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# TRAINER NOTES FOR ASHA TRAINERS

## PART 2

(Includes Content for Rounds 3 and 4 of ASHA training)





# Introduction to the Trainer Notes- Part 2

These trainer notes are intended for the use of trainers who are responsible for training ASHA and her facilitators in Modules 6 and 7. The notes are organized in three parts. This second part is a sequel to The Notes for the Trainer Part 1. Part 1 addresses the key functions of ASHA and the skills she is expected to gain, followed by maternal, newborn, nutrition and child health, covering all of Module 6 and Part A of Module 7. Part 2 for the ASHA trainer covers the remainder of Module 7, viz: management of the sick newborn, general aspects of women's health selected infectious diseases, and other issues.

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

Training of trainers (TOT) for the ASHA takes place as follows: A core of national trainers train state

trainers who are affiliated to state level training sites. These state trainers in turn train trainers drawn from the various blocks of a district who are called the ASHA trainers. They are fulltime faculty dedicated to ASHA training. The state also identifies about four to five resource persons from the district who are experts in subject matter to support the ASHA trainers when required. Together with the ASHA trainers they constitute the district training team.

TOT of ASHA trainers covers the content of ASHA Modules 6 and 7 as well sessions on participatory training, supportive supervision and evaluation. Round 1 TOT of two weeks is designed to cover principles of participatory training, supervision, the entire content of Module 6 and the nutrition and child health content of Module 7, i.e. Part A. This enables the ASHA trainers to carry out the first two Rounds of the ASHA workshops. Round 2 TOT is spread over seven days and covers the management of the high risk and sick newborn and women's reproductive health. The agenda for Round 2 TOT is at Handout 1. Round 3 TOT is spread over five days and will cover malaria, tuberculosis and revision of previous topics, including overall evaluation. The agenda for

Round 3 is in Handout 1a. For ASHA, Round 3 training covers management of the high risk newborn and women's reproductive health. Round 4 covers infectious diseases. Rounds three and four of ASHA training also include substantial time for revision of topics taught in previous rounds. The agenda for Round 3 and Round 4 of the ASHA training is in Handout 2 and Handout 2a. Accreditation and

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

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

### Organization of Trainer Manual- Part 1- already covered in Round 1 TOT

Session No.	Topic	Competencies covered:	Training Modules 6 and 7 Equivalence	Page Nos
1	INTRODUCTION	Structure of training: Training course content Workshop Schedule (Handout 1)	Not part of Module 6 and 7	1-17
2	BEING AN ASHA- MEASURABLE OUTCOMES OF ASHA	Linking measurable outcomes to skills, Role Clarity of an ASHA and how to organize her work.	Module 6 Part A, Sections 1-8, Pages 1 to 17 The ASHA film if available would be an important part of this session.	18-34
3	PARTICIPATORY TRAINING	Principles of participatory training Methods of Participatory Training.	Not part of Module 6 and 7.	35-45
4	FACILITATION AND SUPPORTIVE SUPERVISION	Principles of supportive supervision Facilitation skills. Roles of various functionaries who support and complement her work.	Module 6 Part A Section 9, page 18. In addition, specific skills of facilitation for ASHA supervisors will be taught.	46-69
5	CARE OF THE PREGNANT WOMAN	Pregnancy diagnosis – skills in the use of Nischay kit and Determining LMP and EDD. Antenatal care and Birth planning. Management of Anemia, Identifying complications in pregnancy and referral, Interpersonal communication.	ASHA Modules 6, Part B, Sections 1-4, pages 19-33	70-81
6	THE BIRTH COMPANION ROLE	Why and what is a birth companion? Essential knowledge for birth companion: What happens	ASHA Module 6, Part B, Sections 4-5, Pages 34 to 37	82-26



Session No.	Topic	Competencies covered:	Training Modules 6 and 7 Equivalence	Page Nos
		during labour and birth? Times of different stages of labour. Readiness for emergencies. Recognising pregnancy outcomes, and providing immediate care at birth.		
7	HOME VISITS FOR THE CARE OF THE NEWBORN AND POST PARTUM MOTHER	When to visit and What to do on a home visit to newborns and the post partum mother	ASHA Module 6 part C: Sections 1 to 3, Pages 41 to 49 and Part B, Section 6: pg. 38	87-112
8	BREASTFEEDING	Initiation of breastfeeding. Support to breastfeeding. Breastfeeding problems and issues, Expressing Breastmilk	ASHA Module 6, Section 4: pages 50 to 56,	113-123
9	KEEPING THE NEWBORN WARM	Why keep the newborn warm? How to keep it warm? How to warm a cold baby? How to manage in hot weather? How to manage fever in a newborn?	ASHA Module 6 Section 5: pages 57 to 60.	124-139
10	INFANT AND YOUNG CHILD FEEDING	Why address malnutrition? Adequacy in complementary feeding/IYCF. Skills of counselling. Skills in assessment of malnutrition. Update on immunization	ASHA Module 7: Part A, Sections 1 to 3 pgs 5 to 19.	140-148
11	ASSESSING THE SICK CHILD	What are the Danger signs? Skills in assessing and classifying ARI, diarrhoea, fever, anemia, malnutrition? Knowing immunization status and how to ensure complete immunization.	ASHA Module 7: Part A, Sections 4 and 5, Pages 20 to 23	149-152
12	CLASSIFYING AND MANAGING DIARRHOEA	Classifying diarrhoea Knowing when and where to refer for diarrhoea. Skills to manage diarrhoea at home. Communicating skills on prevention of diarrhoea.	ASHA Module 7, Part A Section 6, pages 24-28	153-155
13	ACUTE RESPIRATORY INFECTIONS (ARI)	Signs of ARI. Skills for suspecting pneumonia. Knowing when to refer. Skills in home management for cough and cold.	ASHA Module 7: Part A Section 7, pages 29-31.	156-159

Session No.	Topic	Competencies covered:	Training Modules 6 and 7 Equivalence	Page Nos
14	FIELD IMMERSION	Working with the ASHA. Understanding her context. Communication with ASHAs	Not part of ASHA Module	160-161
15	EVALUATION OF KNOWLEDGE AND SKILLS OF ASHA	Skills of evaluation and evaluation of ASHA.	Not part of ASHA Module	162-168
16	EVALUATION OF ASHA TRAINERS	How to evaluate trainers and provide feedback	Not part of ASHA Module	169-171

## Organization of Trainer Manual - Part 2 (Rounds 2 and 3 of TOT)

1  2	ASSESSMENT AND MANAGEMENT OF THE HIGH RISK NEWBORN	Skills in diagnosis, management and referral of Low Birth Weight and Preterm Babies, Skills in assessment of asphyxia and sepsis, Skills in management, counseling and referral.	ASHA Module 7, Part C, Sections 1-4, pages 49-55
3	WOMEN'S REPRODUCTIVE HEALTH	Skills in counseling for safe abortion, referral, and post abortion care, methods of family planning, contraceptive counseling, spacing and limiting methods, and referral, Understanding RTI/STI/HIV, counseling, referral for testing, treatment and follow up.	ASHA Module 7, Part B, Sections 1-3, pages 35-46
	INFECTIOUS DISEASES	Malaria and Tuberculosis: Knowing Causes, Signs and Symptoms, Role of ASHA in prevention and treatment,	ASHA Module 7, Part D, 59- 63

## Handout 1:

# Agenda for Round 2 TOT for ASHA Trainers

## Session Detail

### **Day 1:**

Welcome, Sharing of experiences after ASHA Training Rounds 1 and 2, Feedback on methods, materials, Revise Topic on Home visits for the care of the newborn and Post Partum mother (Pages 87- 112 of Trainer Notes -Part 1)

### **Day 2:**

Assessment and Management of the High Risk Newborn: LBW, Pre term and Asphyxia

### **Day 3:**

Practice Session for Assessment and Management of the High Risk Newborn

### **Day 4:**

Neonatal sepsis: Diagnosis, Management and Referral<sup>3</sup>

### **Day 5:**

Practice session for Neonatal Sepsis

### **Day 6:**

Family Planning, Safe Abortion and RTI/STI

### **Day 7:**

Evaluation

## Handout 1a:

# Agenda for Round 3 TOT for ASHA Trainers

## Session Detail

### **Day 1:**

Welcome, Sharing of experiences after ASHA Training Rounds 3, Feedback on methods, materials, Revision of Contents of Round 1 workshop

### **Day 2:**

Revision of Contents of Round 2 workshop

### **Day 3:**

Infant and Young child feeding and Assessment and Management of Sick Child

### **Day 4:**

Infectious Diseases: Malaria and Tuberculosis, Review of forms to be filled in

### **Day 5:**

Evaluation



## Handout 2:

# Agenda for Round 3 of ASHA training

## ASHA Training Workshop Round 3

### Day 1

Welcome and introduction	One hour
Review of field experience	Two hours
Revision of session on Home visit for the newborn and post partum mother:	Rest of the day

### Day 2:

Assessment of the High risk Newborn (Preterm and Low Birth Weight):	Six hours
Asphyxia Diagnosis and Management:	Two hours

### Day 3:

Diagnosis and Management of Sepsis:	Five hours
Safe Abortion	One hour

### Day 4

Family Planning/RTI/STI:	Three hours
Visit to PHC/CHC to see cases of Sepsis and LBW and observe facility management	

### Day 5

Reviewing Forms to be filled in:	Two hours
Evaluation and Summarizing the workshop:	Two hours
Planning for work in the community	Two hours

(On Days Three and Four, trainers must provide time for the ASHAs to practice and evaluate the use of the mucus extractor)

## Handout 2a:

# Agenda for Round 4 of ASHA training

## ASHA Training Workshop Round 4

### Day 1

Welcome and introduction	One hour
Review of field experience	Two hours
Revision of assessment and management of high risk newborn:	Rest of the day

### Day 2:

Home visit to the newborn and care of the post partum mother:	Three hours
Assessment and Management of high risk newborn and neonatal sepsis:	Three hours

### Day 3:

Malaria and Tuberculosis	Four hours
Reviewing records, registers and forms	Three hours

### Day 4:

Community and facility visits for counseling practice	All day
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### Day 5

Evaluation	Four hours
Planning for work in the community	Two hours

### Handout 3:

## Planning the ASHA training workshop: A note for trainers

### Review by trainers and programme managers to plan for and ensure the following points:

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

### Tips on organizing and conducting a successful training programme.

#### *Making it Residential:*

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

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

### Making it participatory, non hierarchical, and building solidarity:

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



evenings. For certain events they may ask the ASHAs to share the responsibility. This develops organization capacity in ASHAs.

