
- Breastfeeding is initiated for less than a quarter of children (23 per cent) within the first hour of birth, thereby losing on the advantages of colostrum and natural immunity. Less than half of all children (46 per cent) are exclusively breastfed until six months of age, while 55 per cent of children receive any complementary foods along with breastfeeding at the appropriate age (6 months).

Immunisation

- Immunisation is an essential, cost-effective and proven intervention that all children should have access to, on the basis of their right to health.
- Only 65 per cent of the children in the age group of 12 to 23 months are fully immunised.
- Four key challenges and the role of community level awareness on immunisation:
  - Children do not get vaccinated if caregivers do not know the value of vaccines, when children need to be immunised and where vaccines are administered.
  - Children do not get vaccinated when communities are excluded or beyond the reach of immunisation services.
  - Children do not get vaccinated if caregivers do not trust the safety of vaccines.
  - Children do not get immunised when vaccines are not available.

Annexure 2

Download a short YouTube video film 'Main Bhi ASHA' on the journey of an ASHA and ANM working to immunising every child as part of Mission Indradhanush - a Ministry of Health & Family Welfare, Government of India, initiative to provide immunisation for all children in India available at:https://www.youtube.com/watch?v=Ua0QmGi_LxQ

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Unit 1.2: Social and Cultural Determinants of Maternal Health, Child Health, Immunisation and Adolescent Health

Key Facts

- As the number of years of educational attainment by women increases, the chances of their children dying in infancy due to diseases reduces (IIPS, NFHS-3, 2007).
- Women with more number of years of education are more likely to:
  - Receive timely check-ups from qualified health practitioners and consume supplements and follow up on immunisation (IIPS, NFHS-3, 2007).
  - Receive counselling regarding complications during pregnancy and seek medical help and deliver their children in a medical facility under trained supervision (IIPS, NFHS-3, 2007).
- Women whose last born is a female or those who have more daughters than sons face social pressure and are likely to continue child bearing (Sunjukta Chaudhari, 2012). Women may resort to unsafe abortions, one of the top causes of maternal deaths and life-long pregnancy-related complications (Lisa B. Haddad and Nawal M. Nour, 2009).

Introduction

Health outcomes are deeply influenced not just by biological factors (e.g., bacteria and virus as causes of infectious diseases, high blood pressure as a cause of stroke, diarrhoea as a cause of child mortality, etc.), but also by the social, economic and cultural environment, including people's positions in various social hierarchies. This environment includes a) Personal factors like age, education, occupation and number of child births, b) Factors related to the physical environment e.g., housing conditions, climate and environmental pollution, c) Social and economic position in the society including wealth status, caste, religion, gender and d) Health-related beliefs possessed by the individual and the community regarding the causation and management of diseases. All these factors increase or decrease the risk of individuals developing different illnesses. Maternal and child mortality are key indicators for maternal and child health and various States in India show dramatic inequalities.

This unit examines factors that determine whether women seek appropriate health services for themselves and their children such as age, number of previous pregnancies, education level and ability to access and pay for health services, etc. It also discusses certain underlying factors influencing health behaviour operating at inter-related levels of social influence: family and peers, the community in which women live and the health facilities available to them, wider cultural norms, the policy environment and institutional structures to help PRIs understand and address these.

Learning Objectives

Participants will be able to:

- Understand and identify the range of factors that determine health.
- Discuss how social determinants such as personal, social and cultural factors impact health and utilisation of key health services, e.g., immunisation, with a specific focus on gender.
- Develop sensitivity regarding socio-cultural determinants that need to be addressed to ensure optimal health for mothers and children.

Session Plan

Time	Session	Content	Methodology	Resource Material
1.5 hrs	Unit1.2: Social And Cultural eterminants of Maternal Health, Child Health, Immunisation and Adolescent Health	• Impact of social and cultural factors on health status • Gender roles and their impact on women's health and overall development • PRIs' role in addressing social and cultural factors influencing maternal and child health	• Participatory exercises • Discussion in small groups and presentations by each group • Flip chart/ PowerPoint presentation by facilitator	• Flip chart, markers, chart papers • Slide projector and slideshows • Printed copies of the handout and copies of table for Activity 3

Tips for the Facilitator

This unit focuses on the concept that health is not just a medical issue based on biological factors and medical interventions - it is also a socio-cultural issue. Where and how people live? What do they do? and their interactions and relationships are factors that affect health. This session addresses the connections between social factors and health outcomes and highlights the differences between male and female health, based on these connections. It also highlights the strong linkages between women's autonomy/decision-making and health outcomes for them and their children.

Step 1

Review slide on determinants of health with participants to discuss manner in which health is determined by interactions amongst biology and the physical, socio-cultural and political environments (Annexure 1, Slide 1). Highlight how multiple factors work together to affect the health of individuals and communities - personal factors such as age, education, occupation; social and economic environment such as wealth, status, caste, gender; physical environment such as housing conditions, climate, pollution, culture and health-related beliefs and practices of the individual and community.

Step 2

Elicit examples from the group for each of the factors mentioned above and write out examples against each of the factors on the flip chart. If necessary, prompt them to describe how income (social and economic environment) relates to health (e.g., access to health services, ability to bear cost of health care). Raise questions on how occupation (physical environment) relates to health (e.g., certain work environments and conditions may be hazardous to health). Ask if they perceive any gender differences in income and the connection to health (division of labour, pay scale of male and female workers, ability to access health facilities). Do they observe ways in which local beliefs and traditions influence health practices, especially in the context of women?

Activity 1

Share information with the participants on social and cultural determinants of health (Annexure 1, slide 2) and relate to factors noted on the flip chart during discussion in Step 2. Inform the participants that they are going to play a game and should divide themselves into two groups. Instruct each group confidentially that they are to depict the male and female roles respectively. Ask both groups to form two circles and stand in position without informing the other group about their gender identity.

Read out the statements (Annexure 2) at a slow pace. Ask the participants to mentally agree or disagree and stay in the same position in the circle if they agree or step back two steps out of the circle if they do not.

When the complete list has been read, declare the sex (male or female) that each circle represented. Ask participants to observe how many persons were out of the circle in both groups (depicting disagreement). It is likely that typical male and female patterns of thinking would emerge

even though all participants are women. Discuss what were the factors that led certain characters to move forward, while others moved back? What was the effect of the visual separation of the group with some moving forward while others moved backward?

Gender refers to socially constructed or culturally determined characteristics of women and men. Sex refers to the biological and physiological differences between males and females.

Gender socialisation is the process whereby women and men learn the 'proper' ways a woman or a man should think, feel and behave, based on their assumption of their gender roles. Gender roles are the activities ascribed to women and men on the basis of perceived differences.

(Share handout 1 on gender as a system)

Activity 2

Ask the participants to work in four small groups to discuss how gender influences women's:

- Household roles and responsibilities
- Health and health-seeking behaviour
- Responsibilities and income at the work place (farm, factory and enterprise)
- Participation in community activities and programmes

The groups can start by sharing whether or not they believe in each of the gender beliefs/ myths read out by the trainer from Handout 1. The output will be the number of group members agreeing or not to each statement. This discussion will help them analyse the implications of these beliefs on the division of tasks and roles of women and men, their ability to participate in decision-making processes at home including those related to their health and that of their children, workplaces and community and organisations. For the next 15 minutes, ask each group to list the effect of gender socialisation in the area assigned to them on a chart paper and think if they would like to change some aspects.

Allow each group to present for five minutes, and then answer any questions or comments from the larger group. Involve participants in a discussion on how gender roles impact relationships, occupations, educational opportunities, participation in political/community activities, how society values men and women and even women's health-seeking behaviour.

Conclude that it is important to be aware of gender stereotypes and expectations of gender roles. For example, gender norms may discourage men from seeking health care related to their own sexual and reproductive needs, which in turn can also undermine the health of their female partners, for example through the transmission of sexually transmitted infections. Gender-based violence may be tolerated or accepted as a way for men to assert their control in relationships, thus impacting women negatively. In some cultures, women, not men, inherit land and resources. Research shows that women tend to ignore or delay seeking institutional care for their own health needs, may discriminate among their children based on gender and/or financial constraints in seeking health services due to social norms. However, we cannot blame either men or women i.e., society as a whole contributes to the norms and dynamics associated with gender. This workshop aims to improve an understanding of how women can develop strategies to attain gender equity in attaining health for themselves and their families.

Step 3

Women's status in a society, described in terms of women's decision-making capacity and autonomy has been identified as a major determinant of health outcomes overall and specifically of maternal and child mortality. Research studies have shown that increase in women's autonomy leads to a decline in mortality and in improved health outcomes for women and their children (Bloom, S.S., et al., 2001) However, due to social norms, women may often experience a lack of power that is characterised by reliance on others for basic needs and an inability to care for one's own well-being or safety. For example :

- Women and girls face immense pressure to drop out of school/college, marry young, initiate childbearing soon after marriage, or have numerous and closely-spaced pregnancies to add status to the family by ensuring a male heir.
- Sex selective abortions are more frequent in urban areas than rural areas and among the higher income category due to easier access to ultrasound for determining the baby's sex. However, this situation is changing rapidly.
- Women who contribute to key decisions regarding self and the household including major and daily household purchases, their own health care and mobility, are more likely to access ante-natal services, opt for safe institutional delivery and get their children immunised.

Step 4

Families usually follow advice from elder females in the family or neighbourhood regarding pregnancy, delivery and child care; some age-old customs and natural remedies are followed even today. However, some of these traditionally recommended practices may be harmful for the mother and child. Ask participants to share some common traditional practices followed by mothers in their village/ block. Read out some common beliefs for discussion (Annexure 3).

Ask participants how many of them follow these restrictions? Do they agree or disagree with these beliefs? Do they believe these restrictions are fair and should be followed? Encourage participants to talk about how these restrictions and others related by them impact their lives, especially women. Do they know any scientific reason for the origin of the restrictions imposed on them by their family members and elders? Do they read/ hear different information about these topics from the media or health workers?

Step 5

Discuss the participants' answers with reference to discussions held in Step 4. Usually, these traditional beliefs do not have a scientific basis. They perpetuate gender bias and negatively impact women's physical and mental health and well-being. Often mothers and elders say certain things and impose restrictions simply because that is what they heard/followed since their teenage. Without questioning or even malice, they repeat it thinking it is the right thing to do. Without blaming them, effort must be made to get them to see that the particular taboo or restriction does not make sense and must therefore be done away with.

Emphasise that change in thoughts and beliefs do not happen overnight. Changes, especially those related to old traditions and myths, take time to be dispelled and participants can help by

spreading awareness among the community, Panchayat and through leaders. Refer to the Social Determinants of Health handout and discuss the examples in the context of the session. (Share Handout 2 - Social Determinants of Health)

Step 6

Tell the participants that as members of the Panchayat, and as Auxiliary Nurse Midwives (ANMs), ASHAs and Anganwadi workers, they have a 'social' and 'public position' in the villages and are often seen as role models by community women. Their position and influence can be effectively leveraged by engaging with the community members on the social and cultural issues impacting the health of women and children. Similarly, the Child Development and Protection officers and the supervisors in the Ministry of Women and Child Development wield considerable influence and authority and can encourage the effective functioning of the anganwadi workers, health workers or ASHAs and their engagement with the issue.

Activity 3

Ask participants to list any three social and cultural determinants that impact women and children's health negatively. How can they raise awareness about these determinants during the course of their duties? Share the following table that illustrates a few examples. Encourage the participants to work in small groups to complete the information.

Summing up

	Task	**Target Audience**	**Collaborators/Stakeholders**	**Message**	**Method**
Anganwadi worker	Register all cases of pregnancy and new- borns to track them			Immunisation	
PRI members		Community, all front line health workers		Promotion of schemes favouring girls – Balika Samriddhi Yojana; Ladli Scheme; ICDS and Kishori Shakti Yojana	
ANM			Panchayat members, local elder women and ASHAs		Participation in village health and nutrition days

Health is determined by interactions between biology and the physical, socio-cultural and political environments. Social norms influence women's health seeking behaviour and they may often experience a lack of power that is characterised by reliance on others for basic needs and an inability to care for one's own well-being or safety.

Women's decision-making capacity and autonomy has been identified as a major determinant of health outcomes overall and specifically of maternal and child mortality.

Participants can use their position and influence to engage with community members on the social and cultural issues impacting the health of women and children, raise awareness on harmful practices, etc.

Handouts

Handout 1: Gender as a System

Gender ...

... defines beliefs in society about men and women

Example: Men are strong, women are weak; men are rational, women are emotional.

... defines norms that shape the behaviour of men and women in society

Example: Men should express themselves and be articulate in public; women should remain quiet and avoid drawing attention.

... defines roles for men and women

Example: The role of elder or chief is traditionally given to men; the role of medium or servant is given to women.

... defines sexual division of labour

Example: Income-generating roles are assigned to men (formal work outside of the home); reproductive roles are assigned to women (bearing and raising children).

... defines activities and interests for men and women

Example: Public domain is for men, private is for women. Women's tasks within the home, such as cooking and craft making, are often undervalued and less visible, while men's roles in the public do main such as political leadership and athletics are highly valued.

... defines differential access to and control over resources and opportunities

Example: Women often have less access to resources like money, land, technology, knowledge, education, space and time; men traditionally control these resources.

... defines differential decision making and power

Example: Power and control is largely invested with men, while women are the objects of domination.

Handout 2: Social Determinants of Health

Poor men and women tend to have inadequate access to healthcare services and poor-quality services when they do access them. This leads to a higher burden of illness and earlier death among poor people as compared to the more affluent.Better education, especially for women, leads to better health outcomes for them and their children.

Men are traditionally expected to provide for their families. If they live in a region suffering from unemployment, they may decide to migrate to seek work, often leaving their families in their home community. Separation from husbands might place women at risk as they lack support and means to seek services for their own and children's health.

Sexual gender norms sometimes imply that women should not have the power to decide whether or when to have sex. When men and women conform to this idea, women are placed at risk for emotional and physical illness, too many and early pregnancies and ensuing risks. Women often haul water and firewood as part of their household duties. This often requires them to travel by foot, sometimes through dangerous areas, putting them at risk of assault or injury. Their cooking duties could lead to health problems associated with hazardous smoke inhalation and exposure to open flames.

Often boys are favoured over girls when a family has limited resources and must decide which children to send to school. Gender roles for girls include helping with household chores and caring for younger siblings. Since some poor families believe that their sons will have better career opportunities than their daughters, they might send boys to school and put girls to work at home. This results in a double burden of poverty and lack of education for women, confirming the gender stereotype that men are better wage earners and that they should support women. It also leads to poorer health for women and their families.

Men are often expected to be strong. This may impact their willingness to seek testing or treatment for a health condition. Instead, they might deny illness or avoid seeking necessary services.

Know Your Progress

Questions

1. What is gender socialisation? Based on the participants' experiences and local context, ask them to strategise to mainstream gender in two issues/areas of health that clearly display a bias.
2. How does education of a woman impact the health of her household? What is the percentage of women who have finished schooling in the participants' village/ block?
3. List three ways to involve local women in health-related programmes in the village/block

Model Answers

1. Gender socialisation is the process whereby women and men learn the 'proper' ways a woman or a man should think, feel and behave, based on their assumption of their gender roles. Gender roles are the activities ascribed to women and men on the basis of perceived differences. A gender bias is noticed among women resorting to home remedies for their health and delaying seeking

institutional health services as they feel guilty about taking rest or spending money on themselves. Gender-based disparity in access to food within households continues from adolescence to adulthood resulting in compromised immunity to infections and even low birth weight babies.

2. According to IIPS-NFHS-3, 2007 report, women with more number of years of education are more likely to:

a. Receive timely check-ups from qualified health practitioners and consume supplements and follow up on immunisation.

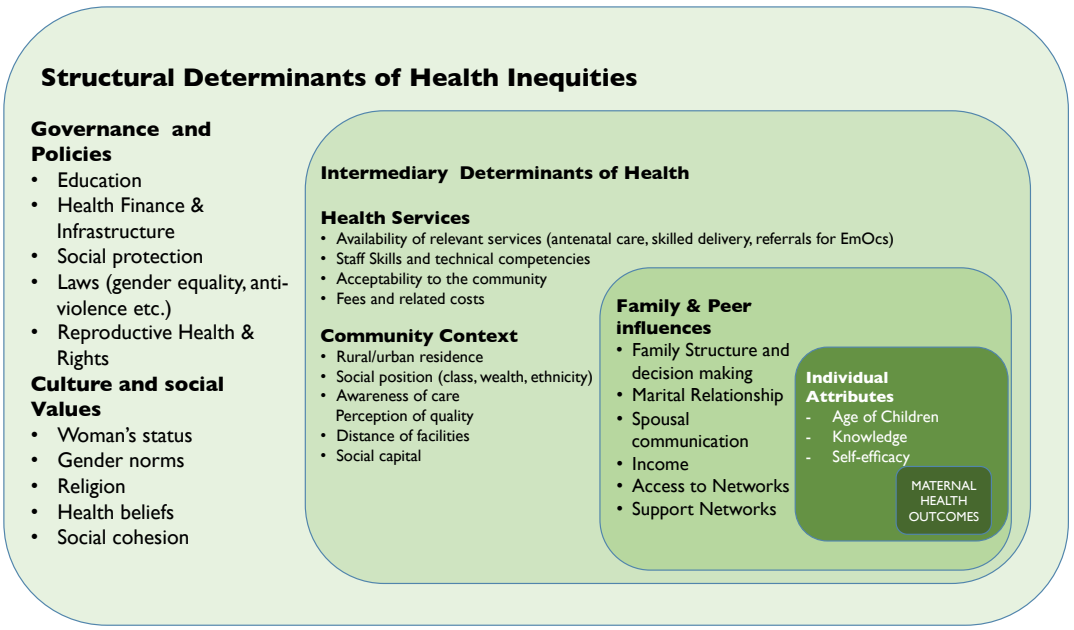
b. Receive counselling regarding complications during pregnancy and seeking medical help and deliver their children in a medical facility under trained supervision.

3. Some suggestions include: Serving on committees, allocating responsibilities to women related to monitoring of health programmes, mobilising communities for events being conducted in the village; formation of women's groups or collectives at the village or block levels, working towards a local health need, sensitising men to encourage women to have control on income and expenditure within households in matters of nutrition and health.

Annexures

Annexure 1: PowerPoint Presentation

Slide 1



Source: *Social Determinants of Maternal Health. Adopted from Closing the Gap: Policy into Practice on Social Determinants of Health, WHO, 2011.*

Slide 2 – Social & Cultural Determinants of Health

- Research has shown that maternal educational status, wealth status, caste, place of residence (rural/urban) and number of births are some of the characteristics that strongly affect maternal and child health outcomes.
- According to IIPS-NFHS-3, 2007 report, women with more number of years of education, belonging to higher economic category, residing in urban areas, with first or second pregnancies are more likely to:
  - Receive timely and more number of ante-natal care sessions from qualified health practitioners.
  - Consume the required dosage of iron folic acid supplements and get tetanus injections.
  - Receive counselling regarding complications during pregnancy and seek medical help.
  - Deliver their children in a medical facility under trained supervision.
  - Receive timely post natal check-up and are less likely to suffer from severe complications like massive bleeding or unexplained high fever.
  - Get their infants immunised.
- **Status of women's literacy and education:** Almost 35 per cent of women in India are illiterate compared to 18 per cent of men. Even among the literate women, more than 50 per cent have only studied up to the primary level (Census of India, 2011).
- **Age at marriage and child birth:** Marriage and child birth in adolescence (under the age of 18 years) have a negative impact on the survival and health of both mothers and children. More than half of the girls in rural India and more than a quarter of girls in urban areas get married before 18 years of age. Further, almost 16 per cent of the girls in India begin child birth before 18 years of age, while 36 per cent are mothers by the age of 19 years (IIPS-NFHS-2, 2007).
- Almost all the pregnancy related outcomes are better in urban areas due to closer proximity to health facilities, easier dissemination of information and easier access to health facilities through better roads and transport facilities. However, within the urban areas, women residing in slum areas have a much higher risk of pregnancy related complications resulting in poor child health outcomes as compared to the non-slum areas.
- Communities' beliefs and cultural traditions related to their own health, diets and modern medicine are a few crucial factors affecting maternal and child health outcomes. For e.g., families are often not convinced about the necessity of immunising their children, or might even view vaccines in a negative light. Similarly, there are instances where on religious grounds women refuse to use contraceptives preferring natural birth spacing, do not consume Iron folic acid tablets or nutritional supplements during pregnancy fearing that doing so might lead to a larger baby, thus giving rise to complications during pregnancy.

Annexure 2

Statements for Activity 1

- Women as child bearers must stay at home and take care of the children.
- A man is the head of the family and a woman must at all times submit to the decisions of her man.
- It is alright for the man of the house to occasionally beat up his wife in case she does not perform her duties well.
- Pregnancy, delivery and childhood are vulnerable periods during which diseases are best treated by traditional faith healers.
- At the end of the day, men, because of their work outside of the house, are more tired than women. Hence, women must let men rest after their work, and must serve them for their needs.
- Women are emotional and men are logical and rational.
- Paid work, done generally by men outside of the house is more important than the unpaid work of women at home.
- Women cannot choose to go where they wish and meet whom they want.
- Girls and women should not eat 'hot' foods such as eggs and dry fruits.
- Quarrels between husband and wife are too personal/private for the community to get involved in.
- Women are responsible for taking care of birth control and family planning; it has nothing to do with the man.
- Children suffer when their mothers work outside the home.
- Women have the right to go to work and also over their earnings.

Annexure 3

List of some commonly held beliefs: (for Step 4)

- Pregnancy, delivery and childhood are considered highly vulnerable periods during which the mother and child are prone to being affected by the 'evil eye'. As a result, diseases are also treated by traditional faith-based healers due to which often delays occur in seeking medical help.
- Certain foods are avoided based on the beliefs that these foods are 'hot' and 'cold' in nature. Adolescent girls are often not allowed to eat eggs or non-vegetarian food for fear of early menstruation.
- IFA tablets and any nutritional supplements might lead to excessive weight gain and difficult labour.
- Some vaccines have serious side-effects so vaccines are unsafe.
- It is believed that sex of the baby can be influenced by eating certain type of foods, herbal medicines, etc.

- Profuse bleeding after delivery may be viewed as a good sign linked to the purification of the uterus.
- Mud/cow dung should be applied on the freshly cut umbilical cord after delivery.
- Some families refuse immunisation at birth and later in childhood due to fears and misconceptions regarding the purpose and side effects of immunisation.
- New-born babies are often fed different types of liquids like honey, ghee, juices, etc., right after birth which delays the initiation of breastfeeding and can also increase the risk of infections.
- White discharge/lower back pain is a normal occurrence among women.

References

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Unit 1.3: International Commitments to Maternal, Child and Adolescent Health and Immunisation

Key Facts

- Major development programmes are related to education, health, housing, employment and livelihoods.
- The Sustainable Development Goals (SDGs) were developed by the United Nations to carry on the momentum generated by the Millennium Development Goals beyond 2015. The new 17 SDGs with their broader sustainability agenda address the root causes of poverty and the universal need for development for all people.
- **'Applying a gender-lens'** to all development programmes helps address gender-specific concerns to ensure that impact is gender inclusive, fair and contributes to women's empowerment from a human right's perspective.

Introduction

In a global economy and inter-connected world, alleviating poverty, improving health and fostering economic development in the world's poorest countries are increasingly seen as the key to improving the chances for prosperity, stability and security everywhere. The international community has developed and outlined various comprehensive and focused frameworks in the form of rights, declarations and goals for reducing poverty and its many manifestations: hunger, disease, gender inequality, lack of education and access to basic infrastructure and healthcare services.

In September 2015, more than 190 countries adopted a set of goals to end poverty, protect the planet and ensure prosperity for all as part of a new sustainable development agenda. Each goal specified targets to be achieved over the next 15 years. The United Nations developed these SDGs to carry on the momentum generated by the Millennium Development Goals (MDGs) beyond 2015. The new SDGs with their broader sustainability agenda go much further than the MDGs, addressing the root causes of poverty and the universal need for development for all people. The new agenda is based on 17 goals, including a stand-alone goal on gender equality and the empowerment of women and girls as well as gender sensitive targets in other goals (United Nations, 2015). The focus is now on building a sustainable world where environmental sustainability, social inclusion and economic development are equally valued.

This unit provides a brief overview of India's commitments to international goals towards health for all with a special focus on maternal, child and adolescent health.

Learning Objectives

Participants will be able to:

- Get an overview of the existing global commitments (to which India is a signatory) towards improving maternal, child and adolescent health.
- Understand the importance of global commitments related to maternal and child health and review India's performance with respect to these indicators.
- Gain an awareness of the 2030 Agenda for sustainable development with special focus on health of women, child and adolescents.

Session Plan

Time	Session	Content	Methodology	Resource Material
1 hrs	**Unit 1.3:** International Commitments to Maternal, Child and Adolescent Health and Immunisation	• Overview of, SDGs,MDGs and other global commit- ments towards ma- ternal and child health • Gender-sensitive programme planning and implementation	• Information sharing • Group discussion	• Flip chart, markers • Printed copies of handouts

Tips for the Facilitator

This session focuses on basic rights of humans that all countries need to strive to provide for their citizens. Approaching this from a right's perspective will help participants realise the importance of global commitments related to maternal and child health and their relevance to their local contexts.

Step 1

Sustainable Development Goals

MDGs have shown that target-based approaches work and have resulted in the following improvements globally:

- Global poverty continues to decline
- More children than ever are attending primary school
- Child deaths have dropped dramatically
- Access to safe drinking water has been greatly expanded
- Targeted investments in fighting malaria, AIDS and tuberculosis have saved millions

In order to take the global development agenda forward post 2015, the United Nations developed a roadmap called the SDGs, which was adopted during the UN Sustainable Development Summit during September, 2015. The SDGs consist of 17 goals with 169 targets. Of these, the following seven goals address the issues of maternal and child health:

Poverty - End poverty in all its forms everywhere
Food - End hunger, achieve food security and improved nutrition and promote sustainable agriculture
Health - Ensure healthy lives and promote well-being for all at all ages
Education - Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all
Women - Achieve gender equality and empower all women and girls
Water - Ensure availability and sustainable management of water and sanitation for all

Within the larger goal of health, specific targets have been laid down with respect to maternal and child health:

- By 2030, reduce the global Maternal Mortality Ratio to less than 70 per 1,00,000 live births.
- By 2030, end preventable deaths of newborns and children under five, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under five mortality to at least as low as 25 per 1,000 live births.
- Achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

Step 2

Substantial progress was made regarding the MDGs when they reached the end of their term in 2015. However, the achievements have been uneven in India and many other nations. Share information on India's progress on reduction of child mortality and improvements in maternal health with the participants (Handout 2). Encourage them to source data on the mentioned indicators for their State, district and block/village.

Activity 1

Ask participants to focus on identifying gender-specific development concerns of their States/ districts/blocks – to verify if services accessible to women and girls, are women benefitting equally from health programmes as compared to men, are the needs of women/adolescent girls being ad dressed in services provided, etc. 'Applying a gender-lens' to all stages of programme planning and implementation will help draw attention to whether it is gender inclusive, fair and contributes to women's empowerment. This kind of an analysis or audit helps in monitoring/ evaluating the impact of development programmes.

Allow 3-4 participants to make observations on various health programmes and their beneficiaries and discuss with the larger group whether these are gender-inclusive. Some pointers for discussion include, are women involved in identifying their health needs and priorities, does the Panchayat/Gram Sabha ensure decisions are pro-women, do they encourage/provide incentives to young adolescent girls to continue education, pressurising parents to choose health over early marriage for their daughters; ensuring health services motivate parents to give more if not equal attention to the girl- child, etc.

Share the Handout-1 on 'Policy Brief: Priorities for the Post-2015 Development Agenda'.

Step 3

Other Global Commitments

Over the years, India has made a number of international commitments in an effort to meet the targets and also improve on maternal and child health related outcomes by reframing policies and setting targets. For instance, India has extended strong support to 'The Global Strategy for Women's and Children's Health' launched by United Nations (UN) Secretary-General - Ban-Ki Moon in 2010, by supporting a number of international commitments (as listed below) involving a wide range of stakeholders such as the WHO, UN Secretary General's 'Every Woman Every Child' movement and other high-level UN groups and experts. The Strategy is a road map to end all preventable deaths of women, children and adolescents by 2030 to improve their health. It also supports achieving the UN health-related; post-2015 SDGs that were finalised in September, 2015 at the United National Gen- eral Assembly meet (use Handout 3 to share information on India's global commitments).

Summing Up

- Indices of human and gender development are increasingly being used to review the progress of the States. The Human Development Index is a composite index of three indicators of health, education and income.
- The MDGs were revolutionary in providing a common language to reach global agreements on health and development. MDGs reached the end of their term in 2015.
- The SDGs, known as the Global Goals, are build on the MDGs, and have a broader sustainability agenda with targets to be accomplished by 2030. The 17 SDGs address the root causes of poverty and the universal need for development that works for all people.
- Applying a 'gender lens' to all stages of health and development programmes ensure fair allocation of resources in ways that are effective and contribute to advancing gender equality and women's empowerment.

Suggested Readings

Ending Preventable Child Deaths from Pneumonia and Diarrhoea by 2025: The Integrated Global Action Plan for Pneumonia and Diarrhoea.

Executive summary: http://apps.who.int/iris/bitstream/10665/79207/1/WHO_FWC_MCA_13_01_eng.pdf?ua=1

India's Newborn Action Plan (INAP) 2014: http://www.newbornwhocc.org/INAP_Final.pdf

Handouts

Handout 1 - Policy Brief: Priorities for the Post-2015 Development Agenda1 (pdf)

Handout 2 - India's progress on reduction of child mortality Committing to Child Survival: A Promise Renewed.Progress Report 2013.UNICEF (2013). Also available at <http://www.unicef.org/lac/Committing_to_Child_Survival_APR_9_Sept_2013.pdf>

- In India, Under Five Mortality Rate (U5MR) has declined from an estimated level of 126 per 1000 live births in 1990 to 53 in 2013.
- The Infant Mortality Rate (IMR) in our country has reduced by nearly 50 per cent during 1990- 2013 and the present level is at 41.
- The national level coverage of the proportion of one-year old (12-23 months) children fully immunised against BCG, measles, polio and DPT is 74.1 per cent in 2009. This is an increase of more than 30 per cent from 1992.

India's Progress on improving maternal health

- From an estimated Maternal Mortality Ratio (MMR) level of 560 per 1,00,000 live births in 1990, the MMR has decreased to 190 during 2013 (RGI,SRS, Govt. of India, 2013).
- As per NFHS (2005-6) delivery attended by skilled personnel is 48.8 per cent, a significant increase from 33 per cent in 1992-93 (IIPS-NFHS-3, 2007).

India's Progress on Key MCH Indicators

Indicator	1990	2013	Source of information	MDG target in 2015
Under 5 Mortality Rate (per 1000 live births)	125	45	Sample Registration System, 2014	42
Infant Mortality Rate (per 1000 live births)	80	39		27
National level coverage of measles immunisation	42.2 per cent	74.1 per cent (2009)	UNICEF & Govt. of India-Coverage evaluation survey 2009	100 per cent (achieved)
Maternal Mortality Ratio (per one lakh live births)	560	167	Registrar General of India, Sample Registration System, 2013	109
Deliveries attended by skilled birth attendants (doctor/ nurse/LHV/ ANM/other health personnel)	35.1 per cent	48.8 per cent	IIPS-NFHS-3, 2007	100 per cent

11Committing to Child Survival: A Promise Renewed.Progress Report 2013.UNICEF (2013). Also available at <http://www.unicef.org/lac/Committing_to_Child_Survival_APR_9_Sept_2013.pdf>

Handout 3: India's Global Commitments

Global Action Plan for Prevention and Control of Pneumonia and Diarrhoea (GAPPD): Ending Preventable Child Deaths from Pneumonia and Diarrhoea by 2025

- Pneumonia and diarrhoea remain major causes for the deaths of young children. Together, these diseases account for 29 per cent of all deaths of children less than five years of age and result in the loss of two million young lives each year.
- The integrated GAPPD proposes a cohesive approach to ending preventable pneumonia and diarrhoea deaths. It brings together critical services and interventions to create healthy environments, promote practices known to protect children from disease and ensure that every child has access to proven and appropriate preventive and treatment measures.

Innocenti Declaration

In 1990, the Innocenti Declaration was produced and adopted by participants at the WHO/ UNICEF policymakers, for protection, promotion and support of breastfeeding.

The Declaration identifies breastfeeding as a unique process essential for optimal health, growth and development of children. It accepts research evidence that states the importance of exclusive breastfeeding for six months followed by timely, appropriate and adequate complementary feeding

and that programmematic intervention can promote appropriate behaviours among communities.

In June 2012, India co-convened **"The Global Child Survival Call to Action: A Promise to Keep"** Summit in Washington DC along with Ethiopia and United States of America.

In February 2013, the Government of India (GoI) held its own Summit **"Call to Action for Child Survival and Development"**, organised in collaboration with USAID and UNICEF. One key outcome of this event was the launch of a roadmap document titled **"A Strategic Approach to Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) in India."** Today, RMNCH+A forms a key component of the government's flagship public health programme – the National Health Mission (NHM).

India's Newborn Action Plan

- In September 2014, the GoI launched India's Newborn Action Plan (INAP) as a response to the global Every Newborn Action Plan (ENAP), launched in June, 2014 at the 67th World Health Assembly.
- India's Newborn Action Plan lays out a vision and a plan for India to end preventable newborn deaths, accelerate progress and scale up high-impact yet cost effective interventions. For the first time, INAP also articulates the GoI's specific attention on prevention of stillbirths.

India hosted the **Call to Action Summit 2015 - Ending Preventable Child and Maternal Deaths** which led to the signing of the 'Delhi Declaration'.

Know Your Progress

Questions

1. What are the key strategies adopted to end preventable child deaths from pneumonia and diarrhoea by 2025? How many of these are being followed up in your area?

2. List the SDGs for maternal and child health. Prepare a chart listing the performance against these indicators both for India and your district/State over the last one year.

Model Answers

1. The key strategies being intensified under GAPPD are: Universalising recommended breastfeeding and complementary feeding practices, universalising vaccination, integrated management of childhood diseases with timely identification at community level, use of ORS and zinc for management of diarrhoea, water sanitation and hygiene along with behaviour change and demand generation activities within the community for the abovementioned services.

2. The SDGs 4 and 5 specifically targeted the reduction of child and maternal mortality, gender equality and women's empowerment. Some of the targets under these goals include:

- By 2030, reduce the global maternal mortality ratio to less than 70 per 1,00,000 live births.
- By 2030, ensure universal access to sexual and reproductive health-care services, including

for family planning, information and education and the integration of reproductive health into national strategies and programmes.

- By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.

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United Nations. 2015. Transforming our World: The 2030 Agenda for Sustainable Development. United Nations.

Unit 1.4: Government Programmes and Policies focused on Maternal, Child and Adolescent Health and Immunisation

Key Facts

- The National Rural Health Mission (NRHM) seeks to provide effective rural health care to the rural population, especially the vulnerable groups including women and children by improving access, enabling community ownership and demand for services, strengthening service delivery and accountability.
- NRHM mandates the formation of Village Health and Sanitation Committees (VHSC) in each village under the Gram Sabha. Through VHSCs and various groups such as Health Sanitation Committees, Hospital Management Committees and Village Panchayat Committees,NRHM facilitates an improved and effective management of the local health system.
- PRIs play a key role in strengthening women's participation in development planning, implementation and inclusion of gender-specific needs through analysis of the health status of women and girls, allocation of funds for their welfare, encouraging their participation in monitoring schemes and sensitising male officials and villagers.

Introduction

Maternal health is important to communities, families and the nation due to its profound effect on the health of women, immediate survival of the newborn and long-term well-being of children, particularly girls and the well-being of families. The central and State governments in India have rightly made maternal and child health a key priority for decades. A package of preventive and curative health services are being provided through the government public health system, aimed at improving the health status of women and children. These services are targeted at different age groups –1. Pregnant women: Ante-natal care, safe delivery and post-natal care; timely identification and referral for complications; 2. Infants and children up to the age of five years: Immunisation, nutritional supplements, prevention of common childhood infections and timely identification and referral; 3. Adolescents: Reproductive and sexual health, menstrual hygiene, nutrition, primary medical care and immunisation. A large number of these programmes are being provided under the governments' flagship programme, the National Health Mission (NHM), which prioritises the provision of healthcare to women and children, particularly in rural areas.

This unit aims to provide an overview of health programmes for women, adolescents and children that impact the health of the community. To ensure that these programmes are functional and effective requires monitoring, convergence with other similar services and active community participation. All of these can be supported and facilitated by women elected PRIs, district and block level officers as well as ASHAs, ANMs and other health workers. In their official capacities, participants can initiate collective thought and action around basic issues of health, nutrition and education. As leaders and officials, they can ensure the fundamental rights and health of their communities by empowering all women.

Learning Objectives

Participants will be able to:

- Identify major health development programmes and schemes for women, adolescents and children.
- Clarify their role in increasing women's awareness and participation in these programmes.
- Strategise to increase the community's and particularly women's awareness and participation in health programmes by using existing resources and networks/committees.

Session Plan

Time	Session	Content	Methodology	Resource Material
1.5 hrs	**Unit 1.4:** Government Programmes and Polices Focused on Maternal Health, Child Adolescent Health and Immunisation	• Overview of major programmes and their entitlements • Significance and strategies of community involvement and women's participation in health programmes	• PowerPoint presentation by facilitator • Discussion and work in small groups	• Slide projector, flip chart, chalkboard, marker and chart papers • Handouts on various health programmes • Sharing case studies/ inviting a strong woman leader to session

Tips for the Facilitator

This session focuses on enhancing the knowledge and information of participants on development schemes, health programmes and entitlements available under these. The goal is to build the capacity of the participants to raise awareness among the community, especially women, to increase their involvement and participation in health programmes. Activities in this unit also aim to help participants strategise to strengthen networks and forums to demand accountability and services for women, adolescents and children through active community participation.

Step 1

Ask participants which health programmes are they aware of? What are the benefits of these programmes? How do they benefit women and children in particular? List the responses on a board/ flip chart.

Following this discussion, make the PowerPoint presentation sharing slides with highlights of the health programmes for women, adolescents and children (Annexure 1). Spend a maximum of 15-20 minutes to make the presentation. Focus more time on eliciting responses from participants about the effectiveness of these programmes in their village/block.

Activity 1

Divide the participants into two groups representing the following categories: a. women; b. adolescents and children. Ask them to study the Handouts of programmes for their respective groups. Give them 15 minutes to study the details of services, facilities and entitlements. Each group should prepare to comment on whether the programme is functioning in their village/ district (services available, personnel employed, infrastructure in place, funding, accessed by target group, etc., and list challenges, if any). The group can select two people to make the presentation before the larger group for 10 minutes each.

Encourage a discussion among all participants on programme information in their respective areas and pose questions to elicit responses. Make sure to write out queries that have not been answered and seek suggestions from participants regarding the institution/person they can be posed to. Assign responsibilities among participants who volunteer to follow up on the queries. Acknowledge the gaps/problems, but emphasise the positive aspects and services, however few.

Step 2

Share with the participants that the Eleventh Five Year Plan (2007-12) had emphasised the need for greater involvement of different tiers of Panchayati Raj Institutions, right from the village to district levels, in the public health delivery system in their respective jurisdiction. The NRHM has also tried to empower the PRIs at each level i.e., Village Panchayat, Intermediate Panchayat and District Panchayat, to take leadership in controlling and managing the public health infrastructure at the district and sub-district levels. This has been facilitated by the formation of a Village Health and Sanitation Committee in each village within the overall framework of the Gram Sabha. The NRHM has also encouraged PRIs by building their capacities as well as those of various groups

such as Health Sanitation Committees, Hospital Management Committees and Village Panchayat Committees for improved and effective management of the local health system.

State governments are predominantly responsible for health provisioning in their States as per the Constitution. Some states like Kerala, West Bengal, Maharashtra and Gujarat have already taken initiatives in line with the NRHM's guidelines and their experiments have shown the positive gains of institutionalising the involvement of PRIs in the management of the health system. Some successful initiatives include:

e-Mamta (Gujarat)

A web-based software programme is being used to register individual pregnant mothers and children in the age group 0-6 years and adolescents along with their full details to ensure complete service delivery of Ante Natal Care (ANC), child birth, Post Natal Care (PNC), immunisation, nutrition and adolescent services. Through work plans, a unique concept introduced for the first time in public health, those mothers who are left out of maternal and child services are tracked. It also provides a management tool to the service providers at the grassroots level to determine the potential recipients of the services along with their details, through comprehensive data and work plans. Finally, the services are aggregated to generate reports that are reliable and valid (Share Handout 1).

Fixed Day Health Services (Andhra Pradesh)

This programme was designed under NRHM to provide a package of preventive and clinical services to remote and difficult-to-reach areas. The major objective of this programme is to provide non-communicable disease screening and treatment to rural populations to strengthen the public health service delivery system in the State.

Under this programme, 475 Mobile Medical Unit (MMU) vans cover 22 districts in the State. Among other services, they provide diagnostic testing, antenatal checkups, supply drugs and provide immunisation. To provide the above mentioned services at each service point, a team consisting of three Auxiliary Nurse Midwives (ANMs), a pharmacist, a lab technician, a data manager and a driver are present in the MMU.

Check with participants whether they are members of any committees or groups involved in facilitating access to public health services or monitoring them. They could be involved in identifying local health needs or developing the health plan for their village or conducting school health activities or immunisation camps.

Help establish the differences that women leaders could make in the health system (from experiences shared by participants when discussing health programmes in their local areas/case studies/inviting a strong woman leader to the session to share her story). See Annexure 2.

Step 3

Role of PRIs in Strengthening Women's Participation

Encourage participants to brainstorm ways of increasing women's involvement and participation in health programmes discussed during the session. Encourage sharing of personal success stories.

Use following examples to initiate the discussion:

- Arranging awareness camps for women on health services available for them through the Gram Sabha.
- Highlighting local health needs by encouraging local women to participate in meetings of the Village Health Committee or the Gram Sabha.
- Enlisting the help of local women and mothers in overseeing the supply of quality nutritious food for children by volunteering for the Anganwadi Monitoring Committee.
- Increasing knowledge and awareness about nutrition needs and local nutritious foods through local Anganwadi centres and health sub-centres.
- Keeping tabs on the attendance of girl children both at Anganwadi centres and schools and applying moral pressure to ensure they do.
- Promoting awareness of women and girl-related schemes and rights, especially among male representatives and villagers to develop sensitisation and inclusion.

Summing Up

The community's awareness and engagement with development programmes and their entitlements helps in inclusive development of the village/block/district. The PRI members play a crucial role in facilitating women's access and participation in the primary health services. People's participation, especially women's participation in health programmes and development helps to achieve gender equality, women's empowerment and accountability from primary health care. Convergence among existing structures, committees and programmes can help in improving outreach and performance of primary health care services. The Village Health Committee of the Panchayat plays a key role in inter-sectoral integration to ensure availability of quality health services at a reasonable cost.

Further Readings

http://mohfw.nic.in/NRHM.htm http://icds.gov.in
http://nrhm.gov.in/images/pdf/communitisation/vhsnc/order-guidelines/ Guidelines_for_ Community_Processes_2014 per cent20English.pdf

Handouts

1. e-Mamta Programme, Gujarat

Mother and child health service delivery has been a challenge for public health providers in rural areas due to high dropout rates, high left out rates, quality of services, inability to track beneficiary pregnant women and children leading to high Maternal Mortality (MMR) and Infant Mortality (IMR) rates. With a vision to improve maternal and child health services delivery in rural as well as urban areas, the Government of Gujarat executed e-Mamta, a mother and child web-based tracking application in Gujarat.

Conceptualised by the State Rural Health Mission of the Health and Family Welfare Department of Gujarat, the funding support for the initiative was sought under National Rural Health Mission (NRHM) and the programme was developed through National Informatics Centre (NIC), Gujarat. To execute the initiative, a Family Health Survey was conducted in rural and urban areas by health workers, wherein individual records of around 92 lakh families comprising 45 million beneficiaries, covering almost 80 per cent of population of Gujarat were entered in the information system. The data was then validated by comparing with below poverty line list, voters list and ration card list. Secondly, a unique family healthcare ID was provided to capture migration details. After that, all pregnant women and children up to the age of six were registered and provided a unique mother and child ID.

With the help of the e-Mamta initiative, 12.54 lakh pregnant women, 4.09 lakh infants and 3.62 lakh children in the age group of one to six have been tracked for essential Reproductive and Child Health (RCH) services. This has increased considerably from 1,65,635 pregnant women and 74,204 infant tracked before the introduction of this initiative.

Under the initiative, SMS alerts are sent to beneficiaries, health workers, and district and block level authorities to monitor due services. Customised and bilingual SMS are sent to target beneficiaries or their relatives in each group before their due dates. More than 17,433 automatic SMS have been sent to beneficiaries to inform them about antenatal care and 13,842 messages have been sent to inform about immunisation for children under the initiative. Also, 3,634 automatic messages have been sent to officers to report maternal death and 14,156 to report infant death. Apart from this, 2,04,324 manual messages have been sent to inter-departmental corporation and to mothers and families for the uptake of services. In addition, 16,000 SMS have been delivered to all nurses and doctors of Gujarat within minutes of infant deaths reported due to measles vaccine.

e-Mamta stores individual-based service information, which can be viewed at the State and district level. It enables instant retrieval of historical data and service records and allows the development of reports, such as height-weight charts and growth and immunisation charts, which can be quickly accessed and analysed by medical, block and district officers. Post the introduction

of the initiative, 24 locations and period-wise graphs are available, that can be viewed in various permutations for quick analysis.

The system has also helped in cutting down the time used in the compilation of reports from sub centre to block, to district to State. Earlier, the total time required for a complete report to reach the State centre from the sub-centre used to take a minimum of 25-30 days. Today, the report can be compiled instantly.

http://www.informationweek.in/diamond_edge/12-02-02/e-mamta_improves_mother_and_child_health_service_delivery_in_gujarat.aspx

Know Your Progress

Questions

1. Name and list services and entitlements of two health programmes available to pregnant mothers and children each provided by the Government of India.
2. Identify programmes that address under nutrition among children and adolescents. Detail the benefits and entitlements available under these programmes.
3. List any three roles and responsibilities of the Village Health, Sanitation and Nutrition Committee?

Model Answers

1. Programmes for pregnant women include Janani Suraksha Yojna and Janani Shishu Suraksha Karyakaram.

Programmes for children include Integrated Management of Neonatal and Childhood Illnesses, Mission Indradhanush, and Rashtriya Bal Swasthya Karyakram.

2. Some programmes that address under nutrition include National Iron Plus Initiative (NIPI) for anemia control, Rashtriya Bal Swasthya Karyakram, Nutrition and Rehabilitation Centres and Infant and Young Child Feeding.
3. Some functions of the VHSC include:
    - Carrying out a survey on nutritional status and nutritional deficiencies in the village, especially among women and children.
    - Monitoring and supervision of Village and Nutrition Day to ensure it is organised every month in the village and there is active participation of villagers.
    - Supervising the functioning of the anganwadi centre in the village and facilitating its work on improving the nutritional status of women and children.

Annexures

Annexure 1: PowerPoint slides: Programmes by Ministry of Health and Family welfare, Government of India

Janani Suraksha Yojana

- A safe motherhood intervention with the objective of reducing maternal and neonatal mortality by promoting institutional deliveries among women from economically backward families.
- The scheme is under implementation in all States and UTs with special provisions for low performing States.
- The scheme provides cash entitlements for women opting for institutional deliveries.

Janani Shishu Suraksha Karyakaram (JSSK)

- Entitles all pregnant women delivering in public health institutions to an absolutely free and no expense delivery, including Caesarean section.
- The initiative stipulates free drugs, diagnostics and diet, besides free transport from home to institution between facilities in case of a referral and drop back to home and free blood, if required.
- Similar entitlements have been put in place for all sick infants accessing public health institutions for treatment till one year of age.

Mother and Child Tracking System (MCTS)

- A name and web-based Mother and Child Tracking System has been put in place to ensure registration and tracking of all pregnant women and newborn babies. This is to ensure provision of regular and complete health and nutritional services to mothers and children.
- Benefits of the MCTS:
  - Better control on estimates of infant and maternal mortality.
  - Better assessment of JSY benefits.
  - Improved supply chain management of vaccines and drugs.
  - Improved deployment of doctors and healthcare workers based on the demand in terms of number of mothers and children.
  - Improvement in registration of births.
  - Used as basis for ICDS, primary education and adolescent health.
  - Better data analysis for preparation of block/district health action plans and State PIPs with realistic/accurate target figures.

Facility-Based Newborn Care (FBNC)

- Aims at improving the delivery of various health services at existing district and sub-district facilities. It has been found that health facility-based interventions can reduce neo-natal mortality by as much as 25-30 per cent.

- The programme responds to the increased demand for health services generated by the JSY and IMNCI.
- Setting up of facilities for care of sick newborns such as Special Newborn Care Units (SNCUs), Newborn Stabilisation Units (NBSUs) and Newborn Care Corners (NBCCs) at different levels is a thrust area under NHM.
- The FBNC guidelines also describe the protocols for management and referral of different types of sickness among newborns and different stages.

Home-Based Newborn Care (HBNC)

- Home-based newborn care through ASHAs has been initiated to improve newborn practices at the community level for early detection and referral of sick newborn babies.
- Together with Janani Suraksha Yojana and Janani Shishu Suraksha Karyakaram, HBNC ensures that the mother and child have access to services in order to ensure positive health outcomes.
- The package of services offered under the HBNC is targeted at reducing newborn mortality, after mother and child return home post institutional deliveries. Adequate training and skill-building of ASHAs is also incorporated in the guidelines to enable them to fulfill these responsibilities.
- Key activities under HBNC:
  - Care for every newborn through a series of home visits by a trained health worker (ASHA pre-dominantly).
  - Information skills to the mother and family of every new-born to ensure better health outcomes.
  - Examination of every new-born for pre-maturity and low birth weight.
  - Extra home visits and referrals for pre-term and low birth weight babies.
  - Early identification of illness and timely referrals as defined in protocols.
  - Follow up for sick newborn babies after they are discharged from facilities.
  - Counseling mothers on postpartum care and complications.
  - Counseling mothers for the adoption of appropriate family planning methods.

Integrated Management of Neonatal and Childhood Illnesses (IMNCI)

- IMNCI is an integrated approach to child health that focuses primarily on the most common causes of child mortality- diarrhoea, pneumonia, measles, malaria and malnutrition.
- It provides a step-by-step guideline for the identification and management of common illnesses, incorporating both preventive and curative elements to be implemented by health workers as well as families.
- The strategy has three main components:
  - Health worker component: Improving their case management skills.
  - Health service component: Improving the quality and functioning of the health facilities.
  - Community component: Improving family and community health care practices through timely home visits by trained health care staff.

Mission Indradhanush

- Full immunisation against preventable childhood diseases is the right of every child. With a view to provide this right to every child, the Government of India launched the Universal Immunisation Programme (UIP) in 1985, one of the largest health programmes of its kind in the world.
- Despite being operational for over 30 years, UIP has been able to fully immunise only 65 per cent children in the first year of their life and the increase in coverage has stagnated in the past five years to an average of one per cent every year. To strengthen and invigorate the programme and achieve full immunisation coverage for all children at a rapid pace, the Government of India launched Mission Indradhanush in December 2014.
- The objective of this mission is to ensure that all children under the age of two years as well as pregnant women are fully immunised for seven vaccine preventable diseases.
- The Mission Indradhanush, depicting seven colors of the rainbow, targets to immunise all children against the following vaccine preventable diseases:
  - Diphtheria
  - Pertussis (Whooping Cough)
  - Tetanus
  - Tuberculosis
  - Polio
  - Hepatitis B
  - Measles
  - Diarrhea
  - Pneumonia
  - Rota virus
- In addition to this, vaccines for Japanese Encephalitis (JE) and Haemophilus Influenza type B (HIB) are also being provided in selected States.

Rashtriya Bal Swasthya Karyakram (RBSK)

- RBSK has been conceptualised to ensure primary health screening and early intervention services and comprehensive care to all the children in the age group of 0-18 years in the community.
- The purpose of these services is to improve the overall quality of life of children through early detection and timely management of:
  - birth defects
  - diseases
  - deficiencies
  - development delays including disability
- The first level of screening is done at all delivery points with the help of existing medical officers, staff nurses and ANMs. After 48 hours till six weeks, the screening of newborns will be done by ASHA at home as a part of Home-Based Newborn Care (HBNC) package.

Outreach screening will be done by dedicated Mobile Health teams for six weeks to six years at anganwadi centres and for children aged 6-18 years at school.

- Once the child is screened and referred from any of these points of identification, it would be ensured that the necessary treatment/intervention is delivered at zero cost to the family.
- Children with any health condition requiring health care will be referred to the District Early Intervention Centre (DEIC) apart from the existing public health facilities.

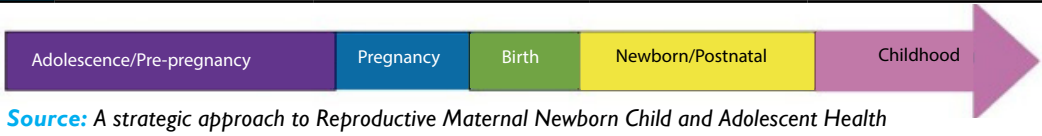
National Iron Plus Initiative (NIPI) for Anaemia Control

- The National Iron Plus Initiative, adopts a life cycle approach for the prevention of anaemia, focusing at the age groups known to be at a high risk of developing anaemia.
- An age and dose specific Iron and Folic Acid (IFA) supplementation programme is being implemented for the prevention of anaemia among the vulnerable age groups like under-five children, children in the age group of 6-10 years, adolescents, pregnant and lactating women and women in the reproductive age along with treatment of anaemic children and pregnant mothers at health facilities.
- The following services are offered under this initiative:
  - Bi-weekly Iron Folic Acid syrup and age appropriate de-worming for preschool children of 6-59 months.
  - Weekly dose of small IFA tablet per child per day for children from 1st to 5th grade in government and government-aided schools, and at AWC for out of school children (6 to 10 years).
  - Weekly dose of large IFA tablet with biannual de-worming in adolescents (10–19 years) under Weekly Iron Folic Acid Supplementation.
  - Weekly supplementation for women in reproductive age, and pregnant and lactating women.

Reproductive Maternal Neonatal Child and Adolescent Health

- Improving maternal and child health has been a focus area for all the governments in India. Newer interventions by the government and various strategies for the delivery of these interventions have been evolving over the past few decades.
- Different interventions aimed at different target groups have been traditionally planned and implemented in isolation, e.g., safe delivery, infant and young child feeding, immunisation, adolescent health, etc.
- The RMNCH+A approach launched in 2013 in 184 high priority districts, encompasses all these services under one umbrella to allow greater co-ordination between the planning and delivery of these services. Maternal and child health programmes can now be understood as per the 'Continuum of Care,' i.e., according to the different stages of the life cycle and according to the places where the care is provided. The table below provides a clear framework for understanding the available maternal and child health services:

	Reproductive Care	Pregnancy and Child birth Care	Newborn and Child Health Care	
Clinical	• Comprehensive abortion care • Postpartum IUCD and sterilisation; interval IUCD procedures • Adolescent-friendly health services	• Skilled obstetric care and immediate newborn care and resuscitation • Emergency obstetric care • Preventing Parent to child Transmission (PPTCT) of HIV • Postpartum Sterilsation	• Essential newborn care • Care of sick newborn (SNCU, NBSU) • Facility based care of childhood illnesses (IMNCI) • Care of children with service acute	
	Reproductive health care	**Antenatal Care**	**Postnatal Care**	**Child health care**
Family and Community Outreach/Sub centre	• Family planning • (Including IUCD insertion, OCP and condoms • Prevention and management of STIs • Perconception Folic acid supplementation	• Full antenatal care package • PPTCT	• Early detection and management of illnesses in mother and newborn • Immunisation	• First level assessment and care for newborn and childhood illnesses • Immunisation • Micro-nutrient supplementation
	• Weekly IFA supplementation • Information and counselling on sexual reproductive health and family planning • Community based promotion and delivery of • contraceptives • Menstrual hygene	• Counselling and preparation for newborn care, breast feeding, birth preparedness • Demand generation for pregnancy care and institutional delivery (JSY, JSSK)	• Home-based newborn care and prompt referral (HBNC scheme • Antibiotic for suspected case of newborn sepsis • Infant and young child feeding (IYCF), including exclusive breast feeding and complementary feeding. • Child health screening and early intevention services (0-18) • Early childhood development • Danger sign recognition and care-seeking for illness • Use of ORS and Zinc in case of diarrhoea	
	Intersectoral: Water Sanitation, hygiene, nutrition, education, empowerment			



Source: *A strategic approach to Reproductive Maternal Newborn Child and Adolescent Health (RMNCH+A), Ministry of Health and Family Welfare, Government of India, 2015.*

Nutrition Rehabilitation Centres

- Severe Acute Malnutrition (SAM) is an important contributing factor for most deaths amongst children suffering from common childhood illness such as diarrhea and pneumonia. Deaths amongst SAM children are preventable, provided timely and appropriate actions are taken.
- Nutritional Rehabilitation Centres (NRCs) are being set-up in the health facilities for inpatient management of severely malnourished children, with counseling of mothers for proper feeding and once they are on the road to recovery, they are sent back home with regular follow up.
- Screening for malnutrition is done in the community by health and ICDS staff using height and weight measurement. Children found to be suffering from SAM are referred to the NRC for admission and treatment. Services offered at the NRC are listed below:
    - Treatment and patient management
    - Nutritional support to children
    - Nutrition education to his/her family members
    - Other counseling services such as family planning, better hygiene practices, psycho-social care and development.
    - Capacity building of the primary caregivers on preparation of low-cost nutritious diet from locally available food ingredients, developing feeding habits and time management in mothers, imparting knowledge of developing kitchen gardens, etc.
    - Follow up services: Growth monitoring and appropriate counseling through home visits.

Infant and Young Child Feeding Practices

IYCF practices are the single most effective preventive intervention for child survival.

- It advocates the following:
    - Early initiation (within one hour of birth) and exclusive breast feeding till six months.
    - Timely complementary feeding after six months with continued breast feeding till the age of 2 years.
- Promotion of appropriate IYCF practices are an integral part of mothers' counseling at the time of ANC and PNC visits at facilities as well as during home visits.

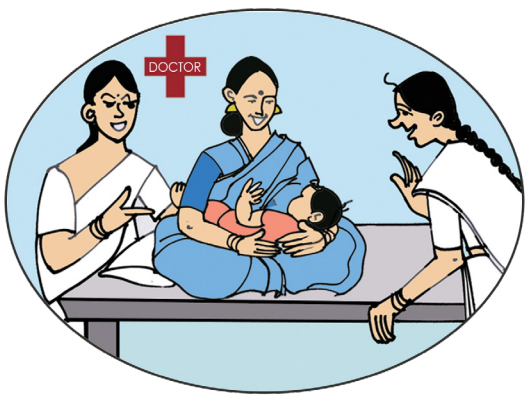
Annexure 2 – Two Case studies from Leadership in Action – Elected women leaders bring health to their villages, The Hunger Project. Print out copies of the following case studies can be shared with the participants:

References

Annual report 2014-15, Ministry of Health and Family Welfare, Government of India, New Delhi.

Hunger Project, Case Studies from Leadership in Action- Elected Women Leaders bring Health to their Villages.

Block 2: Strategies to Address Maternal, Child Health and Immunisation



Unit 2.I: 'Continuum of Care' Approach from Pre-Pregnancy to Children Under Five

Key Facts

- The RMNCHA approach adopted by the GoI in 2013 is based on the 'life-cycle' approach for maternal and child health, and links together all the various interventions designed for women, infants and adolescents.
- Approximately 48 per cent of the 243 million adolescents in our country are girls, and yet we continue to struggle with gender gaps in terms of female access to education, empowerment, agency and autonomy.
- Every year, India loses five lakh children annually due to vaccine preventable diseases (Press Information Bureau, Government of India, 2015).

Introduction

Experience across the world has shown that no single intervention is by itself sufficient to improve maternal and newborn health and reduce morbidity and mortality. What is needed is a gamut of services and care made available to mothers and children throughout pregnancy, childbirth and the post-natal period.

The Continuum of Care approach promotes interventions that are essential for the health of both the mother and the newborn child. This approach promotes the use of health interventions for the care of mothers and children from pre-pregnancy to childhood and adolescence that should be accessible to them at the household, community, district and national levels. A healthy start in life is a stepping stone to a healthy childhood and a productive life (Kerber K J et al., 2007).

Through the RMNCH+A strategy, the Government of India aims to reach the maximum number of people in the remotest corners of the country through a continuum of services, constant innovation and routine monitoring of interventions. In implementing the numerous services under this initiative, programmes aim for high impact interventions in each of the five thematic areas of reproductive, maternal, newborn, child and adolescent health, and on improving the coverage and quality of those interventions in 184 high-priority districts (HPDs) across India.

This unit aims to help participants understand the significance of the continuum of care approach and its integration in the RMNCH+A services. The increased representation of women in the Panchayats provides a unique opportunity to engage with other women in the communities, create awareness among them about their health and rights and empower them to voice their concerns and push for decisions and facilities that will improve their health, children, and by extension, the men in their villages.

Learning Objectives

Participants will be able to:

- Understand the rationale and significance of the integrated RMNCH+A 'continuum of care' approach.
- Get an overview of the existing coverage of RMNCH+A interventions in India and their role in improving the service delivery and uptake of these interventions in their work areas.
- Gain insights to the challenges in implementing the RMNCH+A services both from the perspective of the provider and community.

Session Plan

Time	Session	Content	Methodology	Resource Material
1.5 hrs	**Unit 2.1:** Continuum of Care Approach from Pre-Pregnancy to Children under Five	• Evolution of maternal and child health programmes in India • RMNCH+A: The continuum of care approach • Key challenges in implementing the RMNCH+A interventions • Role of PRIs in increasing demand and utilisation of services in their work area	• Screening of film and PowerPoint presentation on RMNCH+A • Quiz • Group discussion	• DVD with film, PowerPoint presentation on RMNCH+A, chart papers, printed copies of handouts

Step 1: Evolution of Maternal and Child Health Programmes in India

Using a time line, mark the significant years to provide an overview of the evolution of maternal and child health programmes in India. Refer to Annexure 1.