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

### **Getting the training aids ready**

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

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

### **Field visit preparation**

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

### **Training Evaluation**

- a. To be sure the training objectives

have been met, the trainer is asked to evaluate the ASHA whether the learning objective has been met. An evaluation box is found at the end of each session indicating how the trainer should check to see if the objectives have been met. Some of the sessions have formal evaluation through case studies or questionnaires. Through questions and answers, the trainers should ask participants to explain the curriculum; if they answer correctly; this will indicate that the objective has been met.

- b. Answer sheets for evaluation should be checked immediately and the scores should be shared with the trainees. The problems should be discussed with the trainees and misconception should be cleared. If this is not done immediately then the trainees proceed further in learning the content and confusion remains in any part of content based on the content of the test. For quite some time after writing the test paper mind of ASHA still lingers in the test and hence it is necessary to share the result when her memory is still fresh. Never delay sharing the result.

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

### **Other points to note:**

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



## Handout 4:

### Guidelines for State trainers when conducting TOT for ASHA trainers

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

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

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

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

#### Training Tips for State Trainers:

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

twice. One state trainer is responsible for each group of trainees.

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

### **Notes for the Trainer:**

On Day 1 of Round 2 of TOT or Round 3 of ASHA training, the trainer will review the contents of the previous round of training and identify areas of skill and knowledge gap. The trainer will also enable sharing of experiences from the field.

### **Points to revise in preparing for Session 1 on the next day of training:**

- Key task to be undertaken during the first hour after birth
- First examination of the newborn
- The skills and importance of handwashing
- Skills required to measure temperature of the newborn
- Skill to use hand held scale to weigh newborns, correct to the nearest 50gms.(or as per the scale in use ).



## Session:1a High Risk Assessment and Management of Low Birth Weight and Pre Term babies

*(Session 7 of Round 2 ASHA: "Home visits for the care of the newborn and post partum mother" should be revised before this session is taught)*

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

- Understand which newborns are high risk
- Understand her role in the case of a high risk newborn
- Identify and refer high risk newborns.
- Counsel the mother on how to breastfeed a high risk newborn.
- Teach mothers to express milk and feed such babies using a bowl or spoon.

**Methods:** Discussion, Reading, Role Play and case discussion

**Materials:** Worksheet 1

**Duration:** Five hours

### Activities:

**Step 1:** The trainer initiates a discussion with the group which is focused on their understanding of what a high risk baby is?

**Step 2:** The trainer defines when a baby can be classified as low birth weight or pre-term (Module 7, Page 49)

**Step 3:** The trainer then asks the group to read Page 49 individually, and make sure that all ASHAs are familiar with the definitions and classification.

- a When should an ASHA say that the baby is low birth weight? How can the ASHA determine if the baby is low birth weight?
- b When should an ASHA say the baby is pre term?

**Step 4:** The trainer then asks the ASHAs taking in turns to read aloud from Pages 50 and 51, and discusses the contents with the group to ensure that each point is well understood.

**Step 5:** The trainer then discusses the guidance that should be given to the parents of a high risk newborn. This is done in the form of a role play. The trainer divides the ASHAs into groups of five. Give each group a scenario to perform and allow 20 minutes to discuss and prepare their role play. Have each group perform the role play to the whole group and discuss. Examples of such scenarios include:

- At delivery: Baby 1.8 kg; able to suckle well. Normal temperature.
- At delivery: Baby 1.3 kg; Preterm. Cold. Not able to suckle well.
- At delivery: Baby 1.4 kg; Preterm. Not suckling well.
- Day 2: Baby 1.6 kg. Preterm. Able to suckle a little.
- Day 2: Baby delivered at 1.5 kg. Able to suckle well.

**Step 5:** The trainer hands out a worksheet (Handout 1) with a set of cases and asks ASHA, working individually to fill in the responses. The trainer should ensure that the groups are able to cover the various

issues of care, functions of the ASHA, and breastfeeding advice and support

in the case of babies who are able to suckle and who are not.



## Evaluation of the session

Objective	Assessment Method	Output
Assessing knowledge on pre term and LBW babies	Case study analysis	Trainer to collect individual worksheets
Assessing ability of ASHA in providing guidance to families and mothers	ASHA to list all key messages on a sheet of paper	Trainer to collect individual sheets
Assessment of skills on counseling on breastfeeding of high risk babies	Role play in step 4	Trainer to provide feedback
When to refer a high risk newborn?	ASHA to list all key signs on a sheet of paper	Trainer to collect individual sheets

## Worksheet : Hand out 1: Assessment of high risk newborns

1. Baby Sarala was born at 8 months 10 days of pregnancy. The ASHA was present at the birth. She weighed Sarala and found that her weight was 1.9 kg.

Is Sarala preterm? Why?

What about her weight?

Is she at any additional risk?

What kinds of risks?

2. Anand was born at 8 months 24 days of pregnancy and weighed 2.3 kg.

Is he preterm? Why?

Is he low birth weight?

Why?

3. Priya was born at nine months 16 days of age. Her mother had high fever for seven days during pregnancy. Priya weighed 2.0 kgs at birth.

Is Priya preterm? Why?

Is Priya LBW? Why?

What risks does Priya now face?

4. Mira was born at 8 months of pregnancy. Her mother was an

agricultural labour who worked for all the time she was pregnant for almost ten to twelve hours in the day. Mira was born at the PHC and her weight reported by the ANM was 1.8 kgs.

Was Mira Preterm?

Was she LBW?

What are the reasons?

What can be the risks for parents to guard against?

Name of the ASHA :

Date :

Name of the trainer :

Block :

Total score :





## Home Visits



### For high risk babies



If possible visit the baby every day for a week. Then visit once every three days until the baby is 28 days old, and if the baby is improving, once on the 42<sup>nd</sup> day. Advise the mother to keep the baby warm and breastfeed after every two hours.



Weigh the baby on days 7, 15, 21, 28, 42.



If the baby is not gaining weight, and weighs less than 2300 grams on the 28th day, refer the baby to a hospital. Continue to visit once a week until the baby is two months old, and weigh the baby each time.



Remember to fill the home visit form for high risk baby.



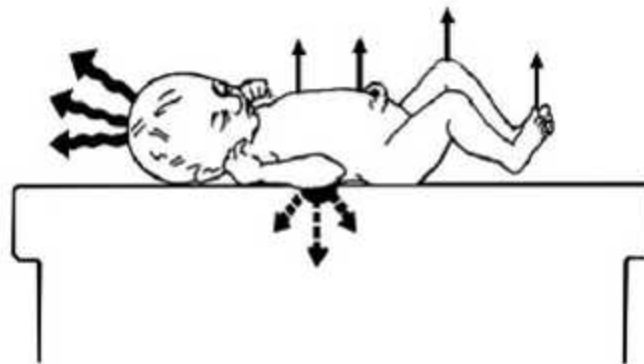
Continue to visit the mother and baby until the baby is two years old.

## Notes for the Trainer:

1. The definition of low birth weight is if a baby is below 2500 grams at birth. It is determined by weighing the newborn at birth. If the ASHA's first visit to the newborn is later than 24 hours, then the ASHA should weigh the baby, and use the chart on Page 49 to determine whether the baby is high risk or not.
2. Ask the ASHAs what is the definition of preterm. (Answer: 8 months 14 days of pregnancy or less) Ask how preterm is determined. (Count from the first day of the last menstrual period to the day of delivery. ASHAs can also use the chart to determine EDD and preterm based on LMP.)
3. Explain that most preterm babies, babies born too soon, are LBW but some babies born at full term pregnancy are also LBW. LBW among newborns born at full term pregnancy can be caused by:
  - Mother who is under weight
  - Mother getting smaller quantity of food to eat or not eating nutritious food during pregnancy
  - Mother has had an illness during pregnancy
  - Mother is anaemic
  - Mother continues to work heavily throughout pregnancy without enough rest
4. Risks of the LBW infant.
  - LBW infants lose body temperature faster than normal babies as they have a difficulty in maintaining their body temperature (less body fat, thinner skin, big head that

loses heat fast, and poor capacity to generate body heat).

- LBW babies are more prone to infections such as pneumonia, or other infections
  - LBW babies may have difficulty in breastfeeding leading to weakness, poor growth, and ill health.
  - Preterm babies are at risk of jaundice (turning yellow) and if very young, of bleeding in the head, and of death.
5. LBW babies are at higher risk of dying:



- If a baby weighs 2.5 kg or more (green colour on the scale), the risk is comparable to 1 paisa in 1 rupee (1 out of 100).
- If a baby weighs less than 2.5 kg (colour yellow on the scale), the risk is comparable to 6 paisa in 1 rupee (6 out of 100).
- If the baby is less than 2 kg (colour red on the scale), the risk is comparable to 36 paisa out of 1 rupee (36 out of 100).
- If the baby is preterm, the risk is comparable to 36 paisa out of 1 rupee (36 out of 100).

## Answers to Handout 1: Worksheet on pre term and Low Birth Weight.

1. Baby Sarala was born on at 8 months 10 days of pregnancy. The ASHA was present at the birth. She weighed Sarala and found that her weight was 1.9 kg. Is Sarala preterm? Why? What about her weight? Is she at any additional risk? What kinds of risks? *(Preterm because Sarala is less than 8 months and 14 days gestation; she is low birth weight, less than 2500 grams; she is at additional risk of hypothermia, infection, problems with breastfeeding; developing jaundice, and death.)*
2. Anand was born at 8 months 24 days of pregnancy and weighed 2.3 kg. Is he preterm? Why? Is he low birth weight? Why? *(Dharam is not preterm because his gestational age is above 8 months and 14 days; he does have low birth weight because he is under 2500 grams.)*
3. Priya was born at nine months 16 days of pregnancy. Her mother had high fever for seven days during pregnancy. Priya weighed 2.0 kgs at birth. (Is Priya preterm? Why? Is Priya LBW? Why? What risks does Priya now face? *(Priya is not preterm, but she is a LBW baby. She faces getting infections, hypothermia, may have difficulty in breastfeeding).*
4. Mira was born at 8 months of pregnancy. Her mother was an agricultural labour who worked for all the time she was pregnant for almost ten to twelve hours in the day. Mira was born at the PHC and her weight reported by the ANM was 1.8 kgs. Was Mira Preterm? Was she LBW? What are the reasons? What can be the risks for parents to guard against? *(Mira is preterm and LBW, maybe because her mother did not get sufficient rest during pregnancy, she is at risk of hypothermia, infections, and poor weight gain).*



## Session 1b: Asphyxia diagnosis and management

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

- Identify signs of asphyxia in the newborn
- Support and if necessary, manage asphyxia in the newborn

**Methods:** Discussion, case analysis, demonstration on a mannequin

**Material:** Worksheet, Life sized doll or mannequin with open nostrils and mouth, saucer, water

**Duration:** Three hours

### Activities:

**Step 1:** The trainer discusses with the ASHA how many home deliveries they have attended. Why are there persistent home deliveries in spite of women being motivated for institutional deliveries? Have the ASHAs been in situations where the delivery has taken place in the vehicle or in the facility where she is alone with the woman and her relatives? How did they cope? The trainer asks the ASHAs to explain local terms for asphyxia, what is generally done for such babies and what the outcome is.