Paradigm shift in programmes for mothers and children (1947–2013)

• Centralised • Goal: Two child norm • Rigid • Target-oriented • Top-down approach • Not need-based • Quality of service not considered • Service: Family planning	• Decentralised • Goal: Enable parents to decide • Non-rigid • Target-free • Bottom-up approach • Need-based and demand-driven • Quality of service emphasised • Service: Full range of MCH care

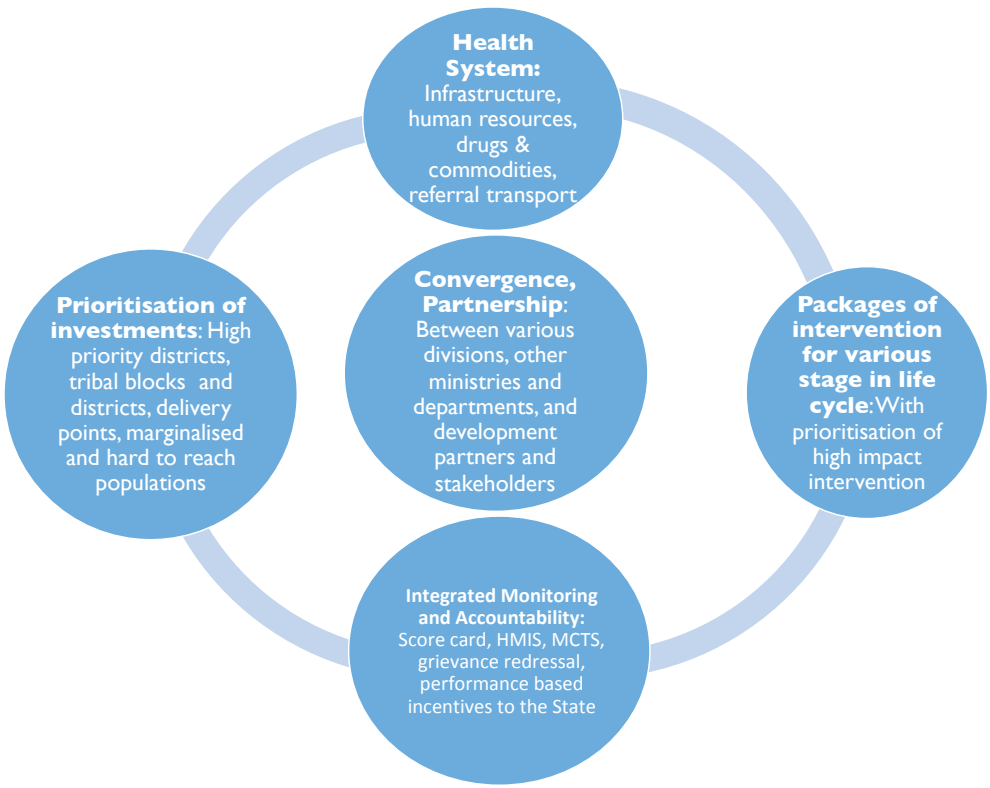
Step 2: RMNCH+A Approach: Reproductive, Maternal, Neonatal, Child and Adolescent Health

Start this step by screening a short film on RMNCH+A. (Refer to Annexure 2). Following the film, explain that this approach is based on the evidence that maternal and child health cannot be improved in isolation as adolescent health and family planning have an important bearing on the out comes. This strategy encompasses various high impact interventions across the life cycle from adolescence – pregnancy – birth – newborn/postnatal – childhood. It aims to improve the coverage and quality of these interventions, along with increasing convergence between various programmes and departments.

Highlight the key features of the RMNCH+A and explain the integration across life stages and programmes with the help of the PowerPoint presentation. Refer to Annexure 3. The emphasis should be on:

- Inter-linkages between different interventions at various stages of the life cycle.
- Linking child survival to other inventions such as reproductive health, family planning and maternal health.
- Sharper focus on adolescents.
- Recognising nurses as 'pivots' for service delivery.
- Expanding focus on child development and quality of life.
- Intensification of activities in 184 HPDs.
- Focus on monitoring: Use of 'Score-cards' to assess and monitor progress at all levels.

Key Features of RMNCH+A



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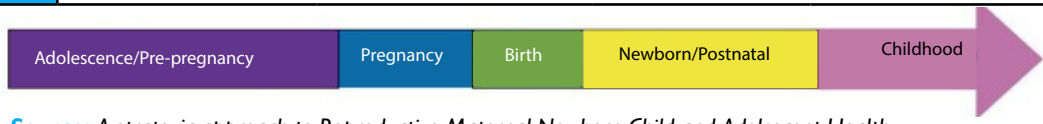
	Intersectoral: Water Sanitation, hygiene, nutrition, education, empowerment			



Source: *A strategic approach to Reproductive Maternal Newborn Child and Adolescent Health (RMNCH+A), Ministry of Health and Family Welfare, Government of India, 2015.*

Activity 1: Quiz on RMNCH+A Services across Life Stages

Divide the participants into two groups – Team A and Team B. Explain that they are going to partici- pate in a quiz to assess their knowledge on the impact of various programmes and services of RMNCH+A. They should appoint two people from each of their teams as spokespersons. Give out the six cards prepared earlier, three to each team.

As Team A reads out the name of age group/stage of life cycle, Team B will respond by enumerating its services and the advantages to the mentioned target age group. Following this, Team B will read out the next programme, giving a chance to Team A to list the answers. Every correct response earns five points and you will help keep the score and evaluate the responses. Declare the winning team and cheer for them.

An example is provided below:
Team A: Reads out the card: Pre-pregnancy
Team B provides the correct response:

Focus area – Use of contraception through

1. Community-based promotion and delivery of contraceptives
2. Promotion of spacing methods (interval IUCD)
3. Sterilisation services (vasectomies and tubectomies)
4. Comprehensive abortion care (includes MTP Act)
5. Prevention and management of sexually transmitted and reproductive infections (STI/ RTI)

Advantages: The practice of contraception methods can lead to a well-planned pregnancy that can result in better maternal and child health. Appropriate contraceptive use is essential for delaying the first pregnancy through family planning and increasing the interval between births for the well-being of both the mother and child.

Step 3

Ask the participants on coverage of key interventions under RMNCH+A in their area of work, at the village or block or district levels. Which services are most popular and are there any that are under-utilised? Share the data on coverage of different services under RMNCH+A for India.

India's Coverage of Key Interventions under the Continuum of Care Approach across the Life Stages of the Mother and the Child

Girls marrying below 18 years	43.4 per cent
Any modern method for family planning	47.3 per cent
Mothers who had full antenatal check-up	26.5 per cent
Mothers who had three or more ANC	68.7 per cent
Institutional delivery	72.9 per cent
Postnatal visit to mothers within 10 days	60.1 per cent
Early initiation of breastfeeding (<1 hour)	40.2 per cent
Postnatal three checkups for newborns within 10 days	45.4 per cent
Exclusive breastfeeding	46.4 per cent
Complementary feeding (6-9 months)	57 per cent
Full immunisation	61 per cent
Children received measles vaccine	74 per cent
Vitamin A supplementation (1st dose)	64 per cent
ORT or increased fluid in diarrhoea	53.6 per cent

Source: *National Rural Health Mission. Promotion of Optimal Infant And Young Child Feeding Practices Through The Health System – India's Initiatives.(DLHS 3; CES 2009)*

- An estimated, 47,000 mothers die every year due to causes related to pregnancy, childbirth and the postpartum period in India (MoHFW, 2013-14).
- In India, the proportion of deaths among young mothers in the age group of 20-29 years has increased by four per cent in 2010-12 i.e., to 67 percentage points from 63 percent in 2007-09 (MDG Report, 2014).
- Every year, India loses five lakh children annually due to vaccine preventable diseases (Press Information Bureau, Government of India, 2015).

The success of this continuum of care approach and programme requires commitment, cooperation and interaction between the different levels of care and between different care providers. Political commitment and inter-sectoral collaboration form an equally significant part of the context for the effective roll out of RMNCH+A services. Efforts need to be made towards building capacities at the individual, family and community level to assure appropriate prevention and care-seeking behaviour.

All participants can ensure in their official capacities that services are available, acceptable and of high quality, particularly for the poor and most vulnerable. They can do so by interacting with the community, ensuring availability of supplies and checking on their utilisation. The responsibility to report or carry any concerns to the Gram Sabha/Panchayat Samiti meetings, or to the appropriate officials such as the Medical Officer lies with them.

Activity 2

Divide the participants into six groups and ask them to select one life-stage from the cards used for Activity 1. Each group needs to discuss two points:

1. The challenges they face while implementing programmes and services related to this life-stage.
2. Their perception of challenges faced by the communities, especially women, in availing these services.

Suggest that each group lists the points for both perspectives on a chart paper and shares these with the larger group. Discuss some of the common challenges that emerge for women. The solutions could be taken up for discussion and brainstorming in the subsequent units.

Summing up

- India has adopted the RMNCH+A approach that incorporates the 'continuum of care' across the life cycle of the mother and child from pre-pregnancy to childhood and adolescence, assuring that the care is available at each level i.e., at home, community and hospitals.
- The 'continuum of care' has become a means to reduce nearly half a million maternal deaths, four million neonatal deaths and six million child deaths across the world (Kerber K. J. et al., 2007). The Government of India has demonstrated its commitment and played a proactive leadership role through the national roll out of the RMNCH+A interventions.
- The RMNCH+A strategy is based on the provision of comprehensive care through the five pillars or thematic areas of reproductive, maternal, neonatal, child and adolescent health, and is guided by the central tenets of equity, universal care, entitlement and accountability. The 'plus' within the strategy focuses on: a) Including adolescence for the first time as a distinct life stage; b) Linking maternal and child health to reproductive health, family planning, adolescent health, HIV, gender, and preconception and prenatal diagnostic techniques; c) Linking home and community-based services to facility-based care and d) Ensuring linkages, referrals and counter-referrals between and among health facilities at the primary (PHC), secondary (CHC), and tertiary levels (district hospital).
- With increasing representation of women in the Panchayats, there is now a distinct opportunity to engage with women in communities, sensitise them and empower them to voice their concerns and push for decisions and facilities that will improve their health, children and by extension, the men in their villages.

Further Reading

http://www.mchip.net/sites/default/files/RMNCH+A per cent20in per cent20India.pdf
PowerPoint presentation: http://www.slideshare.net/knag3/rmncha-new-initiave-of-govt-of-india

Handouts

Handout 1 - 5 x 5 Matrix

5x5 Matrix for High impact RMNCH+A Interventions

To be implemented with High Coverage and High Quality

Reproductive Health	Maternal Health	Newborn Health	Child Health	Adolescent Health
• Focus on spacing methods, particularly PPIUCD at high case load facilities • Interval IUCD at sub centers on fixed days • Doorstep delivery of contraceptives by ASHA • Strengthening safe abortion services • Maintaining sterilization services	• Use MCTS to ensure early registration of pregnancy and provide full ANC • Detect high risk pregnancies and line list and manage severely anemic mothers • Equip delivery points with trained HR & other infrastructure • Review maternal, infant and child deaths for corrective actions • Notify sub-centers with less institutional delivery load, distribute Mesoprostol and incentivise ANMs for domiciliary deliveries	• Early initiation and exclusive breastfeeding • Home based newborn care through ASHA • Essential Newborn Care and resuscitation services at all delivery points • Equip Special Newborn Care Units with highly trained HR and other infrastructure • Empower ANM for community level use of Gentamycin	• Complementary feeding, IFA supplementation and focus on nutrition • Diarrhoea management at community level using ORS and Zinc • Management of pneumonia • Full immunisation coverage • Rashtriya Bal Swasthya Karyakram (RBSK): screening of children for 4D (birth defects, development delays, deficiencies and disease) and its management	• Community-based services through peer educators • Delay in age of marriage • Strengthen ARSH clinics • Weekly IFA Supplementation (WIFS) under national Iron Plus initiative • Promote menstrual hygiene

Health Systems

- Case load based deployment of HR at all levels
- Ambulances, drugs, diagnostics, reproductive health commodities
- Behavior change communication
- Supportive supervision and use of scorecards based on HMIS
- Public grievances redressal mechanism

Cross Cutting

- Equip nurses to provide specialised and quality care
- Address social determinants of health through convergence
- Introduce difficult area and performance based incentives
- Focus on un-served and underserved villages, urban slums and blocks
- Bring down out of pocket expenses

Policy Interventions

A. Adolescence

1. Adolescent nutrition; iron and folic acid supplementation
2. Facility-based adolescent reproductive and sexual health services (adolescent health clinics)
3. Information and counseling on adolescent sexual reproductive health and other health issues
4. Menstrual hygiene
5. Preventive health checkups

B. Pregnancy and Childbirth

1. Delivery of antenatal care package and tracking of high-risk pregnancies
2. Skilled obstetric care
3. Immediate essential newborn care and resuscitation
4. Emergency obstetric and new born care
5. Postpartum care for mother and newborn
6. Postpartum IUCD and sterilisation
7. Implementation of PC&PNDT Act

C. Newborn and Childcare

1. Home-based newborn care and prompt referral
2. Facility-based care of the sick newborn
3. Integrated management of common childhood illnesses (diarrhoea, pneumonia and malaria)
4. Child nutrition and essential micronutrients supplementation
5. Immunisation
6. Early detection and management of defects at birth, deficiencies, diseases and disability in children (0–18 years)

D. Through the Reproductive Years

1. Community-based promotion and delivery of contraceptives
2. Promotion of spacing methods (interval IUCD)
3. Sterilisation services (vasectomies and tubectomies)
4. Comprehensive abortion care (includes MTP Act)
5. Prevention and management of sexually transmitted and reproductive infections (STI/RTI)

Know Your Progress

Questions

1. What do you understand by 'continuum of care approach'? Why is it important?

2. What are some key interventions planned under RMNCH+A for adolescents? Why are adolescent girls an important group for health interventions?

3. List the health services included for newborn infants and child care under RMNCH+A.

Model Answers

1. The RMNCH+A approach essentially looks to address the major causes of mortality among women and children as well as the delays in accessing and utilising healthcare and services. The RMNCH+A strategic approach has been developed to provide 'continuum of care' to ensure equal focus on various life stages. Priority interventions for each thematic area have been included in this to ensure that the linkages between them are contextualised to the same and consecutive life stage.
There are two dimensions to healthcare:
(1) Stages of the life cycle
(2) Places where the care is provided
These together constitute the 'continuum of care' through the services and programmes provided from adolescence – pregnancy – birth – newborn/postnatal – childhood.

2. The health interventions for adolescents under RMNCH+A include:
   1. Adolescent nutrition; iron and folic acid supplementation
   2. Facility-based adolescent reproductive and sexual health services (Adolescent health clinics)
   3. Information and counseling on adolescent sexual reproductive health and other health issues
   4. Menstrual hygiene
   5. Preventive health checkups.

There are 243 million adolescents in our country and 70 per cent of our adolescents live in rural areas, scattered in more than 6,00,000 villages in remote areas across the country. Approximately 48 per cent of these are girls, and yet we continue to struggle with gender gaps in terms of female access to education, empowerment, agency and autonomy. Girls do not get educated beyond or even up to the elementary level; they do not have any control over decisions pertaining to marriage and, therefore, get married early. Parents and families decide their destiny, and after marriage, the husbands take over. These girls are unable to make independent decisions about their own reproductive choices or fertility. The health interventions will enable them to take better care of their health, make informed decisions about education and life and hopefully delay the age of marriage.

3. The services for newborns and children include continuum of care from the community to the facility level through the provision of home-based newborn and child care from ASHAs/ANMs; essential newborn care and resuscitation at all delivery points through established Newborn Care Corners; facility-based care for sick newborns through the Newborn Stabilisation Units (NBSU) and Special Newborn Care Units (SNCU); institutional care for sick children and the provision for management of severe acute malnourished children at the Nutrition Rehabilitation Centre (NRC) at district hospitals; Infant and Young Child Feeding (IYCF) services and nutrition counseling to support early and exclusive breastfeeding, complementary feeding and micro nutrient supplementation through health facilities and provision of universal immunisation.

Annexures

Annexure 1 - Evolution of Maternal and Child Health Programmes in India

a. At the time of independence, the primary focus of public health was on building-up the infrastructure i.e., hospitals and health centres, cadre of health staff and vertical disease control programmes. Over the years, maternal and child health was identified as a core priority area in the National Health Policy of 1983. Accordingly, indicators related to maternal and child health were defined and targets were identified to measure the country's progress in terms of those indicators.

b. Consequently, Reproductive and Child Health programme (RCH Phase 2) was launched in 1997 as a dedicated national programme incorporating elements of child health, maternal health, family planning, reproductive tract infections and adolescent health. The approach was mainly focused on meeting targets in terms of health service delivery and measuring of these targets.

c. RCH Phase 2 launched in 2005 is a step-forward with a more outcome-oriented approach than a target-based approach, with emphasis on ensuring quality through decentralisation, and monitoring and supervision. The concept of utilising trained health workers was also introduced during this phase. Auxiliary Nurse Midwives (ANMs), ASHA workers and AWWs are now the delivery channels for all the major maternal and child health programmes across the country. The health worker approach has not only helped ensure greater penetration in the community, but has also provided employment opportunities to thousands of women.

d. The RMNCHA approach adopted by the GoI in 2013 takes into account the 'life-cycle' approach to maternal and child health and links together all the various interventions designed for women, infants and adolescents.

Thus, the maternal and child health programme in India has shifted from a top-down approach, facility-based, clinical and doctor-centric, vertical programme approach to a decentralised, community-based, participatory and integrative approach. The focus has now broadened to ensure overall reproductive health for women and adolescents.

Annexure 2 – YouTube film on RMNCH+A: http://youtu.be/eUbCE9kkxSE

Annexure 3 - Information for Activity 2: Quiz on RMNCH+A

Prepare two sets of six cards on different stages of the life cycle that are covered by RMNCH+A interventions. Give one set to each team to shuffle and choose on their turn.
Refer to the information below for each stage of life cycle to supplement the answers given by the participants.

A) Pre-pregnancy – Use of Contraception

- The practice of contraception methods leads to a well-planned pregnancy that can result in better maternal and child health.
- It is essential to delay the first pregnancy through family planning and increase the interval

between births. It is well-established that the States with high contraceptive prevalence rate have lower maternal and infant mortalities (MoHFW, 2014). In Haryana, 30.4 per cent of women are not using any contraceptive methods, while in Kerala, this figure is much lower i.e., 19 per cent, which has resulted in better maternal and child health outcomes in Kerala (DLHS-4) - Maternal Mortality Rate reduced to 66 (SRS 2010-12); Infant Mortality Rate reduced to 12 (SRS 2013).

B) Pregnancy – Going for ANC Visits

Antenatal care: Antenatal care involves the provision of information to a pregnant mother on a healthy diet, regular health checkups and healthy practices. In Arunachal Pradesh, only 13.5 per cent of women had full antenatal care, while in Kerala, this percentage is much higher that is 70.3 per cent, which is one of the reasons for lower maternal and child mortality in Kerala (DLHS-4).

Iron pill intake during pregnancy: Estimates from the WHO report state that from 35 per cent to 75 per cent (56 per cent on average) of pregnant women in developing countries are anemic (Allen L H, 2000). Iron pills help in replenishing the required level of hemoglobin for the development of the fetus.

Neonatal tetanus protection: In 2013, Maternal and Neonatal Tetanus (MNT) caused 49,000 newborn deaths across the world (UNICEF, 2015). Tetanus toxoid vaccine prevents the maternal and neonatal deaths occurring due to MNT. India became free of maternal and neonatal tetanus on 15th May, 2015 (BMJ, 2015).

HIV counseling and HIV test during antenatal care: In 2013, the number of children newly infected with HIV in low and middle income countries were estimated to be 2,40,000 (WHO, 2014). HIV counseling and HIV test are important during pregnancy so as to prevent the transmission of HIV from mother to fetus.

C) Birth – Institutional Deliveries

- 2,89,000 women died during and following pregnancy and childbirth in 2013 (WHO, 2013). Women must be assisted at the time of birth by a health professional to avoid the complications at the time of delivery, which can lead to maternal and child death.

D) Postnatal (birth–45 days)– Regular Check-up with Qualified Health Professionals

- In India, 36.8 per cent of women undergo post-delivery complications (DLHS-3, 2007-08). Serious complications or even death can occur immediately after birth and during the first few weeks of life, and hence health checkups are important, especially within two days of delivery for both mothers and the newborn.
- It is recommended that all women and newborns receive care from a competent health provider at least once in the first two to three days, or immediately after birth and once again before the end of the six-week postnatal period (UNICEF, 2011-12).
- Breastfeeding should be initiated within the first hour after the birth.

E) Infancy (Birth–2 years) – Early and Exclusive Breastfeeding

Early exclusive breastfeeding provides vital antibodies that protect the newborn against diseases. Practicing exclusive breastfeeding for the first six months of a child's life and complementing that with soft foods after could prevent millions of Indian children from dying each year.

F) Childhood (3–6 years) – Immunisation

- India records five lakh child deaths annually due to vaccine preventable diseases. The national average for full coverage of immunisation of children in India is only 65 per cent (NFHS-3, IIPS).
- Pneumonia and diarrhoea continue to be the leading causes of death in under-five children, together claiming the lives of more than 1.5 million children in a year (UNICEF, 2014).
- Immunisation plays a key role in reducing child mortality. Vaccines against various life threatening diseases should be administered to children as per the immunisation schedule.

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Unit 2.2: Strategies to Reduce Maternal Mortality

Key Facts

- About one-third of all women in India are categorised as thin according to their Body Mass Index. i.e., they have lower weight than what is ideal for their age and height.
- More than 60 per cent of births occur within three years of the previous birth, thus making it evident that reversible birth spacing methods need to be stressed upon to increase birth spacing. Modern birth spacing methods form less than 10 per cent of all contraceptive use.
- Anaemia is a contributing cause of increased age-specific mortality among female adolescents. NFHS 3 has reported 60 per cent girls and 30 per cent boys in the age group 15-19 to be anaemic.

Source: *International Institute for Population Sciences (IIPS) and Macro International, 2007. National Family Health Survey (NFHS-3), 2005–06: India: Volume I. Mumbai: IIPS.*

Introduction

An estimated, 45,000 mothers die every year due to causes related to pregnancy, childbirth and the post-partum period in India (WHO et al., 2015). Maternal deaths occur most commonly due to the following medical causes: hemorrhage, hypertensive disorders, sepsis, unsafe abortions and obstructed labour. An estimated, 74 per cent of maternal deaths could be averted if all women had access to the interventions for preventing or treating pregnancy and birth complications, in particular, emergency obstetric care.

Low coverage of these life-saving preventive health interventions–stemming from weak or inaccessible health systems, poverty, gender and other inequalities, cultural barriers, social norms, attitudes and practices and lack of knowledge among key population groups contribute to maternal and newborn mortality and morbidity in India. Lack of family planning leading to suboptimal birth spacing and young maternal age at first pregnancy; lack of routine antenatal care or skilled attendance at delivery and poor postnatal follow up will result in avertable morbidity and death.

This unit aims to increase awareness in PRIs and healthcare providers about services available for maternal, child and adolescent health. While programmes to improve family health outcomes are available, the uptake of interventions remains low. PRIs and health care providers can play a key role by understanding the reasons for low utilisation and getting involved in the implementation and monitoring of these interventions. By engaging and involving women in these activities, participants can help improve the health of communities and villages.

Learning Objectives

Participants will be able to:

- Appreciate the importance of health information every pregnant woman and her family should have for optimal health of mother and child.
- Get an overview of the services under RMNCH+A programmes for maternal, adolescent and child health.
- Develop sensitivity regarding health and nutritional needs of adolescent girls to ensure optimal health outcomes of future mothers and children.
- Understand the role of Panchayat members and health workers in promoting health-seeking behaviours among their communities and strategise for improving the coverage and quality of these services.

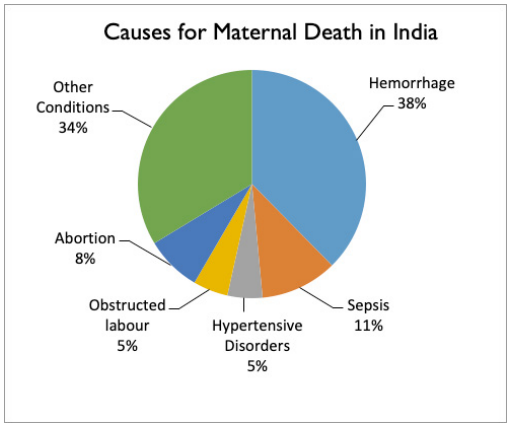
Session Plan

Time	Session	Content	Methodology	Resource Material
1 hr	A. Antenatal and Postnatal Care	• Priority ANC and PNC interventions • Local level experiences in universalising ANC and PNC care	• Group discussions • Question-answer sessions • Role play	• Chart papers/ flipcharts, marker pens and writing board, copies of handouts 1 and 2
1 hr	B. Family Planning	• Overview of family planning services offered through the RMNCH+A • Unmet need and other challenges • Strategies to increase uptake of family planning measures	• Group discussions • Role play	• Chart papers/ flipcharts, marker pens, copies of handouts
1 hr	C. Adolescent Health	• Statistics related to adolescent health issues in India • Overview of RMNCH+A interventions targeted at adolescents	• Discussion and information sharing	• Printed copies of handouts

Sub-Unit 2.2.1: Antenatal and Postnatal Care

Step 1

Share the following graphic with the participants. Discuss and compare the causes for maternal deaths in their local village/block to national causes. Link this discussion to social and cultural factors (discussed in detail in Block 1, Unit 1.2) that combined with limitations within the health system result in high rates of maternal mortality.



Source: *Source: Maternal Mortality in India, 1997-2003: Trends, Causes and Risk factors, Registrar General India, New Delhi , 2006.*

Step 2

Approximately 15 per cent of the pregnancies on an average are expected to develop serious complications resulting in unfavorable pregnancy outcomes. India has so far managed to reduce the Maternal Mortality Ratio to 178 deaths per 1,00,000 live births in 2013 (SRS, 2013).

The RMNCH+A approach has identified a set of priority interventions targeted at the crucial periods of pregnancy, delivery and immediate post-delivery. This section discusses the interventions targeted specifically towards pregnant mothers in the pre-pregnancy and immediate post-delivery phases. With the use of simple preventive measures, timely identification and quality care, these complications can be averted or managed easily (share Handout 1).

Step 3

Research evidence indicates that three or more antenatal check-ups seem to be a catalyst for several targeted behaviors, including institutional delivery, early breastfeeding, postnatal care within seven days of delivery, full immunisation of children aged 12-23 months and postpartum contraception for birth spacing, thereby providing windows of opportunity for providing counseling and advice which, in turn, trigger the adoption of several other healthy behaviours that have a direct bearing on maternal and child health (Khan ME et al., 2010).

Share some successful examples with the group-community celebrations of pregnant mothers such as applying haldi, gifting bangles and awarding certificates to access emergency services; cash rewards of certain schemes for institutional delivery such as JSY; special invites to pregnant and new mothers on Health and Nutrition Day to create awareness regarding nutrition requirements and foods.

Encourage ASHAs and ANMs from among the participants to share how they reach out to women who live in difficult-to-reach geographical areas, disadvantaged women who belong to Scheduled Castes/Tribes, or those belonging to economically weaker sections.

Encourage participants to share with the group any new or innovative methods they use in their offi- cial roles to encourage mothers to maintain contact with ASHAs/ANMs/other front line health workers for registering their pregnancy to regular checkups for seeking help during delivery.

Sub-Unit 2.2.2: Family Planning

Step 4

Discuss with the participants the importance of planning a family. Family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It also improves their income, family stability, mental health and happiness, as well as the well-being of their children.

A woman's ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy (WHO, JHU, 2007). Too early, frequent and repeated pregnancies along with unsafe abortions are major risk factors for maternal mortality, still-births, neo-natal mortality, low-birth weight babies and poor nutritional status of infants and young children. Family planning is acknowledged as a crucial strategy to improve maternal and

child health as well as to reduce mortality. Effective family planning programmes also contribute to population stabilisation, which in turn have a far-reaching impact on the overall health and development of the population.

The types of family planning measures offered under the national programme include:

- Spacing methods
  - Condoms
  - Intrauterine contraceptive device (IUCD Copper –T 380 A)
  - Oral contraceptive pills
- Limiting methods
  - Tubectomy (minilap and laparoscopic)
  - Vasectomy (NSV/conventional)
  - Emergency contraceptive pills
- Expanding contraceptive choices
  - New method : Postpartum IUCD
  - New device : Introduction of Cu IUCD 375

Ask the participants whether they are aware of any women/couples who use traditional contraception methods and how effective these methods are. Discuss periodic abstinence (fertility awareness) method, use of breastfeeding or lactational amenorrhoea method (LAM) and withdrawal method.

	Family Planning Method	Service Provider	Service Location
Spacing Method	• IUD 380 A/IUCD 375	Trained and Certified ANMs, LHVs, SNs and doctors	Sub centre & higher levels
	• Oral Contraceptive Pills (OCPs)		Village level Sub centre & higher levels
	• Condoms		
Limiting Methods	• Minilap	Trained & Certified MBBS doctors & Specialist doctors	PHC & higher levels
	• NSV: No Scalpel Vasetomy		
	• Laparoscopic Sterlisation	Trained & Specialist doctors (OBG & General Surgeons)	Usually CHC & higher levels PHC & higher levels
Emergency Contraception	• Emergency Contraceptive Pills (ECPs)	Trained ASHAs, ANMs, LHVs, SNs and doctors	Village level Sub centre & higher levels

Note: *Contraceptives like OCPs, Condoms are also provided through Social Marketing Organisation*

Step 5

There are many women whose needs to plan their families are unmet. In India, women traditionally do not have the knowledge and decision-making skills regarding reproductive health issues in general and adopting appropriate family planning methods in particular.

> *Unmet need is defined in two ways: Unmet need for limiting childbearing and unmet need for spacing childbearing. Unmet need for limiting childbearing is the proportion of currently married women who do not want any more children but are not using an effective form of family planning. Unmet need for spacing childbearing is the proportion of currently married women who want to postpone their next birth for two years or more, but are not using an effective family planning method.*

There are some significant family planning challenges in India (ICMR, CAMI, WHO, 2012). Only about half of all the eligible couples use some form of family planning method.

- It is estimated that if the current unmet need for family planning could be fulfilled over the next five years, 35,000 maternal deaths and 1.2 million infant deaths could be prevented.
- Women's sterilisation forms almost one third of all the contraception methods adopted in the country, whereas male sterilisation forms just about one per cent. This is in spite of the fact that male sterilisation is a much safer, quicker and an easily reversible method compared to female sterilisation.
- Abortions are often utilised as a birth control measure, highlighting the need for greater awareness and easier availability of birth spacing methods among the community. Only about half of all the abortions are conducted by trained professionals under safe conditions. Unsafe abortions are one of the risk factors for complications leading to chronic reproductive tract infections, infertility and maternal deaths.

Ask the participants about their role in helping communities, especially women and in planning their families. ASHAs, ANMs and nurses/medical officers at the Primary Health Centre or district hospital are routinely involved in identification of eligible couples and conducting awareness activities on family planning methods. ASHA workers usually serve as counselors and providers of contraceptives and follow-up with pregnant women to provide family planning advice. It is important that women are empowered with knowledge and have a basket of choices to make an informed decision about the family planning method best suited to them.

Activity 1: Inform the participants that they are going to enact a role play. The purpose is to provide an opportunity for participants to appreciate the importance of good interpersonal communication skills when counseling and helping a woman seeking an appropriate family planning method. It will also help them review their knowledge of modern methods of family planning. Ask for two volunteers to enact a role play and give them the following directions:

Role Play Situation

Volunteers are to perform the following roles in the role play: A skilled provider and a client seeking a family planning method.

The provider: The provider is an experienced clinician (doctor, nurse or ANM) at a district hospital, who has good communication skills.

The client: Kamla

Kamla has come to the health centre to get information about family planning methods. Kamla has a four year-old daughter and is currently pregnant. Her husband has agreed to her using a family planning method after this delivery, but he does not want to use condoms. She is nervous about the safety of the family planning method; she has heard that it can make it impossible to have more children.

Allow 10 minutes each for both the role play and discussion. (See Annexure 1 for details for the role play discussion).

Step 6

Discuss with the participants what strategies can be used to help improve uptake of family planning methods. Note their suggestions on a flip chart. Share some of the following essential strategies with them:

- Improving the coverage and quality of family planning services: Better counselling services in order that couples are able to make an informed choice, based on the options available to them.
- Greater emphasis on spacing methods: Particularly increasing the coverage of postpartum IUCD insertion.
- Effective behaviour change communication strategy to ensure couples and families are adequately sensitised about family planning and ensure awareness of available services
- Moving from a 'birth control' approach to a comprehensive 'reproductive health' and 'empowerment' approach in delivery of services at the field level by integration of all reproductive health services.
- Integrating family planning counselling and advice with routine immunisation visits as a part of a larger child health and reproductive health package.
- Promoting male participation and ownership: Dispelling myths about male sterilisation, encouraging men to discuss issues related to family planning within their families and with wives.
- Ensuring provision of family planning services to married adolescents.
- Culturally sensitive reproductive and family planning education programmes for adolescents and young adults
- Sensitising practitioners of Indian systems of medicines, local healers and traditional birth attendants about timely referral of patients with complications.

Sub-Unit 2.2.3: Adolescent Health

Step 7

Of the 243 million adolescents in this country, 70 per cent live in rural areas, scattered in more than 6,00,000 villages in remote areas across the country. Approximately 48 per cent of these are girls and continue to struggle with gender gaps in terms of female access to education, empowerment, agency and autonomy. Girls do not get educated beyond or even up to elementary level; they do not have any control over decisions pertaining to marriage and, therefore, get married early. Parents and families decide their destiny, and after marriage, the husbands take over. These girls are unable to make independent decisions about their own reproductive choices or fertility.

Adolescence is a phase of rapid physical, psychological and social transformation and is a crucial stage in the comprehensive life-cycle approach towards health. Health and nutritional needs of adolescent girls are particularly crucial since it has an inter-generational effect on the growth and development of the entire population e.g., under-weight adolescent girls are more likely to grow up into women of small stature and deficient in essential nutrients. These women are prone to various complications during pregnancy and child-birth. This also in-turn affects the survival and health of the new-born baby.

While adolescence is considered as a healthy period, more than 33 per cent of the disease burden and almost 60 per cent of premature deaths among adults can be associated with behaviours or conditions that began or occurred during adolescence. Some common health risks during adolescence include:

- Malnutrition and iron deficiency anaemia
- Early pregnancy and child birth
- Tobacco, alcohol and drug abuse
- HIV
- Mental health issues
- Violence, especially gender-based violence
- Menstrual disorders and HIV infections

Step 8

RMNCH+A: Priority Interventions Targeted at Adolescents

Briefly review the topics that as discussed in Unit 1 of this Block with the participants; one of the key pillars of the RMNCH+A strategy is to work with adolescents unlike in earlier RCH programmes. A majority of health issues are anchored in poor determinants of health that start in adolescence. For instance: early age of marriage, early childbearing, lack of access to contraception and lack of spacing. To address these very fundamental and critical issues which impact maternal and child health outcomes, RMNCH+A has certain key interventions targeted at adolescents under the Rashtriya Kishor Swasthya Karyakram, which was launched on 7th January, 2014.

The programme envisions enabling all adolescents in India to realise their full potential by

making informed and responsible decisions related to their health and well-being and by accessing the services and support they need to do so. The strategy acknowledges the importance of substantially broadening the narrow focus on sexual and reproductive health by bringing in life skills, nutrition, injuries and violence (including gender-based violence), non-communicable diseases, mental health and substance misuse-all critical for the holistic human development of a young adult. A key strength of this strategy is that it adopts a health promotion approach. It reaches out to adolescents in their own environment, such as schools and community and their influencers and caregivers.

Ask participants if they are aware of these programmes and provide a brief overview of the following programmes for adolescents (share Handout 2). Ask questions about their role in implementing these programmes and encourage them to share how they reach out to adolescents in their area of work. Some successful strategies to reach the students of this age group have been worked out with the help of teachers in high schools, working in tandem with the Ministry of Youth Affairs and Sports, through Nehru Yuvak Kendra Sanghathans and Youth Clubs, and involving peer educators.

Step 9

As a re-cap to the Block 2 and its sub-units, focus the attention of participants on the flip chart on challenges women face in accessing health services (prepared in sub-unit 1 on Continuum of Care approach. Brain storm with the participants about their role in creating awareness, implementing and ensuring the uptake of the health programmes and services discussed in the sub-units keeping the noted challenges in mind. Provide them with the following guidelines to allow for a structured discussion. Ask for a volunteer to note down all the suggestions on a flip chart. Allow 10 minutes for this discussion.

- Developing capacities of women, families and communities to stay healthy, make healthy decisions and respond to obstetric and neonatal emergencies.
- Increasing awareness of women, families and communities of their sexual and reproductive rights and of the need for family planning.
- Improving quality of care, health services and health provider interactions with women, men, families and communities.

Summing Up

- Maternal deaths occur most commonly due to the following medical causes: haemorrhage, hypertensive disorders, sepsis, unsafe abortions and obstructed labour. The RMNCH+A has identified a set of priority interventions targeted at the crucial periods of pregnancy, delivery and immediate post-delivery. Under National Health Mission, as per RMNCH+A, antenatal care includes minimum of at least four ANCs including early registration and the first ANC in the first trimester along with physical and abdominal examinations, hemoglobin estimation and urine investigation, two doses of T.T. immunisation and consumption of IFA tablets (six months during ANC and six months during PNC). Postnatal care to be provided within first

24 hours of delivery and subsequent home visits on 3rd, 7th and 42nd day for identification and management of emergencies occurring during postnatal period.

- A woman's ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy. In India, women traditionally do not have appropriate knowledge and decision-making skills regarding reproductive health issues in general and adopting appropriate family planning methods in particular. Abortions are often utilised as a birth control measure, highlighting the need for greater awareness and easier availability of birth spacing methods among the community. Improving the coverage and quality of family planning services by better counselling services is imperative for couples to make an informed choice, based on the family planning options available to them.
- Adolescence is a phase of rapid growth and development. Gender disparities place adolescent girls at a high risk of early age of marriage, early childbearing, lack of access to contraception and lack of spacing. To address these very fundamental and critical issues which impact maternal and child health outcomes, RMNCH+A has certain key interventions targeted at adolescents aimed to improve their nutritional status, and sexual and reproductive health.

Suggested Readings

http://nrhm.gov.in/communitisation/asha/resources/asha-training-modules.html ASHA Module 6: Skills that Save Lives, Focus on Maternal and Newborn Health, NRHM.

Published by: Department of Health and Family Welfare, Ministry of Health and Family Welfare Government of India. Web: www.mohfw.nic.in

http://medind.nic.in/jah/t10/s1/jaht10s1p9.pdf

Impact of JananiSurakshaYojana on selected family health behaviors in rural Uttar Pradesh - M. E. Khan, AvishekHazra and IshaBhatnagar.

IEC Material

http://nrhm.gov.in/nrhm-components/rmnch-a/maternal-health/iec-material.html

Maternal Health - IEC eWarehousewww.unicefiec.org/category/index/ maternal-health

Handouts

Handout 1: RMNCH+A Interventions Targeted at Pre-Pregnancy and Post-Delivery Phases

1. (three months before and after conception) is essential for ensuring a healthy foetal growth and development.
2. **Ante-natal care package and tracking of high risk pregnancies**
   - Easy access to Nishchay pregnancy detection kits for all women in reproductive age-group to ensure timely detection of pregnancies
   - Mother and child tracking system
   - Birth preparedness i.e., discussions with the mother/family members about nearest delivery points and free transport facilities.
3. **Skilled obstetric care and essential newborn care**
   - Operationalising delivery points with skilled human resources and all necessary logistics being made available.
   - Increasing demand for skilled obstetric care: Promoting utilisation of the Janani Suraksha Yojana (JSY), promoting hospital stay for at least 48 hours after delivery along with dedicated counselling on adoption of family planning methods and new- born care practices including breastfeeding and immunisation (share Handout 1 on JSY).
   - Service guarantee and reducing the financial burden: Promoting utilisation of the Janani Shishu Suraksha Karyakram (JSSK) that entitles all pregnant women delivering in public health institutions to absolutely free and no expense deliveries, including caesarean sections. Similar entitlements are in place for all sick newborn (first 30 days of life) accessing public health institutions for treatment. Free assured transport (ambulance service) from home to health facility, inter-facility transfer in case of referral and drop back is an entitlement under JSSK.
   - Ensuring connectivity in hard-to-reach areas through innovative means of transport.
   - Operational Newborn Care Corners at delivery points: Providers trained in basic newborn care and resuscitation through Navjaat Shishu Suraksha Karyakram (NSSK).
4. **Emergency obstetric and new-born care**
   - Close referral linkages between the community, sub-centres and PHCs designated as delivery points up to the level of the district hospital.
   - Under NRHM, dedicated 'Maternal and Child Health (MCH)' wings are being established at high case load facilities in order to expand the health infrastructure for maternal and newborn care, and thus overcome the constraints of limited numbers of beds at health facilities.
5. **Postpartum care for mother and baby**
   - Forty-eight hours of stay at the health facility is mandated in case of institutional delivery.
   - In case of home delivery, the first visit takes place within twenty four hours of birth. In all other cases, at least three postnatal visits to the mother and six postnatal visits to the newborn are to be made within six weeks of delivery/birth.
6. Postpartum IUCD insertion along with counselling on **family planning** and child care.

7. Preventing sex determination and selective abortion through **implementation of the PCPNDT Act.**
8. **Nutritional interventions for women**

- Under-weight and anaemic women are more prone to life-threatening complications like bleeding and seizures during pregnancy and immediate post-pregnancy period. Children born to underweight women are also more likely to have low-birth weight and a higher risk of infections during infancy and childhood.

Almost 60 per cent of women in India suffer from iron deficiency anaemia. To address this, universal implementation of the following nutrition interventions is required, which forms the core of the ANC package:

- Supplementary nutrition to pregnant and lactating mothers through Anganwadi centres
- Iron folic acid tablets provided as a part of the ANC package
- Weight monitoring, dietary advice and counselling on diet-related myths

Handout 2: RMNCH+A: Priority Interventions Targeted at Adolescents

Adolescent Nutrition

Weekly iron and folic acid supplementation: The weekly iron and folic acid supplementation (WIFS) scheme is a community-based intervention that addresses nutritional (iron deficiency) anaemia amongst adolescents (boys and girls) in both rural and urban areas. It aims to cover adolescents enrolled in class VI–XII of government, government-aided and municipal schools as well as 'out of school' girls.

Supplementary nutrition and overall empowerment schemes: The Sabla scheme includes provision of food supplements through the Ministry of Women and Child Development. The key services offered under Sabla include:
nutrition provision

- Iron and Folic Acid (IFA) supplementation
- Health check-up and referral services
- Nutrition and Health Education (NHE)
- Counselling/Guidance on family welfare, ARSH, child care practices and
- Home management
- Life skill education and accessing public services
- Vocational training for girls aged 16 years and above under the National Skill Development programme (NSDP)

Nutrition Education: Nutrition education sessions are held at the community level using existing platforms like VHND, Kishori Diwas, school setting, anganwadi centres and Nehru Yuva Kendra Sangathan (NYKS). Nutritional counselling on a dedicated quarterly Adolescent Health Day (to coincide with Kishori Diwas in Sabla districts) is also proposed. To make deeper inroads, nutrition education is to be included in the school curriculum, establishing working linkages with 'Sakshar Bharat' Abhiyan.

Facility-based Adolescent Reproductive and Sexual Health Services (Adolescent Health Clinics)

Objective: Ensuring access to reproductive and sexual health information and services, including access to contraceptives and safe abortion services, delivered in an adolescent-friendly environment.

- Implementing community-based intervention and demand generation initiatives linked to facility-based services across all levels of the health system e.g., at sub-centres, PHC, district hospital, etc.
- Dedicated counsellor available on all days at higher-level facilities (CHC onwards)
- Establishing linkages with Integrated Counselling and Testing Centres (ICTCs) and making appropriate referrals for HIV testing and RTI/STI management

Information and Counseling on Adolescent Sexual Reproductive Health and Other Health Issues

- Provision of life skills like education through schools and community settings.
- Promoting favourable attitudes against gender-based violence, awareness and skills to challenge gender stereotypes, discrimination and violence.
- Imparting skills to counter experimentation with addictions and establishing linkages to de-addiction centres.
- Encourage physical activity and healthy dietary practices.
- Encouraging a healthy sense of self esteem, healthy relationships and the ability to deal with stress and conflicts positively.
- The community settings for informing adolescents are the Adolescent Health Day, 'Kishori Samooh' under the Sabla scheme (Ministry of Women and Child Development) and Teen Clubs (NYKS under the Ministry of Sports & Youth Affairs).
- Training peer counsellors and field functionaries for increasing coverage of counselling and life skills education.
- Targeted messaging to prevent early marriages, adolescent pregnancies and unsafe abortions.

Menstrual Hygiene

- Promotion of better health and hygiene among adolescent girls (aged 10 to 19 yrs) in rural areas by ensuring that they have adequate knowledge and information about the use of sanitary napkins.
- Dispelling harmful cultural beliefs and practices related to menstruation prevalent among the community.
- Provision of sanitary napkins by ASHAs under NRHM's brand 'Free days'.

Preventive Health Check-ups as a Part of the School Health Programme

- Bi-annual complete health screening is conducted within all government and government-aided schools by dedicated school health teams. The aim is early identification of diseases, nutritional deficiencies, birth defects and deformities.
- The students identified in need of medical care are provided free-of-cost referral services at government hospitals and dispensaries.
- The school health screening sessions are also an important platform to engage with adolescents for health and nutrition education.

Handout 3: Janani Suraksha Yojana (JSY)

Janani Suraksha Yojana aims to decrease the neo-natal and maternal deaths occurring in the country by promoting institutional deliveries. This is a safe motherhood intervention under the National Health Mission. It is a 100 per cent Centrally Sponsored Scheme. It integrates cash assistance with delivery and post-delivery care.

Features of JSY

Janani Suraksha Yojana was launched on April 12, 2005 by modifying the National Maternity Benefit Scheme (NMBS). The JSY has identified an Accredited Social Health Activist (ASHA) as a link between the government and the poor pregnant women to encourage institutional deliveries among the poor women.

In this scheme, the States where there is a low rate of institutional deliveries are classified as 'Low Performing States (LPS)' (the States of Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Odisha and Jammu and Kashmir), whereas the remaining States are termed as High Performing States (HPS).

Role of Health Workers

For the effective implementation and monitoring of the scheme, monthly meeting of all ASHAs/ health workers working under an ANM should be held by the ANM, on a specified day of every month, at any anganwadi centre falling under the ANM's area of jurisdiction. Monthly reports and annual reports also need to be submitted to the department in a format provided by the government for effective monitoring.

Impact

Implementation of JSY has shown phenomenal progress in the States, with the number of women benefiting from it increasing considerably over the years. This has been attributed to an increase in mass awareness and also by making the procedures simple. Many state governments have ordered all payments to be made in one installment before discharge from the health care institutions after delivery. This facility can be availed on producing any document that proves the income status or caste in case of SCs/STs.

Know Your Progress

Questions

1. To calculate the Expected Date of Delivery (EDD), finding out the date of first day of her last missed period (LMP) is not essential. Is the statement correct?
2. Name five complications that women can develop after childbirth. What are the actions a health worker – ASHA or ANM can take?
3. Describe the key nutritional interventions targeted at adolescents under the RMNCH+A initiative.

Model Answers

1. Incorrect. To calculate the Expected Date of Delivery (EDD), finding out the date of first day of her last missed period (LMP) is essential.

2. Some women can develop complications after childbirth. The symptoms of these major complications are:

    1. Excessive bleeding: Ask the mother if the bleeding is heavy. Often this is quite obvious, but sometimes it may be difficult to judge. If the woman is using more than five pads a day or more than one thick cloth in a day, she is having heavy bleeding. The ASHA should immediately refer her to an institution which manages complications and should also ask the mother to begin breastfeeding immediately, which will help reduce the bleeding. Referral is most urgent. The delay of even a few minutes can make a difference.
    2. Puerperal sepsis (infections): Ask if the discharge is foul-smelling. If the answer is yes, then suspect infection. Fever, chills and pain in the abdomen along with the foul smell make infections even more likely. The ASHA should take the temperature to confirm fever. Referral is required since the mother needs antibiotics. Referral on the same day is advisable.
    3. Convulsions with or without swelling of face and hands, severe headache and blurred vision: Such patients need immediate referral. If an ANM is available within 15 minutes, she can stabilise the patient before referral.
    4. Anaemia: The ASHA should check if the mother is pale and enable the mother to get her blood Hb status checked (for management of anaemia in the postpartum period).

5. Breast engorgement and infection
6. Perineal swelling and infection: If the mother has a small tear at the opening of her vagina (or has had stitches during the delivery), she should keep the area clean. She can apply a cloth dipped in hot water, twice a day and hold it to her genitals. This will give her relief and help the healing. If there is fever, she should be referred to the PHC or CHC. A tablet of paracetamol would help both the pain and the fever.
7. Postpartum mood changes: Some women may suffer from mood changes after delivery. They need counselling and family support. The changes usually disappear after a week or so. If the changes become severe then referral is required.

3. Some key nutritional interventions for adolescents under RMNCH+A include:
   a. The WIFS scheme is a community-based intervention that addresses nutritional (iron deficiency) anaemia amongst adolescents (boys and girls) in both rural and urban areas. It aims to cover adolescents enrolled in class VI–XII of government, government-aided and municipal schools as well as 'out-of-school' girls.
   b. Supplementary nutrition and overall empowerment schemes: The Sabla scheme includes provision of food supplements through the Ministry of Women and Child Development.
   c. Nutrition education sessions are held at the community level using existing platforms like VHND, Kishori Diwas, school setting, anaganwadi centres and NYKS.

Bi-annual complete health screening is conducted within all government and government-aided schools by dedicated school health teams. The aim is early identification of diseases, nutritional deficiencies, birth defects and deformities. The students identified in need of medical care are provided free-of-cost referral services at government hospitals and dispensaries. These screening sessions are also an important platform to engage with adolescents for health and nutrition education.

Annexures

Annexure 1: Focus of the Role Play on Provider and Client Seeking Family Planning Advice

The focus of the role play is the interaction between the provider and Kamla. The provider should ask Kamla's purpose for visiting the health centre. She should provide Kamla with information about each of the available methods and assess the appropriateness of each of the methods for Kamla. The provider should provide Kamla with emotional support and reassurance. Kamla should continue to express her fears and concerns until the provider has provided her with enough information and reassurance to decide what method she would like to try. The emphasis is on skills that the provider uses to empower the woman with information and facilitate her decision-making.

Use the following questions to facilitate discussion after the role play:

The steps for Counseling:
G-Greet
A-Ask
T-Tell
H-Hear
E-Explain
R-Return visit

Clients have the right to:
Information
Access to services
Informed choice
Safe services
Privacy and confidentiality

How did the provider approach Kamla? Did the provider give Kamla all the information that she needed to make the best decision for herself? How did Kamla respond to the provider?

What did the provider do to demonstrate emotional support and informed decision-making during her interaction with Kamla? Were the provider's explanations and reassurance effective? What could the provider do to improve her interaction with a client?

Answers

The following answers can be used to guide the class discussion after the role play. Although these are 'likely' answers, other answers provided by the learners during the discussion may be equally acceptable.

- The provider should introduce herself and address Kamla by name. She should speak in a calm and reassuring manner, using terminology that Kamla will easily understand.
- Sufficient information should be provided about each of the family planning methods available.
- The provider should listen and express understanding and acceptance of Kamla's feelings about family planning. She should address each of Kamla's questions with respect, ensuring that Kamla fully understands the family planning methods available to her.
- Non-verbal behaviours such as touching or squeesing Kamla's hand or a look of concern may

be enormously helpful in providing emotional support and reassurance for Kamla. Kamla's responses and non-verbal expressions will tell if the provider's explanation and reassurance was effective or not.

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Unit 2. 3: Strategies to Reduce Infant and Under-five Mortality

Key Facts

- Of all the children born in India, 21.5 per cent children were born with less than 2.5 kg weight
- Only 24.5 percent children are breastfed within one hour of birth
- Anaemia is prevalent among 69.5 percent children under five years

Source: *International Institute for Population Sciences (IIPS) and Macro International, 2007. National Family Health Survey (NFHS-3), 2005–06: India: Volume I. Mumbai: IIPS.*

Introduction

Under nutrition is a hazard for children's survival, health, growth and development, and slows down a nation's progress towards development. Children who are undernourished, not properly breastfed or suffering from micronutrient deficiencies have substantially lower chances of survival than children who are well nourished. In India, 20 per cent of children less than five years of age suffer from wasting due to acute under nutrition (NFHS-3, IIPS, 2007).It is therefore important to understand the underlying causes, address the issues and overcome the problem through proper nutritional interventions at the young age.

The various multidimensional causes for malnutrition among children under five years include food insecurity, illiteracy among mothers and families, poor access to health services and drinking water, and gender inequality. A number of other aspects like economic, social, environmental, geographical, agricultural and cultural factors have contributive effects resulting in malnutrition. Strong social and cultural beliefs prevailing in India remain as the crucial factors leading to child malnutrition (discussed in Block 1, Unit 2). Religious norms place restrictions on consumption of various foods such as dairy products and eggs. Gender discrimination is widely rampant and preference given to the male child over the female child is visible in access to food within households and health care services among others.

The Government of India has various awareness campaigns and intervention programmes such as Integrated Child Development Scheme, JSY, Indira Gandhi Mtritatva Sahyog Yojna, NSSK and RMNCH+A to improve maternal and child health, but there has been limited progress in reducing the Infant Mortality Rate.

As health service provision is an integral part of PRIs, health workers and officials, this unit aims to increase their knowledge of governmental and other programmes on nutritional interventions for young children. It also aims to develop awareness about social issues that need to be questioned to bring about a change in attitude and practices among families and communities.

Learning Objectives

Participants will be able to:

- Understand the significance of preventing malnutrition and childhood diseases to prevent under-five mortality among children
- Get an overview of the services under RMNCH+A and other government programmes for newborns and child health
- Understand the role of Panchayat members and health workers in creating awareness and promoting Infant and Young Child Feeding (IYCF) practices among families and communities

Session Plan

Time	Session	Content	Methodology	Resource Material
1 hr	A. Essential RMNCH+A Interventions (0-5 years age group)	• Overview of the essential RMNCH+A interventions targeted at reducing infant and under-five child mortality • Assessment of local level issues, implementation issues and challenges	• Quiz • Group discussions	• Board, chalks, notepads and pens for the participants, charts on food groups, nutrients and sources of nutrients for display
1 hr	B. Infant and Young Child Feeding (IYCF) Practices	• Overview of key IYCF recommendations and practices • Strategies to promote optimal IYCF behaviour among the community	• Quiz • Group work	• Chart papers/ flipcharts, marker pens, copies of handouts

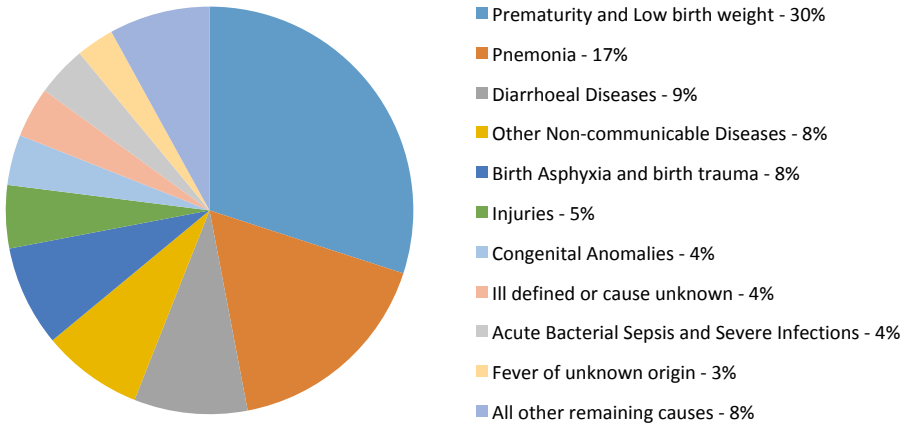
Step 1

Share the following graphic with the participants. Briefly discuss and review the main causes of mortality of children under five years. Ask participants to share data on the number and reasons for death among children under five years of age in their local village/block. Share the following statistics:

- Pneumonia (18.2 per cent) and diarrhoea (17.9 per cent) are the two leading causes of death in children aged 1-4 years in India (Sample Registration System, 2013).
- Under-five child mortality has declined from 109 in 1992-93 (NFHS-1) to 74 in 2005-06 (NFHS-3).

Health outcomes are deeply influenced by not just biological factors, but also by the social, economic and cultural environment. Explain that these complex factors combine to influence health outcomes. Briefly review factors such as feeding and health-related beliefs possessed by the family and the community that influence diet and management of diseases. These have been discussed in detail in Block 1, Unit 2 on Social and Cultural Determinants of Maternal, Child and Adolescent Health, and Immunisation.

Causes of Under-five Child Deaths



Source: *Causes of death statistics 2010-2013,Sample Registration System, Office of Registrar General, India.*

Sub-unit 2.3.1: RMNCH+A: Strategies Targeted at the 0-5 Year Age Group

Step 2

The RMNCH+A approach has identified a set of priority interventions targeted at the crucial period of 0-5 years in a child's life. By focusing on certain thrust areas for newborn, neonate and child health, and following simple preventive measures, timely identification and quality care, and the number of deaths among children under five years can be easily averted. These are:

1. Immediate routine newborn care and care of sick newborns
2. Child nutrition including essential micro-nutrient supplementation
3. Immunisation against common childhood diseases
4. Management of common neonatal and childhood illnesses

Share Handout 1 and ask for volunteers to read out and share information on the key services offered under RMNCH+A with the larger group. Encourage participants to add any details about these programmes.

Step 3

Spend 10-15 minutes on discussing with the participants the status of the above mentioned services in their locality. The following questions will facilitate information sharing:

- Which of the above mentioned programmes are available in their village/block/district?
- How many women and families access these services?
- Do they know of women going to Nutritional Rehabilitation Centres (NRCs) or Newborn Care Units? Ask the ASHA and ANM participants as to how they facilitate it?
- Are they aware of any challenges or problems faced by women in availing services offered

under these programmes?

- What are the main reasons women and newborns do not receive the care they need (financial, lack of transport, lack of caregivers, mother not empowered to make decisions)?
- What are the prevailing beliefs and attitudes associated with prenatal, labour/delivery, and postnatal care for women and newborns?
- Check how many of the participants are a part of the Village Health Sanitation Committee (VHSC) or Health Committee in their area and how they have helped children with malnutrition. Encourage them to share experiences if they have been involved in organising any local events for health planning or formed groups with volunteers from their village for community monitoring of health programmes (to conduct activities such as maintaining registers of births and deaths, organising health melas/screening camps, monitoring performance of local health facilities through Jan Samvads, etc.).

Note the issues mentioned by the participants on a flip chart and pin them up in a prominent place in the room. Inform the participants that these will be discussed later during the next activity.

Sub-unit 2.3.2 Infant and Young Child Feeding Practices (IYCF)

Step 4

National guidelines on IYCF have been adopted and endorsed by the Ministry of Women and Child Development, Ministry of Health and Family Welfare, Ministry of Human Resource and the Indian Academy of Pediatrics. Of all proven preventive health and nutrition interventions, IYCF practices have the single greatest potential impact on child survival. Yet the status of IYCF is very low in our country.

Status of IYCF Practices

Only 25 per cent of new-borns are breastfed within the recommended one hour

Only 65 per cent of infants in India are exclusively breastfed

Only half of all the children aged 6-8 months receive solid, semi-solid or soft complementary foods i.e., the energy and nutrient requirements of more than 50 per cent of these children not being met.

Less than 20 per cent of all children between 6-23 months of age receive the minimum required diet diversity i.e., more than 80 per cent of children in this crucial age group are not being fed the different types of foods required to meet their nutrition needs.

(Source: India Health Report on Nutrition, 2015)

Activity 1

Divide the participants into two groups for a quiz. Each team needs to select a spokesperson to answer on behalf of the team. The team will get two minutes to come-up with the answer, failing which the other team will answer the question and score. A correct and complete answer will be allotted five points (see Annexure 1 for questions and correct answers).

Step 5

Distribute Handout 1 to the participants. Ask a volunteer to read it to the participants. Discuss and check whether they are sharing the essential information with parents of new born babies during the course of their work.

Activity 2: Small Group Work

Current IYCF patterns indicate that lack in practicing some key behaviors among women and communities leads to nutritional deficits and increased infections leading to growth failure, stunting, anaemia and increased neonatal, infant and child morbidity and mortality. Four behaviour patterns that present challenges at the community level include:

1. Timely initiation of breastfeeding immediately after birth and no pre-post lacteal foods
2. Exclusive breastfeeding through six months of age
3. Age-appropriate complementary feeding (quantity, quality, diversified foods and responsive feeding) from 6-24 months
4. Hand washing thoroughly with soap before preparing foods and feeding children aged 6-24 months.

Draw their attention to the flip chart prepared during Step 3 to review the challenges and barriers commonly faced by women and the community in practicing these behaviour patterns and accessing related health services.

Ask them to work in four groups to strategise how to overcome the main barriers for adoption of these four key behaviour patterns from a woman's perspective. They need to come-up with a list of target audience at whom to direct information (convince, gain support from), optimal behaviours that will contribute to the health of the new born baby and a brief description of key messages. Allow them 15 minutes to complete this exercise. Each team can jot down their answers in the format provided below:

Who (Audience)	Action	Message

Distribute Handout 2 to the participants to use as reference material to complete this exercise. List of strategies for community sensitisation and support on IYCF practices:

- Greater focus on IYCF counseling and integration across the RMNCH+A continuum of care in a timely and sustained manner e.g., during ANC and PNC home visits, at delivery points, immunisation days, World Breastfeeding Week (Aug 1-7 every year), National Nutrition Week (September 1-7 every year), VHNDs, etc.
- Improved quality of counseling through:
  - Context-based, age-appropriate and culturally acceptable style of counseling
  - Utilising attractive IEC tools e.g., Mother and Child Protection Cards

  - Highlighting success stories of IYCF from within the communities (mothers who have successfully managed to practice healthy IYCF behaviours)
- Advanced training for field-level functionaries on practical ways to act as lactation consultants.
- Clearly defining key messages for different target groups:
  - Sensitising husbands and families on the need to support mothers
  - Sensitising PRI members on the importance of IYCF through VHSC meetings, Gram Sabha meetings, etc.
- Creating a network of NGOs working on IYCF counseling and ensuring adequate capacity building to ensure uniform dissemination of key messages.
- Utilising the opportunities offered by conditional cash transfer schemes e.g., IGMSY, to further promote adoption of optimal IYCF practices.

Summing Up

- In India, under-nutrition levels remain persistently and unacceptably high, especially in utero and during the first five years of life, among adolescent girls and women across the life cycle.
- The RMNCH+A programmes focus on certain thrust areas for newborn, neonate and child
- health, and simple preventive measures, timely identification and quality care to overcome this challenge of under-nutrition and mortality among children under five years are highlighted.
- Optimal infant and young child feeding includes exclusive breastfeeding for the first six months after birth, followed by continued breastfeeding with adequate complementary foods for up to two years and beyond. Ensuring adequate nutrition in the first two years of life is extremely important to prevent child mortality, ensure resistance against all the life-threatening infections and ensure long-term mental and physical growth and development .

Handouts

Handout 1: RMNCH+A Programmes Targeted at 0-5 years' Age Group Home-Based Newborn Care (HBNC) and Prompt Referral

- HBNC is an effective strategy which helps prevent and address any complications among
- newborns delivered at home or once the mother and baby are discharged from the hospital often before the stipulated 48 hours.
- As a part of the HBNC package, the ASHA worker performs a series of home visits on day 3, 7, 14, 21, 28 and 42. An additional visit on the day of delivery is made in case of home deliveries.
- HBNC aims at provision of the following services:
  - Essential newborn care and prevention of complications
  - Facilitate referral linkages with Special Newborn Care Units (SNCUs) and Newborn Stabilisation Units (NBSUs)
  - Early detection and special care of pre-term and low-birth weight newborns
  - Early identification of illness in the new-born and provision of appropriate care and referral
  - Support the family for adoption of healthy practices and build confidence and skills of the mother to safeguard her health and that of the newborn

Facility-Based Care of the Sick Newborn

- Special Newborn Care Units have been established at district and tertiary hospitals, in about half of all the districts in the country, for the care of sick, pre-mature and low-birth weight newborns.
- The NBSUs are smaller units, at the Community Health Centres, for providing basic levels of medical care for newborns.
- As part of the JSSK, newborns aged up to 30 days are provided free-of-charge services including diagnostics, drugs and other treatments. Free emergency referral transportation services are also to be provided between home/community to the health facilities.
- After discharge from the facility, the newborns are followed up and counseling services are provided by ASHA workers under the HBNC package.
-

Child Nutrition and Essential Micro-Nutrients Supplementation

- Adherence to proper IYCF practices is of paramount importance in ensuring child survival and health.
- Details of the IYCF practices are covered in detail under Sub-unit 2.
- The RMNCH+A strategy envisions utilising various opportunities of contact with mothers and babies, for disseminating and reinforcing the key messages around age appropriate feeding, growth monitoring and promotion.
- Line listing of babies with low birth weight by ANMs and ASHAs, and adequate counseling for appropriate feeding and care precaution is especially crucial.
- Almost 70 per cent of children between six months and five years of age suffer from iron deficiency anemia. The National Iron Plus Initiative mandates provision of bi-weekly iron and folic acid supplementation for children between six months to five years of age to be delivered by the ASHAs. In order to address the problem of intestinal infections, which are an important contributory factor for poor nutrition, bi-annual de-worming programme is also carried out.
- Coupled with the bi-annual de-worming, Vitamin A supplementation is also provided to children between nine months to five years of age.
- Nutritional Rehabilitation Centres (NRCs) have been established in selected districts at the district hospitals to provide medical care and nutritional support to children suffering from severe acute malnutrition.