Trainers should then explain that the skill to be taught in this session will be used by them only in case of home deliveries where there is no skilled birth attendant.

**Step 2:** The trainer then presents on flip charts, the definition, consequences, and signs during

pregnancy and delivery that can warn of asphyxia. (From pages 52 Section 3, Part C, Module 7).

**Step 3:** The trainer emphasizes this point: If a baby has asphyxia, the first five minutes after delivery are an emergency. A baby's life can be saved or lost in these five minutes. Even of these five minutes the first minute is critical.

**Step 4:** The trainer draws the asphyxia action tree and enables the ASHA to understand this with reference to the diagram in their own copy of the Module7, Page 53)

**Step 5:** The trainer then demonstrates the use of the mucus extractor as described in Notes for the Trainer.

**Step 6:** The trainer then asks the ASHA to read pages 52-53 Section 3, Part C, Module 7).

**Step 7:** The trainer now distributes Worksheet 1: Identifying asphyxia and asks ASHA to fill this in individually. (Correct responses are provided in Notes for the Trainer)

**Step 8:** ASHA should be skilled in using the mucus extractor. Since the batch size is likely to be 20-30, this will need to be covered with taking extra time out in Days 3-5 to ensure that all ASHA are able to correctly demonstrate the use of the mucus extractor

**Step 9:** The trainer tells the ASHAs that while they must strive to save the newborn using the mucus extractor, the effort may not be successful and they should not feel bad or blame themselves for this.

## Evaluation of the session

Objective	Assessment Method	Output
Assessing knowledge on identifying asphyxia	ASHA to complete Worksheet 1	Trainer to collect individual worksheets
Skill in using mucus extractor	Trainer to observe ASHA doing this	Trainer to provide feedback and support till ASHA does this correctly



## Worksheet 1: Identifying Asphyxia

For each case example, note if the baby is asphyxiated or not.

	Yes	No
1. Parvin's baby was born at 12:03. At 30 seconds it was crying and breathing well. Is it asphyxiated?		
2. Neela's labour started at noon and she gave birth at 8:30 pm. to a girl. At 30 seconds the baby was not crying and gasping. Is the baby asphyxiated?		
3. Gulabo delivered on April 1. Immediately after delivery her baby had a weak cry and was breathing weakly. Is the baby asphyxiated?		
4. Nanda, aged 40, gave birth to her 4th child. It was a long labour. The baby came out limp and was not crying or breathing. Is the baby asphyxiated?		
5. Mumtaz, 35 years old with 3 children, delivers at 8 months and 15 days. The baby is crying weakly and gasping. Is the baby asphyxiated?		
6. Manju's baby was born with a vigorous cry and was breathing strongly.		

Write if there is a risk of asphyxia and warning signs, if any.

1. Sayra is 32 years old. She went into labour after completing 9 months 20 days of pregnancy. Labour started at 1 pm and she delivered at 11 pm, and it was a dry delivery.	Risk? Signs?
2. Meena is pregnant with her 3rd child and started labour yesterday morning. It is now a day and a half later and she seems tired.	Risk? Signs?
3. Dhanno is pregnant with her 2nd baby. During the delivery you see the baby coming out with the breech presenting (not the head).	Risk? Signs?
4. Yamuna had fever in the 7th month, was diagnosed with malaria and delivered a baby a week later.	Risk? Signs?
5. Sindhu, aged 19, delivered her 1st child. It was a difficult and long delivery lasting over 30 hours.	Risk? Signs?

Name of the ASHA :

Date :

Name of the trainer :

Block :

Total score :

## Handout 1



# Asphyxia



## Signs of Asphyxia during Labour



Prolonged or difficult labour.



Ruptured membranes with little fluid (dry delivery).



Green or yellow coloured thick amniotic fluid.



Cord comes out first or cord wound tightly around baby's neck.



Preterm labour (delivery before completing 8 months and 14 days of pregnancy).



Baby's position such that the head does not come out first.



# Asphyxia



## Managing Asphyxia



Note time of birth, and start counting time. Meanwhile clean baby and cover with a soft dry cloth.



Observe baby 30 seconds after birth. If there is no cry or only a weak cry, or if breathing is weak or there is no breathing, it means the baby is asphyxiated.



Place baby in position with head slightly extended.  
Place a folded cloth under baby's shoulders to keep the head extended.



Immediately clean the mouth with mucus extractor.



If baby does not breathe, suction the throat; if there is still no breath, suction the nose with mucus extractor.

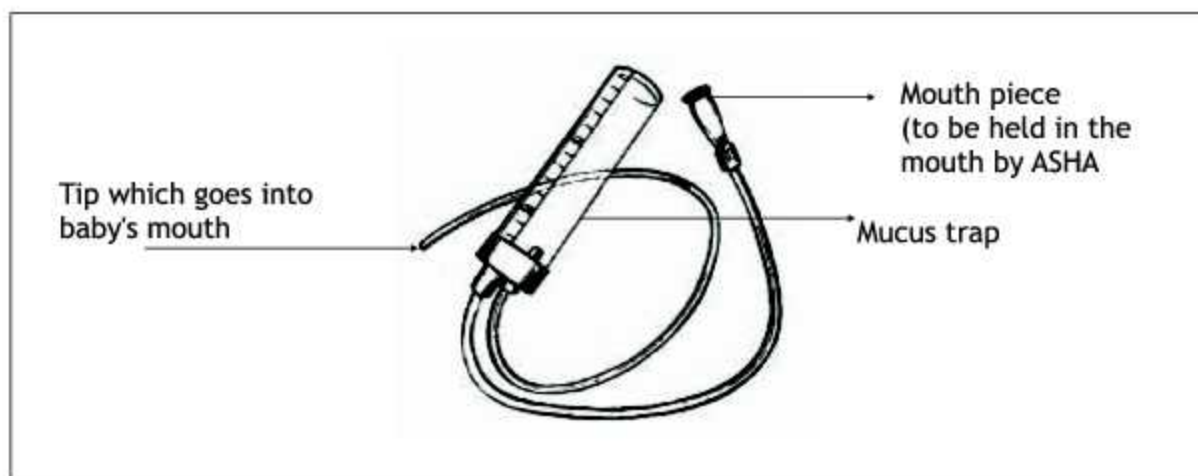
**Call for help as soon as possible.**



## Notes for the Trainer:

1. The trainer should revise Section 6 of Part 1 (The Role of the Birth Companion) and familiarize herself /himself with the section on asphyxia
2. The correct responses to the Worksheet are given below
3. The trainer should demonstrate the use of the mucus extractor using the following steps:
  1. Show the mucus extractor and explain the main parts: plastic mucus trap container, plastic tubing from baby to mucus container, tubing from container to resuscitator's mouth (see Content Box).
  2. Ask ASHAs to refer to the Skills Checklist for the Mucus Extractor, in Annexe 2
  3. First demonstrate how the mucus extractor is used by sucking in some water from a saucer or a small plate.
  4. Then demonstrate use of the mucus extractor on a life size doll. Read the steps out aloud as you perform each step.
    - 1) Place the doll in the proper position, dry and covered, lying on its back with the head slightly extended. Place a folded piece of cloth under the shoulders to help the head maintain the correct position.
    - 2) Take the mucus extractor out of the sterile wrapper.
    - 3) Place the mouth piece in your mouth. Hold the other tube in your hand at least one hand's length from the tip. Avoid touching the tip that goes in the baby's mouth to limit the risk of infection. Hold the tube well away from the end as you place it in the baby's mouth.
  - 4) Place  $\frac{1}{2}$  finger length of clear tubing in the baby's mouth and suck for a few seconds moving the tip around the mouth to clear secretions. If the baby cries and breathes normally—stop. If not, proceed to the next step. Emphasize that it is best to use the mucus extractor quickly, within the first 30 seconds after delivery.
  - 5) If the baby is still not breathing after suctioning the mouth, suction the throat. Insert the tube no further than the distance of your index finger, into the baby's throat and gently suck out any secretions. If the baby cries and breathes normally—stop.
  - 6) If the baby is still not breathing well, remove the clear tubing from the baby's mouth and place the tip into one nostril. Gently suck. Repeat with the other nostril. Be especially thorough if the mother's amniotic fluid was green, or if there is a lot of fluid in the baby's mouth. Suctioning must be done quickly, lasting only about 15-20 seconds.
  - 7) The mucus extractor is for one time use only. After use please dispose it.





## Answers for Worksheet: Identifying Asphyxia

For each case example, note if the baby is asphyxiated or not.

	Yes	No
1. Parvin's baby was born at 12:03. At 30 seconds it was crying and breathing well. Is it asphyxiated?		No
2. Neela's labour started at noon and she gave birth at 8:30 pm. to a girl. At 30 seconds the baby was not crying and gasping. Is the baby asphyxiated?	Yes	
3. Gulabo delivered on April 1. Immediately after delivery her baby had a weak cry and was breathing weakly. Is the baby asphyxiated?	Yes	
4. Nanda, aged 40, gave birth to her 4th child. It was a long labour. The baby came out limp and was not crying or breathing. Is the baby asphyxiated?	Yes	
5. Mumtaj, 35 years old with 3 children, delivers at 8 months and 15 days. The baby is crying weakly and gasping. Is the baby asphyxiated?	Yes	
6. Manju's baby was born with a vigorous cry and was breathing strongly.		No

Write if there is a risk of asphyxia and warning signs, if any.

1. Sayra is 32 years old. She went into labour after completing 9 months 20 days of pregnancy. Labour started at 1 pm and she delivered at 11 pm, and it was a dry delivery.	Risk? Yes Signs? Dry Delivery
2. Meena is pregnant with her 3rd child and started labour yesterday morning. It is now a day and a half later and she seems tired.	Risk? Yes Signs? Prolonged Labour
3. Dhanno is pregnant with her 2nd baby. During the delivery you see the baby coming out with the breech presenting (not the head).	Risk? Yes Signs? Breech
4. Yamuna had fever in the 7th month, was diagnosed with malaria and delivered a baby a week later.	Risk? Yes Signs? Preterm
5. Sindhu, aged 19, delivered her 1st child. It was a difficult and long delivery lasting over 30 hours.	Risk? Yes Signs? Prolonged Labour

## Handout 2



### Using the Mucus Extractor



Place the baby in the proper position, dry and cover with a folded towel under her shoulders. The baby's head should be slightly extended.



Take the mucus extractor out of the sterile wrapper.



Place tube with the mouth piece in your mouth. Hold the other tube in your hand at least one hand's length from the tip.



Place finger length of clear tubing in baby's mouth and suck for a few seconds, moving tip around mouth to clear secretions.

If baby cries and breathes normally, stop. If not, proceed with the next step.



## Mucus Extractor



Insert the tube no further than your index finger into the baby's throat, and gently suck out any secretions.

If baby cries and breathes normally, stop. If not, proceed with the next step.



Remove clear tubing from baby's throat and mouth and place tip into one nostril and gently suck. Repeat with other nostril.



When resuscitation is finished, dispose mucus extractor (do not reuse).



## Session 1c: Neonatal Sepsis : Diagnosis and Management

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

- Key signs and symptoms of sepsis.
- How to prevent sepsis.
- How to teach parents and family to recognize high risk signs.
- How to identify children who have sepsis.
- How to facilitate immediate referral.

**Methods:** Discussion, Worksheets, Case studies

**Material:** Worksheets

**Duration:** Five hours

### Activities:

**Step 1:** The trainer asks the ASHA if they have seen any newborns with infections? What are some of the local terms for this? Why do they think infections happen?

**Step 2:** The trainer asks the ASHA to read aloud from pages 54 and 55 from the ASHA Module 7. This is a guided

reading session with the trainer making interventions at the conclusion of each section. (Notes for the Trainer)

**Step 3:** The trainer then hands out Worksheet 1: Diagnosing sepsis. The ASHA are asked to work individually to mark their responses. The trainer collects the sheets for review and feedback at the end of the session. Correct responses are in the Notes for the Trainer)

**Step 4:** The trainer then discusses the options for management of sepsis (Notes for the trainer)

**Step 5:** The trainer then hands out Worksheet 2

**Step 6:** The trainer asks the ASHA to turn to Annexe 1 of Module 7: Home visit Form for the High risk baby (this covers all the sections of Session 1) and reviews each line with them. The ASHA must be told that although the form has only space for six visits, the newborn must be visited 13 times as indicated in Module 7 on Page 54.





## Evaluation of the session

Objective	Assessment Method	Output
Diagnosing sepsis	Worksheet 1	Trainer to collect individual worksheets
Management of sepsis	Worksheet 2	Trainer to collect individual worksheets

## Notes for the Trainer:

Explain to the ASHAs that when they visit the newborn they need to look for early signs of infection and try to prevent them. Infection in the mother, preterm, LBW, not breastfeeding exclusively, coming in contact with dirty hands or clothes are the main risks for the baby developing sepsis. Early action can help prevent sepsis in the baby.

Emphasize that often infection in the newborn shows itself locally, such as an infection of the umbilicus, or of the lungs (pneumonia) or blood. Yet, in the newborn, infections can become serious very suddenly. Babies-especially preterm and LBW babies-are unable to fight the infection effectively. The toxins spread quickly in the body, the baby

may stop crying and feeding, and become cold. It may be difficult to tell where the infection started, and since the signs and symptoms are not very clear the diagnosis may not be accurate. To help ASHAs overcome this and detect sepsis accurately, a simple method is developed using specific criteria

Point out that for a correct diagnosis of sepsis, it is essential that there is a presence of **two** criteria on the same day. Many baby will exhibit any one sign, but if two signs or more develop, it strongly indicates sepsis. Also note that the first three signs - all limbs limp, feeding less or stopped

Seven sign of Sepsis are:

- 1 All limbs limp
- 2 Reduced feeding or stopped feeding

- 3 Weak cry or stopped crying
- 4 Mother says baby become cold to touch (Hypothermia) or temperature is more 99°F (37.2°C)
- 5 Stomach distended or mother says that baby has been vomiting frequently
- 6 Chest in-drawing
- 7 Pus on the umbilicus

answers. (See Content box below.)

If they say 'practicing good hygiene', ask them to be specific (Possible answers are: *TBA washing hands before the baby is born and not putting hands inside mother, using a clean blade, ASHA and others washing their hands before touching the baby, mother washing her hands after visiting the toilet, or cleaning the baby's stool, sick persons not coming into the birth room.*)

feeding, and weak cry or no cry - are not counted as criteria if these conditions were present at the time of delivery itself. For these three criteria it is essential that the baby should not have had these signs at birth, and that these should have developed later. (For example, a baby having normal sucking at birth later on changes to weak or no suckling)

How do they keep the baby warm? (Possible answers are: *Immediately after delivery, dry the baby and keep covered with dry cloth; place close to mother and start breastfeeding; have baby wear clothes; if LBW, use warm bag and/or skin to skin contact method.*)

Ask ASHAs if sepsis can be prevented. They should answer 'YES'. Ask them to explain how. Listen to their

What are good breastfeeding practices? (Possible answers are: *Early initiation, on demand feeding, usually every 2-3 hours in first weeks, exclusive breastfeeding - i.e., no other fluids or foods.*)

#### Sepsis can be prevented by:

1. Good Hygiene: Frequent handwashing
2. Keeping the baby warm,
3. Breastfeeding (Early initiation & on demand),
4. Keeping the umbilical cord clean and dry.

Explain that ASHAs have an important role to play in preventing sepsis and in promoting infant health during each of their visits; they must check to see that good hygiene is practiced, that the baby is kept warm, especially in winters and that breastfeeding is going well.

- The ASHA should initiate breastfeeding right after delivery.
- During home visits after delivery ASHAs should make sure baby is feeding well : observe breastfeeding, ask how many times the baby fed during the night and day, weigh the baby.
- The same is true for making sure the baby is warm enough. If the temperature is less than normal, the mother needs to warm the baby and make sure it is well clothed and wrapped.
- ASHA should reinforce the practice of frequent hand washing.



## Worksheet 1: Diagnosing sepsis

1. Leela delivered a baby at home on November 30th at 8:20 a.m. At the time of delivery she had completed 8 months 5 days gestation. The baby's birth weight was 1 kg 950 grams. The baby was fine for the first 6 days.

**Was the baby normal or high risk at birth?** Normal / High risk

**Why ?** \_\_\_\_\_

**How many times would you visit the baby in the first 28 days?** \_\_\_\_\_

**What advice would you give the mother at the time of delivery?**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

On the 7th day, when the ASHA visited she found the baby had stopped suckling and had a distended abdomen. She was breathing well but her cry was weak.

**What signs are present in the baby ?**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**What is the diagnosis of baby's problem ?** \_\_\_\_\_

2. Rampyari's baby was born a week after the expected date, in the PHC, and weighed 2.900 kg. He was strong and healthy. The ASHA who was there as a Birth Companion helped Rampyari start breastfeeding and the Nurse performed the examination of the newborn after one hour. Mother and baby went home after 48 hours. On the 10th day the mother said the baby was cold. The temperature was 93°F (33.9°C). He was sleeping a lot but still feeding and crying. His abdomen was soft and his limbs flexed. His umbilical had healed well and he was breathing well with no chest in-drawing.

How was baby's temperature on the 10th day ? Normal / Less than normal

Does the baby have sepsis ? Yes / No

What signs are present in the baby ?

1. \_\_\_\_\_
2. \_\_\_\_\_

What measures can you take to rewarm a baby ?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

3. Tarabai was pregnant with her fourth baby. The baby was delivered in a PHC at 7 months 27 days of pregnancy and weighed 1.650 kg. The baby was not able to suckle well.

How do you describe this baby at birth? Normal / High risk

Why?

If the mother and the family insisted on going home after the first 24 hours and the baby was still not suckling well:

How many times would you visit in the first month? 10 / 13 / 5

What advice would you give the parents of such a baby?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_



On 17th day the baby vomited twice but continued to feed. She was not cold and had a good cry. On 28th day the baby weighed 2.250 kg.

**Depending on weight of the baby on 28th day how is the baby in the second month?**

Normal / High risk

On the 45th day the baby's all limbs were limp and the mother said the baby was cold. You take the temperature and it is 94° F (34.4° C).

**What signs are present in the baby ?**

---

---

**What is your diagnosis ?** \_\_\_\_\_

**On what day did the baby develop this?** \_\_\_\_\_

Name of the ASHA :	Date :
Name of the trainer :	
Block :	

Total Score

## Answers to Worksheet 1

1. Leela delivered at home on November 30th at 8:20 a.m. At the time of delivery she had completed 8 months 5 days gestation. The baby's birth weight was 1 kg 950 grams. The baby was fine for the first 6 days.

**Was the baby normal or high risk at birth? High risk**

**Why ?** *Preterm (less than 8 months 14 days) and low birth weight (less than 2 kg)*

**How many times would you visit the baby in the first 28 days? 13**

**What advice would you give the mother at the time of delivery?**

1. *Keep the baby warm by using the warm bag and place close to mother and/or skin to skin contact method.*
2. *Breastfeed every 2 hours.*
3. *Do not give a bath.*
4. *Wash hands often before touching baby.*
5. *Call the ASHA immediately and prepare for referral if any danger sign is observed.*

*On the 7th day, when the ASHA visited she found the baby had stopped suckling and had a distended abdomen. She was breathing well but her cry was weak.*

**What signs are present in the baby ?** *Stopped suckling, distended abdomen, cry weak*

**What is the diagnosis of baby's problem ?** *Sepsis*

2. Rampyari's baby was born a week after the expected date, in the PHC, and weighed 2.900 kg.  
He was strong and healthy. The ASHA who was there as a Birth Companion helped Rampyari start breastfeeding and the Nurse performed the examination of the newborn after one hour. Mother and baby went home after 48 hours. On the 10th day the mother said the baby was cold. The temperature was 93° F (33.9° C). He was sleeping a lot but still feeding and crying.  
His abdomen was soft and his limbs flexed.  
His umbilical had healed well and he was breathing well with no chest in-drawing.