Integrated Management of Neonatal and Childhood Illnesses (Pneumonia, Diarrhoea, Malaria and Malnutrition)

- IMNCI is a strategy to ensure an integrated delivery of a package of services to simultaneously prevent, identify and manage the cases of common childhood illnesses among the community.
- The strategy defines an operational plan for the health workers to follow while screening children for any illnesses, referring them to the appropriate centre and counseling of parents for prevention, and home-based management of common childhood illnesses.

- Services offered under IMNCI for children between 0-2 months are:
  - keeping the child warm
  - Initiation of breast feeding
  - Counseling for exclusive breastfeeding
  - Cord, skin and eye care
  - Recognition of illness in newborn, and management and referral
  - Immunisation

- Services for children between two months to five years:
  - Management of diarrhoea, ARI, malaria, measles, acute ear infection, malnutrition and anemia
  - Recognition of illness and risk
  - Prevention and management of iron and vitamin A deficiencies
  - Counseling on feeding for all children below two years
  - Counseling on feeding of malnourished children
  - Immunisation

Immunisation

(Inform the participants that this topic will be discussed in detail under unit - 4)

Rashtriya Bal Swasthya Karyakram

- The aim of the programme is to expand focus from child survival to a more comprehensive approach of improving child development and overall quality of life. The programme covers all children in the age group of 0 to 18 years.
- The objective is to detect medical conditions at an early stage, thus enabling early intervention and management.
- Delivery of services:
  - Birth to 48 hours: Through medical officers, nurses and ANMs
  - 48 hours to 6 weeks: Through the HBNC package
  - 6 weeks to 6 years: By mobile health teams at anganwadi centres
  - 6 years to 18 years: At government and government-aided schools.
- Children identified in need of further diagnosis or medical treatment will be referred to Early Intervention Centres established at tertiary level hospitals and other public health facilities.
-

Handout 2: To Download

a. Refer to pages 18-23 of the following document to guide the group work: http://www.unicef.org/bangladesh/IYCF_Plan_Document_06-12-2010.pdf

b. Brief notes are provided in Annexure 1 for each of IYCF behaviours to help you instruct and initiate work among groups.

Know Your Progress

Note: This includes the quiz and group work conducted during this unit.

Annexures

Annexure 1: Quiz

1. When should breastfeeding be initiated? What is colostrum and how does it help the baby?

(As early as possible after birth, preferably within one hour. Colostrum is thick milk that is colorless or yellowish. Colostrum helps protect the child from diseases, as it aids in the development of the newborn's immune system and is rich in several essential vitamins and antibodies. It has a cathartic effect through which it prompts the excretion of excess bilirubin from the newborn and decreases the chances of jaundice).

2. What do you understand by exclusive breastfeeding?

Only breastfeeding or breast milk feeding and no other foods or fluids - no water, juices, tea, pre -lacteal feeds, with the exception of drops or syrups consisting of micro nutrition supplements or medicines in compromised/diseased babies.

3. What do you understand by complementary feeding?

Complementary feeding is giving suitable foods in addition to breast milk to babies around six months of age. These foods should complement, but not replace breast milk. These foods can be liquids like dal water or vegetable soups or semi-solids like suji kheer, rice kheer, khichdi, daliya, or mashed fruits.

4. Should a mother continue to breast feed if she is suffering from an infection or is ill?

If the mother has an infection, the baby, like any other family member, would normally contract the infection through close contact with the mother. Only while breastfeeding, it is unlikely to pass the infection, instead will pass antibodies to the baby that will help the baby fight the infection and get better faster. That being said, breastfeeding should not be stopped if the mother has an infection. However, there are certain infections, like HIV, TB, human T-cell lymphotropic virus type I or II, and untreated brucellosis, which can be dangerous for the newborn, and breastfeeding should be stopped when such infections are present.

5. How many times a day should a baby be fed?

A baby should be fed on demand with at least more than 8 feeds in 24 hours. Initially the demands are very frequent but by 1-2 weeks the frequency decreases. The baby should be fed as frequently and for as long as s/he wants to, even at night. Breastfeeding at night helps maintain the milk supply as more prolactin is secreted during the night. A satisfied child releases breast spontaneously.

6. When should babies receive Iron and Vitamin-A supplementation?

As a part of the National Iron Plus initiative, all children between the ages of six months to five years must receive iron and folic acid tablets or syrup (IFA) (as appropriate) for 100 days in a year as a preventive measure. Vitamin A supplementation doses should be given to children between nine months to five years, every six months. A child must receive nine doses of Vitamin A by the 5th birthday.

Cheer for the winning team with a higher score.

References

International Institute for Population Sciences (IIPS) and Macro International. 2007. National Family Health Survey (NFHS-3), 2005–06: India: Volume I. Mumbai: IIPS

Sample Registration System. 2013. Causes of death statistics (2010-2013), Registrar General, India

Unit 2.4 : Immunisation

Key Facts

- Universal Immunisation programme was launched by the Government of India in 1985. It became a part of Child Survival and Safe Motherhood programme in 1992 and is currently one of the key areas under National Rural Health Mission (NRHM) since 2005.
- NFHS 3 has revealed that the percentage of children aged 12-23 months who received all vaccinations (BCG, measles, and three doses each of DPT and polio vaccine, excluding polio vaccine given at birth) is only 43.5 per cent.
- The elimination of polio as well as maternal and neonatal tetanus are examples of great achievements attained by India in ensuring universal immunisation and disease control.

Introduction

Routine immunisation of all children against preventable life threatening diseases is one of the most widely accepted and successful interventions in reducing under-five child mortality. Preventing diseases before they occur saves money, energy and lives. Complete immunisation at the appropriate age gives a child the best chance for a healthy life.

India has been implementing the Universal Immunisation Programme (UIP) since 1985, as one of the main components of the Reproductive and Child Programme and the National Rural Health Mission. It is the largest immunisation programme in the world. It targets the vaccination of 2.7 crore newborns and three crore pregnant mothers annually for vaccines under UIP. Under this programme, significant achievements have been made in preventing and controlling the Vaccine Preventable Diseases (VPDs). The UIP provides protection against nine vaccine preventable diseases across the country, i.e., diphtheria, pertussis, tetanus, polio, measles, severe forms of childhood tuberculosis and hepatitis B, and meningitis and pneumonia caused by Haemophilus influenza type B. The vaccine against Japanese encephalitis is being provided in some high-risk districts and rotavirus vaccine has also being introduced in the States, in a phased manner.

The elimination of polio as well as maternal and neonatal tetanus are examples of great successes attained by India in ensuring universal immunisation and disease control. India reported its last case of polio on 13th January, 2011. South East Asia Region (SEAR) has been certified polio-free on 27th March, 2014 (NRHM Document, 2015). Also, the elimination of maternal and neonatal tetanus is a huge achievement for India, which until a few decades ago reported 1,50,000 to 2,00,000 neonatal tetanus cases annually (WHO, 2015).

This unit aims to provide an overview of the UIP and sensitise participants about reasons for low coverage. It focuses on the crucial role played by all health functionaries and PRI-elected representatives in preventing the morbidity and mortality of children by ensuring immunisation in their local areas.

Learning Objectives

Participants will be able to:

- Describe the importance of immunisation
- Gain awareness about the vaccination schedule, status of immunisation in India and reasons for low coverage
- Understand their responsibilities as health functionaries to promote immunisation and strategise to increase women's and children's participation in routine immunisation programmes.

Session Plan

Time	Session	Content	Methodology	Resource Material
1.5 hrs	Unit 2.4 Immunisation	• Coverage and importance of Routine Immunisation Programme, Mission Indradhanush and new initiatives • Reasons for low of coverage of immunisation and strategies to overcome them • Role of health functionaries and PRIs in organising and promoting Routine Immunisation Programme • Role play focussing on behaviour change to motivate families to immunise their children (optional)	• Participatory discussion • Role play	• Chart papers, marker pens, story cards, writ- ing board, story cards, and printed copies of handouts

Step I

It is vital to immunise children early in life. Half of all deaths from whooping cough, one-third of all cases of polio, and a quarter of all deaths from measles occur before the age of one year. If not immunised, three out of every 100 children born will die on an average from measles, another two will die from whooping cough, one more will die from tetanus and of every 200 children, one will be disabled by polio and one in 82 will die of diarrhoea before five years of age (NRHM, 2015).

Ask the participants a few questions about the National Immunisation Schedule and new initiatives like Mission Indradhanush and Pentavalent vaccine (Share printed copies of Handouts 1 & 2).

Step 2: Status of Immunisation in India

Share information provided in Table 1 below on status of immunisation in India.

Trends over time in vaccination:
Percentage of Children age 12-23 months who received specific vaccines at any time before the survey (according to a vaccination card or the mothers report), and percentage with a vaccination card seen by the interviewer , by residence , NFHS-3, NFHS-2 and NFHS-1

Vaccinations given any time before the survey	**Urban**			**Rural**			**Total**		
	NFHS-3 (2005-06)	NFHS-2 (1998-99)	NFHS-1 (1992-93)	NFHS-3 (2005-6)	NFHS-2 (1998-99)	NFHS-1 (1992-93)	NFHS-3 (2005-06)	NFHS-2 (1998-99)	NFHS- 1 (1992-93)
BCG	86.9	86.8	77.6	75.1	67.1	57.6	78.1	71.6	62.2
DPT									
1	84.4	86.1	80.5	73.0	67.1	62.2	76.0	71.4	66.4
2	78.1	81.9	75.2	62.6	60.1	54.5	66.7	65.0	59.2
3	69.1	73.4	68.8	50.4	49.8	46.6	55.3	55.1	51.7
Polio[1]									
0	68.5	23.3	7.8	41.3	10.1	3.6	48.4	13.1	4.6
1	94.8	92.2	80.8	92.5	81.1	62.9	93.1	83.6	67.0
2	91.1	89.4	76.9	88.0	75.0	56.6	88.8	78.2	61.2
3	83.1	78.2	70.4	76.5	58.3	48.6	78.2	62.8	53.6
Measles	71.8	69.2	57.5	54.2	45.3	37.7	58.8	50.7	42.2
All basic Vaccinations[2]	57.6	60.5	50.7	38.6	36.6	30.9	43.5	42.0	35.4
No Vaccinations	3.3	6.4	16.4	16.7	16.7	34.0	5.1	14.4	30.0
Percentage of vaccination card seen	46.2	45.9	37.8	30.1	30.1	28.5	37.5	33.7	30.6
Number of children	2,723	2,282	2,715	7,696	7,795	9,138	10,419	10,076	11,853

1. Polio 0 is the polio vaccination given at birth.

2. BCC, measles, and three doses each of DPT and polio vaccine(excluding polio vaccine given at birth

Source: *International Institute for Population Sciences (IIPS) and ORC Macro. National Family Health Survey (NFHS-3), 2005-06; India. Mumbai: IIPS).*

Discuss with participants the status of immunisation in their localities. Are there any specific localities/areas where immunisation rates are particularly low? Do they know the reasons? Are there places where even when the service is available, many infants are not brought for the full course of immunisation, even though they need it? Note down their responses on a flip chart for further discussion under Step 3.

The key reasons for inability to achieve universal immunisation include:

- Lack of awareness among parents about the benefits of vaccination
- Fear of adverse events following immunisation
- Operational reasons such as non-availability of vaccines or vaccinators during vaccination sessions.

Other reasons for low immunisation coverage include failure to provide immunisation at planned outreach, sub centre or PHC sites. Children who receive one or more vaccination, but do not return for subsequent doses may include children whose parents do not know about immunisation or face socio-economic barriers to utilise services, families with children who live too far away from a health centre or an outreach site to realistically complete a full immunisation schedule, children whose parents do not believe in immunisation services; even though a health centre is within reach and children who visit the health centre for some other reason, but are not screened for immunisation by health workers.

Step 3

Emphasise that immunisation has to be sustained as a high priority to further reduce the incidence of all vaccine preventable diseases, control measles, eliminate tetanus and eradicate poliomyelitis. Therefore, universal immunisation is imperative.

Brainstorm about strategies to improve coverage to ensure that all women and children receive complete immunisation as per schedule. Initiate the discussion by asking the participants about various activities carried out during the Village Health and Nutrition Day observed every month in villages. Elicit responses with regard to the role of health workers, ICDS functionaries and PRIs in facilitating maximum attendance at immunisation sessions and tracking drop outs.

Summarise the responses of the groups and add these strategies to the corresponding challenges listed on the flip chart prepared in Step 2.

Desired Behaviour	Actual Behaviour	Feasible Behaviour	Barriers to Desired Behaviour	Motivations and Supports (Message)
• Caregivers bring their children to immunisation service delivery points at the ages recommend in the national schedule with immunisatio n card	• Many Caregivers take their children for complete immu-nisation at some point in time. • Delay in first immu-nisation based 'practice of staying in the home' after delivery for the at least one month and health workers not remembering to advise mothers. • Delay in intervals between immunisations • Many caregivers could not locate their cards (although they could remember place on body and number of times their child received immunisation. • Caregivers bring their child only one time to get immuni-sation	• Most caregivers take their chil- dren to get fully immu-nised • Follow the schedule of immunisa tion • Maintain the immu-nisation card.	• Lake of knowledge about im-munisation. • Lack of awareness of immuni-sation • schedule, place, date • Long dis-tance to closest health • facility. • Worry that mother and infant could get sick if she leaves • the house too early. • One has to pay for vaccine • Attitude of health staff unrespect-able to • caregivers	• Immunisa-tion prevents serious child • sickness • Support of other family members for the mother to take child for immu-nisation. • Under-standing of family members • that mild negative side effects from im-munisation • Immunisa-tion is free.

Strategies to Address the Barriers to Immunisation

An article titled 'Status of Immunisation and Need for Intensification of Routine Immunisation in India' by Vipin M. Vashishtha published in Indian Pediatrics Journal in 2012 states the following strategies to address the barriers to immunisation:

- Increasing demand for vaccination by using effective IEC strategies and community mobilisation.
- Bringing immunisation closer to communities: The number of immunisation 'delivery points' should be increased, especially in rural and remote areas and urban slums with poor access to health facilities.

- Large and varied cadres of volunteers, including local medical practitioners, pharmacists, chemists, school teachers, retired nurses and other health personnel can be recruited to offer immunisation services. Proper training including maintenance of cold chain and basic minimum education on vaccines must be imparted to all of them.
- E.g. The Chhattisgarh government used Sirha-Gunia-Baigas (traditional healers) as agents of behavioural change and to help medical service providers in their work. The Sirha-Gunia-Baigas motivated villagers to go to PHCs for treatment and transition from traditional to modern medicine. This also created an enabling environment, helping health workers be more effective since they now had support from villagers.
- Incentives in cash or kind may be offered to those families having fully immunised kids.
- Proper monitoring and rigorous surveillance.

Some Successful Strategic Approaches used by States

West Bengal: Involved additional workforce - field-level NGOs, hired part-time ANMs (retired) and organised outreach camps. Adequate supervision and monitoring helped increase coverage.
Odisha: Created additional vaccine storage points - Lobbying by an NGO, enabled an increased number of ILR locations. Health staff had to travel shorter distances.
Jharkhand: NGO hired additional ANMs and created VHCs - Catch-up rounds and social mobilisation was carried out through nukkad-nataks (street theatre).
Andhra Pradesh: Identified gaps through baseline survey, capacity building of health staff, ensuring better logistics, fixed easy to attend immunisation sessions and involved local women/ youth groups.
Haryana: Used local NGOs in catalytic role to mobilise families.
Delhi: UNRC trained women's health groups and community volunteers helped in community mapping, enlisted support from charitable hospitals and local councilors.
Multiple States: Converged ICDS and RCH services to provide fixed day, fixed sites immunisation and counseling services.

Share the following information with the participants:
All participants can undertake the following basic measures at their respective levels to ensure immunisation:

- Register all new births for tracking immunisation
- Monitor immunisation sessions by involving SHGs, local women and elected women representatives of the Panchayat
- Become alert to any outbreak of communicable diseases
- Maintain sanitation, safe and regular garbage disposal and regular availability of safe drinking water in anganwadis, schools, health centres, etc.
- They can facilitate awareness activities in the community and in Gram Sabhas, Ward Sabhas, Mahila Sabhas in Self-Help Group meetings and on special days such as VHND, Bal Divas, health melas, etc.

Share print outs of Handout 3: Role of Health, ICDS, PRI, RD, NGOs in the Immunisation programme.

Activity 1

Explain that any health initiative in a community is successful when there are sincere efforts to build trust and confidence in the community. The proposed messages to bring about behaviour change should address the deep rooted beliefs and traditions that may be the bottlenecks in bringing about behavioral change. AWWs, ANMs, ICDS workers need excellent Inter-Personal Communication (IPC) skills to counsel parents as well as skills in group communication during home visits and meetings/campaigns.

Inform the participants that they are going to conduct a role play. Invite three to four volunteers to play the roles. Share the Handout 2 - Shanta's Story on Immunisation with all the participants. Give the volunteers 10 minutes to prepare and another 5-10 minutes to enact it.

On completion of the role play, ask the following questions:

- What did you think of the story? Do you find families like Shanta's who are reluctant to follow your advice?
- How did Sumitra handle the case? Did she try to find out the reasons for Shanta's husband's and mother-in-law's opposition to immunisation? Did Shanta's family accept her advice and get the child immunised as advised?
- How did Sumitra finally convince the family and win Shanta's support in promoting health care?
- What is it that Sumitra could have done better? (Like counseling the family during the first immunisation)

Allow sufficient time for the participants to reflect and share their views on each of the above questions. Keep asking questions to elicit the following:

- During her first visit to Shanta's house, Sumitra was able to create an 'awareness' as well as a 'desire' in Shanta to get the child immunised. But Ramlal and his mother influenced her and dissuaded her from immunising the child.
- On the second visit with the AWW, they were able to get Ramlal, his mother and Shanta to agree to test the 'desired' behavioural change by getting the baby immunised with the first dose.
- But, again, the fact that the baby had fever and also that they were not fully convinced about the cause, stopped the family from bringing the child for the second dose.
- Sumitra again influenced and motivated the family by bringing in the Sarpanch and two of Ramlal's friends and was successful in getting the second dose administered.
- In this manner, the family realised that it was good to get the baby immunised and to follow the advice of the ASHA and therefore they continued to bring the child for immunisation and other services, thereby 'sustaining' the behavioural change.

Taking lead from the discussions on Shanta's story, initiate a discussion on the seven-step behavioural change process (See Annexure 1).

Summing Up

- To have life-long protection against deadly diseases, newborns should begin receiving immunisation, immediately after birth.
- Parents should carry the routine immunisation cards with them at all times during visits to doctors, and especially during travel.
- Vaccines are available free-of-cost at the nearest sub-centre/anganwadi centre and at all government health facilities.
- A child who is suffering from minor ailments such as fever, cough, cold, diarrhoea on the day of immunisation can still be immunised.
- It is common to observe some adverse effects following immunisation such as fever or pain. These will subside in due time and should not be a cause of concern.

Suggested Readings

http://www.searo.who.int/india/topics/routine_immunisation/ Immunisation_Handbook_for_Health_Workers_English_2011.pdf
http://unicef.in/Uploads/Publications/Resources/pub_doc24.pdf

Handouts

Handout 1: National Immunisation Schedule

S. No.	Vaccine	Protection	Number of doses	Vaccination Schedule
1	BCG (Bacillus Calmette Guerin)	Childhood Tuberculosis	1	At birth (up to 1 year if not given earlier)
2	Pentavalent [Diphtheria, Pertussis, Tetanus (DPT), Hepatitis B and Haemophilus influenze b (Hib)]	Diphtheria, Pertussis, Tetanus, Hepatitis B, Haemophilus influenza E type associated Pneumonia and Meningitis	3	Three doses at 6, 10, 14 week
3	DPT (Diphtheria, Pertussis, and Tetanus Toxoid)	Diphtheria, Pertussis And Tetanus	2	Two booster doses at 16-24 month and 5 years of age. Three primary doses at 6,10, &14 wwek are part of Pentavalent Vaccine.
4	Hepatitis B	Hepatitis B	1	Birth dose for institutional deliveries. The Primary doses at 6, 1 0&14 week are part of Pentavalent Vaccine.
5	OPV (Oral Polio Vaccine)	Polio	5	Birth dose for institutional deliveries. The Primary doses at 6, 10&14 week and one booster dose at 16-24 month of age. Given orally
6	IPV (Inactivated Polio Vaccine)$	Polio	1	One dose at 14 weeks, along with OPV#, Injectable dose given
7	Japanese Encephalitis	Japanese Encephalitis	2	9-12 months of age and 2nd dose at 16-24 months
8	Measies	Measies	2	9-12 months of age and 2nd dose at 16-24 months
9	Vitamin A	Night Blindness	9	~ 1st dose at 9 months ~ 2nd dose at 18 months ~ 3rd to 9th dose given at 6 monthly interval upto 5 years.
10	Rota Virus*	Rotavirus diarrhoes	3	Three doses at 6, 10, 14 week. Given orally
11	TT (Tetanus Toxoid)	Tetanus	2 2	~ 10 Years and 16 Years of age ~ For pregnant, two doses given (One dose if previously vaccinated with 3 weeks)

S. At present in six States—Assam, Bihar, Gujarat, M.P., Punjab and U.P. and in process of expansion

 # in endemic districts

** Phased introduction, at present in Andhra Pradesh, Haryana, Himachal Pradesh and Odisha from 2016*

National Immunisation Schedule for Pregnant Women

Vaccine	When to give	Dose
TT-1	Early in pregnancy	0.5 ml
TT-2	4 weeks after TT-1	0.5 ml
TT- Booster	If received 2 TT doses in a pregnancy within last 3 years	0.5 ml

Handout 2: Overview of Mission Indradhanush

Mission Indradhanush is a new initiative launched by Union Health Minister on December 25, 2014. Mission Indradhanush will target 201 high-priority districts in the first year, where more than 50 per cent of the children are either partially immunised or unimmunised; 82 of these districts are located in just four States, namely **Uttar Pradesh, Bihar, Rajasthan and Madhya Pradesh.** These four States alone account for nearly a fourth of the partially vaccinated and unvaccinated children in the country.

India is home to the world's largest vaccination programme, **providing life-saving vaccines against 11 diseases, free-of-cost, to the country's 27 million children** (See Handout 1). The idea behind Mission Indradhanush is to protect children against the childhood diseases that are covered under the Universal Immunisation Programme (UIP). The programme aims to ensure equitable access to these vaccines to all children in the country, irrespective of religion, gender or socio-economic status. In the past, immunisation has contributed to the eradication of deadly diseases like small pox and crippling diseases like polio. Vaccines have helped to dramatically reduce the burden of several common childhood diseases in India.

Despite significantly high coverage for individual vaccines, **India's full immunisation coverage is only 65.2 per cent. Nearly 35 pe rcent (9.46 million) of the children in India remain partially immunised or unimmunised.** Between 2009 and 2013, about a million more children were fully immunised, an increased coverage rate of just one per cent per year. Every unimmunised child carries a six times higher risk of death as compared to a fully immunised child.

Vaccines are among the most cost-effective measures against preventable childhood illnesses. An effective vaccine protects an individual against a specific infectious disease and its complications. Vaccines work by priming our immune system against infectious diseases by triggering antibodies that help fight the infection. This helps the immune system mount a quicker, stronger and more sustained response if exposed to the same pathogen again.

By preventing infections, vaccines also prevent their long-term complications in the vaccinated and provide herd immunity in the community. Herd immunity occurs when a significant proportion of people within a community are protected against a disease through immunisation. In the case of a highly contagious disease, such as measles, more than 95 per cent of the children must be vaccinated to achieve sufficient herd immunity to prevent its spread. This is why it is important to ensure that all children are immunised to protect them and the wider community. The benefits of these vaccines are also far-reaching as healthier children miss fewer days at school and

grow into healthy and productive adults.

Mission Indradhanush brings together government agencies, public health institutions, development partners, civil society, media, corporates and other stakeholders to launch a concerted effort to accelerate improvements in the reach of UIP and aims to achieve full immunisation coverage by the year 2020, so that no child is deprived of the benefits of life-saving vaccines.

Handout – 3

Shanta's Story on Immunisation

Using the story cards, narrate the following story:

Sumitra, the ASHA of village Rampur was concerned that a few families in the village were not bringing their babies for immunisation. So she decided to visit their homes and explain the importance of immunisation to them and the need to get their children immunised. One of the houses she visited was that of Shanta, a lady with a six month-old baby who had never been immunised. When Sumitra discussed the need to immunise her son, Shanta said that her family did not believe in immunisation and that her mother-in-law and husband, Ramlal, would never allow her to immunise the child. Sumitra, in a very friendly and caring manner, explained to Shanta why immunisation was important and asked her to attend the VHND the following Wednesday along with her baby. Shanta promised to discuss this with her family.

On VHND, Sumitra noted that Shanta had not brought her baby for immunisation and so, after the session, she took the AWW to Shanta's house and was fortunate to meet both Ramlal and his mother. She explained to them the need for immunisation. After much persuasion, they agreed to immunise the child. As the ANM was still in the village they were able to administer the first dose of polio and DPT as well as BCG. Sumitra was very happy. She told Shanta and her family that they should bring the baby for the second dose of vaccines on the next VHND in the following month.

A week later, Sumitra visited Shanta's house to find out how the baby was and also to remind them to bring the baby for the second dose. Shanta's mother-in-law complained that the child was restless after immunisation and had fever all through the night. Sumitra explained that it was normal for some babies to get fever after immunisation and that there was no cause for concern.

On the next VHND, Shanta did not come to the PHC. Sumitra sent the AWW helper to Shanta's house again, but she refused to come since her family was against any further immunisation since the child had fever the previous time and they had also heard that it could cripple the child. The child, thus, missed the second dose.

Sumitra then decided that the only way to ensure that the child got immunised was to convince Ramlal. She spoke to the Sarpanch and also to two of Ramlal's neighbors who were his friends.

Together they had a long discussion with the family informing them that all the children in the village were being immunised and that there had been a marked reduction in diseases. They also told the family that it is the right of every child to get immunised and that parents should not be guilty of not taking care of the health of the child. Both Ramlal and his mother were convinced and even accompanied Shanta to the PHC where the child received the second dose of vaccines. Since then the parents have been very careful and have ensured that the child receives all vaccinations,

including against measles, and Vitamin A prophylaxis. Shanta now actively advocates the need to get babies immunised.

Handout – 4

Role of Health Functionaries and PRIs in Organising Routine Immunisation Programme during Monthly Village Health and Nutrition Day (VHND)

Nutrition and Health day is organised once in a month at the anganwadi centre in all areas. On the appointed day, ASHA, AWWs and others mobilise villagers, especially women and children, to assemble at the nearest AWC. On the VHND, health personnel interact freely with villagers and share basic information on common health problems. They can also learn about the preventive and promotive aspects of healthcare, to encourage them to seek healthcare at proper health facilities. The Village Health and Sanitation Committee (VHSC) comprising the ASHA, AWW, ANM and the PRI representatives, if fully involved in organising the event, can bring about dramatic changes in the way people perceive health and healthcare practices.

Immunisation Services

Besides providing ANC services, all the children below one year are to be given vaccines as per the UIP schedule. Vitamin A solution should also be administered to children.

At the village level, an ASHA visits all households and gets to know all the families, and makes it a point to visit all poor households, especially SC/ST families and makes a list of infants who need immunisation, were left out or dropped out.

PRIs ensure that the members of VHSC are available to support the sessions, guarantee participation of school teachers and make clean water and proper sanitation arrangements at the AWC on VHND.

Specific Role of Health, ICDS, PRI, RD, NGO in Immunisation Pogramme

Inter ventions	Health	ICDS	PRI/Rural Development	NGOs (Mobilisers)
Immuni-sation	• ANM will ensure her visit on schedule in her area at fixed date and time • Keep informed ASHA/ AWW/ Mobiliser regarding her visits	AWW and ASHA will assist in organising the mother child protection session	Will support the motivational component	• Promote immunisation services • Help keeping mother-child cards and to communicate date,time and place of session

Vitamin A	• Ensure 1st dose of vitamin A along with measles vaccine • Next doses for 1-5 years children using fixed nutrition months strategy (twice a ear strategy along with fixed day immunisation session)	Support ANM in vitamin A administration	Motivate community and help ASHA/ AWW/ANM	Motivate community and help ASHA/AWW/ANM

Know Your Progress

Give print outs of the following questions to the participants. Ask them to get answers checked by other participants and hand over to you.

Fill in the blanks and select the right answers:

1	Fill in the blanks V accine Route Site Dose BCG _____ _____ _____ DPT _____ _____ _____ Hepatitis B _____ _____ _____ Measles _____ _____ _____	
2	The first dose of Vitamin-A solution is given with measles at 9 months of age. a. Up to what age, is Vitamin A given? _____ b. What is the interval between two doses of Vitamin A? _____ c. How many doses of Vitamin A are given including first dose? _____ How much Vitamin A - solution is given to a child aged one year and above? _____	
3	If a child comes with abscess after immunisation what will you do? Do nothing Reassure parents and refer to PHC and include in monthly report Give Paracetamol	a b c
4	Drop out children are those who have never received any immunisation	True False
5	Which new vaccines have been introduced under the National Immnuisation Schedule?	

Annexures

Annexure 1

Frequently Asked Questions about the Pentavalent

Vaccine Who should be immunised with Hib vaccine?

Generally, all children aged up to one year (after 6 weeks and less than 1 year) should receive Hib vaccine as part of routine immunisation.

What are the limitations of Hib vaccine?

Hib vaccine protects only against diseases caused by the Hib bacterium. After Hib immunisation, a child may still get pneumonia, meningitis, or flu caused by other bacteria and viruses.

How many doses are needed? When should they be given?

Three doses are given. The first dose is given as Pentavalent vaccine only after a child is six weeks old. The second and third doses are given at 10 and 14 weeks of age respectively also in the form of Pentavalent vaccines. There is no booster dose recommended under UIP.

Why is Hib given as a Pentavalent vaccine and not separately?

The schedule for DPT, Hep B and Hib is the same at 6, 10 and 14 weeks. Therefore, if these three vaccines are given separately, a child gets three pricks at the same time. Giving a Pentavalent vaccine will reduce the number of pricks.

Till what age can pentavalent vaccine be administered?

Pentavalent vaccine can be given to any child aged more than six weeks and up to one year of age.

What are the side effects of Pentavalent vaccine?

Pentavalent vaccine has not been associated with any serious side effects. However, redness, swelling, and pain may occur at the limb site where the injection was given. These symptoms usually appear the day after the injection has been given and last from one to three days. Less commonly, children may develop fever for a short time after immunisation.

What types of Pentavalent vaccine are available?

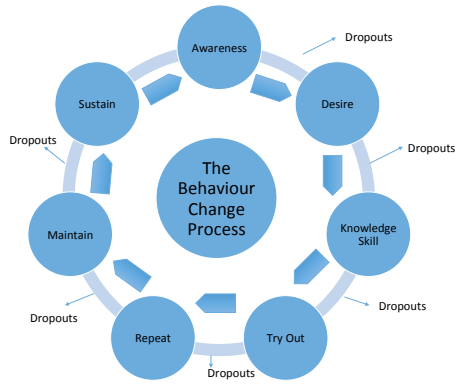
The Pentavalent vaccine is available in various forms of liquid and lyophilised. However, under the UIP in India, the vaccine will be available as a liquid formulation only.

Annexure 2: The Seven Step Behaviour Change Process

Step number one in the change process is to become AWARE of a change that needs to take place. Write 'Aware' on the board and discuss how Shanta became aware that immunisation is good for the child. This awareness could come from a neighbor, a relative or a friend or through the ASHA or the AWW or the ANM or any other functionary. It could also be through the media – newspaper, radio or TV. Once the same message is heard several times (e.g. every child should

be immunised, every child should be in school, institutional deliveries are safest for mother and child, etc.), one develops a DESIRE to test the change.