**How was baby's temperature on the 10th day ?** *Normal / Less than normal*

**Does the baby have sepsis? Yes / No**

**What signs are present in the baby?** *Mother says baby is cold to touch and on measuring temperature is 93°F (33.9°C)*

**What measures can you take to rewarm a baby?**

- *Increase room temperature.*
  - *Remove any wet or cold blankets and clothes.*
  - *Hold the baby with his skin next to his mother's skin (skin-to-skin contact method).*
  - *Place a warmed cloth (not too warm so as to avoid burns) on his back or chest. As it cools down, replace it with another one until the baby is warmer. Continue until the baby's temperature reaches the normal range.*
  - *Put on clothes, put in warm bag, with hat, and keep the baby close to the mother.*
3. Tarabai was pregnant with her fourth baby. The baby was delivered in a PHC at 7 months 27 days of pregnancy and weighed 1.650 kg. The baby was not able to suckle well.

**How do you describe this baby at birth?** *Normal / High risk*

**Why?** *Preterm, Birth weight less than 2000 gms, unable to suckle,*

*If the mother and the family insisted on going home after the first 24 hours and the baby was still not suckling well:*

**How many times would you visit in the first month?** *10 / 13 / 5*

**What advice would you give the parents of such a baby?**

1. *Keep the baby warm by using the warm bag and place close to mother and/or skin to skin contact method.*
2. *Express breastmilk and feed to baby with a spoon every 2 hours until baby can suckle from the breast (try to put him to the breast every day).*
3. *Do not give a bath.*
4. *Wash hands often before touching baby.*
5. *Call the ASHA immediately and prepare for referral*

On the 17th day the baby vomited twice but continued to feed. She was not cold and had a good cry. On 28th day the baby weighed 2.250 kg.

**Depending on weight of the baby on 28th day how is the baby in the second month?**

Normal / *High risk*

On the 45th day the baby's all limbs were limp and the mother said the baby was cold. You take the temperature and it is 94° F (34.4° C).

**What signs are present in the baby ?** *All limbs limp, mother said baby was cold and temperature of baby 94° F (34.4° C).*

**What is your diagnosis ?** *Sepsis*

**On what day did the baby develop this?** *45th day*



## Worksheet 2: Management of Sepsis

1. Dhanno delivered at the sub center on November 30th at 8:20 a.m. At the time of delivery she had completed 8 months 5 days of pregnancy. The baby's birth weight was 1 kg 950 grams. The baby was fine for the first 6 days. On the 7th day, when the ASHA visited the baby at home, she found the baby had stopped suckling and had a distended abdomen. She was breathing well but her cry was weak. Her weight was 1 kg 900 grams. You diagnose sepsis because the baby had stopped feeding and had a distended abdomen.

**What would you do first?**

---

---

---

**How do you facilitate referral?**

**What is the treatment for this baby (dose and number of days)? If there is a nurse/ANM, they would take the decision, but if there is no other service provider then you would need to provide the appropriate treatment?**

---

**How often would you visit?**

---

**What would you tell the parents about home care?**

1. 

---
2. 

---
3. 

---

2. Vimal's baby was born in the PHC a week after the expected date and weighed 2.900 kg. He was strong and healthy. You helped Vimal start breastfeeding and the nurse performed the examination at one hour. The mother and baby left the hospital after 48 hours. On the 10th day the mother said the baby was

cold. The temperature was 93°F (33.9°C). His weight was 3 kg. He was still feeding and crying but he had chest in-drawing. His abdomen was soft and his limbs flexed. His umbilical had healed well. You diagnose sepsis.

**What would you do first?**

---

---

**What treatment does this baby need?**

---

**What do you tell the parents before you leave?**

1. 

---

2. 

---

3. 

---

**How often do you return?**

---

3. Kajubai was pregnant with her fourth baby. The baby delivered at home 7 months 27 days gestation and weighed 1.650 kg. The mother did not want to go to the hospital because there were young children at home and no-one to care for them. The baby could not suckle up to the 14th day. On the 15th day, the baby could suckle from the breast. On 17th day the baby vomited twice but continued to feed. She was not cold and had a good cry. On 28th day the baby weighed 2.250 kg. You began visiting in the 2nd month and strengthened your efforts to improve the infant's weight. On the 45th day the baby was drowsy and the mother said the baby was cold. The baby's temperature is 94°F (34.4°C) and weighed 2.500 kg. The ASHA diagnoses sepsis.

**What risk factors did the baby have at birth?**

---

**What criteria were used to diagnose sepsis?**

---

**How would you explain the problem to the parents?**

---

What treatment does this baby need, what is the dose and for how many days?

---

Name of the ASHA :	Date :
Name of the trainer :	
Block :	

Total Score

## Worksheet 2: Management of Sepsis

Dhanno delivered at the sub center on November 30th at 8:20 a.m. At the time of delivery she had completed 8 months 5 days of pregnancy. The baby's birth weight was 1 kg 950 grams. The baby was fine for the first 6 days. On the 7th day, when the ASHA visited the baby at home she found the baby had stopped suckling and had a distended abdomen. She was breathing well but her cry was weak. Her weight was 1 kg 900 grams. You diagnose sepsis because the baby had stopped feeding and had a distended abdomen.

### What would you do first?

*Explain to the parents that the baby has sepsis, which is a severe infection. She should be treated in the hospital. If that is not possible for the parents, you (the ASHA) can treat the baby at home with a medicine by mouth. The parents should know that the baby may die even with treatment and the ASHA should not be held responsible.*

### How would you facilitate referral?

*You would ask the parents to go to the nearest PHC and if possible go with the family to the health facility.*

**What is the treatment for this baby (dose and number of days)? If there is a nurse/ANM, they would take the decision, but if there is no other service provider and the parents refuse to go the hospital, then you would need to provide the appropriate treatment?**

*Cotramoxizole ¼ teaspoon twice a day for 10 days (teaspoon should be of 5 ml)*

### How often would you visit?

*Twice a day for 10 days*

### What would you tell the parents about home care?

1. *Keep the baby warm*
  2. *Breastfeed every two hours*
  3. *Review risk signs and call you if the baby gets sicker and prepare for immediate referral.*
2. Vimal's baby was born in the PHC a week after the expected date and weighed 2.900 kg. He was strong and healthy. You helped Vimal start breastfeeding and the



nurse performed the examination of the newborn at one hour. The mother and baby left the PHC after 48 hours. On the 10th day the mother said the baby was cold. The temperature was 93°F (33.9°C). His weight was 3 kg. He was still feeding and crying but he had chest in-drawing. His abdomen was soft and his limbs flexed. His umbilical had healed well. You diagnose sepsis.

**What would you do first?**

*Explain to the parents that the baby has sepsis. Suggest they take the baby to the hospital. If this is not feasible, explain the treatment. Treat them with respect but make sure they are aware of how serious the situation is.*

**What treatment will this baby need?**

*Cotrimoxizole ¼ teaspoon two times daily for 7 days (teaspoon should be of 5 ml)*

*The baby weighs 3 kg and was born full term.*

**What do you tell the parents before you leave?**

1. *Keep the baby warm*
2. *Breastfeed every two hours*
3. *Review risk signs and call you if the baby gets sicker and prepare for immediate referral.*

**How often do you return?**

*Two times a day for 7 days.*

3. Kajubai was pregnant with her fourth baby. The baby delivered at home 7 months 27 days gestation and weighed 1.650 kg. The mother did not want to go to the hospital because there were young children at home and no-one to care for them. The baby could not suckle up to the 14th day. On the 15th day, the baby could suckle from the breast. On 17th day the baby vomited twice but continued to feed. She was not cold and had a good cry. On 28th day the baby weighed 2.250 kg. You began visiting in the 2nd month and strengthened your efforts to improve the infant's weight. On the 45th day the baby was drowsy and the mother said the baby was cold. The baby's temperature is 94°F (34.4°C) and weighed 2.500 kg. The ASHA diagnoses sepsis.

**What risk factors did the baby have at birth?**

*Preterm, LBW, poor suckling*

**What criteria was used to diagnose sepsis?**

*Baby had all limbs limp and was cold*

**How would you explain the problem to the parents?**

Explain to the parents that the baby has sepsis which is a dangerous infection. Emphasize to the parents that they must take baby to the hospital.

**Would you begin treatment before they leave? What is the drug and dosage?**

*Yes, with Cortimoxazole,  $\frac{1}{4}$  tsp. (teaspoon should be of 5 ml)*

## Session 2

# Women's Reproductive Health

### Session 2a: Safe Abortion

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

- Advise on method, based on duration of pregnancy.
- Understand the risks of unsafe abortions, and know where safe abortion services are available in her area.
- Help women in need of such services to access safe abortion services.
- Be able to identify signs of post abortion complications and advise appropriate referral.
- Counsel for appropriate post abortion contraception.

**Methods:** Group discussion, Role play

**Material:** Worksheet

**Duration:** Two hours

### Activities:

**Step 1:** The trainer asks the ASHAs what are common reasons that women in the community seek abortion, the period of pregnancy during which abortion is sought and where abortion is sought. These are listed on a flip chart or blackboard

**Step 2:** The trainer then asks the ASHA to read aloud from pages 35-37, of ASHA Module 7, Part B

**Step 3:** The trainer then asks the ASHA to correlate what they have just learned with the material on the board and identify any incorrect facts and corrects the gaps in knowledge. The trainer must emphasize to the ASHA that women in the community who seek abortion, would often confide in ASHA if she is seen as a friend to them. The ASHA must respect the confidentiality of women who come to them seeking information on abortion related services.

**Step 4:** The trainer then hands out Worksheet 1 and asks the participants to complete it.

Objective	Assessment Method	Output
Assessing knowledge of methods of safe abortion	Worksheet 1	Trainer to collect individual worksheets

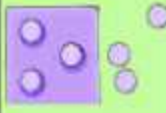




# Safe Abortion




## Methods for Safe Abortion



**Medical Abortion**

- Can be done in less than 7 weeks after LMP
- Under supervision of medical provider



**Manual Vacuum Aspiration**

- Can be done up to 8 weeks of pregnancy
- Woman needs to stay in the health facility for a few hours



**Dilatation and curettage (D and C)**

- Can be done up to 12 weeks of pregnancy
- Is associated with a higher risk of complications

## Post-Abortion Care



**Avoid sex for 5 days post-abortion**



**Drink plenty of fluids**



**Use contraception always**

## Post-Abortion Complications



**Heavy Bleeding**



**High Fever**



**Severe pain in the abdomen**



**Fainting and Confusion**

## ASHA's Role in Safe Abortion



**Counsel women on abortion service**



**Conduct home visits on days 3 & 7 after abortion**



**Provide Information on signs of complications**



**Motivate use of contraception post-abortion**



## Worksheet 1: Safe Abortion

1. Lata is a married woman of 25. She has an eight month old baby and is breastfeeding. She restarted her period when the baby was six months old, i.e. two months ago. She has not got her periods since then. She is worried that she is pregnant and wants an abortion.