This is step two of the change process. Write 'Desire' on the board as shown in the chart and draw an arrow indicating that awareness leads to a desire for change. Now that one desires the change, one will look at ways to make the change and this could be acquiring a new SKILL (as in the case of the skill to breastfeed a baby the right way) or KNOWLEDGE (as in the case of finding out when and where one's child can be immunised).



An enabling environment consists of:

- Supportive relatives and neighbours
- Functionaries and volunteers and other opinion leaders who sustain the encouragement through counselling and dialogue and provision of quality services
- The communication media through supportive messaging

Therefore, Step three is acquiring the necessary skill or knowledge to make the behavioural change. Write 'Knowledge' (in Shanta's case the knowledge was where to get the immunisation done for her baby as well as knowing the schedule of immunisation) or 'Skill' (as in the case of being able to breastfeed a child the right way) on the board as shown in the chart and draw an arrow to indicate that desire leads to acquiring the necessary knowledge and/or skill to make that change.

Now that one has acquired the knowledge and/or the skill, step four will be to TRY OUT that change (e.g., taking the child for immunisation for the first time as advised by the ASHA). Write 'Try out' on the board as shown in the chart and discuss this as the fourth step in the change process. Individuals analyse the experience of trying out the change behaviour and if the assessment is negative (as in Shanta's case); the person drops out from the process. If it is positive, the tendency is to try it out once again. In other words, REPEAT the action. This is step five of the cycle. Write 'Repeat' on the board as shown in the diagram and discuss the same with the participants.

If the experience of step five was good, one will tend to repeat the action; in other words, MAINTAIN (step six) the behaviour and soon it becomes a SUSTAINED (step seven) behavior change or a habit. Write 'Maintain' and 'Sustain' on the board as in the chart with the arrows linking them and discuss these steps with the participants. The behavioural change process with regard to taking the child to immunisation is thus completed.

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Block 3: The Link between Women's Empowerment & Maternal and Child Health

Unit 3.1: Impact of Women's Empowerment on Maternal, Child and Adolescent Health, and Immunisation-Seeking Behaviour and Outcomes

Key Facts

- More than 40 per cent of the women are not involved in decisions pertaining to their own health or major household purchases. A majority of the women do not have much freedom of mobility. Around 50 per cent of the women are not allowed to go to the hospital or market alone, while less than 40 per cent are free to move out of their village/community unaccompanied (IIPS, ORC Macro, 2007).
- 40 per cent of married women have experienced physical, sexual or emotional violence. More than 50 per cent men and women believe wife-beating is justified.
- Women with higher decision-making autonomy are less likely to have a low-birth or stunted child (Shroff M. et al., 2009). Under five child deaths are also less likely among mothers who are able to take domestic decisions on their own (Fantahun, M et al., 2007).

Introduction

Women's empowerment and equality is a fundamental human right and critical to achieve development objectives, including health. There are numerous pathways by which greater gender equality can lead to improvements in health and quality of life for women, children and other family members. Women with greater agency are more likely to have fewer children, access health services and have control over health resources, and less likely to suffer domestic violence. Their children are more likely to survive, receive better childcare at home and receive health care when they need it.

At the same time, improved health outcomes for women can help to strengthen their own agency and empowerment. A healthy woman is a more productive woman, able to join the workforce and contribute to the economy of the household and the country. Healthy women are better capable of actively participating in society and can take collective actions to advance their own interests. They are likely to negotiate better and have control over resources within the household. They have greater autonomy in taking decisions, thereby impacting children's and family's well-being positively.

This unit provides an introduction to the concept of women's empowerment and autonomy. By gaining insights into the facilitating and constraining factors that impact a woman's agency, participants will understand how greater gender equality can lead to improvements in health and quality of life for women and their family members.

Learning Objectives

Participants will be able to:

- Understand the concept and significance of women's empowerment
- Gain insights into how power and gender imbalance impacts women at different stages in their life cycle
- Get an overview of the influence of women's autonomy and decision making ability on their own and the health of their family

Session Plan

Time	Session	Content	Methodology	Resource Material
1.5 hrs	Unit 3.1: Impact of Women's Empowerment on Maternal, Child and Adolescent Health and Immunisation Seeking Behaviour and Outcomes	• What is power? Understanding the concepts of vulnerability and empowerment • Understanding the concept of women's empowerment • Statistics on women's empowerment in India • Experience sharing: women's empowerment strategies • Impact of women's empowerment on child health and survival	• Group discussions and presentations • Role play	• Flip charts • Print copies of Handout

Tips for the facilitator

This unit seeks to draw on participants' knowledge and experience to make them aware of gender inequalities, the concept and significance of women's empowerment. The efficacy of the session will depend on the extent to which it is rooted in their local context. Encourage participants to relate concepts and strategies to their local socio-cultural and environmental circumstances.

Step 1

Initiate the discussion by asking participants what they understand by 'power'. Does power have any relation with rights? Encourage participants to share their views for about five minutes. Write down their responses on a flip chart to guide the discussion.

> Power is usually considered to be the ability or resource of one individual or group to exercise their will over another individual or group. Thus, a person or group is supposed to be able to dictate the action of another person or group. Power dynamics exist at all levels: within a household, at the community level, among different castes, among people living within a village or a slum setting.

Power and rights go hand-in-hand and there exists a very fine balance between the two. Absence or overemphasis on any one of them results in an imbalance in society. Unfortunately, women still continue to be marginalised in our society. The imbalance in various forms of power relations, especially in some societies, hinders women in pursuing their goals, use their fullest potential and participate fully in social, economic and political decision-making processes.

Activity 1: Power, Vulnerability and Empowerment

Inform the participants that the following activity will help them understand the above mentioned concepts through the life cycle approach and see how both power and rights go hand-in-hand. Divide the participants into two or four groups (depending on number) to represent different age groups.

Help them outline the life cycle on a flip chart and discuss step-by-step the different ages of both men and women as has been designated for their group. The focus is on age groups 0-3 years, 4-10 years, 11-19 years and 20-49 years. Ask the participants to work in groups for 15 minutes to draw a parallel between both sexes on significant indicators at a specific age. For example, the following indicators can be discussed for both boys and girls/men and women: Social/ Gender norms at birth, privileges/rights and nutrition during childhood, health care and treatment during illness in childhood and adolescence, education – opportunity and access, responsibility and decision-making in household, participation in community and civil society, etc. Allow each group to present their chart to the larger group followed by inputs from all participants (5 minutes per group, total time for all groups – 20 minutes).

Summarise the key points, thus enabling the participants to appreciate and understand the crucial role and interface that exists between gender, power, rights and empowerment.

Step 2

Understanding Women's Empowerment

Participants would be aware that 'women's empowerment' is a commonly used concept in the development sector. Women's groups, non-governmental organisations, politicians and government and international agencies refer to empowerment as one of their goals. Ask participants what the concept means and entails?

> The World Bank defined empowerment as the "expansion of freedom of choice and action to shape one's life." This definition encompasses two features of women's empowerment: process of change (through which a woman gains power in making decisions) and agency.
>
> Kabeer (2005) defined women's empowerment as a "process by which those who have been denied the ability to make strategic life choices acquire such an ability." This definition involves resources and achievements, in addition to process of change and agency, all of which are interrelated.

Women's empowerment is a broad term encompassing different attributes at the individual and the societal levels. It can mean women's increased control over their own lives, bodies, resources and environment. Emphasis is on women's decision-making roles, their economic self-reliance, their legal rights to equal treatment, inheritance and protection against all forms of discrimination, in addition to the elimination of barriers to access resources such as education and information.

According to World Bank, 2002 key measures of empowerment include:

- Domestic decision-making autonomy: Expenditures, diet intake, health (including number of children and birth spacing) and schooling of children
- Access to or control of resources: Cash, land, household assets, participation in employment
- Freedom of movement: To visit hospitals, markets and family
- Freedom from violence
- Literacy and education level
- Age at marriage and difference in spousal age

Age, education, caste, religion, economic status, place of residence (urban vs. rural), all these factors determine the status of women in a society. As we can see from the different definitions, household and inter-familial relations are central aspects of women's empowerment.

Step 3

Principles of gender equality are enshrined in the Indian Constitution and the States are empowered to adopt measures of positive discrimination in favour of women. However, there still exists a wide gap between the goals outlined in the Constitution, policies, plans and programmes and the situational reality of the status of women in India. Access to education, health and productive resources is inadequate for many women of our country. They are usually accorded

lesser social, economic and political status which negatively impacts women's safety, health and overall development.

Ask if the participants are aware of the National Mission for Empowerment of Women (NMEW). Are there any programmes or schemes that are being conducted for women under the Poorna Shakti Mission in their local areas? Share Handout 1.

Ask participants to share some initiatives from their districts/States that focus on empowering women by facilitating their say and participation in health programmes (Allow 5-10 minutes for sharing of stories).

Activity 2: Role Play

The traditional responsibility of women for nurturing and care implies that advances in women's status viz., empowerment would have a positive spillover impact on children's well-being. More recently, researchers also have been able to prove the significance of women's empowerment in ensuring child survival and health.

Ask for four volunteers to come forward for a role play exercise. They have to play the role of an educated mother and a medical officer and an uneducated mother and a medical officer at the Primary Health Centre. Give them the following scenario to enact with a short briefing:

Meena is very worried. Her baby girl, all of 14 months has had diarrhoea for the last two days. The baby has stopped eating and crying since morning. Her husband has left for work and will not be able to return before evening. The neighbourhood ladies did not offer any advice that worked. Meena could not find any ASHA or ANM as they are busy in the neighbouring village for an immunisation camp. Her only resort is to take the baby to the Primary Health Centre that is three kilometres away.

Let the volunteers enact the scenarios between Meena and the medical officer for about three to four minutes for each pair. Dialogues can centre around cause and extent of diarrhoea, treatment given so far, ORS, feeding and diet, water sanitation, etc.

Questions for Discussion

Did participants observe any difference between the two role plays? What were the difficulties faced by the different Meenas? Was there any difference in their interactions with the medical officer?

Using the example of the role play, explain the pathways for the impact of women's empowerment on child health outcomes:

- Greater awareness about health related information and services
- Greater utilisation of maternal and child health care services
- Better nutritional status of mothers directly impacts child health
- Women's autonomy in terms of decision-making usually leads to higher allocation of resources towards child health

There are numerous pathways by which greater gender equality can lead to improvements in health and quality of life for women and their family members. Women with greater agency

are more likely to have fewer children, more likely to access health services and have control over health resources, and less likely to suffer domestic violence. Their children are more likely to survive, receive better childcare at home and receive healthcare when they need it. At the same time, improved health outcomes for women can help to strengthen their own agency and empowerment. Healthy women are able to participate more actively in society and markets and take collective action to advance their own interests. They are likely to have greater negotiating power and control over resources within the household. Therefore, collaborative action between gender and health can help maximise the impact of gender policies on health and vice versa.

Share some research facts with the participants regarding the relationship between women's empowerment and child health.

- Children of mothers with more number of years of education (12 years and more) and those engaged in employment outside home, have a high chance of survival and show better long-term physical growth i.e., lower rates of stunting (Ibrahim A et al., 2015). These children also have a higher chance of complete and timely immunisation.
- Women who have greater autonomy in domestic decision-making are more likely to use maternal and child health services including contraception, making informed decisions about number of children and birth spacing, get regular health check-ups during pregnancy, ensure safe delivery and immunisation (Mahapatro S., 2012). This has positive outcomes on her own health, helping break the inter-generational cycle of an undernourished adolescent mother giving birth to a low-weight stunted infant.
- Women exposed to episodes of domestic violence often suffer from miscarriages and abortions; have higher chances of delivering a low-birth weight baby and their child dying within five years of age. This impact is because of physical injury to the mother as well as a result of the poor status held by victims of domestic violence within the household.

Summing up

- Degree of women's empowerment is understood in terms of women's educational status, decision-making autonomy, freedom of mobility, episodes of violence and gender role beliefs.
- Research evidence states that women's empowerment status has a direct positive impact on major indicators of child health and development.
- Women's education, employment, higher decision-making capacity and greater freedom of mobility are shown to be linked with better child survival, nutrition levels, immunisation status and access to health care.

Further Readings

National Mission for Empowerment of Women – Poorna Shakti http://www.nmew.gov.in/index.php

Success story - http://nmew.gov.in/showfile.php?lid=343

Handouts

Handout 1

The National Mission for Empowerment of Women was operationalised during the financial year 2011-12 as a Centrally Sponsored Scheme in April, 2011. The focus was to bring convergence of efforts through inter-sectoral coordination amongst different Ministries and programmes with Ministry of Women and Child Development (MWCD) as the nodal point for achieving holistic empowerment of women.

Following the restructuring of the Centrally Sponsored Schemes during the 12th Five-Year Plan period, NMEW was approved for continuation as a sub-scheme of the Umbrella Scheme for Protection and Development of Women.

The revised NMEW Scheme aims to achieve holistic empowerment of women through convergence of schemes/programmes of different Ministries/Departments of the Government of India as well as State governments. Under the revised scheme, technical support to the Ministry of Women and Child Development is being provided by domain experts who are involved in the implementation and monitoring of new initiatives by the Ministry like 'Beti Bachao Beti Padhao' (BBBP Scheme), one stop centres, women helpline, etc., and also facilitates convergence of schemes/programmes of different Ministries/Departments with focus on women. At the national level, experts engaged in the area of:

a) Poverty alleviation and economic empowerment
b) Health and nutrition
c) Gender budgeting and gender mainstreaming
d) Gender rights, gender-based violence and law enforcement
e) Empowerment of vulnerable and marginalised groups
f) Social empowerment and education
g) Media and advocacy
h) Information technology

The scheme aims to strengthen the conceptual and programmatic basis of women centric schemes/ programmes implemented by the MWCD, other Ministries and State governments with the mechanism for convergence. Training and capacity building to enhance and strengthen understanding of gender issues, building a resource pool (trainers) at the national and State levels to bridge gaps between knowledge and practice will be the other focus area of NMEW.

(Refer to National Mission for Empowerment of Women http://www.nmew.gov.in/index.phpfor more information).

Know Your Progress

Questions

1. Name the indicators that can measure women's empowerment.
2. What role does education play in increasing a women's autonomy?

Model Answers

1. Indicators include:
   a. Domestic decision-making autonomy: Expenditures, diet intake, health and schooling of children
   b. Access to or control of resources: Cash, land, household assets, participation in employment
   c. Freedom of movement: To visit hospitals, markets and family
   d. Freedom from violence
   e. Literacy and education level
   f. Age at marriage and difference in spousal age that further impacts age when giving birth, number of children and birth spacing.
2. Education can lead to greater awareness about health related information and services, knowledge about preventive health care and services, greater utilisation of maternal and child

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Unit 3.2 : Experiences in Strengthening Maternal, Child and Adolescent Health through Women's Empowerment

Introduction

Women's empowerment and equality is a fundamental human right that promotes the achievement of development objectives, including health. Women's increased participation in governance, control of resources including land, access to employment and education are crucial for promoting sustainable development. Women with greater agency are more likely to have fewer children, access health services, have control over health resources and less likely to suffer domestic violence. Their children are more likely to survive, receive better childcare at home and receive health care when they need it. The girl children are less likely to be discriminated against and hence, have a better chance of survival as well. At the same time, improved health outcomes for women can help to strengthen their own agency and empowerment. Healthy women are more enabled to actively participate in society and markets and take collective action to advance their own interests. They are likely to have greater bargaining power and control over resources within the household.

Different aspects of women's empowerment from mobility, to decision-making power, to freedom from verbal and physical abuse act upon child health in different ways and in varying degrees. For example, women's decision-making power or control over resources to buy food will affect the diet quality of her family. On the other hand, a woman's ability to take decisions when the child is ill affects the child's health and wellbeing. Women who have experienced domestic abuse might be less able to safeguard their own and their children's nutrition.

The case studies presented in this unit showcase communities and women who have challenged their status quo and health inequities. They stepped up into their roles as Panchayat leaders or as equal citizens of the country to explore leadership within themselves and understand skills required to lead; to envision a future for their ward/village/Panchayats; learnt to translate their vision into reality; and to understand support structures available to them to implement their vision.This unit aims to develop an awareness about the significance of creating a vision among participants and learn to challenge the existing situation and limitations.

Learning Objectives

Participants will be able to:

- Learn about some innovative community and NGO-led programmes for maternal and child health
- Apply learning from shared programmes to develop a vision for the future health of their family/ village/Panchayat
- Develop skills required for articulating local issues affecting their everyday life as these are central to community development

Session Plan

Time	Session	Content	Methodology	Resource Material
1.5 hrs	Unit 3.2: Experiences in Strengthen- ing Maternal, Child and Adolescent Health through Women's Empowerment	• Case studies: Innovative community and NGO-led programmes • Creating a vision statement for improving maternal and child health in a selected geographical area	• Discussion and analysis of case studies • Small group work to develop health related vision and goals	• Copies of the case studies as Handouts

Tips to the Facilitator

These exercises will be most effective if participants are well versed with local data on MCH indicators and services. Encourage the group to get information on MCH services that are underutilised or unavailable. Visioning exercises can then be focussed around gaps and finding resources.

Step 1

Start with a quick review of Unit 3.1 on 'Impact of Women's Empowerment on Maternal and Child Health'. Explain briefly how empowerment of women would help tackle the underlying social, structural and economic conditions that impact health. The following statements can be highlighted:

- In spite of a longer lifespan, women suffer a greater burden of health risks and abuse
- Women are the primary caregivers in almost all families
- Women spend their discretionary money and time differently (from men), prioritising spending on health and quality of life for their children and family
- Compared to men, the targeted education of women regarding health results in greater health benefits to children and families (Kar S.B., et al, 2000).

Ask a few questions to help participants outline the main pathways for the impact of women's empowerment on child health outcomes (for five minutes). Inform them that the current unit will showcase case studies whereby the empowerment of women has positively impacted their children's and family health in Maharashtra and Gujarat.

Step 2

Divide the participants into two groups to represent the two case studies being analysed. Distribute the printed copies of the case studies accordingly (Handouts 1 & 2). Ask whether any of them are familiar with these projects. Give them 10 minutes to read the materials. Following this, discuss the following questions with the participants, encouraging each of the groups to participate.

Q1. How did the communities attain child care and health services for their communities? (Hint: Cooperatives for childcare run by local women ensured food and nutrition security, providing health insurance to all women workers).

Q2. What role did the community play in each of the case studies in safe guarding their own health?
(Hint: Expressing their health needs, seeking and being part of solutions, dialogue with service providers for continuous evolution).

Q3. How was health care provided to target communities and villagers? (Hint: Detailed surveillance system, community health care programme, training in home based care, education in health to village health workers).

Q4. Discuss the significance of the involvement and training of local health workers and women. (Hint: Trained traditional birth attendants, home based care provided by village health workers).

Step 3

Encourage the participants to think whether similar solutions are applicable in their village/ block/district. Inquire whether any health programmes are being successfully conducted by NGOs or UN agencies along with public health services offered by GoI. Is there collaboration between programmes offered by the primary health care and those offered by NGOs?

How can participants help in improving the health of mothers and children in their official capacities? How can they prioritise important issues like healthcare, water, sanitation, early marriage and education in their communities/village health plans? They need to exercise their leadership and decision-making abilities to try and challenge the existing conditions that do not facilitate or improve existing health conditions. Simply put, they need to develop a vision.

Ask participants what they understand by vision? Vision is being able to think ahead and beyond the immediate day-to-day challenges. A vision helps us create a better future for ourselves, our family, community, village and nation.

Ancient wisdom teaches us 'where there is no vision, the people perish'.

Vision is a statement of the future that:

- Is possible to achieve
- Is worth achieving
- Brings us to a new level in the quality of life
- Inspires us to put aside our fears and take action.

Explain to the participants the significance of envisaging some change in some area of MCH they want to achieve and then developing a vision around it. This vision needs to include aspects that have been ignored or neglected and must be formulated through the participation of all stakeholders. Their vision should combine the strengths and opportunities available to them to enable the transformation into reality in a sustainable manner.

Divide the participants into three groups.
Each group can select one option from the following areas:

a. Health of pregnant women and full ANC coverage (including immunisation, prevention of malnutrition and quality ANC including at least four visits and check up).
b. Child health (reducing infant morbidity and mortality through intensification of routine immunisation including childhood diarrheal diseases and pneumonia, eliminating measles and Japanese encephalitis related deaths and polio).
c. Adolescent health (including prevention of anaemia and full coverage of iron supplements).

- Each group needs to be familiar with the existing ground reality of the selected option in their local area of work such as the programmes that address the chosen issue.
- The group should try and identify needs and priorities of the village, especially women and children around the chosen issue.
- The group needs to map and list resources 'who/what' will transform this reality into a desired vision.

Taking an example from the categories suggested above, suggest to the participants that they could work along the following lines:

Vision	**Existing reality**	**Who will transform the vision into ideal reality**
Every child receives complete immunisation	Children living in certain far flung areas and those belonging to certain tribes/ castes remain without required vaccines	Staff at PHC, front line health workers, Gram Sabha and Panchayat leaders, community opinion leaders, elders and spokespersons, families and mothers

Give them 10 minutes to elaborate each step and think of roles of selected persons in transforming the vision into reality. Ask the groups to make their presentations before the larger group for five minutes each. The other participants will analyse and reflect on each presentation (10 minutes).

Summing Up

Encourage the participants by pointing out that they have taken the first important step in creating a vision and sharing it with each other. Once a vision has been articulated, each participant must think and explore how to make their vision a reality.

The people of India have created a structure in which visions can become reality. This structure is the Panchayati Raj. With the 73rd Amendment, local Panchayats have the power and authority to make decisions in all key areas that affect village life, including health.

The one-third reservation of Panchayat seats reserved for women gives the elected women authority, responsibility and accountability to make things work. Elected women representatives can empower other women officials, health workers and women in their community to prioritise all issues critical to the health of women and their families. Increasing women's participation and implementation of programmes leads to inclusive development of the village. Development needs to go beyond construction of roads and infrastructure to holistic development including health care, sanitation and welfare of all.

Further Readings

http://sewabharat.org/program-themes/health-social-security/
http://searchgadchiroli.org/childhealth.html
http://accessh.org/wp-content/uploads/2014/07/Compendium-Report_emailer.pdf

Handouts

Handout 1 - SEARCH: A High Quality, Globally Acclaimed Community-based Health Care Model

- SEARCH was founded in Gadchiroli district in 1986. It is inspired by the social philosophy of Mahatma Gandhi. Its founders, Dr. Abhay Bang and Dr. Rani Bang, received their medical training in India and their public health training at John Hopkins University.
- The organisation's three missions are:
  i) Providing health care to local populations
  ii) Training and education in health
  iii) Research to help shape health policies.
- SEARCH emphasises that field research should be conducted with the full participation of local communities. Its community health action and research approach highlights the importance of living close to, and listening carefully to the health concerns of local communities. Research and solution building activities should then be structured around central health concerns as voiced by community members themselves. Solutions to health problems are tested through rigorous field-based trials, and then published for scrutiny by the scientific community and policymakers.
- SEARCH conducted a field trial in Gadchiroli on home-based neonatal care from 1993 to 1998. SEARCH trained village health workers to make home visits and manage birth asphyxia, premature birth or low birth weight, hypothermia, breast-feeding problems, in addition to diagnosing and treating neonatal sepsis (septicaemia, meningitis and pneumonia).
- 39 Intervention and 47 control villages were selected in Gadchiroli district, with the study results demonstrating that SEARCH's home-based newborn care (HBNC) approach reduced neonatal and infant mortality by nearly 50 per cent.
- SEARCH maintains a comprehensive Demographic Surveillance System in Gadchiroli, which records all births, deaths, migrations (in and out), and marriages in the area. Its activities have now expanded into the areas of non-communicable diseases, tobacco and alcohol consumption, and adolescent sexual and reproductive health.
- Achievements:
  - Successful demonstration of the HBNC approach, yielding a reduction of 50 per cent in neonatal and infant mortality.
  - Research studies in other districts of Maharashtra and neighbouring countries (Bangladesh, Nepal and Pakistan) showed the feasibility of scaling up the SEARCH HBNC model.
  - The HBNC approach is now recommended by WHO, UNICEF and Save the Children, wherever necessary. The Government of India under NRHM made HBNC a part of the training module of ASHAs to enable them to provide HBNC services.

Handout 2: Lok Swasthya Sewa Mandali, an Initiative by Self-employed Women's Association (SEWA), Ahmedabad, Gujarat

A shining example of converging women's development and health programmes

- Women working in the informal economy live in chronically resource constrained environments. Being self-employed, they do not have a fixed employer-employee status and are unable to access labour laws and welfare benefits. Most of these women lack regular income, access to health facilities and food security. This dismal reality led Ela Bhatt to start the Self-Employed Women's Association (SEWA).
- In 1984, SEWA started a State-level community health cooperative called the Lok Swasthya Sewa Mandali (LSSM) in Ahmedabad and several other districts in Gujarat to provide healthcare to its members in the State. Currently, LSSM runs 400 stationary health centres that help conduct mobile health camps and four medical shops. They have 400 community health workers who are called 'Swasthya Saathis', 45 Sevikas or full-time community health educators, 500 midwives and 100 full-time health organisers who help SEWA members and their families obtain proper health care.
- Key components:
  i. **Swasthya Saathi (Health Promoters):** LSSM has trained a cadre of over 400 community health promoters to serve as primary health care providers in Gujarat. They carry out the role of a community link health workers, barefoot counsellors, traditional medicine promoters and insurance promoters. SEWA calls them 'Swasthya Saathis'.
  ii. **Low-cost Pharmacies:** Out-of-pocket expenditure for healthcare is a major concern among low income households. Most of this expenditure is incurred on medicines. To address this concern, LSSM has set up four low-cost pharmacies in Ahmedabad. The pharmacies sell low-cost generic medicines as well as Ayurvedic medicines to SEWA members, their families and public at large. SEWA caters to over 2,25,000 people annually through its four pharmacies.
  iii. **VimoSEWA:** Since 1992, SEWA has offered a composite insurance product (life, hospitalisation, accident and asset insurance) known as VimoSEWA (meaning SEWA insurance) for members and their families in India.
  iv. **Occupational Health:** Screening camps are conducted to diagnose and treat conditions like back pain, pain in limbs, asthma, tuberculosis and hypertension. Women are then counselled to get appropriate treatment from the government set Primary Health Care (PHC) centres and get medicines from the low-cost SEWA pharmacies. Patients in need of specialised medical care are also referred to private clinics with which SEWA has established strong referral linkages. The members are given free or subsidised treatment at these centres.
  v. Linkages between the community and government's social security schemes.
  vi. Reproductive and Child Health (RCH) mobile camps.
  vii. Health education camps.
  viii. Tuberculosis detection and treatment unit.

Know Your Progress

Questions

1. What is visioning in the context of development?
2. What is the role of PRIs in developing a vision for their village?

Model Answers

1. A vision helps create a better future for ourselves, our family, community, village and nation. In the context of development of our village, visioning can highlight local level needs in practical terms, identify gaps and priorities and areas of intervention. Visioning ensures participation of all stakeholders, especially women and other vulnerable groups.

2. PRIs can create awareness of development programmes, highlight gaps and priorities in their implementation. This can increase women's participation in inclusive planning, implementation and monitoring of these programmes. PRIs can also help in mapping and allocation of resources in community level planning through the Gram Sabha.

References

Kar, S.B., Pascual, K.C. and Hazelton, T. (2000).Empowerment of Women for Health Development: A Global Perspective, Social Science Medicine, Vol 50(11):1701.

Unit 3.3: Participatory Planning to Empower Women and Improve Health Outcomes

Introduction

Participatory planning is a process that a community undertakes to reach a given vision/goal by consciously diagnosing its problems and charting a course of action to resolve these problems. Experts are needed, but only as facilitators. A true participatory approach is one in which everyone's perspective is considered. Everyone actually gets to participate in the planning process and plays some role in decision-making. Each person's ideas are respected and it is not assumed that the professionals or the well-educated automatically know what is best.

This unit is a continuation of Unit 3.2, where participants developed a vision around a MCH issue that was identified as a gap in their local area. The focus in this unit is to give participants clarity on steps of planning and inclusive development. Through practical exercises, participants will learn to analyse local needs and priorities, develop an action plan that addresses those needs and gain confidence in presenting the plan to senior authorities.

Learning Objectives

Participants will be able to:

- Understand the significance of being sensitive and responsive to local issues and needs of the community to gain ownership and involvement of community members
- Learn about the steps in the planning process that is inclusive and based on priorities of the community
- Gain confidence about articulating their needs and presenting to officals concerned/ Panchayat

Session Plan

Time	Session	Content	Methodology	Resource Material
1.5 hrs	Unit 3.3: Particpatory planning to empower women and improve health outcomes	• Developing a village/ block level action plan to address the vision statement defined in Unit 3.2	• Small group work and discussions • Presentations	• Flip charts, markers, printed copies of Hand outs

Tips to the Facilitator

As a facilitator, it is important to follow simple local planning methodologies and techniques that can be used at the village level, leaving out the planning jargon so that these processes are widely understood when planning is conducted within the wider community.

As the participants go through the planning steps in teams, be careful to act more as an advisor and less as a decision-maker. Be more reactive than proactive, waiting to be approached for advice rather than just offering it, turning questions asked by the planning teams to points for reflection. As a facilitator, be willing to let the teams make mistakes and learn from trial and error. If they think something a team proposes will not work or is not a good idea, confine yourself to asking questions rather than giving solutions.

Step 1

In the last unit, participants created a vision for the kind of work they want in their village/ block. This unit involves what they need to do to make their vision a reality. This may seem like an overwhelming task and many may feel it is the responsibility of the government or other officials to change things around. However, as Panchayat representatives, health workers and programme implementers, the participants have the power to create their own future. They have the resources and community to support them. They need to learn how to plan to convert their vision into reality. The planning process is critical to achieving goals. Tell the participants what went into the planning of this workshop.

Ask participants to share their understanding of planning and what it entails.

- Have any of them been involved with the VHSNC to develop a village health plan?
- What processes are used by the Village Panchayat Committee to plan activities?

Allow a discussion for five minutes and inform them that this unit will explore and review the key steps of the planning process that can be applied to any situation.

Step 2

Ask the participants to select an example from their work area and talk them through the different steps taken to accomplish tasks to achieve a target. Select a task that participants are familiar with, such as organising a health check up at the Primary Health Centre or planning a village level meeting with local women or campaigning against early marriage. Ask a volunteer to note down the steps of the planning process being mentioned during the discussion by participants on a flip chart.

Stages of the Planning Process

1. Priority: Identify the priority.
2. Community mobilisation: Identify and mobilise community stakeholders, especially women and partner NGOs or organisations.
3. Mapping: What resources are available in the village and with whom and where.
4. Make and present the case: Create a case for action and present this to the Panchayat or Gram Sabha officials.
5. Create a plan of action: Create a plan of action including the first milestone and coordinate with other stakeholders (Village Panchayat Committee/Village Health Committee/SHG groups/ block level officials/medical officers/local women who are considered leaders or positive deviants, etc.).
6. Meeting the goals: Major milestones are accomplished.
7. Building on accomplishments: Is the project complete? What more can be done? How can it be monitored?

Step 3

Highlight some key issues that need to be kept in mind for village/block level planning.

- Plans that reflect local needs and voices facilitate involvement of a greater number of people and mobilisation of local resources because a sense of collective ownership is generated.
- Plans that mainstream the voices of poor, marginalised, women and other disadvantaged groups from all strata of local people gain wider social acceptance.
- Plans made at the local primary health care level need to consider plans made at the national or State level and vice versa. The local plans are the base of district, State and national plans. The village level planning process will not only guide national planners to understand the issues faced by communities at the local level, but also provide an opportunity for local planers to understand the constraints of resources and technology faced by States. Optimal use of available funds and facilities can be made possible by collaborations between different programmes and resources. Share case studies 1 and 2.

Step 4

Ask the participants to re-group as they had during Unit 3.2 for the visioning exercise. Distribute charts and markers, and instruct them to develop a plan for the vision identified by them. Explain that you will be helping all the three groups while they develop their plan on one of the areas mentioned below. Give them 30 minutes for this work. Distribute Handout 1 to guide them to ask the right questions during each stage.

- Health of pregnant women and full ANC coverage (including immunisation, prevention of malnutrition and quality ANC including at least 4 visits and check up).
- Child health (reducing infant morbidity and mortality through intensification of routine immunisation including childhood diarrhoeal diseases and pneumonia, eliminating measles and Japanese encephalitis related deaths and polio).
- Adolescent health (including prevention of anaemia and full coverage of iron supplements).

Inform participants that each team will be allowed 15 minutes to make a presentation before officials from the Gram Sabha or Collector's office. They should prepare their case and plan accordingly. Each member of the team also needs to describe the one important issue they would like to address when they return to their villages post training.

Step 5

Arrange before-hand for some colleagues or officials to attend the presentations to be made by the three teams. Introduce the guest/s as members of the Gram Sabha or Collector's office or District Social Welfare Officer. Allow each team to present their case for 15 minutes. The larger group of participants and guest/s can ask questions and make suggestions to help improve the feasibility of the plan.

Summing Up

Planning that involves the local community and seeks their participation facilitates a process whereby the participants relate an ideal future vision with the realities of today and list the key events and factors where interventions are necessary.

Involving the local people in the planning, project formulation, implementation, monitoring and review of local level developmental initiatives has many advantages. Once the process starts, it leads to involvement of local people, which in turn facilitates the process of social acceptance. Whereas, when development projects are thrust from outside, in most cases, they remain non-integrated with the local social system. People do not develop a sense of ownership about them.

Inclusive planning means sharing of information not just about needs and deficiencies, but also about possible means of solution. This brings an additional resource of local knowledge and expertise, which leads to better planning as well as implementation. This kind of planning facilitates mobilisation of local resources in a significant manner because of the sense of collective ownership that is generated. These resources may be material, human or financial. These may also be experiences and expertise that are locally relevant. Involving the people at the implementation stage also ensures direct and regular monitoring of the project, ensuring timely completion. Thus, the possibility of time and cost overrun is minimised.

After the project is completed, people tend to take initiatives to develop ways and means for operation and maintenance of the new facility. Last but not the least, such planning ensures transparency and accountability, because the project work is always under the critical gaze of the local stakeholders.

Further Reading

http://www.undp.org/content/dam/india/docs national workshop capacity building of elected women representatives and functionaries of pris%20 report.pdf

Handouts

Handout 1: The Planning Process (The Hunger Project in India, 1984)

The objective is to bring out the steps in the planning process from the teams. The questions suggested are critical and facilitate the teams' creativity rather than being instructional.

1. Identifying the priority

- Our team is looking at the area of 'X'
- Why did we pick this priority?
- What is our vision about this issue?

(The team will describe the problem that persists and why it is important to solve it. Local health issues and data will strengthen their case. At this stage, the team has identified the problem and the reasons why they want to solve it.)

2. Community mobilisation

- Are there other people in the village who are concerned about this issue?
- Who are they? List to them
- Is there a way to get local women involved? Could the village women meet together in a SHG?
- Are there any other people in the community who might be interested? Are there any other groups in the village who may be affected?
- Are there any local NGOs who are involved in this work?
- Are there people in the village who might want to stop your project from happening? Who are they? Is there a way to get them on your side?
- Has the issue come up in any organised group meeting or Panchayat meeting before? Is there any official support you could expect?
- Who do you need to work with to make this vision a reality?

(The team will describe the key stakeholders – especially women and NGOs who are supportive. At this stage, the team has determined some people in the community who are concerned with the issue and who are important to resolving it.)

3. Resource mapping

- Using the chart paper, the team needs to create a picture of the situation on their village and what resources they can access.
- How many people in the village are affected by this problem? How many women and children? How many are boys and girls?
- What kinds of resources are available to you in your village (experts, officials who will support the cause, existing facilities/services, land, infrastructure, transport, allocated funds, etc.)?
- What other information can the team get from the key people involved in this issue?

4. Make and present the case

- Now that the team knows what the situation is in their village, are they ready to bring their issue to the Panchayat/officials concerned?
- How often does the Panchayat meet, or block officials or senior medical officers' visit?
- Has the team enlisted support from thought leaders and significant influencers in their village? Are there any other women leaders in the Panchayat who might be supportive? Can any of them help the team bring the issue to an official?
- What if the Panchayat or official does not accept the team's proposal? What could you do next? Could other community leaders support you in reintroducing the issue?

- Are there currently any funds available for this issue? Does the team know of any government scheme that can be accessed? Have you considered meeting with the BDO to see how he/she can assist?
- What will the team say to the other key leaders/stakeholders to get their agreement?

(The team will go through the process of making and presenting their case.)

5. Creating a plan of action

- Now that the background information is available, you have listed resources and made a presentation to Panchayat, what is the plan for action?
- Are there different parts of the plan that can be worked on by different people?
- Is there someone who can be responsible for working with the BDO or other government officials to be sure that your plan of action or requests for funds is successful?
- Is there someone who can go door-to-door to meet with other women and families in the community about this issue?
- What kind of committee will be responsible for keeping this project going? Who should be a part of it?
- Is there a first action that you can take to start your work?

(The team discusses members of the task force, sharing responsibilities and taking the first action.)

6. Implement a plan of action

- Everyone on your task force is taking action in his or her areas.
- How often do you meet together to be sure that your plan is proceeding? Who keeps track of the work to be sure you are on schedule with what you want to achieve?
- What is the first milestone that you can accomplish that will let you know you are succeeding?
- What are the next steps after that?
- What if there are problems or resistance? Do you know whom you can go to for support in overcoming them?

(The team strategises accomplishing their first milestone and working in the face of problems.)

7. Meeting the goals

- How will you know when your plan has been successfully accomplished?
- What are the major successes that you will accomplish in the first month? The first year?
- How will you acknowledge the great work of the people who are your partners in this project?

(The team discusses what will occur when their strategy succeeds.)

8. Building on accomplishments

- Once the plan is working, is there anything the team can do to be ensure it continues that way?
- How will you keep track of your plan's success?
- What will the team do next once this aspect of the vision is complete?
- Take this opportunity to think about the first and most important issue that each member of the team would like to address when they return to their villages.

Case Studies

Case Study 1: Village Health Planning (VHP) Creates Demand for Health Services

Until six months ago, the women in Mategadi Village of Latur district, Maharashtra genuinely did not understand what the big deal was with institutional deliveries. The women had been deprived of health services and benefits meant for them for so long, that they had accepted the occasional complications and hygiene-related problems arising out of home deliveries as part and package of their destiny.

This situation, however, changed altogether once they became aware of government health services meant for women. Now, they are convinced about the benefits of regular checkups at the health centre during pregnancy and also receive mobility support to reach the centre for their delivery.

Testimony to this change lies in the fact that all seven deliveries in last six months have happened in the PHC and women are happy about it.

This sea change is the outcome of local youth volunteers who worked with the women to ensure that pregnant women in their village got access to safe deliveries and benefits from government schemes like Janani Suraksha Yojana (JSY). The youth were motivated to take up community mobilisation as a result of the UNICEF-supported Village Health Planning process that took place in September, 2007 in their village. Village Health Planning (VHP) is a joint venture of UNICEF, the Latur District Administration and NGOs and was field tested for the first time in Devani block in Latur district.

The process of actual VHP, a five-day intensive and interactive village level training was carried out by Aashadeep, an NGO. Well oriented teams from this organisation completed the VHP process in 61 villages, covered by two PHCs and 14 subcentres in the block, over a period of two months. At present, there are 320 volunteers – 140 girls and 180 boys, who have taken it upon themselves to pursue health-related concerns stressed through their respective village action plan. Volunteers have also undergone a foundation training to be able to take up the action plan further.

Bridging the information gap has certainly helped in enhancing community response to institutional deliveries. Devani block as a whole seems to have zeroed in on the issue of malnourishment and institutional deliveries.

"Earlier people were not very clear on how to access them. Now we explain how the scheme works so that the women can take complete benefit of the scheme," said Bharat Gaikwad, a youth volunteer from Mategadi.

The VHP experience in Devani block clearly indicates that the response of community members to health services improves considerably when they are actively involved in health planning. This learning is very close to the idea of health plan as envisaged under NRHM.

See more at: http://unicef.in/Story/45/Village-Health-Planning-creates-demand-for-health-services#sthash.XhLqbRJi.dpuf

Case Study 2: Community Volunteers Help Prevent Polio and Promote Immunisation

Zulfikar Ahmed, a three-months-old boy became seriously ill during the communal riots in Uttar Pradesh. The three-months-old had a sudden, very high fever. He had severe loose motions. His mother Munni took him to the doctor who confirmed of polio.

Her husband, who was a rickshaw puller, earned only a few rupees a day, saved what he could for Zulfikar's treatment, often sacrificing the money the family would have used to pay for food. But despite medication, therapy and an eventual operation, nothing could help heal their son.

"I didn't know immunisation could save my child," she says sadly.

Immunisation is one of the simplest, most cost-effective, health interventions. UNICEF, with funds from the IKEA social initiative, is working to implement a ten-point Child Friendly Agenda, which includes immunisation as a key priority, in the mohallas or slums of Moradabad.

"It's a great example of human rights-based, integrated programming," said Nupur Pande, Project Officer in the UNICEF office of Uttar Pradesh. Uttar Pradesh is India's most populous State with 183 million inhabitants. An estimated 30 per cent of the population in Uttar Pradesh lives below the poverty line.

"We are not developing any new structures, but we are building the capacity of service providers, like health care workers, and empowering people in the slums to demand for better services," she says. "We are bridging the gap, but it's a slow process."

Today, Munni has become a volunteer 'change agent' in her immediate community. She and four other women work together to map the families in their neighbourhood, identifying babies that need to be immunised, mothers who need prenatal care and children who should be in school.

"Generally the families that are left are the most resistant. They need a lot of convincing. They don't understand the reason why their child gets fever or may not be aware of vaccines or know the long-term, positive benefits," says Nupur Pande. "Volunteers go

into their communities and identify families with small children, hold regular discussions to educate them and connect them to the government services available. Trained community volunteers will know the families they need to reach out to and will be accepted by their neighbours as one of their own," she added.

"What we have suffered, they should not suffer," Munni whispers softly.

In India, the Polio Partnership is led by the Government of India, with support from WHO National Polio Surveillance Project (NPSP), Rotary International, the US Centres for Disease Control and Prevention (CDC) and UNICEF as well as significant contributions by the Bill and Melinda Gates Foundation. The partners work with health workers, civil society groups and communities at all levels to make sure every child under five years gets immunised each time Oral Polio Vaccine (OPV) is offered.

See more at: http://unicef.in/Story/19/Community-Volunteers-Help-Prevent-Polio-and-Promote-Immunisation- #sthash.clzoyiSY.dpuf

Know Your Progress

Note: Step 4 in this unit constitutes a learning exercise whereby participants practise what they have learnt in the planning process by transforming their vision into an implementation plan to resolve a MCH issue.

Reference

The Hunger Project, 1984. The Trainer's Manual: The Women's Leadership Development in India,The Hunger Project in India, New Delhi.

BLOCK 4
(Optional Units)

Unit 4.1: Gender Discrimination and Declining Child Sex Ratio

(Unit to be conducted with Block 1, unit 1.2 on Social and Cultural Determinants of Maternal Health, Child Health, Immunisation and Adolescent Health)

Key Facts

- Child Sex Ratio in India has shown a sharp decline from 976 girls to 1000 boys in 1961 to 919 as per the 2011 census. According to global trends, the normal child sex ratio should be above 950.
- The Pre-Natal Diagnostic Techniques (Regulations and Prevention of Misuse) Act came into force in 1994 to curb selective sex determination. With rapid improvements in diagnostic technology, the Act was amended in 2003 in order that it became more comprehensive and was renamed the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act. There are severe challenges in effective implementation of the same.
- The main reason for skewed child sex ratio is son preference, which manifests itself not only in the pre-natal period, but in practices that discriminate against females even after birth. Girls are killed shortly after birth, discriminatorily fed with inappropriate healthcare practices, leading to a huge gender gap in infant and under-five mortality rates in some States (Jha P et al., 2011).

Introduction

The constant decline in the sex ratio in various census reports is the most glaring indicator of the existing gender discrimination in India. As per the 2011 census, the national Child Sex Ratio (CSR) was 914 girls per 1000 boys (children aged 0–6 years), the lowest since independence (see key facts for more data). Widespread gender discrimination and preference for male child, almost across the country, are the possible reasons for this skewed sex ratio.

As discussed under Block 1 Unit 2 (Social and Cultural Determinants of MCH), the preference for boys can be attributed to tradition - boys perform their parents' last religious rites, inherit the family's property and carry on the father's name. Girls are considered 'parayadhan' (the asset of another), a financial burden - their dowry and wedding can cost their family's life savings. These traditional biases coupled with advanced technologies and their abuse (especially ultra-sonography) have become a recipe for disaster. There is evidence to show that prenatal sex determination, followed by selective abortion of females, has been one of the key reasons for 50 million girls missing from the Indian population.

Despite the legislation of Pre-Natal Diagnostic Techniques (PNDT) Act and (PCPNDT Acts – 1996 & 2003), abortions are carried out well beyond the safe period of 12 weeks, endangering the women's life. Too often, women have limited access to reproductive health care information and services and also lack support to exercise their reproductive and sexual rights. Carefully designed and rigorously implemented policies and interventions can significantly improve women's access to reproductive and sexual health and also bring changes in gender-related attitudes and behaviours.

As the reproductive and sexual right is an integral part of the primary health care, it is important for PRIs to understand the disadvantages faced by women in accessing this right for good health. This unit aims to develop an awareness that gender discrimination is a social issue, requiring a change in deep seated attitudes and beliefs, often requiring challenging existing power relations. PRI leaders, men and women, health workers and community leaders thus need to be sensitised to change their attitudes and practices to take a stand for greater gender equality.

Learning Objectives

Participants will be able to:

- Understand the impact of gender discrimination on maternal and child health, especially the most visible form of declining child sex ratio
- Strategise for prevention of sex determination at the local level and understand their role in promoting gender empowerment

Session Plan

Time	Session	Content	Methodology	Resource Material
1.5 hrs	Unit 4.1: Gender Discrimination: (Sex Selection and Son-Preference Leading to Declining Child Sex Ratio To be clubbed with Unit1.2, Social Determinants, Time Permitting	• Concepts of gender discrimination • Understanding its implication for the declining child sex ratio and strategising for the same	• Participative discussion • Game on 'access and power' • small group work	• Chart papers/flip charts, marker pens, printed copies of hand out 1 and 2 and case study • Projector and screen for viewing suggested videos (optional)

Tips for the Facilitator

It is important to get the participants comfortable before initiating discussions on an issue as sensitive as gender. Before beginning the session, ask the participants to keep the pen and paper aside, and involve their inner self for this session. Tell them this session will focus more on working as a group to design our own lessons to deal with this situation.

Step 1

Give participants copies of Handout 1 and ask them to reflect on it for a few minutes. Ask them if they like the situation or would rather want to change the same.

Ask the participants to recollect when they first realised that they are a girl or a boy and how did it benefit or disadvantage them. Give 2-3 minutes to reflect on the answer and then ask them to share their experiences. As the participants share their experiences, note down the types of discriminations and institutions, which nurture the same on a flip chart or writing board.

Highlight the fact that women are generally more at a disadvantage. Emphasise the following issues:

- Men mostly do paid work, whereas women often do unpaid (domestic) or under-paid work. Although the work is similar in nature, the disparity of it being paid or unpaid makes all the difference. For example, a women cooks, but a chef is generally a male, or a women washes clothes at home but we generally know a washer man. Domestic work is not recognised as work, hence it does not get remunerated.
- Usually, men control all resources like home, land, cars, bank accounts, etc., while women have limited or no influence due to societal norms of inheritance rights for male heirs or government giving benefits in the name of the head of the household, who is generally a man. This fact remains unchanged, despite a large number of single women (divorced, separated, widowed) in India. Give the example of a ration card and how a woman who is separated from her husband (but not divorced) can suffer because the card is in her husband's name.

Explain how many such factors lead to women bearing the burden of work, but their position in the society continues to be low. Also, link to discussions under Block 1 Unit 2 that these

differences are generally not biological in nature, but are societal rules and expectations that men and women need to behave in a certain manner. Now, ask them to reflect on how gender impacts the behaviour of men and women around them. You may encourage the discussion by suggesting pointers such as:

a. "Is it true that women are a woman's biggest enemies?"

b. "Women themselves like to be oppressed by their husbands"

c. "Women do not want to come out and be empowered"

Activity 1

Inform the participants that they will now play a game to understand this better. Invite two pairs of volunteers and ask them to leave the room for a few minutes. Explain to the rest of the participants what the exercise is about. They are to observe:

- What happens?
- Who picks up the pen first?
- How are they holding it?
- Who starts the drawing?
- How much of the drawing is done by each participant?
- Was there any struggle going on for control of the pen?

Invite the volunteers back in the room. Lay out two chart papers on the table with a single felt pen on each chart. Get each pair to stand on opposite sides of a chart. Explain the rules:

- They are to draw a picture together, using one pen by holding it together.
- No communication of any kind is allowed between them.
- They must start only when you give them the signal.

Explain what they are to draw and tell them to start. Give them five minutes. Tell them to stop and to remain seated where they are. Ask each person, in turns as to how much of the picture have they drawn. Verify the information given by asking the participants who were observers. Usually it is found that the pairs are not honest about their participation. Ask the participants what else they have observed.

Summarise the experience for understanding the importance of access and control, relating the same to decision-making and empowerment. Give the example of farming. As women and men both work on the farm, women also have access to the land. However, she can never make independent decisions about what crops to grow or whether/not to sell land. Control is having the power to make these decisions. Explain further, that control or power to make decisions is not something which can just be given, but which needs to be supported by an 'inner power' of

having the information to make the decision and the confidence in taking action. Empowerment is all about having this inner power and the right to make decisions.

Activity 2

Divide participants into small groups and give them the case study (see Annexure 1) to read and understand. Ask them to read the case study and present their analysis on a chart paper in the format shown below. Give the groups 20 minutes for this analysis and ask them to put up their charts on the walls.

Issue	**Who is impacted?**	**Who takes the decision?**	**Who controls?**	**Who has the access to information?**
Having more than two children				
Death of the infant girl child				
Need for a son				
Going for one more pregnancy				
Undergoing sonography				
Taking medicines				
Stopping breast feeding				

Pick the most comprehensive analysis and discuss it with the larger group. Some questions can be posed to guide the discussion: Who has access to information, who controls the decisions and who is impacted by the same?

Ask the participants what can be done to improve Sudha's situation. Tell them to suggest what needs to be done to help other women in their locality to prevent multiple pregnancies and sex selection. Encourage them to think how they as community leaders, health workers and Panchayat members can influence these processes. Share Handout 1 and ask them to develop an action plan of what they can do in their villages to deal with such situations.

Ask each participant to share two things they will do to create awareness about harmful effects of gender discrimination. Let them discuss the same in the smaller groups, but each individual should come up with an action plan in the given format.

Action planned	How will it be initiated	What will I do	By when	Whose support will be required	How will I get the support

Summing Up

- Sex is the biological difference between male and female, while gender is the social difference. Sex is universal, while gender is contextual and changes with time, place and culture.
- In the context of childbirth and child rearing, it is the woman who shoulders the most responsibilities. However, she can efficiently navigate this only if she has improved access to health services and information; greater control over decisions related to child birth and care; and recognised ownership (higher status as a girl/woman) in the society.
- It is important to understand that access alone will not result in change; improving control and ownership (status) require challenging the existing status quo in gender relations. Men and boys also need to be proactively involved in this process. Some initiatives can be made to sensitise them about rights of girls and women, encourage them to reflect on their own behaviour, lead by example and take responsibility to support laws and report any lapses.
- Panchayats and local functionaries can play a very important role in enabling these steps. However, it is important to note that the responsibility to question gender discrimination does not lie on women alone.

Further Readings

i. http://countryoffice.unfpa.org/india/drive/Bibloigraphy.pdf
ii. http://countryoffice.unfpa.org/india/drive/ PolicyBrief_GenderBiasedSexSelection_ UNFPAFinal_July2013.pdf
iii. http://jskvrc.gov.in/ipas/2.pdf
iv. http://www.iria.in/pndt/PNDT per cent20FAQ per cent20for per cent20Implementing per cent20Bodies.pdf
v. http://www.unfpa.org/sites/default/files/resource-pdf/UNFPA_Publication-39865.pdf
vi. http://paa2006.princeton.edu/papers/60960
vii. http://www.vigyanprasar.gov.in/Radioserials/9discrimination.pdf
viii. http://paa2015.princeton.edu/uploads/153669
ix. http://asiapacific.unfpa.org/webdav/site/asiapacific/shared/Publications/2014/Sex-Ratios-and-Gender-Biased-Sex-Selection.pdf
x. http://www.theatlantic.com/international/archive/2013/03/the-huge-cost-of-indias-discrimination-against-women/274115/

IEC materials

https://www.youtube.com/watch?v=-Ua-SZ1_GeY
https://www.youtube.com/watch?v=k1IXCpi9hI4
https://www.youtube.com/watch?v=DyG1gu9tkdo
https://www.youtube.com/watch?v=7AuPwuwWvoc
https://www.youtube.com/watch?v=vn9UDmjFxQQ
https://www.youtube.com/watch?v=1rs24NPbmdI
http://unicef.in/Story/1155/Umeedon-Ki-Udaan

Handouts

Handout 1: Child Sex Ratio and Gender Discrimination In India

- The use of ultrasound technology has become the most common mode of sex determination that allows families to act on their preference for sons, at the cost of daughters. This sex selection has increased as reflected in the steep and continued decline in the child sex ratio across the country.
- The Child Sex Ratio (CSR) is a powerful indicator of social health of any society. CSR is calculated as the number of girls per 1000 boys in the 0-6-year age group.
- In certain parts of Punjab, Haryana, Uttar Pradesh, Madhya Pradesh, Maharashtra and even Delhi, there are less than 850 girls for 1000 boys.
- CSRs are falling in large parts of western, central and eastern India which include Maharashtra, Goa, Rajasthan, Madhya Pradesh, Uttar Pradesh, and Andhra Pradesh has joined the ranks from among the southern States.
- Data indicated more deaths of female children who are first or second born, suggesting that there is ignorance and negligence of the female child in the higher birth order.
- It is estimated that the practice of sex selection has resulted in an estimated 50 million girls missing in India.

Child Sex Ratio in India (2001-2011)

S. No.	State/UTs	Child Sex Ratio (0-6)	
		2001	2011
	INDIA	927	919
1	JAMMU & KASHMIR	941	862
2	HIMACHAL PRADESH	896	909
3	PUNJAB	798	846
4	CHANDIGARH	845	880
5	UTTARAKHAND	908	890
6	HARYANA	819	834
7	NCT OF DELHI	868	871
8	RAJASTHAN	909	888
9	UTTAR PRADESH	916	902
10	BIHAR	942	935
11	SIKKIM	963	957
12	ARUNACHAL PRADESH	964	972
13	NAGALAND	964	943
14	MANIPUR	957	936

15	MIZORAM	964	970
16	TRIPURA	966	957
17	MEGHALAYA	973	970
18	ASSAM	965	962
19	WEST BENGAL	960	956
20	JHARKHAND	965	948
21	ODISHA	953	941
22	CHHATTISGARH	975	969
23	MADHYA PRADESH	932	918
24	GUJARAT	883	890
25	DAMAN AND DIU	926	904
26	DADRA AND NAGAR HAVELI	979	926
27	MAHARASHTRA	913	894
28	ANDHRA PRADESH	961	939
29	KARNATAKA	946	948
30	GOA	938	942
31	LAKSHADWEEP	959	911
32	KERALA	960	964
33	TAMIL NADU	942	943
34	PUDUCHERRY	967	967
35	ANDAMAN AND NICOBAR ISLANDS	957	968

Source: Census of India, 2011.

Handout 2: Key Definitions and Role of PRIs in Reducing Gender Discrimination and Preventing Sex Selection

Sex

- Biological difference between male and female
- Is same all over the world

Gender

- Social construct (differences) of men and women
- Is contextual
- Changes with time, culture, class and age

Gender Roles

Gender roles are particular social behaviours associated with gender. They are behavioural models that have been learnt and they differ from one society or culture to another. Gender roles develop continuously and are thus products of particular times. Women have the burden of triple roles including:

- **Reproductive Work:** Work connected with the family (reproductive work), for example household tasks, housekeeping and child-rearing, which is usually unpaid work.
- **Productive Work:** Work connected with production (productive work), for example the production of goods and services, which is usually wage-paid or salaried work.
- **Community-related Work:** For example, taking care of community services, activities and needs, which is usually an unpaid work.

Gender Needs

- **Practical Needs:** Material needs in order to satisfy basic needs of life such as nutrition, and relate to socio-culturally accepted roles in society.
- **Strategic Needs:** Are connected with status of women and men and power structures within the community. Examples: Right to own land, right to make decisions, participation in decision-making.
- **Relief or Special Needs:** Immediate requirement for survival or recouping from a crisis, addressed by short-term practical interventions.

Gender Analysis

Understanding the gender roles and needs in a society and profiling the same to understand the access and control of men and women as well as their condition and position in any given society.

- **Access:** Gives a person the use of a resource, e. g., land to grow crops.
- **Control:** Allows a person to make decisions about who uses the resource or disposal of the resource, e.g., sell land. Base-line data in a complete gender analysis establishes whether there is any differential in men's and women's access to three key categories of resources i.e., economic/ productive, political and time.
- **Condition:** This refers to the material state in which women and men live and relates to their responsibilities and work. Improvements in women's and men's condition can be made by providing for example, safe water, credit and seeds (practical gender needs).
- **Position:** Position refers to women's social and economic standing in society relative to men; for example, male/female disparities in wages and employment opportunities, unequal representation in the political process, unequal ownership of land and property and vulnerability to violence (strategic gender need/interests).

Gender Empowerment

The word `empower' means `to enable'. Enabling implies motivating by enhancing personal efficacy. As a motivational construct, empower means creating conditions for heightening motivation for task accomplishment through development of a strong sense of personal efficacy.

Role of Panchayat in Reducing Gender Discrimination and Preventing Sex Selection

- Create awareness on the importance of the girl child.
- Celebrate events to show value of women and girls, especially valuing parents with only girl children.
- Ensure that women are respected in your village; discuss the issue in the Gram Sabha
- Stand-up for the causes of women and girls in your village.
- The Gram Sabha could pass a resolution against violence against women, especially domestic violence and dowry demands.
- Stand by the daughters of your village who challenge domestic violence and come back home; give them a respectable place in the village.
- Create awareness on PC-PNDT Act and closely monitor and report any cases that you hear about.
- Work to declare your village as a 'Girl-Friendly Village'.

Know Your Progress

Questions

1. State if the following statements are true or false. If false, share the correct statement:

- Women are by nature more suited to cook food. (False, both men and women can learn this skill.)
- Nature has not bestowed men with the capacity to take care of children. (False, both men and women can learn this skill. Other than breast feeding, men can perform all tasks related to caring for children.)
- It is the woman who is responsible for the sex of the child. (False, it is the chromosome Y from the man that determines the sex of the child.)
- Women are more accountable for sex selection than men, since it is the mother who goes for the abortion. (False, while women may go for the abortion, it is social pressure from family and society that determines her behaviour.)
- Child Sex Ratio can be improved only if the position of women in the society is improved. (True)

2. Share two things you will change within yourselves (either behaviour/perception/attitude) to stop gender discrimination in your family and neighborhood.

Annexures

Annexure 1: Case Study for Activity 2

Sudha belongs to a small village in Rajasthan, about 30 kms from the district headquarters. She is 22 years old and works as an agricultural labourer. Sudha is the mother of three girls. Her eldest daughter is six years old, the second one five years and the youngest daughter is 6 months old. She also had another child four years back, who died when she was three months old.

Her mother-in-law is now pressurising her to stop breast feeding the child so that she can begin to conceive soon. Sudha's husband Ram is very loving and supportive. He cares a lot for Sudha and often brings sweets in the evening, hiding it from the family. They cannot afford the same for all their children and other members. His only expectation from Sudha is to give him a waaris to carry on his family name. He is also worried about her declining health due to multiple pregnancies and hence has been suggesting that this time she gets pregnant they should get the child photographed before birth (read sonography).

Ram has also been visiting a local hakim who has given him some powder which he claims will lead to the birth of a son. Ram wants Sudha to start taking the medicine soon. Sudha does not know what to do. Sudha feels very weak and is really afraid of another pregnancy. Also she feels that if she stops feeding her daughter, this girl may also die like her earlier child.
Sudha does not know what to do.

References

Jha P. et al. 2011.Trends in Selective Abortion of Girls: Analysis of Nationally Representative Birth Histories from 1990 to 2005 and Census Data from 1991 to 2011. Published online at www.thelancet.com.

Unit 4.2: Early Marriage and its Impact on Maternal, Child and Adolescent Health

(Unit to be conducted with Block 2, Unit 2.2.3 on Adolescent Health)

Key Facts

- In India almost half (47 per cent) of a nationally representative sample of women aged 20–24 years reported having married before age 18 years (IIPS-ORC MACRO, 2006). Of these, 20 per cent or approximately 3,00,000 are mothers to at least one child.
- Early motherhood is associated with increased likelihood of neonatal death and stillbirth, infants
- born with low birth weight, and child and infant morbidity and mortality. These disproportionate risks are a result of social and health-related vulnerabilities among adolescents, including increased rates of poverty, maternal depression and malnutrition.
- The Prohibition of Child Marriage Act, 2006, was notified on January 10, 2007 and it replaced the Child Marriage Restraint Act, 1929. Child Marriages are voidable and can be annulled.

Introduction

Early marriage, defined as a formal marriage or informal union before age 18, is an unfortunate reality for both boys and girls in India; however, girls are more negatively affected. Marrying young girls is rooted in gender discrimination, characteristic of a patriarchal society. Social norms, perceived low status of girls, poverty, lack of education, safety concerns about girl children and control over sexuality are considered to be reasons for prevalence of early marriages. Girl children in rural areas are more affected than their urban counterparts.

Girls who marry young are essentially forced into sexual relationships that expose them to early pregnancy at the cost of their physical and mental health. Marriage before 18 years usually entails early sexual activity and early and frequent pregnancies. Notably, complications from pregnancy and childbirth continue to be the leading cause of death among girls aged 15-19 years, primarily due to risk of unplanned pregnancies, lack of access to reproductive health information and services and inability to negotiate contraceptive use. This also puts young girls at high risk for contracting sexually transmitted infections and HIV.

Early marriages can be prevented. In India, under Prohibition of Child Marriage Act, 2006, the legally accepted age for marriage is 18 for girls and 21 for boys. The minimum legal age for marriage tries to safeguard the interest of a child so that s/he is able to achieve a minimum level of physical, sexual and emotional maturity before they marry, which otherwise would be detrimental to her/his physical, sexual and mental health.

However, delaying the age of marriage also requires working with communities to question, challenge and change such norms. PRIs have a key role in creating a favorable family and social environment to empower the girl child and help her attain her maximum potential. Actions are needed at the local level to influence family and community norms to delay marriages as well as ensuring education for all girls and boys on the issue. This unit provides an overview of early marriages in India, legal provisions and role of PRIs in community mobilisation.

Learning Objectives

Participants will be able to:

- Understand the status of early marriage in India and its socio-economic and cultural causes
- Describe the consequences of early marriage, particularly on health of girls and its link with child survival
- Get an overview of laws against child marriage and the role of PRIs in preventing early marriages

Session Plan

Time	Session	Content	Methodology	Resource Material
1.5 hrs	**Unit 4.2:** Early Marriage and its Impact on Maternal, Child and Adolescent Health To be clubbed with Unit 2.2 – Adolescent Health, Time Permitting	• Status of early marriage in India and its socio-economic and cultural causes • Consequences of early marriage • Legal provisions and role of PRIs in preventing early marriages	• Group work on causes and consequences framework Presentation on legal provisions for early marriage	• Flip charts, markers, charts for group work • Projector and screen, printed copies of hand outs

Tips for the Facilitator

Practices such as child marriage are deep rooted in traditions and assume moral standing for communities. Participants may not always be open to sharing experiences or relating instances that have occurred in their locality. The aim is to develop an awareness about the harmful consequences of this practice and reassure them about resources available to prevent it.