What would you do?

What method of abortion is appropriate for her?

What are the reasons for choosing this method?

Which service provider would she go to in your locality?

What are the other methods and why did you not select those other methods?

2. Kusum has three children, and is thirty five years old. Her youngest child is four years old. Her LMP was August 10, 2010. She comes to you on September 18, 2010, saying that she has missed her period? She does not want to have another child.

What will you do?

What method of abortion is appropriate for her?

Why did you choose this method?

List four key messages that you would give her on post abortion care.

Discuss why abortion is not to be used as a method of family planning?

3. Leena is 19 years old, and was married eight months ago. Her husband calls you one day as she is bleeding heavily, and has fever. Leena tells you that since she had missed two periods, and three days ago, she went to an untrained provider for an abortion since she did not want anyone in her house to know.

What is your first response?

What do you think happened to Leena and why?

What should she have done?

What advice would you give her after she returns from the hospital?

Name of the ASHA :	Date :
Name of the trainer :	
Block :	

Total Score

---

**Notes to the trainer:**

For this session the trainer should be familiar with the contents of the section on Safe Abortion in Module 7.

During the visit to the PHC, the trainer should show the ASHAs the MVA kit, the set of instruments used for Dilatation and Curettage (D and C), and use the opportunity to revise the session.

## Answers to Worksheet 1: Safe abortion

2. Lata is a married woman of 25. She has an eight month old baby and is breastfeeding. She restarted her period when the baby was six months old, i.e. two months ago. She has not got her periods since then. She is worried that she is pregnant and wants an abortion. What would you do? What method of abortion is appropriate for her? Why did you choose this method? What are the other methods and why did you not select those other methods?

- *Use Nischay kit to confirm that she is pregnant*
- *Determine weeks of pregnancy (about eight weeks)*
- *Method of choice: MVA*
- *Ask her to go to PHC for a safe abortion*
- *Medical abortion can only be done upto seven weeks, and D and C is a risky procedure.*

3. Kusum has three children, and is thirty five years old. Her youngest child is four years old. Her LMP was August 10, 2010. She comes to you on September 18, 2010, saying that she has missed her period. She does not want to have another child. What will you do? What method of abortion is appropriate for her? Why did you choose this method? When would you visit her after the abortion? List four key messages that you would give her on post abortion care.

- *Use Nischay kit to confirm that she is pregnant*
- *Determine weeks of pregnancy (about six weeks)*
- *Ask her to go to PHC for a safe abortion*
- *Method of choice: Medical Abortion*
- *Medical abortion can be done upto seven weeks, and is a safe method that does not require any surgery. However two visits to the doctor / PHC are required*
- *ASHA should visit her on Days 3 and 7.*
- *Four key messages on post abortion care (page 36, of Module 7)*
- *Abortion is not to be used a method of family planning - all forms of abortion have some side effects and it is best to use a method of family planning to prevent pregnancies.*

4. Leena is 19 years old, and was married eight months ago. Her husband calls you one day as she is bleeding heavily, and has fever. Leena tells you that she had missed two monthly periods. Three days ago, she went to an untrained provider in the next town for an abortion since she did not want anyone in her house to know. What is your first response? What do you think happened to Leena and why? What should she have done? What advice would you give her after she returns from the hospital?
- *Immediately ask the husband to arrange transport to take her to the nearby 24/7 PHC*
  - *Leena did not want a child so early and could not share this with her husband and in-laws she had to get the abortion done in secret, and she did not know who to go to.*
  - *She should have gone to a PHC where she could have had a safe abortion using an MVA.*
  - *Counsel Leena and her husband to delay pregnancy for six months at least, to give her body time to heal. You should counsel the use of condoms or oral pills, and a check up by the doctor in the PHC.*



## Session 2b: Family Planning

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

- Develop line lists of eligible couples for identification and follow up
- Understand the side-effects of the methods so as to counsel the woman to continue with the method or seek appropriate assistance.
- Assess which methods are suitable for couples/individuals based on their marital status, number of children, child bearing intentions, and the mother's health status, and counsel for method use based on informed choice.
- Counsel for delay in age of marriage, delay in age of first child bearing and in child spacing.
- Provide contraceptive services like: (i) Condoms, (ii) Emergency Contraceptive Pills (ECP), and (iii) Re-supply of Oral Contraceptive Pills (OCP), and maintain sufficient stocks and client records.
- Provide information on where, when and how to access other methods (sterilisation, Intra Uterine Contraceptive Device (IUCD), starting the use of OCP) and provide information on compensation for sterilisation and IUCD services and family planning insurance scheme.
- Assist ANM in follow-up of contraceptive users.
- Identify side-effects and user problems in contraceptive users and counsel and refer appropriately.
- Help couples and women from

marginalized and poor families to access contraception.

**Methods:** Group discussions, Role plays, Worksheet

**Material:** Samples of Copper T, Oral Pills, Emergency Pills, Condoms,

**Duration:** Four hours

### Activities:

For this session, the trainer should be familiar with the contents of Module 7, pages 38-43, and the Notes to the Trainer given in this manual.

**Step 1:** The trainer asks the ASHA what the commonly used methods of family planning in their community are and which are the various categories of women that they think require family planning.

The trainer asks participants what are the key constraints women face in accessing family planning methods.

These are written up on the blackboard.

**Step 2:** The trainer then lists the major categories of women that are in need of family planning and states why it is important to address them. (Notes to the Trainer). Other questions for discussion are:

- How many marriages are held in your village within one marriage season?
- Is it easy to visit and advice young brides to be?
- What all will you advice young and newly married brides and grooms about?
- Is the onus of family planning on the woman only?

**Step 3:** The trainer then discusses with the group how they would identify and list women in the community that belong in any of these categories. The ASHA are asked to do this as an exercise for their community practice, after the training round before the fourth round of training.

**Step 4:** The trainer then asks the ASHA to read aloud, in turns, pages 38-43. Since there is a lot of information in this chapter the trainer, interrupts the reading as each section is completed and reviews and repeats the key points in the section. The key sections are:

- Women's needs for family planning,
- The Pill,
- Emergency Contraceptive Pills,
- Condoms,
- Intrauterine Contraceptive device,
- Sterilization, (male and female),

Under each head the trainer reviews the side effects, indications for use of the method, availability of method at various service levels.

**Step 5:** The trainer now splits the participants into four groups. Each group is asked to perform a short role

play of ten to fifteen minutes with each demonstrating the interaction between ASHA the woman, (and spouse and family) in a particular situation. The four situations are:

- Newly married woman (aged 19 years)
- A woman who had her first baby about four weeks ago
- A mother of three children who does not want any more children
- Unmarried girl asking for contraception

The rest of the participants should observe the group performing the role play and provide feedback on : ability to provide information on choices available to each category, counsel the woman (using the skills learnt in past training Rounds), give correct information on side effects, where to obtain the method from who should provide the method, and follow up. The participants should be encouraged to use the chapter on Family Planning in Module 7 while observing and giving feedback. The trainer then provides feedback to each group. The groups enacting the role plays should be encouraged to bring into the play the potential challenges encountered when a woman seeks a method.



### Evaluation of the session

Objective	Assessment Method	Output
Assessing knowledge of methods of family planning	Group discussion	Trainer to provide feedback



## Notes to the Trainer:

Family Planning is one of the oldest programmes in India. Most ASHAs would be very familiar with methods of family planning like female sterilization, Copper T, condoms and pills, and to a lesser extent male sterilization. Some of them would also have an understanding of methods such as Injectables and Emergency Contraception. The trainer should use this session to provide ASHA with an understanding of the importance of family planning for the health of the mother and child and also what methods are most appropriate at various stages of a woman's reproductive life.

Family planning is important for many reasons: to protect women's health from early and frequent childbearing, to help couples decide the interval between marriage and the first childbirth, and finally to decide the interval or space between successive children to ensure the survival and health of the children and the health of the mother.

In India family planning is often considered only after the woman has had all the children she wants. Counseling couples who are about to be married and those who are newly wed for family planning is important so that they are aware of the risks of childbirth (where the woman is less than 21 years of age), and to the importance of ensuring that the couple has time to get to know each other well enough to become parents.

### How Can Family Planning Save Mothers?

- By adopting family planning methods, women can protect themselves from unplanned pregnancies and their consequences, e.g., abortion and its possible complications.
- Family planning can prevent high-risk pregnancies and protect women from serious complications which they may have to face due to pregnancy when they are too young, too old, and with too many pregnancies and/or pregnancies with less than two years interval.

### How Can Family Planning Save Infants?

Spacing of births by at least two years could prevent at least 50 percent of infant deaths.

By adopting family planning, women can ensure at least a two year interval between births and ensure proper health, nutrition and well being for the baby and for herself.

### Principles of family planning:

The woman has the right to choose a contraceptive method, without any pressure or coercion from the service provider. The woman must be enabled to make a decision of which method to choose. She should be informed about all the methods available, how they work, their advantages, disadvantages, common side effects and effectiveness, correct use, health risks, warning signs and symptoms, information on return to fertility once the method is stopped, the extent to which it protects from STIs, including HIV/AIDS, so as to be fully informed before making a choice.



### Session 3c: Reproductive Tract Infections and Sexually Transmitted Diseases

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

- Understand RTI/STI and HIV/AIDS; prevention, management and treatment.
- Counsel women on protection from RTI/STI and HIV/AIDS.
- Guide women to appropriate facilities for testing and treatment.

**Methods:** Group Discussion, Worksheet

**Duration:** Two hours

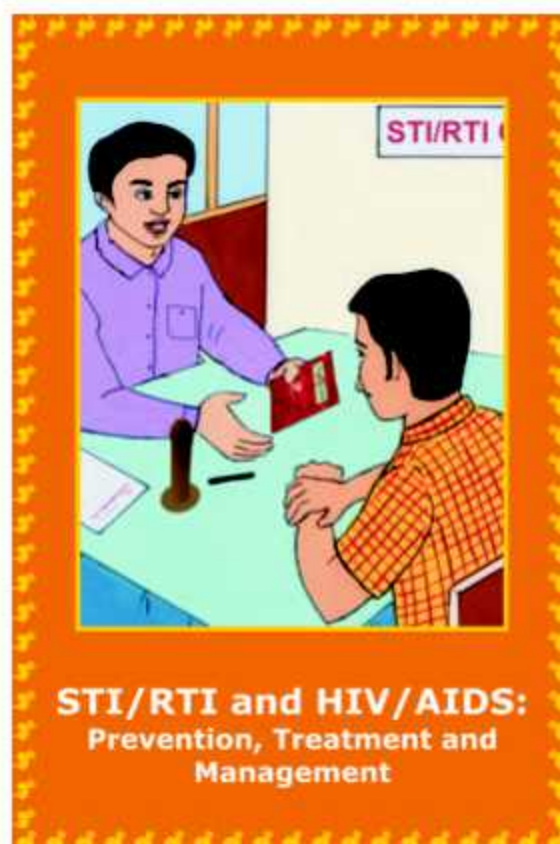
### Activities:

**Step 1:** The trainer asks ASHA to differentiate between white discharge that is normal and abnormal. The participants list those qualities of discharge which are the result of disease. The trainer lists these on the board.

**Step 2:** The trainer then asks the group to distinguish between RTI, STI, and HIV/AIDS and guides the discussion by using the blackboard to record their responses and then correcting the responses if required.

**Step 3:** The trainer then asks the ASHA to read aloud from Module 7, pages 44-46

**Step 4:** The trainer hands out the worksheet and asks ASHA to fill it in individually.



## Worksheet 1: Prevention and Management of RTI/STI

1. Swarna comes to you one day and complains that she is having abdominal pain and also an itchy feeling in the genital area. She has a discharge which is greenish yellow, and foul smelling. Her husband is a migrant labourer. What advice would you give her?
2. Neetha is a married woman, 21 years old. She has a two year old daughter. Her husband is a school teacher. She comes to you with a complaint of white discharge, but with no other symptoms. What would you ask her? What is the diagnosis?
3. Sarala is 35 years old, and has three children. She has had a sterilization operation five years ago. Her husband is an alcoholic and often stays away from home. She complains of foul smelling discharge with itching in her genitalia and burning urination. She says this is the third time she has had such a condition. What would you advise her to do? What methods of local relief would you advise?

<b>Name of the ASHA :</b>	<b>Date :</b>
<b>Name of the trainer :</b>	
<b>Block :</b>	

**Total Score**

## Answers to worksheet 1: Prevention and management of RTI and STI

1. Swarna comes to you one day and complains that she is having abdominal pain and also an itchy feeling in the genital area. She has a discharge which is greenish yellow, and foul smelling. Her husband is a migrant labourer. What advice would you give her?
  - Advise her to go to the PHC since she may have an STD.
  - Ask her to ensure that her husband should also take the treatment which is given to her
  - Ask her to complete the treatment and not stop the medication
  - Ask her to ensure that she uses a condom for every sexual encounter and not have unprotected sex
2. Neetha is a married woman, 21 years old. She has a two year old daughter. Her husband is a school teacher. She comes to you with a complaint of white discharge, but with no other symptoms. What would you ask her? What is the diagnosis?
  - Ask for the colour of the discharge?
  - Ask if there are other symptoms such as burning, itching,
  - Ask if there is a rash or swelling, or lower abdominal pain
  - Since she has no other symptoms, this is most likely normal white discharge, but you should ask her to visit the PHC to get an internal examination done.
3. Sarala is 35 years old, and has three children. She has had a sterilization operation five years ago. Her husband is an alcoholic and often stays away from home. She complains of foul smelling discharge with itching in her genitalia and burning urination. She says this is the third time she has had such a condition. What would you advise her to do? What methods of local relief would you advise?
  - Advise her to go to the PHC and if possible take her husband with her.
  - Advise her to negotiate with her husband to avoid unprotected sex.
  - For local relief advise her on steps she can take at home:
    - Sit in a pan of clean, warm water for 15 minutes. Add lemon juice to the water.
    - Do not have sex until she feels better.
    - Try to wear cotton next to the skin.
    - Wash undergarments every day.
    - Pour clean water on genitals after passing urine.



## Worksheet 2: Quiz on HIV/AIDS

**1. HIV is transmitted through all except:**

- a. From mother to baby
- b. From infected needles
- c. Through unprotected sexual intercourse
- d. Through sharing the same utensils

**2. None of the following can transmit HIV except:**

- a. Kissing
- b. Mosquito bites
- c. Sharing clothes
- d. Mother to baby

**3. Which of the following are at higher risk of getting HIV:**

- a. Truck drivers
- b. Commercial sex workers
- c. Men who have sex with men
- d. Migrant labourers
- e. All of the above

**4. HIV can be prevented by all except:**

- a. Using a condom during sexual intercourse
- b. Avoiding sex with multiple partners
- c. Using sterile needles
- d. Preventing mosquito bites
- e. Ensuring safe blood for transfusion

**5. True or False:**

- a. Persons with HIV are not at greater risk of getting TB
- b. Women whose husbands have multiple sexual partners are at higher risk of getting HIV
- c. Babies born to mothers who are HIV + are at higher risk
- d. Men who have sex with men are not at risk of getting infected with HIV
- e. The test for HIV is available at the district hospital.





## Worksheet 2: Responses to HIV/AIDS Quiz

1. d
2. d
3. e
4. d
5.
  - a. False
  - b. True
  - c. True
  - d. False
  - e. True

## Session 3

# Infectious Diseases

## MALARIA

Total Duration- 3 hours 30 minutes

### Session 3a: Knowing about malaria

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

- Understand what causes malaria, and how it spreads
- Be able to identify the signs and symptoms of malaria

**Methods:** Presentation, group work, demonstration

**Materials:** Chart/board, poster blood slides, lancet, cotton wool, spirit, RDT kits.

**Duration:** 30 minutes

### Activities:

**Step 1 :** Ask the ASHAs "What is malaria? How is it caused?" Write the responses on the board. Trainer explains and discusses the correct answer. The Trainer also explains the two types of malaria.

**Step 2:** Ask the ASHAs what are the symptoms of malaria and how to suspect malaria. Write the responses on the board. Trainer explains and discusses the correct answer. The trainer also discusses ways to confirm malaria. Explain the difference between diagnosis through blood slides and rapid diagnostic tests.

**Step 3:** The trainer then asks who are more susceptible/likely to get malaria and discusses as to why they are more susceptible. Discuss in the context of nutrition, pregnancy and children.

Let the trainees read out pages 59 and 60 till the part 'How to confirm'. Ask the trainees if they have any questions. Clarify and discuss those.

Objective	Assessment Method	Output
Explain how is malaria caused and who are at risk	Questions and answers	

### Notes for the Trainers:

First it is important for the Trainers to understand how much the ASHAs

know about causes, symptoms and signs of malaria in order to understand the common perceptions regarding malaria. Be sure to engage them in discussions.

## Session 3 b: Treating Malaria

**Aim:** By the end of the session, the ASHAs will

- Learn how to treat malaria
- Learn how to bring down fever of the patient

**Methods:** Presentation, discussion, demonstration

**Materials:** Poster with treatment guideline, full dosages of Chloroquine, Primaquine and ACT.

**Duration:** 30 minutes

### Activities:

**Step 1:** Make a 15 minute presentation on the how to treat malaria using power point or posters. Introduce the 3 kinds of medicines (Chloroquine, Primaquine and ACT) and discuss when to give which one. Present the treatment guidelines in a chart and go through in detail the Age-wise guidelines for Chloroquine, Primaquine and ACT. Show the actual drugs/blister packs. Also discuss how to bring down fever and the importance of taking full dose of

medicine for three days. Explain and show how to do sponging and why. Let the trainees read out Annexure 7 showing the treatment guidelines.

**Step 2:** Ask questions on dosages for different age groups and drugs. Let the trainees volunteer to give answer and make them take out the dose in their hand and give it to you. For example:

- I am 6 years old, and I have fever with chills. I have tested negative through RDT. What drugs will you give me and what advise?
- I am 13 years old and tested positive through RDT. What drugs will you give me and what advise?
- I am 32 years old and have fever with chills. No tests are available. What drugs will you give me and what advise?
- I am a pregnant woman with symptoms of malaria. What drugs will you give me and what advise?
- I am 3 years old with symptoms of malaria and very high fever. What drugs will you give me and what advise?

After this, once again make the trainees repeat the treatment guidelines together as given in Annexure 7.

Objective	Assessment Method	Output of the session
Explain the treatment guideline for malaria	Questions and answers	

### Notes for the Trainer:

After this session the trainees should also be able to answer the following questions:

- What to do in case of a pregnant woman?
- Why is it necessary to take full course of the drugs?
- How to give ACT to children



## **Session 3c : Key Skills in diagnosis of malaria**

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

- Be able to make blood slides
- Be able to perform rapid diagnostic test

### **Skill 1 Learning the skill of making a blood slide**

**Methods:** Demonstration, practice

**Material:** Photocopies of Worksheet Skills checklist, Blood slides, disposable lancet, cotton, and spirit or cotton swab for cleaning the finger, lead pencil.

**Duration:** 45 minutes

### **Activities**

**Step 1:** Hold up all the items one by one and ask the ASHAs to identify them. Discuss how each one of the items will be used.

**Step 2:** Ask for two volunteers. Ask one ASHA to read out step by step from Annexure 4. Demonstrate each step as she reads it, with the other ASHA. Now ask the volunteer to repeat the steps with the trainer. You can call a few more trainees to demonstrate in front of the whole group. Ask the trainees whether anyone has any questions. Discuss.

**Step 3:** Divide the trainees into pairs. Have each ASHA practice making a blood slide while the partner follows along with the checklist and records

on the Worksheet skills checklist. Trainers have to go to each pair and check whether each trainee is able to make the blood slide correctly. Make each ASHA make at least two blood slides.

### **Notes for the Trainer:**

Please ensure that there are enough numbers of Blood slides and lancet for each ASHA to practice at least twice. While showing the demonstration, ensure that it is visible to all trainees. Please remember that this may be the first time that the trainees have had to prick a person and take out drops of blood. There may be some reluctance to do so. In order to overcome this, it would be necessary to give some encouragement and instill confidence. You have to ensure that at the end of the session that each trainee is able to make a blood slide correctly.