Step 1

Begin the session by asking the participants what they feel about early marriage, does it still exist in their area? If the participants come up with cases of early marriage, encourage them to talk about the case and consequences.

Share some key facts on early marriage with them. Some of the key facts are as follows:

- The proportion of early marriage is between 50 per cent and 70 per cent in several States. The States with the highest rates of early marriage (50 per cent and above) are Bihar, Rajasthan, Jharkhand, Uttar Pradesh, West Bengal, Madhya Pradesh, Andhra Pradesh and Karnataka (UNICEF, 2012). But even in low prevalence States, there may be regions with high rates of early marriage.
- Girls who marry before 18 are more likely to experience domestic violence than their peers who marry later. The risk of dying from pregnancy-related causes is four times higher for adolescents under 16 years than for women in their early twenties. Girls between 15 and 19 are twice as likely to die of pregnancy-related reasons as girls between 20 and 24.
- If a mother is under the age of 18, her infant's risk of dying in its first year of life is 60 per cent greater than that of an infant born to a mother older than 19. Infants born to young mothers are more likely to be born underweight, premature and experience serious health problems.

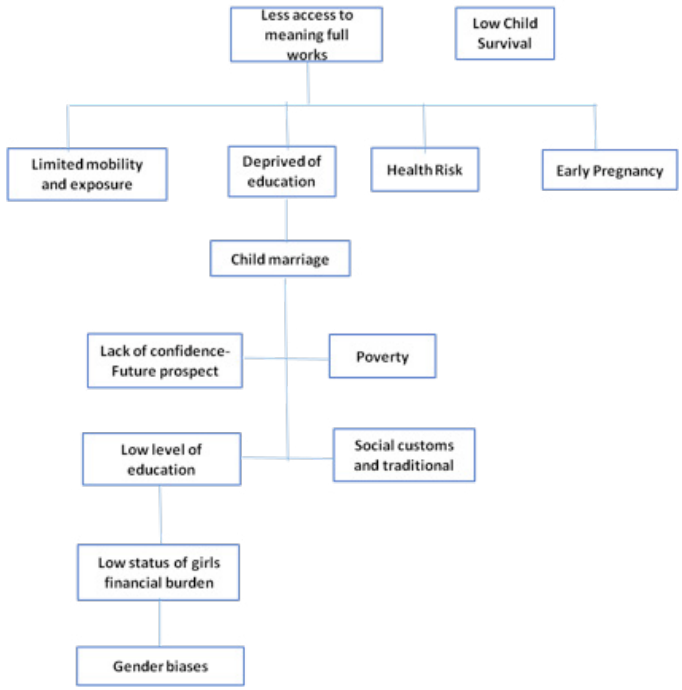
Activity 1: Causes and Consequences of Early Marriage

Ask the participants to list the causes and consequences (impacts) of early marriage. With the help of some volunteers, write each issue on a separate card. Once you have at least 10 cards, start putting them up on the board or a brown paper. Follow the given sequence while sticking the cards:

- Place the card on 'Early Marriage' in the centre
- Place all causes below and consequences above the main card

Now ask the participants, what are the underlying causes behind the listed causes and keep adding cards accordingly (you may have to shuffle cards to accommodate the discussions). Keep probing deeper by asking the question "Why does this happen?" at least 3 to 4 times for each card.

Repeat a similar exercise for "consequences". Place emphasis on health risks to both women and children in discussion. The question that can be asked here is "So what happens next?" You should get a problem tree similar to the one indicated below:



Ask the participants what comes to their mind on seeing the tree. What are actual causes of early marriage and how does it have a long-term impact on women in particular and on child survival (share printed copies of Handout 1).

Now ask the participants, if something could be done to address these issues. Try to identify solutions for each issue separately (write them on each card). Encourage discussions on how to initiate action on these and what is within the purview of the PRIs and local health functionaries to undertake.

Optional: End the exercise by showing a short film on positive action against early marriage (http://unicef.in/Story/1155/Umeedon-Ki-Udaan-Geeta's Story).

Step 2

Legal Provisions and Strategies for Prevention of Early Marriage in India

Make a presentation using PowerPoint slides covering the following aspects (Annexure 1):

- Early marriage-legal provisions
- Limitations of legal provisions and need for societal action to prevent early marriages
- Strategies to prevent early marriage and role of PRIs

Ask each participant to pick up two activities, which they can initiate in the near future (within the next six months) in their villages to ensure rights of girls and women and empower them to delay marriage. Suggest participants pick activities pertaining to some key areas: empowering girls and women; strengthening implementation of laws and policies; ensuring continued and quality education of girls and creating linkages between community members (parents, teachers and village elders) and schemes/government programmes /institutions that support delayed marriages (such as SABLA, Kishori Shakti Yojna, Village Child Protection Committees (VCPC), initiatives led

Action point	Resources and support required	Possible challenges	How will they overcome

by UNICEF or other NGOs) (Refer to Annexure 2). Their action plan can be in the format below:

Summing up

- Early marriage affects children's right to survival, development, protection and participation.
- It is a violation of child rights, whether it happens to a girl or a boy. However, it impacts girls with a stronger incidence and intensity.
- Not only is it a form of sexual abuse and exploitation, but it also limits the child's freedom of decision, access to education and therefore to better life opportunities in the future.
- Early marriage bears important health consequences and exposes young girls to early pregnancies and contraction of HIV/AIDS and other STDs.
- In India, early marriage is defined as the marriage of boys below the age of 21 years, and girls below 18 years and is illegal as per The Prohibition of Child Marriage Act, 2006.
- However, for preventing early marriages legal action is not enough; it requires change in social norms. All participants can help in creating awareness about this harmful social practice by acknowledging progressive role models and creating support groups at all levels.

Further Readings

https://childlineindia.org.in/pdf/Child-Marriage-handbook.pdf
http://www.icrw.org/child-marriage-facts-and-figures
https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/3613210.pdf

http://vikaspedia.in/social-welfare/women-and-child-development/child-marriages
http://unicef.in/Story/1130/Early-Marriage-A-childhood-interrupted#sthash.RVkUmgFp.dpuf

IEC Materials

https://www.youtube.com/watch?v=UamNBfI5P8o&feature=channel_video_title
http://unicef.in/Story/1155/Umeedon-Ki-Udaan https://www.youtube.com/watch?v=qYIeXcpbzKY
https://www.youtube.com/watch?v=Gg7DLNqkjYk
https://www.youtube.com/watch?v=0VW2KTCy6Qk

Handouts

Handout 1- Causes of Early Marriage

Poverty

- A way to relieve the family's finances
- Rich women twice as likely to marry after 18, than poor ones

Dowry and Wedding Costs

- The older the girl, higher the dowry
- Marriage ceremonies of several girls at once, combination of marriage with other ceremonies, etc.

Limited Education Opportunities for Adolescent Girls

- Women with primary education - 26 per cent more likely to marry after 18 than illiterate women
- Women with secondary education - 2.5 times more likely to marry later than illiterate women

Patriarchal Values and Social Norms

- Not worth investing in girls
- Collective beliefs and interdependent decisions. Decisions are made based not only on one's beliefs, but on what we believe others do and others expect from us

Risks for Adolescent Girls (abuse, pre-marital sex and pregnancies, elopement, etc.), and for family's honour

Effects of Early Marriage

Early marriage often results in girls leaving school, leading to low educational levels of girls

A decision to marry a girl early usually means an end to her education.

Limited alternatives for adolescent girls (secondary school, vocational training and employment)

Early marriage also reduces the girls' opportunity to learn and to gain skills that would enable them to start an income-generating activity or to find a job.

Early marriage leads to unintended pregnancy and early pregnancy that increases the risk of complications during pregnancy and childbirth

Low levels of contraceptive use early in marriage and limited use of maternal health services. The increased risk of death or serious lasting complications such as obstetric fistula is greater

for girls in early and middle adolescence. Reduced odds of having given birth in a facility and having had skilled personnel at the delivery.

Early marriage is also linked to high infant mortality

If a mother is under the age of 18, her infant's risk of dying in its first year of life is 60 per cent greater than that of an infant born to a mother older than 19.

Children of child brides are more likely to be born underweight.

Child brides are at risk of violence, abuse and exploitation, particularly the likelihood of HIV infection and of domestic violence.

Handout 2: The Child Marriage Act

This can be downloaded at:https://childlineindia.org.in/pdf/Child-Marriage-handbook.pdf

Know Your Progress

Questions

1. State if the following statements are true or false:

- Child Marriage is good as it helps the girls to adjust easily in her new household. (False)
- Child Marriage is an internal family matter and government or panchayats cannot do anything for this. (False)
- Child Marriage is one of the major causes of low birth weight of babies and high infant
- mortality. (True)
- Child Marriage affects girls and boys equally. (False)
- Child Marriage is illegal and such marriages are not recognised by law. (True)

2. Discussion Question: What will you do if you come to hear of a child marriage about to take place in your family/neighborhood? Mention at least three steps.

Annexures

Annexure 1 - Notes for PowerPoint Presentation

LEGAL PROVISION ON CHILD MARRIAGE

The Prohibition of Child Marriage Act, 2006, was notified on January 10, 2007 and it replaced the Child Marriage Restraint Act, 1929.

A. All offences have been made cognisable and non-bailable (Section 15, PCMA 2006). Persons involved in the arrangement of such marriages may be punished by a fine of up to Rs 1 lakh and/or two years' imprisonment. persons who can be punished under the law include:

- Whoever performs, conducts or directs or abets any child marriage (Section 10, PCMA, 2006)
- A male adult above 18 years marrying a child (Section 9, PCMA, 2006)
- Any person having charge of the child, including – parent or guardian
- Any member of organisation or association, promoting, permitting, participating in a child

marriage or failing to prevent it (Section 11, PCMA, 2006).

B. Courts can issue **injunctions prohibiting solemnisation of child marriages** (Section 13, PCMA, 2006).

C. **Child marriages are voidable and can be annulled (Section 3 (1), PCMA, 2006)**

- The annulment of child marriage can be sought within a period of two years after the child who was a party to the marriage has attained majority (Section 3(3), PCMA, 2006).
- Only the children in the marriage themselves can file a petition for voidability or annulment of marriage.
- And if the petitioner is a minor as per PCMA, the petition can be filed through a guardian or the next best friend of the married child (who must be an adult of 18 years or more), along with the Child Marriage Prohibition Officer (CMPO) (Section 3 (2), PCMA, 2006).

D. **Appointment of 'Child Marriage Prohibition Officers'**

- Vested with the powers of a police officer and shall exercise the powers of investigation, summoning of parties and witness recording of statements, booking of cases against individuals and parties concerned. The said reports shall be treated as material evidence for punishing the offenders legally. Have the power to seek the assistance of the police and the police shall be duty-bound to provide such assistance to the 'Child Marriage Prohibition Officers' to enable her/him to carry out his/her duties under the Act and the Rules.
- In many States like Andhra Pradesh, Panchayat Secretaries and Village Administrative Officers are designated as CMPOs at the village level.

E. **Maintenance and custody**

- The CMPO is empowered to provide support and all possible aid including medical and legal aid to children affected by early marriages (Section 16 (3) (g), PCMA, 2006).
- The adult husband must pay maintenance to the minor girl until her re-marriage. In case the husband is a minor at the time of marriage, his guardian will pay maintenance (Section 4 (1), PCMA, 2006).
- Children born from an early marriage are entitled to custody and maintenance because the law considers such children legitimate for all purposes even after the marriage has been annulled (Sections 5 and 6, PCMA, 2006).

F. **Village Child Marriage Prohibition and Monitoring Committees** should be constituted in every village to monitor and supervise the implementation of the Act. The members of the committee could be Gram Panchayat Sarpanch (Chairperson), Panchayat Secretary, village administrative officers of revenue department, local school teacher, members of self-help group/ gram samakhya, elected panchayat women members, ANMs, NGOs functioning in the

area, members from youth organisations preferably a woman, village officers, ASHA and/or an anganwadi worker.

Annexure 2: Strategies to Prevent Early Marriage- Role of PRIs and Health Functionaries

A. **Assist the Child Marriage Prohibition Officer** in preventing early marriages as per section 16 (2) of the Act by convincing parents against conducting early marriages.

B. **Filing a complaint against any case of early marriage.** Since arranging or solemnising a marriage is a cognisable offence, a complaint has to be made in the nearest police station.

- A complaint can also be filed with a Judicial Magistrate of First Class or a Metropolitan Magistrate
- Complaints can be either oral or written, in the form of a phone call, a letter or a telegram, email, fax or a simple handwritten note duly signed by the complainant

C. Assist the Child Marriage Prohibition Officer or the police in enforcing the law by providing necessary support and information. **Support prosecutions** bereft of emotive issues.

D. **Set-up a Child Protection Committee** within the Panchayat to create awareness and monitor child protection issues such as early marriage.

E. **Community mobilisation**

- Create awareness within the community about the law and educate the community about implications/consequences of early marriage
- Encourage the parents to wait for their children to reach the age of maturity (i.e., 18 years for girls and 21 for boys) before they are married
- Coordinate preventive action around 'auspicious' days
- Engaging adolescents as well as families including parents/ in-laws through formation of groups and behaviour change communication
- Creating local pool of resources i.e., peer educators, youth forums from representative communities, etc.
- Orienting key community influencers including religious leaders and basic health care workers
- Creating safe spaces for adolescents i.e., Adolescent Development Centres, Youth Information Centres, Gender Resource Centres
- Engage with youth groups with equal participation from boys and girls including those out of schools (mostly young people from rural areas)
- Encourage ASHAs who have easy access to women, village leaders and elders as members of the Village Health and Sanitation Committees. They can initiate discussion on health issues like anemia, problems faced by young mothers and reasons of poor health of children born to very young mothers
- Invite officials from different government departments (health, education, social welfare, etc.)

to talk about harmful impacts and legalities of early marriage on occasions like 'Mamta Diwas', 'Kishori Mela', Republic Day celebrations, etc.
- Felicitating positive women and girl role models (with Navjyoti awards) who have resisted early marriage successfully or acted as change agents
- Knowing the strong correlation between education and early marriage and ensuring all girls receive schooling at least up to higher secondary

F. **Encourage life skills-based education programme dealing with:**
- Challenges of growing up
- Negotiating with parents to delay marriage
- Continue education
- Choosing vocation
- Seeking services for their reproductive and sexual health concerns through peer education approach

G. **Enabling environment**
- Building alliances and network with like-minded organisations/agencies
- Work with local media
- Implement various government programmes targeting adolescent/youth like Sabla and informing communities

H. Assist enrolment and retention of all children, especially of girls, in schools by making the Village Education Committee aware of the issue of early marriage and enabling them to play a vigilant role in preventing early marriages. This could be done by keeping track of school dropouts and ensuring their enrolment and retention in schools, and making education accessible to all. Support to married girls attending schools should also be strengthened

I. Initiate compulsory **registration of marriages** by the Gram Panchayats and recording of age at the time of marriage

J. Ensure that no member of the Gram Sabha or Gram Panchayat is involved in promoting early marriages. For offenders within the Gram Panchayat, apart from legal action according to the law, their membership must be revoked. Other elected representatives in the Panchayat must ask the Member Secretary to take necessary action in this regard.

References

International Institute for Population Sciences (IIPS) and ORC Macro. National Family Health Survey (NFHS-3), 2005-06; India. Mumbai: IIPS.

UNICEF. 2012. Child Marriage in India: An Analysis of Available Data 2012. UNICEF India, New Delhi.

Unit 4.3: Understanding and Dealing with Myths and Traditional Beliefs around MCH

(Unit to be conducted with Block 2 unit 2.3.2 on Infant and Young Child Feeding Practices)

Introduction

Myths and traditional beliefs reflect values and beliefs held by members of a community for periods often spanning generations. Some of these are beneficial to all members, while others are harmful to a specific group, such as women. These harmful myths include nutritional taboos and traditional birth practices; son preference and its implications for the status of the girl child; early pregnancy; practices around breast feeding, treatment during illness and immunisation among others. Despite their harmful nature, these behaviours are practiced because they are not questioned and take on an aura of morality in the eyes of those practicing them.

A key reason responsible for the persistence of traditional beliefs and myths detrimental to the health and status of women, is that most women in rural India are unaware of their basic human rights. It is this state of ignorance which ensures their acceptance, and consequently the perpetuation of harmful beliefs and myths, affecting their well-being and that of their children. Even when women acquire a degree of economic and political awareness, they often feel powerless to bring about the change necessary to eliminate gender inequality. Empowering women is vital to any process of change and to the elimination of these harmful traditional practices.

PRI members, health workers and others working for the health of communities and villages can play a key role in undertaking comprehensive and intensive programmes of formal and informal education in collaboration with women's groups, Village Health, Sanitation and Nutrition committee (VHSNC), ICDS functionaries along with non-governmental organisations to create awareness about myths and traditional beliefs that are harmful.

Learning Objectives

Participants will be able to:

- Understand and clarify prevailing local myths and misconceptions around MCH
- Clarify their role in increasing women's and community's awareness regarding myths and traditional beliefs

Session Plan

Time	Session	Content	Methodology	Resource Material
1 hr	**Unit 4.3:** Understanding and Dealing with Common Traditions and Myths around MCH To be clubbed with Block 2nd Unit 2.3 on Infant and Young Child Feeding Practices	• Common myths and taboos, cultural causes • Consequences and clarification of common local myths • Role of PRIs in educating communities	• Discussions on common myths and group work	• Blackboard and chalk, list of common myths written out on a chart and printed copies of hand outs • Printed copies of hand outs

Tips for the Trainer

Be sensitive to participants' feelings and beliefs. Contextualise the beliefs and taboos. Highlight the harmful myths that perpetuate gender bias and have a negative effect on the health of mothers and children, especially girls. There may be some participants who are well informed and can be encouraged to share their experiences and point of view. This can encourage others to follow their example.

Step 1

Display the following set of statements on a chart. Ask participants to state whether these are true or false. Note down the scores of 'T' or 'F' after every statement on the chart.

- A baby needs to be given sugar-water or honey before the first breastfeeding.
- Vaccines like polio drops are contaminated with animal blood that could render their child impotent
- A pregnant woman should consume less food lest the baby's delivery is difficult
- Giving a child multiple vaccinations for different diseases at the same time increases the risk of harmful side effects and can overload the immune system
- A woman who becomes pregnant must stop breastfeeding
- A pregnant woman should not eat certain types of food (spicy, pickle or fruits such as papaya or guavas)

A community's beliefs regarding food are strongly dictated by local practices, upbringing, superstition and religion. Encourage the participants to think and reflect about their own lives and add more points to the discussion, especially listing taboos that they face. Encourage them to recount incidents, comments and altered behaviours of those around them.

Ask the participants whether they agree or disagree with the above statements. They can raise their hands if they agree with the above statements. Share the following example with the

participants: 50 per cent to 70 per cent of the burden of childhood diarrheoa and respiratory infections is attributable to under-nutrition. It is compounded by food restrictions during illness due to false beliefs and myths, leading to a vicious cycle of malnutrition and infection (Benkappa Asha D., Shivamurthy P., 2012). In the long run, this gradually decreases the child's productivity which is an obstacle to sustainable socio-economic development. It is important that the quantity and quality of feeding should be appropriate for a child's age.

Disease consumes calories. Food restriction in illness leads to calorie deprivation and malnutrition, with frequent illnesses. Malnutrition causes mucosal damage and lowers immunity, leading to a vicious cycle of infection and malnutrition. An extra meal for 2 weeks is needed during the period of a child's recovery. Yet, it is commonly observed that families and mothers restrict breast and regular feeding during sickness. A child's illness is a crucial moment for counselling regarding child feeding patterns.

Share copies of Handouts 1, 2, and 3 with the participants.

Activity 1

Divide the participants into three groups. Ask each group to assign a leader who will facilitate discussions in the group. Assign each group to discussing and analysing one common local myth on any one of the following topics: pregnancy and child birth; maternal and child nutrition and immunisation.

The following guidelines may be given to the group members: Use critical thinking to objectively analyse and reflect on the practice without judgment, evaluate the myth on the basis of any scientific or logical reason for the origin of the myth. The groups also need to brainstorm on how to challenge/question the specific myth. They must come up with a strategy and probable actions that can be taken to counter the prevailing myths that are harmful for the community.

Allow each group to present for 15 minutes. Some suggestions to add to their ideas include talking to their elders or family members and convincing them that these restrictions/taboos are not scientific and have no basis; advocating with and involving respected and influential community leaders to build awareness about why it is important to not follow these practices at community gatherings/health melas; involving and motivating religious leaders in the community to dispel some of these deep-rooted religious beliefs in their communities during their talks and interactions. They can demystify beliefs regarding harmful myths and explain that health promoting practices have nothing to do with religious mandates. They can convey and reinforce messages to promote healthy practices during sermons, religious ceremonies or when they informally talk to postpartum women and/or their families. Good communication skills as well as use of creative thinking skills can help participants think of options and solutions.

Give participants 20 minutes to work in groups. Allocate five minutes to each group to share one myth in detail with the larger group.

Summing up

- Despite their harmful nature, many myths and harmful discriminatory behaviours are practiced on the basis of morality, especially as most women in rural India are unaware of their basic human rights.
- Food restrictions during illness prevail due to false beliefs and myths, leading to a vicious cycle of malnutrition and infection. Women and children need to take appropriate, nutritious and healthy diet especially during illness.
- PRIs and health workers play a key role in collaborating with VHSNC and ICDS functionaries to undertake an informal education of communities to dispel myths and taboos.

Handouts

Handout 1: Myths and Facts on Breast Feeding, Published in mdCurrent-India by Dr. Gaurav Gupta in June, 2014

Myth: First milk (colostrum) should not be given to children.
Fact: Colostrum is thick milk that is colourless or yellowish. Colostrum helps protect the child from diseases as it aids in the development of the new-born's immune system (rich in several essential vitamins and antibodies). It has a cathartic effect in that it prompts the excretion of excess bilirubin from the new-born and decreases the chances of jaundice.

Myth: The mother should not breastfeed if suffering from an infection.
Fact: If the mother has an infection, the baby, like any other family member, would normally contract the infection through close contact with the mother. While breastfeeding, in itself, is unlikely to pass the infection, it will pass antibodies to the baby that will help the baby fight the infection and get better faster. That being said, breastfeeding should not be stopped if the mother has an infection. However, there are certain infections like HIV, TB, human T-cell lymphotropic virus type I or II and untreated brucellosis, which can be dangerous for the newborn, and breastfeeding should be stopped when such infections are present.

Myth: Infants need water in addition to being breastfed.
Fact: Breast milk is rich in water, so breastfed babies do not need additional water. Feeding on water and other fluid supplements decreases the newborn baby's interest towards breast milk. The decreased demand for milk from the baby results in the decreased secretion of oxytocin and prolactin, which ultimately decreases the milk production in the lactating mother.

Myth: A pregnant woman must stop breastfeeding.
Fact: Breastfeeding does not have any effect on the pregnancy or the quality of the breast milk, so it can be continued during pregnancy and after the birth of the newborn.

Myth: Breastfeeding changes the shape and size of the breasts.
Fact: Partly true! Hormonal changes during pregnancy alter the look and feel of the breast. When you first begin breastfeeding, your breasts may become swollen with milk and grow to be larger in size. However, a regular, timely feeding for the appropriate duration will diminish the size of your breast. Depending on hereditary factors, breast size may then remain larger or return to their original size.

Myth: Nipples should be washed each time before feeding the baby.
Fact: Washing the nipple makes the area dry by removing all the naturally protective oils. Use of soap should be especially avoided around the nipple. Rubbing hind milk (the milk that comes at the end of the breast feed and is rich in fats) on the breast after feeding can keep the nipple moist and hydrated, as well as prevent soreness.

Myth: A baby needs to be given sugar-water or honey before the first breastfeeding.
Fact: These substances have traditionally been given before the baby is first breastfed, however this does more harm than good to the new born, as they predispose the baby to infection. The new born fed on breast milk from the start has less chance of developing a respiratory tract infection, Sudden Infant Death Syndrome (SIDS), GIT infection, necrotising enterocolitis, obesity, diabetes, childhood leukaemia and lymphoma, celiac disease or inflammatory bowel disease.

Myth: A neonate cries predominantly because of inadequate breast milk.
Fact: Excessive crying doesn't mean inadequate milk, alone. There are several reasons for a baby's excessive crying. Fever, ear infection, abdominal pain, general discomfort and simply wanting to be picked up are all reasons for which a baby could be crying. However, it is recommended to see a pediatrician if crying is excessive to a point of concern.

Myth: No drug is safe to take while breastfeeding.
Fact: There are a limited number of medications that are contraindicated during breastfeeding, for they could potentially pass through the milk to the new born, but the rest can be taken safely.

Myth: The amount of milk secretion in the lactating mother depends on the size of breast.
Fact: Milk production in the lactating mother depends on the demand of the milk from the baby, rather than the size of the breast. An infant sucking at the breast increases the secretion of oxytocin and prolactin in the mother, which ultimately results in the increased secretion of milk.

Hand out 2 - Misconceptions Related to Maternal Health Care

Myth: Morning sickness during pregnancy means baby is probably not getting enough nutrition.
Fact: Morning sickness is just one of the most common symptoms of pregnancy which arises due to hormonal changes in the body. It is a condition where even the sight, smell or thought of food might make pregnant women uneasy. Weight gain in the first few months of pregnancy is minimal. In fact, some women even lose a little weight in the early stages of pregnancy. Unless one notices

warning signs like dehydration, severe weight loss or severe morning sickness, there is no need to panic. One should stick to the advice of the doctor and take supplements as advised.

Myth: Slightest of touch over the tummy can harm the baby.
Fact: Baby in the womb is well protected in the uterus and is cushioned from minor bumps, stumbles, and falls by the amniotic fluid in which s/he floats. Moreover, the abdominal layers protect the fetus from any minor accidents. However, if anyone experience cramps or vaginal bleeding, contact the doctor immediately.

Myth: Carrying heavy things will induce labour.
Fact: This is partly true. Picking up heavy load can aggravate backache and can cause spinal injury. However, if it doesn't strain the pregnant woman and if she does it in the right way, it is fine to lift some amount of weight. For instance, carrying grocery bags and young kids is perfectly fine if one does it in the right way. The right technique is to bend the knees to lift anything and carry it close to the body. It is advisable not to bend from the back as this will prevent weight from affecting the back. Also, instead of straining just one side of body, always divide the weight equally between two arms.

Myth: A woman should not get hair dyed when she is pregnant.
Fact: It is best to avoid chemicals like hair color during the first three months as these get absorbed from the scalp and reach the blood stream. During the latter half of pregnancy, however, it may not be that risky. Still, natural and herbal preparations should be preferred.

Myth: Pregnant women with low belly have a boy, and pregnancy acne means a girl.
Fact: It is totally false. How a woman carries her baby depends on her body type and whether she has been pregnant before. But in either case, it does not reflect the gender at all. Also, in a second pregnancy, the pregnancy may appear to be lower since abdominal muscles may be looser. It is also strongly believed that too much eating would lead to birth of female baby, which is also false.

Myth: Pregnant women should not change cat litter.
Fact: This is true. A virus called Toxoplasmosis infection is carried in cat feces. This virus can be very harmful for pregnancy. In fact, contact with kitty litter is not just limited to changing the cat litter box, the virus can be tracked anywhere a cat walks, including its paws. Due to this, all contact with the cat must be limited and the house must be kept extra clean.

Myth: Fruits like papaya should be avoided during pregnancy for fear of abortion.
Fact: This is an unfortunate and false myth because these fruits are good and cheap sources of vitamin A. Other items like banana, guava and gingelly seeds are also avoided during pregnancy for various reasons. Protein rich foods like fish and eggs are also avoided during pregnancy by many women because of myths.

Handout 3: Common Myths about Immunisation (Published on the website of vaccineindia.org.)

Myth: I am breastfeeding so my child doesn't need immunisations.
Fact: Immunisations are still needed. While breastfeeding is the best nutrition for your baby, it does not prevent infections the way vaccines do. Your child may have fewer colds, but breastfeeding does not protect against many serious illnesses such as whooping cough, polio and diphtheria like immunisations do.

Myth: It is unsafe to immunise a child who has a cold and fever.
Fact: A child with minor illness can safely be immunised. Minor illnesses include the following:

- Low-grade fever
- Ear infection
- Cough
- Runny nose
- Mild diarrhea in an otherwise healthy child

Myth: Children have serious side effects from vaccines, so these vaccines are not very safe for children.
Fact: Reactions to vaccines may occur, but they are usually mild. Severe reactions to vaccines are very rare. Symptoms of a more serious reaction include the following:

- Very high fever
- Generalised rash
- Large amount of swelling at the point of injection

If any of these symptoms occur, contact the health worker/doctor right away.

Myth: Giving a child more than one immunisation at a time can be dangerous.
Fact: Studies and years of experience show that vaccines used for routine childhood immunisations can be safely given together. Side effects when multiple vaccines are given together are no greater than when each vaccine is given on separate occasions. Talk to your pediatrician if you are concerned about the number of vaccines your child is scheduled to receive.

Myth: Infants are too young to get vaccinated.
Fact: Children are immunised in the first few months of life because several vaccine-preventable diseases infect them when they are very young. It is very important for infants to be fully immunised against certain diseases by the time they are six months old. Fortunately, young infants are surprisingly good at building immunity to viruses and bacteria.

Myth: Vaccines weaken the immune system.
Fact: Natural infection with certain viruses can indeed weaken the immune system. This means that when children are infected with one virus, they cannot fight off other viruses or bacteria as easily. This happens most notably during natural infection with either chickenpox or measles. Children infected with chickenpox are susceptible to infection with certain bacterial infections.

Children infected with measles are more susceptible to bacterial infections of the bloodstream (sepsis), but vaccines are different. The vaccine viruses are disabled that they cannot weaken the immune system. Vaccinated children are not at greater risk of other infections (infections not prevented by vaccines) than unvaccinated children.

Know Your Progress

Questions

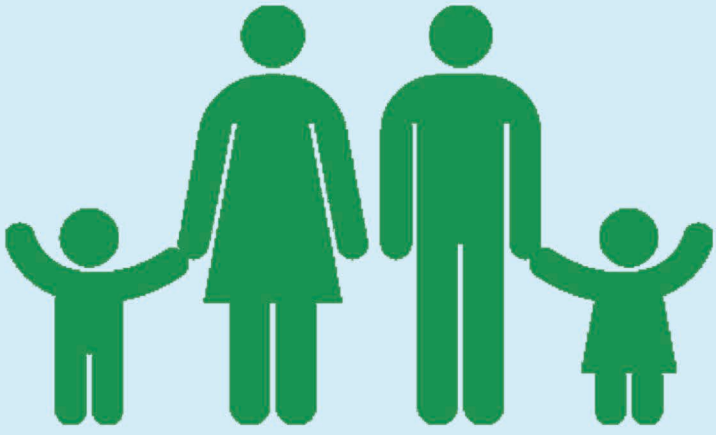
1. The old myth of pregnant women being harmed by cleaning cat litter still persists. Explain.
2. Giving a child multiple vaccinations for different diseases at the same time increases the risk of harmful side effects and can overload the immune system
3. List some resource persons whose help PRIs can use strategically to counter prevailing myths that are harmful for the community.

Model Answers

1. A virus called Toxoplasmosis infection is carried in cat feces. This virus can be very harmful for pregnancy. In fact, contact with kitty litter is not just limited to changing the cat litter box, the virus can be tracked anywhere a cat walks, including its paws. Due to this, all contact with the cat must be limited and the house must be kept extra clean when a woman is pregnant.
2. A child with a minor illness can safely be immunised. Minor illnesses include the following: low-grade fever, ear infection, cough, runny nose or mild diarrhoea in an otherwise healthy child. Studies and years of experience show that vaccines used for routine childhood immunisations can be safely given together. Side effects when multiple vaccines are given together are no greater than when each vaccine is given on separate occasions.
3. Some resource persons such as the village elders, Medical Officer and local celebrities can positively influence the community by explaining the scientific reasoning behind certain myths and endorsing healthy practices.

References

Benkappa Asha D., and Shivamurthy P., 2012. Beliefs Regarding Diet during Childhood Illness. Indian Journal of Community Medicine. Jan-march, 37 (1): 20-24.



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