### **Skill checklist: Making blood slide for malaria**

- i. Record the details of the patient in the appropriate form.
- ii. Select the second or third finger on the left hand and clean it with spirit and cotton swab.
- iii. The site of the puncture is the side of the ball of the finger, not too close to the nail bed. Puncture with the lancet.
- iv. Allow the blood to come up automatically. Do not squeeze the finger.

- v. Take a clean slide and hold the slide by its edges. Note that the size of the blood drop is controlled better if the finger touches the slide from below. Touch the drop of blood with the clean slide and collect three drops for preparing the thick smear.
- vi. Touch another drop of blood with the edge of another clean slide for preparing the thin smear.
- vii. Spread with corner of another slide, the three drops of blood in a circle or square of about 1cm, to make the thick smear.
- viii. Bring the edge of the slide carrying the second drop of blood to the surface of the first slide, wait until the blood spreads along the whole edge. Holding it at an angle of about 45 degrees push it forward with rapid but not too brisk movement.
- ix. Write with a pencil the slide number on the thin film. Wait until the thick film dries before handling or transporting it.

### Remember

- The blood should not be excessively stirred. Spread gently in circular or rectangular for with 3 to 6 movements.
- The circular thick film should be about 1cm (1/5 inch) in diameter.
- Allow the thick film to dry with the slide in the flat, level position protected from flies, dust and extensive heat.
- Label the dry thin film with a soft lead pencil by writing on the thinner film the blood slide number and date of collection.
- Dispose off the lancet and cotton swab

## Worksheet 1: Skills checklist of making blood slide

SN	Skill	Tick if done correctly
1	Records details of patient	
2	Selects correct finger and cleans it	
3	Punctures correctly	
4	Touches the drop of blood with a clean slide and collects three drops of blood for the thick film	
5	Touches the edge of a new slide with a drop of blood	
6	Makes the thick smear	
7	Makes the thin smear	
8	Writes the slide number and date of collection on the thin smear and waits for the thick smear to dry	
9	Dispose off the lancet and swab	

## **Skill 2: Learning the skill of performing rapid diagnostic test**

**Methods:** Demonstration, practice

**Material:** Photocopies of Annexure 5, spirit, cotton swab, disposable lancet, Capillary tube, test strip, multiple well plastic plate, test tube, buffer solution or reagent solution, desiccant.

**Duration:** 45 minutes

**Step 1:** Hold up all the items one by one and ask the ASHAs to identify them. Discuss how each one of the items will be used.

**Step 2:** Ask for two volunteers. Ask one ASHA to read out step by step from Annexure 5. Demonstrate each step as she reads it, with the other ASHA. Now ask the volunteer to repeat the steps with the trainer. You can call a few more trainees to demonstrate in front of the whole group.

Ask the trainees whether anyone has any questions. Discuss if any.

**Step 3:** Divide the trainees into pairs. Have each ASHA perform a rapid diagnostic test on the partner who follows along with the checklist and records on the Worksheet skills checklist. Trainers have to go to each pair and check whether each trainee is able to perform the test correctly. Make each ASHA do the test at least twice.

### **Notes to the trainer:**

Please ensure that there is enough material for each ASHA to practice on at least twice and for demonstration. While showing the demonstration, ensure that it is visible to all trainees. You have to ensure that at the end of the session that each trainee is able to perform the test correctly and dispose off the materials properly.



## **Skill checklist: Performing rapid diagnostic test**

Refer to Annexure : Performing Rapid Diagnostic Test on page 78 of Module 7

## Worksheet 1: Skills checklist of performing rapid diagnostic test

SN	Skill	Tick if done correctly
1	Check expiry date on the kit	
2	Read instructions on the kit	
3	Test desiccant is blue	
4	Take out and keep ready all the materials to be required	
5	Clean finger	
6	Prick with lancet	
7	Get drop of blood to come up in the tube/loop	
8	Place the blood on the test strip in the correctly	
9	Pour 4 drops of buffer solution in test tube and place the test strip properly in it	
10	Read result correctly after 15-20 minutes	
11	Properly dispose off all materials used	

Objective	Assessment Method	Output
Make a blood slide	Practical work in pairs	Trainer to collect worksheet filled on skills checklist and discuss
Perform rapid diagnostic test	Practical work in pairs	Trainer to collect worksheet filled on skills checklist and discuss

## Session 3 d: Prevention of Malaria

**Aim:** At the end of the session, ASHAs will

- Understand how to prevent malaria
- Be able to identify possible breeding sources for mosquitoes
- Be able to plan for controlling mosquitoes in the village

**Method:** Discussion, Group work

**Materials:** empty sheets of paper and pen

**Duration:** 1 hour

**Step 1:** Ask the trainees “Where do mosquitoes breed?” Take the responses. Emphasize on the fact that they breed in clean water and not dirty water. Present the two ways of controlling malaria- by not allowing mosquitoes to multiply and not allowing them to bite.

**Step 2:** Explain the utility of bed nets, especially for children and pregnant women and discuss what may be the barriers to the use of bed nets. Discuss how the ASHA can counsel families on the use of bed nets, especially for pregnant women and children. Introduce the concept of impregnated bed nets and discuss its availability.

**Step 3:** Ask the ASHAs to read out pages 60 to 62.

**Step 4:** Making a village level malaria plan: Divide the trainees into groups of five and send them for 20 minutes, in different directions of the village with the task to count and write down the number of places they find stagnant water and discuss action to be taken to correct it. Refer to ‘Ways of controlling malaria’ on page 61. Once they return, let them present what they saw, describing the area of stagnant water (whether it was a pond, rock pool, broken matka/pot in a courtyard, area around the handpump). They also have to say what corrective measures could be taken to reduce mosquitoes in that area.

For this exercise it will be useful also to call and involve the ANM, Panchayat members and members of women’s group in the village.

After all the presentations, summarize and discuss how to make a village level malaria plan. Discuss the role of ASHA, VHSCs, Panchayats, home visits and counseling, village meetings, awareness about malaria, information about drugs with ASHA etc.



## Malaria Prevention and Treatment: An ASHA's Role



Creating awareness in the community about prevention and treatment of malaria, during house visits and village meetings.



Supporting the Village Health and Sanitation Committee and other village groups in taking measures for malaria prevention, such as spraying insecticide, preventing water stagnation and enabling cultivation of Gambusia fish in ponds and wells.



Persuading people with suspected malarial fever to get themselves tested at the health centre.



Screening those who are unable to go to the health centre for malaria, using RDT and blood slides; and sending negative slides to the laboratory.



Treating those who test positive for malaria, with chloroquine or ACT drugs, followed by primaquine for radical treatment.



Maintaining appropriate records and registers, and ensuring that blood slides are properly transported to the laboratory.



Ensuring that a pregnant woman in a high malaria area uses an insecticide treated mosquito net during pregnancy, and also after delivery for herself and the baby.



Referring a pregnant woman with fever and chills immediately to a doctor, and starting appropriate treatment if there is any delay in doing so.



Objective	Assessment Method	Output
Explain the methods for prevention of malaria	Questions and answers	
Form a village malaria plan	Group work on village malaria plan	Trainer to collect presentations of group work and discuss

### Notes to the Trainers:

In the plan be sure to include-

- Identification of all possible breeding sites in the vicinity of the village
- Action on controlling breeding of mosquitoes
- Action on personal protection, including availability of bed nets, mosquito repellent
- Availability of medicines and materials for diagnosis for malaria with ASHA
- Availability of referral transport for severe cases
- Person/s responsible for each activity

# TUBERCULOSIS

## Session 3e : Understanding on Tuberculosis and role of ASHA

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

- Understand what TB is and how it spreads
- Learn to identify possible cases of TB
- Learn what DOTS is
- Learn the possible side effects of TB drugs and action to be taken
- Learn how TB may be prevented
- Understand ASHA's role in TB diagnosis, treatment, prevention and management

**Methods:** Presentation, group work, demonstration

**Materials:** Chart/board, DOTS drugs, sketch pens and charts for presentation

**Duration:** 2 hours 30 minutes

### Activities:

**Step 1:** Trainer makes a presentation of 10 minutes on what is TB, how it is spread and what are its symptoms. Explain how to identify possible cases of TB.

Discuss who all are at risk of getting the disease and dying of the disease. Remember to discuss in relation to malnutrition, living conditions,

poverty and access to health services.

**Step 2:** Trainer makes a brief presentation on how TB is diagnosed (how many times sputum is tested and time period). Ask the trainees about problems faced by people in going for diagnosis. Discuss issues in access to health facility, awareness about TB, differential access of men and women to TB diagnosis, and cost involved. Discuss how the ASHA can help to resolve the problems.

**Step 3:** Present what is DOTS and show the trainees the DOTS drugs. Explain what may be some of the side effects of common TB drugs. Also present what action ASHA should take if a patient shows any of the side effects. Make the trainees read out Annexure 8.

Let the trainees read aloud pages 63 and 64. Ask the trainees if they have any questions. Clarify and discuss them.

**Step 4:** Group work: Divide the trainees into groups of five each and tell them to read out pages 65 and 66 together. Give each group the task to discuss regarding what the role of ASHAs should be in diagnosis, treatment, prevention and management of TB. Let them present and discuss with relation to what is written in the book. Read pages 65 and 66 again together.



## Tuberculosis Treatment and Management: An ASHA's Role



Educating the community about measures for tuberculosis prevention and treatment, including the importance of a nutritious diet, personal hygiene, and the need for prompt and complete treatment



Serving as the DOTS provider in the village



Motivating tuberculosis patients to take appropriate and complete treatment



Helping patients access drugs from the health facility and deal with any side effects



Encouraging patients to take adequate rest and a nourishing diet during the course of treatment



Counselling patients and their families about the precautions to be taken to prevent the spread of TB in the family



Monitoring health of patients' family members and ensuring prompt referral if any signs of TB are observed



Ensuring that all newborns are immunised in time



Informing the health facility about any previous treatment taken by a patient who has a relapse



Counselling women about the need to take contraceptive measures during the course of treatment, and advising them on what methods would be appropriate

Objective	Assessment Method	Output
Explain the side effects of TB drugs and action to be taken	Questions and answers	
Explain role of ASHA in TB	Group work on role of ASHA	Trainer to collect presentations of group work and discuss

### Notes to the trainer:

It is expected that the trainer will discuss the way TB is considered a

social stigma and the ASHA's role in changing this perception. Also, the ASHAs should clearly understand the precautions to be taken for pregnant women.